Blackpool Council

21 January 2020

To: All Members of the Health and Wellbeing Board

HEALTH AND WELLBEING BOARD

Wednesday, 29 January 2020 at 4.00 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 19 JUNE 2019 (Pages 1 - 4)

To agree the minutes of the last meeting held on 19 June 2019 as a true and correct record.

3 BETTER CARE FUND UPDATE (Pages 5 - 70)

To consider an update on the Better Care Fund 2019/2020.

4 CHILD DEATH OVERVIEW PANEL NEW ARRANGEMENTS (Pages 71 - 76)

To consider a report on revised arrangements for the Child Death Overview Panel.

5 UPDATE OF PHARMACEUTICAL NEEDS ASSESSMENT (Pages 77 - 80)

To approve the process for updating the Pharmaceutical Needs Assessment.

6 DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2018 (Pages 81 - 132)

To receive the Annual Report of the Director for Public Health and consider the recommendations raised.

7 FORWARD PLAN (Pages 133 - 136)

To request the Health and Wellbeing Board members to develop a draft Forward Plan for the meetings of the Board in 2020.

8 DATES OF FUTURE MEETINGS

To note the dates of future meetings as follows:

18 March 2020

17 June 2020
7 October 2020
2 December 2020
(dates to be confirmed at Annual Council)

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, 19 JUNE 2019

Present:

Councillor Cain (in the Chair) Deputy Leader (Children)

Councillor L Williams, Cabinet Member for Adult Social Care and Health
Councillor Mrs Scott, Opposition Group Member

Dr Arif Rajpura, Director of Public Health, Blackpool Council

Lesley Tiffin, Commissioning Manager, Fylde and Wyre Clinical Commissioning Group

Mick Strickland, Station Manager, Lancashire Fire and Rescue Service

Ayesha Rahman, Lancashire Care Trust

Tim Bennett, Director of Finance and Performance, Blackpool Teaching Hospitals Foundation Trust

In Attendance:

Lennox Beattie, Executive and Regulatory Manager, Blackpool Council
Stephen Boydell, Principal Epidemiologist- Public Health, Blackpool Council
Heather Bryan, Clinical Director, Lancashire and South Cumbria Integrated Care System
Rachel Snow-Miller, Director of Commissioning – All Age Mental Health and Learning Disability Services, Lancashire and South Cumbria Integrated Care System

Apologies:
Diane Booth, Director of Children's Services, Blackpool Council
Dr Arif Rajpura, Director of Public Health, Blackpool Council
Karen Smith, Director of Adult Services, Blackpool Council
Jane Cass, Head of Public Health, NHS England (Lancashire and South Cumbria)
David Bonson, Chief Operating Officer, Blackpool Clinical Commissioning Group
Dr Amanda Doyle, Chief Clinical Officer, Blackpool Clinical Commissioning Group
Roy Fisher, Chairman, Blackpool Clinical Commissioning Group
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 5 DECEMBER 2018

The Board considered the minutes of the last meeting held on 5 December 2018.

Resolved:

That the minutes of the meeting held on 5 December 2018 be approved and signed by the Chairman as a correct record.

3 EYE HEALTH IN LANCASHIRE AND SOUTH CUMBRIA NEEDS ASSESSMENT

The Board considered the Joint Needs Assessment for Eye Health in Lancashire and South Cumbria this document replaced the previously published Blackpool based Eye Health needs assessment. The assessment had been produced on the footprint of the Lancashire and South Cumbria Integrated Care System as it had been recognised there were both areas of good practice and concerns over access and awareness of services.

The report was presented by Mr Stephen Boydell, Principal Epidemiologist- Public Health, Blackpool Council. Mr Boydell highlighted that 60,000 people or around 3.6% of the population of Lancashire and South Cumbria had sight loss with an expected increase of a quarter over the next twelve years. It was noted that the number of those 60,000 (1,500 in Blackpool) actually registered as sight impaired was much lower and this meant that many did not receive help and support.

It was considered particularly important to note that appropriate communication was key as a number of eye health related issues were preventable. The number of missed appointments and the system of notification was also highlighted as an area for further work.

A key issue identified in the assessment had been the access to Eye Clinic Liaison Officers. It was noted that these officers provided vital practical and emotional support and improved outcomes where they were available. Ensuring all those diagnosed with sight loss had access to an Eye Clinic Liaison Officer had been identified as key to the delivery of a number of the priority issues.

The agreed priority issues were:
1. Prevention and protection
2. Information and advice
3. Services
4. Data
5. Inequalities
6. Quality of life

The Board noted the Eye Health Needs Assessment report recommendations for action under these priority headings accepting that these were based on best practice and agreed by the project's stakeholder reference group. It suggested that the report should be referred for consideration by the grouping of clinicians within the Blackpool Clinical Commissioning Group to raise awareness of the recommendations and ensure that stakeholders and partners were working towards their delivery.

Resolved:

1. To receive the Eye Health in Lancashire and South Cumbria needs assessment, attached at Appendix 3a to the agenda.

2. To endorse a commitment that the action plans will be developed by partner organisations on the Health and Wellbeing Board, based on the recommendations from the Eye Health in Lancashire and South Cumbria needs assessment.

3. To refer the joint needs assessment and its recommendations to the Joint Clinical Committee of the Blackpool Clinical Commissioning Group.

4 LANCASHIRE AND SOUTH CUMBRIA CHILDREN AND YOUNG PEOPLE'S EMOTIONAL WELLBEING AND MENTAL HEALTH TRANSFORMATION PLAN 2015 - 2020/21 (REFRESHED MARCH 2019)

The Board considered a paper and presentation on the March 2019 refresh of the Lancashire and South Cumbria Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan, the presentation was given by Ms Rachel Snow-Miller, Director of Commissioning – All Age Mental Health and Learning Disability Services, Lancashire and South Cumbria Integrated Care System.

Ms Snow-Miller highlighted the key priorities for 2019/2020 namely the development of additional on-line resources in a way considered most suitable by service users for self-care and advice, a full redesign of the CAMHS service and the development of additional capacity in delivering intensive help. The key priorities translated into key action areas of promoting resilience, prevention and early intervention, improving access to effective support, ensuring appropriate intervention for children and young people in crisis and improving service quality.

In response to questions from the Board, Ms Snow-Miller explained that a key part of the review of CAMHS was to provide capacity and to make referrals as straight forward as possible. Ms Snow-Miller agreed that a key issue was to ensure that appropriate provision was available rather than a barrier between adults and children's services with children's services reaching up for those for whom such services remained appropriate and adult services reaching down for those who it was appropriate for. It was also agreed that capacity in CAMHS and reduced wait times would be essential in avoiding the eventual need for more intensive services.

Resolved:

1. To endorse the strategic direction of the Lancashire and South Cumbria Children and Young People's Emotional Wellbeing and Mental Health Transformation Plan (2015-2020/21) (attached at Appendix 4a, to the agenda) and the principles that underpin the workstreams and objectives.

2. To receive regular updates on progress made on the implementation of the transformation plan.

5 DATE OF NEXT MEETING

The Board noted the date of next meeting as Thursday 3 October 2019.

Chairman

(The meeting ended at 4.50 pm)

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, Deputy Leader of the Council (Children)
Date of Meeting	29 January 2020

BLACKPOOL BETTER CARE FUND UPDATE

1.0 Purpose of the report:

1.1 To provide the Board with details of the Blackpool Better Care Fund 2019-20.

2.0 Recommendation(s):

2.1 That the contents of this report are noted.

2.2 That the Health and Wellbeing Board agrees to continue to devolve ongoing governance to the Better Care Fund Monitoring Group.

3.0 Reasons for recommendation(s):

3.1 The Better Care Fund pooled budget is a statutory requirement 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:

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 There was a considerable delay in the publication of the Policy Framework and Planning Guidance (Appendix 3a) for the Better Care Fund 2019-20, and further delays in reaching agreement by Blackpool Council and Blackpool Clinical Commissioning Group in relation to the uplift to Adult Social Care schemes.

5.2 As it was not possible to present the plan to the Health and Wellbeing Board prior to the submission deadline, it was signed off by Councillor Cain on their behalf on 10 October 2019.

5.3 Blackpool Council and Blackpool Clinical Commissioning Group were required to complete a planning template (Appendix 3b) to show the expenditure plan for 2019-20, and to outline the expected impact.

5.4 The Section 75 agreement, which underpins the Better Care Fund Plan was signed by Blackpool Council and Blackpool Clinical Commissioning Group on 12 December 2019.

5.5 Approval of the Blackpool Better Care Fund 2019/20 was confirmed by NHS England on 8 January 2020 (Appendix 3c).

5.6 Does the information submitted include any exempt information? No

5.7 **List of Appendices:**

Appendix 3a: Better Care Fund 2019-20 Planning Requirements
Appendix 3b: Submitted Blackpool 2019-20 Better Care Fund Planning Template
Appendix 3c: Approval Letter Blackpool 2019-20

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 Better Care Fund 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 Given the delays referred to at 5.1, financial monitoring of the Better Care Fund Schemes has not been possible to date. However a report to quarter 3 will be taken through the Better Care Fund Monitoring Group and then subsequently incorporated into the next Health and Wellbeing Board update.

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 **High Impact Change Model**

ONLY APPLICABLE FOR REPORTS WHICH WILL EVENTUALLY BE CONSIDERED BY THE EXECUTIVE/ CABINET MEMBER

14.0 Key decision information:

14.1 Is this a key decision? Yes/ No

14.2 If so, Forward Plan reference number:

14.3 If a key decision, is the decision required in less than five days? Yes/ No

14.4 If **yes**, please describe the reason for urgency:

(NOTE: This reason must be a sustainable one and not just because it was late and missed the agenda dispatch. Please delete this message prior to submission of this report).

15.0 Call-in information:

15.1 Are there any grounds for urgency, which would cause this decision to be exempt from the call-in process? Yes/ No

15.2 If **yes**, please give reason:

(NOTE: This reason must be a sustainable one and not just because it was late and missed the agenda dispatch. Please delete this message prior to submission of this report).

TO BE COMPLETED BY THE HEAD OF DEMOCRATIC SERVICES

16.0 Scrutiny Committee Chairman (where appropriate):

Date informed: Date approved:

17.0 Declarations of interest (if applicable):

17.1

18.0 Executive decision:

18.1

18.2 **Date of Decision:**

19.0 Reason(s) for decision:

19.1 **Date Decision published:**

20.0 Executive Members in attendance:

20.1

21.0 Call-in:

21.1

22.0 Notes:

22.1

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Department of Health & Social Care

Appendix 3a

NHS

Better Care Fund Planning Requirements for 2019-20

Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England

CONTENTS

PART 1 – THE BETTER CARE FUND

Section 1 - Introduction

1. The Department of Health and Social Care (DHSC) and the Ministry of Housing, Communities and Local Government (MHCLG) have published a Policy Framework for the implementation of the Better Care Fund (BCF) in 2019-20. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The Framework forms part of the NHS mandate for 2019-20. The framework sets an objective for NHS England to issue these further detailed requirements to local areas on developing and implementing BCF plans for 2019-20.

2. The BCF provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, and funding paid directly to local government, including the Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant.

3. BCF planning and reporting will incorporate the separate processes for iBCF and Winter Pressures grants, removing duplication in collection and reducing the reporting burden overall. This will include:

    - Incorporation of narratives into a shorter single template.
    - Removal of the requirement to submit separate plans for Winter Pressures grant.
    - Removal of separate reporting on iBCF schemes and initiatives.
    - Single format for scheme level planning and reporting.

4. This document contains the BCF planning requirements which support the core NHS Operational Planning and Contracting Guidance for 2019-20. CCGs are therefore required to have regard to this guidance by Section 14Z11 of the NHS Act 2006. It is being published jointly with Departments to disseminate it directly to local government.

5. This document also incorporates the BCF Operating Guidance, which in the previous cycle was published in a separate document. All planning and operating guidance for the BCF in 2019-20 is therefore contained in this document.

6. The framework for the Fund derives from the government's mandate to the NHS for 2019-20, issued under Section 13A of the NHS Act 2006, which sets an objective for NHS England to ring fence £3.84 billion to form the NHS contribution to the BCF. These Planning Requirements set allocations for each CCG from this ring fence and apply conditions to their use. BCF plans and their delivery should comply with these conditions as part of the delivery of CCGs' duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006.

The BCF from 2020 and the NHS Long Term Plan

7. In June 2018, the government announced a review of the 'current functioning and structure of the Better Care Fund' to ensure it supports the integration of health and social care. There will be an update later this year.

8. The NHS has set out its priorities for transformation and integration through the NHS Long Term Plan, published on 7 January this year, including plans for investment in integrated community services and next steps to develop Integrated Care Systems. This includes a commitment for a new NHS offer of emergency response and recovery support through expanded multidisciplinary teams in primary care networks. This work will roll out from 2019-20. It is not a requirement that BCF funds are spent on this work, but it is expected that local areas will be considering how provision across health, local government, social care providers and the voluntary sector can support the shared aims of providing better care at or close to people's home and a clear focus on prevention and population health management.

9. The BCF in 2019-20 will continue to provide a mechanism for personalised, integrated approaches to health and care that support people to remain independent at home or to return to independence after an episode in hospital. The continuation of the national conditions and requirements of the BCF from 2017-19 to 2019-20 provides opportunities for health and care partners to build on their plans from 2017 to embed joint working and integrated care further. This includes how to work collaboratively to bring together funding streams to maximise the impact on outcomes for communities and sustaining vital community provision.

Section 2 - BCF Policy and planning requirements in 2019-20

10. The Better Care Fund Policy Framework for 2019-20 provides continuity from the previous round of the programme.

11. The **four national conditions** set by the government in the Policy Framework are:

    i. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed off by the Health and Wellbeing Board (HWB), and by the constituent local authorities (LAs) and CCGs.

    ii. A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG's minimum contribution.

    iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, which may include seven day services and adult social care.

    iv. A clear plan on managing transfers of care, including implementation of the High Impact Change Model for Managing Transfers of Care (HICM). As part of this, all HWBs must adopt the centrally-set expectations for reducing or maintaining rates of delayed transfers of care (DToC) during 2019-20 into their BCF plans.

12. The Policy Framework also sets out the **four national metrics** for the fund:

    i. Non-elective admissions (Specific acute);
    ii. Admissions to residential and care homes;
    iii. Effectiveness of reablement; and
    iv. Delayed transfers of care (DToC).

13. All BCF plans must include ambitions for each of the four metrics and plans for achieving these are a condition of access to the fund. Expectations for reducing DToC will continue to be set centrally for each HWB area. The national ambition for reducing DToC is for the average daily number of people who are ready to go home, but still awaiting discharge to be less than 4,000. Local expectations set in the BCF Operating Guidance for 2018-19 have been retained. Areas that have not already achieved their local expectation should plan to achieve this as early as possible in 2019-20.

14. The main change in the BCF Planning Requirements from 2017-19 is that separate narrative plans will be replaced with a single template that will include short narrative sections covering:

    - the local approach to integration;
    - plans to achieve metrics; and
    - plans for ongoing implementation of the High Impact Change Model for Managing Transfers of Care.

Approval of agreed plans

15. BCF plans will be approved by NHS England following a joint NHS and local government assurance process at regional level. In addition to the national conditions and the condition to set the four national metrics, NHS England is also placing the following requirements for approval of BCF plans:

    - That all funding agreed as part of the BCF plan must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.
    - That all plans are approved by NHS England in consultation with DHSC and MHCLG.

16. NHS England will approve plans for spend from the CCG minimum in consultation with DHSC and MHCLG as part of overall approval of BCF plans.

17. The DFG, iBCF and Winter Pressures grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

Maintaining progress on former national conditions

18. BCF plans in 2017-19 were required to describe how partners would continue to build on progress against former BCF national conditions to:

    - Develop delivery of seven-day services across health and social care;

- Improve data sharing between health and social care; and
- Ensure a joint approach to assessments and care planning.

19. In 2019-20, areas should continue to make progress towards these goals.

Section 3 - Funding sources and expenditure plans

20. It will be a condition of the BCF that plans for spending all funding elements are jointly agreed by local authority and CCG partners. Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these requirements.

21. Scheme level spending details will need to include, where appropriate, an indication of the metric or metrics that a scheme is intended to improve. Where a planned scheme is an enabler for integration (for instance a workforce or digital integration scheme), then areas will be asked to indicate this on the spending plan (linked to the enablers identified in the Logic Model for Integrated Care) and are not required to indicate corresponding outcome metrics. Areas should also include short descriptions of schemes commissioned in the scheme level expenditure plan.

22. Areas can agree to pool additional funds into their BCF plan and associated Section 75 agreement(s). These additional contributions are not subject to the conditions of the BCF but should be recorded in the Planning Template. The mandatory contributions are set out below:

Table 1: BCF mandatory funding sources 2019-20

Minimum NHS ring-fenced from CCG allocation	£3,840 million
Disabled Facilities Grant (DFG)	£505 million
Improved Better Care Fund (iBCF)	£1,837 million
Winter Pressures grant	£240 million
Total	**£6,422** million

CCG minimum contribution

23. The mandate to NHS England for 2019-20 sets out an objective to ring-fence £3.84 billion in 2019-20 within its overall allocation to CCGs to be pooled into the BCF and subject to the conditions set out in the Policy Framework and these Operating Requirements.

24. NHS England has published allocations from this national ringfence for each CCG for 2019-20, on its website. The allocations for all mandatory funding sources are pre-populated in the Planning Template at an HWB level.

25. The allocation for each CCG includes funding to support local authority delivery of reablement, Carers Breaks and implementation of duties to fund carer support under the Care Act 2014.

26. Expenditure details in Planning Templates should set out the level of resource that will be dedicated to delivery of these activities. Reablement and other support to help people remain at home or return home from hospital with support, remain important outcomes for integration and the BCF, and are also priorities in the NHS Long Term Plan.

27. National conditions two and three apply only to the minimum funding allocation from CCGs.

National condition two: NHS contribution to social care is maintained

28. National condition two requires that, in each HWB area, the contribution to social care spending is maintained in line with the percentage uplifts for the CCGs that contribute to the BCF in that HWB. The uplift applies only to the CCG minimum contribution to social care and will be applied to the minimum expectation from 2018-19 for the HWB, rather than the assured contribution in 2018-19 (if this was higher than the minimum expectation). The purpose of this condition is to ensure that support from the NHS for social care services with a health benefit is maintained in line with the overall growth in the CCG minimum contribution to the BCF.

29. As in 2017-19, the minimum expectations will be confirmed in the BCF Planning Template. Any schemes where the spend type is 'social care' and the funding source is the CCG minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum. CCGs and councils can agree larger contributions, where this will deliver value to the system and is affordable.

National condition three: Agreement to invest in NHS-commissioned out-of-hospital services

30. A minimum of £1.091 billion of the CCG contribution to the BCF in 2019-20 is ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims. Each CCG's share of this funding is set out in allocations and will need to be spent as set out in the national condition. This condition will be assured through the Planning Template, based on spend allocated to primary, community, social care or mental health care, that is commissioned by CCGs from the CCG allocation.

Grant Funding to local government to be pooled into BCF plans

31. The DFG, iBCF and Winter Pressures grant monies are paid directly to local authorities under Section 31 of the Local Government Act 2003, with specific grant conditions, including a requirement that the funding is pooled in the BCF. Allocations will be pre-populated in the Planning Template. The conditions for individual grants are set out below.

Improved Better Care Fund

32. The Grant Determination issued in April 2019 sets out that the purposes will replicate those from 2017-18 and 2018-19 – and therefore that the funding be used for:
    - meeting adult social care needs;
    - reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
    - ensuring that the local social care provider market is supported.
33. The grant conditions for the iBCF also require that the local authority pool the grant funding into the local BCF and report as required.

34. iBCF funding can be allocated across any or all of the three purposes of the grant in a way that local authorities, working with CCG(s) determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the three purposes. The funding does not need to be directed to funding the changes in the High Impact Change Model (HICM). This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

35. Since April 2018, reporting on the iBCF has been incorporated into the main BCF reports and this will continue for 2019-20.

Winter Pressures Funding

36. The Grant Determination for Winter Pressures funding was issued in April 2019. In 2019-20, the Grant Determination sets a condition that this funding must be pooled into BCF plans. The grant conditions also require that the grant is used to support the local health and care system to manage demand pressures on the NHS with particular reference to seasonal winter pressures. This includes interventions that support people to be discharged from hospital, who would otherwise be delayed, with the appropriate social care support in place, and which help promote people's independence. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

37. Each BCF plan should set out the agreed approach to use of the Winter Pressures grant, including how the funding will be utilised to ensure that capacity is available in Winter to support safe discharge and admissions avoidance. The BCF process will ensure that the use of this money has been agreed by plan signatories and the HWB, confirmed in the Planning Template.

38. Details of planned schemes and expenditure should be confirmed in the Planning Template. Reporting on the grant will be through the main BCF process.

Disabled Facilities Grant

39. The DFG continues to be allocated through the BCF. Areas should think strategically about the use of home adaptations, the use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Creating a home environment that supports people to live safely and independently can make a significant contribution to health and wellbeing, and should be an integral part of integration plans and strategic use of the DFG can support this.

40. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options. Local housing authority representatives and DFG leads should have a clear role in developing and agreeing BCF plans, supporting closer integration of housing, social care and health services.

41. DFG will continue be paid to upper-tier authorities. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore, each area will need to ensure that sufficient funding is allocated from the DFG monies in the pooled budget to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

42. In two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government must be passed down to the relevant housing authorities (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans.

43. During these discussions, it will be important to continue to ensure that local needs for aids and adaptations are met, while also considering how adaptation delivery systems can help meet wider objectives around integration. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

    - The funding is included in one of the pooled funds as part of the BCF;
    - The funding supports a strategic approach to housing and adaptations that supports the aims of the BCF; and
    - The use of the funding in this way has been developed and agreed with relevant district housing authorities.

44. Since 2008-09, the scope for how DFG funding can be used includes to support any LA expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding for wider purposes.

45. This discretionary use of the funding can help improve delivery and reduce the bureaucracy involved in the DFG application process, helping to speed up the process. For example, LAs could use an alternative means test, increase the maximum grant amount, or offer a service which rapidly deals with inaccessible housing and the need for quick discharge of people from hospital. The Care Act also requires LAs to establish and maintain an information and advice service in their area. The BCF plan should consider the contribution that can be made by the housing authority and local Home Improvement Agency to the provision of information and advice, particularly around housing issues.

46. The government commissioned an independent review of the DFG in February 2018. The review was published in December 2018 and makes 45 detailed recommendations. The government is carefully considering the review and will respond to its findings in due course.

PART 2 – COMPLETING BCF PLANS

Section 4 - The Planning Template

47. BCF plans must meet all four national conditions of the Fund, as set out in the Policy Framework and operationalised by the conditions and requirements contained in this document. Under national condition one**,** local government and CCGs are required to agree a plan for use of the pooled funding in the BCF for 2019-20. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans.

48. Local partners are required to develop a joint spending plan that meets the national conditions and planning requirements. In developing BCF plans for 2019-20, local partners will be required to develop, and agree, through the relevant HWB(s) a completed Planning Template, including:

- A narrative on the approach to integration of health and social care, highlighting key changes from 2017-19;
- Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
- A scheme-level spending plan demonstrating how the fund will be spent and compliance with national conditions two and three;
- A brief description of the overall approach to progressing the implementation of HICM along with the planned level of implementation for each of the changes; and
- Quarterly plan figures for the national metrics on effectiveness of reablement and admissions to residential care. Metrics for non-elective admissions will be mapped directly from CCG operational plans. Areas will be expected to achieve and maintain DToC expectations agreed between NHS England and Departments, pre-populated in individual Planning Templates. Brief narratives describing how elements of the overall HWB plan will impact these metrics are required to accompany the plan figures set out on the template.

Completing the Planning Template

Narratives

49. BCF narrative plans for 2017-19 set out how CCGs and local government were making progress towards integration by 2020, both through BCF funded schemes and more widely. The agreed BCF narrative will be collected through the Planning Template for 2019-20 and it is expected that they will be shorter and focussed on updates to 2017-19 plans.

50. As in 2017-19, BCF plans should represent the joint plan for integration of health and social care locally, with clear governance through the HWB. The narrative sections of the template should confirm these arrangements, particularly highlighting how these have developed since 2017-19. Where a single narrative is agreed across two or more HWB areas, for instance to reflect jointly agreed approaches across a wider geography (for example, Sustainability and

Transformation Partnership (STP)/Integrated Care System (ICS)), this narrative can be submitted in the template of one of the HWBs. Separate Planning Templates will still need to be submitted for all HWBs, with completed expenditure, metrics and confirmations tabs, to enable assurance of the national conditions on behalf of NHSE and Departments.

51. All confirmations of compliance with the requirements will be collected nationally through the Planning Template. Guidance on completing these are included in the Planning Template.

52. Narratives will need to describe:

- The approach to joining up care around the person.
- Approaches to joint commissioning and delivery of health and social care at HWB level.
- How the BCF plan and relevant elements of the STP/ICS plan align, including any jointly owned outcomes.

Joining up care around the person

53. Plans should set out the approach locally to person centred care. This may include single assessments, personal budgets, and Integrated Personalised Commissioning (IPC). There is no specific requirement to fund particular types of activity through the BCF, but the agreed local approach and links to these agendas should be set out in the narrative section. Further information on IPC is set out below.

Integrated Personalised Commissioning

Building on the learning from IPC, NHS England published their vision for personalised care in January 2019. This includes a comprehensive model for personalised care that brings together 6 key components. The components are:-

- Shared decision making
- Personalised care and support planning
- Enabling choice, including legal rights to choice
- Social prescribing and community-based support
- Supported self-management
- Personal health budgets and integrated personal budgets.

There are currently 21 demonstrator sites including three integration accelerator sites (Lincolnshire, Nottinghamshire and Gloucestershire) who are implementing this model and learning will be shared as soon as available on NHS England website.

Some examples from the programme include:

- In Lincolnshire, Nottinghamshire, and Gloucestershire, the council and the NHS are introducing joined-up assessment and personalised

care and support planning for people who have health and social care needs.

- Tower Hamlets are working across health and social care to provide people with integrated provision of wheelchairs and home equipment
- Gloucestershire and Hampshire, the NHS and local government are working together to train staff to deliver personalised care.

