Blackpool Council

10 October 2023

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 18 October 2023 at 3.00 pm
In the Theatre, @The Grange, Bathurst Avenue

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 27 JUNE 2023 (Pages 1 - 6)

To agree the minutes of the last meeting held on 27 June 2023 as a true and correct record.

3 BLACKPOOL SEXUAL HEALTH STRATEGY 2023-2026 (Pages 7 - 92)

To seek approval from the Blackpool Health and Wellbeing Board for the Blackpool Sexual Health Strategy for the time period 2023-2026.

4 PROGRESS UPDATE ON JOINT LOCAL HEALTH AND WELLBEING STRATEGY (Pages 93 - 96)

To provide the Health and Wellbeing Board with an update on progress in the development of a new Joint Local Health and Wellbeing Strategy.

5 BLACKPOOL PLACE-BASED PARTNERSHIP DEVELOPMENT (Pages 97 - 110)

To update the Health and Wellbeing Board on recent progress and developments regarding Blackpool's Place-based partnership

6 BETTER CARE FUND UPDATE (Pages 111 - 178)

To provide the Board with an update on the financial monitoring of the Blackpool Better Care Fund.

7 INTEGRATED JOINT CAPITAL RESOURCE USE PLAN 2022/23 AND 2023/24 (Pages 179 - 188)

To note the Integrated Joint Capital Resource Use Plans for 2022/23 and 2023/24 as shared with the Health and Wellbeing Board for information.

8 DATE OF NEXT MEETING

To note the date of next meeting as Wednesday 13 December 2023.

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 - TUESDAY, 27 JUNE 2023

Present:

Councillor Farrell (in the Chair)

Councillor

Warne

Dr Arif Rajpura, Director of Public Health, Blackpool Council
Karen Smith, Director of Adult Services, Blackpool Council and Director of Health Integration, Lancashire and South Cumbria Integrated Care Board

Roy Fisher, Non-Executive Director, Lancashire and South Cumbria Integrated Care Board
Dr Neil Hartley-Smith, Clinical Representative, Lancashire and South Cumbria Integrated Care Board

Trish Armstrong-Child, Chief Executive Officer, Blackpool Teaching Hospital NHS Trust

Tracy Hopkins, Blackpool Citizens Advice Bureau, Voluntary Sector Representative

In Attendance:
Lennox Beattie, Executive and Regulatory Manager, Blackpool Council
Stephen Boydell, Principal Epidemiologist, Blackpool Council
Dr Sarah Kipps, Consultant in Public Health, Blackpool Council
Liz Petch, Consultant in Public Health, Blackpool Council
Megan Walker, Public Health Co-Ordinator (Alcohol and Tobacco), Blackpool Council

Karen Tordoff, Lancashire and South Cumbria Integrated Care Board
Andy Williams, Lancashire and South Cumbria Integrated Care Board

Apologies:

Apologies were received from Councillor N Brookes who was elsewhere on official Council business.

1 DECLARATIONS OF INTEREST

There were no declarations of interest on this occasion.

2 MINUTES OF THE LAST MEETING HELD ON 8 MARCH 2023

The Health and Wellbeing Board considered the minutes of the last meeting held on 8 March 2023.

Resolved:

That the minutes of the last meeting held on 8 March 2023 be approved and signed by the Chairman as a correct record.

4 BLACKPOOL JOINT LOCAL HEALTH AND WELLBEING STRATEGY UPDATE

The Health and Wellbeing Board received an update on the development of the Health and Wellbeing Strategy from Liz Petch, Consultant in Public Health. The update highlighted that policy development had started with a review of existing strategies, systems and structures and a review of Joint Strategic Needs Assessment data which had taken place during March and April 2023. The next step had taken the form of a stakeholder workshop on the 6 June 2023- to ensure that there would be strong linkages this workshop also considered the development of the Integrated Care Partnership (ICP) and NHS Joint Forward Plan.

The workshop had identified four key priorities:

- Starting Well – First 1,001 days to include smoking in pregnancy and childhood obesity
- Education, employment and training – particularly year round economy and jobs to tackling seasonality, and valuing core community
- Living Well – to include smoking, drugs and alcohol, and physical and mental wellbeing
- Wider determinants of health – particularly housing

The Board endorsed the priorities and agreed that they would address the originally identified broad aim of closing the gap in life expectancy and healthy life expectancy with England.

It was also noted that the next steps would be

- To develop a rationale to explain why certain priorities have been chosen and address why certain priorities were not chosen. This will help to build a shared understanding among stakeholders.
- To identify and engage wider stakeholders who have not yet been involved in the strategy development process, to ensure a more comprehensive and inclusive approach.
- To develop a framework for action that outlines short, medium, and long-term evidence based actions for each identified priority.

Resolved:

1. To note the report.

2. To agree the four priorities identified at the workshop on 6 June 2023 and outlined above as the key steps in developing the Joint Health and Wellbeing Strategy.

4 LANCASHIRE AND SOUTH CUMBRIA INTEGRATED CARE SYSTEM - JOINT FORWARD PLAN 2023 ONWARDS

Further to the meeting on the 8 March 2023, The Board received a presentation giving an overview of the emerging Joint Forward Plan for the Lancashire and South Cumbria Integrated Care Board (ICB). The Board noted that the joint forward plan development process to produce a shared delivery plan for the integrated care strategy that supported

it

The Board was reminded that the plan had been developed to address three broad principles as required by statutory guidance.

- Principle 1: Fully aligned with the wider system partnership's ambitions.
- Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
- Principle 3: Delivery focused, including specific objectives, trajectories and milestones as appropriate.

The Board noted that a final version of this plan – amended to take account of feedback from partners and the public – would be considered by the Integrated Care Board at its 5 July 2023 meeting.

Resolved:

To agree the attached draft version of the Joint Forward Plan and agree that the plan takes proper account of the Blackpool Health and Wellbeing Strategy and note that after taking account of these comments, a final version of the plan will go sign off by the Integrated Care System Board at its 5 July 2023 meeting.

5 TOBACCO FREE LANCASHIRE AND SOUTH CUMBRIA STRATEGY 2023-2028

The Health and Wellbeing Board considered a report on the development of the Tobacco Free Lancashire and South Cumbria Strategy 2023-2028.

Dr Sarah Kipps, Consultant in Public Health, presented the report to the Board.
She highlighted that smoking remained the number one cause of preventable deaths in England and that it had also been a major driver of health inequalities. It was also clear that without change Lancashire and South Cumbria would not meet the national target of under 5% of the population smoking by 2030.

The strategy had been developed collaboratively with tobacco leads and commissioners from each local authority area alongside colleagues from the NHS and Office for Health Improvement and Disparities. It built on the previous Tobacco Free Lancashire Strategy alongside the latest data, evidence, policy and guidance on tobacco control.

The strategy had 4 key priorities for tobacco control:

1. Working together as a system for a smoke free tomorrow
2. Action to address health inequalities
3. Making Smoke Free the new normal
4. Lancashire and South Cumbria - A United Voice against tobacco harm

The Board endorsed the approach but emphasised the need to ensure that services used a range of options for stopping smoking and that different approaches worked differently dependent on individual circumstances. The need to balance nicotine replacement and behavioural change was also noted.

The Board also endorsed the additional separate priority around vaping and the need for consensus and clarity on the Lancashire and South Cumbria position on nicotine vapes. It expressed the view that while vaping could form a useful replacement for some smokers that increasing use of vapes for people that had never smoked especially young people and the unregulated or illicit sales formed a developing risk. Anecdotal evidence that young people were starting smoking after vaping was noted as an additional concern.

Resolved:

To endorse the approach outlined in the report and approve the Strategy attached at Appendix 5a to the agenda with effect until the 31 December 2028.

6 JOINT STRATEGIC NEEDS ASSESSMENT WORKING GROUP

The Board considered a report on the re-establishment of a Joint Strategic Needs Assessment (JSNA) Working Group.

The Board noted a Joint Strategic Needs Assessment (JSNA) would be an essential tool for identifying and addressing the health and wellbeing needs of the local population. This was a key responsibility of the Health and Wellbeing Board and its member organisations.

To support the production of an effective Joint Strategic Needs Assessment, it was considered that a working group should be established to oversee current Joint Strategic Needs Assessment projects, manage the future work plan, and identify colleagues who could contribute to different topics within the Joint Strategic Needs Assessment.

The Board broadly supported the membership with the group to be chaired by the Director of Public Health and with the following members Consultant in Public Health, Public Health Intelligence Analyst, Representative of Adult Services and Children's Services, NHS Business Intelligence Lead, Local Authority Business Intelligence Manager, NHS Place Based Partnership Representative, NHS Population Health Management Representative, Blackpool Health Determinants Research Collaboration Representative and Healthwatch representative. The Board though acknowledged that other roles should be invited to the group as topic areas were covered including education and voluntary sector representatives.

Resolved:

To re-establish a Joint Strategic Needs Assessment Working Group that meets three times a year, chaired by Blackpool's Director of Public Health with a membership as outlined in Appendix 6a to the agenda. The group would be representative of the organisations that contribute to the Health and Wellbeing Board and report progress to the Health and Wellbeing Board.

7 DATE OF NEXT MEETING

The Board noted the date of next meeting as the 18 October 2023.

Chairman

(The meeting ended4.35 pm)

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

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Dr Arif Rajpura, Director of Public Health, Blackpool Council
Relevant Cabinet Member	Councillor Jo Farrell, Cabinet Member for Levelling Up People
Date of Meeting	18 October 2023

BLACKPOOL SEXUAL HEALTH STRATEGY 2023-2026

1.0 Purpose of the report:

1.1 To seek approval from the Blackpool Health and Wellbeing Board for the Blackpool Sexual Health Strategy for the time period 2023-2026.

2.0 Recommendation(s):

2.1 To approve the Blackpool Sexual Health Strategy 2023-2026 attached at Appendix 3a with effect until 31 December 2026.

3.0 Reasons for recommendation(s):

3.1 The provision of sexual health services is statutory and local authorities are mandated to commission open access sexual health services.

This strategy responds to a local needs assessment and stakeholder consultation in order to develop inclusive interventions which meet the needs of our residents.

This strategy sets out plans to respond to local needs, such as high rates of sexually transmitted infections (STIs) and HIV, and to improve the reproductive health of our population.

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 There are no other options available that will meet the requirements of this strategy.

5.0 Council priority:

5.1 The relevant Council priority is both:

- 'The economy: Maximising growth and opportunity across Blackpool'
- 'Communities: Creating stronger communities and increasing resilience'

6.0 Background information

6.1 **What is being proposed?**

The document proposes a new sexual health strategy for Blackpool, for the time period 2023-2026. The scope of the strategy is to cover all aspects of the local sexual health system, for the wider population, beyond simply the provision of sexual health services.

The priority areas and the objectives within the strategy have been developed based upon relevant national context, local data, an evaluation of the previous strategy and consultation with stakeholders. An action plan has been developed to address the objectives within the strategy. This action plan is stakeholder-led: stakeholders have developed and committed to the various actions so as to achieve the objectives identified within the strategy.

The sexual health strategy has been approved by the Blackpool Council Public Health Senior Management Team, by the Blackpool Council Corporate Leadership Team and by the Blackpool Council Adult Social Care and Health Scrutiny Committee.

6.2 **Why is the strategy necessary?**

Sexual health is a broad area, covering wide-ranging and complex issues. Services delivered by local authority, primary care, third sector and community-based organisations form an essential part of the local sexual health system.

To improve the sexual health of the population of Blackpool, a coordinated, multi-agency approach needs to be adopted. A strategy is necessary to identify the priority areas of improvement for Blackpool specifically, to identify specific and measurable objectives that should be achieved and to propose a coordinated action plan to achieve these.

6.3 **How will the strategy be implemented and monitored?**

A stakeholder-led action plan has been developed to address the objectives stated within the sexual health strategy. All stakeholders to whom actions have been allocated have agreed to their actions and to the estimated target completion dates.

A system has been set up by the Public Health team to monitor the status of each action (e.g. not yet started, in progress, completed).

Implementation of the strategy will be managed via a multi-agency Sexual Health Strategy Group. This will be led by the lead commissioner for Sexual Health within the Public Health Team, and will consist of stakeholders from a range of internal teams and external organisations based within Blackpool. The Sexual Health Strategy Group will meet regularly (approximately 2 – 3 times per year) and will review progress made in relation to the strategy. Progress will be reviewed through the following:

- Assessment of progress made in relation to quantitative indicators identified within each priority area of the strategy (this will be undertaken on an annual basis only).
- Review of the status of each action within the action plan.
- Overall assessment of the direction of progress in relation to each priority area.

In addition to the Sexual Health Strategy Group, oversight of the strategy will be undertaken by the different Boards identified within the governance section of the strategy document.

6.4 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 3a: Draft refresh of Blackpool Sexual Health Strategy 2023 – 2026

Appendix 3b: Current version of Blackpool Sexual Health Strategy 2023 – 2026 Action Plan

Appendix 3c: Equality Analysis Record Form – Sexual Health Strategy 2023 – 2026

8.0 Financial considerations:

8.1 Funded within monies already available to all key partners through their own budgets.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 The risks of not producing a new sexual health strategy for Blackpool are:

- There will be a lack of a coordinated, multi-agency approach to address the needs of the Blackpool population with regards to sexual health.

- Stakeholder organisations will work less collaboratively, with the risk of work to improve sexual health being duplicated or missed.

- Progress in terms of improvement in sexual health will not be monitored.

- Groups of the population who face greater challenges in accessing sexual health services will continue to do so

11.0 Equalities considerations and the impact of this decision for our children and young people

11.1 The strategy has been informed by a local sexual health needs assessment, including groups where the burden of sexual ill health is recognised to be greater, such as people experiencing poverty, young people, asylum seekers and the LGBTQI community. Consideration of reducing health inequalities is a theme which underpins all elements of the strategy. In addition, priority area 5 is focused on reducing inequalities experienced by specific groups of the population.

Priority area 4 focuses on young people, with the aim of providing young people with the skills, support and services that they need to achieve optimal sexual health. Our Children and Care Leavers are also specifically considered within the strategy, most notably within priority area 5, under the objective 'Ensure that local services meet the sexual health needs of Our Children and Care Leavers'.

An Equality Analysis has been undertaken for the strategy attached at Appendix 3c, and has been reviewed by the Head of Equality and Diversity at Blackpool Council.

12.0 Sustainability, climate change and environmental considerations:

12.1 None.

13.0 Internal/external consultation undertaken:

13.1 As outlined above.

14.0 Background papers:

14.1 Framework for Sexual Health Improvement in England (published 2013): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

Women's Health Strategy for England (published 2022): https://www.gov.uk/government/publications/womens-health-strategy-for-england/womens-health-strategy-for-england

Towards Zero: the HIV Action Plan for England - 2022 to 2025: https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025

National guide to commissioning for sexual health, reproductive health and HIV (published 2014): https://www.gov.uk/government/publications/commissioning-sexual-health-reproductive-health-and-hiv-services

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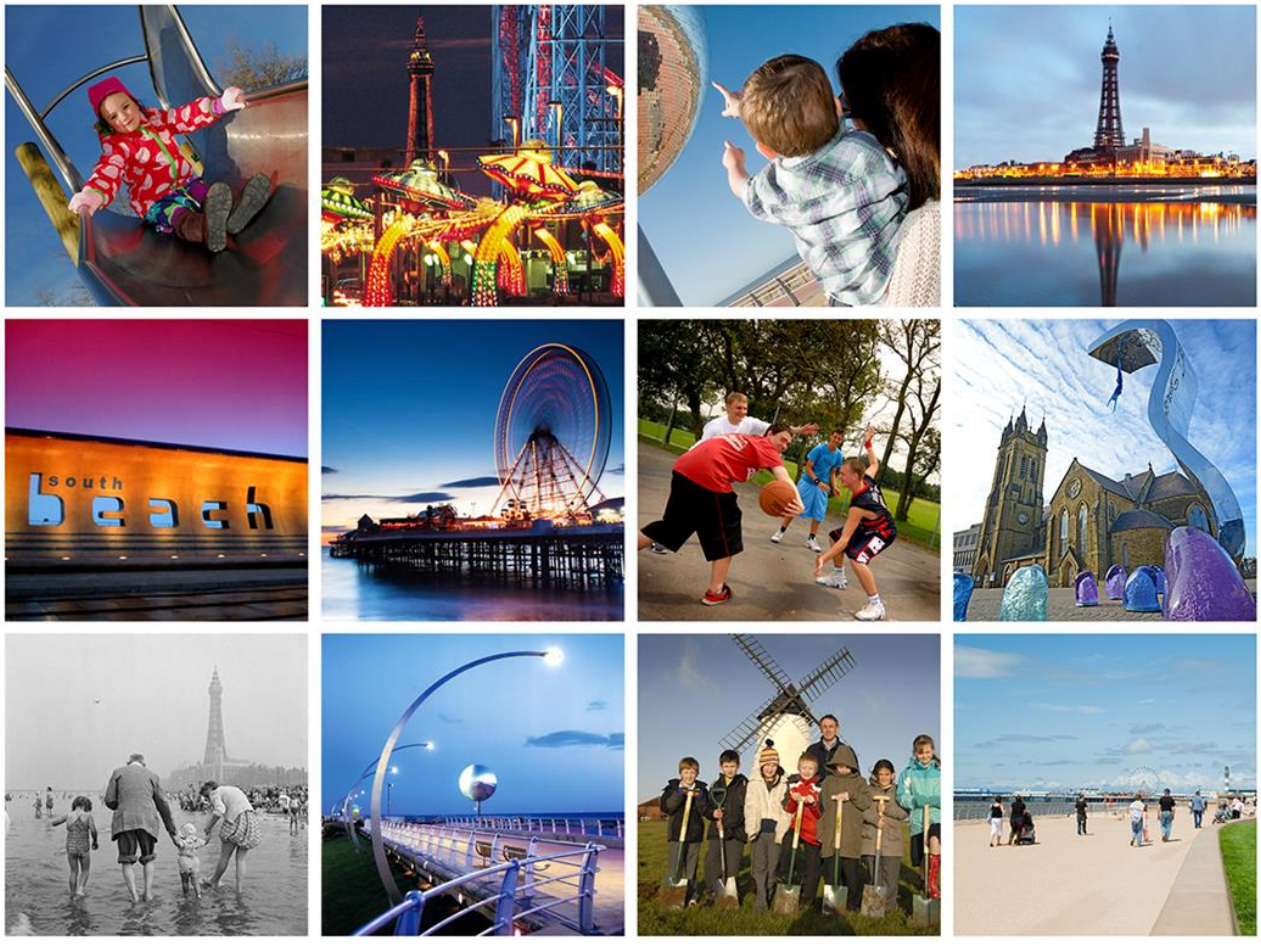
Appendix 3a

Blackpool Sexual Health Strategy

2023 – 2026

Blackpool Council



Contents

INTRODUCTION

Sexual health is an important and integral part of overall health. This is captured in the working definition of sexual health developed by the World Health Organisation (WHO)[1]:

'Sexual health is a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be protected, respected and fulfilled'.[1]

The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies, and allow non-residents to use the sexual health services provided in Blackpool.

This sexual health strategy has been designed to deliver on our vision to support everyone to achieve optimal sexual health and wellbeing, regardless of their circumstances, and to be able to access the sexual health services that they need, when they need them. The strategy builds on the progress made by the previous 2017 – 2020 sexual health strategy and on the findings of the 2022 sexual health needs assessment for Blackpool. The strategy provides a strategic framework to shape the planning and delivery of services and interventions to enable the vision to be realised.

NATIONAL CONTEXT

Relevant national strategies and plans

National strategies and plans that are particularly relevant to sexual health include the Framework for Sexual Health Improvement in England (published 2013)[2], the Women's Health Strategy for England (published 2022)[3], 'Towards Zero: the HIV Action Plan for England - 2022 to 2025' (published 2021)[4] and the national guide to commissioning for sexual health, reproductive health and HIV (published 2014).[5]

Framework for Sexual Health Improvement in England (published 2013)[2]

The 'Framework for Sexual Health Improvement in England' was published in 2013. This framework sets out steps towards achieving a reduction in sexual health inequalities and aims to support the commissioning of sexual health services, setting priority areas for sexual health improvement. Prioritising prevention is one of the key principles outlined in the framework.

A new national strategy for sexual health is expected soon.

Women's Health Strategy for England (published 2022)[3]

In 2022, the Department for Health and Social Care published their Women's Health Strategy for England. The strategy advocates a life course approach, which focuses on understanding the changing health and care needs of women and girls across their lives. This approach aims to identify the critical stages, transitions and settings where there are opportunities to promote good health, prevent negative health outcomes and restore health and wellbeing.

Priority areas identified within the strategy include menstrual health and gynaecological conditions; fertility, pregnancy, pregnancy loss and postnatal support; menopause; mental health and wellbeing; cancers; health impacts of violence against women and girls, and healthy ageing and long-term conditions.

Some key principles promoted within the strategy include embedding personalised care and shared decision-making in all areas of women's health, and better representing women and women's health expertise in the commissioning of research, design of curriculua for healthcare professionals, policy-making, and commissioning and delivery of services. The strategy advises that fragmented commissioning and delivery of sexual and reproductive health services can negatively impact women's access to services, in particular contraception. The strategy therefore advocates service provision that is more joined up and holistic.

The strategy includes a focus on disparities in health outcomes between women, and emphasizes the importance of improving health outcomes for those in 'inclusion health' groups, i.e. groups who are socially excluded (e.g. women who are sleeping rough).

Towards Zero: the HIV Action Plan for England - 2022 to 2025 (published 2021)[4]

In 2021, the Department for Health and Social Care published its national HIV action plan, in which was stated the ambition to achieve zero new HIV infections, AIDS and HIV-related deaths in England by 2030. The action plan advocates partnership working around four core themes: 'prevent', 'test', 'treat' and 'retain'. Based upon these themes, four key objectives are stated, and associated actions listed. These objectives are:

- Objective 1: Ensure equitable access and uptake of HIV prevention programmes
- Objective 2: Scale up HIV testing in line with national guidelines
- Objective 3: Optimise rapid access to treatment and retention in care
- Objective 4: Improving the quality of life for people living with HIV and addressing stigma

National guide to commissioning for sexual health, reproductive health and HIV (published 2014)[5]

In 2014 Public Health England published 'Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV'.[5] The guide advocates for key principles within the commissioning of sexual health, reproductive health and HIV services including collaborative working, whole system commissioning and consideration of how to address wider determinants of health.

