Blackpool Council

2 October 2018

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 10 October 2018 at 3.00 pm
in Committee Room A, Town Hall, Blackpool

A G E N D A

1 DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned either a

(a) personal interest
(b) prejudicial interest
(c) disclosable pecuniary interest (DPI)

and

(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Governance in advance of the meeting.

2 MINUTES OF THE LAST MEETING HELD ON 20 JUNE 2018 (Pages 1 - 6)

To agree the minutes of the last meeting held on 20 June 2018 as a true and correct record.

3 BLACKPOOL BETTER CARE FUND UPDATE (Pages 7 - 58)

To provide the Board with an update on the details of the Blackpool Better Care Fund (BCF) 2018-19.

4 PUBLIC HEALTH ANNUAL REPORT 2017 (Pages 59 - 90)

To present "From the Ground Up: Annual report on the health of the people of Blackpool 2017" the Director of Public Health's latest annual independent assessment of local health needs, determinants and concerns.

5 GREEN AND BLUE INFRASTRUCTURE STRATEGY PRESENTATION (Pages 91 - 94)

To consult members of the Health and Wellbeing Board on the draft Green and Blue Infrastructure Strategy for Blackpool.

6 DATE OF NEXT MEETING

To note the date of next meeting as the 5 December 2018.

Venue information:

First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:

For queries regarding this agenda please contact Lennox Beattie, Executive and Regulatory Manager, Tel: 01253 477157, e-mail lennox.beattie@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 20 JUNE 2018

Present:

Councillor Cain, Cabinet Secretary (Resilient Communities) (in the Chair)
Councillor Clapham, Conservative Group Member

Dr Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning Group
Roy Fisher, Chairman, Blackpool Clinical Commissioning Group

Jerry Cragg, Area Group Manager, Lancashire Fire and Rescue Service

Tracy Hopkins, Blackpool Citizens Advice Bureau, Third Sector Representative

Dr Arif Rajpura, Director of Public Health, Blackpool Council
Karen Smith, Director of Adult Services, Blackpool Council

In Attendance:
Lennox Beattie, Executive and Regulatory Support Manager, Blackpool Council
Matthew Burrow, Head of Corporate Assurance, Blackpool, Fylde and Wyre Hospital Trust
Nicky Dennison, Senior Public Health Practitioner, Blackpool Council
Lynn Donkin, Consultant in Public Health, Blackpool Council
Andrew Foot, Head of Housing, Blackpool Council
Claire Grant, Divisional Commissioning Manager, Blackpool Council
Dawn Haworth, Senior Programme Manager, Midlands and Lancashire NHS Commissioning Support Unit
Liz Petch, Public Health Specialist, Blackpool Council
Ian Treasure, Partnership Manager, Blackpool Fulfilling Lives

Apologies:

Diane Booth, Director of Children's Services, Blackpool Council
Jane Cass, Head of Public Health, NHS England (Lancashire and South Cumbria)
Dr Leanne Rudnick, GP Member, Blackpool Clinical Commissioning Group

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 22 MARCH 2018

The Board considered the minutes of the last meeting held on the 22 March 2018.

Resolved:

That the minutes of the meeting held on 22 March 2018 be approved and signed by the Chairman as a correct record.

3 INTEGRATED COMMISSIONING GROUP

The Board considered a report on the Integrated Commissioning Group and its future. It noted that the group had been created as a formally constituted sub-group but had not met in that format since the 30 November 2017. The minutes of the meeting were attached with the agenda and the Board noted that they duplicated discussions that had taken place at other meetings. The Board noted that informal discussions between the members of the group regularly took place.

The Board agreed that it was unnecessary to continue with formal reporting structures when it appeared that the meeting's formal status had now become superfluous. It was also noted that the areas of responsibility would revert back to the Health and Wellbeing Board.

Resolved:

1. To note the minutes of the last meeting on 30 November 2017 as attached at Appendix 3a to the agenda.

2. To agree that the Integrated Commissioning Group no longer acts as a formally constituted sub-group to the Health and Wellbeing Board.

4 HEALTH PROTECTION FORUM UPDATE

Mrs L Donkin, Consultant in Public Health, presented the report of the Health Protection Forum for the period April 2017 to April 2018.

Mrs Donkin highlighted in terms of infectious diseases the issue of measles and the increase in serious cases including deaths in continental Europe. The need to address groups of people who were frequent visitors to locations where outbreaks had occurred and equally to ensure that all children had received the MMR vaccine was highlighted.

Mrs Donkin and Dr Rajpura reported on seasonal flu vaccination commenting on the existing good practice within some large employers, the need to begin the implementation of arrangements for the forthcoming winter imminently and the need to share what worked for those organisations with the best vaccination rates.

The level of healthcare acquired infections in Blackpool was also highlighted and it was noted that these were in line with national figures. However the need to avoid complacency and ensure that the response to this issue remained strong was also emphasised.

Resolved:

To receive the Health Protection Forum report for the period April 2017-April 2018.

5 FYLDE COAST SELF-CARE STRATEGY 2017-2020

Ms Liz Petch, Specialist in Public Health, presented to the Board for approval the Fylde Coast Self-Care Strategy. Ms Petch explained to Board members that the creation of the Fylde Coast New Models of Care and its aim to transform the delivery of health and care had at its centre a key workstream of self-care.

Ms Petch highlighted that improvements in healthcare needed to be underpinned by how people themselves protected their own health, made healthy lifestyle choices and chose appropriate treatment options in order to manage incidents of ill-health and long-term conditions. The strategy's fundamental aim was one of empowering individuals to have the confidence, knowledge, resources and support to self-care and awareness of when to contact services for additional support.

Ms Petch emphasised that as outlined in the report, the strategy aimed to build on the strengths that already existed in the community, aimed to ensure people and communities (which includes the workforce) would be equal partners in changing behaviours, building resilience and providing mutual support, and would put the community at the heart of the New Models of Care transformation agenda.

The strategy had been the result of significant period of consultation, had been developed through a multiagency approach and attempted to address the contagion of self-care. The implementation of the strategy would be driven by a Development Group and the Board expressed a keenness for as many partners as possible to become involved in that group.

Resolved:

1. To approve the Fylde Coast Self-Care Strategy 2017- 2020.

2. To note the aims and ambitions for action against the strategy.

3. To inform any partners interested in getting involved in actions to deliver the strategy join the Self Care Strategy Development Group – next meeting Friday 22 June 2018 at 1pm.

6 BLACKPOOL FULFILLING LIVES - HELPING ADULTS WHO HAVE MULTIPLE COMPLEX NEEDS

The Health and Wellbeing Board received a presentation on the work of the Blackpool Fulfilling Lives from Mr Ian Treasure, Partnership Manager, Blackpool Fulfilling Lives. Mr Treasure was accompanied by John, a service user, and by Nicola Plum, one of the navigators, who also provided the Board with their experience

Blackpool Fulfilling Lives (BFL) had received Big Lottery Fund funding for a seven year pilot project to support people with multiple and complex needs. Mr Treasure explained multiple-complex needs had been defined as those affected by two or more of homelessness, offending, problematic substance use (including alcohol) and mental ill health. Mr Treasure highlighted that at the core of the offer had been the use of

navigators with a small caseload and the emphasis on recruiting navigators with lived experience of the issue to break down potential and actual barriers. The focus would then be on the strategic outcomes of improved lives for service users, a coordinated approach and empowerment of Service Users. Mr Treasure further explained that evaluation formed a key part of the lottery project at national and local level and he highlighted the recent positive evaluation report which had been made available to members.

It was noted that to date the programme had worked directly with 366 beneficiaries in Blackpool. All beneficiaries had a combination of multiple and complex needs including homelessness, problematic substance misuse, re-offending behaviour and mental ill health and a past history of not engaging with services.

Members of the Board asked questions and Mr Treasure explained that at the cessation of the Lottery funding it was intended that the robust evidence base could be used to direct future resources and it was hoped that the involvement of staff who had lived experience would better inform the future direction of service provision.

Resolved:

1. To note the presentation on the work of Blackpool Fulfilling Lives.

2. To note the work being undertaken by the Blackpool Fulfilling Lives Strategic Board to cause systemic change in Blackpool for people with Multiple Complex Needs.

3. To agree to receive an update on the project every 12 months.

7 LANCASHIRE CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH TRANSFORMATION PROGRAMME- UPDATE

The Health and Wellbeing Board received an update on the Lancashire Children and Young People's Emotional Wellbeing and Mental Health Transformation Programme from Ms Claire Grant, Divisional Commissioning Manager, and Ms Dawn Haworth, Senior Programme Manager, Midlands and Lancashire NHS Commissioning Support Unit.

The presentation began with outlining how the Transformation Programme had made significant progress on improvements, after just 2 years of operation of the 5 year period of the plan. Emphasis was given to the nationally set access targets of children and young people with an Eating Disorder to be able to access support in the community within 1 week if urgent and 4 weeks if routine, and of 35% of children and young people with diagnosable mental health conditions to have received support from NHS mental health services. Ms Haworth explained that locally 11,461 children and young people had accessed NHS funded mental health services in 2017/18 which represented 7% above the national target.

Ms Dawn Haworth explained the need for a refreshed Transformation Plan and need for a fundamental redesign of CAMHS services to improve access and reduce variation across the area. In common with many areas, it had appeared clear that for many young people clinical services would not be appropriate for their needs and that access could more reasonably in the form of services provided by local authorities, schools or the voluntary and community sector. This had led to the creation of the THRIVE model moving away

from the tiered approach to one that is integrated, person centred, goal focussed and evidence informed. The aim being to deliver services in four key ways; getting advice (signposting, self-management and one-off contacts), getting help (goals focused interventions), getting more help (intensive treatment services) and getting risk support (crisis response and risk management). The intention had been confirmed as to ensure that all partners collaborated to provide children and young people's mental health services in line with the THRIVE model.

Resolved:

1. To note the current strategic context.

2. To note the progress made in delivering against the Transformation Plan and note the publication of the refreshed Transformation Plan.

3. To note the challenges that the programme is facing, in particular variations in access, waiting times and investment levels.

4. To note the update on the CAMHS Redesign project.

8 HOUSING AND HOMELESSNESS STRATEGIES

The Board received a presentation from Mr Andrew Foot, Head of Housing, Blackpool Council. Mr Foot reminded members that addressing the quality and range of housing was Priority One in the Health and Wellbeing Strategy 2016 and the latest annual report from the Director of Public Health had drawn attention to the links between poor housing, transience and lifestyle-related illnesses, and on the impact of high levels of homelessness. Mr Foot linked his presentation to that given by Fulfilling Lives at Agenda Item 6 and emphasised that services to prevent and respond to homelessness had managed to increase the number of cases where there ~~is~~ was successful prevention work and slightly reduce the overall number of people ending up homeless, but there had been at the same time been an increase in the number of individuals found rough sleeping and cases had typically become more complex in nature.

He highlighted to members the steps taken to address the objectives by the Council in the approval of its new Housing Strategy**,** the Homelessness Prevention Strategy and the implementation of the Housing Plan for an Ageing Population previously approved in 2017.

Mr Foot highlighted the work undertaken by Blackpool Housing Company to improve the private sector rented offer and by the Council in building new houses at Foxhall Village and Queens Park. It was also noted that the Executive meeting on the 18 June 2018 had approved a scheme to deliver supported housing for those with learning disability alongside new Council houses. Mr Foot however highlighted that government funding was becoming increasingly difficult to access as it had been directed towards those areas with affordability issues.

Mr Foot completed his presentation by outlining that it remained difficult to progress new work on some of these issues, with all partners struggling to find sufficient capacity and expertise to initiate new approaches. The Health and Wellbeing Board was then asked to confirm support for joint work on the key housing issues set out in the report and Board members were requested to ask their organisations to consider in detail how the necessary staff and financial resources could be made available.

Resolved:

To confirm the Board's support for joint work to address the key housing issues set out in 5.6 of the report namely:

- How to Better match the provision of support around mental health and substance misuse to support for rough sleepers

- How to re-invest in assistance to vulnerable older people to enable them to stay safely in their own homes and avoid injury and unnecessary care and support

- To review how investing in a range of adapted accommodation for older people could reduce health and care costs

- To review how building more supported accommodation for people with long term support needs, such as learning disabilities and long term mental health conditions, could achieve better outcomes and reduce care costs

- To link support to people within deprived communities of inner Blackpool to wider services and investment to improve those areas and make them more attractive and sustainable

9 DATE OF THE NEXT MEETING

To note the date of the next meeting as 10 October 2018.

Chairman

(The meeting ended at 5.10pm)

Any queries regarding these minutes, please contact:
Lennox Beattie Executive and Regulatory Manager
Tel: 01253 477157
E-mail: lennox.beattie@blackpool.gov.uk

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Jayne Bentley (Care Bill Implementation and Better Care Fund Project Lead)
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	10 October 2018

BLACKPOOL BETTER CARE FUND UPDATE

1.0 Purpose of the report:

1.1 To provide the Board with an update on details of the Blackpool Better Care Fund (BCF) 2018-19.

2.0 Recommendation(s):

2.1 To note the update on the Blackpool Better Care Fund 2018-19.

3.0 Reasons for recommendation(s):

3.1 The monitoring of the Better Care Fund pooled budget is a statutory requirement for Health and Wellbeing Boards under the amended NHS Act 2006.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None, The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006.

4.0 Council Priority:

4.1 The relevant Council Priority is: "Communities: Creating stronger communities and increasing resilience".

5.0 Background Information

5.1 The Integration and Better Care Fund Operating Guidance for 2017-19 was published on 18 July 2018 (Appendix 3a), along with a letter to Health and Wellbeing Board Chairs (Appendix 3b). These documents outlined the following:

- the framework for the ongoing requirements for approved Better Care Fund plans for 2017-19;
- the opportunity to refresh metrics submitted in the approved Better Care Fund plans, for Residential admissions and reablement;
- updated expectations for the reduction of Delayed Transfers of Care (DToCs), set using an updated baseline (Q3 2017-18) with the scale of the expected reduction set according to the distance each area is from the national target rate.

5.2 Blackpool Council and Blackpool Clinical Commissioning Group agreed that as metrics have been set in line with other reporting structures, they would not be refreshed, other than the requirement to adopt those prescribed as above for DToCs.

5.3 The NHS England (NHSE) reporting template for Q1 2018-19 (Appendix 3c) shows that the Blackpool Better Care Fund is on track to meet all targets with the exception of Delayed Transfers of Care. It should be noted that the Delayed Transfers of Care target had not been revised at this time. A summary of published Delayed Transfers of Care data for Blackpool shows performance over the last 12 months (Appendix 3d).

5.4 Financial monitoring of the Better Care Fund is undertaken on a monthly basis with the focus on the Outturn position of each Scheme within the Better Care Fund. This enables the prediction of underspends and overspends at an individual scheme level to be reported.

5.5 One-off funding via the improved Better Care Fund (iBCF) will end in 2019/20, and contribute to a shortfall of £3.2m which is currently funding schemes aimed at supporting people within the community rather than acute and residential settings.

5.6 In accordance with Better Care Fund requirements, the Section 75 agreement between Blackpool Council and Blackpool Clinical Commissioning Group has been refreshed.

5.7 Does the information submitted include any exempt information? No

5.8 **List of Appendices:**

Appendix 3a: Integration and Better Care Fund Operating Guidance for 2017-19
Appendix 3b: Letter to Health and Wellbeing Board Chairs
Appendix 3c: Q1 2018/19 NHS England reporting template
Appendix 3d: Blackpool Delayed Transfers of Care performance

6.0 Legal considerations:

6.1 The legal framework for the Better Care Fund derives from the NHS Act 2006 (amended by the Care Act 2014), which requires that in each area the BCF is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with Department of Health (DH) and Department of Communities and Local Government (DCLG). The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans.

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 None.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

13.0 Background information by weblink:

2017-19 Integration and Better Care Fund Policy Framework

Integration and Better Care Fund planning requirements for 2017-19

High Impact Change Model

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS England

The Integration and Better Care Fund

Operating Guidance For 2017-19

Published 18 July 2018

CONTENTS

1. PURPOSE OF THIS DOCUMENT

1. This document is for local partners that agree and administer Better Care Fund 2017-19 plans – Clinical Commissioning Groups (CCGs), local authorities (LAs) and Health and Wellbeing Boards (HWBs).

2. This document sets out refreshed operating guidance for approved Better Care Fund (BCF) plans for 2017-19.

3. This document sets out:

    - accountability structures and funding flows for 2017-19 plans
    - refreshed metric plans for 2018-19
    - guidance on amending BCF plans
    - guidance on reporting on and continued compliance with BCF 2017-19 conditions
    - the support, intervention and escalation process
    - the legislation that underpins the BCF

4. This document should be read alongside the 2017-19 Integration and Better Care Fund Policy Framework (the Policy Framework)[1], published by Department of Health (now the Department of Health and Social Care or DHSC) and the Department for Communities and Local Government (now the Ministry of Housing, Communities and Local Government or MHCLG) and the Integration and Better Care Fund Planning Requirements for 2017-19 (the Planning Requirements), published by NHS England, the Department of Health and the Department for Communities and Local Government.[2] If there is any disparity between the Planning Requirements and this operating guidance then this operating guidance will take precedence. This includes changes to Delayed Transfer of Care metrics, legal powers and the process for escalation.

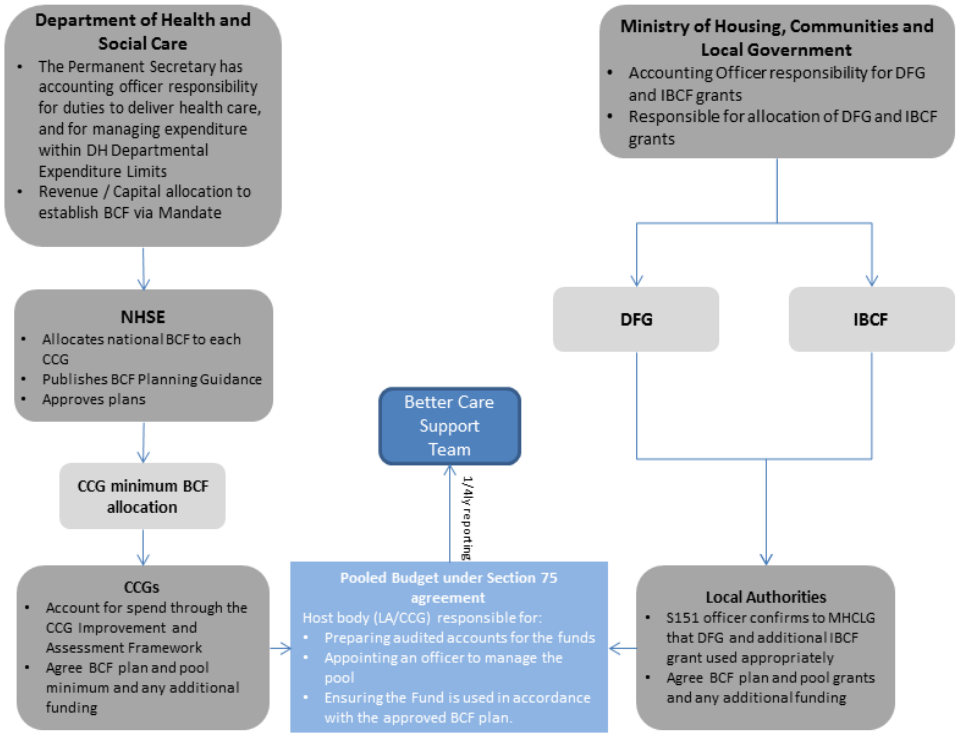
5. This document replaces the BCF Operating Guidance for 2016-17 and has been co-produced in consultation with BCF national partners.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf

2. ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 2017-19

6. The below diagram sets out the accountability arrangements and flow of funding for the BCF.



7. In summary, at a national level:

- The BCF funding for CCGs is part of NHS England's budget allocation.
- From 2017-18, the Improved Better Care Fund (iBCF) is paid to Upper Tier Local Authorities by the MHCLG and is part of the MHCLG's Departmental Expenditure Limit.
- MHCLG provides funding for the Disability Funding Grant (DFG), and MHCLG is accountable for the allocation of funds to local authorities, as well as for the policy framework. A Memorandum of Understanding, signed by both DHSC and MHCLG, governs this arrangement. A Grant Determination issued under section 31 of the Local Government Act 2003 requires that the DFG is spent in accordance with a BCF spending plan jointly agreed between the local authority and relevant CCGs.
- The BCF minimum funding allocation must be transferred into one or more pooled funds as established under section 75 of the NHS Act 2006 (s.75).
- The NHS England Accounting Officer (the Chief Executive) is accountable for the effective use of the BCF funding allocation to CCGs made by NHS England

via the reporting requirements set out in NHS England's mandate from Government.

- Section 151 Officers (Chief Finance Officers) in local authorities are required to certify that the additional iBCF (the 2017 Spring Budget money) is being used exclusively on adult social care in 2018-19.The BCF funding allocations from the CCGs to the BCF will pass from NHS England to CCGs through 2017-19 allocations, and then from CCGs to pooled budgets (via s.75 agreements).
- The iBCF and DFG funding will flow from MHCLG to LAs, and then into the pooled budget via s.75 agreements. In two tier areas, DFG funding will flow from the county to the districts (in full, unless jointly agreed to do otherwise).
- The monies will then be spent on services in line with the approved BCF spending plan for 2017-19.

8. At a local level:

    - As legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the funding in accordance with the approved plan and their general duties.
    - CCGs (Accountable Officers) will be the accountable body for the BCF funding allocation allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
    - LAs (section 151 officers) will be the accountable body, under the terms of their grant agreements, for the DFG and iBCF grant funding that comes from MHCLG (and any additional monies they plan to voluntarily add to the pooled fund).