Other parts of the country are encouraged to consider this approach and how they can plan to support the roll out of this comprehensive model including joint working to expand the use of joint assessments and care and support planning, integrated personal budgets and expand social prescribing schemes in partnership with primary care networks.

HWB level plans

54. Plans should set out the high-level approach to integrated care in the area. This could include:

- Approaches to joint commissioning
- Delivery of integrated care, preventative services and population health management.
- Approaches to integration with housing and other local services, including work with the local voluntary sector.

Links to system level plans

55. Narrative plans should set out the alignment locally between the BCF plan and the STP or STPs it overlaps.

56. The NHS Long Term Plan sets out how STPs and ICSs should work with local government to plan and commission health and care services at 'place' level – usually HWB level, including shared decisions on the use of resources. This will include production of five-year plans by each ICS and STP in 2019. The expectation is that local systems will align these geographies in a way that makes sense in relation to local authority and health boundaries. The Long Term Plan sets an expectation that all ICSs will have a partnership board that includes representation from local government and that ICSs and HWBs will work closely together. One key consideration should be how data and information will be made accessible and shared across sectors.

Continuing to address inequalities in BCF plans

57. Local partners should continue to consider how the activities in their BCF plan will address health inequalities in the area in line with duties in the Health and Social Care Act 2012, and reduce inequalities for people with protected characteristics under the Public Sector Equality Duty in the Equality Act 2010, building on approaches agreed in 2017-19 plans. Local strategies for reducing inequalities across the constituent organisations can be referenced where appropriate, but the narrative plan must include a short overview of any priorities and investment to address inequalities.

Implementation of the High Impact Change Model for Managing Transfers of Care

58. National condition four requires health and social care partners in all areas to work together to:

    - Agree a clear plan for managing transfers of care and improved integrated services at the interface of health and social care that reduces DToC, encompassing the HICM, and home based intermediate care (including reablement).
    - Continue to embed the HICM.

59. In the HICM section of the Planning Template, areas should set out the current state of implementation for each of the eight changes in the model and the planned level of implementation by March 2020. Areas should agree a narrative describing the priorities and actions for 2019-20 to embed the model, including:

    - Details of changes;
    - Anticipated improvements to care and discharge, minimising delays and ensuring that as many people as possible are discharged safely to their normal place of residence.

60. Areas were expected to implement the model during 2017-19 as part of the BCF planning and operational requirements, and should be able to confirm that each of the eight changes are at least established. If this is not the case for any of the changes, the plan should set out what is being done to ensure that the relevant change is implemented as soon as possible.

61. Where all parties in an area have implemented a variation on the model (for example if an existing, successful, approach would be duplicated by elements of the change model) the plan should briefly explain the rationale for this, that sets out how the aims of the specific change are met. All partners, including relevant A&E Delivery Boards, should be involved in agreeing the approach.

62. The LGA, Association of Directors of Adult Social Services (ADASS), NHS England and NHS Improvement and Government are reviewing the HICM and a new version will be published later in the year. For the purposes of the BCF in 2019-20, areas should set out their plans against the existing model.

Developing approaches to managing transfers of care

63. In 2017-18, the Better Care Support programme commissioned Newton, to work with nine HWBs in 14 health and care systems experiencing persistent challenges with levels of DToC. In addition to the specific diagnostic, planning and improvement work done in these systems, the findings have been brought together into a report '<u>People First, manage what matters</u>'.

64. The report makes several recommendations for all areas to consider:

    - Ensure that those making decisions about people's discharge from acute settings have robust, timely and accurate information about the flow and capacity within the entire system (enabled by interoperability, data and information sharing between health and social care).

- Question the outcomes achieved for people once discharged.
- Put rigorous systems of outcome measuring and monitoring in place.
- Assess the effectiveness of system-wide leadership.
- Ensure that the mechanisms of governance in place are aligned with the outcomes the system is seeking to achieve.
- Align resource allocation with achieving the best outcomes for people, rather than with current patterns of discharge decision-making.

65. Local areas are encouraged to take these recommendations into account in developing their ongoing implementation of the HICM.

Reablement and the NHS Long Term Plan

66. The Long Term Plan outlines how the NHS, over the next five years, will be implementing the commitments to invest in reablement, crisis response and intermediate care services, to increase their responsiveness and reduce delays in people receiving the right care in the right place. The NHS has set itself a target for services to be in place to support people within two days for reablement and two hours for crisis response. These targets are not BCF conditions, and areas are not required to implement any specific schemes or allocate BCF funds to their implementation in 2019-20. Local health systems will need to continue to work with social care colleagues to deliver these commitments over the coming years and agree the approach to commissioning and co-ordination to ensure that these services are in place and deliver the best outcomes for individuals who need them.

Further guidance

67. There is an increasing range of material available to support local systems with the practical development of joint integration strategies and integrated services. The NHS England Integrating Better project recently produced a practical guide based on learning from 16 areas, which is available to health and care practitioners as part of the STP/ICS library of good practice. The LGA also provide a range of support, tools and case studies, such as through the recently published evidence review and case studies of integrated care or the support provided through its Care and Health Improvement Programme. Further guidance includes:

- BCF ‘How to’ guides are available on the BCF pages of the NHS England Website;
- Guidance supporting the High Impact Change Model, which can be found on the LGA website;
- A series of ‘Quick guides’ from NHS England to support health and social care systems;
- The Logic Model for Integrated Care, developed by the Social Care Institute for Excellence on behalf of government.

Expenditure plans

68. The Planning Template will include the scheme-level spending plan for the use of the full value of the budgets pooled through the BCF. These plans will need to include:

    - area of spend;
    - scheme type;
    - commissioner type;
    - provider type;
    - funding source;
    - the metrics that the scheme is intended to influence;
    - total 2018-19 investment (if existing scheme);
    - total 2019-20 investment;
    - the anticipated number of beneficiaries (for certain schemes).

69. To understand and account for the impact of funding committed to the BCF, the Policy Framework makes a commitment that more information on the impact of the BCF will be collected, through the planning process. The BCF Planning Template for 2019-20 will collect this through:

    - Clear narratives on the four national metrics describing the activity that is being commissioned through the BCF to support achieving these ambitions, including preventative approaches.
    - Scheme level data to indicate the metric(s) or integration enablers that schemes are intended to impact on (where appropriate).
    - Planned outputs from certain scheme types (comprising significant spend areas that have easily definable outputs).

70. Detailed instructions on completing this are included in the guidance section of the Template.

71. Expenditure plans must include indicative outputs for the scheme types listed in Table 2.

Table 2: Output measures for selected BCF scheme types.

Service	Unit
Domiciliary care	Packages/hours of care
Reablement/rehabilitation	Packages/hours of care
Bed-based intermediate care Step up/step down	Number of beds
Residential placements	Placements
Personalised care at home	Packages

72. There will be an option to select the output unit that is relevant to the scheme – for instance for a domiciliary care scheme this might be total hours or number of packages planned. Plans will not need to show additional packages.

73. As the Planning Template is now collecting more information on the outputs expected from schemes, iBCF reporting will be significantly reduced. Local authority finance directors have still been asked to certify that the iBCF grant is being used exclusively on adult social care in 2019-20.

74. This information will not be used to make judgements on value for money or to make assurance decisions, but will be used to understand how the BCF is used and the levels of activity it supports. National partners recognise that further work is needed to improve measurements of the impact of integrated approaches through the BCF. They will work with local areas to develop models to inform future programmes.

75. CCGs should ensure that these returns mirror their operational planning returns for 2019-20, submitted through central UNIFY and finance return templates. This will include some of the same data, for example funding contributions and baseline Non-elective admission metrics agreed in the CCG operational plans. There will be a national reconciliation process to ensure the data provided matches in all cases.

Section 5 - National metrics

76. The BCF Policy Framework confirms that the existing four national metrics will continue as conditions for the fund. The metrics are:

    a. Non-elective admissions (Specific acute);
    b. Admissions to residential and care homes;
    c. Effectiveness of reablement; and
    d. Delayed transfers of care;

77. Information on all four metrics will continue to be collected nationally. The table below sets out a summary of the information required and where this will be collected. The detailed definitions of all metrics are set out in Appendix 2.

Table 3: National Metrics

Metric	Collection method	Data required
Non-elective admissions (Specific acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Template	Quarterly HWB level activity plan figures for 2019-20.
Admissions to residential and care homes	• Collected through nationally developed high level Planning Template	Plans should confirm an annual metric for 2019-20
Effectiveness of reablement	• Collected through nationally developed high level Planning Template	Plans should confirm an annual metric for 2019-20

Metric	Collection method	Data required
Delayed transfers of care	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through the Planning Template	Local expectations will be set at HWB level and prepopulated in the metrics tab of each HWB Template.

Metric plans

78. BCF plans must include narratives that describe how the schemes and enabling activity for health and social care integration in the agreed BCF plan will support the delivery of each metric.

79. These narratives should include any significant changes from 2017-19 plans, including any schemes that have been decommissioned or planned new schemes.

Non-elective admissions (NEAs)

80. The detailed definition of the NEA metric is set out in the Planning Round Technical Definitions. Figures submitted in CCG operating plan returns have been pre-populated into the Template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for reducing NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

Delayed transfers of care

81. The BCF Policy Framework for 2019-20 retains the centrally set expectation for reducing DToC nationally to below 4,000 delays per day across England. The expectations set for HWBs for 2018-19 in the BCF Operating Guidance 2017-19 have been retained and are pre-populated in each area's Planning Template. Where an area has not met their expectation, they should ensure that there are plans in place to do so as soon as possible. Where areas have already met these expectations, they should continue to implement joint plans to manage discharge and flow to minimise delays.

82. Progress in reducing DToC will continue to be monitored regularly by national partners. Support for areas experiencing significant challenges (and areas keen to further improve and innovate) will continue to be provided through the Better Care Support offer based on performance over time, taking into account the overall rate of delays as well as the distance from BCF plan expectations. This will include a review of progress prior to Winter.

83. Narratives for implementing the HICM and reducing DToC must set out how CCGs, LAs, NHS providers of acute, community and mental health bed-based services and providers of social care will work together to achieve the DToC expectation. Local plans should focus on system wide approaches to ensuring that people are discharged in a safe and timely way to the most appropriate setting, taking account of guidance referenced in Section 4 of this document.

84. Expectations for reducing DToC in 2019-20 are articulated as a single HWB ambition and have not been split into separate NHS and social care expectations. This is intended to support joint working and accountability at system level and BCF plans should describe how these ambitions will be met locally through integrated, collaborative approaches.

PART 3 - ASSURANCE, APPROVAL AND INTERVENTION

Section 6 - Local plan development, sign off and assurance

85. Plans will be assured and moderated regionally, which will be a joint NHS and local government process. Recommendations for approval of BCF plans will be made following cross regional calibration of outcomes to ensure consistent application of the requirements nationally. From April 2019, the NHS has moved to a new regional structure with integrated NHS England and NHS Improvement regional offices. Moderation of HWB BCF plans will be carried out at the new NHS regional footprint, with full involvement of local government.

86. The main Planning Requirements included in this document (summarised on Appendix 1) and a set of underpinning key lines of enquiry (KLOE) have been produced to support a consistent assurance process. These will be available to local areas on the planning requirements confirmations sheet within the Planning Template.

87. The Better Care Support team (BCST) will provide a range of resources to help local areas develop their plans, including signposting to support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Better Care Managers (BCMs) will provide practical support and advice during the planning process.

88. The assurance of plans will be a single stage, with an assessment of whether a plan should be approved or not approved. Plans should be submitted by 27 September 2019, having been approved or scheduled to be approved by the relevant HWB(s).

89. Areas are asked to send their Planning Template to their BCM, copied to england.bettercaresupport@nhs.net. The BCST will collate data from the Planning Template to assist regional assurance. If an agreed plan is not submitted by the deadline, the BCSt will work with the local BCM to agree appropriate support for the area to agree a plan promptly. Areas will be expected to take up this support. If it appears that a plan is unlikely to be agreed locally within a reasonable timeframe, formal escalation will be considered.

90. The assurance process, including reconciling any data issues, will be a joint NHS England and local government process. Local government has been funded to carry out assurance via regional local government leads. BCMs and the BCST will work with these teams to ensure they are fully briefed on the requirements of the BCF for 2019-20 and have capacity in place to participate in the process. The confirmations sheet in the Planning Template sets out the main planning requirements for the BCF and associated KLOEs. NHS regional finance teams will be involved in assurance, particularly in assuring that larger increases to social care from the CCG minimum contribution are affordable and present value to the NHS.

Calibration and plan approval

91. Following regional assurance and moderation, the BCST will co-ordinate a cross-regional calibration exercise with regional colleagues to provide assurance that plans have been assured in a consistent way across England. The BCST will

provide data on provisional assurance outcomes and facilitate the cross-regional discussion to agree a consistent approach to assurance outcomes across all regions. This may result in regions being asked to revisit recommendations from assurance panels where it is agreed that the requirements have not been applied consistently. Following this, recommendations and advice for approval will be provided to DHSC and MHCLG and then to NHS England for approval of spending plans from the CCG minimum contribution.

Table 4: BCF assurance categories

Category	Description
Approved	• Plan agreed by HWB. • Plan meets all national conditions. • Agreement on use of local authority grants (DFG, iBCF and Winter Pressures). • Metrics are set and plans agreed for delivery of these metrics. • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions or metrics.

Not approved	• One or more of the following apply:
	  • Plan is not agreed.
	  • One or more national conditions not met.
	  • No local agreement on use of local authority grants (DFG, iBCF and Winter Pressures).
	  • Plans not agreed for delivery of metrics.

92. Formal approval of BCF plans and authorisation for CCGs to use the CCG minimum element of the BCF will be given by NHS England, following agreement with DHSC and MHCLG that all conditions are met. These decisions will be based on the advice of the assurance process set out above. Where plans are not initially approved, the BCST may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

93. Following formal approval, CCG funding agreed within BCF plans must be transferred into one or more pooled funds established under Section 75 of the NHS Act 2006.

Section 7 - Intervention and escalation

94. Escalation will be considered in the event that:
    - CCGs and local authority are not able to agree and submit a plan to their HWB; or
    - The HWB do not approve the final plan; or
    - Regional assurers rate a plan as ‘not approved’.

95. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. This will initially be a regional process. If regional escalation is not able to address the outstanding planning requirements, senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to a National Escalation Panel meeting to discuss concerns and identify a way forward.

96. If a plan is not approved, the area should not proceed with the signing of a Section 75 agreement in relation to NHS monies.

Section 8 - Monitoring continued compliance with the conditions of the fund

97. BCMs and the wider BCST will monitor continued compliance against the national conditions (including the metrics) through the BCF reporting process described below and their wider interactions with local areas.

98. If an area is not compliant with any of the 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, or if performance against metrics is problematic, the BCST, in consultation with national partners, may make a recommendation to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

99. It is recognised that owing to various circumstances, places may wish to amend plans in-year to:

- Modify or decommission schemes
- Increase investment or include new schemes.

100. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the LA and the CCGs and continue to meet the conditions and requirements of the BCF. A jointly agreed and HWB approved resubmission of an updated BCF Planning Template with an accompanying rationale will be required. If the need arises to amend BCF plans in-year please contact the relevant BCM in the first instance.

101. 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.

Section 9 - Reporting in 2019-20

102. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

103. To serve these purposes, areas are required to provide quarterly reporting for the BCF over 2019-20 in relation to the CCG minimum contribution and the Winter Pressures grant.

104. 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. Monitoring will include confirmation that s.75 agreement is in place.

105. The 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.

Section 10 – Timetable for planning and assurance

106. The submission and assurance process will follow the timetable below:

Table 5: BCF Planning and assurance timetable

BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercaresupport@nhs.net	By 27 September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	By 30 October
Regionally moderated assurance outcomes sent to BCST	By 30 October
Cross regional calibration	By 5 November
Assurance recommendations considered by Departments and NHSE	5 – 15 November
Approval letters issued giving formal permission to spend (CCG minimum)	Week commencing 18 November
All Section 75 agreements to be signed and in place	By 15 December

Appendix 1 - BCF planning requirements

Condition/Requirement	Collection method	Assurance approach
Jointly agreed plan including; • Confirmation of funding contributions • National conditions • Scheme level spending plan	Collected through single Planning Template, submitted to Better Care Managers and copied to england.bettercaresupport@nhs.net	Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level, supported by collation and analysis of data on national conditions and expenditure plans carried out nationally.
National Metrics	Submitted through UNIFY (NEA) and through the Planning Template (Effectiveness of Reablement and Residential admissions)	Collated and analysed nationally, with feedback provided to relevant NHS teams and local government assurers for regional moderation and assurance process. Regional assurance will also confirm that the area has a coherent plan for achieving these metrics.

Appendix 2 - Specification of Better Care Fund metrics

Metric One: Total Non-elective spells (specific acute) per 100,000 population

Outcome sought	A reduction in the number of unplanned acute admissions to hospital.
Rationale	Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
Definition	**Description**: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population. Numerator: Number of specific acute non-elective spells in the period. Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider. Number of specific acute hospital provider spells for which: • Der_Management_Type is 'EM' and 'NE' **Where** 'EM' = Emergency and 'NE' = Non-Elective Please refer the Joint Technical definitions for Performance and Activity (2019-20) and see Appendix A- SUS Methodology for details of derivations and Appendix B for full list of Treatment Function Code categorisation. **Denominator:** ONS mid-year population estimate for all ages (mid-year projection for population
Source	Secondary Uses Service NCDR(SEM) – SUS+ NCDRis derived from SUS+ (SEM) and not the SUS+ PbR Mart. Adjustments are made to the data to correct for improbably high or low data points and ensure a consistent time series; this is in line with monthly activity reporting within NHS England. For more details see Joint Technical definitions for Performance and Activity (2019-20). Population statistics (ONS)
Reporting schedule for data source	Collection frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing of availability: data is available approximately 6 weeks after the period end.
Historic	From 2017-18, total number of specific acute non elective spells replaces non elective (general and acute) episodes metric

Metric Two: Long term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Overarching measure: Delaying and reducing the need for care and support.
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: NHS Digital (SALT) Population statistics (ONS)
Reporting schedule for data source	Collection frequency: Annual (collected Apr-March) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2014-15 following a change to the data source.

Metric Three: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Delaying and reducing the need for care and support When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence.
Rationale	There is strong evidence that reablement services lead to improved outcomes and value for money across the health and social care sectors. Reablement seeks to support people and maximise their level of independence, in order to minimise their need for ongoing support and dependence on public services. This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether an individual remains living at home 91 days following discharge – the key outcome for many people using reablement services. It captures the joint work of social services, health staff and services commissioned by joint teams, as well as adult social care reablement.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from SALT collected by NHS Digital Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework
Reporting schedule for data source	Collection frequency: Annual (although based on 2x3 months data – see definition above) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2011-12 (currently five years data final available (2011-12, 2012-13, 2013-14, 2014-15 and 2015-16)

Metric Four: Delayed transfers of care from hospital per 100,000 population

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
Definition	Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	DToCs (NHS England) Population statistics (ONS)
Reporting schedule for data source	Collection Frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing: data is published approximately 6 weeks after the period end.
Historic	Data first collected Aug 2010

Appendix 3 - Support, escalation and intervention

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** – a. Concern during planning process that a compliant plan will not be agreed b. BCF plan not submitted c. BCF plan submitted does not meet one or more planning requirement	The BCM and regional partners in consultation with the BCST 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 support.
4. Formal regional meeting	Areas will be invited to a formal meeting with regional NHS and local government representatives and the BCST to discuss the concerns, plans to address these and a timescale for addressing the issues identified.
5. **Commencing Escalation** as part of non-compliance	If, following the regional meeting, a solution is not found or issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, BCF national partners 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.

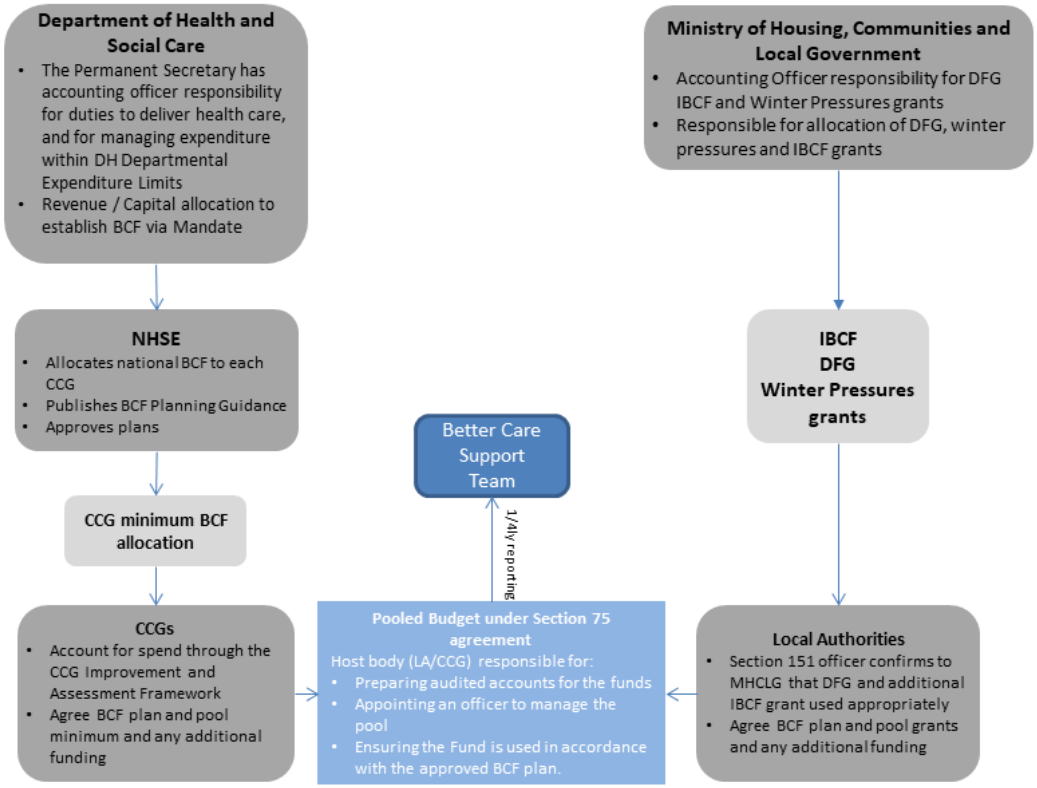
6. The **Escalation Panel**	The Escalation Panel will be jointly chaired by MHCLG and DHSC senior officials, supported by the BCST, with representation from: • NHS England • LGA Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer(s) from LA
7. **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. 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.
8. **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.
9. Consideration of **further action**	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. • 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.

NHS England has the ability to direct the use of the CCG funds where an area fails to meet one of the BCF conditions and NHS England considers that the CCG(s) in question is failing, has failed or is at significant risk of failing to discharge any of its functions. This includes the duties under Sections 14Z1 (duty to promote integration), 14Q (duty as to effectiveness, efficiency etc), 14R (duty as to improvement in quality of services) and 14T (duty as to reducing inequalities) of the NHS Act 2006. If a CCG fails to develop a plan that can be approved by NHS England or 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 ministers. The final decision will then be taken by NHS England. Once a decision has been taken any directions would be made under Section 14Z21 of the NHS Act 2006.

The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG, Winter Pressures or iBCF. This money is not subject to NHS England powers to direct. A BCF plan will not be approved, however, if there is not agreement between health and local government partners on the use of these grants (a requirement of national condition one). Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

Appendix 4 – Funding flows and accountability



This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact 0300 311 22 33 or email england.contactus@nhs.net stating that this document is owned by the Better Care Support Team, Operations and Information Directorate.

If you have any queries about this document, please contact the Better Care Support Team at: england.bettercaresupport@nhs.net

For further information on the Better Care Fund, please go to: https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

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Community and Social Care Group/Care and Transformation Directorate/Commissioning, Integration and Transformation Unit

www.gov.uk/dhsc

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Better Care Fund 2019/20 Template

1. Guidance

Overview

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

For a more optimal 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 sheet for readability if required.

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section 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 are green before submission.

2. Cover (click to go to sheet)

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
3. Please note that in line with fair processing of personal data we collect email addresses to communicate with key individuals from the local areas for various purposes relating to the delivery of the BCF plans including plan development, assurance, approval and provision of support.
We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.
Please let us know if any of the submitted contact information changes during the BCF planning cycle so we are able to communicate with the right people in a timely manner.

4. Strategic Narrative (click to go to sheet)

This section of the template should set out the agreed approach locally to integration of health & social care. The narratives should focus on updating existing plans, and changes since integration plans were set out until 2020 rather than reiterating them and can be short. Word limits have been applied to each section and these are indicated on the worksheet.

1. Approach to integrating care around the person. This should set out your approach to integrating health and social care around the people, particularly those with long term health and care needs. This should highlight developments since 2017 and cover areas such as prevention.
2 i. Approach to integrating services at HWB level (including any arrangements at neighbourhood level where relevant). This should set out the agreed approach and services that will be commissioned through the BCF. Where schemes are new or approaches locally have changed, you should set out a short rationale.
2 ii. DFG and wider services. This should describe your approach to integration and joint commissioning/delivery with wider services. In all cases this should include housing, and a short narrative on use of the DFG to support people with care needs to remain independent through adaptations or other capital expenditure on their homes. This should include any discretionary use of the DFG.
3. How your BCF plan and other local plans align with the wider system and support integrated approaches. Examples may include the read across to the STP (Sustainability Transformation Partnerships) or ICS (Integrated Care Systems) plan(s) for your area and any other relevant strategies.

You can attach (in the e-mail) visuals and illustrations to aid understanding if this will assist assurers in understanding your local approach.

5. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund (BCF) plan and pooled budget for 2019/20. On selected the HWB from the Cover page, this sheet will be pre-populated with the minimum CCG contributions to the BCF, DFG (Disabled Facilities Grant), iBCF (improved Better Care Fund) and Winter Pressures allocations to be pooled within the BCF. These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from Local Authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be utilised to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact England.bettercaresupport@nhs.net

6. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Condition 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.
On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- While selecting schemes and sub-types, the sub-type field will be flagged in 'red' font if it is from a previously selected scheme type. In this case please clear the sub-type field and reselect from the dropdown if the subtype field is editable.
5. Planned Outputs
- The BCF Planning requirements document requires areas to set out planned outputs for certain scheme types (those which lend themselves to delivery of discrete units of delivery) to help to better understand and account for the activity funded through the BCF.
- The Planned Outputs fields will only be editable if one of the relevant scheme types is selected. Please select a relevant unit from the drop down and an estimate of the outputs expected over the year. This is a numerical field.