Evidence-based standards and guidelines

The provision of integrated sexual health services is supported by accredited training programmes and evidence-based guidance from relevant professional bodies. Providers of sexual and reproductive health services must ensure that commissioned services are delivered in accordance with this evidence base:

- The British Association for Sexual Health and HIV (BASHH) has published Standards for the Management of Sexually Transmitted Infections (BASHH, 2019).[6]

- The Faculty of Sexual and Reproductive Healthcare (FSRH) has recently published a Service Standard for Sexual Reproductive Healthcare (2022).[7]

- The FSRH has recently published the Hatfield Vision (2022),[8] which outlines priority goals and actions endorsed by 28 organisations in areas such as access to contraception, reproductive rights, menopause, menstrual health, cervical screening and maternal health outcomes in women in ethnic minority groups. It aims to leverage commitment and accountability at national and regional levels to achieve comprehensive, joined-up women's reproductive healthcare.

- The British HIV Association (BHIVA) has issued Standards of Care for People living with HIV (2018).[9]

- The Royal College of Obstetrics and Gynaecologists provides a range of guidance on topics relating to clinical practice and service provision.

- The National Institute for Health and Care Excellence has produced a Quality Standard covering sexual health, focusing on preventing sexually transmitted infections (STIs), and describing high-quality care in priority areas for improvement (2019).[10]

Economic evidence

Appropriate investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of STIs including HIV, preventing significant health and social care costs in the future. A financial and economic report produced in 2013 as part of the 'We can't go backwards campaign' considered the potential financial consequences of increased restrictions on access to contraceptive and sexual health services in the UK.[11] The report suggested that worsened access to contraceptive and sexual health services (compared to the status quo in 2013) could result in additional costs to the NHS and to the wider public sector of between £8.3 billion and £10 billion. On the other hand, improved access was deemed to have the potential to result in cost savings to the NHS and wider public sector of between £3.7 billion and £5.1 billion.

LOCAL CONTEXT: OUR PREVIOUS STRATEGY

The Blackpool 2017 – 2020 Sexual Health Strategy[12] was built upon the findings of a sexual health needs assessment for Blackpool. Six strategy priorities were agreed locally:

1. Reduce unplanned pregnancies among all women of fertile age
2. Reduce the rate of sexually transmitted infections and re-infections
3. Improve detection rate in chlamydia diagnosis in 15-24-year-olds
4. Reduce onward transmission and proportion of late diagnoses of HIV
5. Reduce inequalities and improve sexual health outcomes
6. Tackling sexual violence

The strategic priorities and action plan were developed by a range of stakeholders. A comprehensive action plan listed agreed objectives and actions for each priority area.

To measure success, high level indicators were identified that indicate good sexual health or at least avoidance of sexual ill health. Targets were set for 2019/20, and the strategy aimed to achieve an improvement on the position at the time and achievement of the targets. In addition, it was agreed that success would also be evaluated by revisiting the School Health Education Unit (SHEU) survey to explore changes in young people's attitudes and knowledge of sexual health and services available.

An evaluation of progress made by the previous sexual health strategy, in terms of indicators and actions, is presented next, according to each of the previous strategy's priority areas.

Data sources for the evaluation of the previous strategy are listed in Appendix 1.

Evaluation of previous strategy priority area 1: Reduce unplanned pregnancies among all women of fertile age

Progress on indicators

DIRECTION OF CHANGE*	INDICATOR	TARGET ACHIEVED?
Improved	Under 18s conception rate	No
Worse*	Rate of abortions	No
Marginally improved	Under 25s repeat abortions (%)	Not set
Improved*	Rate of LARC (excluding injections) prescribed by SRS	Yes

*Statistically significant at 5% level

Progress on action plan

1.1	1.2	1.3	1.7	1.8
1.9	1.10	1.12	1.13	1.16
1.19	1.4	1.11	1.14	1.15
1.17	1.18	1.5	1.6	

PRIORITY AREA 1:
Reduce unplanned pregnancies among all women of fertile age

What has the previous strategy achieved?

- Significant ↑ **in LARC** prescription by **SRS**
- Promotion of **LARC to** those with **complex needs** through **ADDER** and **Changing Futures**
- **Targeted campaign** to **promote LARC** undertaken by BTH
- **Pilot** underway to embed **LARC in maternity** pathway
- **Collaborative working** between **SRS** and **TOP services** – TOP services now offering fitting/removal of LARC

Which areas of the previous strategy should be built upon?

- Build upon work to promote **LARC** to **women with complex needs**
- Continue to promote **uptake of LARC**
- Continue to develop the **pilot** programme to **embed LARC in the maternity** pathway
- Continue to explore ways to **work with local pharmacies** to promote **LARC uptake**

Evaluation of previous strategy priority area 2: Reduce the rate of sexually transmitted infections and re-infections

Progress on indicators

DIRECTION OF CHANGE	INDICATOR	TARGET ACHIEVED?
Improved	STI testing rate (excl chlamydia < 25y)	Not set
Improved*	STI testing positivity rate (excl chlamydia <25y)	Not set
Worse	New STI diagnoses (excl chlamydia <25y)	Not set
Improved	STI re-infection, men	No
Improved	STI re-infection, women	Yes
Worse*	HPV vaccination coverage for 2 doses[+]	Not set

*Statistically significant at 5% level

[+]13 – 14 year old females

Progress on action plan

2.1	2.3
2.4	2.6
2.2	
2.5	2.7

PRIORITY AREA 2: Reduce the rate of sexually transmitted infections and re-infections

What has the previous strategy achieved?

- Blackpool has a **high testing rate**
- Blackpool has a **high testing positivity rate**
- Progress in **preventing STI re-infection**:
  - **Decreased rate**
  - Reinfection covered in **PHSE**
- Implementation of **digital services for STI testing**
  - Increased **access** digitally
  - **Patient choice** in mode of access

Which areas of the previous strategy should be built upon?

- Continue to work with **primary care** (tier 2 services) around **STI testing recall**
- Build further on **digital access to sexual health services**:
  - Develop an **online booking** facility
  - Explore **remote consultancy** options
  - Consider and address **barriers to digital access**

Evaluation of previous strategy priority area 3: Improve detection rate in chlamydia diagnosis in 15-24-year-olds

Progress on indicators

DIRECTION OF CHANGE	INDICATOR	TARGET ACHIEVED?
Worse	Chlamydia detection rate (females aged 15-24 years)	Yes
Worse	Chlamydia detection rate (males aged 15-24 years)	No
Improved	Proportion screened for Chlamydia (aged 15-24 years)	No

Progress on action plan

3.2	3.3	3.4
3.5	3.8	3.9
3.10	3.11	3.6
3.7	3.1	

PRIORITY AREA 3:
Improve detection rate in chlamydia diagnosis in 15-24-year-olds

Chlamydia detection rate is **high** in Blackpool

Sector-led improvement on **Chlamydia screening → resolution of data flow issues**

Pathways developed between **Termination of Pregnancy services** and **sexual health services** to improve **follow-up** and **contact tracing** for **Chlamydia** positive patients.

What has the previous strategy achieved?

Continue to **work with GP practices** which undertake **Chlamydia testing**

Chlamydia detection rate, although high, is **declining** → action needs to be taken

The **new National Chlamydia Screening Programme guidance**, which now advocates targeted screening of women, needs to be **implemented locally**

Which areas of the previous strategy should be built upon?

Evaluation of previous strategy priority area 4: Reduce onward transmission and proportion of late diagnoses of HIV

Progress on indicators

DIRECTION OF CHANGE	INDICATOR	TARGET ACHIEVED?
Improved*	HIV testing coverage	No
Improved	Repeat HIV testing in gay, bisexual and other men who have sex with men	Not set
Improved	HIV late diagnosis	Yes

*Statistically significant at 5% level

Progress on action plan

4.1	4.2	4.3	4.4
4.5	4.6	4.7	4.8
4.9	4.10	4.11	4.12
4.13	4.14	4.15	4.16

PRIORITY AREA 4:
Reduce onward transmission and proportion of late diagnoses of HIV

What has the previous strategy achieved?

Opt-out HIV testing was successfully implemented in the **Emergency Department**.

An **MSM outreach clinic** for sexual health and harm reduction was **piloted.**

Testing coverage has improved in Blackpool, and is **higher than in the North West and England.**

The **proportion** of patients **diagnosed late** has **decreased,** and is **lower than in England and the North West** → patients in **Blackpool** are being **diagnosed earlier.**

Which areas of the previous strategy should be built upon?

Locally adapt the **national HIV action plan**.

Continue to ensure that **training on HIV testing** is offered to **healthcare professionals**.

Further **improve opt-out HIV testing** → explore how to ↑ **uptake** and **embed the testing into routine ED clinical practice**.

Continue to **work with substance misuse and harm reduction services** to promote **HIV awareness** and **testing.**

Evaluation of previous strategy priority area 5: Reduce inequalities and improve sexual health outcomes

Progress on indicators: Comparison 2015 to 2019 of SHEU survey responses relevant to sexual health

INDICATOR	Direction of change 2015 - 2019*
PRIMARY SCHOOL PUPILS: *Proportion reporting that…*	
They have been told how to stay safe online	↑
Someone they don't know in person has asked to meet with them	↓
SECONDARY SCHOOL PUPILS: *Proportion reporting that….*	
They know how to access contraceptive and sexual health advice **(Year 10 boys)**	↓
They know how to access contraceptive and sexual health advice **(Year 10 girls)**	↓
They were currently in a sexual relationship **(Year 10 pupils)**	↓
They had a sexual relationship in the past **(Year 10 pupils)**	↓
They were currently in a relationship and thinking about having sex **(Year 10 pupils)**	↑
They have received a chat message that scared them or made them upset	↑
They have seen images aimed at adults	↑
They had looked online for pornographic or violent images, games or films	↑
They had looked online for pornographic or violent images, games or films **(Year 10 boys)**	↔

*This column indicates a potential trend only – the lack of confidence and the smaller number of secondary school respondents in 2019 mean that any apparent trends should be interpreted with caution.

Progress on action plan

5.1	5.2	5.3
5.4	5.5	5.8
5.9	5.11	5.12
5.6	5.10	
5.7		

PRIORITY AREA 5: Reduce inequalities and improve sexual health outcomes

What has the previous strategy achieved?

New legislation for **Relationships Education/Relationships and Sex Education** to be **compulsory** in schools has been **implemented** locally.

A **local PSHE primary school coordinator** has been appointed.

Local consensus reached regarding the need for **pathways** between **sexual health services** and **services supporting vulnerable individuals** (e.g. Mental Health, substance misuse, learning disabilities)

Which areas of the previous strategy should be built upon?

Build on the **delivery of relationships and sex education (RSE) in schools:**

- Capture **information on content covered**
- Ensure that local RSE is **tailored to local need** and covers **access to local sexual health services**.
- Consider how best to **support schools** in delivering RSE.

Develop and implement robust **pathways** between **sexual health service** and **services that support vulnerable individuals**

Revisit the extent to which **NICE guidance on harmful sexual behavior** is being **implemented** in relevant plans.

Evaluation of previous strategy priority area 6: Tackling sexual violence

Progress on indicators

DIRECTION OF CHANGE	INDICATOR	TARGET ACHIEVED?
Worse	Rate of sexual violence offences	Not set

Progress on action plan

6.1	6.2	6.3
6.4	6.5	6.7
6.8	6.9	6.11
6.12	6.13	6.14
6.15	6.16	6.17
6.18	6.19	6.21
6.6	6.10	6.20

PRIORITY AREA 6: Tackling sexual violence

What has the previous strategy achieved?

An evidence-based approach to the primary prevention of sexual violence has been implemented:

- An **evidence review** for primary prevention strategies was undertaken.
- The **'Bystander approach'** was piloted in two local colleges and evaluated.
- The **'Bystander Green Dot programme'** is underway.

Actions have been taken locally to **prevent and reduce child sexual exploitation**.

Independent Sexual Violence Advisor pathways were **reviewed** and **improvements** made

Which areas of the previous strategy should be built upon?

Explore how training on the **'bystander' principles** could be **embedded** into the **community** and **local businesses**

Explore how **consent, sexual violence and media** is covered in **PHSE** lessons.

Continue to provide **sexual health outreach**, e.g. in brothels and saunas

Consider how to **reverse** the recent **increase in sexual violence**.

Review how **ISVA pathways** are currently operating, including **capacity**

Exploring ways to **prevent and reduce** the **sexual exploitation of vulnerable adults**.

LOCAL NEED: WHAT DOES THE DATA TELL US?

In 2022, a Sexual Health Needs Assessment was undertaken by the Public Health team at Blackpool Council. For the full report and data, please see the relevant sections of the Blackpool Joint Strategic Needs Assessment website:

- Main sexual health needs assessment: https://www.blackpooljsna.org.uk/Living-and-Working-Well/Health-Protection/Sexual-Health.aspx
- Teenage conceptions: https://www.blackpooljsna.org.uk/Developing-Well/Children-and-young-peoples-health/Teenage-Conceptions.aspx
- Termination of pregnancy: https://www.blackpooljsna.org.uk/Living-and-Working-Well/Health-Protection/Termination-of-Pregnancy.aspx

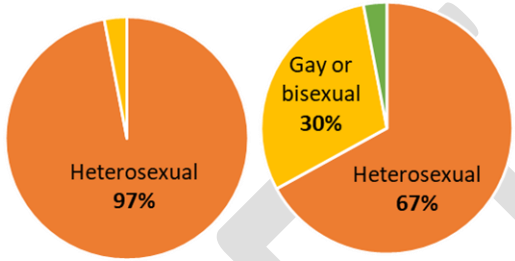
An overview of the Health Needs Assessment findings is presented below.

National ↓ in new diagnoses of STIs in 2020 – particularly STIs requiring **diagnosis by physical examination**

Rate of **new diagnoses** of STIs ↑ in Blackpool compared to England

STI testing **positivity rate** in Blackpool ↑ compared to NW and England

Of the 5 main STIs diagnosed in Blackpool:



FEMALES **MALES**

GENITAL WART infections ↓

HPV vaccination programme for young women and MSM up to age 45 years

Recent ↑ and then slight ↓ in new **GENITAL HERPES diagnoses** in Blackpool – maybe due to ↑ test sensitivity

STIs

46.5% of **new STI diagnoses** in Blackpool = **CHLAMYDIA**

Annual chlamydia **detection rate** ↑ compared to national rate AND > Public Health Outcomes Framework (PHOF) recommendation

Chlamydia testing **positivity rate** ↑ compared to national rate AND > National Chlamydia Screening Programme (NCSP) recommendation

	RECOMMENDATION	BLACKPOOL (2019)	NATIONAL (2019)
Annual detection rate (/ 100,000 15-24-year-olds)[1]	>=2300	2,776	2,058
Test positivity rate[2] (%)	5-12	12.5	10.0

[1]PHOF recommendation [2]NCSP recommendation

BUT… **recent ↓ in Blackpool** chlamydia detection rate

Rate of **GONORRHOEA diagnoses ↑** nationally, particularly **sharp ↑ in Blackpool**

Rate of **SYPHILIS diagnoses↑** in Blackpool and nationally

National concern at **↑ in gonorrhea and syphilis** amongst **MSM**

SEXUALLY TRANSMITTED INFECTIONS

Page 27

Prevalence of diagnosed HIV in Blackpool ↑ compared to nationally

Rate of **new diagnosis of HIV ↑ in Blackpool** compared to nationally

HIV testing coverage in Blackpool ↑ compared to the NW and nationally

HIV and AIDS

Of those living with HIV in Blackpool, likely acquisition is:

77% sex between men

18% sex between men and women

Routine screening for HIV in the Emergency Department in Blackpool Teaching Hospitals NHS Trust since November 2020

Proportion of late diagnoses in Blackpool ↓ compared to nationally

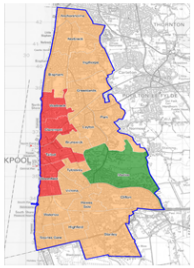
In Blackpool and nationally, **acquisition through sex between men** has ↓ over recent years

In 2021, **10,375 tests** recorded, including **7 new HIV diagnoses**

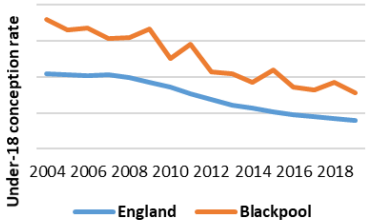
TEENAGE CONCEPTION

Under-18 and under-16 conception rates ↑ in Blackpool compared to England

Rate of teenage conception **varies widely within Blackpool**.



During 2004-2019, the **under-18 conception rate fell by 57% in Blackpool** – a **smaller reduction than for England** (62%).



TERMINATION OF PREGNANCY

Abortion rate is ↑ compared to England, and is **rising more quickly**.

38.2% of under-18 conceptions resulted in **abortion**: ↓ than in **England**. (2019)

IN BLACKPOOL

Under-18 abortion rate is ↑ compared to England, but ↓ **by >50%** during 2008-2019.

Abortion rate is **highest** for women aged **20-24 years**, then **25-29 years**.

EARLY ABORTION (<10 weeks) ≈ national rate

Early MEDICAL abortions ↑ compared to England

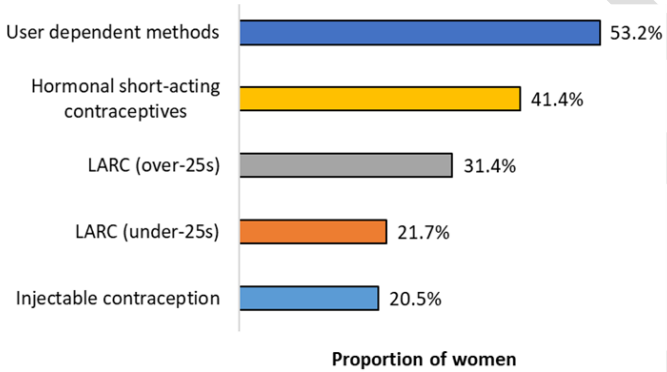
Proxy measures of service quality in Blackpool

REPEAT ABORTIONS ↑ compared to England and rising

ABORTIONS in under-25s FOLLOWING PREVIOUS BIRTH ↑ compared to England

CONTRACEPTION

Most popular choices of contraception in Blackpool in 2020:



Compared to England overall…

↑ Rate of emergency contraception provision by SHS in Blackpool (2019/20)

Proportion of female residents in Blackpool **accessing SHS for contraception ↑** compared to England (NB. ↓ during 2020/21 Covid-19 period)

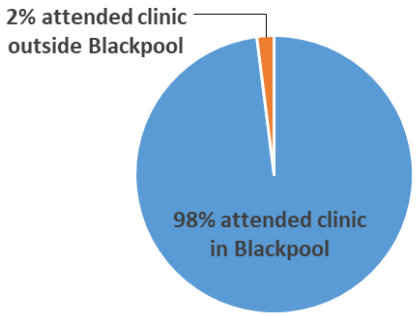
Blackpool residents accessing **contraception services** tend to be **younger.**

↑ LARC prescriptions in Blackpool (**highest rate in the country**) (NB. Local and national ↓ in LARC fittings and removals during 2020 'lockdown' periods.)

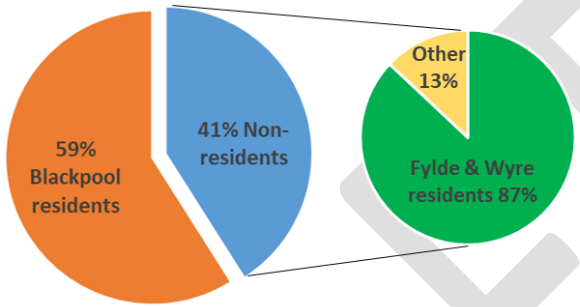
↑ Proportion of women having **hormonal contraceptive implant removed** in Blackpool – also ↑ relative to removal of other LARC methods.

DEMAND FOR SEXUAL HEALTH SERVICES (SHS)

Blackpool residents using SHS in 2019:



Patients using Blackpool SHS in 2019:



Proportion of first attendees at SHS who had **sexual health screen ↓ in 2020** (especially for age <19y)

HARM REDUCTION

Blackpool's recorded **crime rate for sexual offences** is **one of the highest** in the country.

↑in sexual offences in 2021 – possibly reflecting fewer offences during 2020 lockdown periods being offset by an ↑ in 2021.

Rape has the **greatest impact** in terms of **harm** in Blackpool.

HIGH RISK GROUPS

SEX WORKERS

Sex workers in Blackpool operate **on the street** and in venues such as **saunas and massage parlours**.

Often **have multiple vulnerabilities** (e.g. previous LAC, drug/alcohol misuse).

High level of self-reported **STIs, TOP** and **sexual assault** within this group.

VULNERABLE ADULTS (including those with LEARNING DISABILITIES)

Coping **with puberty, sexual identity and sexual feelings** can be **more difficult**.

The **sexual needs** of people with learning disabilities have **historically been ignored**.

PRISONERS ON DAY RELEASE

The sexual health of **prisoners on day release who spend their time in Blackpool** can place a significant **burden on prison health care** in treating associated **infections**.

LGBTQI COMMUNITY

Blackpool has a **large LGBTQI community**.

LGBTQI individuals experience **health inequalities** which are often **unrecognized** in health and social care settings.

May be **reluctant to disclose sexual orientation** due to **fear of discrimination** or poor treatment.

Healthcare/other professionals often **mistakenly assume** that the **needs of all** LGBTQI people are **the same**.

Research indicates that a **high proportion** of lesbian and bisexual women and gay and bisexual men have **never been tested for STIs**.

LOOKED AFTER CHILDREN (LAC)

Blackpool has the **highest rate of LAC** within England.

LAC often have **poorer sexual health.**

LAC may be at **↑ risk of**:
Involvement in **risky sexual activity**
Exploitive and **abusive** relationships
Early parenthood

Many LAC in Blackpool **come from other areas → little/no knowledge of local services**.

IMPACT OF COVID-19

COVID-19 has impacted on sexual health and sexual health services in a number of ways.