9. HWBs are expected to continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[3]. Given they are a committee of the LA, HWBs are accountable to elected members and ultimately to the electorate. Where members of a HWB include providers delivering care that is or could be commissioned under BCF, particular care should be taken to ensure that any conflicts of interest are dealt with appropriately.

10. The regulations[4] governing s.75 agreements require the agreement to set out (amongst other provisions):

[3] Section 195 of the Health and Social Care Act 2012

[4] NHS Bodies and Local Authorities Partnership Agreements Regulations 2000

- the arrangements for monitoring the delivery of the services that it covers;
- who the "host" organisation is that will be responsible for accounting and audit; and
- who the "pool manager" is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

11. Therefore, arrangements for monitoring delivery, accounting and audit should be governed by the local s.75 agreement, in addition to the separate reporting and accountability arrangements each partner organisation will have for their share of the funding being pooled.

12. Guidance and support[5] is available from the Better Care Support Team (BCST) for local areas in developing their local s.75 agreements where required. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that have signed up to the agreement. Each individual who has signed the agreement should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

13. Where a risk sharing arrangement linked to the Non-Elective Admissions (NEA) activity is put in place by the HWB through the planning process for 2017-19, local areas should ensure that arrangements for this are clear and there is a process in place for monitoring this locally. This should be detailed within s.75 agreements. If the local area chooses to use the model for a risk sharing arrangement set out by NHS England in the Planning Requirements (and summarised here at annex 1), then CCGs should ensure that they have withheld the funding related to NEA activity from the pooled fund at the beginning of the year as set out.

14. In order for the HWB to review performance of the BCF and consider future work, it would need to have the appropriate information reported to it from a partnership board. HWBs can require CCGs that are represented on the HWB, and the LA that established the HWB, to provide it with relevant information, for example the quarterly reports and annual report. This can be done under section 199 of the Health & Social Care Act 2012. For the purposes of the BCF, there should be a partnership board with minimum representation across the relevant CCG(s) and LA(s) – many localities will already have a partnership board in place and where this is the case there is no need to set up one specifically for the BCF.

15. In setting up, and overseeing, the s.75 agreement, it is strongly recommended to CCGs and LAs:

[5] http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

- that a partnership board is in place to govern the s.75 agreement;
- that the s.75 agreement includes a clause that sets out what information should be included in the host partner's quarterly reports and annual reports. This is to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to BCF national partners as to the appropriate use of the fund (this is explained in more detail in the next section); and
- that a clause is included to ensure the quarterly reports and annual returns are signed off by the HWB.

Conditions of the Better Care Fund

16. As in previous years every CCG has a set of standard conditions placed on its BCF funding in 2017-19. These conditions are set in the BCF Planning Requirements for 2017-19. The legal basis for imposing these conditions is set out below. It is a requirement that in each area the BCF funding is transferred into one or more pooled budgets, established under s. 75, and that plans are approved by NHS England in consultation with DHSC and MHCLG.

17. Grant Conditions for the iBCF and DFG require that the grants are transferred into one or more pooled budgets and their use agreed, in line with the grant conditions, through the BCF Plan.

18. The Planning Requirements apply the four national conditions from the Policy Framework to ensure plan approval, as set out in the BCF Planning Requirements. In summary these four conditions require:

    i) That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
    ii) A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
    iii) That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
    iv) All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

19. The Planning Requirements also sets the four national metrics for which each area must agree ambitions in their BCF plans. Some of these are discussed further below. The BCST collect quarterly monitoring data for each of these metrics as well as progress against and compliance with the national conditions of the fund.

3. REFRESHING METRIC PLANS FOR 2018-19

20. The BCF Policy Framework 2017-19 applies for a two year period and BCF plans have already been submitted and assured for this period. This section updates some of the national expectations for metrics for 2018-19.

Non Elective Admissions (NEAs)

21. The baseline for the NEA metric in the BCF for 2018-19 is the target set for NEAs in CCG Operating Plans for 2017-19. Local BCF plans could set additional reductions over and above the NEA CCG Operating Plans where there was local agreement. For 2018-19, areas can consider and submit revisions to these additional reductions or apply additional reductions where none are in place currently. Areas that set additional NEA reduction targets as part of their BCF plan for 2018-19 should confirm any changes, by resubmitting a planning template with details of any retained or amended additional reduction targets.

22. Revisions to the baseline NEA CCG Operating Plans are not required to be submitted, via the BCF planning template unless they impact on any additional reductions agreed in the original 2017-19 BCF plan, as this is sourced nationally from Unify.

23. For the 'Residential admissions' and 'Reablement' metrics, local areas can submit revisions to the planned metrics for 2018-19 on their planning templates with an accompanying note summarising the rationale for this revision.

Delayed Transfers of Care (DToCs)

24. As part of the BCF 2017-19 planning round, all areas were required to set a metric for reducing DToCs to meet nationally set expectations and to submit a separate monthly trajectory to the end of March 2018. This plan was used as the basis for assurance of DToC metrics in 2017-19 BCF plans, rather than the quarterly plans submitted via the BCF main planning template.

25. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. Based on this national ambition, Departments and NHS England have agreed updated expectations for each local BCF plan for 2018-19, in consultation with local government partners and regions. These expectations have been sent to individual HWBs and will be published shortly on the GOV.UK website along with a more detailed explanation of the methodology. The guidance to

CCGs and NHS Trusts[6] for refreshing 2018-19 plans has also set an expectation that local health and social care commissioners will work together to reduce delays to the equivalent of around 4,000 daily delays.

26. The expectations for each HWB for 2018-19 include centrally set expectations for reducing DToCs attributable the NHS and social care, based on the principle that both health and social care contribute equally to reducing delays. Joint delays are expected to remain at their current level. These expectations have applied an updated baseline (Q3 2017-18) and the scale of the expected reduction has been set according to the distance each area is from the national target rate – with areas further away from this rate expected to contribute a larger reduction.

27. Areas will be expected to agree a DToC metric for 2018-19 that meets the nationally set HWB level expectations for 2018-19. Areas should plan based on the assumption that the expectation will be met by the end of September 2018 and that this level will be maintained or exceeded thereafter. Further detail can be found in Annex 3. Where more than one CCG is signatory to a BCF plan, the CCGs can agree the level of the reduction of delays that they will each be responsible for.

28. If there is a change in expectation to that set in 2017-18, CCGs, local authorities and NHS acute, community and mental health trusts, should revisit local plans for reducing delays to ensure that they are still fit for purpose and agree amendments where necessary. This could include:

    - Consideration of implementation plans for the High Impact Change Model (HICM) (national condition four of the BCF in 2018-19).
    - Other BCF schemes that contribute towards reducing delays and managing transfers.

29. Overall performance in reducing DToC has been encouraging, with the national rate of delays reducing from a peak of over 6,500 daily delays in February 2017, to under 4,500 in May 2018. We are grateful for the considerable effort and collaboration that has delivered this and to those areas that have met challenging expectations in 2017/18. In 2018/19 it is important that all local partnerships continue to focus on minimising DToCs and for areas that remain furthest from their expected levels address this. National partners will continue to offer support to areas to reduce DToCs and your local Better Care Manager (BCM) will be able to discuss available support with you as well as share information on schemes and good practice from other areas.

[6] https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

30. For all BCF metrics, areas should agree any changes at their HWB, or seek delegated approval from all local partners. Any revised metrics, besides adoption of revised DToC ambitions, should be submitted to the BCST, copied to BCMs.

4. AMENDING BCF PLANS

31. Better Care Fund plans were agreed for two years (2017-18 and 2018-19). Places are not, therefore, required to revise their plans for 2018-19 other than in relation to metrics for DToC as set out above. Places can, if they wish, amend plans to:

    - Modify or decommission schemes.
    - Increase investment, including new schemes.

32. Any changes to plans that impact on schemes or spending in the assured BCF planning template must be jointly agreed between the LA and the CCGs that are signatory to the plan and be accompanied with an updated Planning Template and brief rationale.

33. Amended plans must continue to meet all planning requirements and conditions. Please speak to your BCM if you are planning to refresh your BCF plan. Amended plans should be submitted to the BCST, copied to BCMs by 24 August 2018**.** These plans will be scrutinised by your BCM to ensure that they continue to meet the requirements of the Fund.

34. Similarly, if a change is made in-year that impacts on schemes or spending in assured BCF planning template, this change should be jointly agreed between the LA and CCGs that are signatory to the plan and a revised template and rationale should be sent to the BCST and your BCM.

5. REDUCING THE NUMBER OF PATIENTS WITH LONG STAYS OF 21 DAYS OR MORE IN HOSPITAL

35. NHS England and NHS Improvement have recently set out their ambition for reducing long stays in hospital by 25% to reduce patient harm and bed occupancy. NHS England and NHS Improvement have asked trusts and CCGs to work with local government partners to agree local sectoral ambitions to achieve this reduction. Figures have been shared with local systems that show the baseline (average number of beds occupied by patients in hospital for 21 days or more) and the expected reduction.by December 2018. These ambitions are intended to reduce the number of long stay patients by 4,000 nationally. The percentage reduction required from each system is based on their baseline rate of long stay patients. The level of improvement expected from each system is based on the proportion of beds occupied

by long stay patients, with the most challenged systems expected to make the greatest levels of improvement.

36. Achieving this will require concerted effort across the health and care leadership system: at least half the opportunity rests within the direct control of hospitals, and the remainder in joint working with GPs, local authorities, community health, social care providers and others.

37. BCF plans will support delivery of this reduction through the continuing focus on delivery of the local DToC expectations (paras 24-30) and through the implementation of national condition four – the High Impact Change model. Particular focus in relation to length of stay should be given to the implementation of the HICM in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven). National partners will give consideration to applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19. Any revisions to existing plans for implementing the High Impact Change model should be reflected in Better Care Fund quarterly reporting.

6. REPORTING ON AND CONTINUED COMPLIANCE WITH THE BCF NATIONAL CONDITIONS OVER 2017-19

Monitoring continued compliance with the conditions of the fund

39. Better Care Managers (BCMs) and the wider BCST will monitor continued compliance against the national conditions through the BCF quarterly reporting process described below and their wider interactions with local areas.

40. If an area is not compliant with any of the standard conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan resulting in a risk to meeting the national conditions, the BCST, in consultation with national partners, may make a recommendation to NHS England to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

41. The intervention and escalation process (outlined in subsequent sections) ultimately leads to NHS England exercising its powers of intervention provided by NHS Act 2006, in consultation with DHSC and MHCLG, as the last resort. These powers and interventions are summarised in subsequent sections.

Quarterly Reporting in 2017-19

42. The primary purpose of the Better Care Fund quarterly reporting is to provide national partners with a clear and accurate account of compliance with the key requirements

and conditions of the fund as set out in the Policy and the Planning Requirements. The secondary purpose is to inform policy making and the national support offer by providing a fuller insight, based on narrative feedback from systems, on local progress, issues and highlights on implementation of the BCF plans.

43. To serve these purposes, areas are required to provide quarterly reporting for the BCF over 2017-19.

44. It is expected that these reports are discussed and signed-off by HWBs (or with appropriate delegation) as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into s.75 agreements. Quarterly monitoring will include confirmation that s.75 agreement is in place.

45. The quarterly reporting template will be made available to the local systems with associated guidance and timetables via the Better Care Exchange, an online platform that all Better Care leads are able to access. For the first time this also includes the reporting template for the additional improved Better Care Fund, as collected by MHCLG, responding to calls to align and integrate reporting.

7. SUPPORT, INTERVENTION AND ESCALATION PROCESS

Support

46. The Better Care Support Programme leads and facilitates the delivery of the Better Care Fund policy. This includes bespoke support for areas, performance management, formal guidance and, where needed, intervention. This section describes these functions and advises areas of the support available. Areas should speak to their BCM if they have concerns over the delivery of their BCF plan or performance against metrics.

47. The support programme constitutes:

    a. the national Better Care Support Team (BCST)
    b. the regional Better Care Managers (BCM)
    c. the national and regional Better Care Support Offer
    d. the Better Care Exchange

48. The BCST and BCMs are responsible for ensuring that local systems continue to comply with the conditions of the BCF and for improving performance against the national metrics, as well as supporting the wider ambition in relation to the overall integration of health and social care. This includes:

- Support and advice through the national BCST

- Formal support to address high levels of DToC
- Intervention where there are performance or compliance concerns, including:
    - Performance discussions with regional leads;
    - Formal escalation to national partners;
    - Use of NHS England intervention powers, including the power to direct CCGs regarding expenditure

49. The Better Care support offer for 2017-19 is delivered through two streams: the centrally-led national support programme and the regionally-led support offer. The scope of this support focuses on plan, delivery and improvement.

50. The centrally-led national support consists of a number of elements:

- **Better Care Advisers**: a pool of advisers that local areas can draw upon to provide senior level support where requested or required. This hands on support will be available to areas who wish to drive their integration agenda forward, whether that be through facilitated discussions and workshops, or peer-led interviews, it will enable areas to challenge themselves and share learning from other areas.

  This strand continues to provide independent facilitation for local areas that are facing difficulties or disagreements, as well as support any assurance requirements.

- **Intensive support for better managing transfers of care**: the BCST and national partners will offer a range of support to assist local areas in working together to ensure people benefit from speedy and safe transfers of care from hospital to their community. This will include:

    - Workshops on the High Impact Change Model
    - DToC counting workshops
    - National CQC learning events
    - Local area peer reviews
    - Bespoke peer support

- **National workshops**: a programme of workshops focussing on the key challenges associated with integrated care. The thematic workshops are intended to look at and share different approaches and experiences around a theme of interest at national level. They are expected to bring together the most up to date information, insight and solutions on priority themes associated with integrated care.

- **Regional workshops**: regionally-led events focussed on sharing experiences and dealing with challenges locally. This aspect of the support programme is concerned with creating the links and relationships between peers from

different health and social care systems within a region, to encourage peer-to-peer support, learning and challenge. Workshops can cover a theme of specific importance/interest to the region.

- **Programme of guidance and insight**:
    - Case studies
    - Webinars
    - Guide to the Better Care Fund

- **Integrated Care Learning Programme**: Access to two learning programmes developed in conjunction with the Social Care Institute for Excellence (SCIE). One tailored to BCMs and the other for local area BCF leads, which will count towards Continuous Professional Development (CPD).

51. The programme of support for 2018-19 is intended to build on the 2017-18 offer. Support will continue to be developed utilising ongoing feedback from local areas through the quarterly reporting, discussions with BCMs, key partners, the 2018-19 needs assessment and in response to national policy.

52. The regionally-led support offer consists of funding that has been allocated to each region, in order to enhance and support regions' capacity and capability to achieve the overall aims and vision for the Better Care Fund. BCMs are in place across each region to gather learning and co-ordinate support to local areas. Regions can commission bespoke packages of support to respond to regionally identified needs, generate shared solutions at a regional level and tailor national resources and products to regional needs.

53. The Better Care Exchange is the collaboration platform operated by the BCST. The purpose of the exchange is to provide a shared collaboration space for individuals from both health and social systems who work on delivering the BCF plans or work closely with the BCF with the shared agenda of health and social integration. The platform the forum for operational communication, providing quarterly reporting and other BCF related templates and to share information and insight.

54. If further information is of interest on the components of the Better Care Fund Support Programme, please contact ENGLAND.bettercaresupport@nhs.net which is the primary point of contact for the BCST.

Intervention and escalation

55. Where an area remains non-compliant, or performance remains poor, further intervention will be considered.

56. If it becomes apparent that local implementation is not in line with the approved BCF plan, and that this resulted in one or more requirements of the BCF not being met in an area – for instance through the quarterly monitoring process or through information given to the BCM or BCST– the BCST will consider commencing an escalation process.

57. Prior to escalation, for a plan that has previously been approved, the BCST will work with national partners, the BCF Programme Board and BCF Senior Responsible Officer (SRO), the BCM for the area and local partners to consider options to resolve the issues, including use of Better Care Advisor support. Senior staff from the LA and the CCG(s) will need to attend a formal discussion with regional NHS England and local government representatives and their BCM to attempt to agree a resolution or recovery plan.

58. Escalation will be considered if there is evidence that:

- One or more of national conditions 1-4 are no longer being met.
- There have been changes to spending made without agreement, particularly those that would impact on continued compliance with the national conditions.
- There are significant concerns over performance against any of the BCF metrics.
- The area does not locally agree a compliant metric for reducing DToCs in 2018-19.

59. As outlined in the Planning Requirements, the purpose of escalation in the event of a non-compliant plan is to:

"… assist areas to reach agreement on ***a compliant plan and is not an arbitration process.*** *Senior representatives from all parties required to agree a plan will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward."*

60. Escalation is not arbitration, mediation or legal advice. The single aim of the escalation process is to ensure that an area has and maintains a compliant Better Care Fund plan. More details on escalation as part of the assurance process is set out in the Integration and Better Care Fund Policy Framework 2017-19; Integration and Better Care Fund Planning Requirements 2017-19; and the Better Care Fund 2017-19: A guide to assurance of plans.

61. If an area that is performing poorly against BCF metrics is unable, following support and local intervention, to make improvements, then escalation will be considered. The purpose of escalation will be to consider the actions that the area is taking to address underperformance and whether further intervention or use of powers of direction is warranted. National Partners will review progress against 2018-19 DToC expectations

once data for September 2018 are available. Progress on reducing DToC will continue to be monitored by national partners and will be taken into account in setting expectations for 2019-20.

62. Appendix 2 describes the steps involved in escalation as applicable to the ongoing BCF compliance. The escalation process which will be initiated if any of the conditions of the BCF are not met following the return of the quarterly reports and wider information collected by BCMs.

63. The BCST will support the escalation process, which will involve DHSC, MHCLG, NHS England and the LGA.

64. The Escalation Panel members will take into account all relevant information, including financial and performance issues. This could include:

- Wider financial context, such as whether the LA has taken sufficient action to protect its funding for social care – including, but not limited to, making use of precepting powers, the balance of financial risk between parties and appropriate use of reserves;
- Whether all financial commitments mandated in the BCF have been met, including passporting of Care Act funding, funding for social care managed reablement and carers' breaks (see paragraphs 35, 36 and 37 of the Planning Requirements);
- Whether agreed spending on social care services funded by CCG minimum contributions has been maintained in real terms i.e. taking into account inflation. This will also include consideration of transfers prior to the establishment of the BCF;
- Previous and current diagnostic reports that have been prepared by Better Care Advisers or those appointed to work with the area, such as on enhanced support for DToC.

65. NHS England has the ability to direct use of the CCG minimum contribution to a local BCF fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that has been locally agreed and approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DHSC and MHCLG, with the final decision then taken by NHS England.

66. The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

67. A summary of the approach to support, escalation and intervention is at Annex 2.

8. GRADUATION

68. We hope that a first wave of shortlisted areas eligible for graduation from the Better Care Fund will be confirmed in 2018-19. National partners would then work with shortlisted areas to test readiness for full graduation and co-produce what a meaningful graduation model would look like. . NHS England, MHCLG, DHSC and the LGA will agree a memorandum of understanding with graduate areas, setting out the BCF requirements that will be removed or relaxed and any expectations of graduate areas, including:

    - Participation in learning events
    - Commitment to work with BCF national partners to develop models of integration, informing development of Integrated Care Systems and the health and care integration agenda.
    - Areas for improvement – for instance on specific metrics
    - Expectations for light touch self-certification process.

69. Through 2018-19, DHSC, MHCLG, NHS England, the LGA and the BCST, will work with these areas to develop the model for graduation further.

BCF 2018-19

70. The mandate to NHS England for 2018-19[7] has been published and contains deliverables around the BCF.

71. NHS England will be using section 223G(4) to impose conditions on the allotment of BCF funding to CCGs that is identified in the mandate to NHS England for 2018-19.

72. The conditions that NHS England is imposing are again those set out in the 2017-19 BCF Policy Framework (page 16) and the BCF Planning Requirements for 2017-19 (pages 9-14) i.e. the four national conditions plus establishing a pooled fund under section 75 of the NHS Act 2006 and agreeing plans locally with sign off by the relevant local authority and CCG(s).

73. The funding awarded by NHS England under section 223G is also conditional on the fact that if the national conditions are not met, future payments of minimum BCF funding can be withheld and minimum BCF payments already made can be clawed back by NHS England at NHS England's discretion. Under section 223G(6), NHS England may direct CCGs as to the expenditure of the allotment of BCF funding. In

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

practice this means that the interventions available to NHS England if conditions are not met are the same from 2018-19 as for 2017-18.

ANNEXES

ANNEX 1 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. National condition three of the 2017-19 Better Care Fund required areas that had agreed additional target to reduce Non Elective Admissions over and above the metrics in CCG operating plans to consider holding a portion of the CCG minimum contribution in contingency against the additional costs of these targets not being met. The Planning Requirements set out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2017-19. Where this is the case the arrangements are described within narrative plans.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. The Planning Requirements set out the mechanism for calculating the maximum value of the contingency.

3. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.