6. Metric Impact
- This field is collecting information on the metrics that a chem will impact on (rather than the actual planned impact on the metric)
- For the schemes being planned please select from the drop-down options of 'High-Medium-Low-n/a' to provide an indicative level of impact on the four BCF metrics. Where the scheme impacts multiple metrics, this can be expressed by selecting the appropriate level from the drop down for each of the metrics. For example, a discharge to assess scheme might have a medium impact on Delayed Transfers of Care and permanent admissions to residential care. Where the scheme is not expected to impact a metric, the 'n/a' option could be selected from the drop-down menu.
7. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
8. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme from the provider. If there is a single commissioner, please select the option from the drop-down list.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.
9. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

10. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop-down list
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.
11. Expenditure (£) 2019/20:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
12. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2019/20 and will inform the understanding of planned spend for the iBCF and Winter Funding grants.

7. HICM (click to go to sheet)

National condition four of the BCF requires that areas continue to make progress in implementing the High Impact Change model for managing transfers of care and continue to work towards the centrally set expectations for reducing DToC. In the planning template, you should provide:
- An assessment of your current level of implementation against each of the 8 elements of the model – from a drop-down list
- Your planned level of implementation by the end March 2020 – again from a drop-down list
A narrative that sets out the approach to implementing the model further. The Narrative section in the HICM tab sets out further details.

8. Metrics (click to go to sheet)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2019/20. The BCF requires plans to be agreed for the four metrics. This should build on planned and actual performance on these metrics in 2018/19.

1. Non-Elective Admissions (NEA) metric planning:
- BCF plans as in previous years mirror the latest CCG Operating Plans for the NEA metric. Therefore, this metric is not collected via this template.
2. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
- Please include a brief narrative associated with this metric plan
3. Reablement (REA) planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
- Please include a brief narrative associated with this metric plan
4. Delayed Transfers of Care (DToC) planning:
- The expectations for this metric from 2018/19 are retained for 2019/20 and these are prepopulated.
- Please include a brief narrative associated with this metric plan.
- This narrative should include details of the plan, agreed between the local authority and the CCG for using the Winter Pressures grant to manage pressures on the system over Winter.

9. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2019/20 for further details.
The Key Lines of Enquiry (KLOE) underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.
1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

10. CCG-HWB Mapping (click to go to sheet)

The final sheet provides details of the CCG - HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity figures.

Better Care Fund 2019/20 Template

2. Cover

Version 1.2

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

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2019/20.
- 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:	Councillor Graham Cain
Will the HWB sign-off the plan after the submission date?	No
If yes, please indicate the date when the HWB meeting is scheduled:	

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Graham	Cain	graham.cain@blackpool.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		David	Bonson	david.bonson@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		Jeannie	Harrop	jeannie.harrop@nhs.net
	Local Authority Chief Executive		Neil	Jack	neil.jack@blackpool.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Karen	Smith	karen.smith@blackpool.gov.uk
	Better Care Fund Lead Official		Jayne	Bentley	jayne.bentley@blackpool.gov.uk
	LA Section 151 Officer		Steve	Thompson	steve.thompson@blackpool.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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

	Complete:
2. Cover	Yes
4. Strategic Narrative	Yes
5. Income	Yes
6. Expenditure	Yes
7. HICM	Yes
8. Metrics	Yes
9. Planning Requirements	Yes

<< Link to the Guidance sheet

Checklist

2. Cover ^^ Link back to top

	Cell Reference	Checker
Health & Wellbeing Board	D13	Yes
Completed by:	D15	Yes
E-mail:	D17	Yes
Contact number:	D19	Yes
Who signed off the report on behalf of the Health and Wellbeing Board:	D21	Yes
Will the HWB sign-off the plan after the submission date?	D23	Yes
If yes, please indicate the date when the HWB meeting is scheduled:	D24	Yes
Area Assurance Contact Details - Role:	C27 : C36	Yes
Area Assurance Contact Details - First name:	F27 : F36	Yes
Area Assurance Contact Details - Surname:	G27 : G36	Yes
Area Assurance Contact Details - E-mail:	H27 : H36	Yes
Sheet Complete		Yes

4. Strategic Narrative ^^ Link back to top

	Cell Reference	Checker
A) Person-centred outcomes:	B20	Yes
B) (i) Your approach to integrated services at HWB level (and neighbourhood where applicable):	B31	Yes
B) (ii) Your approach to integration with wider services (e.g. Housing):	B37	Yes
C) System level alignment:	B44	Yes
Sheet Complete		Yes

5. Income ^^ Link back to top

	Cell Reference	Checker
Are any additional LA Contributions being made in 2019/20?	C39	Yes
Additional Local Authority	B42 : B44	Yes
Additional LA Contribution	C42 : C44	Yes
Additional LA Contribution Narrative	D42 : D44	Yes
Are any additional CCG Contributions being made in 2019/20?	C59	Yes
Additional CCGs	B62 : B71	Yes
Additional CCG Contribution	C62 : C71	Yes
Additional CCG Contribution Narrative	D62 : D71	Yes
Sheet Complete		Yes

6. Expenditure ^^ Link back to top

	Cell Reference	Checker
Scheme ID:	B22 : B271	Yes
Scheme Name:	C22 : C271	Yes
Brief Description of Scheme:	D22 : D271	Yes
Scheme Type:	E22 : E271	Yes
Sub Types:	F22 : F271	Yes
Specify if scheme type is Other:	G22 : G271	Yes
Planned Output:	H22 : H271	Yes
Planned Output Unit Estimate:	I22 : I271	Yes
Impact: Non-Elective Admissions:	J22 : J271	Yes
Impact: Delayed Transfers of Care:	K22 : K271	Yes
Impact: Residential Admissions:	L22 : L271	Yes
Impact: Reablement:	M22 : M271	Yes
Area of Spend:	N22 : N271	Yes
Specify if area of spend is Other:	O22 : O271	Yes
Commissioner:	P22 : P271	Yes
Joint Commissioner %:	Q22 : Q271	Yes
Provider:	S22 : S271	Yes
Source of Funding:	T22 : T271	Yes
Expenditure:	U22 : U271	Yes
New/Existing Scheme:	V22 : V271	Yes
Sheet Complete		Yes

7. HICM ^^ Link back to top

	Cell Reference	Checker
Priorities for embedding elements of the HCIM for Managing Transfers of Care locally:	B11	Yes
Chg 1) Early discharge planning - Current Level:	D15	Yes
Chg 2) Systems to monitor patient flow - Current Level:	D16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Current Level:	D17	Yes
Chg 4) Home first / discharge to assess - Current Level:	D18	Yes
Chg 5) Seven-day service - Current Level:	D19	Yes
Chg 6) Trusted assessors - Current Level:	D20	Yes
Chg 7) Focus on choice - Current Level:	D21	Yes
Chg 8) Enhancing health in care homes - Current Level:	D22	Yes
Chg 1) Early discharge planning - Planned Level:	E15	Yes
Chg 2) Systems to monitor patient flow - Planned Level:	E16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Planned Level:	E17	Yes
Chg 4) Home first / discharge to assess - Planned Level:	E18	Yes
Chg 5) Seven-day service - Planned Level:	E19	Yes
Chg 6) Trusted assessors - Planned Level:	E20	Yes
Chg 7) Focus on choice - Planned Level:	E21	Yes
Chg 8) Enhancing health in care homes - Planned Level:	E22	Yes
Chg 1) Early discharge planning - Reasons:	F15	Yes
Chg 2) Systems to monitor patient flow - Reasons:	F16	Yes
Chg 3) Multi-disciplinary/Multi-agency discharge teams - Reasons:	F17	Yes
Chg 4) Home first / discharge to assess - Reasons:	F18	Yes
Chg 5) Seven-day service - Reasons:	F19	Yes
Chg 6) Trusted assessors - Reasons:	F20	Yes
Chg 7) Focus on choice - Reasons:	F21	Yes
Chg 8) Enhancing health in care homes - Reasons:	F22	Yes
Sheet Complete		Yes

8. Metrics ^^ Link back to top

	Cell Reference	Checker
Non-Elective Admissions: Overview Narrative:	E10	Yes
Delayed Transfers of Care: Overview Narrative:	E17	Yes
Residential Admissions Numerator:	F27	Yes
Residential Admissions: Overview Narrative:	G26	Yes
Reablement Numerator:	F39	Yes
Reablement Denominator:	F40	Yes
Reablement: Overview Narrative:	G38	Yes
Sheet Complete		Yes

9. Planning Requirements ^^ Link back to top

	Cell Reference	Checker
PR1: NC1: Jointly agreed plan - Plan to Meet	F8	Yes
PR2: NC1: Jointly agreed plan - Plan to Meet	F9	Yes
PR3: NC1: Jointly agreed plan - Plan to Meet	F10	Yes
PR4: NC2: Social Care Maintenance - Plan to Meet	F11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Plan to Meet	F12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Plan to Meet	F13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Plan to Meet	F15	Yes
PR9: Metrics - Plan to Meet	F16	Yes
PR1: NC1: Jointly agreed plan - Actions in place if not	H8	Yes
PR2: NC1: Jointly agreed plan - Actions in place if not	H9	Yes
PR3: NC1: Jointly agreed plan - Actions in place if not	H10	Yes
PR4: NC2: Social Care Maintenance - Actions in place if not	H11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Actions in place if not	H12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Actions in place if not	H13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Actions in place if not	H15	Yes
PR9: Metrics - Actions in place if not	H16	Yes
PR1: NC1: Jointly agreed plan - Timeframe if not met	I8	Yes
PR2: NC1: Jointly agreed plan - Timeframe if not met	I9	Yes
PR3: NC1: Jointly agreed plan - Timeframe if not met	I10	Yes
PR4: NC2: Social Care Maintenance - Timeframe if not met	I11	Yes
PR5: NC3: NHS commissioned Out of Hospital Services - Timeframe if not met	I12	Yes
PR6: NC4: Implementation of the HICM for Managing Transfers of Care - Timeframe if not met	I13	Yes
PR7: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I14	Yes
PR8: Agreed expenditure plan for all elements of the BCF - Timeframe if not met	I15	Yes
PR9: Metrics - Timeframe if not met	I16	Yes
Sheet Complete		Yes

^^ Link back to top

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Blackpool

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,304,619	£2,304,619	£0
Minimum CCG Contribution	£14,519,972	£14,519,972	£0
iBCF	£9,651,859	£9,651,859	£0
Winter Pressures Grant	£903,685	£903,685	£0
Additional LA Contribution	£2,200,409	£2,200,409	£0
Additional CCG Contribution	£3,182,099	£3,182,099	£0
Total	£32,762,643	£32,762,643	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£4,126,164
Planned spend	£4,507,155

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£5,200,475
Planned spend	£9,554,066

Scheme Types

Assistive Technologies and Equipment	£2,281,832
Care Act Implementation Related Duties	£138,000
Carers Services	£979,921
Community Based Schemes	£4,686,447
DFG Related Schemes	£2,304,619
Enablers for Integration	£9,613,750
HICM for Managing Transfer of Care	£3,694,429
Home Care or Domiciliary Care	£2,002,415
Housing Related Schemes	£126,766
Integrated Care Planning and Navigation	£678,576
Intermediate Care Services	£1,608,650
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£1,089,061
Prevention / Early Intervention	£1,192,047
Residential Placements	£0
Other	£2,366,130
Total	£32,762,643

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	**Early discharge planning**	Mature
Chg 2	**Systems to monitor patient flow**	Established
Chg 3	**Multi-disciplinary/Multi-agency discharge teams**	Mature
Chg 4	**Home first / discharge to assess**	Established
Chg 5	**Seven-day service**	Mature
Chg 6	**Trusted assessors**	Established
Chg 7	**Focus on choice**	Established
Chg 8	**Enhancing health in care homes**	Mature

Metrics >>

Non-Elective Admissions	Go to Better Care Exchange >>
Delayed Transfer of Care	

Residential Admissions

		19/20 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	876.1820981

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.861538462

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	**PR6**	Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
	PR8	Yes
Metrics	**PR9**	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Blackpool

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes

Your approach to integrating care around the person, this may include (but is not limited to):

- Prevention and self-care
- Promoting choice and independence

Remaining Word Limit: 345

In line with the Care Act 2014, Blackpool Council has a duty to promote prevention, and to reduce and/or delay the need for formal care and support services. As well as being an inherent element of the assessment, review and Safeguarding Adults processes, the universal information and advice service required by the Care Act 2014 is enabling those who can to maintain their own independence and wellbeing. Where formal care and support is needed, Blackpool Council provides services which promote person-centred outcomes and choice. Compliance with the statutory duties set out in the Care Act 2014 has seen an increase in the number of assessments and carers assessments, and subsequently reviews, being undertaken by Blackpool Council. However, there is currently no waiting list for Adult Social Care assessments, and Blackpool Council will not be operating one. Reviews are largely up to date, and are addressed on a monthly basis.

Blackpool CCG and Blackpool Council have developed neighbourhood care teams, initially under Vanguard, which include multi-disciplinary hubs based within our community to provide care and support for people in their preferred place. Co-location of health and social care disciplines in six hubs ensures that health and social care and support is personalised to an individual's needs The neighbourhood teams include social workers and health and wellbeing workers, who can look at a variety of non-medical models to ensure a person-centred, outcome-based approach is in place. The integrated services continue to work well together and, and in addition to being aligned with the Primary Care Networks (PCNs), further integration is planned with frailty, community stroke rehabilitation and intermediate care pathways. As part of the development of PCNs, social prescribing link workers will also be supporting people to improve their personal outcomes and provide options and signposting around prevention, self-care and independence. Some staff disciplines complete Patient Activation Monitoring (PAM) scores, and people's individual outcomes are recorded and then monitored to track their improvement and personal goals. Primary care and the neighbourhood care teams try and ensure that where possible individuals remain responsible for their own self-care, for example by using local community pharmacies, and being signposted to friendships groups. Our multi-disciplinary neighbourhood and hospital discharge teams, and our community social work teams liaise closely with service users, their families and carers to ensure that they are fully aware of their options in a timely manner.
Blackpool CCG and Blackpool Council work in partnership to offer individuals Personal Health Budgets (PHBs) to people who receive Continuing Health Care (CHC) at home. Individuals are offered the choice of a notional budget, a direct payment or a third party, and those who chose a direct payment are also offered the option of having a managed account. Support is provided by a CHC Nurse Advisor and the PHB Co-ordinator, with the content of all care and support plans and the indicative/final budget being reviewed and approved by the CCG. Reviews are completed at either 3 or 12 months in line with the National Framework for Continuing Health Care and Funded Nursing Care, and PHBs paid on as a direct payment are audited on a quarterly basis.
Blackpool's BCF supports health and social care outcomes through new and existing joint initiatives which are underpinned by a focus on maintaining independence and control through personalisation of care, alongside self-care and early intervention approaches to improve resilience and address health inequalities in our communities. The schemes within the BCF have been subject to equality impact assessments to ensure that they deliver services in accordance with the Equality Act 2010. The Joint Health and Wellbeing Strategy for Blackpool 2016-2019 sets out the Health and Wellbeing Board's priorities and approach to health inequalities, which is fully reflected in the development and delivery of schemes within our BCF. Public Health works alongside health and social care colleagues around all aspects of prevention and this is included in the clinical pathway work, e.g. frailty, long term conditions. ICP partner organisations, including the Fylde Coast CCGs, the two borough councils and Blackpool Council are being led by Public Health to plan for this year's Self Care week which is taking place in November. This year will build on the award winning success of last year and encourage local groups to promote themselves by organising special taster sessions of their activity during the week. The taster sessions will be promoted as a chance for people who do not currently take part in healthy activity to get involved and choose good self-care practices. Activity will be targeted at different age groups with something for families with young children, school aged young people, working aged people and retirees. Last year 72 events took place and we are hopeful for something similar this year with hundreds of people taking part. At the same time the FYI directory continues to be promoted and is well utilised with an average of 30,000 visitors to the site each month. A group is being set up to conduct a review of the self-care strategy with the aim of refreshing it beyond 2020.

We have already made significant progress, and continue to work together towards our 2020 aspirations:

• Co-ordinated health and social care focused on the needs of the individual, so that people get appropriate help and support when they need it, where they need it;
• Co-located integrated teams, with multi-professional leadership, based around clusters of GP practices coordinating primary, community and social care;
• Integrated teams that enable rapid access and direct referral to appropriate specialist services;

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):

- Joint commissioning arrangements
- Alignment with primary care services (including PCNs (Primary Care Networks))
- Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

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Blackpool Council and Blackpool CCG are key partners in the adoption and delivery of the Fylde Coast Self-Care Strategy 2017-2020. Prevention and self-care is at the heart of this strategy, which requires all partners across the Fylde Coast to look at innovative approaches to address the health inequalities that exist in our communities whilst responding to the prevalence increase in long-term conditions, including those with multi-morbidity. We have already made good progress in working towards a vision of achieving greater levels of integrated services and self-care across Blackpool and the Fylde Coast. This work has been fully embedded within the delivery of the new models of care neighbourhood teams, and the four Primary Care Networks (PCNs), which became operational in July 2019.
The organisations which commission and deliver services are becoming more joined-up across geographical 'places'. The change people experience most vividly is within neighbourhoods – geographical areas of typically 30,000 to 50,000 residents. The neighbourhood approach brings groups of GP practices together with community health services, social care, mental health services, and others, to provide a joined-up health and wellbeing services. Working together in this joined-up way, the teams can make a complete assessment of a person's health, wellbeing and social needs and liaise with their colleagues to make sure they receive the right support.
Blackpool's PCNs include health coaching, assistive technology and health and wellbeing workers working with GP practices, and community health and social care professionals, to understanding of an individual's ability to contribute to the management of their own health and wellbeing. A Standard Operating Framework is currently being developed to align the neighbourhood teams across the Fylde Coast, recognising that an integrated, multi-disciplinary approach is central to designing patient-centred care plans and goals. This includes the development of a unique non-clinical role of a 'Health and Wellbeing Support Worker'. Use of the PAM tool will also help to identify the knowledge, skills, and confidence an individual has to manage their own health and wellbeing, and then for services to tailor their approach to supporting the individual.
The voluntary, community, faith and social enterprise sectors (VCS) provide a rich range of activities, including information, activities, support, advice and advocacy. They deliver vital services with paid and volunteer expert staff. The NHS Five Year Forward View recognised that they are often better able to reach under-served groups, and are a source of advice for commissioners on particular needs. They are essential partners in empowering patients and communities in health and care, and are an important aspect of the development of integrated prevention and self-care strategies in Blackpool. As such, the Standard Operating Framework, overseen by the Fylde Coast Integrated Primary and Community Care Transformation Group, includes core and linked services with the VCS. The VCS Lead is integral to the Integrated Primary and Community Care Transformation, and VCS services are a key part of the Standard Operating Framework model.
The Fylde Coast Urgent and Emergency Care Transformation Programme is primarily looking at improving the way patients move throughout the hospital, improving waiting times in the emergency department and tackling delays when discharging patients out of hospital to home or to other care settings. The schemes within the Better Care Fund align and support the programmes' key priorities of 'admission avoidance' and 'return to home'. Our established multi-disciplinary Hospital Discharge Team has staff from health and social care who liaise to ensure that discharge planning begins as soon as possible and maintains momentum. As well as covering every ward within Blackpool hospital settings, there is also cover within the Accident and Emergency department, supporting triage functions to avoid unnecessary admissions. Blackpool also has a number of well-established services, some of which operate on a 7-day basis, such as the Rapid Response Service, Rapid Response Plus and our residential intermediate care facilities. These teams have direct access to Council funded short term intensive domiciliary support avoid admission to an acute setting. In cases where admission is unavoidable, these teams will also facilitate timely and effective discharge. The Rapid Intervention and Treatment Team provide a 7-day service within the referral and support pathway for Older Adults Mental Health.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:

- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the

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In line with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care, the Local Authority and Health partners have agreed how funding is best used within Adult Social Care, and also the outcomes expected from investment. Improved BCF (iBCF) funding received through the 2015 Spending Review and the 2017 Spring Budget has been invested to meet the requirements of the 2017-19 Integration and Better Care Fund Policy Framework, the High Impact Changes for Managing Transfers of Care, and locally set outcomes. The BCF offers the opportunity to develop existing programmes of joint working, and to foster integration between health, adult social care and other partners including housing.

Blackpool Council's Housing Plan for the Ageing Population 2017-2020 and Blackpool Council Housing Strategy 2018-2023 – Making Blackpool Better set out an integrated approach, involving Adult Social Care, Blackpool CCG, Public Health, VCS organisations and housing providers to ensure a wide range of housing and services provision to enable people with disabilities and/or care needs to live independently. Key outcomes are which align to our Health and Wellbeing level approach are:

• All older people living in Blackpool have access to warm, safe, secure and affordable homes enabling them to live independently wherever possible;
• Information and advice is available to everyone, empowering them to make appropriate lifestyle choices;
• Homes and neighbourhoods meet the current and future needs of Blackpool's population and supports independence, health and wellbeing.

Adaptations and technologies
Blackpool Council in partnership with housing providers has developed a new policy and procedure for adaptations, to streamline the process to reduce waiting time. The policy places a great emphasis on reviewing housing options with the applicant to determine whether a move would be a better option. The DFG Policy has been written to address some of the issues that cause unacceptable waiting times for residents. Some of the key improvement areas addressed in the policy are:
• Adopting a 'necessary and appropriate' and 'reasonable and practicable' attitude to adaptations requested;
• Ensuring Occupational Therapists are aware of and 'buy into' the notion of appropriateness and suitability when assessing residents.

Our assistive technology service, Vitaline, offers a range of services that are designed to keep people safe in their own home and thus enables them to live an independent lifestyle. They are currently supporting 5000 residents in Blackpool, provide a 24/7 telecare service and tailor services to meet individual needs. With the aim of supporting independent living, Vitaline provides a range of individually designed assistive-technology packages coupled with a personal mobile response to emergency calls. Equipment ranges from basic pendant alarms through to the very latest wireless controlled environmental sensors that can detect a potential problem without the need of client input e.g. movement sensors that will 'know' if there has been no movement in a property – a possible indication of a fall. Vitaline forms part of Blackpool Council's Care Act assessment and are included in personal budgets where eligibility and financial assessment conditions are met. Blackpool CCG offers free Vitaline services to those individuals with primary health needs, and Vitaline is also available privately. Among the benefits, Vitaline's Telecare can provide:

• Early detection of emergencies and a fast response to them;
• Early detection of lifestyle changes that may indicate deterioration in health;
• The opportunity to address problems at an early stage before they become acute;
• A sense of security and peace of mind for the client.

C) System level alignment, for example this may include (but is not limited to):

- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans
- A brief description of joint governance arrangements for the BCF plan

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Blackpool sits within the Fylde Coast Integrated Care Partnership (ICP), Healthier Fylde Coast, one of five ICPs which make up the Lancashire and South Cumbria Integrated Care System ICS), Healthier Lancashire and South Cumbria.
The schemes within the Blackpool Better Care Fund align with the local and regional priorities, which are informed by the Care Act 2014 and the NHS Long Term Plan. Fylde Coast CCGs are working with patients, the public and partners – including local councils, the voluntary and community sector and social care – to develop local plans to turn the national ambitions contained in the Long Term Plan into real improvements to services and outcomes for patients, building on the progress we've already made together over the last few years.
The Blackpool BCF has existing governance arrangements in place that provide a direct line into the Blackpool Health and Wellbeing Board:
• The Health and Wellbeing Board is the accountable body for the BCF and receives quarterly reports from the Better Care Fund Monitoring Group, scrutinising and signing off quarterly submissions to NHS England, along with the approval of the overall BCF plan.
• The BCF Quality and Monitoring Group is made up of representatives from Blackpool CCG and Blackpool Council, with representatives from other services being invited as and when appropriate. This group investigates the effectiveness of the schemes within the BCF and monitors income and expenditure, providing regular governance updates and escalating any areas of concern to organisational Executive Boards. This group also acts as the main link to local partnership arrangements and other individual scheme project management resources, in line with the terms of the Section 75 agreement.

The finances of the BCF are managed within a pooled fund created under the Section 75 agreement. Blackpool Council hosts the fund and provides regular financial reports to Senior Management and Executive Boards. The Health and Wellbeing Board has overall responsibility for performance managing and monitoring of actual income and expenditure in relation to the pooled fund. It has been agreed that those social care services that are evidence-based, that meet the BCF vision and deliver our locally defined outcomes will be included as part of the BCF. These schemes are restricted to and listed as expenditure schemes in the 2019/20 planning template. The schemes and details of finances within this plan are built on the principles of integration and joint working. All BCF schemes are protected by the governance arrangements supporting the BCF. Any proposed changes to schemes must be jointly agreed by all partners following an evidence based recommendation which is then submitted to, and approved by, Executive Boards and the Health and Wellbeing Board prior to any changes taking place.

Established partnership arrangements are in place across the Fylde Coast health and social care economy, and Blackpool contributes to the governance and delivery of joint initiatives which impact on the BCF and beyond. A longer term challenge is to align with Lancashire and Blackburn with Darwen BCFs while retaining individual organisation accountabilities that are clear and manageable.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Blackpool

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Blackpool	£2,304,619
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,304,619**

iBCF Contribution	Contribution
Blackpool	£9,651,859
Total iBCF Contribution	**£9,651,859**

Winter Pressures Grant	Contribution
Blackpool	£903,685
Total Winter Pressures Grant Contribution	**£903,685**

Are any additional LA Contributions being made in 2019/20? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Blackpool	£2,200,409	.
Total Additional Local Authority Contribution	**£2,200,409**	

CCG Minimum Contribution	Contribution
NHS Blackpool CCG	£14,519,972
Total Minimum CCG Contribution	**£14,519,972**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	Yes

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Blackpool CCG	£3,182,099	.
Total Addition CCG Contribution	**£3,182,099**	
Total CCG Contribution	**£17,702,071**	

	2019/20
Total BCF Pooled Budget	**£32,762,643**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
.