Data from the National Survey of Sexual Attitudes and Lifestyles (NATSAL) COVID study[13] suggests that in 2020, compared with in 2010, there was less sexual high risk behaviour, including lower reporting of multiple partners, new partners and condomless partners. There was an increased level of sexual dissatisfaction and distress. Compared with the previous decade, in 2020 there was a lower use of STI related services, lower levels of chlamydia testing and fewer conceptions and abortions.

Overall, diagnoses of STIs decreased in 2020 and 2021, with a decrease of 33.2% from 2019 to 2021.[14] This decline likely reflects a combination of reduced STI testing as a result of disruption to sexual health services leading to fewer diagnoses, and changes in behaviour during the coronavirus pandemic which may have reduced STI transmission. Despite the fall in diagnoses, STI diagnoses overall remain high.

COVID-19 resulted in a reduction in the overall number of sexual health service consultations undertaken during 2020. However, this trend has now been reversed, with an overall increase in sexual health service consultations of 3.9% from 2019 to 2021.[14] During 2020, there was a substantial decline in the number of sexual health screens undertaken, and, although this number is now rising again, there was still an overall 13.2% reduction between 2019 and 2021.[14] Sexual health services both nationally and locally made significant adaptations to their services during the pandemic, with the introduction or expansion of online services (including testing) and remote consultations accompanying face-to-face consultation for those in urgent need.

WHAT ARE STAKEHOLDERS TELLING US?

Individual consultations were held with a range of local stakeholders between August and November 2022, to explore the areas which they perceived to be of high priority for sexual health in Blackpool. Stakeholder views have informed the development of this strategy.

An overview of the topics that arose within stakeholder discussions is shown below.

Sexually transmitted infections Syphilis STI testing HPV vaccine	**HIV** Testing Pre-Exposure Prophylaxis (PrEP) Complex needs and co-morbidities
Contraception Condoms, including barriers to use Training/upskilling in Long-Acting Reversible Contraception	**Personal, social, health and economic (PSHE) education** Empowerment to be able to negotiate safe sex Practical information about sexual health services Practical information about condom use
Tackling inequalities Better data on ethnicity Holistic support for sex workers Reducing inequalities faced by LGBTQI groups Support for drug and alcohol users	**Access to sexual health services** Digital/remote access options Face-to-face access options Drop-in clinics Sexual health outreach work
Ways of working Collaborative working Multi-agency, fast-track pathways Commissioning and tendering Service user consultation	**Data** Comparisons with statistical neighbours Learning from other areas Effects of integrating services on performance data

Topics arising during stakeholder discussions, August – November 2022

WHAT ARE YOUNG PEOPLE TELLING US?

A consultation was held with local young people, facilitated by Healthwatch Blackpool, to explore their views and experiences in relation to sexual health and services in Blackpool. The views of the young people have informed the development of this strategy.

An overview of the topics that arose within the discussion with young people is shown below.

Accessing sexual health services (SHS) Discretion / privacy Opening times Transport	**Peer influence** Positive influences Negative influences, and peer pressure to be sexually active
Messaging Positive promotion of sexual health checks Use of social media Balance between emphasizing discretion of SHS and yet normalizing attendance at a sexual health clinic	**Relationships and sex education in schools/colleges** Sexually transmitted infections Practical information about SHS Practical information about condom use Greater focus on non-heterosexual sex Better coverage of unplanned pregnancy and abortion Links to topical news stories, e.g. monkey pox
LGBTQI groups Stigma and discrimination within school/college pupils Barriers to accessing support Importance of education in removing and challenging stigma	**Unplanned pregnancy** Importance of not normalizing underage sex Stigma attached to unplanned pregnancy and abortion Barriers to accessing pregnancy tests
Gynaecological conditions in young people (e.g. PCOS, endometriosis) Support for those who experience these conditions	**Sexual violence** Desire for safer streets with better street lighting Accessibility of support for victims of sexual assault Barriers to talking about male rape

Topics arising during the consultation with young people, November 2022

OUR NEW STRATEGY

Based upon national context, local data, evaluation of the previous strategy and consultations with stakeholders and young people, a new strategy for sexual health in Blackpool has been produced.

Vision

For everyone to be supported to achieve their optimal sexual health and wellbeing, regardless of their circumstances, and to be able to access the sexual health services that they need, when they need them.

Guiding principles

- **Quality**: Provide services of high quality
- **Accessible**: Provide services that are accessible to all
- **Collaborative**: Work in partnership across clinical and non-clinical services
- **Place-based:** Adopt a place-based approach
- **Co-produced**: Work with service users to design and deliver services
- **Innovative**: Be creative in delivering services that are integrated, efficient and provide value for money

Priority areas

Priority area 1: Prevent and reduce the transmission of sexually transmitted infections

Priority area 2: Reduce unplanned pregnancy

Priority area 3: Improve prevention, testing, treatment and support for people living with HIV

Priority area 4: Provide young people with the skills, support and services that they need to achieve optimal sexual health

Priority area 5: Reduce inequalities in sexual health

Priority area 6: Tackle sexual violence

Our vision For everyone to be supported to achieve their optimal sexual health and wellbeing, regardless of their circumstances, and to be able to access the sexual health services that they need, when they need them.

The areas we will focus on

Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Priority 6
Prevent and reduce the transmission of sexually transmitted infections	Reduce unplanned pregnancy	Improve prevention, testing, treatment and support for people living with HIV	Provide young people with the skills, support and services that they need to achieve optimal sexual health	Reduce inequalities in sexual health	Tackle sexual violence

Guiding principles	Quality	Accessible	Collaborative	Place-based	Co-produced	Innovative

Priority area 1: Prevent and reduce the transmission of STIs

Objectives

1. **Increase opportunistic sexually transmitted infection (STI) testing in non-sexual health settings.**

2. **Provide choice in patient access to STI testing, building upon recent digital innovation whilst also ensuring that those who need or prefer to access services in person are still able to do so.**

3. **Promote condom use.**

What does the evidence tell us?

The National Institute for Health and Care Excellence (NICE) have concluded that evidence supports the use of remote self-sampling kits to test for STIs. STI testing uptake is significantly higher in home self-sampling than in clinic-based testing, and is generally well received, provided that the sampling kit is practical, well-designed and accessible. The evidence also indicated that self-sampling can help minimise issues around stigma and embarrassment that are common in clinic testing.[15]

There is moderate evidence that Chlamydia screening is effective in reducing the development of sequelae (pelvic inflammatory disease), but evidence is currently lacking for the effect of screening on population prevalence of Chlamydia.[16, 17] As a result of the English National Chlamydia Screening Programme (NCSP) Evidence Review, the aim of the NCSP has now changed to a focus on reducing the harms from untreated chlamydia infection. The harmful effects of chlamydia occur predominantly in women, and so the opportunistic offer of asymptomatic chlamydia screening outside of sexual health services now focuses on women, combined with reducing time to test results and treatment, strengthening partner notification and retesting.[18]

Evidence of the impact of vaccination has shown reductions in HPV type 16/18 infection, genital warts, pre-cancerous lesions and cervical cancer among vaccinated cohorts.[19] Based upon the available evidence, the Joint Committee for Vaccinations and Immunisations currently recommends that the HPV vaccine is offered to all adolescents (boys and girls) in school Year 8 (usually aged 12 and 13), and to men who have sex with men up to and including 45 years of age who are attending specialist sexual health services and/or HIV clinics, regardless of risk, sexual behaviour or disease status.[20]

Action plan

A detailed, stakeholder-led action plan has been developed to address the objectives identified within this priority area.

How will we measure success?

Success will be measured by improvement in the following indicators:

- New STIs diagnoses (excluding chlamydia aged under 25 years)
- STI testing rate
- STI testing positivity rate
- Chlamydia detection rate for females aged 15 – 24 years

Priority area 2: Reduce unplanned pregnancy

Objectives

1. **Reduce the rate of teenage pregnancy amongst Our Children.**

2. **Develop a robust training programme for long-acting reversible contraception (LARC) fitting for non-specialist healthcare professionals.**

3. **Build upon work to promote LARC uptake to women with complex needs, including those with substance misuse issues and asylum seekers.**

4. **Build upon work to embed LARC provision within maternity services.**

5. **Improve LARC provision in medical termination of pregnancy services.**

6. **Work towards establishing Women's Health Hubs within primary care networks and tier 3 sexual and reproductive health services.**

What does the evidence tell us?

NICE provide evidence-based recommendations on how best to deliver contraceptive services to under-25s, including a review of the evidence for different types of interventions to prevent teenage pregnancy.[21]

Every £1 spent preventing teenage pregnancy saves £11 in health care costs.[22]

Implantable methods of long-acting reversible contraception are highly effective contraceptive methods.[23] From an NHS perspective, LARC methods of contraception are cost-effective, and are more cost-effective than the combined oral contraceptive pill.[24] A systematic review is currently underway to assess the effectiveness of interventions designed to increase access to LARC.[25]

Action plan

A detailed, stakeholder-led action plan has been developed to address the objectives identified within this priority area.

How will we measure success?

Success will be measured by improvement in the following indicators:

- Under-18s conception rate
- Rate of total prescribed LARC excluding injections in females aged 15-44 years
- Under-25s repeat abortions (%)
- Under-25s abortion after a birth (%)

Priority area 3:

Improve prevention, testing, treatment and support for people living with HIV

Objectives

1. **Help individuals to maintain their negative HIV status through greater awareness and uptake of pre-exposure propyhlaxis.**

2. **Reduce the number of people living with undiagnosed HIV**
   a) **Increase the offer and uptake of HIV testing in primary care**
   b) **Further increase uptake of opt-out HIV testing in the Emergency Department**
   c) **Increase awareness of HIV testing within both sexual health services and wider, non-sexual health settings.**
   d) **Continue to minimize the number of late diagnoses of HIV.**
   e) **Improve the process of partner notification.**

3. **Reduce the number of individuals with a transmissible level of HIV by minimizing loss to follow-up and maximizing engagement with services.**

4. **Monitor and improve the quality of services to support people living with HIV, especially those facing multiple disadvantage.**

What does the evidence tell us?

HIV transmission in the UK has continued to fall, particularly amongst gay, bisexual and other men who have sex with men.[26] The Joint United Nations Programme on HIV/AIDS (UNAIDS) previously set a global '90-90-90' target for 90% of people living with HIV to be diagnosed, 90% of people diagnosed to be receiving anti-retroviral therapy (ART) and 90% of people on treatment to be virally suppressed and unable to pass on the infection.[27a] These targets are estimated to have been exceeded in Blackpool: in 2021, 94.7% of people living with HIV were diagnosed with HIV, 99.8% of people diagnosed with HIV were on ART and 97.4% of people on ART were virally suppressed.* The original UNAIDS 90-90-90 targets have now been updated and expanded.[27b] In England in 2021, the Department for Health and Social Care stated its ambition to achieve zero new HIV infections, AIDS and HIV-related deaths in England by 2030.[4]

**Estimates provided by UK Health Security Agency (UKHSA) HIV analysts, based upon estimates from the HIV/AIDS Reporting System and a Bayesian multi-parameter evidence synthesis (MPES) model.*

Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person. People with HIV who have been on treatment and show undetectable levels of the virus for at least six months are unable to pass HIV on.[26]

Early testing and diagnosis of HIV reduces treatment costs – £12,600 per annum per patient, compared with £23,442 with a later diagnosis.[2] Offering and recommending HIV testing in primary care and hospital settings has been shown to be acceptable and feasible to patients and staff, operationally feasible, successful in identifying and transferring to care HIV-positive patients, and also cost-effective.[28,29] However, additional staff training and infrastructural resources are required.[29]

Pre-exposure prophylaxis (PrEP) is a course of HIV drugs taken before sex to reduce the risk of getting HIV. The UK's PROUD study reported an 86% reduction in the risk of HIV infections in men who have sex with men who were taking PrEP. The trial provided evidence for the effectiveness of PrEP in a real-world setting.[30] From 2020, PrEP has been available in England free of charge on the NHS from sexual health clinics, for those at higher risk of HIV.[31]

Action plan

A detailed, stakeholder-led action plan has been developed to address the objectives identified within this priority area.

How will we measure success?

Success will be measured by improvements in the following indicators:

- HIV testing coverage (%)
- HIV late diagnosis (%)

Priority area 4:

Provide young people with the skills, support and services that they need to achieve optimal sexual health

Objectives

1. **Ensure that the content of Personal, Social, Health and Economic (PSHE) education is tailored to local need, is co-produced with young people and includes information about how to access local sexual health services.**

2. **Through consultation and co-production, ensure that the design and delivery of sexual health services meet the needs of local young people.**

3. **Work with young people to ensure consistent, localised and appropriate messaging regarding sexual health.**

4. **Provide fast-track pathways into appropriate services for young people at risk of poor sexual health outcomes.**

5. **Review and improve the extent to which NICE guidance on harmful sexual behaviour is being implemented within educational settings.**

What does the evidence tell us?

Locally, through an online survey and subsequent focus group, Healthwatch Blackpool have published a report about young people's views and experiences of accessing local sexual health services.[32] Contraception and combined contraception and sexual health screening were the most common reasons for young people visiting services, and those who accessed sexual health services rated their experience highly. The report highlighted a lack of awareness amongst young people of information related to sexual health and sexual health services. Recommendations were made for improvements to make sexual health services more accessible to young people.

Research shows that comprehensive sex and STD/HIV education programmes positively affect young people's sexual behaviour, including both delaying initiation of sex and increasing condom and contraceptive use.[33] Hence, a broad, comprehensive programme of sex and relationships education, that includes learning about contraception, is essential.

Action plan

A detailed, stakeholder-led action plan has been developed to address the objectives identified within this priority area.

How will we measure success?

Success will be measured by the following:

- Reduction in re-infection rates in 15-19 year olds (male and female)
- Improvements in knowledge and behaviour in SHEU survey responses that are relevant to sexual health and sexual behavior.
- Review of young people's feedback within the SHEU survey on the delivery of PSHE education related to sexual health
- Review of attendance rate at the PSHE Forum by local PSHE leads for schools.
- Repeat of a young people's sexual health survey to help inform sexual health service improvements

Priority area 5: Reduce inequalities in sexual health

Objectives

1. **Improve access to sexual health services for those with complex needs.**

2. **Ensure that sexual health services meet the needs of LGBTQI individuals.**

3. **Ensure that local services meet the sexual health needs of Our Children and Care Leavers.**

4. **Improve the delivery of sexual health services to refugees and asylum seekers.**

What does the evidence tell us?

The State of the Nation report[34], produced by the Terrence Higgins Trust and the British Association for Sexual Health and HIV (BASHH) identified that:

- Men who have sex with men, young people and some ethnic minority communities are among those disproportionately impacted by STIs.
- Individuals living in poverty experience higher rates of STIs.
- Current available research does not provide an adequate understanding of the inequalities in sexual health, with little focus on the impact of structural inequalities on STIs.

A recent systematic review provides evidence for different types of interventions to improve the health of sex workers. The review found that those new to working in an area faced greater challenges in accessing services, and that data on interventions were scarce for male, transgender, and indoor-based sex workers. Co-designed and co-delivered interventions that are either multicomponent or focus on education and empowerment are most likely to be effective.[35]

Action plan

A detailed, stakeholder-led action plan has been developed to address the objectives identified within this priority area.

How will we measure success?

Success will be measured by the following:

- Increase in LARC uptake in women facing multiple disadvantage (measured via the method developed in actions for priority area 5, objective 1).

- Feedback from individuals facing multiple disadvantage about the quality of and access to sexual health services (collated through the action listed in priority area 5, objective 1).

Priority area 6: Tackle sexual violence

Objectives

1. **Adopt a Public Health approach to tackling sexual violence, including primary prevention programmes.**

2. **Improve education to young people about consent, sexual violence and media.**

3. **Provide high quality services for victims of rape and sexual violence.**

4. **Reduce barriers to proceeding with prosecution for victims of sexual violence crimes.**

5. **Prevent and reduce the sexual exploitation of children, young adults and adults in Blackpool.**

6. **Create safer streets, especially after dark.**

What does the evidence tell us?

A recently published qualitative evidence synthesis provides insight into how survivors, family members and professionals experience different types of psychosocial interventions in the aftermath of sexual abuse and violence.[36] The review explores how different features of the contexts and the interventions influence the extent to which an individual can benefit from the intervention. Interventions were found to not only benefit survivors' mental health, but also have wider positive impacts, including on their physical health, mood, understanding of trauma, interpersonal relationships and on re-engagement with other areas of their lives. The review identified that further research is needed to explore the experiences of male survivors of sexual abuse and violence and of those from minority groups.

Evidence-based NICE guidelines provide best practice recommendations for managing children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences.[37] The guidance aims to ensure these problems don't escalate and possibly lead to the child or young person being charged with a sexual offence.

There is a growing body of evidence that a variety of 'bystander' interventions can be effective in preventing the perpetration of intimate partner and sexual violence.[38,39] Research has identified nine principles that are strongly associated with positive effects across multiple public health programmes and that should be considered when implementing primary prevention strategies, including bystander programmes.[38]

Action plan

A detailed, stakeholder-led action plan has been developed to address the objectives identified within this priority area.

How will we measure success?

Success will be measured by the following:

- Reduction in the rate of sexual violence offences
- Feedback captured from local PSHE leads about the delivery of education related to consent, sexual violence and media

Governance: How will this strategy be delivered?

Oversight

Performance will be monitored by the Blackpool Council Public Health Senior Management Team, who will support progress of key elements of the strategic approach to improving sexual health in Blackpool. This will include ensuring alignment with cross cutting strategies and actions plans. A range of boards and groups across Blackpool will also play a role in providing oversight of the strategy and implementing the action plan, as shown in the figure below.

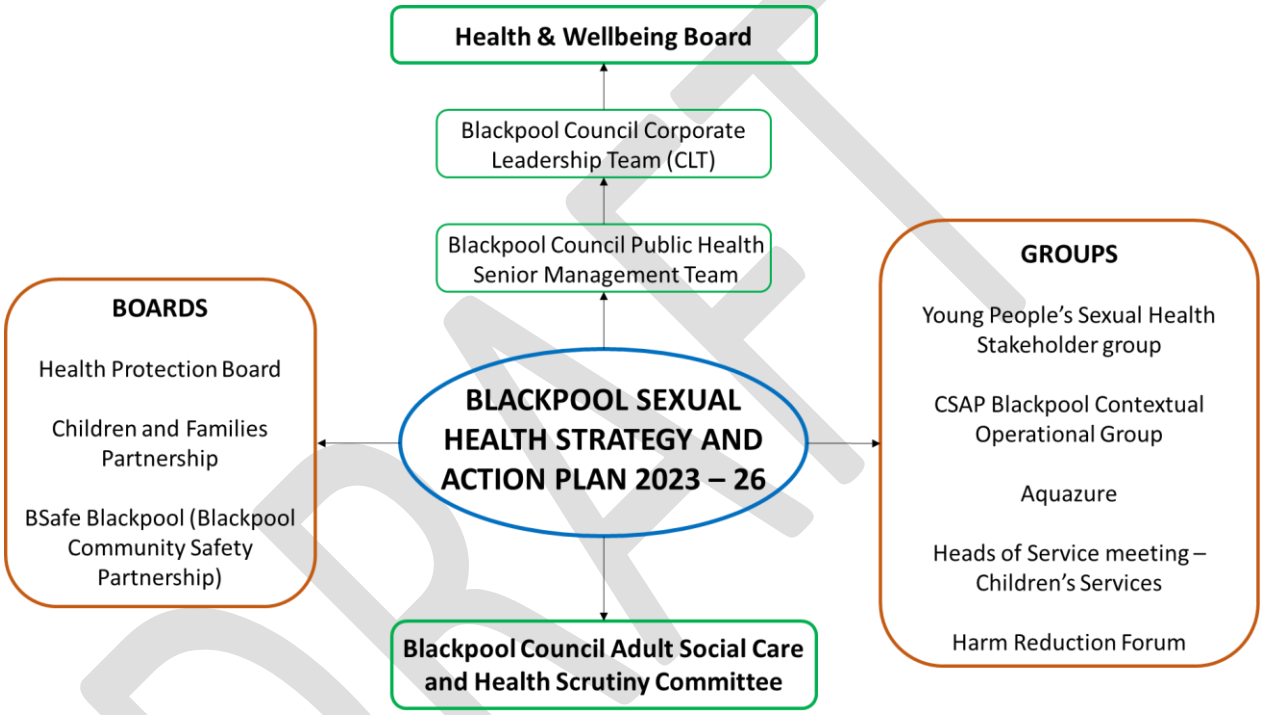


Figure 1. Boards and groups across Blackpool who will play a role in providing oversight of the strategy and implementing the action plan.