ANNEX 2 – SUPPORT AND INTERVENTION 'LADDER'

Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCST and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

1. **Trigger** - identification of BCF non-compliance or significant concerns about performance on BCF metrics	The BCM and regional partners in consultation with the BCST and the Programme's Director will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or Local Government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal Support	The BCM will work with the BCST to agree provision of a Better Care Advisor, multi-disciplinary consultancy or other support, including provision of specific support to address compliance and/or high levels of DToC.
4. Formal regional meeting	Areas will be invited to a formal meeting with NHS England regional and regional local government representatives to discuss the compliance or performance concerns, the area's plans to address these and a timescale for addressing the issues identified.
5. Pre-escalation meeting	Discussion with BCST, BCM and regional representatives from NHS England and local government. This meeting will seek to agree a set of actions to address issues without the need to escalate further. A timescale for completion of these actions will be agreed at the meeting.
6. **Commencing Escalation** as part of non-compliance	If, following the pre escalation meeting, a solution is not found or performance issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, the members of the Integration Partnership Board will be consulted on next steps.

	To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the Escalation Panel.
7. The **Escalation Panel**	The Escalation Panel will be jointly chaired by MHCLG and DHSC senior officials with representation from: • NHS England • LGA/Association of Directors of Adult Social Services (ADASS) Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer/s from local authority
8. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter, summarising the Escalation Panel meeting and clarifying the next steps and timescales for submitting a compliant plan or addressing performance issues. If support was requested by local partners or recommended by the Escalation Panel, an update on what support will be made available will be included.
9. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCST.
10. Consideration of **intervention options**	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • Agreement that the Escalation Panel will work with the local parties to agree a plan • Appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan. • Appointment of an advisor to develop a compliant plan, where the Escalation Panel does not have confidence that the area can deliver a compliant

	plan • Appointment of an advisor or support to address performance issues, including progress towards agreed DToC metrics. • Clawback of BCF funding already paid • Withholding BCF payments that are due to be made • Directing the CCG as to how the minimum BCF allocation should be spent The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

ANNEX 3 – REVISION OF DTOC METRICS – METHODOLOGY

1. In order to ensure that the expected contributions to continued reduction in DToC are proportionate and achievable in each area of England, national partners have agreed to revise the existing HWB-level expectations.

2. In approaching this year's ambition setting, we have determined key guiding principles to steer this work: providing a clearer, easier to explain methodology with a consistent rationale, and balancing fairness and stretch across local systems.

3. The expectations have been set as follows:

    - A common baseline for (i) NHS and (ii) adult social care delays (October to December 2017).
    - Expectations set to deliver an equal reduction in the number of daily delays attributable to each of the NHS and social care.
    - Expected progress from this baseline calculated for NHS and adult social care delays is based on the distance from a target rate. The target rates are 5.5 daily delays per 100,000 population for NHS delays and 2.6 daily delays per 100,000 of the population for adult social care.
    - The level of improvement expected depends on the distance from the target rate – this is set out in more detail below.
    - The maximum target reduction is capped at 30% for NHS delays and 40% for Adult Social Care. The target date for achieving these reductions is the end of September 2018. As in 2017-18, joint delays are expected to remain the same and no stretch target has been set.

4. The bandings are shown below:

Baseline	Expectation
Adult Social Care	
DToC rate below 2.6 daily delays per 100,000 18+ population	Maintain that rate
DToC rate between 2.6 and 4.3 daily delays per 100,000 18+ population	Reduce to 2.6 daily delays per 100,000 18+ population
DToC rate over 4.3 daily delays per 100,000 18+ population	Reduce delays by 40%

NHS	
DToC rate below 5.5 daily delays per 100,000 18+ population	Maintain that rate
DToC rate between 5.5 and 7.9 daily delays per 100,000 18+ population	Reduce to 5.5 daily delays per 100,000 18+ population
DToC rate over 7.9 daily delays per 100,000 18+ population	Reduce delays by 30%
Joint	
Average number of jointly attributed daily delays October to December 2017 per 100,000 18+ population	Remain at or below this rate

Appendix 3b

NHS England
Skipton House
80 London Road
London
SE1 6LH

19 July 2018

To: (*by email*)

Health and Wellbeing Board Chairs
Local Authority Chief Executives
Clinical Commissioning Group Accountable Officers

Dear Colleagues

THE INTEGRATION AND BETTER CARE FUND OPERATING GUIDANCE FOR 2017-19

I am writing to you today to let you know that The Integration and Better Care Fund (BCF) Operating Guidance for 2017-19 has been published and is now available at https://www.england.nhs.uk/publication/better-care-fund-operating-guidance-for-2017-19/

The BCF continues to hold a unique position of formally bringing local partners together to agree their plans for integrating health and social care by supporting: personalisation, co-ordination of care and assisting people with long term needs to remain closer to home. You will have seen that the Government's recent announcements on future funding for the NHS make integration of health and social care one of the priorities to be delivered with this additional resource. The services and relationships developed through the BCF across the country provide a firm footing to deliver this expectation.

The attached updated Operating Guidance provides the framework for the ongoing requirements of the BCF as you continue to implement your plans for 2017-19 that were approved last year. The Guidance also sets out the ways in which plans can be reviewed and how metrics for 2018-19 can be refreshed, particularly in relation to Residential admissions and Reablement.

In addition, the Guidance sets out the requirements, agreed with the Department of Health and Social Care and Ministry of Housing, Communities and Local Government in consultation with Local Government, for reducing Delayed Transfers of Care (DToC) in 2018-19, which should be adopted as metrics in your local BCF plan. These replace the expectations set for 2017-18 in the BCF Planning Requirements. Based on the national ambition, departments and NHS England have agreed updated expectations for each local BCF plan for 2018-19, in consultation with national partners, including the LGA, and Better Care Managers.

The expectations for Health and Wellbeing Boards (HWB) have been set using an updated baseline (Q3 2017-18) and the scale of the expected reduction will be set according to the distance each area is from the national target rate – with areas further away from this rate expected to contribute a larger reduction. HWB areas are expected to adopt the DToC metric expectations as set for 2018/19.

A detailed explanation of the methodology used to determine the expectations is provided in the Operating Guidance. The expectations for each HWB accompany this letter as a separate document, which also sets out a process for areas to raise issues with the Q3 2017-18 baseline figures used. Please note that the deadline for this process is 3 August 2018. The final DToC expectations will be subsequently published on the gov.uk website.

Areas should plan based on the assumption that the expectation will be met from September and that this level will be maintained or exceeded thereafter. We are expecting that a revised guide on counting DToC will be published in the coming months for implementation in October 2018. The guidance will provide greater clarity on the process for recording and attributing delayed transfers, with a view to reducing the degree of variation in recording that currently exists across the country. It will be important that all areas follow this revised DToC counting guidance from this point as it will ensure that performance in managing DToC from the end of September is on the same basis across the country.

I want to acknowledge the progress made in your HWB in managing Delayed Transfers of Care. The most recent figures show that your area is below the nationally set expectation for reducing DToC set for September 2018. This is positive news and I commend you for the ongoing partnership working that has enabled this.

Although your BCF plan is set for two years, if there are any major changes to your plans these should be discussed, in the first instance, with your Better Care Manager who will advise on any formal reassurance that might be required. This process is also set out in the new Operating Guidance.

NHS England and NHS Improvement have recently set out their ambition for a reducing the number of people in hospital who experience an extended stay (21

days or over) by 25% to reduce patient harm and bed occupancy. NHS England and NHS Improvement have asked trusts and CCGs to work with local government partners to agree local sectoral ambitions to achieve this reduction and free up at least 4,000 beds compared to 2017-18 by December 2018. BCF plans will support delivery of this reduction through the continuing focus on delivery of the local DToC expectations and through the implementation of national condition four – the High Impact Change model. Particular focus in relation to length of stay should be given to the implementation of the HICM in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven).

I also encourage you to share information on schemes and good practice on what you are doing by way of "what's working" both formally and informally.

Yours faithfully,

Neil Permain
Director of NHS Operations and Delivery and SRO for the Better Care Fund

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Better Care Fund Template Q1 2018/19

Guidance

Overview

The Better Care Fund (BCF) quarterly reporting requirement is set out in the BCF Planning Requirements for 2017-19 which supports the aims of the Integration and BCF Policy Framework and the BCF programme jointly led and developed by the national partners Department of Health (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of the BCF quarterly reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)

2) To provide information from local areas on challenges, achievements and support needs in progressing integration and the delivery of BCF plans
3) To foster shared learning from local practice on integration and delivery of BCF plans
4) To enable the use of this information for national partners to inform future direction and for local areas to inform delivery improvements

BCF quarterly reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including clinical commissioning groups, local authorities and service providers) for the purposes noted above.

BCF quarterly reports are submitted by local areas are required to be signed off by HWBs as the accountable governance body for the BCF locally and these reports are therefore part of the official suite of HWB documents.

The BCF quarterly reports in aggregated form will be shared with local areas prior to publication in order to support the aforementioned purposes of BCF reporting. In relation to this, the Better Care Support Team (BCST) will make the aggregated BCF quarterly reporting information in entirety available to local areas in a closed forum on the Better Care Exchange (BCE) prior to publication.

For 2018-19, reporting on the additional iBCF Grant (from the funding announced in the 2017 Spring Budget) is included in the BCF quarterly reporting as a combined template to streamline the reporting requirements placed on local systems. The BCST along with NHSE hosted information infrastructure will be collecting and aggregating the iBCF information and providing it to MHCLG. Although collected together, BCF and iBCF information will be reported and published separately. MHCLG aim to publish the additional iBCF information in 2018-19.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The details of each sheet within the template are outlined below.

Checklist

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before sending to the Better Care Support Team.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference for the question and the 'checker' column which updates automatically as questions within each sheet are completed.

3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.

2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to england.bettercaresupport@nhs.net

2. National Conditions & s75 Pooled Budget

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Integration and Better Care Fund planning requirements for 2017-19 continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf
This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met within the quarter and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager.

In summary, the four national conditions are as below:
National condition 1: A jointly agreed plan
Please note: This also includes confirming the continued agreement on the jointly agreed plan for DFG spending
National condition 2: NHS contribution to social care is maintained in line with inflation
National condition 3: Agreement to invest in NHS-commissioned out-of-hospital services
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care

3. National Metrics

The BCF plan includes the following four metrics: Non-Elective Admissions, Delayed Transfers of Care, Residential Admissions and Reablement. As part of the BCF plan for 2017-19, planned targets have been agreed for these metrics.
This section captures a confidence assessment on meeting these BCF planned targets for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in meeting the BCF targets, any achievements realised and an opportunity to flag any Support Needs the local system may have recognised where assistance may be required to facilitate or accelerate the achievement of the BCF targets.

As a reminder, if the BCF planned targets should be referenced as below:
- Residential Admissions and Reablement: BCF plan targets were set out on the BCF Planning Template
- Non Elective Admissions (NEA): The BCF plan mirrors the CCG (Clinical Commissioning Groups) Operating Plans for Non Elective Admissions except where areas have put in additional reductions over and above these plans in the BCF planning template. Where areas have done so and require a confirmation of their BCF NEA plan targets, please write into england.bettercaresupport@nhs.net
Please note that while NEA activity is not currently being reported against CCG Operating Plans (due to comparability issues relating to specialised commissioning), HWBs can still use NEA activity to monitor progress for reducing NEAs.
- Delayed Transfers of Care (DToC): The BCF plan targets for DToC should be referenced against your current provisional trajectory. Further information on DToC trajectories for 2018-19 will be published shortly.
The progress narrative should be reported against this provisional monthly trajectory as part of the HWB's plan.

This sheet seeks seeks a best estimate of confidence on progress against targets and the related narrative information and it is advised that:
- In making the confidence assessment on progress against targets, please utilise the available published metric data (which should be typically available for 2 of the 3 months) in conjunction with the interim/proxy metric information for the third month (which is eventually the source of the published data once agreed and validated) to provide a directional estimate.
- In providing the narrative on Challenges, Achievements and Support need, most areas have a sufficiently good perspective on these themes by the end of the quarter and the unavailability of published metric data for one of the three months of the quarter is not expected to hinder the ability to provide this very useful information. Please also reflect on the metric performance trend when compared to the quarter from the previous year - emphasising any improvement or deterioration observed or anticipated and any associated comments to explain.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

4. High Impact Change Model

The BCF National Condition 4 requires local areas to implement the High Impact Change Model (HICM) for Managing Transfers of Care. This section of the template captures a self-assessment on the current level of implementation, and anticipated trajectory in future quarters, of each of the eight HICM changes and the red-bag scheme along with the corresponding implementation challenges, achievements and support needs.

The maturity levels utilised on the self assessment dropdown selections are based on the guidance available on the published High Impact Changes Model (link below). A distilled explanation of the levels for the purposes of this reporting is included in the key below:
Not yet established - The initiative has not been implemented within the HWB area

Planned - There is a viable plan to implement the initiative / has been partially implemented within some areas of the HWB geography
Established - The initiative has been established within the HWB area but has not yet provided proven benefits / outcomes
Mature - The initiative is well embedded within the HWB area and is meeting some of the objectives set for improvement

Exemplary - The initiative is fully functioning, sustainable and providing proven outcomes against the objectives set for improvement

https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/systems-resilience/high-impact-change-model

In line with the intent of the published HICM model self assessment, the self assessment captured via BCF reporting aims to foster local conversations to help identify actions and adjustments to progress implementation, to understand the area's ambition for progress and, to indicate where implementation progress across the eight changes in an area varies too widely which may constrain the extent of benefit derived from the implementation of the model. As this is a self assessment, the approaches adopted may diverge considerably from area to area and therefore the application of this information as a comparative indicator of progress between areas bears considerable limitations.

In making the self-assessment, please ensure that a representative range of stakeholders are involved to offer an assessment that is as near enough as possible to the operational reality of the area. The recommended stakeholders include but are not limited to Better Care Managers, BCF leads from CCGs and LAs, local Trusts, Care Sector Regional Leads, A&E Delivery Board representatives, CHIAs and regional ADASS representatives.

The HICM maturity assessment (particularly where there are multiple CCGs and A&E Delivery Boards (AEDBs)) may entail making a best judgment across the AEDB and CCG lenses to indicatively reflect an implementation maturity for the HWB. The AEDB lens is a more representative operational lens to reflect both health and social systems and where there are wide variations in implementation levels between them, making a conservative judgment is advised. Where there are clear disparities in the stage of implementation within an area, the narrative section should be used to briefly indicate this, and the rationale for the recorded assessment agreed by local partners.

Please use the 'Challenges' narrative section where your area would like to highlight a preferred approach proposed for making the HICM self-assessment, which could be useful in informing future design considerations.

Where the selected maturity levels for the reported quarter are 'Mature' or 'Exemplary', please provide supporting detail on the features of the initiatives and the actions implemented that have led to this assessment.

For each of the HICM changes please outline the challenges and issues in implementation, the milestone achievements that have been met in the reported quarter with any impact observed, and any support needs identified to facilitate or accelerate the implementation of the respective changes.

To better understand the spread and impact of Trusted Assessor schemes, when providing the narrative for "Milestones met during the quarter / Observed impact" please consider including the proportion of care homes within the locality participating in Trusted Assessor schemes. Also, any evaluated impacts noted from active Trusted Assessor schemes (e.g. reduced hospital discharge delays, reduced hospital Length of Stay for patients awaiting care home placements, reduced care home vacancy rates) would be welcome.

Hospital Transfer Protocol (or the Red Bag Scheme):
- The template also collects updates on areas' implementation of the optional 'Red Bag' scheme. Delivery of this scheme is not a requirement of the Better Care Fund, but we have agreed to collect information on its implementation locally via the BCF quarterly reporting template.
- Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.
- Where there are no plans to implement such a scheme please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.
- Further information on the Red Bag / Hospital Transfer Protocol: A quick guide has been published:
https://www.nhs.uk/NHSEngland/keogh-review/Pages/quick-guides.aspx
Further guidance is available on the Kahootz system or on request from the NHS England Hospital to Home team through england.ohuc@nhs.net. The link to the Sutton Homes of Care Vanguard – Hospital Transfer Pathway (Red Bag) scheme is as below:
https://www.youtube.com/watch?v=XoYZPXmULHE

5. Narrative

This section captures information to provide the wider context around health and social integration.
Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Please tell us about an integration success story observed over reported quarter highlighting the nature of the service or scheme and the related impact.

6. Additional improved Better Care Fund - Part 1

For 2018-19 the additional iBCF monitoring has been incorporated into the BCF form. The additional iBCF section of this form are on tabs '6. iBCF Part 1' and '7. iBCF Part 2', please fill these sections out if you are responsible for the additional iBCF quarterly monitoring for your organisation, or geographic area.
To reflect this change, and to align with the BCF, data must now be entered on a HWB level.
The iBCF section of the monitoring template covers reporting in relation to the additional iBCF funding announced at spring budget 2017 only.
More specific guidance on individual questions is present on the relevant tabs.

Please find a list of your previous Quarter 4 2017/18 initiatives / projects on tab 'iBCF Q4 1718 Projects'.

Section A: Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.
Section B: Please enter at least one initative / project, but no more than 10. If you are funding more than 10 initiatives / projects, you should list those with the largest size of investment in 2018-19.

7. Additional improved Better Care Fund - Part 2

Section C: The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please could you enter 0 in the appropriate box.
Section D: Please enter at least one metric, but no more than 5.

Better Care Fund Template Q1 2018/19

1. Cover

Version 1.0

Please Note:
- The BCF quarterly reports are categorised as 'Management Information' and are planned for publishing in an aggregated form on the NHSE website. ***Narrative sections of the reports will not be published.*** *However as with all information collected and stored by public bodies, all BCF information including any narrative is subject to Freedom of Information requests.*
- As noted already, the BCF national partners intend to publish the aggregated national quarterly reporting information on a quarterly basis. At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Blackpool
Completed by:	Jayne Bentley
E-mail:	jayne.bentley@blackpool.gov.uk
Contact number:	01253-477433
Who signed off the report on behalf of the Health and Wellbeing Board:	Karen Smith

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

Complete

	Pending Fields
1. Cover	0
2. National Conditions & s75 Pooled Budget	0
3. National Metrics	0
4. High Impact Change Model	0
5. Narrative	0
6. iBCF Part 1	0
7. iBCF Part 2	0

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | Local Government Association | NHS England

[<< Link to Guidance tab]

1. Cover

	Cell Reference	Checker
Health & Wellbeing Board	C8	Yes
Completed by:	C10	Yes
E-mail:	C12	Yes
Contact number:	C14	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	C16	Yes

Sheet Complete:	Yes

2. National Conditions & s75 Pooled Budget

^^ Link Back to top

	Cell Reference	Checker
1) Plans to be jointly agreed?	C8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements?	C9	Yes
3) Agreement to invest in NHS commissioned out of hospital services?	C10	Yes
4) Managing transfers of care?	C11	Yes
1) Plans to be jointly agreed? If no please detail	D8	Yes
2) Social care from CCG minimum contribution agreed in line with Planning Requirements? Detail	D9	Yes
3) Agreement to invest in NHS commissioned out of hospital services? If no please detail	D10	Yes
4) Managing transfers of care? If no please detail	D11	Yes
Have the funds been pooled via a s.75 pooled budget?	C15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please detail	D15	Yes
Have the funds been pooled via a s.75 pooled budget? If no, please indicate when	E15	Yes

Sheet Complete:	Yes

3. Metrics ^^ Link Back to top

	Cell Reference	Checker
NEA Target performance	D11	Yes
Res Admissions Target performance	D12	Yes
Reablement Target performance	D13	Yes
DToC Target performance	D14	Yes
NEA Challenges	E11	Yes
Res Admissions Challenges	E12	Yes
Reablement Challenges	E13	Yes
DToC Challenges	E14	Yes
NEA Achievements	F11	Yes
Res Admissions Achievements	F12	Yes
Reablement Achievements	F13	Yes
DToC Achievements	F14	Yes
NEA Support Needs	G11	Yes
Res Admissions Support Needs	G12	Yes
Reablement Support Needs	G13	Yes
DToC Support Needs	G14	Yes

Sheet Complete:	Yes

4. High Impact Change Model ^^ Link Back to top

	Cell Reference	Checker
Chg 1 - Early discharge planning Q1 18/19	E12	Yes
Chg 2 - Systems to monitor patient flow Q1 18/19	E13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q1 18/19	E14	Yes
Chg 4 - Home first/discharge to assess Q1 18/19	E15	Yes
Chg 5 - Seven-day service Q1 18/19	E16	Yes
Chg 6 - Trusted assessors Q1 18/19	E17	Yes
Chg 7 - Focus on choice Q1 18/19	E18	Yes
Chg 8 - Enhancing health in care homes Q1 18/19	E19	Yes
UEC - Red Bag scheme Q1 18/19	E23	Yes
Chg 1 - Early discharge planning Q2 18/19 Plan	F12	Yes
Chg 2 - Systems to monitor patient flow Q2 18/19 Plan	F13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q2 18/19 Plan	F14	Yes
Chg 4 - Home first/discharge to assess Q2 18/19 Plan	F15	Yes
Chg 5 - Seven-day service Q2 18/19 Plan	F16	Yes
Chg 6 - Trusted assessors Q2 18/19 Plan	F17	Yes
Chg 7 - Focus on choice Q2 18/19 Plan	F18	Yes
Chg 8 - Enhancing health in care homes Q2 18/19 Plan	F19	Yes
UEC - Red Bag scheme Q2 18/19 Plan	F23	Yes
Chg 1 - Early discharge planning Q3 18/19 Plan	G12	Yes
Chg 2 - Systems to monitor patient flow Q3 18/19 Plan	G13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q3 18/19 Plan	G14	Yes
Chg 4 - Home first/discharge to assess Q3 18/19 Plan	G15	Yes
Chg 5 - Seven-day service Q3 18/19 Plan	G16	Yes
Chg 6 - Trusted assessors Q3 18/19 Plan	G17	Yes
Chg 7 - Focus on choice Q3 18/19 Plan	G18	Yes
Chg 8 - Enhancing health in care homes Q3 18/19 Plan	G19	Yes
UEC - Red Bag scheme Q3 18/19 Plan	G23	Yes
Chg 1 - Early discharge planning Q4 18/19 Plan	H12	Yes
Chg 2 - Systems to monitor patient flow Q4 18/19 Plan	H13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Q4 18/19 Plan	H14	Yes
Chg 4 - Home first/discharge to assess Q4 18/19 Plan	H15	Yes
Chg 5 - Seven-day service Q4 18/19 Plan	H16	Yes
Chg 6 - Trusted assessors Q4 18/19 Plan	H17	Yes
Chg 7 - Focus on choice Q4 18/19 Plan	H18	Yes
Chg 8 - Enhancing health in care homes Q4 18/19 Plan	H19	Yes
UEC - Red Bag scheme Q4 18/19 Plan	H23	Yes
Chg 1 - Early discharge planning, if Mature or Exemplary please explain	I12	Yes
Chg 2 - Systems to monitor patient flow, if Mature or Exemplary please explain	I13	Yes
Chg 3 - Multi-disciplinary/agency discharge teams, if Mature or Exemplary please explain	I14	Yes
Chg 4 - Home first/discharge to assess, if Mature or Exemplary please explain	I15	Yes
Chg 5 - Seven-day service, if Mature or Exemplary please explain	I16	Yes
Chg 6 - Trusted assessors, if Mature or Exemplary please explain	I17	Yes
Chg 7 - Focus on choice, if Mature or Exemplary please explain	I18	Yes
Chg 8 - Enhancing health in care homes, if Mature or Exemplary please explain	I19	Yes
UEC - Red Bag scheme, if Mature or Exemplary please explain	I23	Yes
Chg 1 - Early discharge planning Challenges	J12	Yes
Chg 2 - Systems to monitor patient flow Challenges	J13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Challenges	J14	Yes
Chg 4 - Home first/discharge to assess Challenges	J15	Yes
Chg 5 - Seven-day service Challenges	J16	Yes
Chg 6 - Trusted assessors Challenges	J17	Yes