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Blackpool

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,304,619	£2,304,619	£0
Minimum CCG Contribution	£14,519,972	£14,519,972	£0
iBCF	£9,651,859	£9,651,859	£0
Winter Pressures Grant	£903,685	£903,685	£0
Additional LA Contribution	£2,200,409	£2,200,409	£0
Additional CCG Contribution	£3,182,099	£3,182,099	£0
Total	£32,762,643	£32,762,643	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,126,164	£4,507,155	£0
Adult Social Care services spend from the minimum CCG allocations	£5,200,475	£9,554,066	£0

Link to Scheme Type description

						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Disabled Facilities Grant - Capital	Adaptations to enable independent living	DFG Related Schemes	Adaptations				Medium	Medium	Medium	High	Social Care		LA			Local Authority	DFG	£2,304,619	Existing
2	Phoenix Centre	Mental Health Crisis and Respite Centre	Prevention / Early Intervention	Other	MH Crisis Centre			High	Medium	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£446,431	Existing
3	ARC - Incl Social Workers	Residential Reablement Service	Intermediate Care Services	Other	Residential reablement	Planned service capacity	90.0	High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,608,650	Existing
4	Internal Homecare	Domiciliary care to support admission avoidance and support	Home Care or Domiciliary Care			Hours of Care	1,600.0	High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,002,415	Existing
4	Internal Homecare	Domiciliary care to support admission avoidance and support	Other		Home Care or Domicilary Care (total output on			High	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£691,374	Existing
5	Vitaline	Assistive technology service, including falls response.	Assistive Technologies and Equipment	Telecare				High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£146,685	Existing
5	Vitaline	Assistive technology service, including falls response.	Assistive Technologies and Equipment	Telecare				High	High	High	High	Social Care		LA			Local Authority	Additional LA Contribution	£952,397	Existing
6	Keats	Day centre providing carer respite and support for people with	Carers Services	Respite Services				High	Low	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£238,013	Existing
7	Extra Support Service	Short term interventions for LD cases in crisis to get back on track and	Personalised Care at Home			Placements	15.0	High	Low	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,089,061	Existing
7	Extra Support Service	Short term interventions for LD cases in crisis to get back on track and	Other		Personalised care at home (total output at			High	Low	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£521,119	Existing
8	Coopers Way	Respite provision for LD	Carers Services	Respite Services				Medium	Low	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£521,908	Existing
8	Coopers Way	Respite provision for LD	Carers Services	Respite Services				Medium	Low	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£95,000	Existing
9	Gloucester Av	MH Rehabilitation	Prevention / Early Intervention	Other	MH Rehab Centre			Medium	Low	Medium	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£254,313	Existing

10	Primary MH Care	MH Social Care Team	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Medium	High	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£241,551	Existing
11	Hospital Discharge Team	Intregrated hospital discharge team	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Low	High	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£614,059	Existing
12	MH Day Services	Mental Health day support services	Prevention / Early Intervention	Other	MH Day Support			Medium	Medium	Medium	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£233,335	Existing
13	CHC Team	Continuing Health Care social care team.	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	Medium	Low	Low	Continuing Care		LA			Local Authority	Additional LA Contribution	£85,661	Existing
14	Additional Social Workers - A&E,HDT,	Social care posts within A&E, hospital discharge team, and	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				High	High	High	High	Social Care		LA			Local Authority	iBCF	£506,870	Existing
14	Additional Social Workers - A&E,HDT,	Social care posts within A&E, hospital discharge team, and	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				High	High	High	High	Social Care		LA			Local Authority	Additional LA Contribution	£121,237	Existing
15	6 Additional Social Work Posts	Social care posts across Adult Social Care	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	High	High	High	Social Care		LA			Local Authority	Winter Pressures Grant	£212,311	Existing
16	Transitons	Dedicated transitions post to work across Childrens and Adults	Care Act Implementation Related Duties	Other	Transitions Specialist Worker			Low	Low	Low	Not applicable	Social Care		LA			Local Authority	Additional LA Contribution	£41,000	Existing
17	Autism	Dedicated autism posts to work alongside LD team	Care Act Implementation Related Duties	Other	Autism Specialist Workers			Low	Low	Low	Not applicable	Social Care		LA			Local Authority	Additional LA Contribution	£97,000	Existing
18	Homefirst Pilot	Multi disciplinary team to implement home first discharge approach	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Medium	High	High	High	Social Care		LA			Local Authority	Additional LA Contribution	£124,000	Existing
19	Review of ASC	Post reviewing ASC policies and procedures, including DTOC	Enablers for Integration	Joined-up regulatory approaches				Not applicable	High	Not applicable	Not applicable	Social Care		LA			Local Authority	Additional LA Contribution	£44,000	Existing
20	Occupational Therapy	Post to support early discharge and independent living	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	High	Low	Social Care		LA			Local Authority	Additional LA Contribution	£45,000	Existing
21	Quality Assurance Team	QA team to monitor provider standards	Enablers for Integration	Market development (inc Vol sector)				Low	Low	Not applicable	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£358,776	Existing
23	Adults Equipment	Community equipment service to enable independent living	Assistive Technologies and Equipment	Community Based Equipment				High	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,182,750	Existing
24	Care & Repair Contract - BCH	Handyman and repair service	Housing Related Schemes					Low	Low	Low	Low	Social Care		LA			Local Authority	Additional LA Contribution	£126,766	Existing
25	Spending Review Original iBCF	Uplift in provider rates	Enablers for Integration	Fee increase to stabilise the care provider market				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£8,371,989	Existing
26	Increase Rates - Additional iBCF - Spring 17 Budget	Uplift in provider rates	Enablers for Integration	Fee increase to stabilise the care provider market				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		LA			Local Authority	iBCF	£773,000	Existing
27	Children's Equipment	Community contract allocation	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Other	Childen's	LA			Local Authority	Additional CCG Contribution	£7,282	Existing
28	Hub Manager	Community contract allocation	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Other	Childen's	LA			Local Authority	Additional CCG Contribution	£56,998	Existing
29	Speech & language	Community contract allocation	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Other	Childen's	LA			Local Authority	Additional CCG Contribution	£45,598	Existing
30	YOT	Community contract allocation	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Other	Childen's	LA			Local Authority	Additional CCG Contribution	£15,442	Existing
31	Care Co-ordinator Manager	Community contract allocation	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Other	Childen's	LA			Local Authority	Additional CCG Contribution	£6,218	Existing

32	Enhanced Primary Care and Care Homes	Development of neighbourhood care team and care home	HICM for Managing Transfer of Care	Chg 8. Enhancing Health in Care Homes				High	High	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£676,468	Existing
33	Out of Hospital IV therapy service	Community IV therapy service for walk in, housebound and care	Prevention / Early Intervention	Social Prescribing				Medium	High	Low	Low	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£257,968	Existing
34	Frequent Callers	Targeted support for patients who access primary care regularly	Community Based Schemes					High	Low	Low	Low	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£70,000	Existing
35	Intermediate Care model	Step up / step down provision for intermediate care with	Community Based Schemes					High	High	Medium	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,041,247	Existing
36	Carers support workers/grants	Grant to Carers Centre for carers advice and support.	Carers Services	Carer Advice and Support				Medium	Medium	Low	Low	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£125,000	Existing
37	Rapid Response	Multi disciplinary team to respond to crisis and avoid admission. Also in-	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				High	High	High	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£473,805	Existing
38	HD Team	Multi-disciplinary team covering all wards in acute settings to enable	HICM for Managing Transfer of Care	Chg 1. Early Discharge Planning				Not applicable	High	High	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£133,179	Existing
39	Hospital Aftercare service (existing)	Voluntary sector service providing aftercare on discharge from acute	HICM for Managing Transfer of Care	Chg 7. Focus on Choice				Low	High	High	Low	Other	Red Cross	CCG			Charity / Voluntary Sector	Additional CCG Contribution	£39,033	Existing
40	Extensive Care Service	Community frailty service providing different levels of	Community Based Schemes					High	High	High	Low	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,200,000	Existing
41	GP Plus NEL scheme	GP utilisation of care coordination to avoid non-elective admissions	Community Based Schemes					Low	Low	Low	Low	Primary Care		CCG			CCG	Additional CCG Contribution	£2,186,200	Existing
42	Enhanced Support Discharge	Community service providing nursing and therapy to support	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				Low	High	High	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£346,774	Existing
43	Speech & Language Therapy - BTH	Community service providing speech and language provision	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£458,751	Existing
44	Richmond Fellowship	Community support and housing to support mental health patients	Integrated Care Planning and Navigation	Care Coordination				Low	Low	Low	Low	Other	Richmond Fellowship	CCG			Private Sector	Minimum CCG Contribution	£224,714	Existing
45	Community End of Life Team	Community team overseeing the development of EPaCCS	Community Based Schemes					Medium	Low	Low	Low	Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£106,000	Existing
46	Adult Beds	Community service responsible for providing beds for housebound	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Medium	Low	Acute		CCG			NHS Acute Provider	Additional CCG Contribution	£390,983	Existing
47	Community Stroke and Neuro	Service providing support for stroke and neuro patients	Community Based Schemes					Medium	Medium	Medium	Medium	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£83,000	Existing
48	Rapid Response	Multi disciplinary team to respond to crisis and avoid admission. Also in-	HICM for Managing Transfer of Care	Chg 5. Seven-Day Services				High	High	High	Medium	Social Care		CCG			Local Authority	Additional CCG Contribution	£137,360	Existing
49	50% Quality Assurance Manager	Health contribution to management of quality assurance team.	Enablers for Integration	Market development (inc Vol sector)				Low	Low	Low	Low	Social Care		CCG			Local Authority	Additional CCG Contribution	£25,000	Existing
50	CCG Contribution to Safeguarding Adults Board	Contribution towards multi-agency Safeguarding Adults	Enablers for Integration	Joined-up regulatory approaches				Not applicable	Not applicable	Not applicable	Not applicable	Social Care		CCG			Local Authority	Additional CCG Contribution	£40,985	Existing
27	Children's Equipment	Community contract allocation	Other		Childrens Services			Not applicable	Not applicable	Not applicable	Not applicable	Other	Childen's	LA			Local Authority	Additional LA Contribution	£94,618	Existing
51	Additional Homecare Hours	Domiciliary care to support admission avoidance and support	Other		Home care or Domiciliary Care (total output on			High	High	High	High	Social Care		LA			Local Authority	Additional LA Contribution	£468,730	Existing

Better Care Fund 2019/20 Template

7. High Impact Change Model

Selected Health and Wellbeing Board: Blackpool

Explain your priorities for embedding elements of the High Impact Change Model for Managing Transfers of Care locally, including: - Current performance issues to be addressed - The changes that you are looking to embed further - including any changes in the context of commitments to reablement and Enhanced Health in Care Homes in the NHS Long-Term Plan - Anticipated improvements from this work
As outlined elsewhere on this plan, Blackpool has well established multi-disciplinary teams working in our community and in Blackpool Teaching Hospital (BTH). The Hospital Discharge Team liaise closely with ward staff, patients and families to ensure that discharge to their preferred place can be planned effectively and take place as soon as possible. Our neighbourhood and Rapid Response teams provide support once discharge has taken place, to ensure success. They also reach into the acute setting to help facilitate discharge where appropriate, and participate in our 24/7 offer. Our Home First pathway is developing, and it is anticipated that it will be expanded prior to winter 2019 to enable up to 30 discharges per week across the Fylde Coast. The Fylde Coast Frailty pathway is

		Please enter current position of maturity	Please enter the maturity level planned to be reached by March 2020	If the planned maturity level for 2019/20 is below established, please state reasons behind that?
Chg 1	Early discharge planning	Mature	Mature	
Chg 2	Systems to monitor patient flow	Established	Established	
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature	Mature	
Chg 4	Home first / discharge to assess	Established	Established	
Chg 5	Seven-day service	Mature	Mature	
Chg 6	Trusted assessors	Established	Established	
Chg 7	Focus on choice	Established	Established	
Chg 8	Enhancing health in care homes	Mature	Mature	

Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Blackpool

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	At month 3 2019/20 Blackpool Teaching Hospital, non-elective admission activity for Blackpool has reduced by 16 cases. There has been a downward trend since the beginning of this planning cycle, and over 60% of our BCF schemes are expected to have a high or medium impact on reducing this activity further. A proportion of our iBCF funding has been used to enhance, extend and develop schemes to provide early interventions of care to prevent hospital admissions, diverting people away from A&E. Social workers are embedded in the Neighbourhood Teams across Blackpool, and whilst their role is not primarily about admission avoidance, they support holistic and timely

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	13.8	All of our recorded figures for Delayed Transfers of Care (DTOC) are currently below the nationally imposed targets, and they continue to move in the right direction – reduced numbers of DToCs relating to a smaller number of patients and typically for shorter periods. The majority of DToCs are towards the end of relatively short and unplanned hospital stays with limited scope for early discharge planning. There are several events which take place within hospital settings to ensure that patients are discharged in as timely a manner as possible: • 'long-stay Tuesday' takes an MDT approach to all patients with a length of stay over 7 days to identify why they are still in hospital and to facilitate discharge where appropriate;

Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	933	876	Our stretch target has been set taking into account recent performance and current pressures. We anticipate we will achieve targets due to the impact of our investment of the iBCF into schemes which focus on enabling people to live well at home for longer, and will complement existing schemes within the BCF.
	Numerator	265	249	
	Denominator	28,402	28,419	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	86.2%	86.2%	Our target has been set based on recent performance, and the anticipated impact of BCF schemes to support people at home following a period of reablement. The Assessment and Reablement Centre (ARC) provides health and social care input as a step down between hospital and home, or a step up to avoid hospital or residential
	Numerator	112	112	
	Denominator	130	130	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

Better Care Fund 2019/20 Template

9. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Blackpool

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	**Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted?** Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Do the governance arrangements described support collaboration and integrated care? Where the strategic narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure, metric and HICM sections of the plan been submitted for each HWB concerned?	Yes	The plan has been signed off by the Chair of the Health and Wellbeing Board on behalf of the Board. It will be ratified by the Board at their next meeting on 5/12/19.		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that covers:** - Person centred care, including approaches to delivering joint assessments, promoting choice, independence and personalised care? - A clear approach at HWB level for integrating services that supports the overall approach to integrated care and confirmation that the approach supports delivery at the interface between health and social care? - A description of how the local BCF plan and other integration plans e.g. STP/ICSs align? - Is there a description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? This should include confirmation that equality impacts of the local BCF plan have been considered, a description of local priorities related to health inequality and equality that the BCF plan will contribute to addressing. Has the plan summarised any changes from the previous planning period? And noted (where appropriate) any lessons learnt?	Yes	Joint Health and Wellbeing Strategy for Blackpool 2016-2019 Fylde Coast Self-Care Strategy 2017-2020		
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home. In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Yes	Blackpool Council's Housing Plan for the Ageing Population 2017-2020 Blackpool Council Housing Strategy 2018-2023 – Making Blackpool Better		
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Yes	.		
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Yes	.		
NC4: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	**Is there a plan for implementing the High Impact Change Model for managing transfers of care?**	**Does the BCF plan demonstrate a continued plan in place for implementing the High Impact Change Model for Managing Transfers of Care?** Has the area confirmed the current level of implementation and the planned level at March 2020 for all eight changes? Is there an accompanying overall narrative setting out the priorities and approach for ongoing implementation of the HICM? Does the level of ambition set out for implementing the HICM changes correspond to performance challenges in the system? If the current level of implementation is below established for any of the HICM changes, has the plan included a clear explanation and set of actions towards establishing the change as soon as possible in 2019-20?	Yes	.		
Agreed expenditure plan for all elements of the BCF	PR7	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	Have the planned schemes been assigned to the metrics they are aiming to make an impact on? Expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (tick-box) Is there an agreed plan for use of the Winter Pressures grant that sets out how the money will be used to address expected demand pressures on the Health system over Winter? **Has funding for the following from the CCG contribution been identified for the area?** - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Yes	.		
	PR8	**Indication of outputs for specified scheme types**	Has the area set out the outputs corresponding to the planned scheme types (Note that this is only for where any of the specified set of scheme types requiring outputs are planned)? (auto-validated)	Yes	.		
Metrics	PR9	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric? Is there a proportionate range of scheme types and spend included in the expenditure section of the plan to support delivery of the metric ambitions for each of the metrics? Do the narrative plans for each metric set out clear and ambitious approaches to delivering improvements? **Have stretching metrics been agreed locally for:** - Metric 2: Long term admission to residential and nursing care homes - Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement	Yes	.		

CCG to Health and Well-Being Board Mapping for 2019/20

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.7%	87.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.9%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.4%	0.6%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.5%	3.5%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.1%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.1%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	1.0%	0.7%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	3.0%	2.4%
E09000003	Barnet	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000003	Barnet	08D	NHS Haringey CCG	2.2%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.6%	98.1%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.5%	98.3%
E06000022	Bath and North East Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.9%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.7%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.4%	89.8%
E09000004	Bexley	07Q	NHS Bromley CCG	0.1%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.2%	8.4%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	15E	NHS Birmingham and Solihull CCG	78.4%	81.7%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.1%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	39.2%	17.8%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	88.9%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.7%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.4%	97.6%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.1%	2.4%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.5%
E08000001	Bolton	00V	NHS Bury CCG	1.5%	1.0%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000058	Bournemouth, Christchurch and Poole	11J	NHS Dorset CCG	52.4%	99.7%
E06000058	Bournemouth, Christchurch and Poole	11A	NHS West Hampshire CCG	0.2%	0.3%
E06000036	Bracknell Forest	15A	NHS Berkshire West CCG	0.5%	2.0%
E06000036	Bracknell Forest	15D	NHS East Berkshire CCG	26.1%	96.9%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.0%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.2%	0.1%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.2%	18.4%
E08000032	Bradford	02W	NHS Bradford City CCG	98.9%	23.9%
E08000032	Bradford	02R	NHS Bradford Districts CCG	98.0%	56.3%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	15F	NHS Leeds CCG	0.9%	1.4%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.3%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.7%	86.4%
E09000005	Brent	07R	NHS Camden CCG	3.9%	2.8%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.3%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000005	Brent	08E	NHS Harrow CCG	5.9%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.3%	2.7%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.9%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	49.3%	100.0%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.6%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.2%	1.4%
E09000006	Bromley	08A	NHS Greenwich CCG	1.4%	1.2%
E09000006	Bromley	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.2%
E09000006	Bromley	08L	NHS Lewisham CCG	1.9%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%

E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	14Y	NHS Buckinghamshire CCG	94.4%	94.9%
E10000002	Buckinghamshire	15D	NHS East Berkshire CCG	1.4%	1.2%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.7%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.0%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.6%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.6%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.4%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	71.8%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.3%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.6%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%
E09000007	Camden	07R	NHS Camden CCG	83.9%	88.9%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.6%	4.8%
E09000007	Camden	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.2%	3.0%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.6%	95.0%
E06000056	Central Bedfordshire	14Y	NHS Buckinghamshire CCG	0.8%	1.5%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.9%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000056	Central Bedfordshire	04F	NHS Milton Keynes CCG	0.1%	0.1%
E06000049	Cheshire East	15M	NHS Derby and Derbyshire CCG	0.1%	0.3%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.2%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.8%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.2%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.6%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.2%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.4%	29.5%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.1%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	7.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.1%	2.5%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	70.4%
E09000001	City of London	08C	NHS Hammersmith and Fulham CCG	0.0%	1.2%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.6%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.0%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.2%
E06000052	Cornwall & Scilly	15N	NHS Devon CCG	0.3%	0.6%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.0%	52.4%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.7%	46.3%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.5%	99.8%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.4%	0.2%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.3%	93.2%
E09000008	Croydon	09L	NHS East Surrey CCG	2.9%	1.3%
E09000008	Croydon	08C	NHS Hammersmith and Fulham CCG	0.2%	0.0%
E09000008	Croydon	08K	NHS Lambeth CCG	3.0%	3.0%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.5%

E10000006	Cumbria	01K	NHS Morecambe Bay CCG	54.0%	36.6%
E10000006	Cumbria	01H	NHS North Cumbria CCG	99.9%	63.4%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.1%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.2%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.2%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.6%
E06000015	Derby	15M	NHS Derby and Derbyshire CCG	26.5%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	15M	NHS Derby and Derbyshire CCG	70.9%	92.6%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	7.9%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.1%	0.5%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.1%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	13.9%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	15N	NHS Devon CCG	65.7%	99.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.5%	0.6%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.8%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%
E06000059	Dorset	11J	NHS Dorset CCG	46.0%	95.6%
E06000059	Dorset	11X	NHS Somerset CCG	0.6%	0.9%
E06000059	Dorset	11A	NHS West Hampshire CCG	1.7%	2.5%
E06000059	Dorset	99N	NHS Wiltshire CCG	0.7%	1.0%
E08000027	Dudley	15E	NHS Birmingham and Solihull CCG	0.1%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.3%	90.7%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.8%	0.3%
E09000009	Ealing	07P	NHS Brent CCG	1.8%	1.6%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.9%	90.4%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.5%	3.1%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.7%	3.5%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.3%	85.1%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.2%	7.9%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.6%	6.8%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.0%	1.2%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.2%	90.9%
E09000010	Enfield	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.2%	11.5%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.6%	0.6%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.5%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.7%
E10000012	Essex	08N	NHS Redbridge CCG	2.9%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.8%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%

E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.5%	97.7%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.2%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E08000037	Gateshead	00P	NHS Sunderland CCG	0.0%	0.1%
E10000013	Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.1%	0.1%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	89.2%	89.3%
E09000011	Greenwich	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.4%	4.9%
E09000011	Greenwich	08Q	NHS Southwark CCG	0.1%	0.1%
E09000012	Hackney	07R	NHS Camden CCG	0.7%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.2%	93.8%
E09000012	Hackney	08C	NHS Hammersmith and Fulham CCG	0.5%	0.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.6%	3.7%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.6%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.5%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.3%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.7%	1.1%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.5%	2.5%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.1%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	82.8%	87.6%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.2%	0.3%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.5%	7.2%
E10000014	Hampshire	15A	NHS Berkshire West CCG	1.7%	0.6%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.1%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	15D	NHS East Berkshire CCG	0.2%	0.0%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.5%	14.3%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.5%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.6%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.1%	1.0%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E09000014	Haringey	07M	NHS Barnet CCG	1.0%	1.4%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.6%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.1%	3.2%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08C	NHS Hammersmith and Fulham CCG	0.4%	0.3%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.0%
E09000014	Haringey	08H	NHS Islington CCG	2.5%	2.1%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.4%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	2.1%
E09000015	Harrow	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.1%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%

E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.6%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.4%	99.4%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.5%	2.9%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.2%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.2%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.2%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	14Y	NHS Buckinghamshire CCG	0.2%	0.1%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	97.0%	46.5%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.5%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.0%	50.7%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.2%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	14Y	NHS Buckinghamshire CCG	0.0%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.8%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.1%	1.0%
E09000018	Hounslow	07W	NHS Ealing CCG	5.4%	7.4%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.2%	0.9%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.7%	3.8%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.9%	5.4%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.5%
E09000019	Islington	07T	NHS City and Hackney CCG	3.4%	4.2%
E09000019	Islington	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000019	Islington	08D	NHS Haringey CCG	1.2%	1.5%
E09000019	Islington	08H	NHS Islington CCG	89.1%	87.9%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.3%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.4%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.2%	1.7%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.9%	92.5%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.3%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.2%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.1%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.8%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.1%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.8%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	86.9%	95.9%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.7%	1.2%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.7%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.4%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.6%	54.7%
E08000034	Kirklees	15F	NHS Leeds CCG	0.1%	0.3%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.3%

E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.4%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.1%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.2%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08C	NHS Hammersmith and Fulham CCG	0.6%	0.4%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.5%	92.2%
E09000022	Lambeth	08R	NHS Merton CCG	1.0%	0.6%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.9%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.5%	3.7%
E09000022	Lambeth	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.1%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.6%	1.9%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.9%	13.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	16.6%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	44.1%	12.1%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.2%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	96.9%	8.7%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.7%	0.2%
E08000035	Leeds	02N	NHS Airedale, Wharfdale and Craven CCG	0.1%	0.0%
E08000035	Leeds	02W	NHS Bradford City CCG	1.1%	0.2%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.5%	0.2%
E08000035	Leeds	15F	NHS Leeds CCG	97.7%	98.8%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.1%	1.8%
E06000016	Leicester	04C	NHS Leicester City CCG	92.8%	95.5%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.8%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.5%	0.0%
E10000018	Leicestershire	15M	NHS Derby and Derbyshire CCG	0.4%	0.6%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.5%	39.8%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.2%	4.1%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	53.1%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.2%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.4%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.5%	92.0%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.9%	3.9%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.1%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.6%	29.9%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	4.9%	1.1%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.1%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.4%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.6%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.7%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.0%	1.6%

E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	93.9%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.2%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08C	NHS Hammersmith and Fulham CCG	0.2%	0.2%
E09000024	Merton	08J	NHS Kingston CCG	3.4%	2.9%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.7%
E09000024	Merton	08R	NHS Merton CCG	87.7%	80.9%
E09000024	Merton	08T	NHS Sutton CCG	3.3%	2.6%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.3%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.2%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.9%	95.2%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	5.9%	4.0%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.3%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.2%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.6%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	25.2%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	24.1%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.4%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.3%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	94.9%	96.9%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	21.8%	98.3%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.6%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.2%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.5%	8.3%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.3%	22.8%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.8%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.1%
E10000023	North Yorkshire	15F	NHS Leeds CCG	0.9%	1.3%
E10000023	North Yorkshire	01K	NHS Morecambe Bay CCG	1.9%	1.0%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.8%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.2%	9.8%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	2.0%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.1%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.1%	1.0%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.5%
E06000057	Northumberland	01H	NHS North Cumbria CCG	0.1%	0.1%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	97.9%	98.7%