The strategy will be implemented by an action plan, managed via a multi-agency Sexual Health Strategy Group. This will be set up and led by the lead commissioner for Sexual Health within the Public Health Team, and will consist of stakeholders from a range of internal teams and external organisations based within Blackpool. The Sexual Health Strategy Group will meet regularly and will review progress made in relation to the strategy. Progress will be reviewed through the following:

- Assessment of progress made in relation to indicators identified within each priority area of the strategy
- Review of the status of each action within the action plan
- Overall assessment of the direction of progress in relation to each priority area

GLOSSARY OF TERMS

AIDS	Acquired Immunodeficiency Syndrome
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
BTH	Blackpool Teaching Hospitals NHS Foundation Trust
CLT	Corporate Leadership Team
Complex needs	Needs that are complex due to underlying vulnerabilities, including (but not limited to) substance misuse, homelessness, contact with the criminal justice system, domestic violence, Mental Health issues, physical co-morbidities, learning disabilities and autistic spectrum disorders, refugee/asyslum seeker status.
CSAP	Children's Safeguarding Assurance Partnership
ED	Emergency Department
FSRH	Faculty of Sexual and Reproductive Healthcare
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ISVA	Independent Sexual Violence Advisor
JSNA	Joint Strategic Needs Assessment
LARC	Long Acting Reversible Contraception
LET	Lived Experience Team
LGBTQI	LGBTQI is an umbrella term for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and others
MSM	Men who have Sex with Men
Multiple disadvantage	People experiencing a combination of some or all of the following: substance misuse, homelessness, contact with the criminal justice system, domestic violence and Mental Health issues.
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities
Our Children	A child who has been in the care of their local authority for more than 24 hours is known as a 'looked after child'. Looked after children are also often referred to as 'children in care'. In Blackpool, children who are in our care are referred to as 'Our Children'.
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PSHE	Personal, Social, Health and Economic Education
SHEU	Schools and Student Health Education Unit
SMT	Senior Management Team
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy or abortion
WHO	World Health Organization

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APPENDIX 1. List of data sources used for evaluation of previous sexual health strategy

Local data on sexual violence offences provided by Lancashire Police

Office for Health Improvement and Disparities, Fingertips Public Health data

Public Health England, Blackpool local authority HIV, sexual and reproductive health epidemiology report (LASER): 2015, December 2016

School Health Education Unit (SHEU) surveys of young people in Blackpool, 2015 and 2019

UKHSA SPLASH Supplement Report for Blackpool, June 2022

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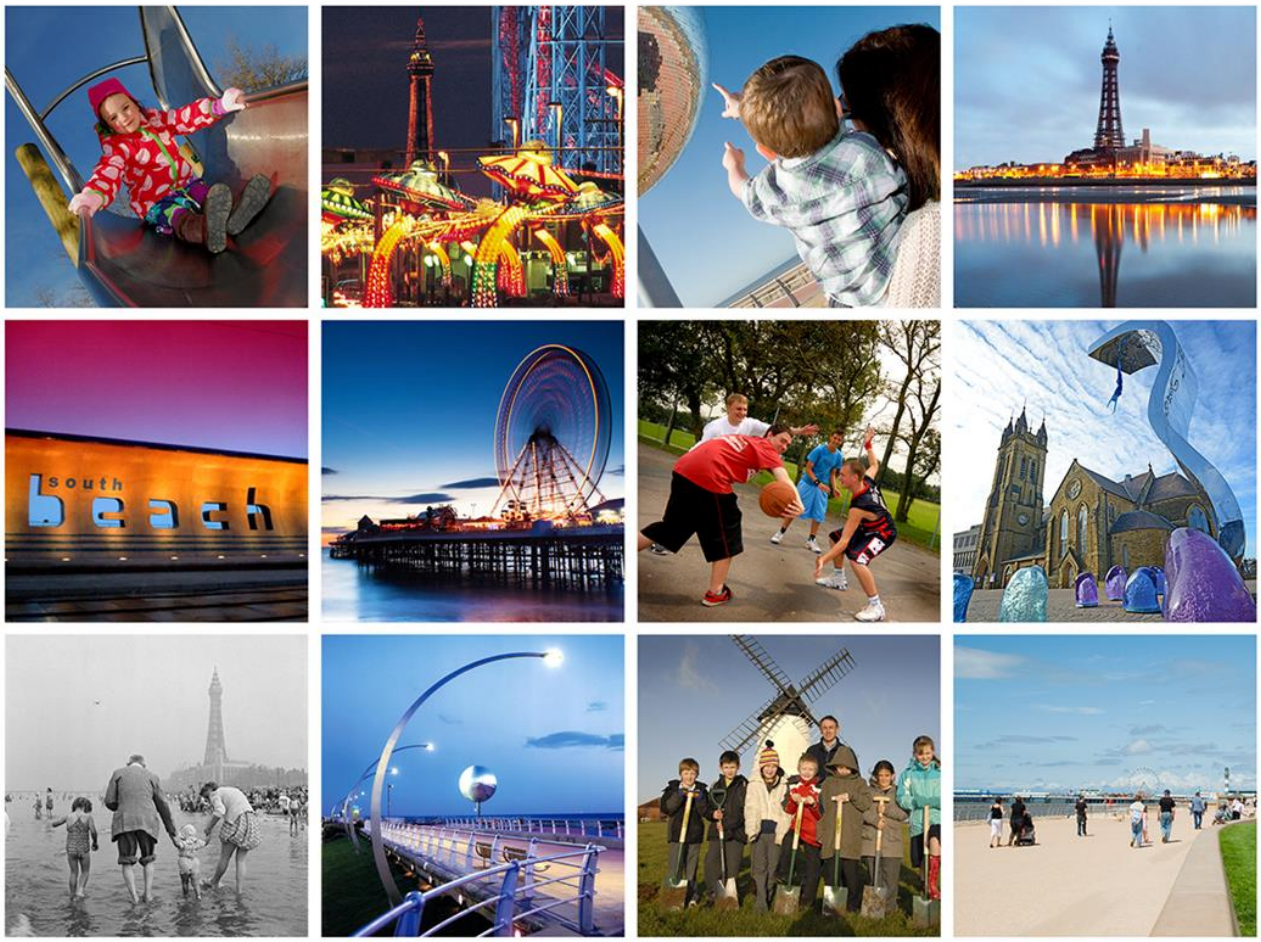
Blackpool Sexual Health Strategy

2023 – 2026:

ACTION PLAN

Blackpool Council



Version number: **10**

Date: **October 2023**

Our vision For everyone to be supported to achieve their optimal sexual health and wellbeing, regardless of their circumstances, and to be able to access the sexual health services that they need, when they need them.

The areas we will focus on

Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Priority 6
Prevent and reduce the transmission of sexually transmitted infections	Reduce unplanned pregnancy	Improve prevention, testing, treatment and support for people living with HIV	Provide young people with the skills, support and services that they need to achieve optimal sexual health	Reduce inequalities in sexual health	Tackle sexual violence

Guiding principles	Quality	Accessible	Collaborative	Place-based	Co-produced	Innovative

Priority area 1: Prevent and reduce the transmission of STIs

Objectives

1. **Increase opportunistic sexually transmitted infection (STI) testing in non-sexual health settings.**

2. **Provide choice in patient access to STI testing, building upon recent digital innovation whilst also ensuring that those who need or prefer to access services in person are still able to do so.**

3. **Promote condom use.**

Action plan

OBJECTIVE	ACTION	ESTIMATED TARGET COMPLETION DATE
1. Increase opportunistic STI testing in non-sexual health settings	1.1 Include STI testing in the health offer made by drug and alcohol clinical/treatment services.	Dec 2023
	1.2 Ensure that the Public Health behaviour change training offer includes training for frontline practitioners in clinical and non-clinical settings (including outreach workers) on: • Having conversations about sexual health • Delivering brief interventions for sexual health	Mar 2024
	1.3 Promote and improve uptake of the Public Health behaviour change training offer on sexual health to non-sexual health settings, including outreach services and services supporting individuals with complex needs.	Jun 2024
	1.4 Explore ways to increase the uptake of chlamydia testing in medical termination of pregnancy services.	Oct 2023
	1.5 Explore whether phlebotomy training can be offered to drug and alcohol services.	Dec 2023
2. Provide choice in patient access to STI testing, building upon recent digital innovation whilst also ensuring that those who need or prefer to access services in person are still able to do so	1.6 Develop an online booking system for specialist sexual health services (including developing online consultancy).	May 2024
	1.7 Review and consider the optimal mix of booked versus drop-in appointment options for clinical sexual health services.	Jan 2024
	1.8 Explore whether modifications could be made to the online sexual health service to further improve access to testing and patient experience.	Sep 2023
3. Promote condom use	1.9 Ensure that BTH include safer sex/condom use in any sexual health campaigns.	Ongoing – review biannually
	1.10 Develop a targeted campaign around safer sex/condom use to the MSM group.	Mar 2024

Priority area 2: Reduce unplanned pregnancy

Objectives

1. **Reduce the rate of teenage pregnancy amongst Our Children.**

2. **Develop a robust training programme for long-acting reversible contraception (LARC) fitting for non-specialist healthcare professionals.**

3. **Build upon work to promote LARC uptake to women with complex needs, including those with substance misuse issues and asylum seekers.**

4. **Build upon work to embed LARC provision within maternity services.**

5. **Improve LARC provision in medical termination of pregnancy services.**

6. **Work towards establishing Women's Health Hubs within primary care networks and tier 3 sexual and reproductive health services.**

Action plan

OBJECTIVE	ACTION	ESTIMATED TARGET COMPLETION DATE
1. Reduce the rate of teenage pregnancy amongst Our Children	2.1 Establish a rolling programme of education for foster carers and Personal Advisers about contraception and prevention of unplanned pregnancy.	Jun 2024
	2.2 Expand domiciliary sexual health nursing provision to provide an outreach service to children's homes and Our Children.	Feb 2024
	2.3 Provide training to Supporting Our Children Social workers and Personal Advisers for Our Children in having regular conversations about sexual health with children for whom they are responsible.	Oct 2023
	2.4 Explore the feasibility of establishing a text reminder service for young people on Depot contraception.	Nov 2023
2. Develop a robust training programme for LARC fitting for non-specialist healthcare professionals	2.5 Map and review which professionals and/or services within primary care are providing LARC fitting.	Oct 2023
	2.6 Increase uptake of training in LARC fitting for services and/or professionals identified in the above review.	May 2024
3. Build upon work to promote LARC uptake to women with complex needs, including those with substance misuse issues and asylum seekers.	2.7 Expand the Harm Reduction Forum to include maternity and other reproductive services.	Sep 2023
	2.8 Identify whether there is interest in holding an annual multi-agency conference for frontline workers in sexual health to share information about existing service provision.	Apr 2024
	2.9 Increase uptake of LARC in women who access the Early Parenthood Service.	Mar 2025
	*Also see action **5.20** (outreach contraceptive clinic for refugees and asylum seekers).*	

4. Build upon work to embed LARC provision within maternity services.	2.10 Explore the opportunity of using the London Measure of Unplanned Pregnancy to measure the rate of unplanned pregnancy and to support targeted interventions for contraception.	Dec 2023
	2.11 When the new senior midwifery team is in post, explore the use of the Depot injection before discharge from midwifery.	Dec 2023
	2.12 Establish a training programme in postnatal contraception for doctors working in Obstetrics and Gynaecology.	Nov 2024
	2.13 Explore the feasibility of offering depot injections and the progesterone-only pill (POP) routinely after childbirth if a LARC method is inappropriate or not available, including the option of expanding the current Patient Group Directive for contraception to cover midwives for Depot injections and POP.	Jan 2025
5. Improve LARC provision in medical termination of pregnancy (TOP) services	2.14 Establish a robust pathway for LARC provision for women undergoing medical TOP.	Apr 2024
6. Work towards establishing Women's Health Hubs within primary care networks and tier 3 sexual and reproductive health services.	2.15 Explore the business case to establish an intermediate Women's Health Hub at Whitegate Drive.	Oct 2024
	2.16 Pilot a Women's Health Hub in the South Shore Primary Care Network.	Jul 2023
Objectives 1 - 5	2.17 Amend existing LARC removal templates to include a standard conversation for women requesting early removal of LARC.	Apr 2024
Other	2.18 Review future risk in relation to access to termination of pregnancy services for women with complex needs, and identify potential options for the future.	Dec 2024

Priority area 3: Improve prevention, testing, treatment and support for people living with HIV

Objectives

1. **Help individuals to maintain their negative HIV status through greater awareness and uptake of pre-exposure propyhlaxis.**

2. **Reduce the number of people living with undiagnosed HIV**
   a) **Increase the offer and uptake of HIV testing in primary care**
   b) **Further increase uptake of opt-out HIV testing in the Emergency Department**
   c) **Increase awareness of HIV testing within both sexual health services and wider, non-sexual health settings.**
   d) **Continue to minimize the number of late diagnoses of HIV.**
   e) **Improve the process of partner notification.**

3. **Reduce the number of individuals with a transmissible level of HIV by minimizing loss to follow-up and maximizing engagement with services.**

4. **Monitor and improve the quality of services to support people living with HIV, especially those facing multiple disadvantage.**

Action plan

OBJECTIVE		ACTION	ESTIMATED TARGET COMPLETION DATE
All objectives		3.1 Explore the option of a clinical and non-clinical collaborative training programme to improve knowledge and understanding of HIV testing, treatment and prevention (e.g. PrEP, PEP) for vulnerable groups.	Mar 2024
		3.2 Blackpool to join the 'Fast Track Cities' initiative, and sign up to the Paris Declaration.	Sept 2024
1. Help individuals to maintain their negative HIV status through greater awareness and uptake of Pre-exposure prophylaxis (PrEP)		3.3 Develop a standard protocol for administering post-exposure prophylaxis (PEP) that includes consideration of long-term PrEP.	Oct 2023
		*Also see action **4.3** (covering the topic of PrEP within PSHE lessons).*	
2. Reduce the number of people living with undiagnosed HIV	**All parts of Objective 2**	3.4 Explore additional opportunities to increase uptake of HIV testing by those in ethnic minority groups, particularly people of Black African ethnicity.	Mar 2024
	(a) Increase the offer and uptake of HIV testing in primary care	3.5 Work with the Lancashire and South Cumbria Integrated Care Board/Place-Based Partnership to increase uptake of training on HIV testing in primary care.	June 2025
	(b) Further increase uptake of opt-out HIV testing in the Emergency Department	3.6 Increase testing in the Emergency Department through the inclusion of the Same Day Emergency Clinic (SDEC).	Jun 2023
		3.7 Continue to explore ways to increase uptake of HIV testing in the ED.	Ongoing

	(c) Increase awareness of HIV testing within both sexual health services and wider, non-sexual health settings	3.8 Engage with services that support vulnerable individuals (e.g. services supporting those with learning disabilities and autistic spectrum disorders, Mental Health difficulties, substance misuse issues and those experiencing domestic abuse) to ensure and facilitate staff access to local HIV awareness training.	Mar 2024
		3.9 Develop and implement a marketing plan and campaign(s) to promote awareness of HIV testing and PrEP.	Jun 2023
		3.10 Develop a brief training/awareness podcast for sharing with primary and secondary care services, to promote the need for routine HIV testing and increase awareness of how to clinically recognize a patient with HIV.	Apr 2024
	(d) Continue to minimize the number of late diagnoses of HIV	3.11 Review the processes by which all late diagnoses of HIV are investigated.	Nov 2023
	(e) Improve the process of partner notification	3.12 Review the 2019 partner notification audit and undertake a re-audit to compare results and explore compliance with BHIVA targets.	Oct 2023
3. Reduce the number of individuals with a transmissible level of HIV by minimizing loss to follow-up and maximizing engagement with services		3.13 Review and ratify the recall policy in place to reduce lost to follow-up and promote engagement with the services.	Aug 2023
		3.14 Undertake an audit of the recall policy to explore the extent to which patients are being managed in accordance with the policy.	Mar 2024
		3.15 Develop a specific pathway to support individuals with HIV who have been lost to follow up for over 12 months to re-engage with treatment services.	Feb 2024
4. Monitor and improve the quality of services to support people living with HIV, especially those facing multiple disadvantage.		3.16 Continue to hold weekly HIV MDT meetings.	Ongoing (bi-annual review)
		3.17 Continue to ensure representation from HIV services at MDT meetings across wider services, e.g. Mental Health, maternity, dermatology, oncology, etc.	Ongoing (bi-annual review)

	3.18 Explore whether to re-establish quarterly meetings between clinical and non-clinical HIV services.	Jul 2023
	3.19 Explore the option of developing a joint service user group with clinical and non-clinical HIV services.	Jan 2024
	3.20 Explore the need for a befriending service for those living with HIV, to run alongside the HIV Support Service.	Feb 2024

Priority area 4: Provide young people with the skills, support and services that they need to achieve optimal sexual health

Objectives

1. **Ensure that the content of Personal, Social, Health and Economic (PSHE) education is tailored to local need, is co-produced with young people and includes information about how to access local sexual health services.**

2. **Through consultation and co-production, ensure that the design and delivery of sexual health services meet the needs of local young people.**

3. **Work with young people to ensure consistent, localised and appropriate messaging regarding sexual health.**

4. **Provide fast-track pathways into appropriate services for young people at risk of poor sexual health outcomes.**

5. **Review and improve the extent to which NICE guidance on harmful sexual behaviour is being implemented within educational settings.**

Action plan

OBJECTIVE	ACTION	ESTIMATED TARGET COMPLETION DATE
1. Ensure that the content of Personal, Social, Health and Economic (PSHE) education is tailored to local need, is co-produced with young people and includes information about how to access local sexual health services	4.1 Facilitate consultation work with young people to explore the extent to which content of PSHE lessons meet their needs.	Nov 2023
	4.2 Review the current content of PSHE education locally, including the extent to which is tailored to local context. Develop an action plan, co-produced with young people, to make improvements as needed.	Jan 2024
	4.3 Ensure that the topics of HIV and PrEP are covered robustly within local PSHE lessons.	Jan 2024
	4.4 Ensure that local PSHE content includes the topics of consent, sexual violence and media.	Dec 2024
	4.5 Undertake consultation work with young people to explore their views on how PSHE education could help address stigma associated with identifying as LGBTQI.	Jun 2024
	4.6 Through the SHEU survey, explore new ways to capture young people's feedback on PSHE education related to sexual health.	Nov 2024
2. Through consultation and co-production, ensure that the design and delivery of sexual health services meet the needs of local young people	4.7 Consult with young people to explore whether opening times of sexual health services could be amended to better meet their needs.	Aug 2023
	4.8 Explore young people's views on the locations from which young people are most likely to access condoms.	Aug 2023
	4.9 Explore what role Family Hubs could play, if any, in promoting sexual health and/or delivering sexual health services for young people.	Oct 2023
	4.10 Review the current training offer around sexual health for early help practitioners and school nursing staff.	Oct 2023

	4.11 Explore the option of developing a training offer on brief intervention for sexual health for early help practitioners and school nursing staff.	Feb 2024
3. Work with young people to ensure consistent, localised and appropriate messaging regarding sexual health	4.12 Through the young people's sexual health stakeholder group, set up a working group of young people and stakeholders from relevant agencies to develop appropriate campaigns and messaging around sexual health.	Apr 2024
4. Provide fast-track pathways into appropriate services for young people at risk of poor sexual health outcomes	4.13 Link to actions **5.2, 5.3 and 5.4** (section 5) for developing fast-track and domiciliary care pathways, to consider how to amend these pathways for young people (e.g. considering links with school nursing).	As per section 5
5. Review and improve the extent to which NICE guidance on harmful sexual behaviour is being implemented within educational settings.	4.14 Review what is currently offered to mainstream and special schools in terms of training on identifying and managing harmful sexual behaviour, and develop further resources if needed.	Dec 2023
	4.15 Based on the offer to schools (see above), develop a training offer to community youth settings (e.g. youth workers, residential settings) for identifying and managing harmful sexual behaviour.	Mar 2024

Priority area 5: Reduce inequalities in sexual health

Objectives

1. **Improve access to sexual health services for those with complex needs.**

2. **Ensure that sexual health services meet the needs of LGBTQI individuals.**

3. **Ensure that local services meet the sexual health needs of Our Children and Care Leavers.**

4. **Improve the delivery of sexual health services to refugees and asylum seekers.**

Action plan

OBJECTIVE	ACTION	ESTIMATED TARGET COMPLETION DATE
ALL	5.1 Develop an action plan to address the findings of the sexual health services equity audit.	Oct 2023
1. Improve access to sexual health services for those with complex needs	5.2 Set up a task and finish group, to include co-production with those with lived experience, to improve access to sexual health services for those who are vulnerable and/or have complex needs (including multiple disadvantage, learning disabilities and autistic spectrum disorders, sex work, Mental Health issues).	Jul 2023
	5.3 Through the above task and finish group, develop formal fast-track pathways into sexual health services for those who are vulnerable and/or have complex needs (including multiple disadvantage, learning disabilities and autistic spectrum disorders, sex work, Mental Health issues).	Jul 2024
	5.4 Review the sexual health offer included within the domiciliary pathway for individuals facing multiple disadvantage.	Sept 2023
	5.5 Through the above task and finish group, work with sexual health services to develop a method of reporting uptake of Long-Acting Reversible Contraception (LARC) in women facing multiple disadvantage.	Sept 2023
	5.6 Explore whether/how service user feedback on quality of and access to sexual health services can be captured for individuals facing multiple disadvantage.	Nov 2023
	5.7 Review the current sexual health offer for prison leavers who become resident in Blackpool.	Jan 2024
	5.8 Include a discussion about sexual health needs as part of pre-engagement work undertaken with individuals accessing multiple disadvantage services (e.g. ADDER, Changing Futures).	Feb 2024
	5.9 Ensure that staff working in sexual health services are included in the offer of trauma-informed training being made to wider services across Blackpool.	Oct 2023
	5.10 Undertake insight work with women who have experienced menopause-related mental ill health to identify common themes and to help inform better care. *(Link to Blackpool Community Suicide Prevention Action Plan.)*	Mar 2024

2. Ensure that sexual health services meet the needs of LGBTQI individuals	5.11 Undertake an assessment of the health needs of the local transgender population.	Sept 2024
	5.12 Implement recommendations from the health needs assessment of the local transgender population.	Mar 2025
	5.13 Undertake an evidence review of barriers to accessing sexual health services for LGBTQI individuals, particularly the MSM group.	Oct 2024
	5.14 Undertake insight work to explore the needs and wishes of young LGBTQI individuals in relation to sexual health services.	Sept 2024
	5.15 Explore the level of uptake by transgender and male sex workers of support offered by the harm reduction service.	Apr 2024
	5.16 Review the MSM outreach clinic pilot.	Sept 2023
	5.17 Promote awareness of eligibility for the HPV vaccination amongst the MSM group, including where to access this.	Sept 2023
	5.18 Explore the need for a PrEP Users Peer Support group, to address risky behaviour and adherence.	Jan 2024
3. Ensure that local services meet the sexual health needs of Our Children and Care Leavers	*See actions listed in priority area 2, objective 1.*	
	5.19 Review the extent to which sexual health is included within the Our Children medical template, if at all. Explore whether the template should/could be amended to better address sexual health.	Apr 2024
4. Improve the delivery of sexual health services to refugees and asylum seekers	5.20 Establish outreach clinics at an appropriate venue (e.g. Metropole Hotel), with access to information in alternative languages for asylum seekers. Services to include: • Contraception advice and provision • STI testing • HIV testing	Oct 2023

Priority area 6: Tackle sexual violence

Objectives

1. **Adopt a Public Health approach to tackling sexual violence, including primary prevention programmes.**

2. **Improve education to young people about consent, sexual violence and media.**

3. **Provide high quality services for victims of rape and sexual violence.**

4. **Reduce barriers to proceeding with prosecution for victims of sexual violence crimes.**

5. **Prevent and reduce the sexual exploitation of children, young adults and adults in Blackpool.**