Chg 7 - Focus on choice Challenges	J18	Yes
Chg 8 - Enhancing health in care homes Challenges	J19	Yes
UEC - Red Bag Scheme Challenges	J23	Yes
Chg 1 - Early discharge planning Additional achievements	K12	Yes
Chg 2 - Systems to monitor patient flow Additional achievements	K13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Additional achievements	K14	Yes
Chg 4 - Home first/discharge to assess Additional achievements	K15	Yes
Chg 5 - Seven-day service Additional achievements	K16	Yes
Chg 6 - Trusted assessors Additional achievements	K17	Yes
Chg 7 - Focus on choice Additional achievements	K18	Yes
Chg 8 - Enhancing health in care homes Additional achievements	K19	Yes
UEC - Red Bag Scheme Additional achievements	K23	Yes
Chg 1 - Early discharge planning Support needs	L12	Yes
Chg 2 - Systems to monitor patient flow Support needs	L13	Yes
Chg 3 - Multi-disciplinary/multi-agency discharge teams Support needs	L14	Yes
Chg 4 - Home first/discharge to assess Support needs	L15	Yes
Chg 5 - Seven-day service Support needs	L16	Yes
Chg 6 - Trusted assessors Support needs	L17	Yes
Chg 7 - Focus on choice Support needs	L18	Yes
Chg 8 - Enhancing health in care homes Support needs	L19	Yes
UEC - Red Bag Scheme Support needs	L23	Yes

Sheet Complete:	Yes

5. Narrative ^^ Link Back to top

	Cell Reference	Checker
Progress against local plan for integration of health and social care	B8	Yes
Integration success story highlight over the past quarter	B12	Yes

Sheet Complete:	Yes

6. iBCF Part 1 ^^ Link Back to top

	Cell Reference	Checker
A) a) Meeting adult social care needs	D11	Yes
A) b) Reducing pressures on the NHS	E11	Yes
A) c) Ensuring that the local social care provider market is supported	F11	Yes
Initative 1 - B1: Individual title	C18	Yes
Initative 1 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	C19	Yes
Initative 1 - B3: 2017-18 Project names as provided in the 2017-18 returns.	C21	Yes
Initative 1 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	C22	Yes
Initative 1 - B5: Which of the following categories the initiative / project primarily falls under.	C23	Yes
Initative 1 - B6: If "Other", please specify.	C24	Yes
Initative 1 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	C25	Yes
Initative 1 - B8: Report on progress to date:	C26	Yes
Initative 2 - B1: Individual title	D18	Yes
Initative 2 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	D19	Yes
Initative 2 - B3: 2017-18 Project names as provided in the 2017-18 returns.	D21	Yes
Initative 2 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	D22	Yes
Initative 2 - B5: Which of the following categories the initiative / project primarily falls under.	D23	Yes
Initative 2 - B6: If "Other", please specify.	D24	Yes
Initative 2 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	D25	Yes
Initative 2 - B8: Report on progress to date:	D26	Yes
Initative 3 - B1: Individual title	E18	Yes
Initative 3 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	E19	Yes
Initative 3 - B3: 2017-18 Project names as provided in the 2017-18 returns.	E21	Yes
Initative 3 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	E22	Yes
Initative 3 - B5: Which of the following categories the initiative / project primarily falls under.	E23	Yes
Initative 3 - B6: If "Other", please specify.	E24	Yes
Initative 3 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	E25	Yes
Initative 3 - B8: Report on progress to date:	E26	Yes
Initative 4 - B1: Individual title	F18	Yes
Initative 4 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	F19	Yes
Initative 4 - B3: 2017-18 Project names as provided in the 2017-18 returns.	F21	Yes
Initative 4 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	F22	Yes
Initative 4 - B5: Which of the following categories the initiative / project primarily falls under.	F23	Yes
Initative 4 - B6: If "Other", please specify.	F24	Yes
Initative 4 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	F25	Yes
Initative 4 - B8: Report on progress to date:	F26	Yes
Initative 5 - B1: Individual title	G18	Yes
Initative 5 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	G19	Yes
Initative 5 - B3: 2017-18 Project names as provided in the 2017-18 returns.	G21	Yes
Initative 5 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	G22	Yes
Initative 5 - B5: Which of the following categories the initiative / project primarily falls under.	G23	Yes
Initative 5 - B6: If "Other", please specify.	G24	Yes
Initative 5 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	G25	Yes
Initative 5 - B8: Report on progress to date:	G26	Yes
Initative 6 - B1: Individual title	H18	Yes
Initative 6 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	H19	Yes
Initative 6 - B3: 2017-18 Project names as provided in the 2017-18 returns.	H21	Yes
Initative 6 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	H22	Yes
Initative 6 - B5: Which of the following categories the initiative / project primarily falls under.	H23	Yes
Initative 6 - B6: If "Other", please specify.	H24	Yes
Initative 6 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	H25	Yes
Initative 6 - B8: Report on progress to date:	H26	Yes
Initative 7 - B1: Individual title	I18	Yes
Initative 7 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	I19	Yes
Initative 7 - B3: 2017-18 Project names as provided in the 2017-18 returns.	I21	Yes
Initative 7 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	I22	Yes
Initative 7 - B5: Which of the following categories the initiative / project primarily falls under.	I23	Yes
Initative 7 - B6: If "Other", please specify.	I24	Yes
Initative 7 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	I25	Yes
Initative 7 - B8: Report on progress to date:	I26	Yes
Initative 8 - B1: Individual title	J18	Yes
Initative 8 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	J19	Yes
Initative 8 - B3: 2017-18 Project names as provided in the 2017-18 returns.	J21	Yes
Initative 8 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	J22	Yes
Initative 8 - B5: Which of the following categories the initiative / project primarily falls under.	J23	Yes
Initative 8 - B6: If "Other", please specify.	J24	Yes

Initative 8 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	J25	Yes
Initative 8 - B8: Report on progress to date:	J26	Yes
Initative 9 - B1: Individual title	K18	Yes
Initative 9 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	K19	Yes
Initative 9 - B3: 2017-18 Project names as provided in the 2017-18 returns.	K21	Yes
Initative 9 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	K22	Yes
Initative 9 - B5: Which of the following categories the initiative / project primarily falls under.	K23	Yes
Initative 9 - B6: If "Other", please specify.	K24	Yes
Initative 9 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	K25	Yes
Initative 9 - B8: Report on progress to date:	K26	Yes
Initative 10 - B1: Individual title	L18	Yes
Initative 10 - B2: Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19?	L19	Yes
Initative 10 - B3: 2017-18 Project names as provided in the 2017-18 returns.	L21	Yes
Initative 10 - B4: If this is a 'New Initative / Project' for 2018/19, the key objectives / expected outcomes.	L22	Yes
Initative 10 - B5: Which of the following categories the initiative / project primarily falls under.	L23	Yes
Initative 10 - B6: If "Other", please specify.	L24	Yes
Initative 10 - B7: Planned total duration. For continuing projects, include running time before 2018/19.	L25	Yes
Initative 10 - B8: Report on progress to date:	L26	Yes

Sheet Complete:	Yes

6. iBCF Part 2

	Cell Reference	Checker
C) a) The number of home care packages provided for the whole of 2018-19	D11	Yes
C) b) The number of hours of home care provided for the whole of 2018-19	E11	Yes
C) c) The number of care home placements for the whole of 2018-19	F11	Yes
D) Metric 1	C18	Yes

Sheet Complete:	Yes

^^ Link Back to top

Better Care Fund Template Q1 2018/19

2. National Conditions & s75 Pooled Budget

Selected Health and Wellbeing Board: Blackpool

Confirmation of Nation Conditions		
National Condition	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**
1) Plans to be jointly agreed? (This also includes agreement with district councils on use of Disabled Facilities Grant in two tier areas)	Yes	
2) Planned contribution to social care from the CCG minimum contribution is agreed in line with the Planning Requirements?	Yes	
3) Agreement to invest in NHS commissioned out of hospital services?	Yes	
4) Managing transfers of care?	Yes	

Confirmation of s75 Pooled Budget			
Statement	**Response**	**If the answer is "No" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:**	**If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)**
Have the funds been pooled via a s.75 pooled budget?	Yes		

Better Care Fund Template Q1 2018/19

Metrics

Selected Health and Wellbeing Board: Blackpool

Challenges Please describe any challenges faced in meeting the planned target
Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics
Support Needs Please highlight any support that may facilitate or ease the achievements of metric plans

Metric	Definition	Assessment of progress against the planned target for the quarter	Challenges	Achievements	Support Needs
NEA	Reduction in non-elective admissions	On track to meet target	As part of winter planning we are currently reviewing "lessons learned" from winter 2017/18 to identify avoidable admissions and how these could be better managed in the community.	Significant work has been underway for the last year. We have been working closely with primary care, residential care, community teams along with Out of Hours providers, A&E and ambulance providers to	n/a
Res Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)	On track to meet target	n/a	Care home model integrated with the neighbourhood care teams to support care homes and coordinate patient care. Extensive Care service in place in community led by a Care of the Elderly	n/a
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Data not available to assess progress	The year-end ASCOF indicator is based only on discharges between October and December.	n/a	n/a
Delayed Transfers of Care	Delayed Transfers of Care (delayed days)	Not on track to meet target	Patient flow remains a significant area of challenge/focus. Work required to understand why BCF DTOCs (Blackpool LA level) are over plan, whereas hospital (BTH) DTOCs are much closer to the 3.5% target.	Implementation/rollout of: SAFER, boardround compliance, red-to-green, 6 discharge facilitators recruited, NEXUS real-time patient tracker IT system, D2A, additional capacity for home packages/spot	Continued support from ECIP, Newton Europe etc.

Better Care Fund Template Q1 2018/19

4. High Impact Change Model

Selected Health and Wellbeing Board: Blackpool

Challenges Please describe the key challenges faced by your system in the implementation of this change
Milestones met during the quarter / Observed Impact Please describe the milestones met in the implementation of the change or describe any observed impact of the implemented change
Support Needs Please indicate any support that may better facilitate or accelerate the implementation of this change

		Maturity Assessment					Narrative			
		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If 'Mature' or 'Exemplary', please provide further rationale to support this assessment	Challenges	Milestones met during the quarter / Observed impact	Support needs
Chg 1	**Early discharge planning**	Mature	Mature	Mature	Mature	Mature	We have a multi-disciplinary Hospital Discharge Team with staff from health and social care liaising with ward staff, patients and families to ensure that discharge planning begins as soon as possible and maintains	Achieving access to data across all professional disciplines to provide a co-ordinated approach to discharge.	A pilot is in place in a neighbourhood hub with a local GP lead to identify patients on the wards using Nexus, and where appropriate 'pull out'.	A dedicated IT team in the Acute Trust are currently developing the Nexus model. Plans are in place to produce further 'tabs' to monitor patient groups., ie care home patients.
Chg 2	**Systems to monitor patient flow**	Established	Established	Established	Established	Established		Access to 'real time' detailed data to be able to understand the patient's needs, and when they are ready to be discharged.	A 'real time' process called Nexus has been developed locally which is being used by the local Acute Trust across the wards to monitor patient flow and improve discharge	A dedicated IT team in the Acute Trust are currently developing the Nexus model. Plans are in place to produce further 'tabs' to monitor patient groups., ie care home patients.
Chg 3	**Multi-disciplinary/multi-agency discharge teams**	Established	Established	Established	Established	Established		n/a	We now have access to LCC iBCF band 4 staff for cross-border cases. This means that all wards are covered by HDT.	n/a
Chg 4	**Home first/discharge to assess**	Established	Established	Established	Established	Established		Ensuring that clinicians adopt a Home First mindset in discharge planning and ongoing care decision making.	We are in the early stages of testing a Home First pathway utilising existing health and social care teams. A Fylde Coast project team meets fortnightly .	n/a
Chg 5	**Seven-day service**	Mature	Mature	Mature	Mature	Mature	We have a number of well-established services to support this commitment such as the Rapid Response Service, Rapid Response Plus and our residential intermediate care facilities. These teams have direct access to	The recruitment process has inevitably slowed down the impact of iBCF spend in this area.	Recruitment of A&E Social Workers is now complete.	n/a
Chg 6	**Trusted assessors**	Plans in place	Plans in place	Plans in place	Plans in place	Plans in place		Funding is non-recurrent.	Non recurrent BCF monies are being used to pilot an Impartial Assessor model for care home discharge pathways. The leads developing the model are working with the Acute Trust, Council leads and other CCG	n/a
Chg 7	**Focus on choice**	Established	Established	Established	Established	Established		n/a	Our multi-disciplinary neighbourhood and hospital discharge teams work closely with service users, families and carers to ensure that they are fully aware of their options in a timely manner. Home of Choice letters are	n/a
Chg 8	**Enhancing health in care homes**	Mature	Mature	Mature	Mature	Mature	As part of the NHS Framework for EHCH, a self assessment is completed and classed as 'in place - no change required' for most areas.	The area shown as 'requires change' is for medication reviews. Other areas shown as 'implementation undeway' include linked health and social care data sets; access to care record and secure email; better use of	After the initial baseline assessment, work is ongoing across all the areas for EHCH. Further work has been completed to improve the EoLC pathways through the completion of EPaCCS for all care home patients. Funding	Funding has been agreed by NHSE.

Hospital Transfer Protocol (or the Red Bag scheme)
Please report on implementation of a Hospital Transfer Protocol (also known as the 'Red Bag scheme') to enhance communication and information sharing when residents move between care settings and hospital.

		Q4 17/18	Q1 18/19 (Current)	Q2 18/19 (Planned)	Q3 18/19 (Planned)	Q4 18/19 (Planned)	If there are no plans to implement such a scheme, please provide a narrative on alternative mitigations in place to support improved communications in hospital transfer arrangements for social care residents.	Challenges	Achievements / Impact	Support needs
UEC	**Red Bag scheme**	Established	Established	Established	Established	Established		The scheme was launched locally, but feedback from care homes meant that the scheme was paused. Bags were going missing and ward staff were unsure of the process. The concerns are currently being addressed	n/a	n/a

Better Care Fund Template Q1 2018/19

5. Narrative

Selected Health and Wellbeing Board: Blackpool

Remaining Characters:	18,846

Progress against local plan for integration of health and social care

Blackpool Council and Blackpool CCG have Integrated Commissioning staff who jointly commission and monitor schemes in the local area. They meet regularly to discuss the impact of agreed changes on the population and continually look at ways to meet increased demand and care for people in their preferred place of care. The Fylde Coast is an accelerator site for an Integrated Care Partnership (ICP) with plans being developed under key workstreams to address issues such as NELs, DToC rates, flow, length of stay and discharge processes. The Vanguard process has provided an opportunity to develop neighbourhood hubs and co-locate social workers who then complete joint visits with staff to ensure coordinated patient care. The model encourages an holistic approach to patient care with neighbourhood hubs wrapped around primary care. Staff within the neighbourhood hubs have different skill levels so they can provide the most appropriate care for each patient ie Health and Wellbeing workers with PAM (Patient Activation Measure) scores. These scores are completed by the patient as a means of showing their individual improvements and outcomes.

Please tell us about the progress made locally to the area's vision and plan for integration set out in your BCF narrative plan for 2017-19. This might include significant milestones met, any agreed variations to the plan and any challenges.

Remaining Characters:	18,808

Integration success story highlight over the past quarter

A Fylde Coast Home First Partnership has been created to test a Home First integrated pathway and embed a Home First mindset utilising all stakeholders. The partnership includes NHS Blackpool CCG, NHS Fylde and Wyre CCG, Blackpool Council, Lancashire County Council, Blackpool Teaching Hospitals NHS Foundation Trust and British Red Cross. Patients are identified via Board Rounds in the acute hospital by Discharge Facilitators and via Therapists within Clifton Hospital when identified as medically fit for discharge. Discharge plans are made with the patient and carried out within 24 hours. Patients are assessed by either Hospital Therapists or Community based Integrated Therapy teams within their own home. Plans are put in place to ensure patients are safe and able to function at home as independently as possible with crisis support arranged as and when required. Ongoing health and care needs are identified and community based teams are accessed. Social Care within our neighbourhood hubs then formally assess the patient at home within 3 days. Operational meetings take place fortnightly to review practice and progress to date, and to develop the pathway for eventual roll out.

Please tell us about an integration success story observed over the past quarter highlighting the nature of the service or scheme and the related impact.

Better Care Fund Template Q1 2018/19

Additional improved Better Care Fund - Part 1

Selected Health and Wellbeing Board:	Blackpool
Additional improved Better Care Fund Allocation for 2018/19:	£ 2,590,669

Section A

What proportion of your additional iBCF funding for 2018-19 are you allocating towards each of the three purposes of the funding?	**a) Meeting adult social care needs**	**b) Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready**	**c) Ensuring that the local social care provider market is supported**
Please enter the amount you have designated for each purpose as **a percentage of the total additional iBCF funding you have been allocated for the whole of 2018-19.** If the expenditure covers more than one purpose, please categorise it according to the primary purpose. **Please ensure that the sum of the percentage figures entered does not exceed 100%. If you have not designated any funding for a particular purpose, please enter 0% and do not leave a blank cell.**	0%	41%	59%

Section B

What initiatives / projects will your additional iBCF funding be used to support in 2018-19?	**Initiative/Project 1**	**Initiative/Project 2**	**Initiative/Project 3**	**Initiative/Project 4**	**Initiative/Project 5**	**Initiative/Project 6**	**Initiative/Project 7**	**Initiative/Project 8**	**Initiative/Project 9**	**Initiative/Project 10**
B1) Provide individual titles for no more than 10 initiative / projects. If you are funding more than 10 initiatives / projects, you should list those with the largest size of investment in 2018-19. Please do not use more than 150 characters.	Maintaining in-house home care service capacity	Funding of assistive technology units above commission for health and social care, alongside associated increase in staffing to assure response	Additional in-house home care capacity	Increase in regulated care hourly rate	Social work cover at weekends in A&E	Neighbourhood Response Team				
B2) Is this a continuation of an initiative / project from 2017-18 or a new project for 2018-19? Use the drop-down menu, options below: Continuation New initiative/project	Continuation	Continuation	Continuation	Continuation	Continuation	Continuation				
Click here for a reminder of initative / project titles submitted in Quarter 4 2017/18										
B3) If you have answered question B2 with "Continuation" please provide the name of the project as provided in the 2017-18 returns. See the link above for a reminder of the initiative / project titles submitted in Q4 2017-18. Please do not select the same project title more than once.	Maintaining in-house home care service capacity.	Funding of assistive technology units above commission for health and social care, alongside associated increase in staffing to assure response	Additional in-house home care capacity.	Increase in regulated care hourly rate.	Social work cover at weekends in A&E.	Neighbourhood Response Team				
B4) If this is a "New Initative / Project" for 2018/19, briefly describe the key objectives / expected outcomes. Please do not use more than 250 characters.										
B5) Use the drop-down menu provided or type in one of the categories listed to indicate which of the following categories the initiative / project primarily falls under. Hover over this cell to view the comment box for the list of categories if drop-down options are not visible.	3. DTOC: Reducing delayed transfers of care	14. Technology	16. Stabilising social care provider market - fees uplift	17. Stabilising social care provider market - other support (e.g. training, property maintenance)	9. NHS: Reducing pressure on the NHS	11. Prevention				
B6) If you have answered question B5 with "Other", please specify. Please do not use more than 50 characters.										
B7) What is the planned total duration of each initiative/project? Use the drop-down menu, options below. For continuing projects, you should also include running time before 2018/19. 1) Less than 6 months 2) Between 6 months and 1 year 3) From 1 year up to 2 years 4) 2 years or longer	3. From 1 year up to 2 years	3. From 1 year up to 2 years	3. From 1 year up to 2 years	3. From 1 year up to 2 years	3. From 1 year up to 2 years	3. From 1 year up to 2 years				
B8) Use the drop-down options provided or type in one of the following options to report on progress to date: 1) Planning stage 2) In progress: no results yet 3) In progress: showing results 4) Completed	3. In progress: showing results	3. In progress: showing results	3. In progress: showing results	4. Completed	3. In progress: showing results	3. In progress: showing results				