E06000018	Nottingham	04K	NHS Nottingham City CCG	89.9%	95.4%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.6%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.1%	1.1%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.1%	13.5%
E10000024	Nottinghamshire	15M	NHS Derby and Derbyshire CCG	1.5%	1.8%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	97.9%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.1%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.1%	17.2%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.8%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.3%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.5%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	15A	NHS Berkshire West CCG	0.5%	0.3%
E10000025	Oxfordshire	14Y	NHS Buckinghamshire CCG	2.4%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.4%	96.5%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.7%	0.9%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	23.0%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	15N	NHS Devon CCG	22.1%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.5%	1.4%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.2%	0.2%
E06000038	Reading	15A	NHS Berkshire West CCG	35.3%	99.4%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	4.9%	3.3%
E09000026	Redbridge	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.4%	1.7%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.3%	89.4%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.3%	3.1%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.1%	1.1%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.3%	98.9%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.5%	0.5%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.4%	0.7%
E08000005	Rochdale	00V	NHS Bury CCG	0.7%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.3%	3.1%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.2%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.7%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.2%	0.5%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.9%	86.3%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.6%	11.5%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.4%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	1.1%	2.5%
E08000006	Salford	01G	NHS Salford CCG	94.1%	94.6%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	15E	NHS Birmingham and Solihull CCG	1.9%	7.0%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	55.1%	88.6%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.0%	51.6%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.8%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%

E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	15M	NHS Derby and Derbyshire CCG	0.2%	0.4%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.4%	0.2%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.5%	99.1%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.5%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.7%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.4%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	14Y	NHS Buckinghamshire CCG	1.8%	6.2%
E06000039	Slough	07W	NHS Ealing CCG	0.0%	0.1%
E06000039	Slough	15D	NHS East Berkshire CCG	33.8%	93.4%
E06000039	Slough	08G	NHS Hillingdon CCG	0.0%	0.1%
E06000039	Slough	07Y	NHS Hounslow CCG	0.0%	0.1%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E08000029	Solihull	15E	NHS Birmingham and Solihull CCG	17.0%	98.9%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.3%
E10000027	Somerset	15N	NHS Devon CCG	0.2%	0.5%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.1%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.8%	0.6%
E06000025	South Gloucestershire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	28.2%	97.5%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.9%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.8%	4.7%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.3%
E09000028	Southwark	07R	NHS Camden CCG	0.3%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.5%	1.6%
E09000028	Southwark	08C	NHS Hammersmith and Fulham CCG	0.7%	0.5%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.1%	2.0%
E09000028	Southwark	08Q	NHS Southwark CCG	94.1%	87.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.2%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.1%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	15E	NHS Birmingham and Solihull CCG	0.3%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	15M	NHS Derby and Derbyshire CCG	0.5%	0.5%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.1%	14.7%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.4%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.3%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.6%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.7%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.8%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.1%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.6%	0.8%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	94.9%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.6%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.4%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.7%

E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.3%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.2%	97.1%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.3%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.9%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.3%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.9%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	1.9%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.5%	0.3%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.0%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.3%	0.4%
E10000030	Surrey	15D	NHS East Berkshire CCG	3.4%	1.2%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.7%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.5%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.5%
E10000030	Surrey	08P	NHS Richmond CCG	0.7%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.4%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.5%	3.4%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.3%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.3%	1.9%
E09000029	Sutton	08T	NHS Sutton CCG	94.7%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.0%	98.2%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.5%
E08000008	Tameside	14L	NHS Manchester CCG	2.2%	5.8%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.9%
E08000008	Tameside	01W	NHS Stockport CCG	1.8%	2.3%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.2%	88.0%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.3%	0.3%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.4%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.5%	99.0%
E06000027	Torbay	15N	NHS Devon CCG	11.7%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08C	NHS Hammersmith and Fulham CCG	0.8%	0.5%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.2%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.2%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	96.9%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	7.0%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.7%	92.7%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	15F	NHS Leeds CCG	0.4%	1.0%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.0%
E08000030	Walsall	15E	NHS Birmingham and Solihull CCG	1.1%	4.8%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.8%	90.4%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.4%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.4%	0.4%
E09000031	Waltham Forest	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000031	Waltham Forest	08D	NHS Haringey CCG	0.1%	0.1%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.3%	1.7%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.1%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.6%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.2%	3.5%
E09000032	Wandsworth	08R	NHS Merton CCG	2.8%	1.6%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	92.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.6%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	15E	NHS Birmingham and Solihull CCG	0.2%	0.5%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.7%	0.2%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.8%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.7%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	15A	NHS Berkshire West CCG	30.0%	97.6%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.5%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	14.0%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.1%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.9%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	79.3%	71.3%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.6%	0.6%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.1%	22.6%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	0.8%	0.6%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.2%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.8%	1.0%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.7%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.9%	0.4%
E06000054	Wiltshire	15A	NHS Berkshire West CCG	0.2%	0.2%
E06000054	Wiltshire	15C	NHS Bristol, North Somerset and South Gloucestershire CCG	0.2%	0.5%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.3%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	15A	NHS Berkshire West CCG	0.4%	1.3%
E06000040	Windsor and Maidenhead	14Y	NHS Buckinghamshire CCG	0.3%	1.1%
E06000040	Windsor and Maidenhead	15D	NHS East Berkshire CCG	34.1%	96.9%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	15A	NHS Berkshire West CCG	31.5%	97.0%
E06000041	Wokingham	15D	NHS East Berkshire CCG	1.0%	2.6%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.3%	1.5%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.8%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.4%	3.5%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.4%
E10000034	Worcestershire	15E	NHS Birmingham and Solihull CCG	0.9%	2.0%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.7%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	0.9%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.8%	27.7%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.2%	49.3%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.3%	18.6%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.2%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

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08 January 2020

To: *(by email)*

Councillor Graham Cain	Chair, Blackpool Health and Wellbeing Board
David Bonson	Clinical Commissioning Group Accountable Officer (Lead)
Jeannie Harrop	Additional Clinical Commissioning Group(s) Accountable Officers
Neil Jack	Local Authority Chief Executive

Dear Colleagues

BETTER CARE FUND 2019-20

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance and approval. We recognise that the BCF has again presented challenges in preparing plans at a late stage and at pace and we are grateful for your commitment in providing your agreed plan.

I am pleased to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. The Clinical Commissioning Group (CCG) BCF funding can therefore now be formally released subject to the funding being used in accordance with your final approved plan, and the conditions set out in the BCF policy framework for 2019-20 and the BCF planning guidance for 2019-20, including transfer of funds into a pooling arrangement governed by a Section 75 agreement. Your Section 75 agreement should aim to be confirmed by the end of January 2020.

These conditions have been imposed through the NHS Act 2006 (as amended by the Care Act 2014). If the conditions are not complied with, NHS England is able to direct the CCG(s) in your Health and Wellbeing Board area as to the use of the funding.

The Disabled Facilities Grant (DFG), the improved Better Care Fund (iBCF) and the Winter Pressures grant are also pooled along-side the CCG allocations. The DFG, iBCF and Winter Pressures grants are paid directly to local authorities via a Section 31 grant from the Ministry of Housing, Communities and Local Government. These

grants are subject to grant conditions set out in their respective grant determinations made under Section 31 of the Local Government Act 2003, as specified in the BCF Planning Requirements.

Ongoing support and oversight will continue to be led by your local Better Care Manager (BCM). Following the assurance process, we are asking all BCMs to feedback identified areas for improvement in your plan and share where systems may benefit from conversations with other areas.

Once again, thank you for your work and best wishes with implementation and ongoing delivery.

Yours sincerely,

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

NHS England and Improvement

Copy (by email) to:

Karen Smith	Local Authority Director of Adult Social Services (or equivalent)
Jayne Bentley	Better Care Fund Lead Official
Steve Thompson	LA Section 151 Officer
Bill McCarthy	Regional Director of Delivery, NHS England North West Region
Clare Duggan	Director of Strategy & Transformation
Graham Urwin	Director of Performance & Improvement
Rosie Seymour	Programme Director, Better Care Support Team, NHS England
Tim Barton	Better Care Manager (interim), North West

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Graham Cain, Deputy Leader (Children)
Date of Meeting	29 January 2020

CHILD DEATH OVERVIEW PANEL NEW ARRANGEMENTS

1.0 Purpose of the report:

1.1 Due to the implementation of the Children and Social Work Act 2017 revised statutory guidance was issued that created a new framework of expectations around safeguarding arrangements and Child Death Overview Panels (CDOP).

Subsequently, consideration has been given as to how statutory duties in relation to Child Death Overview Panel can most effectively be met moving forward in a changing safeguarding landscape, alongside sub-regional partners, with whom responsibilities are jointly discharged.

2.0 Recommendation(s):

2.1 To agree to continue with a Pan-Lancashire Child Death Overview Panel approach with periodic reviews. This includes a commitment to the current funding and business support model

2.2 The governance for the Child Death Overview Panel is requested to develop a more effective relationship between the Children's Safeguarding Assurance Partnership (CSAP) and Health and Wellbeing Boards (H&WBB) in line with local agreements.

2.3 That Child Death Overview Panel members for each area take responsibility for reporting into the most appropriate local forum for their area and link with peer networks to ensure necessary activity is undertaken

2.4 That Child Death Overview Panel members will review any required operational changes to be in line with statutory guidance such as the undertaking of thematic reviews, policy, and practice guidance amendments.

3.0 Reasons for recommendation(s):

3.1 Overall, after a review with Child Death Overview Panel members it would appear that Child Death Overview Panel can continue in its current format with the same stakeholders ensuring the operational activity is in line with statutory requirements. The main area for focus appears to be strategic accountability due to the changes to Local Safeguarding Children Board formats.

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

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

4.0 Other alternative options to be considered:

4.1 None.

5.0 Council priority:

5.1 The relevant Council priority is: "Communities: Creating stronger communities and increasing resilience".

6.0 Background information

6.1 The implication of the Children and Social Work Act 2017 is that Local Authorities, Clinical Commissioning Groups and Police forces have had to revise their current Local Safeguarding Children Board (LSCB) arrangements. As well as disestablishing Children's Safeguarding Boards and creating new arrangements for scrutiny of child safeguarding, as part of these changes they have also been required to establish Child Death Overview Panels (CDOP) as a distinct set of arrangements rather than as an adjunct to Local Safeguarding Children Boards. The split has been reinforced by the introduction of separate Child Death Overview Panel statutory guidance outside of the revised Working Together Statutory guidance.

6.2 Under the revised guidance the new Child Death Review (CDR) partners, the Local Authority (LA) and the Clinical Commissioning Groups (CCG) in an area, have statutory responsibilities to:

- Make arrangements to review all deaths of children normally resident in the local area and, if they consider it appropriate, for any non-resident child who has died in their area.
- Make arrangements for the analysis of information from all deaths reviewed
- Prepare and publish reports on what they have done and effectiveness of arrangements

6.3 The Child Death Review partners have been given freedom to decide the structure within their area to meet these statutory duties which includes continuing with the current arrangements provided a minimum of 60 cases are reviewed and the learning is conducted in a way that can be shared nationally. This includes supporting the plans for a national database and utilising revised forms for the collation and analysis of data.

6.4 Child Death Overview Panel Model in the past

Within Lancashire this has operated on a Pan-Lancashire footing with the Child Death Overview Panel representing the three local authorities (Blackburn with Darwen, Blackpool and Lancashire County Council) and 6 Clinical Commissioning Groups in the area under the scrutiny of the Local Safeguarding Children's Board. The Child Death Overview Panel meets monthly to review all Child Deaths and formerly made proposals to the Local Safeguarding Children's Boards regarding escalation issues or directed specific agencies to respond to actions arising from a child's death, including the instigation of a Serious Case Review where appropriate.

Funding is received from statutory partners which is proportionate to the local child population. This funding has ensured that statutory duties in relation to recording child deaths, collating multi-agency information, reporting to the national system and reviewing child deaths for modifiable factors are conducted. It also generates quarterly reports and an annual report on activity and concerns for the locality.

Meetings are organised with three different focuses with the following membership:

Business Meeting (Strategic Overview)	**Review Meetings**	**Neo-natal Review Meetings**
Chair	Chair	Chair
Public Health	Public Health	Public Health
Children's Social Care	Children's Social Care	Children's Social Care
Lancashire Constabulary	Lancashire Constabulary	Lancashire Constabulary
Designated Doctor for child deaths	Paediatrician/Designated Doctor for child deaths	Paediatrician and/or Neonatologist /Designated Doctor for child deaths
Designated nurse	Named Nurse for Safeguarding	Named Nurse for Safeguarding
SUDC Lead Nurse	Named Midwife	Named Midwife
Member of the Health Executive Group	Primary Care (Health Visitor/ GP)	

The business lead for the multi-agency safeguarding arrangements	SUDC Nurse	SUDC Nurse
Lay/parent representative	Education (School/ Early Years Rep)	Specialist Professional: Obstetrician/ Neonatologist/ Neonatal Nurse (at least 1)
Coronial and Registrar Services when relevant	Lay/parent representative	Lay/parent representative

6.5 Future Arrangements

Numerous discussions have taken place involving partners and Child Death Overview Panel members. The current Child Death Overview Panel model is working effectively and is in line with statutory guidance in relation to reviewing deaths and identifying local lessons.

The opportunity to share learning and collaborate on a larger footprint for action on shared issues (for example campaigns and thematic reviews) will continue across the North West region. This is currently supported through the activity of the Chair and the panel administrator. A Memorandum of Understanding has been developed and supported by statutory partners, which agreed that Child Death Overview Panel would take on responsibility for providing assurance of Child Death Reviews across Lancashire.

Therefore, partners have agreed that the Pan-Lancashire model is maintained. Partners will monitor the effectiveness of Child Death Overview Panel in 12 months to ensure it continues to operate within Statutory guidance and meet the needs of the Child Death Review partners and the model supports the most effective response to Child deaths in the area.

6.6 Governance

The Child Death Overview Panel continues to be managed and hosted by Lancashire County Council, alongside the Children's Safeguarding Assurance Partnership function, which will help maintain the important links between the two. The guidance is clear that Child Death Overview Panel is now a parallel rather than a subgroup process. The partners have identified that the requirement for analysis and the subsequent lessons emerging from Child Death Overview Panel are predominantly public health

matters as opposed to safeguarding issues.

The functions for Health and Wellbeing Boards focus on the joint activity required between Local Authorities and health partners to improve the health and wellbeing of the community they serve. Where preventable, factors that may influence the death of a child can be identified, such as smoking, obesity and substance misuse for example, the Health and Wellbeing Board is the most appropriate place to address these matters on a population basis rather than being addressed via the current safeguarding mechanisms.

The themes and trends identified through the Child Death Overview Panel process should be placed within the context of the wider health and wellbeing data already considered at Health and Wellbeing Boards to inform their priorities and action, including joint commissioning. Children's Safeguarding Assurance Partnership would still be significant in leading on individual reviews where abuse or neglect is identified in a child death and being assured on the effectiveness of services responsible for supporting parents whose parenting capacity is compromised by their mental health, drug and alcohol misuse and/ or domestic abuse.

In order to manage costs, reporting into these forums will be led by Child Death Overview Panel members for that area, as well as engaging with professional peer groups. This will enable informed scrutiny of Child Death Overview Panel activity and local accountability for ensuring relevant learning is actioned in each area. Therefore, each area will treat its Health and Wellbeing Board as the default governance taking lead responsibility for scrutinising the work of Child Death Overview Panel, agreeing the actions, and over-seeing the effectiveness of those actions, and the Health and Wellbeing Board and how this will function so assurance is provided.

6.7 Next Steps

Child Death Overview Panel members have revised policy, procedures and practice guidance on behalf of the Cheshire Area to ensure that compliant documentation is in place by the deadline which was June 2019 and in operation by September 2019. To facilitate this a workshop is arranged to revise terminology and map the pathways for child death reviews as needed. This will also include revisiting the terms of reference for Child Overview Panel to ensure there is sufficiently robust data analysis for the area in quarterly and annual reports.

It was acknowledged that the transition of the safeguarding arrangements across Lancashire are varied which has created a lack of clarity currently in relation to the continuation of shared approaches. Warrington has agreed to continue to provide business manager support to the Child Death Overview Panel processes up to January 2020 when the model will be reviewed; Lancashire County Council will continue to host and manage the business support functions. This will provide some consistency

during the transition period and allow decisions to be reviewed when greater clarity of the Pan-Lancashire landscape is available.

6.8 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 None.

8.0 Legal considerations:

8.1 None.

9.0 Human resources considerations:

9.1 None.

10.0 Equalities considerations:

10.1 None.

11.0 Financial considerations:

11.1 None.

12.0 Risk management considerations:

12.1 None.

13.0 Ethical considerations:

13.1 None.

14.0 Internal/external consultation undertaken:

14.1 As outlined in the report with key stakeholders.

15.0 Background papers:

15.1 None.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Liz Petch, Public Health Specialist / Stephen Boydell, Public Health Intelligence
Relevant Cabinet Member	Councillor Graham Cain, Deputy Leader (Children)
Date of Meeting	29 January 2020

UPDATE OF PHARMACEUTICAL NEEDS ASSESSMENT

1.0 Purpose of the report:

1.1 This paper informs the Blackpool Health and Wellbeing Board that the process of creating the 2021 Pharmaceutical Needs Assessment is about to get underway.

The Health and Wellbeing Board is requested to consider the approach recommended and give approval to initiate the project.

2.0 Recommendation(s):

2.1 To agree to the production of a Pharmaceutical Needs Assessment, as in previous years, that covers all three areas of Blackburn with Darwen, Blackpool and Lancashire.

2.2 To agree that it remains appropriate to consider the use of locality areas within the Pharmaceutical Needs Assessment and recommend that the Steering Group continues to use used the 12 Lancashire districts and 2 unitary authorities as localities, giving a total of 14 localities.

3.0 Reasons for recommendation(s):

3.1 To ensure the new Pan-Lancashire Pharmaceutical Needs Assessment is published by the statutory deadline of 1 April 2021. To allow effective and efficient joint working. The approach has been recommended by the Pharmaceutical Needs Assessment Steering Group.

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

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

4.0 Other alternative options to be considered:

4.1 None.

5.0 Council priority:

5.1 The relevant Council priority is: "Communities: Creating stronger communities and increasing resilience".

6.0 Background information

6.1 Health and Wellbeing Boards have a duty to publish a Pharmaceutical Needs Assessment (PNA) every three years, and the next version is due to be published in March 2021 to meet the duty to be in place by 1 April 2021. Pharmaceutical Needs Assessments (PNAs) are used for a number of purposes including consideration of applications for new pharmacies in an area as well as by commissioners to identify local health needs that could be addressed by pharmacy services. The Pharmaceutical Needs Assessment describes current pharmaceutical provision, health needs that could be mitigated by pharmaceutical services, future population changes, and is ultimately used to inform decision making regarding future market entry. In previous years, the Health and Wellbeing Board has agreed to develop a joint Pharmaceutical Needs Assessment with Blackburn with Darwen and Lancashire Health and Wellbeing Boards, this process ensures consistency over the area but has been combined with locality areas to ensure a balanced approach. It is recommended that a similar approach be taken in

6.2 The process of developing the Pharmaceutical Needs Assessment takes approximately a year and a steering group has been set up to manage this. This group will include representatives of the three upper tier local authorities, NHS England, Community Pharmacy Lancashire, NHS commissioners and other parties as required. Action notes from the Pharmaceutical Needs Assessment Steering Group and progress against the project plan will be published online to allow the tracking of progress.

6.3 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 None.

8.0 Legal considerations:

8.1 The Health and Wellbeing Board has a duty to publish a Pharmaceutical Needs Assessment by 1 April 2021. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013.

9.0 Human resources considerations:

9.1 None.

10.0 Equalities considerations:

10.1 None.

11.0 Financial considerations:

11.1 None.

12.0 Risk management considerations:

12.1 None.

13.0 Ethical considerations:

13.1 None.

14.0 Internal/external consultation undertaken:

14.1 None.

15.0 Background papers:

15.1 None.

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Graham Cain, Deputy Leader (Children)
Date of Meeting	29 January 2020

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2018

1.0 Purpose of the report:

1.1 To receive the Annual Report of the Director for Public Health and consider the recommendations raised.

2.0 Recommendation(s):

2.1 To receive the Director of Public Health's report on the health of the people of Blackpool 2018.

2.2 To endorse the key impact areas and the Director of Public Health's recommendations as outlined on page 127 of the agenda.

2.3 To consider developing a workplan for the Board to address the key impact areas and the Director of Public Health's recommendations.

3.0 Reasons for recommendation(s):

3.1 To allow for scrutiny of the annual report.

To allow the Board's workplan to be aligned with the annual report.

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

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

4.0 Other alternative options to be considered:

4.1 None.

5.0 Council priority:

5.1 The relevant Council priority is: "Communities: Creating stronger communities and increasing resilience".

6.0 Background information

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

6.2 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).

6.3 The report presents the Director of Public Health's independent assessment of local health needs, determinants and concerns.

6.4 This year's report focuses on the health and wellbeing of children and young people in Blackpool and shows how investment in these early years can help to build a bright and healthy future.

6.5 This report, and previous reports in the series, are available to view in public libraries across the town and published electronically to the JSNA website www.blackpooljsna.org.uk

6.6 The 2018 annual report can be found at the following link and is attached to the report as an Appendix: https://joom.ag/5V3e

6.7 The Board is requested to consider the report and agree next steps so that the annual report can be aligned with the Board's workplan, see Item 7 on the agenda.

6.8 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 6(a): Director of Public Health's Annual Report

8.0 Legal considerations:

8.1 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).

9.0 Human resources considerations:

9.1 None.

10.0 Equalities considerations:

10.1 None.

11.0 Financial considerations:

11.1 None.

12.0 Risk management considerations:

12.1 None.

13.0 Ethical considerations:

13.1 None.

14.0 Internal/external consultation undertaken:

14.1 None.

15.0 Background papers:

15.1 None.

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Appendix 6a

HEALTHY BEGINNINGS FOR A HEALTHY FUTURE

THE HEALTH OF THE PEOPLE OF BLACKPOOL 2018

Blackpool Council

CONTENTS

WELCOME

Welcome to this year's Annual Report, which focuses on the health and wellbeing of our children and young people and how investment in these early years can help to build a bright and healthy future for Blackpool.

FOREWORD

FOREWORD

HEALTHY BEGINNINGS FOR A HEALTHY FUTURE

The way in which healthcare and social care are delivered in Lancashire and South Cumbria (including Blackpool and Blackburn with Darwen) is changing. Local authorities and NHS organisations are working more closely together towards delivering more integrated health and social care services. The Integrated Care System (ICS, known as "Healthier Lancashire and South Cumbria") undertaking this work have nominated me to be a Children's Champion and it is my responsibility to make sure the welfare and health of our children is pushed to the foreground in every aspect of the ICS's work.

From this point of view, I wanted to take a closer look at the health of children here in Blackpool and take this opportunity to highlight the great work being undertaken in the town and celebrate successes in improving our children's health.

Early in 2018 the children and young people's commissioning group for the ICS completed a needs assessment for the whole of Lancashire and South Cumbria, outlining key aspects of the health and wellbeing of our younger citizens and making recommendations for how to support this going forward. This annual report on the health of Blackpool's population draws from that needs assessment and other sources, to show how Blackpool compares to the regional and national picture and the ways in which we are already working to protect, promote and champion our children's health and the town's future.

There have been significant developments over the past few years in understanding the importance that children's health and wellbeing in early years plays in determining their health and wellbeing as adults. The environment and experiences a child grows up with can change the likelihood of developing poor health in adulthood and adversity in childhood has been linked to increased likelihood of diseases including cancer, cardiovascular disease, lung or liver disease, as well as increasing the likelihood of undertaking health harming behaviours such as smoking, drug or alcohol misuse and violence. With some of the highest levels of these diseases and behaviours in the country in Blackpool, it is imperative that we maximise all opportunities to reduce risks for our population.

Since last year's report, the Public Health Team has continued to work tirelessly to improve the health of all our citizens and have been working hard to make sure that the residents of Blackpool are at the heart of everything we do.

Our Citizens' Inquiry programme gives residents a chance to share their opinions and experiences and put forward recommendations of how to improve wellbeing in their community and the project was awarded Project of the Year at the Patient Participation Group Awards organised by the NHS Blackpool and NHS Fylde and Wyre Clinical Commissioning Groups (CCGs).

FOREWORD

We worked with Blackpool and Fylde and Wyre CCGs to create and promote Self Care Week in November - a campaign to encourage local people to 'choose self-care for life' by making health-savvy decisions. During the week, more than 70 self-care themed events were organised by local charities, organisations and community groups, ranging from mindfulness taster sessions, literature afternoons to HIV testing in Blackpool town centre. The initiative won a national award for exemplary partnership working.

Another success that demonstrates our commitment to putting our residents at the centre of our work has been the renovation and rejuvenation of @The Grange (previously the Blackpool City Learning Centre). The team received a Highly Commended Award for delivering better outcomes from the MJ Local Government Awards. The volunteering and community shop HIS Provision (also based at @the Grange) won the Tenant's Project Fund (TPF) Award from the Blackpool Coastal Housing Community Awards. This was particularly special as it is voted for by the community themselves (the tenants).

2018 has been a year of challenges, but also a year of hard work, progress and successes. I hope this report demonstrates how we are achieving improvements in children and young people's health and wellbeing with a view to securing a healthy future for Blackpool.

Dr. Arif Rajpura
Director of Public Health
Blackpool Council

> INTRODUCTION


Photo Credit

Children aged 0-19 years make up about a quarter of our town's population. Protecting and promoting the health and wellbeing of the children living in our communities is a key responsibility of the Public Health team at Blackpool Council, but should also be a priority for anyone living or working around Blackpool.

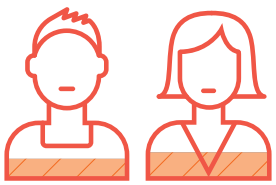
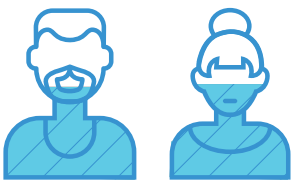
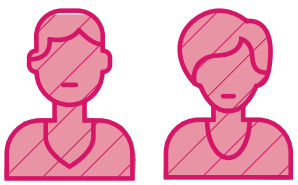
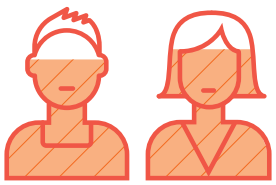
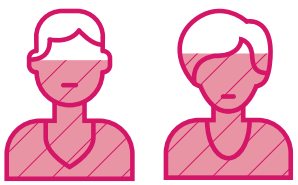
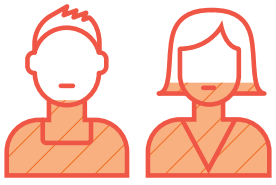
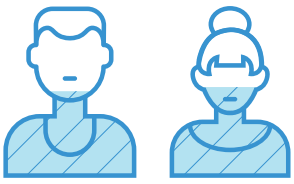
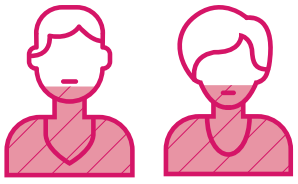
Childhood is a time of rapid development and growth and is full of opportunities for creating a good foundation for health across the whole lifetime. Body systems that are critical to health, including the brain, nervous, endocrine and immune systems are under construction even before birth and from the earliest moments of life, a child's experiences and environments exert powerful influences on his or her development and long-term health.