6. **Create safer streets, especially after dark.**

Action plan

OBJECTIVE	ACTION	ESTIMATED TARGET COMPLETION DATE
1. Adopt a Public Health approach to tackling sexual violence, including primary prevention programmes	6.1 Ensure that prevention and early intervention is a priority for the Aquazure working group.	Jun 2023
	6.2 Work to embed 'Green Dot' bystander principles into the community and local businesses.	Ongoing (review quarterly)
	6.3 Ensure that there are regular reminders and support sessions in relation to promoting awareness of bystander activity and training.	Ongoing (review quarterly)
	6.4 Explore ways to reduce the number of sexual assaults and rape within the nighttime economy.	Ongoing (review quarterly)
2. Improve education to young people about consent, sexual violence and media	*See actions on PSHE in area 4, objective 1.*	
	6.5 Identify possible funding opportunities to address gaps in PSHE education in relation to the topics of consent, sexual violence and media.	Sept 2024
	6.6 Work with PSHE education leads to support mainstream and special schools in providing regular, ongoing training on consent, sexual violence and media.	Ongoing (review biannually)
3. Provide high quality services for victims of rape and sexual violence	6.7 Work with commissioners to map sexual violence support services and identify gaps.	Sept 2023
	6.8 Seek funding opportunities to address gaps identified in mapping exercise.	Jan 2024
	6.9 Develop a directory of services available to support victims of rape and sexual violence.	Jun 2023
	6.10 Develop a system for effectively maintaining the directory of services to ensure it is accurate and up-to-date.	Jun 2023
	6.11 Review how sexual violence pathways are currently operating (including ISVA pathways and pathways for reporting, referral and support), and explore how to improve effectiveness and equity of provision.	Jan 2024

	6.12 Explore interventions to prevent individuals being repeat victims of rape and sexual violence.	Mar 2024
4. Reduce barriers to proceeding with prosecution for victims of sexual violence crimes	6.13 Undertake an evidence review of reasons why individuals who report sexual violence may choose not to proceed with prosecution.	Feb 2024
	6.14 Consider undertaking insight work locally to explore reasons for not proceeding with prosecution.	Feb 2024
	6.15 Based upon the available evidence, develop an action plan to increase the proportion of victims who proceed with prosecution.	Jul 2024
5. Prevent and reduce the sexual exploitation of children, young adults and adults in Blackpool	6.16 Develop a formalized process for the referral and support of young adults and adults who are at risk of sexual exploitation (drawing upon work already undertaken to prevent/reduce child sexual exploitation).	Sept 2024
	6.17 Regularly review processes for the prevention and reduction of child sexual exploitation, to ensure that they continue to operate effectively.	Sept 2024
	6.18 Increase the use of civil tools and powers in tackling perpetrators of sexual violence.	Oct 2024
6. Create safer streets, especially after dark	6.19 Continue to apply for available funding to implement further interventions to improve the safety of streets.	Ongoing (review biannually)

GLOSSARY OF TERMS

AIDS	Acquired Immunodeficiency Syndrome
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
BTH	Blackpool Teaching Hospitals NHS Foundation Trust
CLT	Corporate Leadership Team
Complex needs	Needs that are complex due to underlying vulnerabilities, including (but not limited to) substance misuse, homelessness, contact with the criminal justice system, domestic violence, Mental Health issues, physical co-morbidities, learning disabilities and autistic spectrum disorders, refugee/asyslum seeker status.
CSAP	Children's Safeguarding Assurance Partnership
ED	Emergency Department
FSRH	Faculty of Sexual and Reproductive Healthcare
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ISVA	Independent Sexual Violence Advisor
JSNA	Joint Strategic Needs Assessment
LARC	Long Acting Reversible Contraception
LET	Lived Experience Team
LGBTQI	LGBTQI is an umbrella term for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex, Asexual and others
MSM	Men who have Sex with Men
Multiple disadvantage	People experiencing a combination of some or all of the following: substance misuse, homelessness, contact with the criminal justice system, domestic violence and Mental Health issues.
NATSAL	National Survey of Sexual Attitudes and Lifestyles
NCSP	National Chlamydia Screening Programme
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OHID	Office for Health Improvement and Disparities
Our Children	A child who has been in the care of their local authority for more than 24 hours is known as a 'looked after child'. Looked after children are also often referred to as 'children in care'. In Blackpool, children who are in our care are referred to as 'Our Children'.
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PSHE	Personal, Social, Health and Economic Education
SDEC	Same Day Emergency Care
SHEU	Schools and Student Health Education Unit
SMT	Senior Management Team
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy or abortion
WHO	World Health Organization

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Appendix 3c: Equality Analysis (EA) Record Form
Formerly Equality Impact Assessment

Revised February 2015

Department: **Public Health**

Team or Service Area Leading Assessment: **Public Health**

Title of Policy/ Service or Function: **Blackpool Sexual Health Strategy 2023 - 2026**

Proposals to introduce/ alter/ delete policy, service, expenditure etc:

Date of proposals: **2023 - 2026** Committee/Team: **Public Health**

Lead Officer: **Janet Duckworth**

STEP 1 - IDENTIFYING THE PURPOSE OR AIMS

1. What type of policy, service or function is this?

Existing ☐ New/ proposed ☐ Changing/ updated ×

2. What is the aim and purpose of the policy, service or function?

The Blackpool Sexual Health Strategy 2023 – 2026 and associated action plan indicate the commissioning and provider actions to improve the sexual health of the population of Blackpool over the next 3 years.

3. Please outline any proposals being considered.

The Blackpool Sexual Health Strategy 2023 - 2026 aims to improve the sexual health of the population of Blackpool, by providing clear direction and focus for sexual health improvement. The strategy has identified six locally agreed strategic priorities:

- Prevent and reduce the transmission of STIs
- Reduce unplanned pregnancy
- Improve prevention, testing, treatment and support for people living with HIV
- Provide young people with the skills, support and services that they need to achieve optimal sexual health
- Reduce inequalities in sexual health
- Tackle sexual violence

An action plan has been developed for each priority area, to coordinate multi-agency work, by a range of stakeholders, to make improvements in the above six areas.

4. What outcomes do we want to achieve?

The broad outcomes that we aim to achieve are:

- Prevent and reduce the transmission of STIs
- Reduce unplanned pregnancy
- Improve prevention, testing, treatment and support for people living with HIV
- Provide young people with the skills, support and services that they need to achieve optimal sexual health
- Reduce inequalities in sexual health
- Tackle sexual violence

5. Who is the policy, service or function intended to help/ benefit?

The strategy is universal, designed to help and provide benefit to all adults and young people resident in Blackpool. In addition, specific actions have been developed to target support to individuals identified as being at higher risk of poor sexual health outcomes. These include:

- Individuals facing multiple disadvantage
- Individuals with a learning disability and/or autistic spectrum disorder
- Individuals with mental health difficulties
- LGBTQI individuals, with a particular focus on the MSM group and transgender individuals
- Our Children and Care Leavers
- Asylum seekers and refugees
- Young people
- Sex workers
- Individuals in ethnic minority groups, particularly those of Black African ethnicity

The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies. Services include:

- Free testing and treatment for sexually transmitted infections (STI);
- Free contraception, and reasonable access to all methods of contraception;
- Notification of sexual partners of infected persons.

6. Who are the main stakeholders/ customers/ communities of interest?

The strategy is universal, therefore aiming to benefit all adults and young people in Blackpool. Particular groups identified as needing targeted support include:

- Individuals facing multiple disadvantage
- Individuals with a learning disability and/or autistic spectrum disorder
- Individuals with mental health difficulties
- LGBTQI individuals, with a particular focus on the MSM group and transgender individuals
- Our Children and Care Leavers
- Asylum seekers and refugees
- Young people
- Sex workers
- Individuals in ethnic minority groups, particularly those of Black African ethnicity

Organisations/teams with an interest in the strategy include:

- Clinical sexual health services based at Blackpool Teaching Hospitals and within Primary Care
- Midwifery services
- Termination of pregnancy services
- Non-clinical sexual health services
- Harm reduction services
- Community safety partnership
- Schools
- Various voluntary and community sector organisations, e.g. Fylde Coast Women's Aid, Empowerment charity

7. Does the policy, service or function have any existing aims in relation to Equality/ Diversity or community cohesion?

The strategy aims to provide targeted support to the groups listed below, seeking to improve their sexual health outcomes and remove any barriers to their access to services:

- Individuals facing multiple disadvantage
- Individuals with a learning disability and/or autistic spectrum disorder
- LGBTQI individuals, with a particular focus on the MSM (men who have sex with men) group and transgender individuals

- Our Children and Care Leavers
- Asylum seekers and refugees
- Young people
- Sex workers
- Individuals within ethnic minority groups, in particular those of Black African ethnicity

STEP 2 - CONSIDERING EXISTING INFORMATION AND WHAT THIS TELLS YOU

8. Please summarise the main data/ research and performance management information in the box below.

Data/ information

The strategy was informed by a detailed needs assessment which used equalities information from a range of sources:

- Joint Strategy Needs Assessment (see https://www.blackpooljsna.org.uk/Home.aspx)
- Conception and abortion data
- Public Health Outcomes Framework Data
- PHE Sexual and Reproductive Health Profiles HIV/STI web Portal data
- National Chlamydia Screening Programme (CTAD)
- Attitudes to Sexual Health - National Survey of Sexual Attitudes and Lifestyles (NATSAL)
- Blackpool Young People's Health Related Behaviour Survey (School Health Education Unit)
- Stakeholder Engagement

Data is available on an annual basis regarding the uptake of clinical sexual health services according to certain protected characteristics.

Research or comparative information

The strategy has been informed by evidence-based guidelines and frameworks, most notably the following:

- Framework for Sexual Health Improvement in England (published 2013)
- Women's Health Strategy for England (published 2022)
- Towards Zero: the HIV Action Plan for England - 2022 to 2025 (published 2021)
- National guide to commissioning for sexual health, reproductive health and HIV (published 2014)

Other, specific, pieces of evidence are referenced within the strategy document.

Key findings of consultation and feedback
Individual consultations were held with a range of clinical and non-clinical stakeholders during August – September 2022, and a consultation was held with a small group of young people in November 2022. The views of the stakeholders and young people on priorities for a new sexual health strategy for Blackpool informed the development of the strategy. The strategy document includes summaries of the topics that arose during consultations. In November 2023, a stakeholder workshop was held, which included a representative of those with lived experience of certain challenges. At the workshop, findings of the needs assessment and the evaluation of the previous sexual health strategy were presented. Stakeholders worked in groups to provide feedback on draft priorities and objectives for the new strategy and to develop actions to address the objectives.

9. What are the impacts or effects for Key Protected Characteristics?

Age
We do not anticipate that this strategy will adversely impact individuals according to their age. Sexually active young people (15-24 years old) are one of the key priority groups in the new Blackpool Sexual Health Strategy.
Disability
We do not anticipate that this strategy will adversely impact individuals according to whether or not they have a disability. Targeted actions have been developed to improve access to sexual health services for individuals with learning disabilities, and to improve training in HIV testing awareness for those working in services that support individuals with learning disabilities. An action plan will be developed to address findings of the sexual health services equity audit.
Gender Reassignment
We do not anticipate that this strategy will adversely impact individuals according to their gender reassignment status. Some targeted actions have been developed to ensure that the sexual health needs of transgender individuals are met. The strategy action plan includes work to

identify the health needs of local transgender individuals, and to implement recommendations to address these needs. The action plan also includes work to explore uptake by transgender individuals of the support offered by the harm reduction service.

An action plan will be developed to address findings of the sexual health services equity audit.

Marriage and Civil partnership

We do not anticipate that this strategy will adversely impact individuals according to their marriage or civil partnership status.

Pregnancy and Maternity

We do not anticipate that this strategy will adversely impact individuals according to their pregnancy/maternity status.

Objectives in the strategy related to prevention of unplanned pregnancy include improving the provision of Long-Acting Reversible Contraception within maternity services and within termination of pregnancy services, and reducing the rate of teenage pregnancy amongst Our Children.

Race

We do not anticipate that this strategy will adversely impact individuals according to their ethnicity. However, some actions have been developed to address greater risk of poor sexual health outcomes in ethnic minority groups, as outlined below.

Within the strategy and action plan, targeted work has been proposed to address the sexual health needs of refugees and asylum seekers.

Individuals of Black African ethnicity have been identified as being disproportionately affected by HIV. An action has been developed to explore opportunities to increase uptake of HIV testing in ethnic minority groups, in particular those of Black African ethnicity.

An action plan will be developed to address findings of the sexual health services equity audit.

Religion and Belief

We do not anticipate that this strategy will adversely impact individuals according to their religion and/or beliefs.

We recognise the need to ensure that professionals have an awareness and understanding of how faith and culture can inform the choices that people make

with regards to their sexual health.

We also recognise the need to ensure that that Relationships and Sex Education (RSE) and Personal, Social, Health and Economic (PSHE) information is accessible to all young people, and provided in a way that is sensitive to religion and beliefs.

Sex

The strategy aims to improve sexual health outcomes for both males and females. Where appropriate in the strategy, either males or females have been identified as requiring targeted actions to improve sexual health. Examples include work to increase uptake of Long-Acting Reversible Contraception amongst females facing multiple disadvantage; work to increase uptake of chlamydia testing in medical termination of pregnancy services, and actions related to improving awareness of safe sex within the MSM group and improving delivery of sexual health services to MSM individuals.

Sexual Orientation

We do not anticipate that this strategy will adversely impact individuals according to their sexual orientation.

Some aspects of the strategy focus on sexual orientation because certain groups have been identified as being at higher risk of poor sexual health outcomes. These areas are outlined below.

Within priority area 5 ('Reduce inequalities in sexual health'), one objective is to ensure that sexual health services meet the needs of LGBTQI individuals, and specific actions have been developed to address this aim. There is also specific work planned to increase awareness of safe sex amongst the MSM group and to improve the provision of sexual health services to the MSM group.

In addition, consultation work with young people is planned, to explore their views on how PSHE education could help address stigma associated with identifying as LGBTQI.

10. What do you know about how the proposals could affect community cohesion?

The proposals will promote community cohesion through normalising HIV screening for the whole Blackpool population.

Work is planned to develop a fast-track pathway to sexual health services for individuals with multiple, complex needs. This group will include sex workers, and hence the pathway should help to better support/reduce street sex workers, thus contributing to community cohesion.

Finally, the sixth priority area is to tackle sexual violence. This priority area covers a

range of objectives and actions designed to prevent and reduce sexual violence, provide better support for victims of sexual violence and create safer streets, especially after dark. All of these strands of work should help improve community cohesion.

11. What do you know about how the proposals could impact on levels of socio –economic inequality, in particular Poverty?

Proposals have been made to improve the offer and uptake of long-acting reversible contraception to women who have complex needs, including those who face multiple disadvantage. Better prevention of unplanned pregnancy for these women may help them improve other areas of health and wellbeing (such as reducing substance misuse), and may help them in other areas of their lives, such as securing/maintaining a tenancy, and accessing training, volunteering, education and employment.

Actions have been developed to reduce unplanned pregnancy, with a particular focus on reducing teenage conceptions in Our Children. Teenage conception rates are higher within more socially deprived areas, and therefore reducing these rates may help young people to continue education, training and/or employment, thus potentially providing them with greater opportunities to improve their social and financial situation.

Proposals have been made to improve the delivery of sexual health services (including contraception) to refugees and asylum seekers. Refugees and asylum seekers often live in greater poverty in their new country than they may have done in their country of origin. Helping refugees and asylum seekers achieve better sexual health outcomes and greater control over reproductive choices may help them to access education, training, volunteering and/or employment, thus optimising their income and the stability of their social situation.

Finally, actions to increase the retention of individuals living with HIV in treatment services, and to improve the quality of support offered to these individuals, may help those of working age and not currently in the workforce to access education, training or employment.

STEP 3 - ANALYSISING THE IMPACT

12. Is there any evidence of higher or lower take-up by any group or community, and if so, how is this explained?

We are aware that uptake of sexual health services can be lower in certain groups of the population, for example those facing multiple disadvantage (e.g. substance misuse, homelessness, criminal justice system contact), individuals with a learning disability and/or autistic spectrum disorder, refugees and asylum seekers, care

leavers and Our Children, those with mental health issues and sex workers. Targeted actions have been developed to improve uptake within these groups.

Actions have also been developed to explore uptake of sexual health services and harm reduction services by LGBTQI individuals, and to explore and address barriers to accessing sexual health services.

Individuals of Black African ethnicity have been identified as being disproportionately affected by HIV. An action has been developed to explore opportunities to increase uptake of HIV testing in ethnic minority groups, in particular those of Black African ethnicity.

13. Do any rules or requirements prevent any groups or communities from using or accessing the service?

None identified.

The local authority has a mandated responsibility to commission comprehensive, open access sexual and reproductive health services. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies. Services include:

- Free testing and treatment for sexually transmitted infections (STI);
- Free contraception, and reasonable access to all methods of contraception;
- Notification of sexual partners of infected persons.

14. Does the way a service is delivered/ or the policy create any additional barriers for any groups of disabled people?

No additional specific barriers have been identified.

Actions have been developed to work with staff in services that support individuals with learning disabilities to increase awareness of HIV testing and to develop a fast-track pathway into sexual health services.

In addition, there are actions to improve promotion and uptake of the Public Health behaviour change training offer on sexual health to staff in non-sexual health settings, who support individuals with complex needs.

15. Are any of these limitations or differences “substantial” and likely to amount to unlawful discrimination?

Yes ☐ No ×

If yes, please explain (referring to relevant legislation) in the box below

N/A

16. If No, do they amount to a differential impact, which should be addressed?

Yes ☐ No ×

If yes, please give details below.

N/A

STEP 4 - DEALING WITH ADVERSE OR UNLAWFUL IMPACT

17. What can be done to improve the policy, service, function or any proposals in order to reduce or remove any adverse impact or effects identified?

This Equality Analysis has been used as a tool to further develop the Sexual Health Strategy action plan. Actions have been added to address any gaps identified. We are satisfied that the Sexual Health Strategy and associated action plan will not adversely impact any particular group according to protected characteristics. Moreover, we believe that the strategy and action plan will enable progress to be made in reducing inequalities in sexual health within Blackpool.

18. What would be needed to be able to do this? Are the resources likely to be available?

All those involved in delivering actions need to be aware of the need to remove

barriers to access to sexual health services for groups at higher risk of poor sexual health outcomes. Increasing and maintaining this awareness can be achieved using existing resources.

Joined up partnership working will be utilised to address the actions set out in the strategy and action plan for 2023 – 2026.

19. What other support or changes would be necessary to carry out these actions?

We require the continued engagement and commitment of all stakeholders to ensure that the actions outlined are carried out and that the desired outcomes are achieved.

STEP 5 - CONSULTING THOSE AFFECTED FOR THEIR VIEWS

20. What feedback or responses have you received to the findings and possible courses of action? Please give details below.

Individual consultations were held with a range of clinical and non-clinical stakeholders during August – September 2022, and a consultation was held with a small group of young people in November 2022. The views of the stakeholders and young people on priorities for a new sexual health strategy for Blackpool informed the development of the strategy. The strategy document includes summaries of the topics that arose during consultations.

In November 2023, a stakeholder workshop was held, which included a representative of those with lived experience of certain challenges. At the workshop, findings of the needs assessment and the evaluation of the previous sexual health strategy were presented. Stakeholders worked in groups to provide feedback on draft priorities and objectives for the new strategy and to develop actions to address the objectives.

21. If you have not been able to carry out any consultation, please indicate below how you intend to test out your findings and recommended actions.

N/A

STEP 6 - ACTION PLANNING

Please outline your proposed action plan below.

Issues/ adverse impact identified	Proposed action/ objectives to deal with adverse impact	Targets/Measure	Timeframe	Responsibility	Indicate whether agreed

Development of the Blackpool Sexual Health Strategy 2023 – 2026 has led to a comprehensive and detailed action plan being produced, which includes actions to reduce inequalities in sexual health.

The strategy and action plan have been reviewed by the Blackpool Council Public Health Senior Management Team and by the Blackpool Council Corporate Leadership Team, and feedback has been actioned.

The strategy is due to be presented soon to the Blackpool Health and Wellbeing Board and to the Blackpool Adult Health and Social Care Scrutiny Committee. Any amendments requested will be addressed.

STEP 7 - ARRANGEMENTS FOR MONITORING AND REVIEW

Please outline your arrangements for future monitoring and review below.

Agreed action	Monitoring arrangements	Timeframe	Responsibility	Added to Service Plan etc.

The governance and reporting structure is outlined in the strategy. A newly formed Sexual Health Strategy Group will monitor progress made by the strategy in terms of key indicators and implementation of actions. Feedback on progress will be provided to the Public Health Senior Management Team, Council Corporate Leadership Team and Blackpool Health and Wellbeing Board, as required.

Date completed: **28th June 2023** Signed: JDuckworth

Name: **Janet Duckworth** Position: **Public Health Practitioner (Sexual Health)**

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Liz Petch, Consultant in Public Health, Blackpool Council
Relevant Cabinet Member	Councillor Jo Farrell, Cabinet Member for Levelling Up People
Date of Meeting	18 October 2023

PROGRESS UPDATE ON JOINT LOCAL HEALTH AND WELLBEING STRATEGY

1.0 Purpose of the report:

1.1 To provide the Health and Wellbeing Board with an update on progress in the development of a new Joint Local Health and Wellbeing Strategy.

2.0 Recommendation(s):

2.1 To note this update and provide comment on the activities presented.

3.0 Reasons for recommendation(s):

3.1 To ensure that the Health and Wellbeing Board is aware of the latest progress and direction of travel with regards to priorities and content.

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 both:

- 'The economy: Maximising growth and opportunity across Blackpool'
- 'Communities: Creating stronger communities and increasing resilience'

6.0 Background information

6.1 The development of the Integrated Care Board is progressing well. Following a series of discussions with relevant stakeholders to identify gaps and opportunities in existing strategies linked to the priority areas previously agreed by Board members; the sub-priorities have been drafted as follows:

- **Priority 1: Starting Well (first 1001 days)** – this includes addressing challenges such as smoking in pregnancy and childhood obesity.
- **Priority 2: Education, Employment and Training** –this includes a specific focus on the year round economy, tackling seasonality, and valuing core community contributions.
- **Priority 3: Living Well** – this includes initiatives related to stopping smoking, drugs and alcohol consumption, and promoting physical and mental wellbeing.
- **Priority 4: Housing –** this includes proactive outreach to identify early signs of housing failures, enhancing the health sectors understanding of housing issues, and lobbying the government to extend the Decent Homes Standard to the private rented sector.