Better Care Fund Template Q1 2018/19

Additional improved Better Care Fund - Part 2

Selected Health and Wellbeing Board:	Blackpool
Additional improved Better Fund Allocation for 2018/19:	£ 2,590,669

Section C

What impact does the additional iBCF funding you have been allocated for 2018-19 have on the plans you have made for the following:			
	a) The number of home care packages provided for the whole of 2018-19:	**b) The number of hours of home care provided for the whole of 2018-19:**	**c) The number of care home placements for the whole of 2018-19:**
C1) Provide figures on the planned number of home care packages, hours of home care and number of care home placements you are purchasing/providing as a direct result of your additional iBCF funding allocation for 2018-19. The figures you provide should cover the whole of 2018-19. Please use whole numbers with no text, if you have a nil entry please could you enter 0 in the appropriate box.	80	1,200	-

Section D

Indicate no more than five key metrics you will use to assess your performance.					
	Metric 1	**Metric 2**	**Metric 3**	**Metric 4**	**Metric 5**
D1) Provide a list of up to 5 metrics you are measuring yourself against. Please do not use more than 100 characters.	Number of Home's Best Hours delivered	Number of recipients of service provided by Home's Best			

Better Care Fund Template Q1 2018/19

Additional iBCF Q4 2017/18 Project Titles

Selected Health and Wellbeing Board: Blackpool

[<< Link to 6. iBCF Part 1]

Quarter 4 2017/18 Submitted Project Titles

Project information not submitted in 2017-18 reporting

Project Title 1	Project Title 2	Project Title 3	Project Title 4	Project Title 5	Project Title 6	Project Title 7	Project Title 8	Project Title 9	Project Title 10	Project Title 11	Project Title 12	Project Title 13	Project Title 14	Project Title 15
Maintaining in-house home care service capacity.	Funding of assistive technology units above commission for health and social care, alongside associated increase in staffing to assure response time.	Additional in-house home care capacity.	Increase in regulated care hourly rate.	Social work cover at weekends in A&E.	Neighbourhood Response Team									

Project Title 16	Project Title 17	Project Title 18	Project Title 19	Project Title 20	Project Title 21	Project Title 22	Project Title 23	Project Title 24	Project Title 25	Project Title 26	Project Title 27	Project Title 28	Project Title 29	Project Title 30

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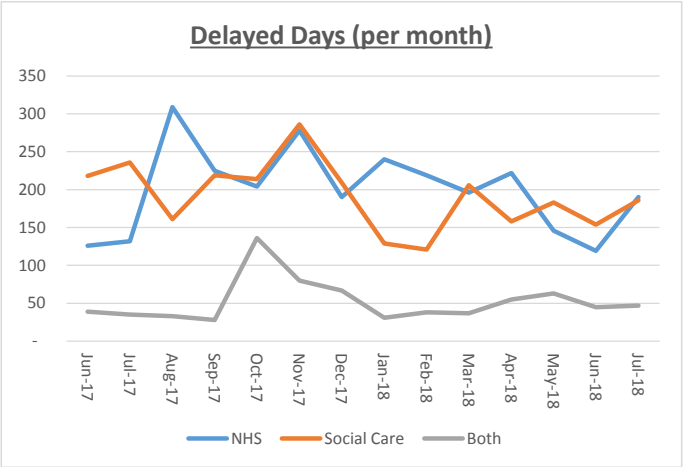
Appendix 3d

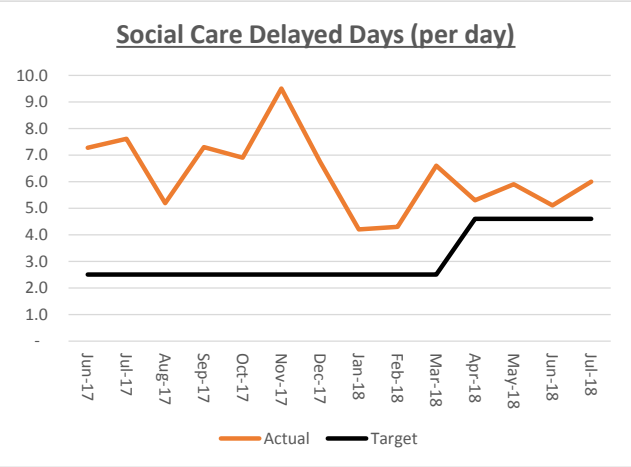
Delayed Transfers of Care (DToC) - Blackpool

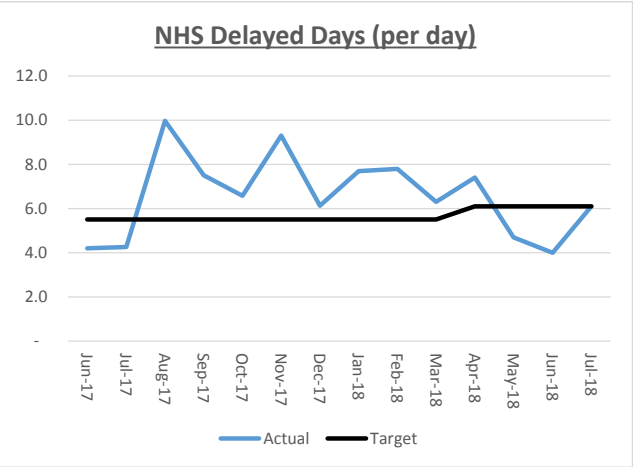
Period	Delayed Days (per month)		
	NHS	Social Care	Both
Jun-17	126	218	39
Jul-17	132	236	35
Aug-17	309	161	33
Sep-17	225	219	28
Oct-17	204	214	136
Nov-17	278	286	80
Dec-17	190	209	67
Jan-18	240	129	31
Feb-18	219	121	38
Mar-18	196	206	37
Apr-18	222	158	55
May-18	146	183	63
Jun-18	119	154	45
Jul-18	190	186	47

Period	Social Care Delayed Days per Day	
	Actual	Target
Jun-17	7.3	2.5
Jul-17	7.6	2.5
Aug-17	5.2	2.5
Sep-17	7.3	2.5
Oct-17	6.9	2.5
Nov-17	9.5	2.5
Dec-17	6.7	2.5
Jan-18	4.2	2.5
Feb-18	4.3	2.5
Mar-18	6.6	2.5
Apr-18	5.3	4.6
May-18	5.9	4.6
Jun-18	5.1	4.6
Jul-18	6.0	4.6

Period	NHS Delayed Days per Day	
	Actual	Target
Jun-17	4.2	5.5
Jul-17	4.3	5.5
Aug-17	10.0	5.5
Sep-17	7.5	5.5
Oct-17	6.6	5.5
Nov-17	9.3	5.5
Dec-17	6.1	5.5
Jan-18	7.7	5.5
Feb-18	7.8	5.5
Mar-18	6.3	5.5
Apr-18	7.4	6.1
May-18	4.7	6.1
Jun-18	4.0	6.1
Jul-18	6.1	6.1







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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Amy Cross, Cabinet Member for Adult Services and Health
Date of Meeting	10 October 2018

PUBLIC HEALTH ANNUAL REPORT 2017

1.0 Purpose of the report:

1.1 To present "From the Ground Up: Annual report on the health of the people of Blackpool 2017" the Director of Public Health's latest annual independent assessment of local health needs, determinants and concerns.

2.0 Recommendation(s):

2.1 To receive the Public Health Annual Report 2017 (attached at Appendix 4a).

2.2 To consider any action from the Board regarding and to endorse the report's headline statements namely:

1. To welcome the forthcoming Blackpool Housing Strategy and to note that the key to success will be to deliver all the actions identified within the strategy, at scale and pace.

2. To note that Blackpool Council has experienced amongst the highest budget cuts of authorities across the country and this has been especially challenging given the high levels of need and transience within the town. Although the Council has been very creative in managing these significant challenges, it is important now to recognise the need for future funding formulas to fully incorporate the high level of need and address the root causes of ill health locally.

3.0 Reasons for recommendation(s):

3.1 This year's report starts with a look back at trends for a selection of key population health indicators and describes the changes seen over the past ten years. Over the decade, the health of the population has improved. There have been significant

reductions in early deaths form major killers including heart disease and cancer, as well as in deaths form suicide. There is good progress too in reducing smoking rates, one of the major lifestyle factors influencing health. There is also a strong trend in reducing rates of teenage pregnancies. This progress shows the importance of having in place population-wide strategies based on good academic evidence to address key issues affecting our public's health. There are, however, some emerging challenges and it is of concern to note the steep rise in rates of self-harm, and of drug and alcohol misuse. Effective action by the Big Lottery's HeadStart programme, and the implementation of a new Drug Prevention Strategy both offer chances to make a difference.

This year's report presents detailed analyses of the impact of population change on our population health statistics and considers the role of the local housing market in driving this change. The picture that emerges from these analyses is that an abundance of low-cost accommodation is driving inward migration of a younger population that is less healthy and less well-educated into central areas of the town. This increasing the population level inequalities in health experienced within the town.

The report contains headline statements as follows:

1. It welcomes the forthcoming Blackpool Housing Strategy. The key to success will be to deliver all the actions identified within the strategy, at scale and pace.

2. Blackpool Council has experienced amongst the highest budget cuts of authorities across the country and this has been especially challenging given the high levels of need and transience within the town. Although the Council has been very creative in managing these significant challenges, it is important now to recognise the need for future funding formulas to fully incorporate the high level of need and address the root causes of ill health locally.

3.2a	Is the recommendation contrary to a plan or strategy adopted or approved by the Council?	No
3.2b	Is the recommendation in accordance with the Council's approved budget?	Yes

3.3 Other alternative options to be considered:

None.

4.0 Council Priority:

4.1 The relevant Council Priority is "Communities: Creating stronger communities and increasing resilience".

5.0 Background Information

5.1 The Director of Public Health has a statutory duty to write an annual report on the health of the local population.

5.2 The Annual Report on the Health of the People of Blackpool 2017 is the latest in the series of annual reports and is circulated widely across senior leaders and partners across the town. These reports are available for public viewing the Libraries and recent ones are published electronically on the Blackpool Joint Strategic Needs Assessment (JSNA) website at www.blackpooljsna.org.uk.

5.3 Does the information submitted include any exempt information? No

5.4 **List of Appendices:**

Appendix 4a: From the Ground Up Public Health Annual Report 2017

6.0 Legal considerations:

6.1 The local authority has a duty to publish the annual report of the Director of Public Health (section 73B(5) and (6) of the 2006 Act, inserted by section 31 of the 2012 Act).

7.0 Human Resources considerations:

7.1 None.

8.0 Equalities considerations:

8.1 Reducing inequalities in health is a key activity for public health and features and a fundamental consideration in many of the work areas and initiatives discussed in the report.

9.0 Financial considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Ethical considerations:

11.1 None.

12.0 Internal/ External Consultation undertaken:

12.1 None.

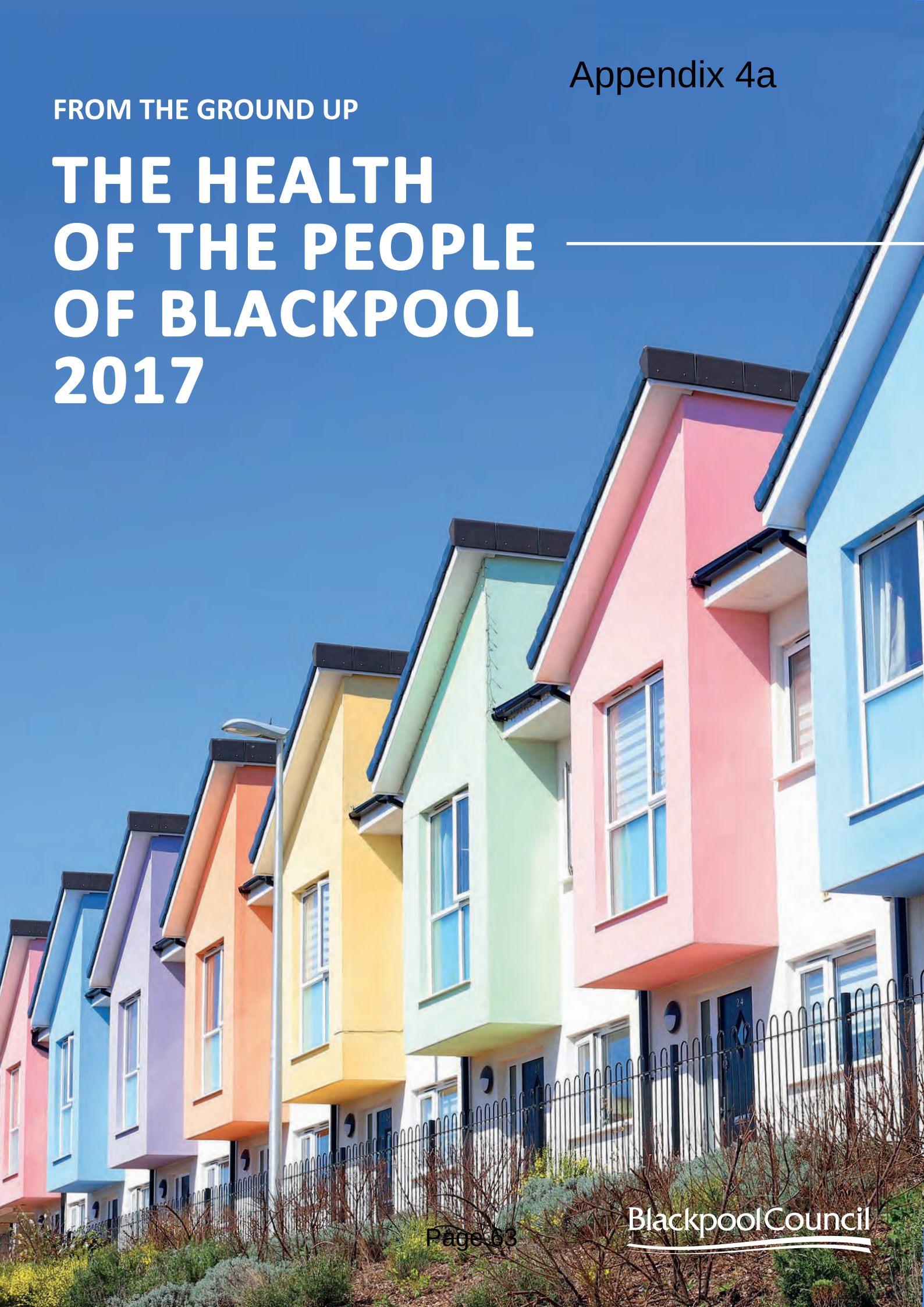
13.0 Background papers:

13.1 None.

Appendix 4a

FROM THE GROUND UP

THE HEALTH OF THE PEOPLE OF BLACKPOOL 2017



Blackpool Council

Foreword

Foreword

This year marks my tenth anniversary as Director of Public Health for Blackpool. 2017 has seen the completion of a number of major pieces of work that will help improve the health and wellbeing of Blackpool residents.

These include collaboration with Blackpool's Better Start programme to introduce a new model for health visiting, which will see all young children within the town benefit from at least eight contacts with their health visitor to monitor their development, and provide support to parents. The new approach aims to ensure that all our infants and young children can achieve their full potential in terms of growth and development, and are fully ready to learn when they start school. I look forward to seeing this new model embed over the coming year. Staying with young children for a moment, I am pleased to report that we will be working with national Public Health England colleagues after being identified as a pilot site for their Start Well programme to promote good oral health amongst our children.

Members of my public health team have worked closely with Positive Steps and Horizon drug and alcohol treatment services to submit a successful bid to Public Health England to take part in a research project on Individual Placement Support for people with Drug and Alcohol addiction.

The project will offer support to those in drug and alcohol treatment services to gain training, education and employment. The project will run as a pilot over the next two years and is anticipated to make a difference to supporting these individuals back to work and sustain their employment.

There has been excellent progress in work with the local NHS on the development of new neighbourhood models of care and support to patients and communities. We have played a key role in making sure that commissioning decisions have been made based on the needs, opportunities and solutions to improving community health and wellbeing to ensure that health and social care providers move beyond medical intervention, treatment and care. Social prescribing, using our new Directory of Service (FYI) is now a key element of any treatment and care intervention planning.

Members of my team have taken a lead in putting people and communities at the heart of current and future planning of services, with the ambition to incorporate fully this 'coproduction' approach as the way forward. We have facilitated discussions (including Integration 20:20 events) between the NHS and wider partners, such as my Council colleagues and the voluntary, community and faith sectors, to ensure that all are aware of the plans and ambitions with these new models of care.

All new neighbourhood models need all key partners around the table; and that includes people and communities if they are to be fully integrated. A Self Care Strategy for the Fylde Coast has recently been completed and sets the tone of our ambitions to ensure everyone has the opportunity to make informed lifestyle decisions, can access healthy lifestyle choices and are equal partners in any decisions about the care and support they may receive as patients should they fall ill. Our work on resident-led Citizens Inquiries will continue in 2018 as we take a further step towards Integration 20:20.

The priority of reducing inequalities in health has featured in some way in all my reports as Director of Public Health for Blackpool and indeed many of those by my predecessors. The latest release of data for local authorities shows that not only do Blackpool residents continue to experience the lowest life expectancy in the country, but this has slightly dropped for the first time in 20 years. Blackpool is not alone and it offers no comfort to note that other disadvantaged areas of the country also see this happening. Life expectancy is a useful indicator of the population's health, but it does mask important changes in the types of health conditions experienced. In the first section of this report, I describe how health has changed for the residents of the town over the past ten years.

The importance of lifestyle and wider social and environmental conditions in determining our population's health is another common feature of my reports. New analyses by my team has explored wider factors that may be contributing to reduced life expectancy in the town and has focused attention on the issue of the abundant supply of poor quality, cheap housing and how this may be driving poor health in the town in a number of ways. The links between physical conditions of homes and residents health are well accepted and the evidence-base can point us towards effective intervention. The relationship between housing supply, population flow and population health is more complex and there is concern that this may be drawing people with poor health into the town. This is an important area for further research and discussion. In section two, I present local analyses that I hope will stimulate this debate.

In 2018, I look forward to the publication of a Green and Blue Infrastructure Strategy by Blackpool Council. Together with the ten year action plan, this will help to make the most of Blackpool's existing assets, identify where more parks or green spaces are required, build green infrastructure into plans for the future of the town centre and explain how we plan to increase the engagement of local people to maintain our local gardens, trees and parks. A key part of the plan is the creation of a Community Farm as part of the redevelopment of the former City Learning Centre site. This development, known as @theGrange, brings a new community-focused centre for the Grange Park community and people living in the surrounding area. The centre will include our first community shop, sponsored by Blackpool's Fairness Commission, which will sell, amongst other things, produce from the farm @theGrange will be the hub at the heart of the plans to develop further housing on Grange Park.

Over the coming year we can also expect to see work progress on plans to develop Whyndyke Garden Village, a new housing development on the boundary of Blackpool and Fylde. Backed by NHS England, this will be a demonstrator site promoting good practice nationally and internationally in putting health and wellbeing at the centre of new housing developments.

It is evident to me that the health and wellbeing of Blackpool's residents is improving, however, there remain considerable challenges we must address in order to build on and accelerate the progress made.

Dr Arif Rajpura **Director of Public Health**

2. HOW HEALTH IN BLACKPOOL IS CHANGING

Ten years on from my appointment as Blackpool's Director of Public Health, it seems timely to look at how the health of residents in the town has changed over the decade.

We can use life expectancy to summarise today's death rates amongst different age groups in our population in a single figure. Over the past ten years, life expectancy in Blackpool has increased from 73.2 to 74.3 for men and from 78.8 to 79.4 for women. Whilst life expectancy is a convenient summary, there is more to learn about how our population's health is changing by looking at a range of indicators including trends in specific diseases, health risk factors and wider determinants of health. Blackpool's Health Profiles include a selection of indicators and the 2017 release is included in Appendix 1 of this report.

In the analyses that follow, I present a selection of indicators from this profile and from Public Health England's Public Health Outcomes Framework (https://fingertips.phe.org.uk/) that show particularly notable changes.

Trends in premature deaths from heart disease, stroke and cancer

Cardiovascular disease (heart disease and stroke) and cancer are the two most common broad causes of death locally and nationally. According to the Office for National Statistics (ONS), for England and Wales in 2016, cardiovascular disease accounted for 28.5% of all deaths registered and cancer accounted for 25.5%. Therefore, taken together, these two broad causes account for over half of all deaths.

> **I am pleased to report significant improvements in Blackpool. Most notable is that early deaths from cardiovascular disease have reduced by a third and we now see more than 65 fewer people each year in Blackpool die before they reach their 75th birthday. The improvement in premature deaths from cancer is more modest at around 4%, but still important given the numbers of people affected.**

These diseases are major killers and even small improvements in death rates can have a significant impact on our population's life expectancy. The NHS Health Checks Programme, commissioned locally by the council, is a systematic way of finding people with high blood pressure and other risk factors, and providing advice and referral for treatment.