The social, cultural, and economic environment a child grows up in and the experiences they have all interact with their biology and genetics to shape future health and wellbeing. The environment, experiences and social interactions during childhood can alter the physical risks of disease later in life and can influence the beliefs and values people have about themselves and others and ways of behaving such as smoking, eating and exercise.

Childhood provides brilliant opportunities for maximising the health and wellbeing of the future of our town. As well as securing the health of the children themselves, investing in evidence-based and well implemented preventive services and in health and development interventions in the early years of life has been shown to deliver economic and social benefits for the wider population.

This report highlights the health of our children, the challenges they face but also the work and achievements being made in giving our children the best opportunities for good health now and in their future.

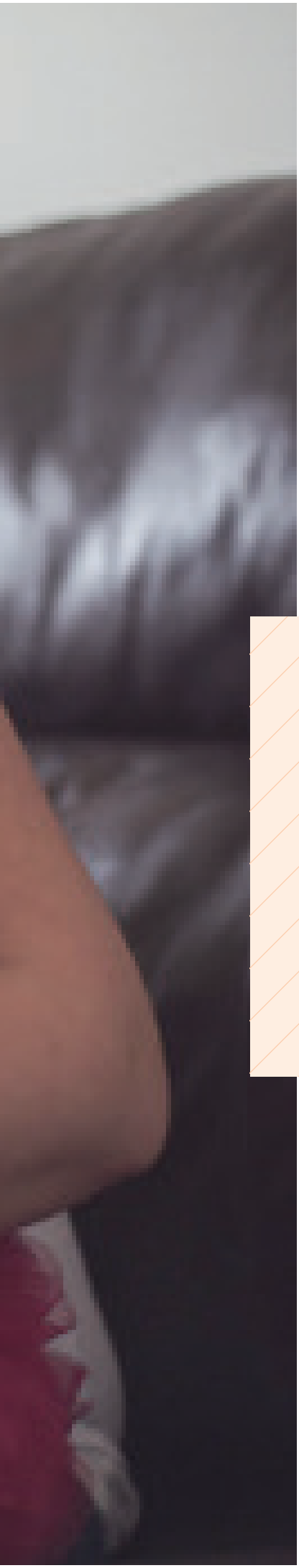
BLACKPOOL'S POPULATION

	BLACKPOOL	NORTH WEST	ENGLAND
Population (Mid-year estimate 2018)	69,146 Male, 70,724 Female  139,870	3,581,219 Male, 3,677,408 Female  7,258,627	27,481,053 Male, 28,138,377 Female  55,619,400
Live Births (2017)	1,643	83,882	646,794
Children aged 0-4 (2017)	8,500 (6.1%)	439,200 (6.1%)	3,384,900 (6.1%)
Children aged 0-19 (2017)	31,800 (22.8%)	1,715,600 (23.6%)	13,169,100 (23.7%)
School children from minority ethnic groups (2018)	12.0%	23.8%	32.3%
Children living in poverty aged <16 (2016)	26.2%	18.0%	17.0%
Life expectancy at birth (2015-17)	74.2 Boys, 79.6 Girls 	78.2 Boys, 81.8 Girls 	79.6 Boys, 83.1 Girls 
Healthy life expectancy at birth (2015-17)	54.7 Boys, 58.6 Girls 	61.2 Boys, 62.3 Girls 	63.4 Boys, 63.8 Girls 

INTRODUCTION

GETTING THE BEST START

PREGNANCY INTO THE EARLY YEARS



Research increasingly shows that events in the first thousand days of a child's life (from during pregnancy until around aged two) have significant impact on lifetime health and wellbeing. During pregnancy, its mother meets all of a baby's needs, so all factors affecting a mother's health such as stress, diet, drug use, alcohol use and smoking, can have a significant impact on the development of the baby both before and after birth. Securing good maternal health and wellbeing is fundamental to making sure Blackpool's children get a good start in life.

The importance of the earliest phase of life as an opportunity to intervene for the benefit of life-long health and wellbeing has been recognised by The Better Start Partnership. In collaboration with Public Health, NHS and community services, it is implementing a ten-year program aimed at improving the outcomes for a whole generation.

The first projects started in 2015, enabling every pregnant woman in Blackpool to have access to an evidence based programme of antenatal care. The Family Nurse Partnership (FNP) supports pregnant women aged 19 and under, and Baby Steps is designed for all those aged 20 and over.

The Better Start Partnership has also undertaken a full review and redesign of the health visiting offer in the town and Blackpool parents now receive a minimum of eight visits (nationally the minimum is five). It is expected that by increasing the number of contacts a family has with a Health Visitor, families who need help and support during the first five years of life will be easier to identify. The structure of the visits has also changed to be more trauma informed. Parents are encouraged to be actively involved in conversations with health visitors and be open about their concerns so the appropriate advice and support can be accessed.

FACTS AND FIGURES

In Blackpool, we have approximately 1,600 live births a year with a live birth rate of 70.6 per 1,000 women (known as the 'general fertility rate'). Only 3.9% of births in Blackpool were to black or minority ethnic (BME) mothers (2016/2017), which is in keeping with our relatively low proportion of the whole Blackpool population from BME groups (approximately 3%).

Being born prematurely or with a low birthweight (LBW) due to growth restriction during pregnancy (classified as below 2500g or below 2000g for very low birth weight, VLBW) can increase the risk of health problems in the first weeks of life and increase hospital stays for new-borns. LBW is associated with cognitive impairment and the development of chronic disease that can last into later life. In 2017, 5.3% of babies born at full-term had LBW (significantly higher than the England rate of 2.8%), and when incorporating premature births, 7.9% were LBW. Only 0.85% of all live births were classified as VLBW, which was not significantly higher than the national average.

Blackpool experiences higher than average stillbirth, neonatal and infant mortality rates; however the actual number of deaths each year is small, which means the rates are subject to large annual variation and need to be interpreted with caution. In the last three year period recorded (2015-2017) there were 6.4 per 1,000 infant deaths (under one year) per 1,000 live births (compared to 3.9 per 1,000 in England). In 2016, there were 9.4 stillbirths and deaths under 28 days per 1,000 births in Blackpool (compared to 7.1 per 1,000 in England).

THE FAMILY NURSE PARTNERSHIP work with young first time mothers, fathers and wider family to enable them to make choices which will support their child to achieve their optimum development, be school ready and have the best possible outcomes for the future. The same family nurse works with each family over two years to develop trusting, therapeutic relationships that promote engagement.

They support parents to consider their child's safety and think how their relationships can ensure a child is protected from harm. In 2018, the team worked with 150 families using a strength-based approach, underpinned by consideration of early trauma to ensure these often vulnerable families feel listened to and heard. Family nurses support parents to access other services, such as mental health or domestic violence services, in a targeted and individualised way to ensure families get the right support at the right time in the right place for them.

WHAT IS BEING "TRAUMA INFORMED"?

Trauma is “an event, a series of events or a set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening”*.This can include events in adulthood but also covers some adverse childhood experiences that are known as ACEs (e.g. abuse, neglect or household factors such as domestic violence, parental incarceration or drug/alcohol misuse).

Experiencing trauma is relatively common, but the experience and its impact are often hidden. Over the last 20 years, it has become clearer that the experience of trauma can affect the likelihood of experiencing poor health and social outcomes, as well worse mental health.

The experience of trauma can affect individuals in a number of ways, including the direct impact of the trauma, its impact on a person’s coping responses and the impact on a person’s relationships with others and influence this has on help seeking and engaging with services.

Trauma Informed Practice is a way of working that recognises

- that anyone using a service may have experienced trauma or ACEs
- that people with a history of trauma may be less likely to engage with services
- the importance of relationships in preventing and recovering from the effects of trauma and ACEs.

Many organisations in Blackpool and Lancashire are working towards becoming more trauma-informed and understanding that trauma may impact the way clients cope with stresses or interact with staff and others. We are moving towards asking “What’s happened to you?” rather than “What’s wrong with you?”. We have a vision that all public services will eventually incorporate this understanding of trauma into all policies and areas of practice by:

- Creating physically and emotionally safe spaces
- Working transparently and establishing trust
- Giving people choice and control over their care
- Helping people to heal and develop healthy coping strategies
- Working in collaboration with service-users, respecting their experience and co-producing policies and materials wherever possible
- Creating a culture of compassion within the organisation.

*SAMHSA, 2014, p. 7

PERINATAL MENTAL HEALTH

Pregnancy related mental illnesses affects up to 30 in every 100 women following childbirth or during pregnancy[1]. It is becoming more recognised that around 10% men suffer impaired mental health around the time of becoming a father[2]. Pre-existing mental health conditions in parents can also affect children's health and wellbeing, and approximately 68% of women and 57% of men with mental health problems are parents.

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression. Having a poor relationship with a partner is also a risk factor for postnatal depression. In Blackpool, 9.2% of births were registered by just one parent, which is higher than the average of 5.1%. Using the number of births which were registered by just one parent may give a rough indication of the number of women that are likely to lack the support of the father during pregnancy and as a new mother[3].

Poor parental mental health can disrupt the bond formed between a baby and its parents, and may affect the care they receive. Good mental health starts in infancy and research shows that when the bond between a baby and its parents is interrupted or not formed, there is a much higher risk of that baby developing mental health problems later in life, than a child with a strong connection to the person who cares for them.

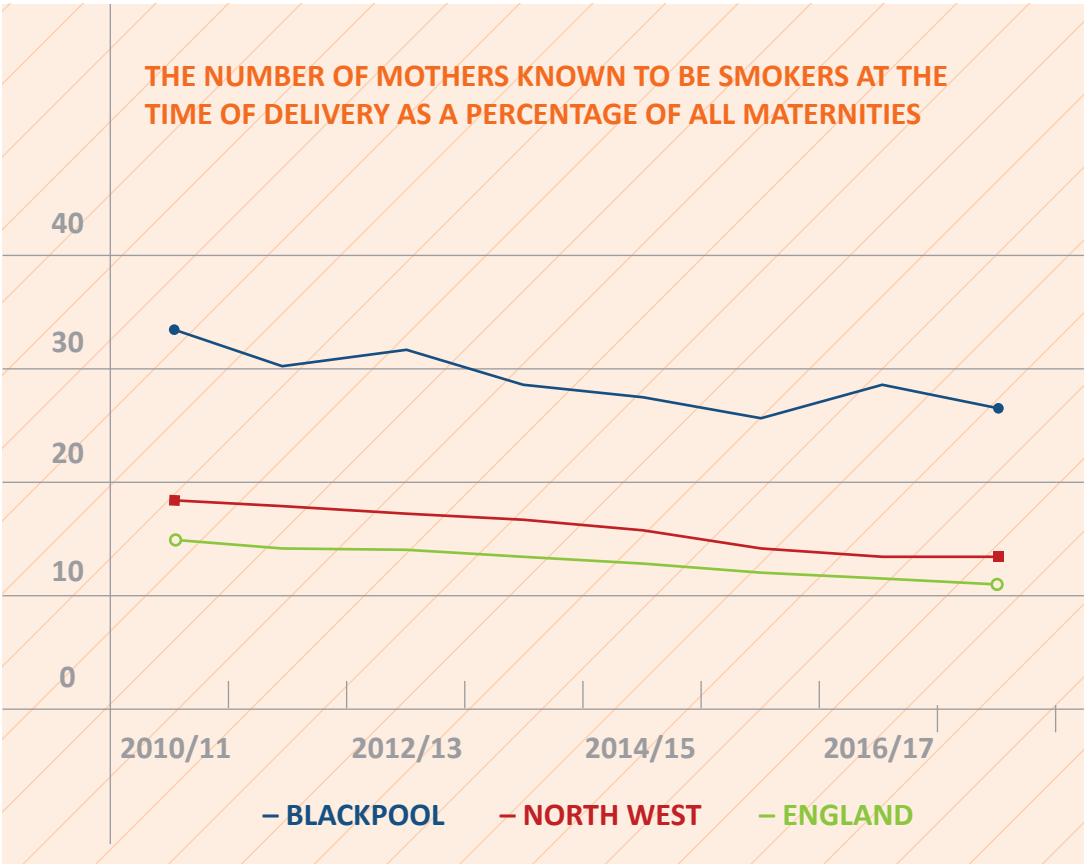
Blackpool Better Start run the Survivor Mums' Companion programme, designed to support pregnant women who have a history of childhood trauma. The programme aims to help survivors who are at risk of, or are experiencing, PSTD symptoms during pregnancy and helps them feel they are not the only one.

It is a telephone based service that provides pregnant women with information, emotional support and the opportunity to learn new skills. The service explores pregnancy and birth, PTSD symptoms, supports women to calm intense emotions and tackles any worries she may have about parenting and bonding with her baby.

1. https://maternalmentalhealthalliance.org/about/the-issue/
2. https://www.nct.org.uk/life-parent/emotions/postnatal-depression-dads-10-things-you-should-know
3. Mental health in pregnancy, the postnatal period and babies and toddlers: Report for Blackpool local authority. National Child and Maternal Health Intelligence Network, 2017.

SMOKING

Smoking in pregnancy is a risk factor for low birthweight and is associated with stillbirth, sudden infant death syndrome (also known as cot death), and asthma. Despite some improvement over the past eight years, the percentage of Blackpool mothers smoking at the time of delivery is more than double the national average and is significantly higher than the North West average.



As part of a National programme, in 2016/2017 Blackpool CCG received extra funding from NHS England to address high rates of maternal smoking. The Council's Public Health team has worked closely with the CCG to develop an evidence-based model to help women to stop smoking in pregnancy was developed; midwifery health trainers offer in-house stop smoking services including tailored behavioural support and direct access to nicotine replacement therapy for a minimum of 12 weeks. This model of stop smoking service includes an incentive scheme with the aim to support all pregnant women to set a quit date, achieve a carbon monoxide (CO) validated four week quit and sustain the quit with support throughout pregnancy and 12 weeks post-partum (post-natal or following pregnancy). Incentive payments are offered at stages throughout the pregnancy and evidence has shown this to be an effective adjunct to traditional smoking cessation methods. In 2018, there was a 44% increase in the number of women who quit when compared to 2017.

ALCOHOL AND DRUGS

Alcohol Exposure during pregnancy is considered one of the main preventable cause of birth defects and a diverse range of developmental disorders known collectively as Foetal Alcohol Spectrum Disorders. Harm caused by alcohol in pregnancy is significantly higher in Blackpool than the national average and is amongst the highest in the country. Members of the Public Health team and The Better Start Partnership have been conducting research to investigate local perspectives on the issue to better inform interventions to reduce alcohol consumption in pregnancy. As a result of this research, a 12-month media campaign was launched in November 2018, featuring a local Mum, Dad, Nan and best friend dressed as superheroes with the aim to reduce the number of alcohol exposed pregnancies in Blackpool.

The **PREGNANCY PARTNERSHIP CLINIC** was developed in conjunction with obstetricians, anaesthetists, midwives and addiction specialists to provide a multi-agency and person-centred approach to manage pregnancy in women with addiction issues. Women attend the clinic four weekly and are also offered weekly or fortnightly appointments with their key worker and a specialist midwife at Horizon. Referrals to additional support for domestic violence and mental health support are made as needed. The clinic facilitates delivery of high intensity behaviour change interventions, which are critically important at this stage in a woman's addiction to support safe delivery of a healthy baby and to provide the woman with the best possible opportunities to lead a healthier lifestyle for her and her family.

NUTRITION

Infant feeding involves both the dependent child and mother or caregiver and this relationship evolves during the early years of life until the child is able to eat independently. The nature of this relationship is a key determinant of the child's nutritional intake; the way in which food is offered or administered and the age at which foods are presented may affect acceptance of foods. This may either help or hinder broadening of the diet and may have long-term implications for eating behaviour and developing preferences for healthy foods.

The World Health Organization (WHO) recommends initiation of breastfeeding within the first hour after birth, exclusive breastfeeding for the first six months, with continued breastfeeding along with appropriate complementary foods up to two years of age or beyond[4]. Babies who are not breastfed are more likely to suffer infectious diseases such as gastroenteritis, respiratory disease and otitis media (middle-ear infections) leading to increased hospitalisation, morbidity and mortality[5]. Children who have not been breastfed have increased rates of childhood diabetes and obesity, and increased dental disease[5].

Breastfeeding prevalence in Blackpool is low, and there has been little change at population level breastfeeding uptake in Blackpool historically. Women who are overweight and obese are less likely to initiate and continue to breastfeed. Breastfeeding initiation rates in 2016/2017 were 57%, down from 63% in 2013/2014, and maintaining breastfeeding to six to eight weeks similarly remains low at around 25%.

In both cases, the rates for Blackpool are considerably lower than the England average. It is likely that high rates of bottle feeding and risk associated to formula feeding and premature introduction of solid foods, with other practices is likely to contribute to increased admissions for gastroenteritis (which are significantly higher in Blackpool than the England average).

The Better Start Partnership is training volunteers to work with new parents to help them to feel confident in their choices about how they feed their baby, from birth through to weaning and beyond.

The Public Health team has also been developing a Junior Healthier Choices Award, to celebrate food establishments in Blackpool that welcome breastfeeding and bottle-feeding on their premises, offer smaller portions and healthier choices for infants.

4. https://www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding
5. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Victoria, C et al. The Lancet, Volume 387, Issue 10017, 475 – 490. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01024-7/abstract

VACCINE-PREVENTABLE DISEASES AND IMMUNISATIONS

Many diseases that would once have caused widespread illness and deaths amongst children are now extremely rare due to the UK routine childhood immunisation programme. Most vaccines are given in the early weeks-months of life to equip the children's immune systems to deal with infections they may come across as they meet new people and encounter new environments.

The European Region of the World Health Organization (WHO) currently recommends that on a national basis at least 95% of children are immunised against diseases preventable by immunisation and targeted for elimination or control (specifically, diphtheria, tetanus, pertussis, polio, Hib, measles, mumps and rubella). Coverage at a regional level should be at least 90%. The UK schedule includes additional vaccinations that are approved by the Joint Committee on Vaccination & Immunisation[6].

SUMMARY OF ROUTINE VACCINATIONS UP TO THE AGE OF 5 YEARS OLD

Disease (Vaccine)	Age	Notes
Diphtheria, tetanus, pertussis, polio and Haemophilus influenza type b (DTaP/IPV/Hib)*	1st dose: 8 weeks 2nd dose: 12 weeks 3rd dose: 16 weeks	Primary course
Pneumococcal disease (PCV)	1st dose: 8 weeks 2nd dose: 16 weeks	Primary course
Rotavirus	1st dose: 8 weeks 2nd dose: 12 weeks	Primary course
Meningococcal group B (MenB) (from September 2015)	1st dose: 8 weeks 2nd dose: 16 weeks	Primary course
Haemophilus influenza type b and meningococcal group C (Hib / MenC)	One year	MenC Primary Hib Booster
Measles/mumps/rubella (MMR)	One year	First dose
Pneumococcal disease (PCV)	One year	Booster
Meningococcal group B (MenB) (from September 2015)**	One year	Booster
Children's flu vaccine	Aged 2 to 8 years	Annual vaccination
Diphtheria, tetanus, pertussis, and polio (DTaP/IPV or DTaP/IPV)	3yrs/4 months to 5 years	Booster: 3 years after completion of primary course
Measles/mumps/rubella (MMR)	3yrs/4 months to 5 years	Second dose

6. https://files.digital.nhs.uk/55/D9C4C2/child-vacc-stat-eng-2017-18-report.pdf

In general, Blackpool's rates of vaccination are similar to the national picture, however nationally there are concerns that rates are not high enough to prevent outbreaks and there is large variation in coverage when you look at smaller geographies.

Only 88% of Blackpool's children were fully vaccinated against measles, mumps and rubella (two doses MMR by age five); a similar rate to the national average, but below the rate required for "herd immunity". The exact number of cases of measles mumps or rubella diagnosed in the town are not published, but there were 32 cases of measles and 86 cases of mumps confirmed in children aged 0-19 the North West region in 2017.

SCHOOL READINESS

The Early Years Foundation Stage (EYFS) sets standards for the learning, development and care of children from birth to five years old. All schools and Ofsted-registered early years' providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes. The areas covered by the EYFS include communication and language, physical development, personal, social and emotional development, literacy, mathematics, understanding the world, expressive arts and design. Children from poorer backgrounds are at greater risk of poorer development and the evidence shows that differences by social background emerge early in life. In 2017/2018, 67.9% of five year olds had achieved a good level of development at the end of reception, compared to 71.5% nationally. Only 54.7% of children eligible for free school meals (a crude indicator of socioeconomic deprivation) achieved a good level of development at the end of reception.

The development of a child's literacy skills are directly impacted upon by their early language skills. This relationship starts very early on in a child's life. A child's language skills at age two strongly influence their school readiness at the age of five and this can continue to impact upon their attainment and achievement throughout their school life[7]. The Better Start Partnership has introduced several interventions to promote parents' understanding of important role they play in supporting their child's communication and literacy skills. Activities include working with Dads to promote reading with their children, Book Start bundles of books and Literacy weeks with a variety of activities for families with children under five to take part in.

7. Roulstone S, et al 2011 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/181549/DFE-RR134.pdf)

SCHOOL AGED CHILDREN

In the time between starting and leaving school, a lot can happen in a child's life. In order that our children can grow and learn and thrive, their health, wellbeing and the environment they live in needs to be at its best.

From a physical health point of view, Blackpool's children are more likely than the national rate to be admitted to hospital with asthma, diabetes or accidental or non-accidental injury and have a higher over-all rate of emergency admissions to hospital.

While good healthcare in both primary and secondary care settings is crucial, it contributes only around 10% of overall health. A further 10-20% of health is thought to be shaped by genetic factors, but even genes can be influenced by environmental factors. Most of what makes people healthy are the physical and social environments that they live in and giving children safe and healthy surroundings to grow up in can have significant impacts on their health, wellbeing and ability to learn and develop.

> The relationships between these "wider determinants of health" and health outcomes are complex, and it is the Public Health department's job to advocate and work towards improving the underlying foundations of health as well as targeting interventions more directly on improving health outcomes.

POVERTY

Around 26% of Blackpool's children (dependent children aged under 20) were living in poverty in 2016. This figure is likely to be higher when housing costs are taken into account. Bloomfield ward has the highest proportion of children (aged 0-15) living in poverty in the country, based on the Indices of Multiple Deprivation 2015 and Claremont and Brunswick wards also fall in the 20 wards with the highest levels of child poverty. About a quarter of Blackpool children are eligible and claiming free school meals and this has remained steady across the past four years[8].

Children from poorer backgrounds lag at all stages of education[9]:

- By the age of three, poorer children are estimated to be, on average, nine months behind children from more wealthy backgrounds.
- By the end of primary school, pupils receiving free school meals are estimated to be almost three terms behind their more affluent peers and this lag increases further by age 14 and 16.
- Children receiving free school meals achieve 1.7 grades lower at GCSE.

Poverty is also associated with a higher risk of both illness and premature death[10].

- Children born in the poorest areas of the UK weigh, on average, 200 grams less at birth than those born in the richest areas.
- Children from low-income families are more likely to die at birth or in infancy compared to children born into richer families.
- Children living in poverty are also more likely to suffer chronic illness during childhood or to have a disability.

8. https://fingertips.phe.org.uk/profile/child-health-profiles/
9. http://www.cpag.org.uk/content/impact-poverty
10. http://www.cpag.org.uk/content/impact-poverty

HOUSING AND FUEL POVERTY

Closely linked to poverty, the quality of housing can affect health and wellbeing of children as well as educational achievement. Children living in poverty are almost twice as likely to live in bad housing.

Fuel poverty also affects children detrimentally as they grow up as low income families do sometimes have to make a choice between food and heating. Long-term exposure to a cold home can affect weight gain in babies and young children, increase hospital admission rates for children and increase the severity and frequency of asthmatic symptoms.

Children in cold homes are more than twice as likely to suffer from breathing problems and those in damp and mouldy homes are up to three times more likely to suffer from coughing, wheezing and respiratory illness, compared with those with warm, dry homes.

Struggling with high energy bills can have an adverse impact on the mental health of family members. Fuel poverty may even affect children's education – for example, if health problems keep them off school, or if a cold home means there is no warm, separate room to do their homework[11].

Last year's Annual Report focussed on the impacts of poor housing and transience within the town on health and highlighted the Council's Housing strategy that aims to deliver new housing supply, improve the private rental sector and to stabilise lives to prevent and resolve homelessness. This year the Public Health Team has taken on responsibility for the Warm Homes Fund and is delivering on two schemes for improving the energy efficiency and heating in houses in Blackpool.

WARM HOMES FUND SCHEMES

The Warm Homes Health Fund aims to help vulnerable households across Blackpool through two schemes to reduce fuel poverty.