6.2 The following draft measures of success have been identified for each priority area, and comparisons between Blackpool and England statistics have been made where the data is available:

Priority 1 – Starting Well (first 1001 days)		
Measure	**Blackpool**	**England**
Proportion of those setting a quit date who successfully achieve a 4-week quit (Maternity Service)	32.0% (2022/23)	46.1% (2022/23)
Smoking at the time of delivery	21.1% (2021/22)	9.1% (2021/22)
Breastfeeding: proportion of mothers partially or exclusively breastfeeding for first feed	54.5% (2020/21)	71.7% (2020/21)
School readiness: early years - percentage at a good level of development at the end of reception	60.1% (2021/22)	65.2% (2021/22)
NCMP - overweight (including obesity) reception-aged children	26.5% (2021/22)	22.3% (2021/22)
Five-year-olds: dental survey - % with experience of visually obvious dentinal decay	31.2% (2021/22)	23.7% (2021/22)

Priority 2– Education, Employment and Training		
Measure	**Blackpool**	**England**
Proportion of 16-17-year-olds who are not in employment, education or training (NEET)	7.0% (Mar 23)	2.8% (Mar 23)
Proportion of people 16-64 years old who are	23.2% (2022)	21.3% (2022)

economically inactive		
Engagements, job starts - individual placement and support via drug and alcohol treatment	65 (2022/23)	Data unavailable
Engagements, job starts - individual placement and support via mental health support	229 (2022/23)	Data unavailable
Job starts - individual placement and support via drug and alcohol treatment	37% (2022/23)	Data unavailable
Job starts - individual placement and support via mental health support	94 (2022/23)	Data unavailable

Priority 3– Living Well		
Measure	**Blackpool**	**England**
Smoking prevalence in adults 18+ years	20.6% (2021)	13.0% (2021)
Deaths from drug misuse (per 100,000) (all persons, all ages)	22.1 (2019-21)	5.0 (2019-21)
Alcohol-specific hospital admissions (per 100,000) (all persons, all ages)	1282.0 (2020/21)	586.6 (2020/21)
Self-reported wellbeing: proportion of people with a low satisfaction score (16+)	8.2% (2021/22)	5.0% (2021/22)
Percentage of physically active adults (19+)	59.1% (2021/22)	67.3% (2021/22)

Measures of success have not yet been identified for Priority 4 (Housing) as impact would be difficult to measure quantifiably. Instead, the intention is to draft a list of milestones that will provide qualitative insights into the proposed actions to be taken.

Additionally, life expectancy is one of the key indicators of health in a population and as such will be monitored to track progress. Life expectancy at birth is defined as the average number of years that a new-born is expected to live if current patterns of mortality continue to apply. Life expectancy for men in Blackpool is 74.1 years and for women is 79.0 years (2018-20), both lower than England as a whole. Blackpool's life expectancy is 5.3 years below England in Males. Female life expectancy is 4.2 years below England (2018-20).

6.3 The next steps in the Integrated Care Board writing process are to finalise the draft document, which will include identifying milestones and actions in collaboration with topic/area leads, as well as finalising the graphic design.

The draft document will be shared with Health and Wellbeing Board members prior to public consultation – expected in December 2023.

6.4 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 None.

8.0 Financial considerations:

8.1 None.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations and the impact of this decision for our children and young people:

11.1 A full Equality Analysis will be completed to ensure that the Integrated Care Board does not disproportionately impact any particular protected group.

11.2 The needs of children and young people will be considered to ensure that the actions resulting from the Integrated Care Board has a positive impact on their lives.

12.0 Sustainability, climate change and environmental considerations:

12.1 None.

13.0 Internal/external consultation undertaken:

13.1 As outlined above.

14.0 Background papers:

14.1 None.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Karen Smith, Director of Adult Social Services / Director of Health and Care Integration, Lancashire and South Cumbria Integrated Care Board (ICB)
Relevant Cabinet Member:	Councillor Neal Brookes, Cabinet Member for Adult Social Care
Date of Meeting:	18 October 2023

BLACKPOOL PLACE-BASED PARTNERSHIP DEVELOPMENT

1.0 Purpose of the report:

1.1 To update the Health and Wellbeing Board on recent progress and developments regarding Blackpool's Place-based partnership

2.0 Recommendation(s):

2.1 To consider the Place-based partnerships progress to date and to continue to support the partnership in its ambition to promote health and care integration further.

2.2 To note the Place Integration Deal for the Lancashire and South Cumbria places that was agreed by the Lancashire and South Cumbria Integrated Care Board (ICB) in July and offer reflections on such.

2.3 To agree to receive a further update report at the 13 December 2023 meeting, outlining options and recommendations for governance of the joint planning, delivery and commissioning arrangements that will enable the implementation of the Place Integration Deal in Blackpool.

3.0 Reasons for recommendation(s):

3.1 The Blackpool place-based partnership will require the support of partners across Blackpool, to be successful in its ambition to promote integration. An ambition which aligns with the key statutory functions of the Health and Wellbeing Board and which includes setting the strategic direction to improve health and wellbeing (Department of Health and Social Care (2022) Health and Wellbeing Boards – Guidance. Available at: Health and wellbeing boards – guidance - GOV.UK (www.gov.uk)

Promoting integrated, person-centred care and health improvement is a key objective of:

- the DHSC's adult social care reform vision
- the Health and Care Act 2022
- the NHS Long Term Plan
- the DHSC's integration white paper (Health and social care integration: joining up care for people, places and populations)

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 Members will recall from the March 2023 Health and Wellbeing Board meeting's Place-based partnership update that there is a long-term vision for developing and delegating responsibility to the 4 Lancashire and South Cumbria Place-based Partnerships which comprise:

- Blackburn with Darwen
- Blackpool
- Lancashire
- South Cumbria

The long-term aspirations are that each of the 4 Lancashire and South Cumbria Places will:

- Coordinate the planning and delivery of all-age, community-based service provision for physical and mental health care.
- Focus on supporting people to live well and independently; reducing health inequalities

and unwarranted variation within their place.

- Collaborate with a different place (Place+) or as a collective of four places in Lancashire and South Cumbria (all places).
- Hospitals Trusts will be important as partners and large-scale employers, to ensure seamless pathways for residents and in supporting health creation, prevention, providing care in neighbourhoods and ongoing support for people to remain at home.
- However, planning and delivery of most hospital-based (secondary) and specialist (tertiary) care provision is not in scope for planning and delivery within Place-based Partnerships.
- While this is a broad overview of the Integrated Care Partnership's aspirations for places in Lancashire and South Cumbria, the focus in Blackpool will be on Blackpool and its specific and unique needs.

To facilitate this, a programme of work has been underway with the Integrated Care Board to consider delegations to place.

The Lancashire and South Cumbria Place Integration Deal was agreed by the Integrated Care Board on 5 July 2023 and sets out the way in which places will operate within the Integrated Care Board's operating arrangements.

It describes:

- The expectations of places - what we agree should be planned and delivered in places.
- The resources that places will receive from the Integrated Care Board to deliver these expectations – delegations, people and funding allocations.
- The ways of working that will enable the primacy of place and the principle of subsidiarity to be enacted successfully – how places will interact with the Integrated Care Board ICB directorates and how decision-making will happen between partners in each place.

Underpinning the Deal, is the assumption that planning and delivery will happen at place unless required as one of these three subsidiarity tests:

- Working at scale is necessary to achieve a critical mass to get the best outcomes.
- Where variation in outcomes is unacceptably high and working together will help to reduce variation and share best practice.
- Where working at scale offers opportunities to solve complex, intractable problems.

Delegations are to be enacted in a staged way through a series of phases, with the ICB's Better Care Fund and Population Health resources potentially flowing first (by April 2024).

Key practicalities, such as what exactly is in scope for each of the areas which are being identified, how this will actually be implemented and what this means in terms of resource to support, is still being considered and worked through, acknowledging the scale and complexities of this work.

Delegations and authority to act, from the Integrated Care Board ICB in this first instance, will allow the Blackpool Place-based partnership to be even more agile in terms of mobilising transformation and being more responsive to local need and bringing decision making closer to the communities it serves. This will ultimately ensure more effective delivery of the Partnership's key priorities and those of the newly emerging Health and Wellbeing strategy, which members considered at the Health and Wellbeing workshop back in June 2023.

Following agreement with the Integrated Care Board in July 2023, discussions are now commencing with local council and other place partners, to consider their ambitions for integration and practically how this could work and via what means and mechanisms.

The Board is being asked to note that implementation of the Place Integration Deal is likely to be a 2-3 year development journey for the Lancashire and South Cumbria places and those organisations that are key partners in places across the Lancashire and South Cumbria system. There will also be a robust process to determine the readiness of places in terms of delegation – the detail for which is also being worked through currently.

Effectively managing the responsibility and budgetary allocations associated with the Place Integration Deal will require the relevant governance to be in place. This work is also currently underway and considering existing mechanisms e.g. the Better Care Fund (BCF).

Further detail with regards to the Place Integration Deal, potential scope and suggested phased approach to governance is available to members in Appendix 4a.

It is proposed that a report will be brought back to the Health and Wellbeing Board at the meeting scheduled for 13 December 2023 , to outline and consider options and recommendations.

6.2 Place-based partnership delivery update –

In tandem with the work outlined above, Blackpool Place-based partnership continues to make progress. Two examples of such are outlined below –

- Active into Autumn – a follow-up event to that which took place in March 2023, highlighting all the great activities and support which is available to the community of Blackpool. Over 50 organisations willingly gave up their time to showcase at this event – a true testament of collaboration.
- Emerging Joint Local Health and Wellbeing strategy (JLHWS) – members had asked previously that the emerging, new strategy takes account of what is already in existence,

particularly the Place-based partnership priorities and ensuring alignment with. Following a series of discussions with stakeholders to identify gaps and opportunities in existing strategies, sub priorities have now been drafted as outlined within the Progress update report.

6.3 Does the information submitted include any exempt information? No

7.0 List of Appendices:

7.1 Appendix 4a – Lancashire and South Cumbria Place integration deal slides

8.0 Financial considerations:

8.1 None presently.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations:

11.1 An underlying theme of Place-based partnerships is to improve people's health and wellbeing and reduce health inequalities that exist in Blackpool. It is not anticipated that this early work would adversely impact on key protected equality groups.

12.0 Sustainability, climate change and environmental considerations:

12.1 Reducing Blackpool's contribution to the climate crisis and creating resilience to respond to the worst impacts of climate change is an opportunity to protect health.

Examples of how the work of the Place-based partnership could promote healthy living while reducing environmental impacts include promoting active travel, reducing the carbon footprint of healthcare facilities, and ensuring that new programmes support the local environment.

However, programmes of work are still in their early development.

13.0 Internal/external consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.

Lancashire and South Cumbria Integrated Care System
Proposals for a Place Integration Deal

Appendix 5a

ICB Board Meeting
5 July 2023

Our vision for places as part of the LSC system

It is our ambition in Lancashire and South Cumbria to have a world class, all age, community centric, integrated care system which has our four places at its heart, acting as the engine room for driving the transformation and changes that we need to see to **improve health outcomes and experiences, responding to the needs of our population.**

Our aims

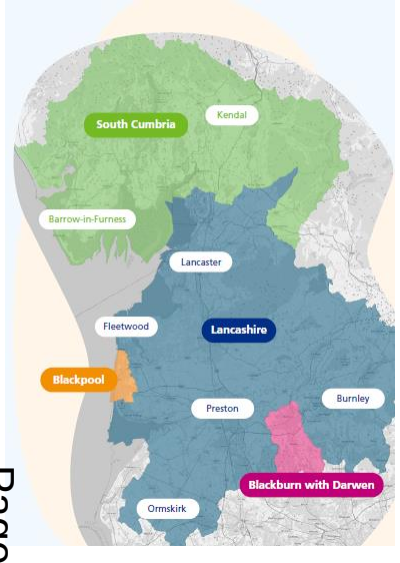
- A much stronger focus on prevention
- A step change in community-based services to a more integrated approach across health and care
- Delivering world class care for priority diseases, conditions, population groups and communities
- Getting better value from our collective resources
- Using data and intelligence to focus on local needs
- Strengthening places and neighbourhoods to ensure decision-making happens closer to people and with local communities

The impact for our people

What is the Place Integration Deal?

Lancashire and South Cumbria Integrated Care Partnership

NHS Lancashire and South Cumbria Integrated Care Board



The 'Place Integration Deal' sets out the way in which places will operate as part of the Lancashire and South Cumbria integrated care system, specifically in relation to the NHS Lancashire and South Cumbria Integrated Care Board (ICB).

It describes:

Why
- Why the Place Integration Deal is key to meeting national and local expectations

What
- What will be planned and delivered in places

How
- How the Place Integration Deal will be implemented

This is the first stage of the Place Integration Deal. It sets out the way in which the ICB will work with places at the centre of our integrated care system and lays the foundations for more integrated working with local government.

In line with our strategic narrative for places and the Directors of Health and Care Integration holding shared roles across the NHS and our local authorities, **the next stage will be to consider the '*what*' and the '*how*' from the perspective of local authorities, thus enabling deeper integration in each place**. This will mean agreement to joint leadership, decision making and financial arrangements between the ICB and partners in our places. Detailed design and implementation of the Place Integration Deal is likely to be a 2- to 3-year development journey for our places and those organisations that are key partners in places and across the system.

Year 1 – Increasing maturity of places, the ICB,
- Begin delivery of operational priorities in places as DsHCI act as convenors of place partnerships
- Agreement of Place Integration Deal and start of delegations from ICB to places through DsHCI

Year 2 – and local authorities with earned autonomy
- Formalised delegations from ICB to places, with place-based governance arrangements
- Agreement of local authority delegations to places
- Increased pooling of funding across NHS and local authority

Year 3 – freedom and flexibility for places
- Formalised delegations from local authorities to places, with local decision-making
- Further pooling of funding across NHS and local authority
- Integration of NHS and local authority teams

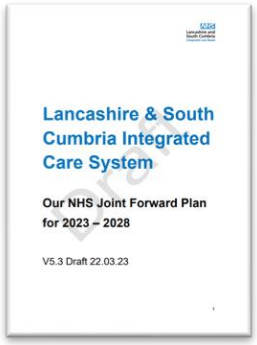
Implementation of the Place Integration Deal will enable delivery of key commitments…

Why

Integrated Care Strategy (April 2023) – five long-term measures of success for our system

Development of this strategy included review and inclusion of key elements from the local authority Health and Wellbeing strategies.

- Early years development
- Years in good health
- Avoidable mortality
- Unemployment rate for the working age population
- Life satisfaction



Joint Forward Plan (March 2023 – in draft) – sets out six long-term measures of success for the NHS

- Improved financial sustainability
- Improved healthy life expectancy
- Enhanced and seamless care provision within our neighbourhoods
- Improved quality of care across all providers
- Improved pathways of care across the system

'Turning challenges into opportunities – The state of our system report' (March 2023) and the ICB financial recovery programme – set out key ambitions for a sustainable system

- All trusts will be high performing
- Maximise efficiency across emergency and elective care
- Rationalize our system for greater efficiency
- Invest in community services
- Reconfigure the ICB itself to support this approach.

The scope in relation to the ICB – key areas of NHS planning and delivery in our places

This is the first stage of the Place Integration Deal. It sets out the way in which places will operate as part of the Lancashire and South Cumbria integrated care system, specifically in relation to the NHS via the ICB and working with key partners. Therefore, we have set out the NHS functions / services where we envisage planning and delivery to happen at place, but recognise that this will evolve over time as places and the ICB mature, and as delegations happen from other partners in place.

What

Health creation	Prevention, self help and care navigation	Anticipatory neighbourhood based care	Ongoing support to remain at home	Community based, short term crisis intervention
• All age population health and wellbeing	• All age population health and wellbeing, including health checks, smoking cessation, healthy weight, etc. • Secondary prevention • Care navigation • Social prescribing	• Population health management approach • Primary care (non-core) • Integrated neighbourhood teams (all age) • Community nursing and therapies (all age) across physical and mental health, learning disabilities and autism • Pharmacy / medicines management	• Long term condition management for specific programmes / specific pathways (e.g., frailty, mental health) • Enhanced care at home – bed and non-bed based	• Falls • Community stroke services • Discharge to Assess • 2-hour urgent community response • Virtual wards • Primary Care Enhanced Access and Out-of-Hours • Mental health initial response service • Continuing Health Care • Care market sustainability • Winter operational schemes

Greater use of a population health management approach to planning
Joint commissioning in place, including VCFSE commissioned services and the scope of the Better Care Fund
Engagement, coproduction and evaluation with our communities

Maintaining clear focus on delivery - priorities across our places

Lancashire and South Cumbria Integrated Care Partnership

NHS Lancashire and South Cumbria Integrated Care Board

What

From 2023/24

Operational delivery

Common priorities for operational delivery through leadership in places from 2023/24

- Population health – addressing inequalities
- Primary care – development of Integrated Neighbourhood Teams (INTs) and transformation
- Scope of the Better Care Fund (BCF) and Section 75/256 agreements
- Community services – transaction and transformation
- Continuing Health Care (CHC)

	Phase 1	Phase 2	Phase 3
Blackburn with Darwen	• Integrated neighbourhoods incl. Physical, Mental, Family Hubs & Fuller * • Improve care sector quality * • Focused interventions based on need – start, live, age, die well – frailty • Community services (incl. enhanced care at home) • Population health • Winter operational schemes (*inc meds optimisation)	• CHC and Personal Health budgets – roll out wider • Discharge to assess and effective step-up care • Local primary care quality and access improvement (GP) • Joint commissioning opportunities with Council • Focused interventions based on need – start, live, age, die well – mental health	• Local primary care quality and access improvement (dental, optometry, pharmacy) • Focused interventions based on need – start, live, age, die well – children and young people
Blackpool	• Continuing Health Care / Personalised Health Budgets • Community services – transaction / transformation (including enhanced care at home) • Focused interventions based on need – specific cohorts	• Long term conditions pathways • Personal Health budgets – roll out wider (offer to host on behalf of all areas)	
South Cumbria	• Community wellness centre • Enhanced Care at Home programme • Workforce model – Local workforce analysis • Whole System Flow Programme • Thriving Communities - alignment of Community Development; Population Health & Public Health priorities and programmes	• Community wellness centre • MBRN roll out south Cumbria (subject to investment proposal) • Whole System Flow programme • Joint governance arrangements between ICB and Local Authority (to oversee the BCF and Section 75/256 agreements) • Focussed interventions based on need – reflecting JSNA	• Community wellness centre • Whole System Flow Programme • Focused interventions based on need – reflecting JSNA
Lancashire	• Integrated Commissioning of Care at Home Services • Alignment of Care Navigation/ Brokerage of Care Sector • ASC and ICB workforce-agreed approach to recruitment and rostering of agency workers • Discharge to Assess (D2A)	• Learning Disabilities Pooled Budgets	• Urgent Care Services (such as out of hospital emergency care, including Urgent Treatment Centres, and on the day urgent Primary and Community Care) • TBC following engagement with District Council Chief Execs

Impact for our people

Lancashire and South Cumbria Integrated Care Partnership

NHS Lancashire and South Cumbria Integrated Care Board

Considering the scope of place, the phased approach to delegations, and the priority areas for delivery, we envisage that a core set of metrics could be adopted to measure successful integration and the impact of integration in our places. These will evolve as our places increase in maturity and further work will be undertaken with residents and partners in order to scope what these metrics could be.

What

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People will live in a places that actively supports economic development and has a culture of enabling them and their families to take care of themselves and their communities

People will have to access help, advice and signposting when they need it

People will get more help or support in the community to help them remain at home

People get the right care, from a trained professional, in the right place, when they need it

People will receive intensive, short term care or longer term support in the community, which enables them to maintain their independence, or in some cases remain safe

Initial Metrics

Smoking cessation rates

Annual health checks for people with a learning disability

Access to mental health support for children & young people

Access to GP appointments

People 65+yrs with a recorded frailty score have a care plan

Use of 2hr urgent community response

Lengths of hospital stays

Phased approach to governance arrangements

We recognise that delegation of decision-making to places will evolve as as our places and the ICB mature, and as confidence grows in place-based ways of working. Our decision making arrangements in place will evolve across three stages of maturity – 'in development', 'in shadow' and 'ready for delegation'.

In development

- Interim Place-Based Partnership Board established as a 'consultative forum'
- Partners come together to undertake the core responsibilities of each place
- This may be through:
  - Members of the board having delegated decision-making from their own organisation;
  or
  - The consultative forum making recommendations for approval by individual organisations

In shadow

- Place-Based Partnership Board confirmed as a 'shadow board' and operates as if it has delegations
- DHCI has delegated authority from the ICB around any NHS budget allocated to place
- Some DsHCI may also have delegated authority from the upper tier/unitary local authority, depending on their role
- DHCI exercises some/all delegations via the Place-Based Partnership Board to support collective decision-making between partners in place

Ready for delegation

- Place-Based Partnership Board fully constituted as a committee of the ICB (or a joint committee of the ICB and local authority if local authority delegations are also included)
- There is an appointed chair of the Place-Based Partnership
- Terms of Reference are formally agreed by all place partners
- The ICB SORD (and local authority Constitution if relevant) confirm any delegations
- Over time, wider partners may delegate into the committee.

We anticipate all places should have reached this phase by April 2024

Our governance will be an enabler to achieving:

- Improved experiences and outcomes for our local people
- Joined up care and delivery
- Bringing decision-making closer to our local people
- Making decision-making more focused on local population needs
- Creating greater transparency and accountability to the public

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Lucia Plant, Lead for Better Care Fund, Blackpool Council
Relevant Cabinet Member:	Councillor Jo Farrell, Cabinet Member for Levelling Up People
Date of Meeting:	18 October 2023

BETTER CARE FUND UPDATE

1.0 Purpose of the report:

1.1 To provide the Board with an update on the financial monitoring of the Blackpool Better Care Fund.

2.0 Recommendation(s):

2.1 To note the report and any verbal update.

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 report is for information to ensure that the Board is kept aware of the status of the Blackpool Better Care Fund and future actions.