Refer to Figure 1

Trends in smoking

The prevalence of smoking in a population is a major contributor to the differences or inequalities in health seen between populations. Over the last ten years in Blackpool, we have seen a steady improvement in smoking rates and hints of an acceleration in this decline in the past few years. This trend follows the national pattern, and whilst rates in Blackpool are above average, they have kept pace with the national improvement. Rates amongst the population subgroup of 'Routine and Manual' workers, who typically have the highest rates of smoking, have similarly improved in line with the national picture. It is encouraging to see indications that this may be happening at a faster rate in Blackpool, which has the effect of narrowing the gap between our rates and the national average.

Smoking related deaths appear to have slightly improved overall. Although higher than average, this again appears to reflect the national trend. It will be some years before reduced rates of smoking impact on smoking related death rates.

Smoking remains the single biggest lifestyle factor affecting health in the town and we must continue to make progress to reduce smoking. My team is currently developing new arrangements to provide effective support to help people quit.

Refer to Figure 2

Overweight and obesity

The weight of our children has been the subject of much attention in the media in recent years. Disadvantaged areas across the country report higher than average rates of overweight and obesity amongst children. Rates have been rising over the past ten years, and this rise became more pronounced from 2011/2012 onwards. The latest set of figures appear to show a change in our local rates that may provide early signs of improvement. It is important to be cautious in interpreting this single figure and we need to see this sustained if we are to conclude that rates have turned around. The current rates for Year 6 children (aged 10-11) in Blackpool are in line with the national average. However, I consider the national average is unacceptably high. It remains that one in four young children are overweight or obese when they start school and one in three children leave primary school overweight or obese.

Obesity places individuals of any age at increased risk of a number of serious health conditions. Losing weight and keeping a healthy weight can be very difficult to achieve. The environment around us can often undermine our best efforts to make healthier choices. The underlying causes of obesity are complex and it is too simplistic to expect education and messaging alone to make a difference. We have to make healthier choices easier wherever we can. Blackpool Council's Declaration on Healthy Weight and the resulting actions will see the Council doing its part and encouraging organisations, businesses and communities across the town to join in action.

Refer to Figure 3

Trends in self-harm and suicide

Suicide rates and admissions to hospital for self-harm offers an indication of the mental health of our population. Deaths from suicide tend to occur amongst younger and middle age groups and this can have a disproportionately large impact on the life expectancy figure. Deaths from suicide make a significant contribution in explaining the lower than average life expectancy rate amongst the town's residents.

The relatively small number of deaths from suicide seen amongst Blackpool residents means that on a technical level, trends can be unstable and need careful interpretation. However, the overall picture is that suicide rates are moving in the right direction and improving.

Rates of self-harm have increased sharply over the last decade. They appear to have stabilised and slightly improved over the past four years, but remain very high and strikingly different to the national picture. This highlights the importance of programmes such as HeadStart that promote mental wellbeing and support the development of emotional resilience.

Refer to Figure 4

Figure 1 **Premature mortality (age <75) from cardiovascular diseases and cancer**

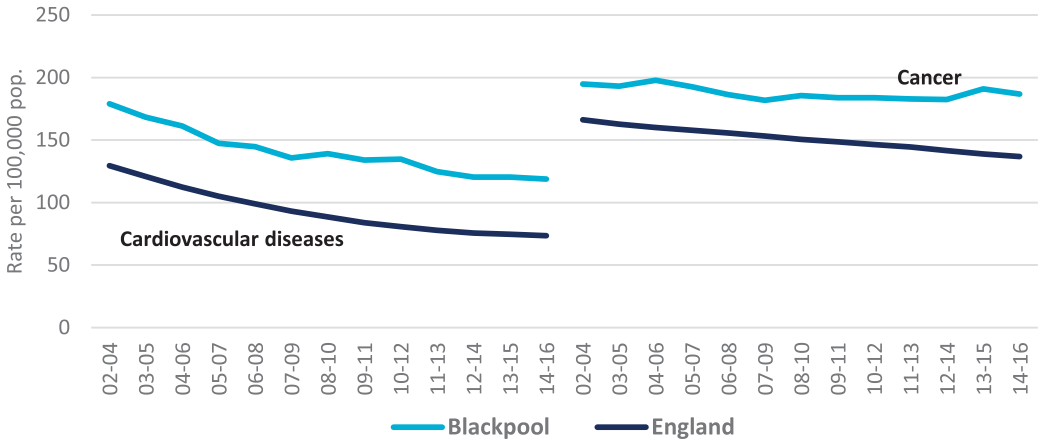


Figure 2 **Smoking**

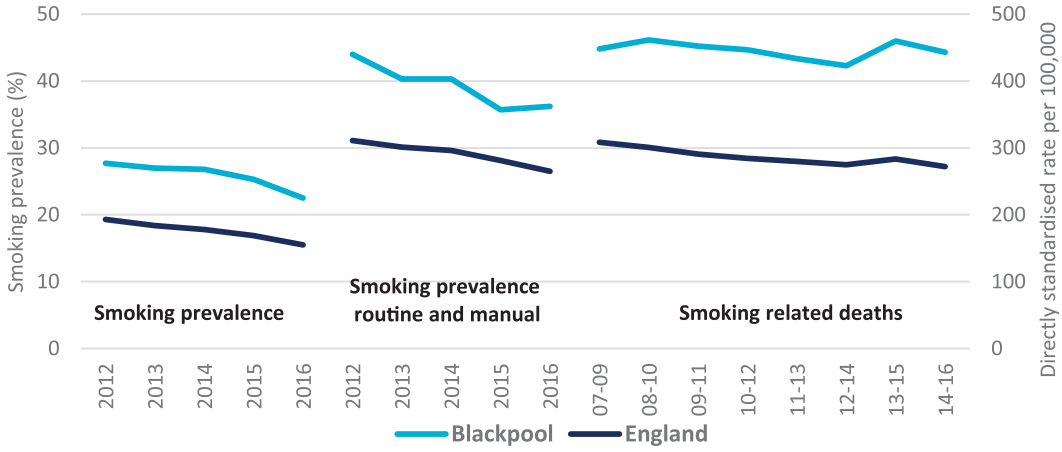


Figure 3 **Prevalence of overweight (including obese) among children in Reception and Year 6**

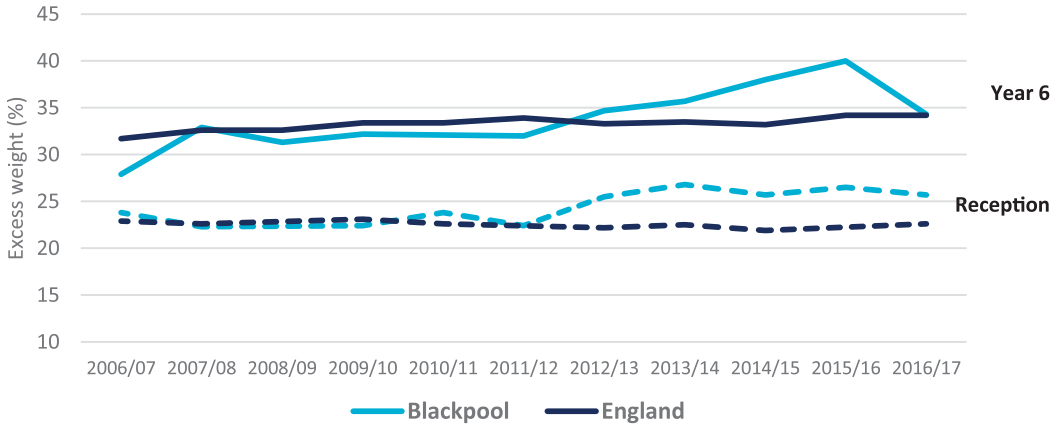
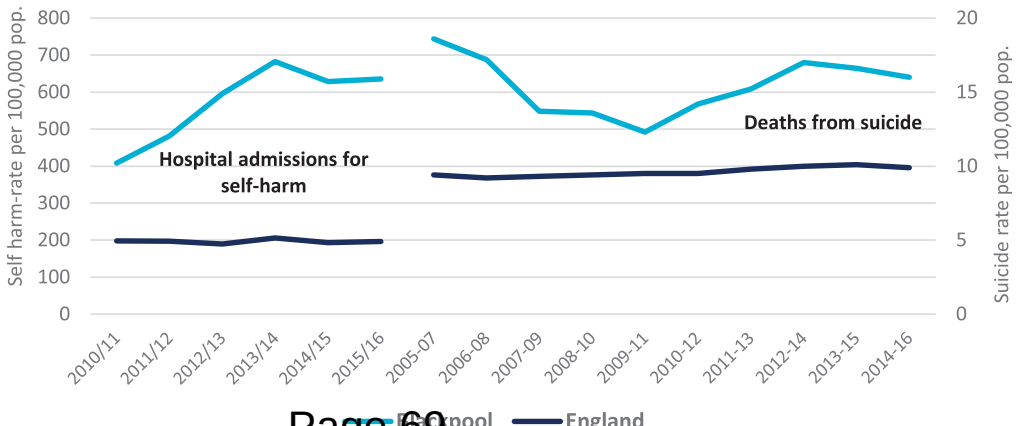


Figure 4 **Self harm and suicide**



Trends in alcohol-related harm, substance misuse and drug-related deaths

Higher than average rates of alcohol-related conditions and substance misuse are, along with suicide, important factors that help explain Blackpool's lower than average life expectancy. Rates of alcohol-related harm have risen steadily over the decade and diverged from the national average, although have improved over the last few years. Rates of substance misuse amongst young people have risen steeply and at very much greater rates than the national average. To me this highlights just how vital it is that the Council and other organisations across the town work alongside the community to improve the opportunities and aspirations of our young people.

Drug-related deaths rates for Blackpool are based on small numbers and so show considerable year on year variation, but overall the trend is increasing. These deaths tend to occur amongst younger age groups and therefore even small numbers of deaths can make a significant impact on the life expectancy figure for an area. These trends are recognised and my team has recently led the production of a Drug Prevention Strategy for the town. I commend this strategy to colleagues across the Council and to partner organisations, who can all play a part in addressing this issue.

Refer to Figure 5 & 6

Trends in teenage pregnancy

Teenage pregnancy is an acknowledged public health issue since it is associated with poorer social, economic, educational and health and wellbeing outcomes for young parents and their children. The number of teenage pregnancies has fallen considerably over the past decade from 176 during 2005 to 108 in 2015.

Blackpool rates remain high relative to the national average, but these have changed more quickly in Blackpool than they have nationally and the gap has narrowed. This is significant progress and it is important to recognise the evidence-based strategy that has been in place tackling this issue in Blackpool.

Refer to Figure 7

Homelessness

My final choice of indicator is particularly relevant in the context of the following section, which looks at the links between housing and health. Homelessness is associated with severe poverty and is a social determinant of health. It is also associated with adverse health, education and social outcomes, particularly for children. The data discussed here relates to the number of households that have presented themselves to their local authority, but under homelessness legislation have been deemed not in priority need. The majority of the people that fall under this cohort are single homeless people. Households and individuals that are eligible, but not in priority need or are in temporary accommodation can have greater public health needs than the population as a whole.

Data published in the Public Health Outcomes Framework appears to indicate a rise in the number of households accepted as non-priority homeless in Blackpool. These figures require careful interpretation as they are partly driven by whether councils have chosen to undertake a homelessness assessment, and practices in regards to assessments varies between councils and over time. However, we can say that overall the picture is one of consistently high levels of homelessness in Blackpool over the last five years with some slight rises in recent years.

Refer to Figure 8

Figure 5 **Hospital admissions from alcohol Hospital admissions from alcohol**

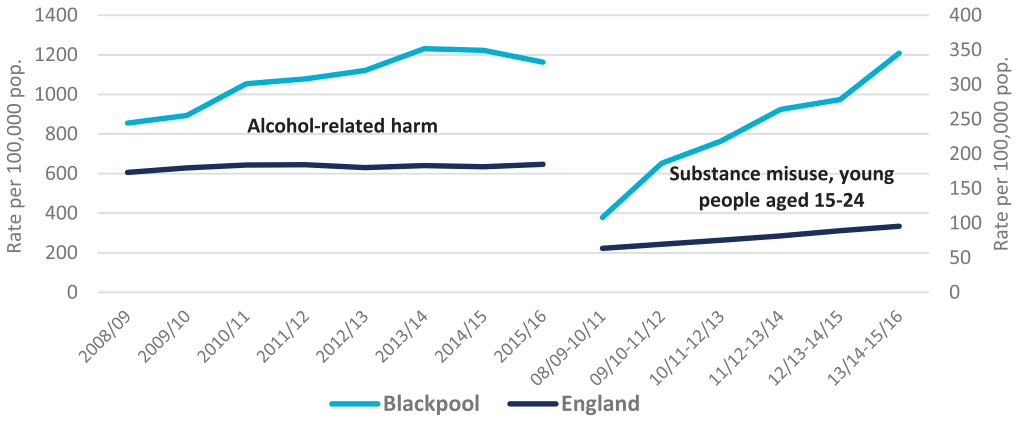


Figure 6 **Drug related deaths**

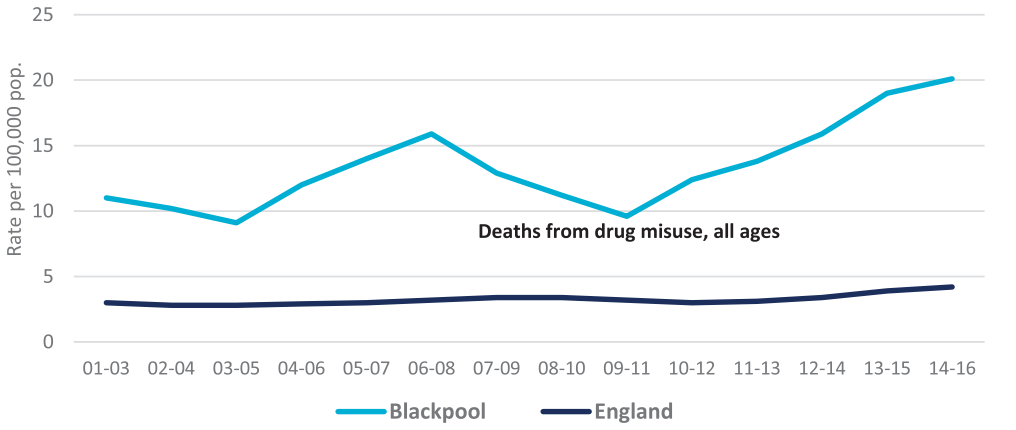


Figure 7 **Trend in conception rates, all ages and under 18 years**

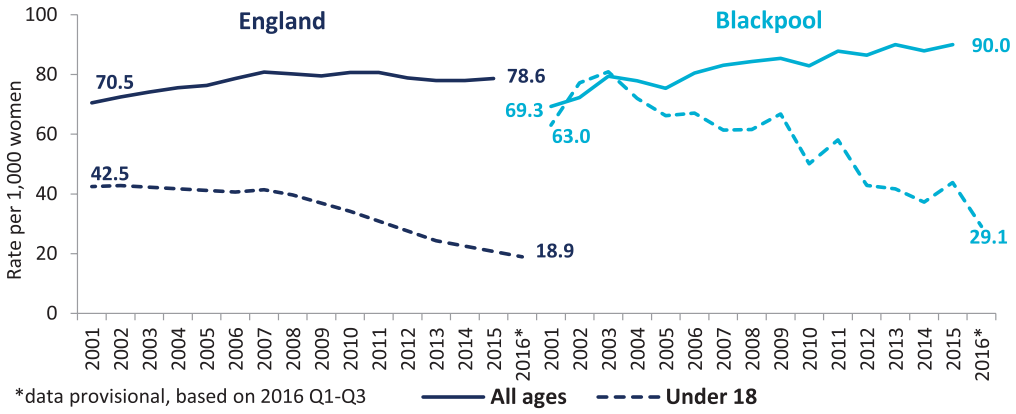
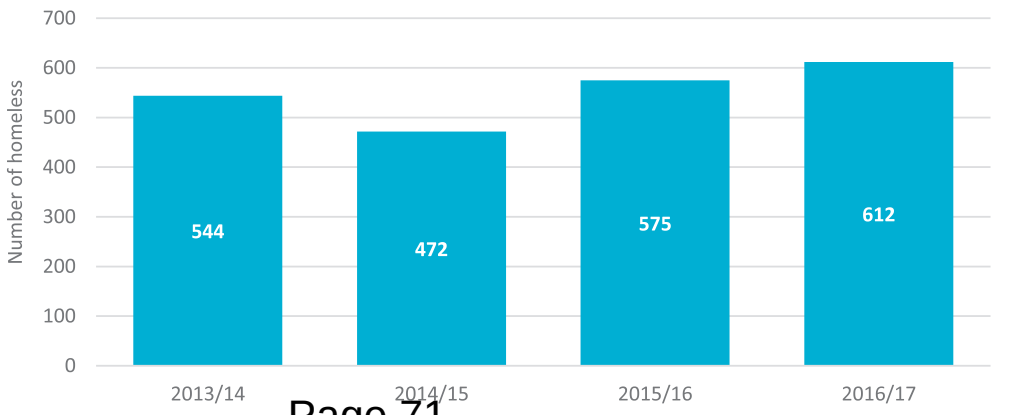


Figure 8 **Statutory homelessness - eligible homelessness people not in priority need, Blackpool**



Summary

We can see that overall the health of our resident population has improved over the past decade. Particularly significant are the improvements in early deaths from major killers of heart disease, stroke and cancer, as well as in deaths from suicide. There is good progress too in improving smoking rates, one of the major lifestyle factors influencing health.

It is important to continue with action to maintain this momentum if we are to secure the contribution this can make to reduce inequalities in the years to come.

Similarly, there have been significant reductions in teenage pregnancy, which will help improve social, health and wellbeing and educational outcomes for young women in the town.

The steep rises seen in self-harm and in drug and alcohol-misuse especially amongst young people are alarming and a cause for concern. I take this opportunity to highlight the importance of programmes such as HeadStart and of the Drug Prevention Strategy, both of which offer real chances to make a difference.

It's great to see some of the progress that has been made, and vital that we continue to build on this. Understanding the underlying drivers of our population health statistics is key to developing and refining action to improve health. One area that is worthy of closer inspection is the role of that housing, in particular the characteristics of the local housing market, plays in driving migration to the town. There are concerns that people moving into the town are in poorer health. I explore this consideration in more detail in the next section which presents analyses by my team on migration.

2. HOUSING AND HEALTH IN BLACKPOOL

In this section, I firstly consider the issue of housing and health from a range of perspectives including housing quality and health, homelessness and health and the impact of housing supply and demand on migration and population.

Secondly, I present recent local analyses that explore the impact of population change on our local population health indicators.

Thirdly, I look at housing related interventions that could improve our local population's health and wellbeing.

Housing and health: issues to consider

Housing quality and health

There is little doubt that for individual residents, living in poor housing exposes them to a range of physical hazards and may be associated with overcrowding and social isolation. These issues can have a disproportionate impact on vulnerable groups in our communities. For individuals, the impact of the physical condition of housing on health is well understood. Hazards such as excess cold, damp and mould or structural problems (such as poor lighting or lack of handrails on stairways) increase the risk of cardiovascular disease, respiratory disease, depression and anxiety and accidents.[1]

Homelessness

Being homeless or not having a stable home are also well documented risk factors for poorer health, particularly mental health problems.

You count as homeless if you are:

- staying with friends or family
- staying in a hostel, night shelter or Bed and Breakfast (B&B)
- squatting (because you have no legal right to stay)
- at risk of violence or abuse in your home
- living in poor conditions that affect your health
- living apart from your family because you do not have a place to live together[2]

Source: Shelter, 2016

1. Parliamentary Office of Science and Technology. Housing and Health. POSTNOTE Number 371, January 2011

2. http://england.shelter.org.uk/housing_advice/homelessness/rules/what_is_homelessness

Population turnover and health

A number of academic researchers have written about population change and mobility and have proposed models for describing these patterns. In this section I describe two of these models that have been applied within UK populations. These models are helpful in understanding the factors driving population movement, some aspects of the models may require modification for the context in Blackpool. The term 'spatial segregation' describes the phenomenon where residents become grouped in areas according to socioeconomic status, so that people on low incomes are concentrated in more disadvantaged areas. The subject has been recognised and discussed amongst academic researchers for many years and it is evident that the picture varies over time and between places.

However, the processes and scale of flows that drive such changes in populations and communities are less clear. A study of 2001 England and Wales Census data suggested that population flows act to continually reinforce spatial segregation particularly in deprived areas through net loss of better qualified individuals (those who get on, get out). The researchers offer some evidence to support this although it is somewhat weak and they suggest the effect may be small.[3] The same study concluded that demographics, not deprivation, drives population turnover. Neighbourhoods with high proportions of young adults and families with young children are most likely to have high turnover.

A more recent study of working age people using the 2001 Scottish Census has attempted to quantify flow and found that the 1991 and 2001 populations comprised very different individuals and that one third of the original people had 'exited' and been replaced with others ('entries').[4] The same author suggests that exits tend to increase segregation, whereas entries tend to reduce it. This conclusion assumes that entries into deprived communities are typically younger, healthier and better educated and that a process known as the 'demographic conveyor' is at work. This process describes how populations in deprived areas steadily turnover in relation to the age of residents. Younger people tend to move up the neighbourhood hierarchy as they age and their incomes rise, although applied to the Blackpool context, we will see shortly that this assumption may not hold true locally. The same authors also note that individual decisions to move are dominated by housing needs and demand and how easy it is to move. If people are not able to move, then segregation falls.

In summary, the research literature suggests that a number of processes may be driving mobility and population changes in our deprived communities. Three broad processes appear to feature:

1. demographic characteristics and age-related churn;
2. housing needs and demands; and
3. how easy or difficult it is for people to move.