Scheme 1 – The Energy Efficiency and Health Related Solution

- Conducting 'Energy Audits'

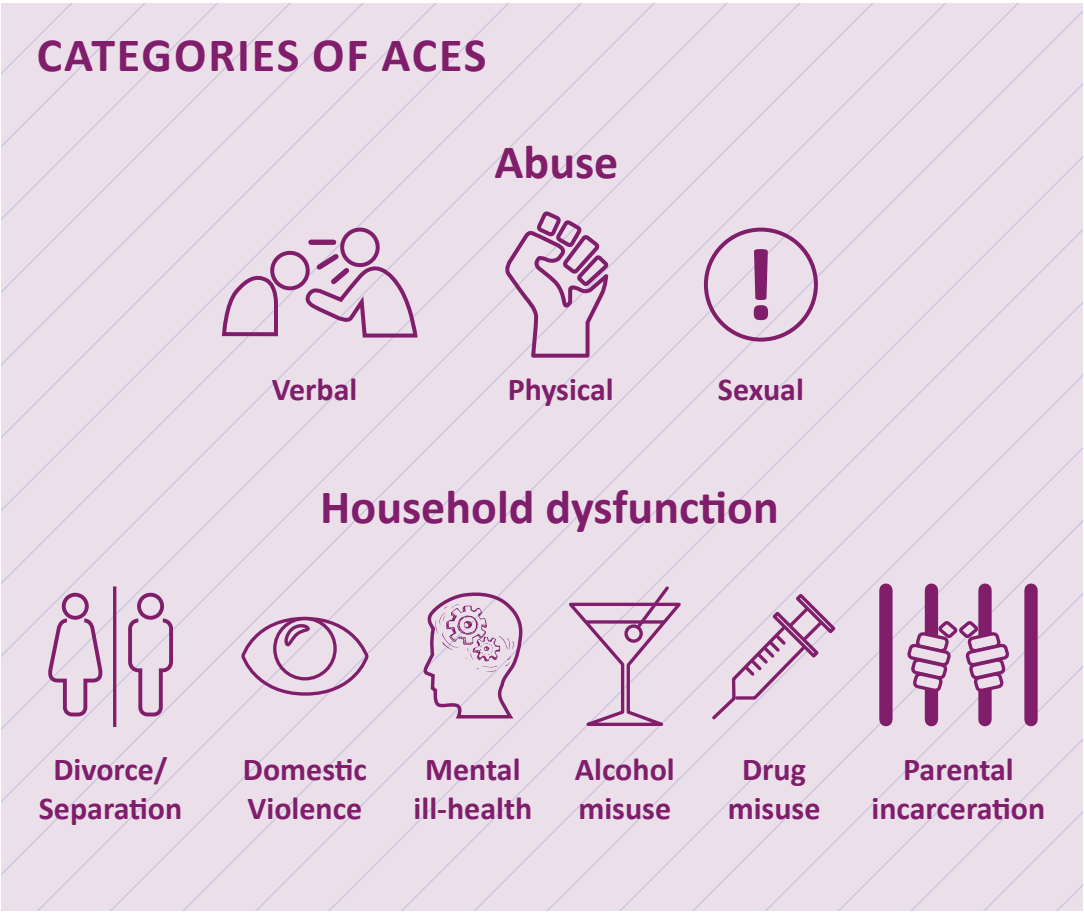
11. Pedro Guertler and Sarah Royston, Fact-File: Families and Fuel Poverty, Association for the Conservation of Energy

CHILDHOOD ADVERSITY AND EXPERIENCE OF THE CARE SYSTEM

Blackpool has the highest proportion of looked after children in the country with 185 children in care per 10,000 population aged under 18 years. Children and young people in care are among the most socially excluded children in England. Entry into the care system is associated with significant inequalities in health and social outcomes compared with all children and this contributes to poor health and social exclusion of care leavers later in life[12].

In general, the reasons why children enter the care system is through safeguarding mechanisms designed to protect them from adversities such as abuse, neglect and exposure to domestic violence or drug or alcohol misuse. To compound these early life experiences, children who come into foster households are typically from families/ communities, which already struggle with factors that correlate with social exclusion (unemployment, poor skills, low income, poor housing, high crime and bad health).

Children in care often have multiple risk factors that contribute to limiting educational attainment. A higher proportion of children in care have special educational needs and poorer emotional and behavioural health, again affecting educational attainment and in turn health outcomes in later life.



12. https://www.thetcj.org/foster-care/children-and-foster-care-inclusion-exclusion-and-life-chances

Adverse Childhood Experiences (ACEs – see image) such as those experienced by children in care as well as many others have been shown to have strong correlations with poor adult health outcomes. Studies conducted that looked at the ACEs experienced by adults in England[13] found that compared to those with no ACES, adults who had experienced four or more ACEs were:

- **2.3 times more likely to develop cancer**
- **3.1 times more likely to have cardiovascular disease**
- **2.5 times more likely to have liver or digestive disease**
- **2.1 times more likely to a regular binge drinker**
- **3.3 times more likely to be a current smoker**
- **10.9 times more likely to be a heroin or crack user**
- **7.5 times more likely to have been a victim of violence in the previous 12 months**
- **7.7 times more likely to have perpetrated violence in the previous 12 months**
- **11.3 times more likely to have been in prison or cells.**

ACEs have also been shown to have impacts on educational attainment, with poor childhood health and school absenteeism increased with number of ACEs reported. These findings indicate that ACEs are associated with significant burden on health and social care, the education and criminal justice systems and wider society.

Modelling based on the England ACEs study indicates that preventing ACEs in future generations could reduce levels of smoking by 22.7%, binge drinking by 11.9%, poor diet by 13.6%, violence perpetration by 52.0%, heroin/crack cocaine use by 58.7%, and unintended teenage pregnancy by 37.6%14.

Blackpool Council Public Health team is working in collaboration with partners from across Lancashire and South Cumbria, including local authorities, health services, education, policing and the Better Start Partnership to create “Trauma Informed Lancashire”. The aim is to establish an evidence base of interventions and ways of working designed to prevent ACEs, reduce their impact should they occur in childhood and enable adults with ACEs or other trauma to engage with services and activities that enable healing. The ultimate vision of this working group is to propagate a cultural shift towards the whole of Lancashire and South Cumbria becoming trauma informed and ACE-aware, with a view to reducing the poor health outcomes associated with ACEs and trauma.

13. Bellis MA et al. Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. Journal of Public Health 2015 Jan-1;37(3):445-454.

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EDUCATION

Educational attainment is linked with health behaviours and outcomes. Individuals that are more educated are less likely to suffer from long-term diseases and to report themselves in poor health, or suffer from mental disorders such as depression or anxiety. Pupils in deprived areas (such as Blackpool) are more likely to miss school and therefore have lower levels of educational attainment. Disadvantaged pupils are defined as those who are registered as eligible for free school meals, children looked after by the local authority and children who left care. In 2017, 45% of pupils at the end of KS2 were classed as disadvantaged in Blackpool.

Blackpool has 3,367 pupils with special educational needs (SEN) within its schools, this is 17.9% of all pupils and compares to 14.4% nationally. There are 957 children with a learning difficulty known to schools, the rate of 50.4 per 1,000 children is higher than the national average of 33.9 per 1,000. In 2018, there were 206 children with autism known to Blackpool schools.

Educational attainment is measures predominantly at Key Stage 2 (age 11 in year 6 of Primary School) and at Key Stage 4 (age 15, GCSEs or equivalent). Data for 2017 shows that overall, 62% of children in Blackpool attained the expected standard in all of reading, writing and maths, an increase from 48% in 2016. This is now the same as the national average. Only 53% of children classified as disadvantaged attained the expected standard, which is slightly better than the national level of 48%.

14. Bellis et al. BMC Public Health (2018) 18:792

At Key stage 4, the “Attainment 8” and “Progress 8” scores are used to assess how well pupils are performing[15]. The average Attainment 8 score for Blackpool pupils was 38.5 in 2017/2018, compared to 44.5 nationally. Disadvantaged students in Blackpool attained an average score of only 32.2, compared to non-disadvantaged pupils who attained and average score of 43.5[16].

The average Progress 8 score shows Blackpool pupils achieve over half a grade lower than similar pupils nationally and are making below average progress.

Work is being undertaken to improve the educational attainment of Blackpool’s children and Blackpool has been designated an “Opportunity Area”, with a strategy spanning 2017-2020 with the aims of

- Raising attainment and progress in Blackpool’s schools
- Supporting vulnerable children and families to improve attendance and outcomes and to reduce exclusions from school
- Improve advice and support for young people when moving between schools/colleges and into work.

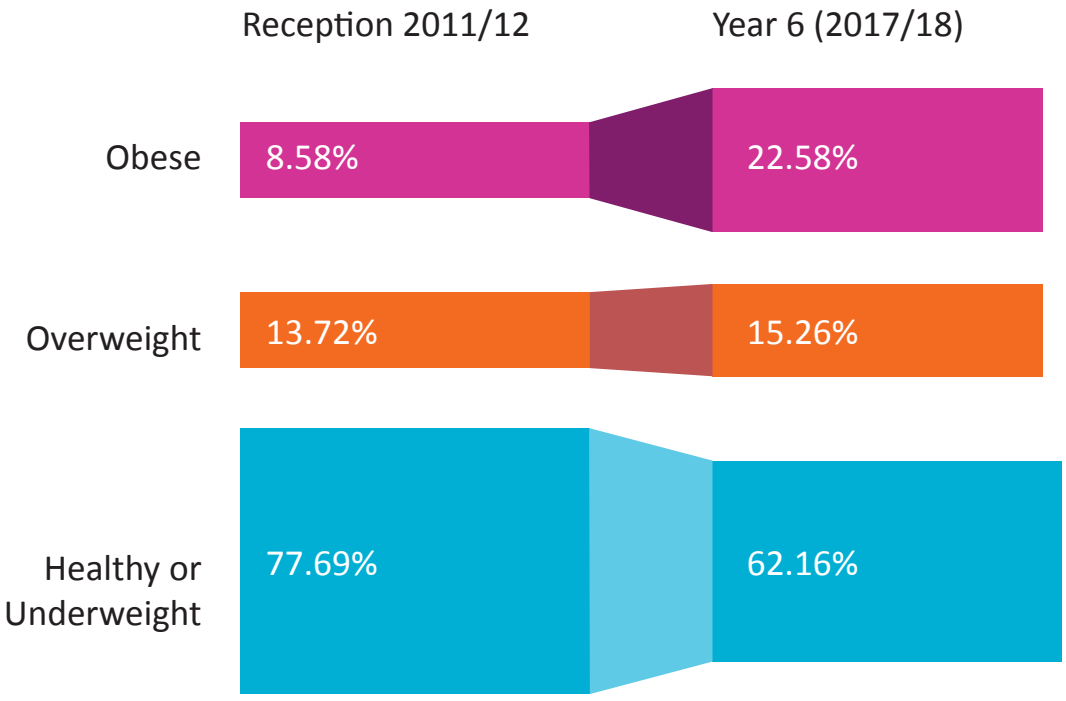
15. https://www.gov.uk/government/publications/progress-8-school-performance-measure
16. Data obtained from DfE https://www.gov.uk/government/statistics/secondary-school-performance-tables-in-england-2018-revised

HEALTHY WEIGHT AND PHYSICAL ACTIVITY

Obesity is defined as excess body fat accumulation that may impair health. The foundations of obesity start in childhood. The prevalence of obesity has trebled since the 1980s and well over half of all adults are either overweight or obese.

Over a quarter (27.1%) of children in Blackpool aged four/five years are overweight or obese when they start school. The proportion of children who are overweight or obese rises considerably during primary school years and 37.8% of today's year six children living in Blackpool are overweight or obese by the time they finish primary school at age 10-11 years compared to only 22.31% when they were in reception in 2011/2012. Within this expansion in numbers, obesity increases 2.5 times and overweight remains at a similar proportion. The prevalence of excess weight at year six is significantly higher than the England average (34.3%) and there is evidence that rates in disadvantaged areas continue to increase at a faster rate than less disadvantaged areas.

CHANGES IN PROPORTION OF BLACKPOOL CHILDREN IN OBESE, OVERWEIGHT OR HEALTHY WEIGHT CATEGORIES IN BETWEEN RECEPTION (2011/2012) AND YEAR 6 (2017/2018)



In January 2016, Blackpool Council became the first local authority in the country to sign a Local Authority Declaration on Healthy Weight and made a commitment to support employees and residents of Blackpool to tackle the issue of obesity. Work to achieve these commitments has been on going and during 2018,, the Public Health team has been working with a range of partners to develop a variety of interventions and actions to achieve them.

The children and families weight management programme, which is operated by Blackpool Council leisure services, continues to provide a programme which support families improve their knowledge and skills around healthy eating and physical activity, to enable them to use these skills to make and sustain healthy lifestyle choices.

The Council has made good progress during 2018 on tackling obesity in the town, but there is still more work to be done. As we look forward to 2019, the Public Health team will be undertaking a review of the healthy weight work and delivering a series of workshops on a whole systems approach to obesity to engage other council departments and work with key stakeholders across Blackpool. This work will help shape the future direction of the Healthy Weight strategy which will have a focus on our Early Years.

The Give Up loving Pop (GULP) campaign continues to grow from strength to strength within the Primary Schools, with the campaign being run for both Year 4 and 5 pupils encouraging children to choose sugar-free alternatives to fizzy drinks.

To build on this in November 2018 with the support of Better Start we launched an Early Years Gulp campaign 'Be Kind to Teeth'.

In addition to the work taking place specifically targeting obesity, there is complementary activity taking place to encourage children to become more physically active. Emerging evidence suggests an association between being physically active and academic attainment and attention. Being physically active also helps to promote physical and emotional health and wellbeing and children and young people who are physically active are more likely to continue the habit into adult life[17].

There are a number of Fit2Go programmes in the town including Family Fit2Go and Better Start Fit2Go. All these are about supporting children and families make healthier choices and live a healthier lifestyle. The Public Health nutritionist has been working with our primary schools to develop healthy packed lunch guidance to support parents with making healthy packed lunches and our the Blackpool Football Community Trust are promoting these resources as part of the Fit2Go programme in the primary schools.

17. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/469703/What_works_in_schools_and_colleges_to_increas_physical_activity.pdf

WOW – the year-round walk to school challenge is Living Streets' flagship walk to school scheme, is a pupil-led initiative where children self-report how they get to school every day using the interactive WOW Travel Tracker. If they travel sustainably (walk, cycle or scoot) once a week for a month, they are rewarded with a badge. On average, WOW schools see a 30% reduction in car journeys taken to the school gate and a 23% increase in walking rates.

Children are excited to walk to school every day because they want to earn a badge and they arrive to school refreshed, more focused and ready to learn having walked in the fresh air. In Blackpool 25 out of the 33 schools take part in the scheme supported by a local coordinator.

ORAL HEALTH

Good oral health is integral to a child's general health and wellbeing. Oral health affects how children grow, enjoy life, look, speak, chew, taste food and socialise, as well as their feelings of social wellbeing. Poor oral health and associated pain and disease can lead to difficulties in eating, sleeping, concentrating and socialising, thereby affecting health-related quality of life with individual, family and societal consequences (school absence, time off work and financial impacts to the individual and society). Tooth decay is the most common chronic disease in childhood even though it is largely preventable.

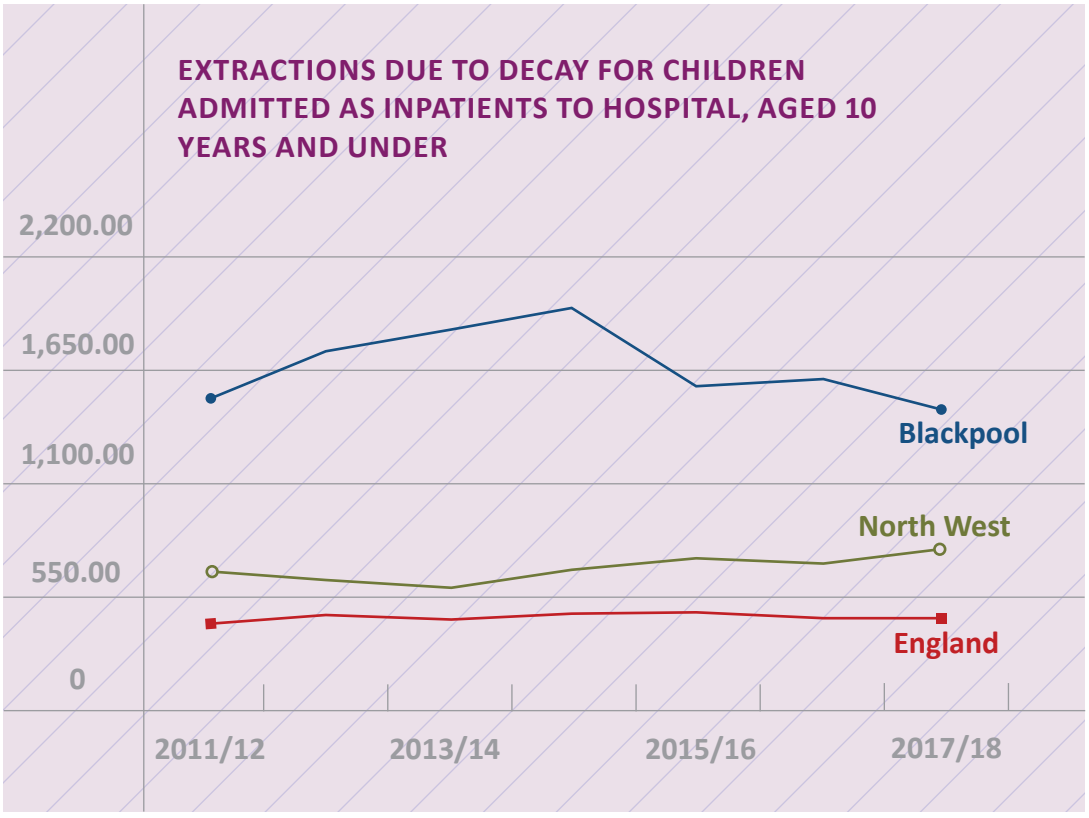
Often dental treatment for young children (such as extractions of decayed teeth) may only be done under general anaesthetic, which is both distressing for the families concerned and carries a financial burden. Tooth decay accounts for high numbers of child general anaesthetics and for children aged between five and nine years across England, it is the most common reason for hospital admission.

Tooth decay is the most common chronic disease in childhood even though it is largely preventable and is the top cause for hospital admission across England for children aged five to nine years.

Between 2014/2015 and 2016/2017 Blackpool's child dental health has improved significantly with the average number of decayed, missing or filled-teeth (DMFT) per five-year-old child reducing from 1.83 to 0.96, and the proportion of five year olds with no decay increasing from 57.5% to 75.1%. Tooth extractions due to decay for children admitted as inpatients to hospital, aged ten years and under had been increasing in the town, but since 2014 have had an overall downward trajectory, indicating that we have made some progress in improving our children's dental health.

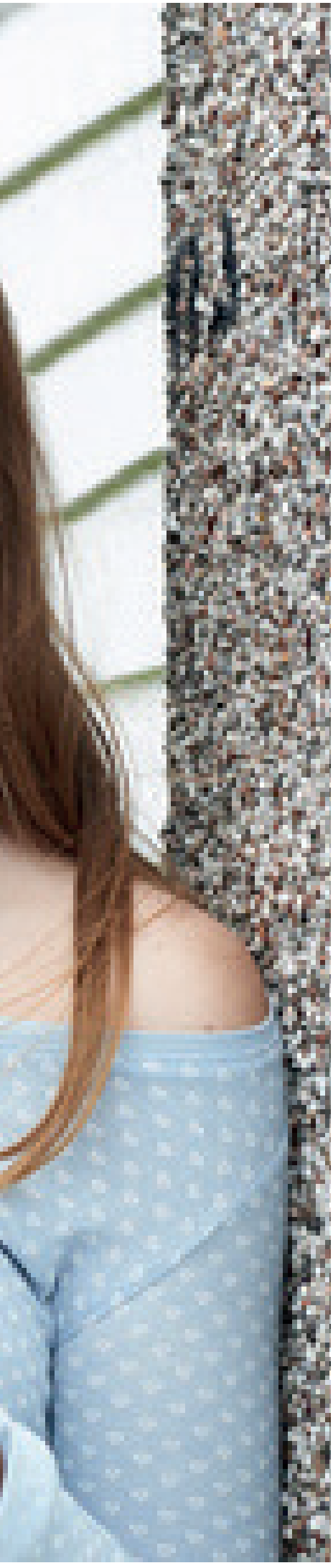
WHAT ARE WE DOING FOR BETTER DENTAL HEALTH IN BLACKPOOL?

- Dental Epidemiology
  The Public Health department is responsible for commissioning annual surveys to monitor children and young people's dental health
- Brushing for Life scheme
  Toothbrush and toothpaste distribution scheme to all new mums via Health Visitors
- Fluoridated Milk programme available to children in years one to six in primary schools



ADOLESCENCE

Adolescence is another period when experiences encountered can have a lasting impact on life-long health. Changes in brain structure, hormones and the physical body can interact with changing relationships, societal expectations and educational pressures to create a period of vulnerability to both mental and physical health challenges.



TOBACCO, ALCOHOL AND SUBSTANCE MISUSE

The harms to health from tobacco are well known; smoking is the leading cause of preventable illness and premature death in England. It is an addiction that is most commonly acquired in adolescence – in England in 2014, 77% of smokers aged 16 to 24 began smoking before the age of 18[18].

Short-term health consequences, such as shortness of breath, are experienced by teenagers who smoke almost three times as often as teens who do not. Smoking reduces young people's physical fitness in terms of both performance and endurance.

Long-term health consequences of youth smoking are reinforced by the fact that most young people who smoke regularly continue to smoke throughout adulthood. Early signs of heart disease and stroke can be found in adolescents who smoke and there is an increased risk of lung cancer in those who start smoking early. For most smoking-related cancers, the risk rises as the individual continues to smoke.

There is also a threefold increase in alcohol use in smokers compared to non-smoking teens. They area also eight times more likely to use marijuana, and 22 times more likely to use cocaine. Smoking is associated with a host of other risky behaviours, such as fighting and engaging in unprotected sex[19].

The latest statistics on smoking in adolescence from 2014/2015 indicate that 13.4% of 15 year olds in Blackpool were current smokers at the time compared to 8.2% nationally (11% regular smokers in Blackpool versus 5.5% in England) and 33.9% of Blackpool respondents had tried e-cigarettes or vaping (18.4% in England). A more recent survey is due to be published on 25 July 2019 and will be available at http://digital.nhs.uk/pubs/sdd18.

As the evidence for what works to reduce smoking uptake and tobacco use in young people is limited[20], in 2018 Blackpool launched a pilot programme to engage with schools and other settings to engage young people and co-design a service tailored to them, with the appointment of a Children and Young People's Stop Smoking Advisor. The pilot will enable us to understand the most effective way to support young people to stop smoking and assess the demand for such a service, to enable us to shape future provision.

18. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
19. https://www.who.int/tobacco/research/youth/health_effects/en/
20. https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD003289.pub6/abstract

MENTAL HEALTH

Mental health can affect on all areas of young people's lives – how they feel about themselves and others, their relationships and their psychological and emotional development. Poor mental health underlies many risk behaviours, including smoking, alcohol and drug misuse and higher-risk sexual behaviour[21]. Being mentally healthy helps people to realise their potential, gives them strength to cope with change, overcome challenges and adversity and make a positive contribution to their community[22].

Blackpool has some of the highest levels of need with respect to mental health – it is estimated that 10.3% of children aged 5-16 are likely to have mental health disorders. One in every 100 children and young people aged 10-24 were admitted to hospital due to self-harm in 2017-2018, and around 3.3% of secondary school pupils are reported as having social, emotional and mental health needs.

Since 2017 the eight CCGs covering Blackpool, Blackburn with Darwen and Lancashire have been implementing a joint plan for the transformation of services for supporting resilience, emotional wellbeing and mental health of children and young people.

NHS Child and Adolescent Mental Health Service (CAMHS) provider organisations were tasked to work collaboratively with voluntary community and faith sector providers and with CCGs to co-produce a core model for CAMHS services across Lancashire and South Cumbria through a process of engagement and co-production with children, young people, families and wider stakeholders. The group of provider and CCG representatives leading this work are referred to as The Care Partnership.

In Phase 1 of the redesign, which took place in early 2018, children and young people told The Care Partnership that:

- there isn't enough support for young people from services
- people in communities as well as professionals need more knowledge about mental health and its impact
- waiting times are too long
- criteria get in the way of accessing support
- there needs to be more options for treatment
- there continues to be a negative stigma about mental health.

In line with the project timeline the Care Partnership Team submitted an outline proposal for a new care model in August 2018. This was evaluated by an independent panel and the panel's recommendations to proceed to Phase 2 of the project was approved by the Transformation Board in September 2018.

Preparations for Phase 2 (to take place in early 2019) involved development of a Phase 2 project timeline and a Co-production and Engagement Plan. The Phase 2 timeline was approved by the Transformation Board in October 2018.

21. Royal College of Psychiatrists Position Statement PS4 (2010)
22. World Health Organisation (2005) Promoting Mental Health; Concepts, emerging evidence and practice.

Blackpool CAMHS Based at Blackpool Victoria Hospital has set up a patient participation group called Entwined Minds (named by the service users), which runs once a month and is open to all ages. They discuss patient experiences and ask for young people's views on our website/waiting room/ leaflets with the plan for them to redesign tools and spaces within CAMHS. They have redesigned information leaflets and are in the process of redesigning the waiting room to make it a more welcoming place for children of all ages.

Since 2014, HeadStart have been working in collaboration with children and young people and various partner organisations in Blackpool to develop a programme of activities and action to create a cultural shift in support of building resilience in young people and Blackpool as a community. By taking a proportionate universalism approach, they aim to maximise the potential to achieve outcomes through supporting the whole cohort towards resilience. Activities undertaken include workforce development, with training of professionals in various fields being trained in the HeadStart concept of resilience, provision of the online counselling service KOOTH, "Saddle Up" - a project combining equine care and art therapy, youth work ,family support and peer mentoring, amongst others.