3.2 The Better Care Fund pooled budget is a statutory requirement under the amended NHS Act 2006.

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 governance requirements contained within the 'Framework Partnership Agreement relating to the Commissioning of Health and Social Care Services and Other Arrangements' require Blackpool Council to provide regular monitoring of the Better Care Fund (BCF) to the Health and Wellbeing Board.

6.2 Whilst the individual organisations (Blackpool Council and Lancashire and South Cumbria ICB) are still monitoring their respective schemes as part of their own financial reporting requirements officers have been unable to submit a consolidated report for this financial year, this is due to the continued delayed publication of the Better Care Fund Policy Statement.

6.3 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 Farrell on the Board's behalf on 28 June 2023.

6.4 Blackpool Council and Lancashire and South Cumbria Integrated Card Board were required to complete a planning template (Appendix 4b) to show the expenditure plan for 2023-25, and to outline the expected impact.

6.5 The Better Care Fund plan 2023-25 has received national assurance on 19 September 2023.

6.6 The Section 75 agreement, which underpins the Better Care Fund Plan has required extensive revision due to the enactment of the Health and Care Act 2022 and the transfer of Clinical Commissioning Groups to Integrated Care Boards. This was approved by the Council's Executive on 5 December 2022.

6.7 Does the information submitted include any exempt information No

7.0 List of Appendices:

7.1 Appendix 6a: Better Care Fund 2023-25 Planning Requirements
Appendix 6b: Submitted Blackpool 2023-25 Better Care Fund Planning Template

8.0 Financial considerations:

8.1 As explained in the body of the report.

9.0 Legal considerations:

9.1 None.

10.0 Risk management considerations:

10.1 None.

11.0 Equalities considerations and the impact of this decision for our children and young people:

11.1 None.

12.0 Sustainability, climate change and environmental considerations:

12.1 None.

13.0 Internal/external consultation undertaken:

13.1 None.

14.0 Background papers:

14.1 None.

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Classification: Official

Publication approval reference: PR00315

HM Government

NHS England

Better Care Fund planning requirements 2023-25

4 April 2023, Version 1

Contents

Introduction

Key dates

Optional draft BCF planning submission (including intermediate care and short term care capacity and demand plan)	19 May
BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government).	28 June

Better Care Fund Vision and Objectives

1. The Better Care Fund (BCF) Policy Framework sets out the Government's priorities for 2023-25, including improving discharge, reducing the pressure on Urgent and Emergency Care and social care, supporting intermediate care, unpaid carers and housing adaptations.

2. The vision for the BCF over 2023-25 is to support people to live healthy, independent and dignified lives, through joining up health, social care and housing services seamlessly around the person. This vision is underpinned by the two core BCF objectives:

    - **Enable people to stay well, safe and independent at home for longer**
    - **Provide the right care in the right place at the right time**

3. This document sets out the requirements for two year plans to enable areas to deliver tangible impacts in line with the vision and objectives set out in the Policy Framework. It is published by NHS England and Government to be actioned jointly by Integrated Care Boards (ICBs) and local councils. These requirements focus the use of BCF funding on the objectives of the fund and improving performance against

the metrics for working age and older adults. Intermediate Care Capacity and Demand plans will continue to be collected as part of BCF plans and should be used to estimate the existing or upcoming capacity deficits and inform the use of BCF pooled funding for delivery of the objectives.

4. BCF planning information in 2023-25 will be collected in a way that provides more data on the activity that BCF will fund, and the contribution of integrated working to improving outcomes for local people. This will include:

    - Expected outputs from scheme types related to discharge, intermediate care unpaid carers and housing.

    - Estimates of BCF spend on different services and activities as a proportion of all health and care spend on these services in the Health and Wellbeing Board (HWB) area. We are collecting this information to help better identify and articulate the contribution of BCF funding to delivering capacity, but, as estimates, these figures will not be subject to assurance.

5. Mental health, learning disability and autism continue to be an integral area of the BCF and should be considered on an equal footing to physical health. The objectives apply to all settings and contexts including preventative support or where a person may be discharged from adult or older adult mental health (including dementia), learning disability and autism inpatient settings as well as acute hospitals. People discharged from mental health, learning disability and autism inpatient services who need to access intermediate care services should be included in BCF intermediate care capacity and demand plans.

Legal framework

6. The Secretary of State for Health and Social Care has published a direction to NHS England under section 223B of the NHS Act 2006 to ringfence £5,059 million to form the NHS contribution to the BCF in 2023-24. This figure includes additional funding for discharge via ICBs (£300m) in 2023-24. The direction sets a requirement for NHS England to consult with The Secretary of State for Health and Social Care before giving any direction to ICBs under section 223GA(1) of the Act about designated amounts to be used for purposes relating to service integration, or before exercising any of its powers under section 223GA(5) of the Act relating to these designated amounts.

7. This document represents NHS England exercising its powers under section 223GA of the 2006 Act. It sets out the detail in relation to the conditions and requirements agreed with the government in relation to the receipt and use of NHS and local government contributions to the BCF, including details of how conditions and requirements will be monitored to ensure they are met. This guidance is also an annex to the NHS operational and contracting guidance for 2023/24. ICBs should ensure that plans for use of the NHS minimum contribution, discharge funding in ICB allocations and assumptions related to capacity and demand for intermediate care align to their wider activity and financial plans.

8. Grants to local government (improved Better Care Fund and Disabled Facilities Grant) will continue to be paid to local government under s31 of the Local Government Act 2003, with a condition that they are pooled into local Better Care Fund plans.

9. There will be an additional £600m in 2023-24, and £1bn in 2024-25 to support discharge from hospital and reduce delays, half of which will be allocated via ICBs in each year. The £300m NHS funding of the additional £600m in 2023-24 is included in the Secretary of State direction outlined in para 6. The other £300 million in 2023-24 will be paid as a grant to local government, under the condition that it is pooled into the Better Care Fund. Specific requirements and conditions in relation to this funding are included in paragraphs 41-51 and will be assured as part of wider BCF assurance.

10. The following minimum funding must be pooled into the BCF in 2023-25.

Source	2022-23 (£m)	2023-24 (£m)	2024-25 (£m)
NHS contribution	4,504	4,759	£5,029
Discharge Funding	500	600	1000
Improved Better Care Fund	2,140	2140	2140
Disabled Facilities Grant	573	573	573

National Conditions

National Condition 1: Plans to be jointly agreed.

11. BCF Plans must be agreed by the ICB(s) (in accordance with ICB governance rules) and the local council chief executive, prior to being signed off by the HWB. Once the plan is agreed and approved, the funding must be placed into one or more pooled funds under section 75 of the NHS Act 2006. Local NHS trusts, social care providers, voluntary and community service partners and local housing authorities must be involved in the development of plans, including the strategic approach to delivering the objectives of the BCF. Areas can agree to pool additional funds into their BCF plan and associated section 75 agreement(s) where they are assured that voluntary pooling provides value for money. These additional contributions are not subject to the conditions of the BCF but should be recorded in the planning template.

12. The planning template will collect data on use of BCF funding and ambitions for performance on BCF metrics (performance objectives) and activity to achieve these as well as on Intermediate Care plans for capacity and demand (see Appendix 2). All sections of the template must be completed in line with this guidance.

13. Narrative plans will collect the joint approach to delivering the objectives of the fund (see para 2) and should also set out:

    - A brief summary of the strategic approach to integration of health, social care and home adaptations to support further improvement of outcomes for people with care and support needs. As part of this local areas should explain why particular services and schemes have been prioritised and what outcomes they are trying to achieve. This should include a local scheme of governance for plans that demonstrates how the plan has been signed off, and how oversight of ongoing delivery and performance and the section 75 agreement, will be achieved.

    - Areas for development (based on learning from previous years).

    - Actions resulting from Intermediate Care Capacity and Demand plans.

    - Approach to supporting unpaid carers.

- Joint commissioning – how the local council and ICB will work together to further join up commissioning and develop the care market (in support of the local government duty). This should complement planning undertaken as part of the Market Sustainability and Improvement Fund (MSIF).

- How activity in BCF plans will support equality and address health inequalities.

14. Systems should review the assessment of health inequalities and equality for people with protected characteristics under the Equality Act 2020 from their 2022-23 plans and update these, where appropriate. Narrative plans should briefly set out any changes to local priorities in terms of health inequality or equality for people with protected characteristics, and how BCF funded services are being delivered to address these, including data where this is appropriate. Where data is available, local areas should also consider any differential outcomes for people from groups with protected characteristics and other vulnerable groups (for example those experiencing homelessness) in relation to the metrics of the BCF and how actions in their plan can contribute to reducing these.

15. Areas will also need to consider local government's priorities under the Equality Act and NHS actions in line with Core20PLUS5.

National Condition 2: Enabling people to stay well, safe and independent at home for longer.

16. Areas should agree how the services they commission will support people to remain independent for longer, and where possible support them to remain in their own home. This might include:

- embedding personalised care and delivering asset-based approaches

- implementing joined-up approaches to population health management and proactive care, and how the schemes commissioned through the BCF will support these approaches

- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake where appropriate

- how work to provide additional support to those who need it, such as unpaid carers and people who require adaptations and improvements to their home, will support this objective

17. Whilst there is no specific requirement to fund implementation of the Fuller Stocktake, there are clear overlaps between the delivery of the vision for Primary Care Network (PCN) level multi-disciplinary teams supporting prevention and focussing on people in the Core20PLUS5 population, and the aims of the Better Care Fund. Many areas are already funding neighbourhood teams. When developing BCF plans, areas should consider the extent to which delivery through neighbourhood teams would be beneficial in the context of existing local priorities.

18. The LGA published a high impact change model for reducing preventable admissions to hospital and long-term care in 2021.

19. BCF narrative and expenditure plans for 2023-25 should set out how BCF funding (including any voluntarily pooled funding) supports improvement against this objective. This should include:

    - the approach to integrating care to deliver better outcomes, including how collaborative commissioning will support this and how primary, intermediate, community, mental health and social care services are being delivered to help people to remain at home.

    - providing details in the BCF planning template of planned spend on prevention-related activity. You should indicate whether schemes contribute wholly or partly to this objective.

    - how joint health and social care activity under this objective will contribute to the ambitions agreed against BCF national metrics, particularly unplanned hospitalisation for chronic ambulatory care sensitive conditions, people over 65 who are admitted to long term residential care and rate of admissions to acute hospital following a fall.

20. Activity to deliver this condition should take account of the capacity and demand plan for intermediate care.

National condition 3: Provide the right care in the right place at the right time

21. Areas should agree how the services they commission will support people to receive the right care in the right place at the right time. BCF plans should set out how ICB and social care commissioners will continue to:

    - Support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance[1].

    - Implement the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

22. This should include details of how additional funding for discharge in 2023-24 will be used in line with the conditions set out in paragraphs 40-50 to improve outcomes for people being discharged and performance against the relevant metrics. Planning for 2024-25 discharge funding is provisional at this point as conditions will be updated according to the evaluation findings of the 2022-23 ASC Discharge Fund.

23. Areas should review the self-assessment of the area's implementation of the High impact change model for managing transfers of care and summarise progress against areas for improvement identified in 2022-23.

24. BCF plans for 2023-25 should set out how BCF funding (including any voluntarily pooled funding) supports improvement against this objective. This should include:

    - a narrative detailing how BCF spending will support the area's approach and details in the BCF planning template of planned spend on discharge -related activity, taking account of the capacity and demand plan for intermediate care

    - how joint health and social care activity will contribute to the improvements agreed against BCF national metrics particularly discharge to usual place of residence and reablement.

[1] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

Funding sources

NHS minimum contribution to the Better Care Fund

25. NHS England has published allocations from the national ringfenced NHS contribution for each ICB and HWB area for 2023-24 and 2024-25 on its website. The allocations are pre-populated in the BCF planning template at HWB level.

26. As with 2022-23, the allocations of the NHS contribution to the BCF have been increased by 5.66% for each HWB area. The contribution for each HWB area continues to include funding to support local government delivery of reablement (£300 million), carers' breaks (£130 million) and implementation of duties to fund carer support under the Care Act 2014 (£197 million). Local allocations of these elements of the NHS minimum contribution are not set for each area, and it is for local government and ICBs to agree the funding to allocate to these services as part of their local BCF plans. BCF plans should reflect clearly how this funding has been identified.

27. The way services and local areas work in partnership with, and support, unpaid carers is critical. We know that poorer health and wellbeing outcomes can be associated with caring as the intensity of the caring role increases.

28. The narrative section of BCF plans should include a brief overview of how BCF funding available in their locality is being used to support unpaid carers with reference to funding to support carers' breaks and carer support under the Care Act 2014. Areas will also be asked to improve the clarity and transparency of spend on unpaid carers through our reporting requirements and activity data. Local areas should also highlight good practice examples through their narrative plans to help aid understanding and improvement of unpaid carers services delivered via the BCF. This supports the government's recent commitments on empowering unpaid carers, as set out in the Adult Social Care Reform White Paper: People at the Heart of Care.

Grant funding to local government

Improved Better Care Fund (iBCF)

29. The grant determination for the iBCF in 2023-24 was issued on 4th April 2023. Since 2020-21, funding that was previously paid as a separate grant for managing winter

pressures has been included as part of the iBCF grant but is not ringfenced for use in winter. The value of the iBCF in 2024-25 is indicative only. Final decisions on the 2024-25 iBCF, (including allocations) will be made, and full details published, as part of the 2024-25 Local Government Finance Settlement. For planning purposes, pending those decisions, areas should plan on the basis that allocations will be consistent with the approach taken in 2023-24.

30. The funding may only be used for the purposes of:

- meeting adult social care needs
- reducing pressures on the NHS, including seasonal winter pressures
- supporting more people to be discharged from hospital when they are ready
- ensuring that the social care provider market is supported.

31. iBCF funding can be allocated across any or all of the four purposes of the grant in a way that local councils, working with ICB(s), determine best meets local needs and pressures. No fixed proportion needs to be allocated across each of the purposes.

32. The grant conditions for the iBCF also require that the local council pools the grant funding into the local BCF and reports as required through BCF reporting. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care (national condition 4).

Disabled Facilities Grant

33. Ringfenced DFG funding continues to be allocated through the BCF and will continue to be paid to upper-tier local councils. The statutory duty to provide DFGs to those who qualify for them is placed on local housing authorities. Therefore, each area must ensure that sufficient funding is allocated from the DFG monies to enable housing authorities to continue to meet their statutory duty to provide adaptations to the homes of eligible people of all ages.

34. In two-tier areas, decisions around the use of 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.

35. The funding allocations for DFG will be published soon. Once published, areas should input their figures into the relevant section of the income tab in the BCF Planning Template. Assumptions will be provided for DFG allocations in 2024-25.

36. The DFG is pooled into the BCF to promote joined-up approaches to meeting people's needs to support more people of all ages to live in suitable housing so they can stay independent for longer. 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, including social care, and strategic use of the DFG can support this.

37. Where some DFG funding is retained by the upper tier local council, plans should be clear that:

    - the funding is included in one of the pooled funds as part of the BCF
    - the DFG capital funding is used only for the allowed purposes as described in the DLUHC Guidance for Local Authorities.
    - the funding supports a strategic approach to housing and adaptations that supports the aims of the BCF
    - the use of the funding in this way has been developed and agreed with relevant housing authorities.

38. The scope for how DFG funding can be used includes to support any local government expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables local government to use specific DFG funding more flexibly to help people live independently. There are numerous case studies of innovative use of DFG funding on the Better Care Exchange[2] and Foundations websites.

39. 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. The Care Act 2014 also requires local councils 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.

[2] An account is needed to access the Better Care Exchange, if you do not have one and would like to set one up, please email england.bettercarefundteam@nhs.net

40. The Government published updated guidance for local councils on 28 March 2022 that sets out how they can effectively and efficiently deliver DFG funded adaptations to best serve the needs of local older and disabled people.

Additional Discharge funding

41. In 2023-24, the Government is providing £600 million (£300 million for ICBs, £300 million for local councils) to enable local areas to build additional adult social care (ASC) and community-based reablement capacity to reduce delayed discharges and improve outcomes for patients. As in 2022-23 the ICB will agree with relevant local HWBs how the ICB element of funding will be allocated rather than being set as part of overall BCF allocations, and this should be based on allocations proportionate to local area need.

42. This funding is intended to provide increased investment in social care and community capacity to support discharge and free up beds. Areas can use this funding where appropriate to continue to support investments made in services from the ASC Discharge Funding in 2022-23 but should not use the new discharge funding in 2023-24 to replace existing expenditure on social care and community services.

43. Local areas should use the discharge funding as part of BCF plans, particularly in relation to National Condition 3, and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvements for patients.

44. Local areas should plan how best to deploy this funding over the period April 2023 to March 2024, taking account of the capacity and demand work to identify likely variation in levels of demand over the course of the year, including winter pressures. Local areas should work with local providers to determine how best to build the workforce capacity needed for additional services.

45. Local areas should use the funding in ways that support the principles of ‘Discharge to Assess’: to enable timely discharge from hospital with appropriate short-term support, where needed, pending assessment of long-term care needs.

46. Local areas should take account of learning from previous discharge funding, including the evaluation of the impact of 2022-23 discharge funding when available.

47. As part of the BCF plan, local areas will be required to set out how they intend to deploy the additional discharge funding, and submit fortnightly reports throughout the year, setting out – among other information – the additional services commissioned with the funding and the numbers of patients receiving short-term support following discharge. Detailed reporting requirements and templates will be published as soon as possible.

48. £1bn has been added to the BCF for 2024-25 to provide ongoing support for discharge. We intend to update the 2024-25 discharge funding conditions according to the evaluation findings of the 2022-23 ASC Discharge Fund. This may impact priority areas for spending and reporting requirements. However, our overarching objective for the funding will remain to reduce delayed discharges. Therefore, areas should provisionally agree plans and include this in the spending template. Final details regarding the 2024-25 additional funding for discharge will be published in due course and plans may need to be amended or updated to reflect any changes to conditions once these are published.

49. ICB allocations for the 2024-25 discharge funding have been allocated solely on a 'fair shares' basis. Final decisions on the 2024-25 local council share of the discharge funding including allocations will be made, and full details published, as part of the 2024-25 Local Government Finance Settlement. For planning purposes, pending those decisions, guidance will be given to what areas should include in the Planning Template for 2024-5 to support planning over the two year period.

50. As set out in the Delivery plan for recovering urgent and emergency care services, DHSC, NHS England, the Department for Levelling Up, Housing and Communities (DLUHC), Local Government Association, and Association of Directors of Adult Social Services, have introduced an integrated approach to performance improvement and support in local systems, bringing together local leaders from across the NHS, local government and the social care sector to target support to the most challenged areas, and to rapidly identify and help spread innovative practice.

51. Information from this integrated approach to performance improvement and support will be made available to those involved in assurance. Systems that have been identified as requiring additional support and performance improvement in relation to discharge performance will be communicated to regional assurance teams and this will be considered in relation to BCF plans and metric ambitions. Additional

conditions relating to performance improvement and support may be included as part of approval of the discharge funding aspects of the BCF plan.

Spending related conditions

National Condition 4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services.

52. In each HWB area, the minimum expected expenditure on social care spending and spending on NHS commissioned out of hospital services from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF. The NHS minimum contributions for social care and NHS commissioned out of hospital spend for all HWB areas in both 2023-24 and 2024-25 has been uplifted by 5.66%.

53. As in previous years, the minimum expectations in each HWB area will be confirmed in the BCF planning template. ICBs and councils may agree a higher level of spend, where this will deliver value to the system and is affordable.

54. For the purposes of the social care minimum spend - any schemes where the spend type is 'social care' and the funding source is the NHS minimum will count towards this expectation. It is for local areas to agree the schemes that will be funded from this minimum.

55. For the purposes of the minimum spend on NHS Commissioned out of hospital services, any schemes where the spend area is allocated to primary, community health, continuing care or social care that is commissioned by ICBs from the NHS minimum contribution will count towards this expectation.

Metrics

56. The 2023-25 BCF Policy Framework sets national metrics (performance objectives) that must be included in BCF plans.

57. The BCF planning process will collect agreed ambitions for 2023-24 only, including supporting rationales, plans for achieving these ambitions and how BCF funded services will support this. From Q3, areas will be required to set ambitions for a new metric that measures timely discharge (see below).

58. Baseline data on discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions will be made available on the Better Care Exchange. Hospital trusts, local councils and ICBs should work together to continue to improve the use of situation reporting and other data to understand flow.

59. Ambitions for 2023-24 should be set based on:

- current performance (from locally derived and published data)
- local priorities and anticipated demand and available capacity. Ambitions should reflect demand and capacity planning for intermediate care as well as wider capacity planning as part of the Market Sustainability and Improvement Fund (MSIF) and the UEC capacity plan.
- planned (particularly BCF funded) services and changes to locally delivered services based on performance to date.

New discharge data collection

60. The discharge ready date field in the Commissioning Data Set has become a required field and will be used to collect the date a person no longer meets any of the criteria to reside from April 2023. This data will be used as a basis for a metric linked to delayed discharge, contingent on further testing and data quality.

61. As set out in the Delivery plan for recovering urgent and emergency care services, we will work with local systems to develop a new metric that measures the time from the discharge-ready date to the actual date of discharge. We will publish the new data as soon as possible ahead of next winter following trialling and testing with local providers and patient groups, in support of collaborative action across the NHS, local government

and the social care sector to improve discharge planning and capacity planning. Within the development of this metric we will consider how to include the clinically ready for discharge metric for mental health, leaning disability and autism services.

62. We have outlined expected changes to metrics for 2024-25 in the Policy Framework. Ahead of the start of 2024-25, local areas will be asked to review their metric ambitions in relation to BCF plans for 2024-25 in collaboration with health and social care partners. Metrics outlined for 2024-25 are designed to build on wider developments including the new Office for Local Government (OFLOG), client level data developments and the implementation of the new discharge delay metric. Areas will be required to submit metric ambitions for 2024-25 as part of this review. Further detail and the updated requirements and template will be published in early 2024. Monitoring and additional oversight is likely to be in place for areas where data shows that delayed discharges are significantly higher or increasing at a greater rate than the national averages.