3. Bailey N and Livingston M. Population turnover and area deprivation. Joseph Rowntree Foundation (JRF), 2007. https://www.jrf.org.uk/report/population-turnover-and-area-deprivation

4. Bailey N. How spatial segregation changes over time: sorting out the sorting processes. Environment and Planning A 2012, volume 44, pages 705-722

Analyses: Local life expectancy trends and migration patterns

Life expectancy is one of the key indicators of health in a population. Life expectancy is the average number of years that a new baby is expected to live if current age-specific mortality rates continue to apply through their lifetime. Across England, a steady improvement in life expectancy has been seen since the Second World War, but that has slowed in recent years for both males and females, and this pattern is evident in Blackpool. **Figure 9** shows that although life expectancy in Blackpool has continued to improve over the past 20 years, it has not kept pace with England as a whole and now a considerable gap in life expectancy exists between Blackpool and England. Life expectancy in males in Blackpool is 74.2 years, compared to 79.5 years for England, a gap of 5.3 years. Life expectancy in females in Blackpool is 79.5 years, compared to 83.1 years in England, a gap of 3.6 years. The factors that create this long-term, structural gap in life expectancy between Blackpool and England as a whole are important to explore.

Male life expectancy in Blackpool is the lowest of any local authority in England and female life expectancy is the second lowest.

Figures 10 and 11 show there is considerable variation within the town. Male life expectancy in Stanley ward is 78.8 years compared to 65.8 years in Bloomfield ward, a 13-year difference. Male life expectancy in Bloomfield ward is the second lowest of all electoral wards in England. There is a gap of seven years in female life expectancy between Stanley ward (83.8 years).

Figure 9 **Trend in life expectancy at birth**

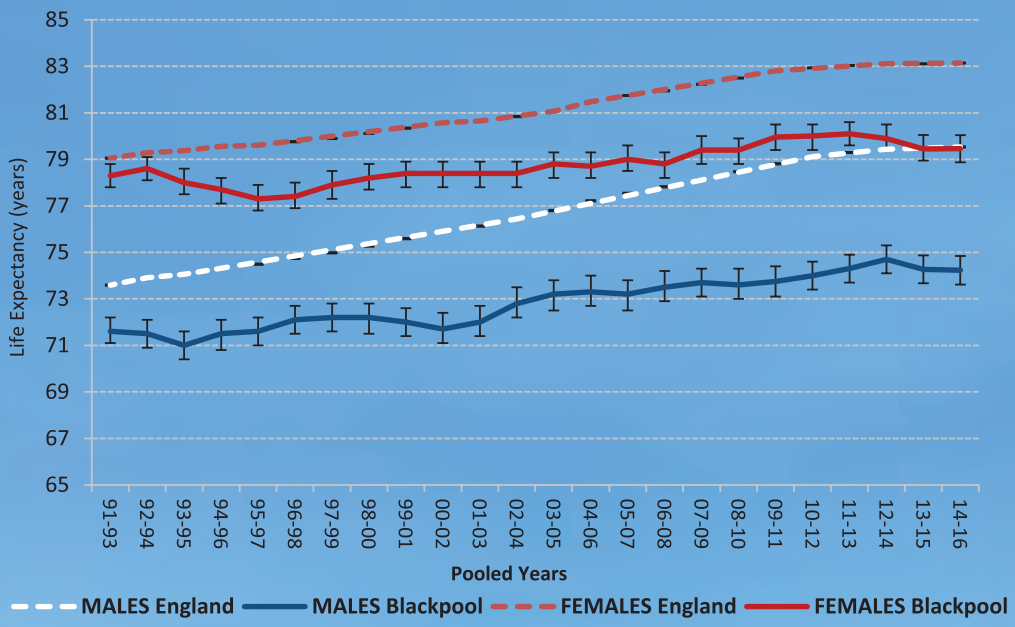


Figure 10

Male life expectancy by ward 2011-15

Source: PHE Local Health

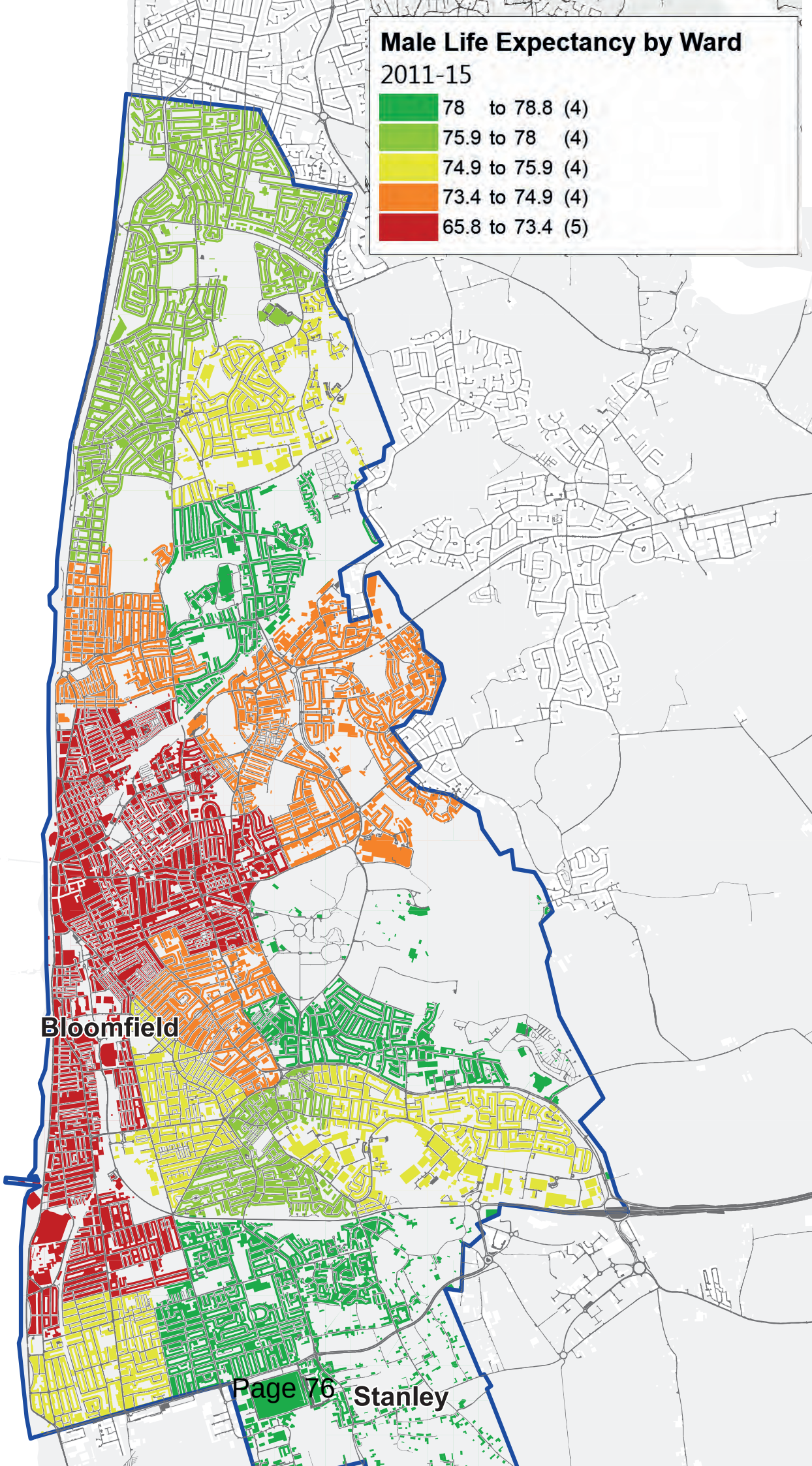
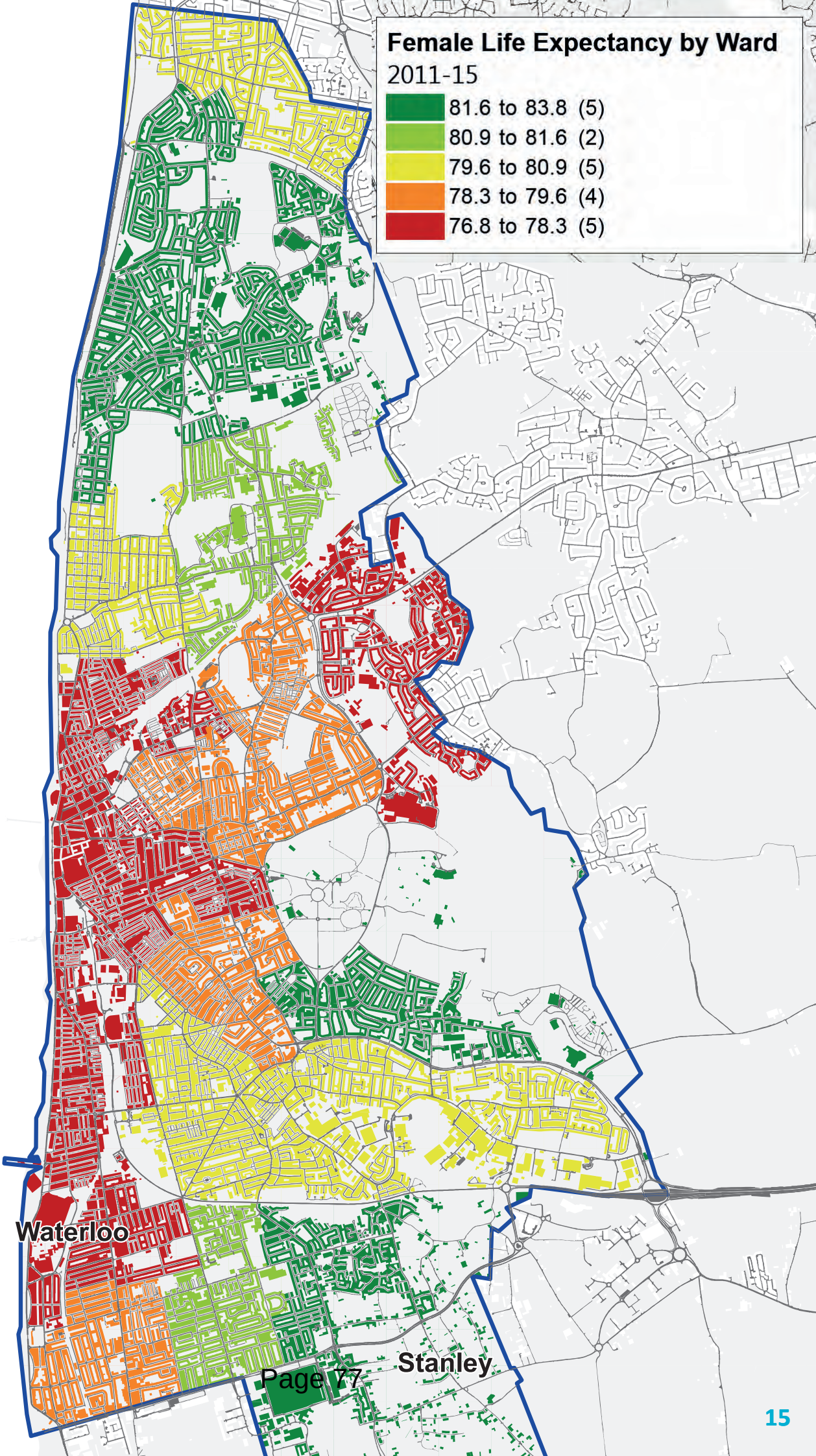


Figure 11

Female life expectancy by ward 2011-15

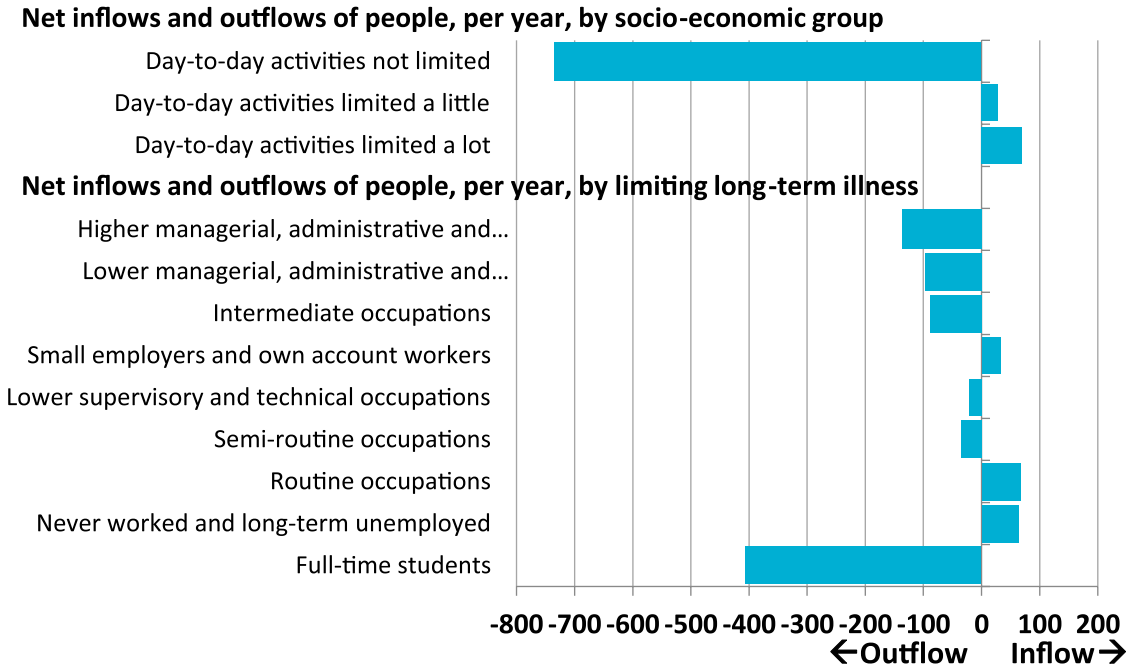
Source: PHE Local Health



Migration and population turnover

Figure 12 presents data gathered in the 2011 census and suggests that Blackpool is a net importer of people with poorer health, unemployment and precarious labour and a net exporter of people with good health and skilled labour.

Figure 12 **Blackpool Net Inflow and Outflow of People per Year, 2011**



Source: Census 2011. Tables UKMIG005 & UKMIG007

The availability of seasonal employment and low cost accommodation are two key drivers of the type of migration we see in **Figure 12.** Many holiday flats and Bed and Breakfasts in the central area of Blackpool have been converted into houses of multiple occupancy (HMOs). In Blackpool there are a large number of buildings that have been converted for use by more than one household, with many of these made up of self-contained flats. While the latest local planning policies require higher quality conversions, the town has a legacy of more than 3,000 poor quality HMOs producing high yields for landlords, fuelled by Housing Benefit payments and a constant demand from people migrating to Blackpool from other parts of the country. Surrounding areas of small terraced houses have also become part of this transient market. As over 50% of homes in inner Blackpool are privately rented, this creates entrenched deprivation and is the antithesis of stable communities.

Approximately 8,000 people move to Blackpool from elsewhere in the UK each year, with a similar number leaving the town. This level of migration helps explain the 5,667 entirely new housing benefit claimants in Blackpool in the financial year 2013/2014. 86% of these claimants had a last address outside of Blackpool borough.

On a person's death, coroners record where individuals were born and this data can be examined. For Blackpool residents who died between the ages of 35 and 74 (an important group in contributing to Blackpool's lower life expectancy) over the three years between 2012 and 2014, 21% of people were born in Blackpool compared to 45% in Lancashire and 48% in Blackburn with Darwen. In Blackpool, only 4% of those born elsewhere were born outside the UK. It is not recorded at what age individuals moved to Blackpool, but this analysis supports what is known about the high level of migration to Blackpool and the potential vulnerability of some of the people who move to the town.

Quality of housing in Blackpool

The 2008 Private Sector House Condition Survey showed that 38.7% of all private sector dwellings in Blackpool were classed as non-decent compared to an average 27.1% for England.
The same survey found that poor housing conditions in Blackpool were mostly associated with pre 1919 properties, the private rented sector, converted flats, occupiers on the lowest incomes and those in receipt of benefits. 46.7% of private sector dwellings occupied by vulnerable tenants are estimated to be non-decent with the majority being concentrated in inner Blackpool.

Houses of multiple occupancy (HMOs)

The relocation of potentially vulnerable people into the town and high level of transience within Blackpool leaves many people socially isolated and in poor quality housing. The extent of houses of multiple occupancy (HMO) in Blackpool is estimated using the MOSAIC population segmentation tool, with its classification L50 – Renting a room a good match to HMO locations in Blackpool.[5] **Figure 13** shows the spread of HMOs across the town. The locations identified in Figure 13 are the same areas that experience the highest levels of disadvantage in Blackpool, as can be seen when compared against Figure 14. The location of HMOs also correlates closely with the electoral wards with the lowest life expectancy identified in Figures 10 and 11. In Blackpool, approximately 23,000 people live in the type of accommodation identified in Figure 13.

Figure 13
Approximate location of HMOs

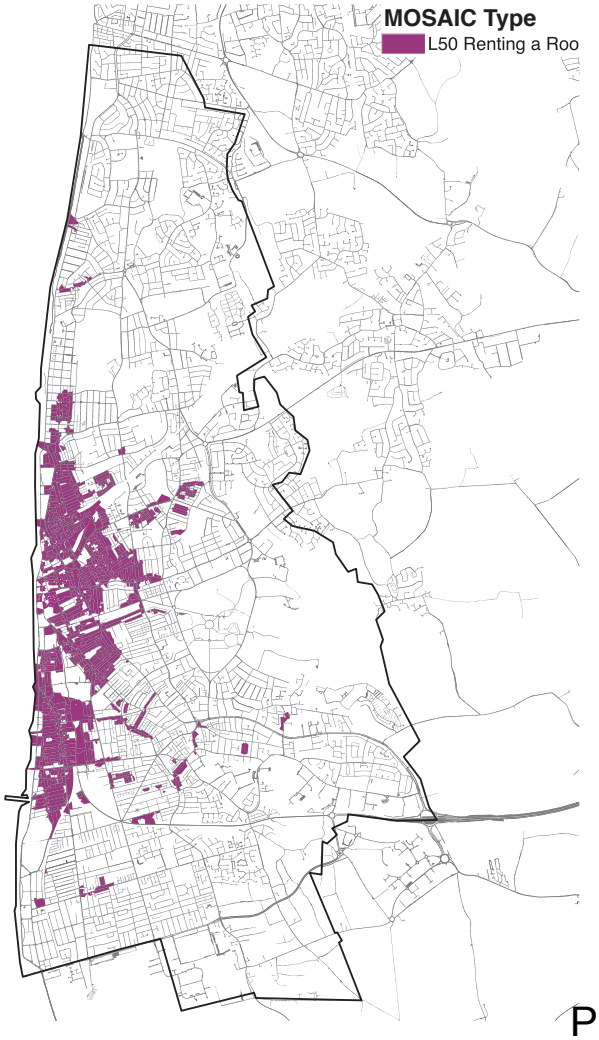


Figure 14
Communities in the 10% most Deprived in England (IMD 2015)

Source: Index of multiple deprivation 2015

5. Source: MOSAIC
http://www.experian.co.uk/marketing-services/products/mosaic/mosaic-in-detail.html

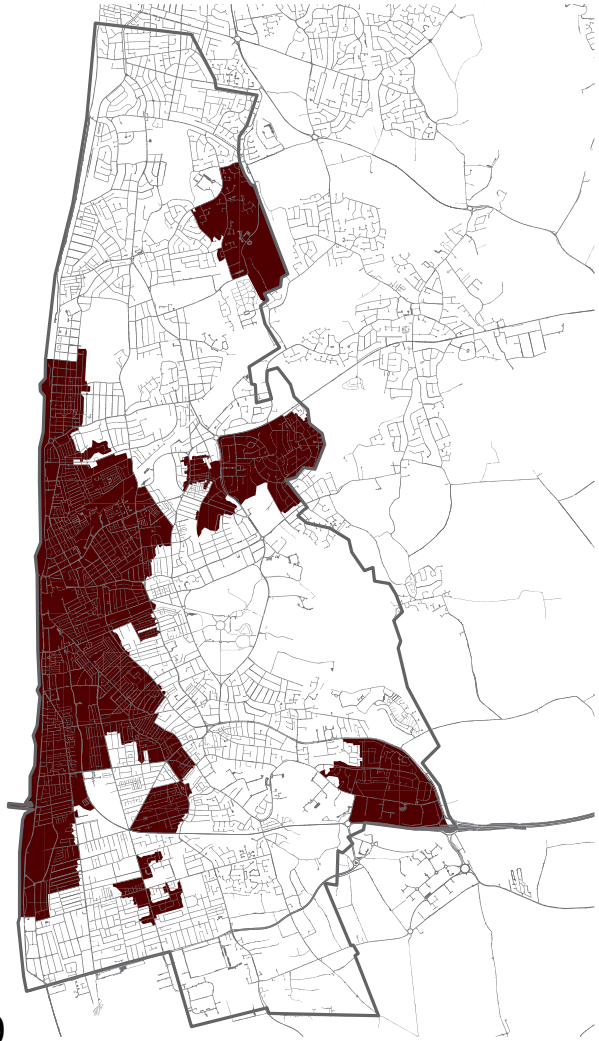


Figure 15 shows areas of Blackpool where over 10% of the population have moved from elsewhere in the UK to the neighbourhood in the previous year, as at the 2011 census. This demonstrates that the same central areas of the town highlighted in previous charts, have the highest levels of inward migration. In fact, in the areas highlighted in Figure 15, 13.3% of the population arrived from elsewhere in the UK in the previous year, compared to 7.7% in the rest of Blackpool and 8.2% across the North West.