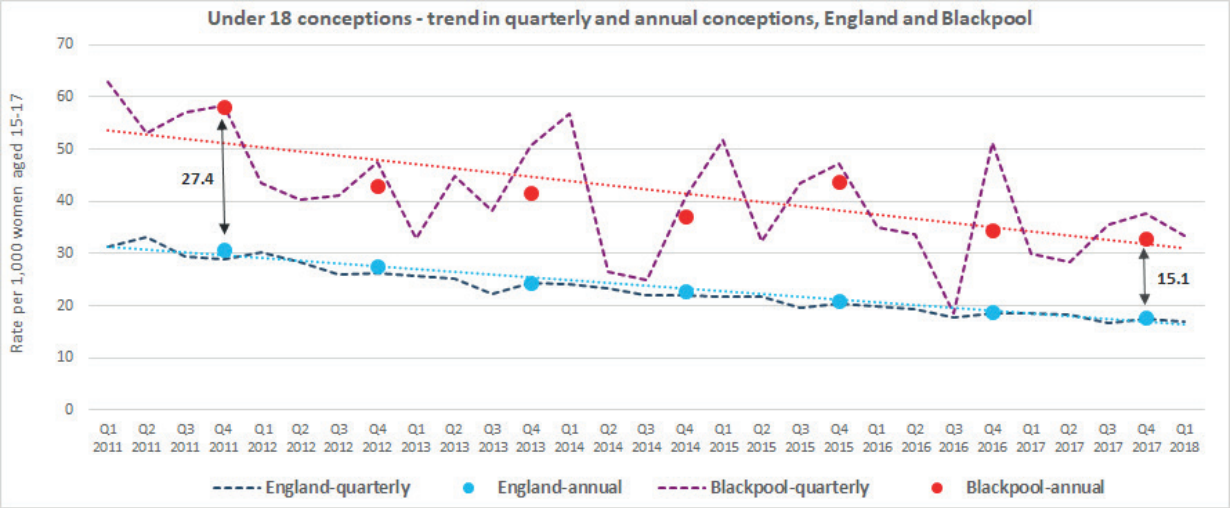
SEXUAL HEALTH

Young people aged 15-24 are the age group most affected by sexual infections and there are rising numbers of people under 24 years of age living with HIV[23]. Nationally around two thirds of new STI diagnoses are in women under 25 years old. Over half of new diagnoses in men are also in the under-25s[24]. Adolescence and young adulthood is a time when individuals often begin to explore their sexuality, and is an important time to educate about sexual health.

Chlamydia is the most commonly diagnosed bacterial sexually transmitted infection in England, with rates substantially higher in young adults than any other age group. It causes avoidable sexual and reproductive ill health, including symptomatic acute infections and complications such as pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility. The National Chlamydia Screening Programme recommends screening for all sexually active young people under 25 annually or on change of partner (whichever is more frequent)[25]. Other infections with prominent emphasis for young people are the human papilloma virus (HPV), chlamydia, and, recently in the UK headlines, an increasing prevalence of multi-drug resistant gonorrhoea.

In 2017, Blackpool had the second highest rate of chlamydia diagnoses in 15-24 year olds, and this is reflective of the success of the 15-24 chlamydia screening programme, which achieved the third highest proportion of 15-24 year olds tested. Blackpool also has the highest rates of detection of STIs in under-25 year olds in the North West (excluding chlamydia).

HPV is a sexually transmitted virus that is associated with cervical (and other) cancers. In 2008 a universal programme of HPV vaccination in girls aged 12-13 years in schools was rolled out. Blackpool has achieved a similar rate of HPV vaccination coverage to the national rate (two doses for females 13-14 years old), but has not yet reached the ideal target of greater than 90%.



23. http://nursinginpractice.com/article/hiv-and-aids-update
24. https://www.nursinginpractice.com/article/sexual-health-young-people
25. https://www.gov.uk/government/collections/sexually-transmitted-infections-sti-surveillance-data-screening-and-management

Teenage pregnancy is a cause and consequence of education and health inequality for young parents and their children. Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes; in particular, babies born to mothers under 20 years had a 30% higher rate of stillbirth than average and a 60% higher rate of infant mortality than average (England and Wales data).

Despite Blackpool's under-18 conception rate being approximately double that of England, over the past few years we have managed to narrow the gap. In order to continue this trend, new actions are needed and we need to be innovative.

Reduction in first and subsequent pregnancies has contributed to improving under-18 conception rates. We have worked to increase the uptake long-acting reversible contraception (LARC) by collaboration between and co-location of Sexual health and Termination of Pregnancy (ToP) services, enabling all women presenting for a ToP to have timely HIV/STI testing and seamless access to LARC.

In Blackpool, the Council has always prioritised teenage pregnancy, but with a smaller than average reduction of 32% and the highest under-18 conception rate in England, efforts have been redoubled.

To ensure consistent best practice in all schools, a new PSHE scheme has been developed, concentrating on sexual health and relationships, drugs and alcohol and emotional health and consent. Teachers and other school staff are trained in awareness of risky behaviours, a local support forum for PSHE leads has been set up. All schools have participated, with overwhelmingly positive feedback from pupils and positive comments from Ofsted in individual school inspection reports.

To strengthen targeted prevention, a domiciliary care pathway has been developed to enable joint visits with staff working with vulnerable young people, mental health, drug/ alcohol and learning disabilities. Domiciliary visits are working effectively as a multiagency approach, engaging with individuals who have previously not engaged with services and with a fast track to the LARC method of contraception.

TRANSITION INTO ADULTHOOD

The transition from childhood to adulthood is a challenging time for teenagers. Taking on adult responsibilities such as housing, budgeting and employment can be challenging for any teenager, but those with additional difficulties and vulnerabilities can need extra support.

One in five of 16 and 17 year olds experience five or more factors in their lives that may contribute to vulnerability. This equates to approximately 24,000 16 and 17 year olds in England[26]. Applying this statistic to Blackpool, over 600 out of approximately 3,000 16 and 17 year olds would fall into this category and likely more due to the levels of deprivation and numbers of children in care in the town.

Issues that lead to older teenagers being referred to children's services include domestic violence, mental ill health, drug or alcohol abuse and a risk of child sexual exploitation (CSE) and often these issues present in combination. For the 16- and 17- year olds experiencing a high number of risks and vulnerabilities, these issues are likely to remain, or intensify, as young people become young adults. Young people who are registered as 'children in need' are more likely to have poor educational attainments at the age of 17, more likely to be NEET (not in education, employment or training), claim benefits and experience homelessness than young people not in contact with social services.

In Blackpool in 2018, 18% of all 17-16 year olds were NEET (compared to the England rate of 6%), rising to 28.1% (England rate 9.6%) when looking at 17-16 year olds with Special Educational Needs (SEND). This puts Blackpool in the position of having the fourth highest rate of NEET in the country (third highest for SEND adolescents).

BYSTANDER

Tackling sexual/domestic violence is a key priority in the Blackpool Sexual Health Strategy and Action Plan (2017-2020) and the Domestic Violence Strategy and Action Plan (2017/2020). Through the Drug Strategy action plan there is an objective to support vulnerable people through early action, prevention and education across partner agencies, including domestic violence.

The bystander programme aims to equip individuals with the skills to help when participants witness behaviour that put others at risk. Bystander intervention aims to change the 'social norms' that this is 'normal' or 'acceptable' behaviour.

The strength of the bystander model lies in its emphasis on the role of peers in the prevention of violence. By treating young people as part of the solution to sexual assault, rather than part of the problem, bystander programmes limit the risk of defensiveness or backlash among participants.

26. https://www.childrenssociety.org.uk/sites/default/files/seriously-awkward-full-report.pdf

During 2018, a task and finish group was set up and an action plan developed. Links have been made with UCLAN, who have already piloted the programme with positive feedback, to align evaluation methodology for any future collaboration or comparisons.

The proposed programme is designed to be delivered by experienced facilitators. In support of implementation, a 'Train the Trainer' workshop was held on 14th December 2018, in preparation for a start date in February 2019.

TRANSITIONS

Transition describes the move from children's services to adult services. This can involve leaving school, transferring from children and family services to adult social care services and/ or transferring from paediatric services to adult health or mental health services.

These periods of transition are recognised as a time when young people may "fall though the gaps" and may not receive the care or services they need to stay healthy or fully engage in society.

Since 2010, the Government has put in place guidelines for enabling smooth and safe transitions and the Department of Education state that *"successful transition depends on early and effective planning, putting the young person at the centre of the process to help them prepare for transfer to adult services. The process of transition should start while the child is still in contact with children's services and may, subject to the needs of the young person, continue for a number of years after the transfer to adult services. This will ensure that young people and parents know about the opportunities and choices available and the range of support they may need to access.*[27]"

27. Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care - guidance on eligibility criteria for adult social care, 25th February 2010.

CARE LEAVERS

Blackpool has the highest number of "Looked after Children" (LAC) in the country. Children in care must leave local authority care by their 18birthday. Local authorities must support care leavers until they are 21 years old (or 25 if they are in education or training)[28].

In the year ending March 2018, 44% of Blackpool's care leavers aged 17–18 and 46% of care leavers aged 19–21 were in education, employment or training. Around a fifth of the 19–21 age group that were NEET, were so due to pregnancy or parentingand about two fifths due to illness or disability[29].

A major issue facing care leavers is the availability of secure housing and a lack of skills to be able to maintain tenancies. Historically 100% of care leavers who were accommodated in Blackpool Coastal Housing (BCH) properties without floating support failed to maintain their tenancies. There were incidences of young people leaving semi-independent on their 18th birthday and presenting as homeless at Housing Options and the quality of available accommodation options in the private rented sector was problematic resulting in numerous failed tenancies.

The Positive Transitions Housing Model was developed in September 2017 following agreement by Corporate Leadership Team (CLT) for implementation in November 2017. The scheme provides accommodation in the social housing sector for young people who are 17 years of age and above and have low- medium support needs. The model is a step down from either semi-independent group living, flat with floating support or supported accommodation and foster care.

This model was introduced to improve outcomes for young people by supporting them in to safe, secure, quality assured accommodation that has the potential to be a long term home.

By the end of 2018, 18 young people had been through the Positive Transitions Housing Model and despite challenges encountered around antisocial behaviour, non-engagement and rent arrears (in some cases due to the introduction of universal credit), the scheme has been broadly successful and is certainly a move in the right direction for supporting some of Blackpool's most vulnerable young people.

28. National Audit Office. 2016. Care leavers' transition to adulthood
29. https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2017-to-2018

MENTAL HEALTH

Discharge from Child and Adolescent Mental Health Services (CAMHS) and a potential move to Adult Mental Health Services (AMHS) takes place at varying ages, but most commonly when young people are aged between 16 and 18. The point of transition is a time of potential upheaval for young people. They may find it difficult to navigate new service settings or to manage their mental health and wellbeing following discharge from CAMHS, especially as the availability and offer of support can change dramatically.

During May and June 2018, local Healthwatch teams from the Lancashire and South Cumbria local Healthwatch Collaborative supported the facilitation of several co-production workshops at a variety of locations with young people in a collaborative approach to improve how CAMHS services are delivered. The Transition workshop highlighted several areas of practice that need to be “fixed” and ways in which the transition period could be managed to be more person-centred. These findings were fed into the wider CAMHS transformation plan and work in this area is ongoing.

RECOMMENDATIONS

This report has highlighted the many opportunities during childhood at which we, as health and social care professionals, may take action to protect and promote health and protect our children from illness in later life.


Photo Credit

RECOMMENDATIONS

As mentioned in the forward, the Integrated Care System (ICS) is committed to keeping children's health and wellbeing at the core of all its activities and has suggested the following key impact areas to work on in the coming year:

- Smoking in pregnancy
- Perinatal mental health
- Infant feeding
- Dental health
- School readiness and 'life' readiness
- Taking an ACE/trauma informed approach

This report has shown that Blackpool is already making great strides to improve some of these areas (in particular smoking in pregnancy, dental health, the Health Visiting transformation and taking an ACE/ trauma informed approach), and we are committed to taking action to improve the health of Blackpool's children at every stage of their lives. 2019 brings further opportunities to benefit the health of children as we embark on renewing our healthy weight and 0–19 strategies.

In light of all we have achieved so far and all that there is still to do, I make the following recommendations for ensuring the best health outcomes for Blackpool:

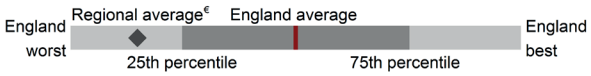
1. Continue to invest in early years interventions – for the health of our children and future health of Blackpool as a whole
2. Work with our partners across the whole system to continue to make progress towards the aims of the Healthy Weight Declaration
3. Continue to advocate wider measures to protect children's ability to engage in education and improve their prospects for the future (poverty, housing, preventing ACEs)
4. Commit to innovative and creative approaches towards reducing teen pregnancy rates to national levels
5. Work with Head Start to build personal and community resilience and give young people the tools to support their emotional and psychological wellbeing
6. Be proactive within the health and care sectors to advocate for our young people and ensure that no child or young person falls through the net at points of transition.

APPENDIX

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 value for each indicator is shown as a circle. The England average is shown by the red 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



	Indicator names	Period	Local count	Local value	Eng value	Eng worst	Eng best
Life expectancy and causes of death	1 Life expectancy at birth (Male)	2014 – 16	n/a	74.2	79.5	74.2	83.7
	2 Life expectancy at birth (Female)	2014 – 16	n/a	79.5	83.1	79.4	86.8
	3 Under 75 mortality rate: all causes	2014 – 16	2,093	545.7	333.8	545.7	215.2
	4 Under 75 mortality rate: cardiovascular	2014 – 16	456	118.8	73.5	141.3	42.3
	5 Under 75 mortality rate: cancer	2014 – 16	721	186.8	136.8	195.3	99.1
	6 Suicide rate	2014 – 16	57	16.0	9.9	18.3	4.6
Injuries and ill health	7 Killed and seriously injured on roads	2014 – 16	195	46.6	39.7	110.4	13.5
	8 Hospital stays for self–harm	2016/17	774	578.9	185.3	578.9	50.6
	9 Hip fractures in older people (aged 65+)	2016/17	165	575.8	575.0	854.2	364.7
	10 Cancer diagnosed at early stage	2016	301	44.7	52.6	39.3	61.9
	11 Diabetes diagnoses (aged 17+)	2017	n/a	80.0	77.1	54.3	96.3
	12 Dementia diagnoses (aged 65+)	2017	1,726	78.5	67.9	45.1	90.8
Behavioural risk factors	13 Alcohol–specific hospital stays (under 18s)	2014/15 – 16/17	64	74.3	34.2	100.0	6.5
	14 Alcohol–related harm hospital stays	2016/17	1,589	1,151.1	636.4	1,151.1	388.2
	15 Smoking prevalence in adults (aged 18+)	2017	24,850	22.3	14.9	24.8	4.6
	16 Physically active adults (aged 19+)	2016/17	n/a	60.4	66.0	53.3	78.8
	17 Excess weight in adults (aged 18+)	2016/17	n/a	63.5	61.3	74.9	40.5
Child health	18 Under 18 conceptions	2016	82	34.6	18.8	36.7	3.3
	19 Smoking status at time of delivery	2016/17	507	28.1	10.7	28.1	2.3
	20 Breastfeeding initiation	2016/17	1,068	59.2	74.5	37.9	96.7
	21 Infant mortality rate	2014 – 16	28	5.4	3.9	7.9	0.0
	22 Obese children (aged 10–11)	2016/17	291	21.1	20.0	29.2	8.8
Inequalities	23 Deprivation score (IMD 2015)	2015	n/a	42.0	21.8	42.0	5.0
	24 Smoking prevalence: routine and manual occupations	2017	n/a	33.4	25.7	48.7	5.1
Wider determinants of health	25 Children in low income families (under 16s)	2015	7,205	27.6	16.8	30.5	5.7
	26 GCSEs achieved	2015/16	666	45.5	57.8	44.8	78.7
	27 Employment rate (aged 16–64)	2016/17	58,300	70.8	74.4	59.8	88.5
	28 Statutory homelessness	2016/17	612	9.6	0.8		
	29 Violent crime (violence offences)	2016/17	5,895	42.2	20.0	42.2	5.7
Health protection	30 Excess winter deaths	Aug 2013 – Jul 2016	306	17.5	17.9	30.3	6.3
	31 New sexually transmitted infections	2017	1,010	1,154.3	793.8	3,215.3	266.6
	32 New cases of tuberculosis	2014 – 16	43	10.3	10.9	69.0	0.0

For full details on each indicator, see the definitions tab of the Health Profiles online tool: www.healthprofiles.info

Indicator value types
1, 2 Life expectancy - Years 3, 4, 5 Directly age-standardised rate per 100,000 population aged under 75 6 Directly age-standardised rate per 100,000 population aged 10 and over 7 Crude rate per 100,000 population 8 Directly age-standardised rate per 100,000 population 9 Directly age-standardised rate per 100,000 population aged 65 and over 10 Proportion - % of cancers diagnosed at stage 1 or 2 11 Proportion - % recorded diagnosis of diabetes as a proportion of the estimated number with diabetes 12 Proportion - % recorded diagnosis of dementia as a proportion of the estimated number with dementia 13 Crude rate per 100,000 population aged under 18 14 Directly age-standardised rate per 100,000 population 15, 16, 17 Proportion - % 18 Crude rate per 1,000 females aged 15 to 17 19, 20 Proportion - % 21 Crude rate per 1,000 live births 22 Proportion - % 23 Index of Multiple Deprivation (IMD) 2015 score 24, 25 Proportion - % 26 Proportion - % 5 A*-C including English & Maths 27 Proportion - % 28 Crude rate per 1,000 households 29 Crude rate per 1,000 population 30 Ratio of excess winter deaths to average of non-winter deaths (%) 31 Crude rate per 100,000 population aged 15 to 64 (excluding Chlamydia) 32 Crude rate per 100,000 population

€"Regional" refers to the former government regions.

If 25% or more of areas have no data then the England range is not displayed.

Please send any enquiries to healthprofiles@phe.gov.uk

Blackpool Child Health Profile June 2018

The chart below shows how children's health and wellbeing in this area compares with the rest of England. The local result for each indicator is shown as a circle, against the range of results for England shown as a grey bar. The line at the centre of the chart shows the England average.

↔ No significant change
↑↓ Increasing / decreasing and getting better
↑↓ Increasing / decreasing and getting worse
▪ Trend cannot be calculated

● Not significantly different from the England average
● Significantly better than England average
● Significantly worse than England average
○ Significance cannot be tested

England average | Regional average | 25th percentile | 75th percentile

	Indicator		Local no. per year*	Local value	Eng. ave.	Eng. worst	Eng. best
Premature mortality	1 Infant mortality	↔	***9***	5.4	3.9	7.9	1.6
	2 Child mortality rate (1-17 years)	▪	***5***	19.2	11.6	22.4	6.2
Health protection	3 MMR vaccination for one dose (2 years) ● ≥95% ● <90% ● 90% to 95%	↔	1,738	89.8	91.6	69.8	97.5
	4 Dtap / IPV / Hib vaccination (2 years)	↓	1,861	96.2	95.1	74.7	98.6
	5 Children in care immunisations	↔	315	94.6	84.6	5.0	100.0
Wider determinants of ill health	6 Children achieving a good level of development at the end of reception	↑	1,141	66.7	70.7	60.9	78.9
	7 GCSE attainment: average Attainment 8 score	▪	-	38.8	44.6	37.6	56.2
	8 GCSE attainment: average Attainment 8 score of children in care	▪	-	20.4	22.8	12.1	34.2
	9 16-17 year olds not in education, employment or training	▪	300	8.8	6.0	44.8	2.1
	10 First time entrants to the youth justice system	↓	53	430.6	327.1	739.6	97.5
	11 Children in low income families (under 16 years)	↓	7,205	27.6	16.8	30.5	6.1
	12 Family homelessness	↔	15	0.2	1.9	8.4	0.1
	13 Children in care	↑	525	184	62	184	20
	14 Children killed and seriously injured (KSI) on England's roads	▪	***10***	39.4	17.1	46.8	1.3
Health improvement	15 Low birth weight of term babies	↔	52	3.5	2.8	5.2	1.3
	16 Obese children (4-5 years)	↔	161	10.0	9.6	13.5	4.8
	17 Obese children (10-11 years)	↑	291	21.1	20.0	29.2	11.3
	18 Children with one or more decayed, missing or filled teeth	▪	-	24.9	23.3	47.1	12.9
	19 Hospital admissions for dental caries (0-4 years)	▪	***68***	797.5	234.7	1,144.8	25.3
	20 Under 18 conceptions	↓	82	34.6	18.8	36.5	4.6
	21 Teenage mothers	↔	36	2.1	0.8	2.1	0.0
	22 Admission episodes for alcohol-specific conditions - under 18s	↓	***21***	74.3	34.2	100.0	6.5
	23 Hospital admissions due to substance misuse (15-24 years)	▪	***56***	339.0	89.8	339.0	32.1
Prevention of ill health	24 Smoking status at time of delivery	↓	507	28.1	10.7	28.1	2.3
	25 Breastfeeding initiation	↑	1,068	59.2	74.5	37.9	96.7
	26 Breastfeeding prevalence at 6-8 weeks after birth	▪	-	-	44.4	19.3	75.6
	27 A&E attendances (0-4 years)	↑	3,399	399.1	601.8	1,926.8	333.5
	28 Hospital admissions caused by injuries in children (0-14 years)	↑	433	181.1	101.5	190.5	43.3
	29 Hospital admissions caused by injuries in young people (15-24 years)	↔	407	254.8	129.2	254.8	64.0
	30 Hospital admissions for asthma (under 19 years)	↑	141	465.6	202.8	497.5	63.6
	31 Hospital admissions for mental health conditions	↔	54	188.8	81.5	188.8	14.3
	32 Hospital admissions as a result of self-harm (10-24 years)	↑	273	1,156.8	404.6	1,156.8	98.2

*Numbers in italics are calculated by dividing the total number for the three year period by three to give an average figure

Where data is not available or figures have been suppressed, this is indicated by a dash in the appropriate box

Notes and definitions

1 Mortality rate per 1,000 live births (aged under 1 year), 2014-2016
2 Directly standardised rate per 100,000 children aged 1-17 years, 2014-2016
3 % children immunised against measles, mumps and rubella (first dose by age 2 years), 2016/17
4 % children completing a course of immunisation against diphtheria, tetanus, polio, pertussis and Hib by age 2 years, 2016/17
5 % children in care with up-to-date immunisations, 2017
6 % children achieving a good level of development within Early Years Foundation Stage Profile, 2016/17
7 GCSE attainment: average attainment 8 score, 2016/17
8 GCSE attainment attainment: average attaiment 8 score of children looked after, 2016
9 % not in education, employment or training (NEET) or whose activity is not known as a proportion of total 16-17 year olds known to local authority, 2016
10 Rate per 100,000 of 10-17 year olds receiving their first reprimand, warning or conviction, 2016
11 % of children aged under 16 years living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income, 2015
12 Statutory homeless households with dependent children or pregnant women per 1,000 households, 2016/17
13 Rate of children looked after at 31 March per 10,000 population aged under 18 years, 2017
14 Crude rate of children aged 0-15 years who were killed or seriously injured in road traffic accidents per 100,000 population, 2014-2016
15 Percentage of live-born babies, born at term, weighing less than 2,500 grams, 2016
16 % school children in Reception year classified as obese, 2016/17
17 % school children in Year 6 classified as obese, 2016/17
18 % children aged 5 years with one or more decayed, missing or filled teeth, 2016/17
19 Crude rate per 100,000 (aged 0-4 years) for hospital admissions for dental caries, 2014/15-2016/17
20 Under 18 conception rate per 1,000 females aged 15-17 years, 2016
21 % of delivery episodes where the mother is aged less than 18 years, 2016/17
22 Hospital admissions for alcohol-specific conditions – under 18 year olds, crude rate per 100,000 population, 2014/15-2016/17
23 Directly standardised rate per 100,000 (aged 15-24 years) for hospital admissions for substance misuse, 2014/15-2016/17
24 % of mothers smoking at time of delivery, 2016/17
25 % of mothers initiating breastfeeding, 2016/17
26 % of mothers breastfeeding at 6-8 weeks, 2016/17
27 Crude rate per 1,000 (aged 0-4 years) of A&E attendances, 2016/17
28 Crude rate per 10,000 (aged 0-14 years) for emergency hospital admissions following injury, 2016/17
29 Crude rate per 10,000 (aged 15-24 years) for emergency hospital admissions following injury, 2016/17
30 Crude rate per 100,000 (aged 0-18 years) for emergency hospital admissions for asthma, 2016/17
31 Crude rate per 100,000 (aged 0-17 years) for hospital admissions for mental health, 2016/17
32 Directly standardised rate per 100,000 (aged 10-24 years) for hospital admissions for self-harm, 2016/17

HEALTHY BEGINNINGS FOR A HEALTHY FUTURE

THE HEALTH OF THE PEOPLE OF BLACKPOOL 2019

Blackpool Council

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health
Relevant Cabinet Member	Councillor Graham Cain, Deputy Leader (Children)
Date of Meeting	29 January 2020

FORWARD PLAN

1.0 Purpose of the report:

1.1 To request the Health and Wellbeing Board members to develop a draft Forward Plan for the meetings of the Board in 2020.

2.0 Recommendation(s):

2.1 That Board Members consider the development of Forward Plan linked to the Director of Public Health's Annual Report and advise of any forthcoming initiatives, projects, policy developments and any other agenda items from individual organisations that are of interest to and are the business of the Board.

2.2 To note the potential for a joint meeting of the Health and Wellbeing Board and those of Blackburn with Darwen and Lancashire in March to discuss the Integrated Care System Strategy Delivery Plan.

3.0 Reasons for recommendation(s):

3.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties a Forward Plan should be developed. This will enable the Board to strategically plan its future agendas and ensure that items are aligned to and relevant to the delivery of the Board's priorities.

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

4.0 Other alternative options to be considered:

4.1 None.

5.0 Council Priority:

5.1 The relevant Council Priority is "Creating stronger communities and increasing resilience."

6.0 Background Information

6.1 In order to maintain a strategic oversight of the health and wellbeing agenda and ensure that the Board fulfils its statutory duties, the Board should develop a forward plan of discussions. It is proposed that the workplan mirrors the recommendations of the Director for Public Health's annual report which each meeting concentrating on one of the recommendations in his plan. This would enable an in depth discussion of key recommendations/priorities to take place with it being proposed that each meeting would focus on one recommendation with that taking the majority of each meeting with some time set aside at the start of the meeting for other items.

6.2 The Board has a role in developing the Integrated Care System Strategy Delivery Plan. It is proposed that this role be undertaken jointly with the Health and Wellbeing Boards of Blackburn with Darwen and Lancashire. It is anticipated that a joint meeting will therefore be held in March 2020 and at that meeting further discussion would take place on other possible areas of cooperation.

6.3 Does the information submitted include any exempt information? No

6.4 **List of Appendices**

None.

7.0 Legal considerations:

7.1 None.

8.0 Human Resources considerations:

8.1 None.

9.0 Equalities considerations:

9.1 None.

10.0 Financial considerations:

10.1 None.

11.0 Risk management considerations:

11.1 None.

12.0 Ethical considerations:

12.1 None.

13.0 Internal/ External Consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.

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