Figure 15

Migration to Blackpool from with the UK over a single year

Source: ONS – Census 2011

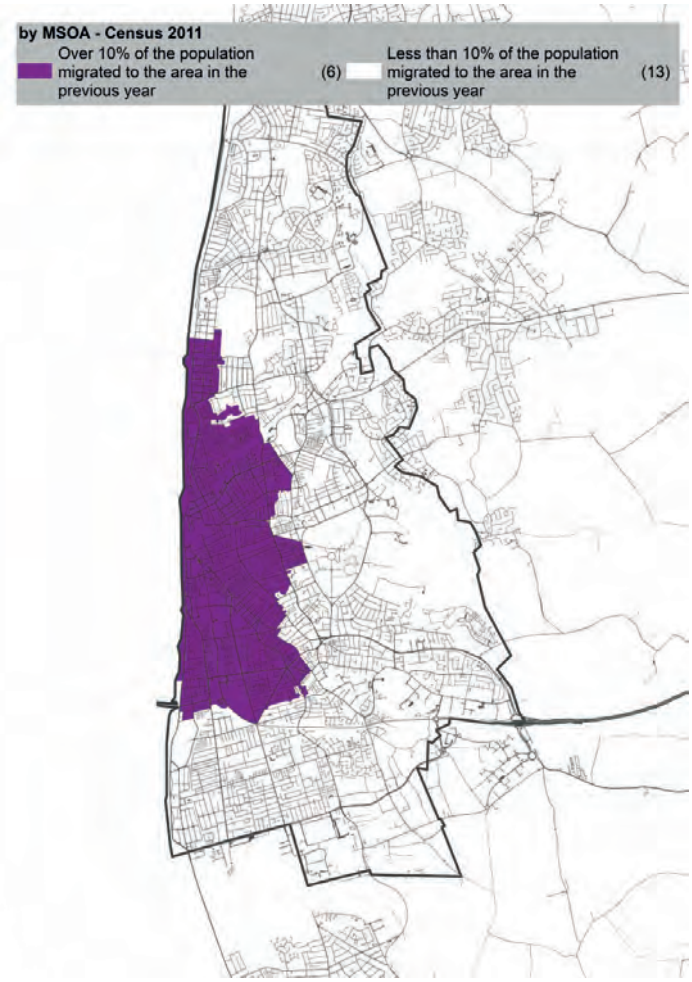
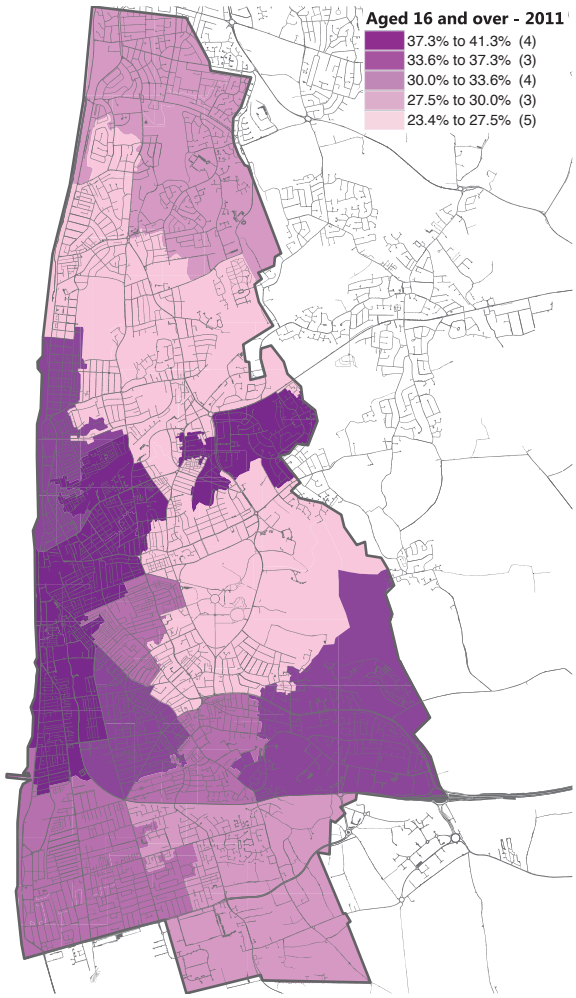


Figure 16 shows that, as well as the high level of migration into the central neighbourhoods of Blackpool, educational attainment of the adult population tends to be lower, with 35.7% of adults holding no qualification in the central areas, compared to 29.5% in the rest of Blackpool and 24.8% across the North West.

Figure 16

Educational Attainment - No Qualification

Source: Census 2011



The central area of Blackpool has a younger population profile than the rest of the town, with 44.1% of residents under the age of 35, compared to 39.2% across the rest of the town. Deaths that occur at younger ages have a disproportionate impact on the overall life expectancy of a community. This pattern of mortality at much younger ages is something that can be seen quite clearly in the L50 – Renting a room group, with high rates of mortality in those aged under 65 and particularly among men.

High levels of substance misuse, particularly of alcohol, opiate and crack cocaine is seen in these areas of the town and contribute to the unusual pattern of mortality.

For example, 16.5% of the Blackpool population lived in this type of accommodation, in the period 2011 to 2015, yet 48.0% of drug related deaths and 37.0% of alcoholic liver disease deaths occurred in this group of Blackpool residents. 30.5% of suicides of Blackpool residents also occurred in this group. This is likely a reflection that residents of HMOs are more likely to be socially isolated with no supportive networks, and corresponds with very high rates of substance misuse.

Summary and conclusions

Much of the data presented is descriptive in nature or based on modelled estimates and aspects of these local analyses are not without limitations. However taken together, the picture that is beginning to emerge from this collection of analyses can be summarised as follows:

- Blackpool has a net outflow of working people in managerial and intermediate occupations.
- Central areas of the town see high levels of inward migration and a younger population. This process initially seems to fit with the 'demographic conveyor' effect, however some factors that underpin the 'demographic conveyer' effect appear not to hold true for Blackpool. We do not see inward migration of healthy, well-educated and relatively well-paid young people in the same way that deprived areas of big cities do, which would serve to limit socio-economic polarisation.
- Instead, we appear to see a variation of this effect and suggest that an abundance of low cost accommodation is driving migration of a less healthy and less well-educated population into the central area of Blackpool. The population leaving (exits) is replaced with individuals (entries) with less means and greater needs.
- Blackpool has a very large quantity of low quality, low cost private rented accommodation, largely consisting of HMOs. This means it is easy to move to Blackpool and easy to move within Blackpool.
- Our local analyses appear to support a hypothesis that Blackpool is a net importer of poor health and net exporter of good health, a scenario which is consistent with increasing spatial segregation along socioeconomic lines.

3. INTERVENTIONS TO MAKE A DIFFERENCE

There are three things to focus on in this section.

Firstly, the national toolkit developed by Professor Chris Bentley for the Department of Health, which sets out opportunities for achieving reduced inequalities and improved life expectancy through local action at scale.

Secondly, the Council's Housing Strategy, which is currently being prepared.

Thirdly is the Council's Homelessness Strategy, also in preparation at the time of writing.

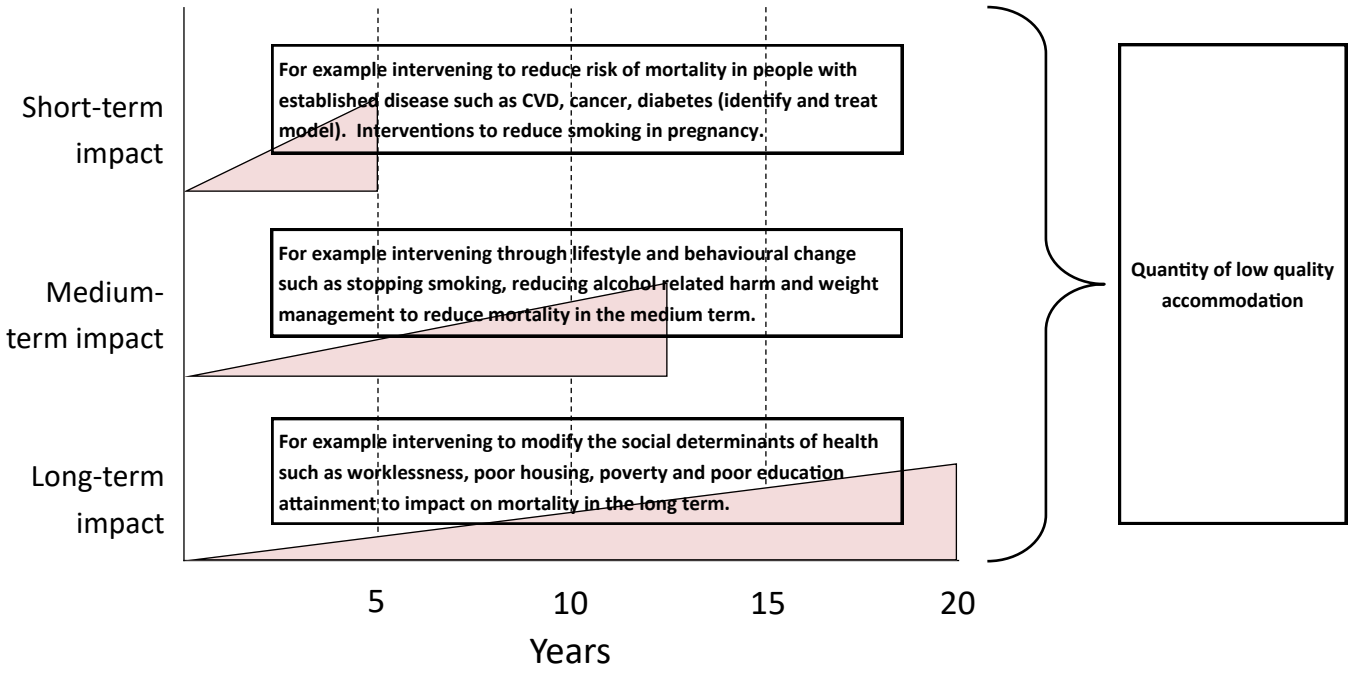
Reducing health inequalities through action at scale

Several years ago I had the pleasure of welcoming Professor Chris Bentley, an expert in interventions to reduce inequalities, to Blackpool as part of the Department for Health initiative to increase life expectancy. Professor Bentley's work focused on local analyses of the causes of reduced life expectancy, identifying effective interventions and introducing these at scale. Following this work, some good progress has been made particularly with regard to some of the shorter-term interventions. For example, I described earlier the marked improvement in premature deaths from cardiovascular diseases. It is helpful to revisit aspects of Professor Bentley's work as action on poor housing featured in the underlying model.

Figure 17 is based on a model developed by Professor Bentley and illustrates interventions that can have a positive impact on the overall life expectancy of a population and includes action on poor housing. The interventions have been categorised according to whether the impact is likely to be over the short, medium or long term. The national model indicates that tackling poor housing as an action can drive positive health outcomes in the longer term. However, we have seen that in Blackpool the volume of low-cost rental accommodation may be importing a population with poorer health into the town.

Reducing the supply of this type of housing should have an impact on migration to the town, internal transience within the town and the overall quality of housing within Blackpool. We have included a suggested adaptation to the model, to reflect the opportunities that action across a range of housing issues offer in terms of affect across the short and medium term, as well as the longer-term indicated in the original model.

Figure 17 **Timescales for interventions to increase life expectancy**



Source: Public Health England (modified)

Blackpool Council's Housing Strategy 2018: Building a Better Blackpool

At the time of writing, colleagues within the Council are in the final stages of drafting a Housing Strategy for the town and kindly allowed me to have sight of the draft. The Housing Strategy presents the Council's approach to address the housing issues within the borough. It sets the vision and priorities to support the delivery of the Council's plan to make Blackpool a great place to live in, with a thriving economy that supports a happy and healthy community.

The Strategy identifies four priorities for action:

1. New housing supply
Local authorities are uniquely placed to address housing supply, acting as both a direct provider and as an enabler of private and social housing developments. Local action includes introducing Supplementary Planning Documents (SPDs) for New Affordable Housing and to manage transition of guest houses to quality homes. The strategy highlights the need for government funding to enable action to reduce the density of established HMOs and bring forward quality new housing stock.

2. Improving the private rented sector
Local action includes the establishment of 'My Blackpool Home' a wholly owned Council Company to buy up failing HMOs and guest houses to improve quality, reduce density and promote standards in the private rental sector through lettings and property management.

3. Stabilising lives
In recent years, pressures on budgets have seen withdrawal of housing-related support, but new funding opportunities are being secured to alleviate homelessness, support vulnerable residents and address transience.

4. Increasing delivery capacity
A key action here is the creation of a Housing Board to pioneer new ways of tackling issues faced by local communities and coordinate activities within the town.

> The overall message of the Housing Strategy is that there is an urgent need to re-structure the housing stock, particularly in inner Blackpool, to deliver a more sustainable and attractive mix of accommodation. This must take into account needs associated with those in the population with specific needs including a growing older population.

The priorities within the new Housing Strategy will provide opportunities for important action to improve the quality of the existing housing stock and promote mixed-income communities. The legacy of over 3,000 poor quality HMOs, primarily located in central areas of the town is a very significant challenge and reducing the volume of this stock is required at scale and pace if we are to reduce inward migration and to stabilise communities.

Use of existing enforcement tools, such as selective licensing and additional licensing can help improve quality, but these tools can only enforce to statutory standards, which are low.

Homelessness Prevention Strategy 2018-21

Reducing homelessness and helping people to establish themselves and maintain a stable home is important both for the individuals themselves and of the wider town. A stable home can support successful education, employment and good health.

Also in preparation, at the time of writing this report, is the Council's Homelessness Prevention Strategy. This sets out how the Council will deliver its new duties with regard to reducing homelessness, which are effective from April 2018.

The strategy focuses on three key areas of the Homelessness Reduction Act:

1. Preventing homelessness by working with partners to identify risk and intervene earlier.
2. Resolve homelessness efficiently to minimise harm to an individual's health and wellbeing.
3. Support individuals to avoid repeat homelessness.

The Strategy identifies the role of the poor quality accommodation on offer in the private rental section and notes that, alongside the town's low wage economy, this continues to drive transience and disadvantage, which directly affect levels of homelessness within the town.

4. RECOMMENDATIONS

1.

I welcome the forthcoming Blackpool Housing Strategy and the recommendations within it to deliver new housing supply, improve the private rental sector, stabilise lives to prevent and resolve homelessness, and increase delivery capacity internally within the Council. The key to success will be to deliver all these recommendations at scale and pace.

2.

Blackpool Council has experienced amongst the highest budget cuts of authorities across the country and this has been especially challenging given the high levels of need and transience within the town.

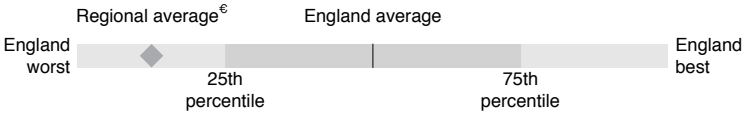
Although the Council has been very creative in managing these significant challenges, it is important now to recognise the need for future funding formulas to fully incorporate the high level of need and allow us to address the root causes of ill health locally.

APPENDIX
Health Profile 2017: Blackpool

Health summary for Blackpool

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- Not compared



Domain		Indicator	Period	Local count	Local value	Eng value	Eng worst	England range	Eng best
Our communities	1	Deprivation score (IMD 2015)	2015	n/a	42.0	21.8	42.0		5.0
	2	Children in low income families (under 16s)	2014	8,410	32.1	20.1	39.2		6.6
	3	Statutory homelessness	2015/16	575	8.9	0.9			
	4	GCSEs achieved	2015/16	666	45.5	57.8	44.8		78.7
	5	Violent crime (violence offences)	2015/16	5,157	36.7	17.2	36.7		4.5
	6	Long term unemployment	2016	665	7.8 ^20	3.7 ^20	13.8		0.4
Children's and young people's health	7	Smoking status at time of delivery	2015/16	463	26.0	10.6 $[1]	26.0		1.8
	8	Breastfeeding initiation	2014/15	1,189	61.6	74.3	47.2		92.9
	9	Obese children (Year 6)	2015/16	341	22.5	19.8	28.5		9.4
	10	Admission episodes for alcohol-specific conditions (under 18s)†	2013/14 - 15/16	76	87.8	37.4	121.3		10.5
	11	Under 18 conceptions	2015	108	43.8	20.8	43.8		5.4
Adults' health and lifestyle	12	Smoking prevalence in adults	2016	n/a	22.5	15.5	25.7		4.9
	13	Percentage of physically active adults	2015	n/a	47.9	57.0	44.8		69.8
	14	Excess weight in adults	2013 - 15	n/a	73.9	64.8	76.2		46.5
Disease and poor health	15	Cancer diagnosed at early stage	2015	265	41.7	52.4	39.0		63.1
	16	Hospital stays for self-harm†	2015/16	866	635.3	196.5	635.3		55.7
	17	Hospital stays for alcohol-related harm†	2015/16	1,612	1163.3	647	1,163		374
	18	Recorded diabetes	2014/15	10,477	7.4	6.4	9.2		3.3
	19	Incidence of TB	2013 - 15	40	9.5	12.0	85.6		0.0
	20	New sexually transmitted infections (STI)	2016	1,005	1150.3	795	3,288		223
	21	Hip fractures in people aged 65 and over†	2015/16	182	642.4	589	820		312
Life expectancy and causes of death	22	Life expectancy at birth (Male)	2013 - 15	n/a	74.3	79.5	74.3		83.4
	23	Life expectancy at birth (Female)	2013 - 15	n/a	79.4	83.1	79.4		86.7
	24	Infant mortality	2013 - 15	34	6.5	3.9	8.2		0.8
	25	Killed and seriously injured on roads	2013 - 15	183	43.4	38.5	103.7		10.4
	26	Suicide rate	2013 - 15	59	16.6	10.1	17.4		5.6
	27	Smoking related deaths	2013 - 15	1,188	459.7	283.5			
	28	Under 75 mortality rate: cardiovascular	2013 - 15	460	120.3	74.6	137.6		43.1
	29	Under 75 mortality rate: cancer	2013 - 15	733	190.8	138.8	194.8		98.6
	30	Excess winter deaths	Aug 2012 - Jul 2015	309	17.7	19.6	36.0		6.9

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Further reading:

JSNA website
www.blackpooljsna.org.uk

FROM THE GROUND UP

THE HEALTH OF THE
PEOPLE OF BLACKPOOL
2017

Blackpool Council

Report to:	**Health and Wellbeing Board**
Relevant Officer:	John Blackledge, Director of Community and Environmental Services
Relevant Cabinet Member	Councillor Graham Cain, Cabinet Secretary (Resilient Communities)
Date of Meeting	10 October 2018

GREEN AND BLUE INFRASTRUCTURE STRATEGY PRESENTATION

1.0 Purpose of the report:

1.1 To consult members of the Health and Wellbeing Board on the draft Green and Blue Infrastructure Strategy for Blackpool.

2.0 Recommendation(s):

2.1 To consider and comment on the draft strategy presentation.

3.0 Reasons for recommendation(s):

3.1 The aim of the presentation is consult members of the Health and Wellbeing Board and to ensure they are involved in the development of this emerging strategy.

3.2a Is the recommendation contrary to a plan or strategy adopted or approved by the Council? No

3.2b Is the recommendation in accordance with the Council's approved budget? Yes

3.3 Other alternative options to be considered:

None

4.0 Council Priority:

4.1 The relevant Council Priority is: "Communities: Creating stronger communities and increasing resilience".

5.0 Background Information

5.1 Officers have been worked to start the development of a draft new strategy and with that aim wish to consult members of the Health and Wellbeing Board on the draft Green and Blue Infrastructure Strategy for Blackpool. The presentation will cover:-

- What is Green and Blue Infrastructure?
- Why a draft Green and Blue Infrastructure strategy has been developed and action plan
- The process so far
- Key high level recommendations
- What is asked of you as health and wellbeing leaders
- Get your thoughts, feedback and ideas

5.2 Green and Blue Infrastructure has been shown to have a large number of health and wellbeing benefits. These include:-

Reduces surface water and flooding and therefore seawater quality
Reduces the energy we need to spend on managing that water through drains
Reduces urban heat island effect – green air conditioning
Removes air pollutants
Encourages people to play, walk and cycle
Improves the mental health of adults and children
Increased employee productivity including reducing sickness absence
Increases property values
Attracts inward investment and motivated staff

5.3 This presentation forms part of a process of consultation of stakeholders and partners to ensure that the strategy will be deliverable and fit for purpose. There is also intended to be a further stage of public consultation before the strategy is approved by the Council's Executive.

5.4 Does the information submitted include any exempt information? No

5.5 **List of Appendices:**

None.

6.0 Legal considerations:

6.1 None at this point, all projects will be individually reviewed for its legal consideration.

7.0 Human Resources considerations:

7.1 None at this point, All projects will be individually reviewed for its impact on Human Resources.

8.0 Equalities considerations:

8.1 None, all projects will be individually reviewed for its impact on equalities.

9.0 Financial considerations:

9.1 The 10 year strategy and action plan will be broken into 1 – 3 year action plans dependent on initiatives and external funding sources.

10.0 Risk management considerations:

10.1 The action plan is dependent on partners' participation and bids for external sources of funding.

11.0 Ethical considerations:

11.1 In support of a sustainable Blackpool reducing carbon levels and promoting community cohesion.

12.0 Internal/ External Consultation undertaken:

12.1 This report forms part of the initial consultation process

13.0 Background papers:

13.1 None.

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