63. It is recommended that systems update the Capacity Tracker with bed vacancy data daily, where possible, as this information can be used by local discharge and brokerage teams when planning patient discharges. It also helps ensure that patients are discharged to the right place for their specific care needs.

Process and Timeline

64. Final narrative plans and completed planning templates (including capacity and demand plans), should be submitted by 28 June. Areas are strongly encouraged to submit draft plans (including capacity and demand plans) to BCMs (copied to the BCF team) by 19 May for review and feedback.

Intermediate care capacity and demand planning

65. Capacity and demand planning for intermediate care is an integral part of the BCF this year and should be used to ensure areas are improving their performance against BCF metrics, as well as working towards the objectives of the programme and improving understanding of how funding could be best used locally. Intermediate care capacity and demand plans will need to be submitted as part of BCF plans and will form part of the assurance process. Assurers will review narrative plans and capacity and demand

information, looking at how estimates of capacity and demand have been taken on board and reflected in the wider BCF plans. Please see Appendix 2 for further detail and definitions.

66. The estimates of capacity and demand should be drawn up alongside, and influence, plans for delivering against national conditions 2 and 3, and plans for use of BCF funding. In relation to discharge, capacity and demand for Pathway 3 should also be captured where this is a short term placement prior to assessment for long term care. The template for collecting capacity and demand estimates is included in the main BCF planning template.

67. Areas will need to jointly develop a single picture of intermediate care needs and resources across health and social care, funded by the BCF and other sources for the financial year 2023-24 with a further review ahead of winter. Intermediate care capacity and demand plans for 2024-25 will be drawn up in the final quarter of 2023-24 so as to reflect the most up to date position and build on progress in 2023-24. There is no expectation that the BCF should be used to fund all services within this intermediate care capacity and demand plan.

68. Areas should work closely across all partners to produce the capacity and demand plan for intermediate care, and utilise data submitted by NHS organisations on acute, community and mental health hospital discharge pathway activity – as well as local government service data – as part of operational plans. NHS trusts should be involved in, and contribute to, the development of these plans; and areas should build a shared understanding of the data and evidence. The plans should also complement and build on the capacity and demand sections of UEC recovery plan returns in the NHS planning returns – where these can be mapped to local council area and wider capacity and demand planning initiatives such as those through the Market Sustainability and Improvement Fund (MSIF) where possible. MSIF aims to capture long term social care capacity whereas the BCF intermediate care capacity and demand plans will capture short term capacity across health and social care.

69. Further guidance is set out in Appendix 2, and bespoke support will be available through the BCF external support programme. This support will include specialised support on intermediate care capacity and demand, including working across organisational boundaries and sourcing capacity and demand data across all discharge pathways and sectors.

Narrative planning

70. Narrative plans must be submitted alongside the main BCF planning template. A narrative template has been made available on the Better Care Exchange site, but areas can use their own formats.

71. Two or more Health and Wellbeing Board areas can agree and submit a joint narrative plan, where approaches to integration and meeting the requirements of the BCF are aligned. In these cases, a separate planning template will still need to be completed for each HWB.

Expenditure planning

72. The planning template will continue to be used to collect expenditure details, confirmed funding contributions and confirmation that planning requirements are met. This will include information on discharge and non-discharge spend, as in previous years.

73. The requirement to indicate planned activity and the percentage of planned spend that BCF activity represents are new for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity, but, as estimates, these figures will not be subject to assurance.

74. When completing the BCF planning template, areas should, as far as possible, avoid classifying scheme types as ‘other’ where a specific scheme category can be used. The clarity of this information is important in being able to account properly for the effective use of the funding pooled into the BCF. Areas may be asked for further information on spend classed as 'other’ through the assurance process.

BCF Support Programme

75. The Better Care Fund Support Programme will ensure that local areas have the right support available as they work towards the requirements, conditions and metric ambitions set out in delivering their BCF plans. This will include support in relation to

reducing delays in discharge, improving prevention, managing overall system flow and improving integration between health, housing and social care services.

76. The support programme has now been expanded and will be in place for the next two years. A contract is in place with the LGA working with ADASS and Newton to ensure responsive and comprehensive support is available to all systems that need it, as well as supporting the development of national tools and good practice guidance (including in relation to capacity and demand). Regular webinars and events will also be part of the support on offer.

Assurance

77. The regionally led assurance processes will confirm that the content of local areas' plans enable significant progress towards delivering against the BCF objectives and priorities outlined in the BCF policy framework and these Planning Requirements. Spending and reporting requirements relating to the additional discharge funding may be impacted by updates to conditions in 2024-25 (see paragraph 47).

78. As set out in para 50 assurance panels will be provided with information on systems that have been identified as requiring additional support and performance improvement in relation to wider discharge performance in order to take this into account. Assurance of final plans will be led by Better Care Managers (BCMs) for each region with input from NHS England and local government representatives. It will be a single stage exercise based on a set of key lines of enquiry (KLoEs).

79. A cross-regional calibration meeting will be held after regions have submitted their recommendations, bringing together representatives from each region.

80. Following the calibration meeting, recommendation for approval will be made by NHS England regional directors – this will include confirmation that local government representatives were involved in assurance and agree the recommendations. NHS England will approve BCF plans in consultation with DHSC and DLUHC. NHS England, as the accountable body for the NHS minimum contribution to the fund, will write to areas to confirm that the NHS minimum funding can be released subject to ongoing compliance with the conditions. There may be additional approval conditions relating to discharge improvement and support.

Table 1: BCF assurance categories

Category	Description
Approved	• Plan meets all national conditions and planning requirements. Agreed ambitions for BCF metrics are sufficiently stretching • Agreement on use of local government grants (DFG, iBCF and discharge funding) • No or only limited work needed to gather additional information on plan – where there is no impact on national conditions
Not approved	• One or more of the following apply: – plan is not submitted – one or more national conditions or requirements are not met, including in relation to capacity and demand plans and metric ambitions. – no local agreement on use of local government grants (DFG, iBCF and discharge funding).

81. Where plans are not submitted or not initially approved, the BCF team may implement a programme of support, with partners, to help areas achieve approval as soon as possible or consider placing the area into formal escalation (see Appendix 1).

Monitoring, reporting and continued compliance

Updating BCF plans in year and in 2024-25

82. It is recognised that areas may wish to amend plans in-year, following sign off and assurance, to:

- modify or decommission schemes
- increase investment or include new schemes.

83. In such instances, any changes to assured and approved BCF plans arising in-year must be jointly agreed between the local council and ICBs and continue to meet the conditions and requirements of the BCF.

84. Revisions to plans should be approved by the HWB and confirmed in the end-of-year reporting template with an accompanying rationale. If the need arises to amend BCF plans in-year, please contact the relevant BCM in the first instance.

85. Areas will be required to submit ambitions for BCF metrics and plans of intermediate care capacity and demand for 2024-25 in the final quarter of the 2023-24 financial year. Any changes to discharge funding requirements, or revisions to allocations for 2024-25 will also need to be included. Further information on these requirements will be published prior to 2024-25. These updates will be reviewed by BCF assurers at regional level.

Reporting

86. 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.

87. Quarterly reporting will recommence from Quarter 2 in 2023-24 and will cover progress in implementing BCF plans, progress against metrics and ongoing compliance with the requirements and conditions of the fund. Timely submission of reports is a requirement for the BCF, including as a condition of the iBCF. These reports need to be signed off by HWBs as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into section 75 agreements. Reporting will include confirmation that the section 75 agreement is in place. As set out in para 46 reporting requirements in relation to the additional discharge funding will continue on a fortnightly basis, further details and the templates will be provided as soon as possible.

Monitoring compliance with BCF plans

88. In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

89. Where an area is not compliant with the requirements and conditions of the BCF, or if metric ambitions are not being met, or if the funds are not being spent in accordance with the agreed plan and risk the requirements being unmet, then the BCF team, in consultation with national partners, including NHS England and the LGA, may make a recommendation to initiate an escalation process. Monitoring of the new metric on delayed discharge will be contingent on further testing and data quality. BCF monitoring will be linked to the integrated approach to performance improvement and support in local systems described earlier that brings together leaders from across the NHS, local government and the social care sector to target support to the most challenged areas, particularly in relation to discharge. Any intervention will be proportionate to the risk or issue identified.

90. The intervention and escalation process could lead to NHS England exercising its powers of direction through section 223G/223GA/223GB to ICBs, in consultation with DHSC and DLUHC. Further information on this approach is outlined in Appendix 1.

Timetable

The timescales for agreeing BCF plans and assurance are set out below:

BCF planning requirements published	5 April
Optional draft BCF planning submission (including intermediate care capacity and demand plan) submitted to BCM and copied to the BCF team (england.bettercarefundteam@nhs.net)	19 May
BCF planning submission (including intermediate care and short term care capacity and demand plan; and discharge spending plan) from local HWB areas (agreed by ICBs and local government). All submissions will need to be sent to the local BCM, and copied to england.bettercarefundteam@nhs.net	28 June
Scrutiny of BCF plans by regional assurers, assurance panel meetings and regional moderation	28 June – 28 July
Regionally moderated assurance outcomes sent to BCF team	28 July
Cross-regional calibration	3 August
Approval letters issued giving formal permission to spend (NHS minimum)	8 September
All section 75 agreements to be signed and in place	31 October

Appendix 1: Support, escalation and intervention

92. Where plan development is a concern or a plan is not submitted or in-year there are concerns over compliance with the requirements of the BCF or concerns about progress against metrics, the BCF team and BCM will take steps to return the area to compliance or support improvement. In relation to discharge, this process will work with the integrated approach to performance improvement and support outlined earlier to identify if BCF escalation is appropriate.

93. The purpose of escalation in relation to plan approval is to assist areas to reach agreement on a compliant plan and support local areas to use BCF funding in the best possible way locally to enable them deliver against the objectives of the fund. It is not an arbitration or mediation process. This will initially be a regional process, facilitated by the BCF programme and team involving NHS England and local government. 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.

94. The escalation panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. However, a BCF plan will not be approved if there is no 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 not to be met.

95. Broadly this will involve the following steps:

1. **Trigger:**	The BCM and regional partners in consultation with the BCF team will consider whether to recommend specific support or if the area should be recommended for escalation.

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 d. Area is no longer compliant with their approved plan (in year) e. Area is not making progress against metrics	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 or national meeting.
3. Formal support	The BCM will work with the BCF team 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 BCF team to discuss the concerns, plans to address these and a timescale for addressing the issues identified.
5. **Commencing escalation**	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. **Escalation panel**	The escalation panel will be jointly chaired by DLUHC and DHSC senior officials, supported by the BCF team, with representation from:

	• NHS England (as the accountable body for NHS spend and for plan approval) • The LGA, in its role as a national partner for the BCF. Representation from the local area needs to include the: • health and wellbeing board chair • accountable officers from the relevant ICB(s) • chief executive from the local council.
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 BCF team.
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 • directing the ICB, eg regarding its use of resources. 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.

Appendix 2: Capacity and demand plans

Capacity and Demand Planning

Introduction

100. As in 2022-23, systems are expected to submit capacity and demand plans for intermediate care as part of their 2023-25 BCF plans. Areas are expected to agree estimated demand for intermediate care (rehabilitation and reablement) services, and other short term services lasting up to 6 weeks (including all other short term domiciliary services). This includes patients discharged from mental health, learning disability and autism inpatient services that need to access these services and before a long-term social care or health needs assessment is carried out (if necessary), covering demand for both services to support people to stay at home (including avoiding unnecessary hospital admissions) and hospital discharge pathways 0–3 inclusive, or equivalent. In line with the rest of the BCF planning requirements, references to hospitals include acute, mental health and community hospitals.

101. Intermediate care (rehabilitation and reablement) services are provided to individuals, usually older people, after leaving hospital or when they are at risk of being sent to hospital. Intermediate care helps people to avoid going into hospital or residential care unnecessarily, helps them to be as independent as possible after a stay in hospital, and can be provided in different places (for example community hospital, residential home or in people's own homes). Plans should cover all short term care, which in some cases may be separate to intermediate care.

102. Areas should outline expected capacity and demand for their intermediate care services lasting up to 6 weeks and before a long-term social care needs assessment is carried out (if necessary). Plans should cover demand for both services to support people to stay at home (including avoiding unnecessary hospital admissions) and hospital discharge pathways 0–3 inclusive, or equivalent, on a monthly basis for the whole of 2023-24. These plans should cover both BCF funded activity and non BCF funded activity.

103. Areas are asked to review actual demand and use of services from the previous year, expected changes, and use this to review capacity (including how utilisation of capacity could be improved). As set out earlier, these should initially cover the 12 months from April 2023 to March 2024, with refreshed plans required ahead of winter and before the start of 2024-25.

Aims of capacity and demand planning

104. For the commissioning of intermediate care to work well in an integrated context, there needs to be a joint understanding of the demand for health and social care services and a comprehensive picture of capacity. The aims of capacity and demand planning in the BCF are to:

- Ensure that an integrated approach to capacity and demand planning for intermediate care is happening across health and social care in all systems. This will ensure local areas are commissioning sufficient capacity to maintain individuals' independence, support flow through urgent and emergency care services (including mental health, learning disability and autism services), and improve hospital discharge.

- Continue to improve understanding (locally, regionally and nationally) of the capacity required and potential gaps in systems, with the resulting business intelligence driving commissioning decisions to support and enable long term planning and solutions.
- Inform nationally commissioned support (particularly BCF support) and policy.
- Provide insights regarding the potential to improve the impact and outcomes for people who use intermediate care – with a view to increasing the number of people receiving support in their own home, where appropriate.

- Ensure that areas are able to allocate resources effectively and improve value for money of these services.

105. The capacity and demand plans should also build, as appropriate, on any assumptions made in development of Urgent and Emergency Care Recovery plan capacity and demand plans in the NHS planning round.

Content of plans

106. Capacity and demand planning should include consideration of work to improve commissioning, the plans will need to reflect:

- Reducing over-prescription.
- Addressing duplication in terms of service and referral route.

- Anticipating staffing and resource needs.
- Expected demand and planned capacity for services to help a person remain independent at home.
- Expected demand and planned capacity for services to help a person be discharged from hospital.

107. The demand sections will now include a comparison of the previous year's demand with expected demand for the next year. Information will be gathered via the main BCF planning template.

108. The overall process includes:

- Using BCF narrative plans to review demand for intermediate care from 2022-23, including:
    - referrals in 2022-23, compared to expectations;
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services); and
    - expected increases in demand based on demographics or other factors from 2022-23.
- Considering capacity, including:
    - current commissioned services;
    - use of different pathways against plan and potential gaps (impact of efforts to reduce bedded intermediate care and long term care, where a different service would achieve a better outcome; and
    - areas for additional investment (including use of additional discharge funding) to improve access to intermediate care and outcomes for local people.

109. The capacity and demand template for BCF plans collects information on capacity for the following types of service:

- Short-term domiciliary care to support someone to remain at home following a deterioration, fall, or following a spell in hospital.

- Reablement and rehabilitation provided to people in their own homes either to recover function and avoid admission to hospital/residential care (step-up), or to enable a return to home, following a spell in hospital (step-down).

- Reablement and rehabilitation provided in a bedded setting, either to recover function and avoid admission to hospital/residential care (step-up), or to facilitate an eventual return home following a spell in hospital (step down).

- Urgent Community Response (crisis response) to prevent hospital admissions.

- Low level support provided to a person to help them return home following a stay in hospital, or to help someone stay at home in a crisis. This could include voluntary organisations that provide social and practical support to people or other neighbourhood support that is less intensive than reablement or intermediate care.

110. For discharge, capacity and demand for Pathway 3 should also be captured where this is specifically a short-term placement prior to assessment for long-term care.

Assurance

111. These capacity and demand plans will need to be submitted as part of BCF plans and the assurance process will review whether the plans are robust and ensure that the narrative, spending and metrics elements of the plan have taken on board the findings in the capacity and demand estimates. Assurance will be focused on how the modelling has been taken into account in the main BCF plan rather than the estimates themselves.

Completing the template

112. Some changes have been made to the capacity and demand sheets to reflect learning from 2022-23. The structure of each collection and additional guidance is set out below.

Community demand

113. Systems will need to use this section to estimate demand for each type of intermediate care service from people currently living at home. ‘Home’ should include care homes where this is the usual place of residence.

114. Consider different routes of referral – e.g. 111/999, Single Point of Access (SPA), and self-referral. The table has been updated to collect referrals from different sources. The name of the source is not pre-populated. Referrers should be involved in the process to help understand unmet demand – i.e. where a person has received care from a service, but their needs could have been more appropriately met

elsewhere. In reviewing demand, systems should try to avoid assuming that the actual number of users or capacity of services reflects demand.

115. These considerations could include:

- People who are not offered the support, due to capacity constraints.
- Unplanned admissions for chronic conditions – could some have been prevented?
- People offered long term care or short term care without reablement instead of reablement or rehabilitation (this might be care in their current place of residence or admission to a care home).

116. These factors from 2022-23 will need to be considered when recording expected community demand for 2023-24, as well as any expected changes from the previous year.

117. Demand for low level support should include people whose short term needs could be met by social support from Voluntary sector organisations or similar services (those that fall short of the definition of Urgent Community Response with a two hour response time.)

Community capacity

118. When reviewing the range of commissioned services that support people in crisis, areas should identify services in the LA area that provide intermediate care by service type, and review data on planned capacity, actual referrals and time spent in the service. You should review information from providers, data on the Community Services Dataset (for example on Urgent Community Response) and data submitted on ASC activity to the Short and Long Term Care dataset.

119. These estimates should cover current expected commissioned capacity (not including spot purchasing, although use of spot purchasing in 2022-23 should be reviewed to try and improve capacity assessments going forward).

120. Capacity is measured as the number of new users the service can accept per month. This should be based on the maximum safe capacity at any time, the average length of stay and the number of days in the month – see below.

$$\frac{\text{Number of people the service can support at any given time* x days in the month}}{\text{average length of stay (in days)*}}$$

* +/- 5%

121. Where services accept community and hospital referrals, the capacity available should be adjusted to reflect the estimated proportion of users that are accepted into the service from the community.

Discharge demand

122. The discharge expected demand section should also review activity from the previous year, including:

- Average discharges per month at LA level (SUS).
- Adjustments for population and possibly higher turnover with additional funding.
- The pathways people were discharged into.
- Number/proportion discharged into rehabilitation at home (SALT/Trust data that feeds ASCOF on coverage of reablement).
- Include people waiting for onward referral from community hospital/nursing home for support at home.
- Do not include people moving from a hospital ward to a virtual ward, but do include people coming out of virtual ward into the community.

123. Pathway 0 demand should reflect only those cases where a person may require support from VCS or neighbourhood team for a short period. Do not include simple discharges or where there is no support other than outpatient or GP follow up, or where a person is returning to an existing care home or domiciliary care package with no additional support needs.

Discharge capacity

124. As with last year, areas will need to set out expected intermediate care capacity available for supporting discharge at the HWB level, covering both LA and ICB commissioned activity and taking into account expected demand changes. Areas will need to:

- Set out planned commissioned services for the 12 months – not including spot purchasing but reviewing the use of this in 2022-23.
- Include additional services funded with the additional discharge funding for 23-24.
- The template will collect data from individual services – e.g. a set of intermediate care beds, or a reablement team.

125. Where packages of care are commissioned at ICB level, the capacity should be apportioned to LAs based on locally held data on hospital occupancy and discharges and service provision.

126. Capacity is measured as the number of new users the service can accept per month. This should be based on the maximum safe capacity at any time, the average length of stay and the number of days in the month – see below.

$$\frac{\text{Number of people the service can support at any given time* x days in the month}}{\text{average length of stay (in days)*}}$$

* +/- 5%

127. Where services accept community and hospital referrals the capacity available should be adjusted to reflect the estimated proportion of users that are accepted into the service from hospital.

Low level support for simpler discharges

128. We are collecting information on the number of less complex discharges (classed as Pathway 0 i.e. do not need a full package of reablement or intermediate care) but where support from the VCS or local services is needed to help the person return home. You should estimate number of people that can be supported/facilitated by commissioned VCS capacity and also expected numbers of people that will be supported by community providers and the local council (short of reablement) that can be delivered.

Other sources of guidance

Further guidance and advice on capacity and demand planning is available.

- Report for the LGA on developing a capacity and demand model for out-of-hospital care by Professor John Bolton, based on work with seven systems.
- The NHS England Demand and Capacity Team have resources available to support with capacity and demand planning including models, guidance about fundamentals and principles and other resources here.
- The Better Care Exchange, where some additional supporting documents including an FAQ will be published

Contact us:

If you have any queries about this document, please contact the BCF team at: england.bettercarefundteam@nhs.net

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

For more information and regular updates on the Better Care Fund, sign up to our fortnightly bulletin and the Better Care Exchange by emailing england.bettercarefundexchange@nhs.net

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This publication can be made available in a number of other formats on request.

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BCF Planning Template 2023-25

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 blue background, as below:

Data needs inputting in the cell

Pre-populated cells

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).
3. The checklist helps identify the sheets that have not been completed. All fields that appear highlighted in red with the word 'no', should be completed before sending to the Better Care Fund Team.
4. The checker column, which can be found on each individual sheet, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'.

5. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
6. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
7. Please ensure that all boxes on the checklist are green before submission.
8. Sign off - HWB sign off will be subject to your own governance arrangements which may include delegated authority.

4. Capacity and Demand

Please see the guidance on the Capacity&Demand tab for further information on how to complete this section.

5. Income

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2023-25. It will be pre-populated with the minimum NHS contributions to the BCF, iBCF grant allocations and allocations of ASC Discharge Fund grant to local authorities for 2023-24. The iBCF grant in 2024-25 is expected to remain at the same value nationally as in 2023-24, but local allocations are not published. You should enter the 2023-24 value into the income field for the iBCF in 2024-25 and agree provisional plans for its use as part of your BCF plan

2. The grant determination for the Disabled Facilities Grant (DFG) for 2023-24 will be issued in May. Allocations have not been published so are not pre populated in the template. You will need to manually enter these allocations. Further advice will be provided by the BCF Team.

3. Areas will need to input the amount of ASC Discharge Fund paid to ICBs that will be allocated to the HWB's BCF pool. These will be checked against a separate ICB return to ensure they reconcile. Allocations of the ASC discharge funding grant to local authority will need to be inputted manually for Year 2 as allocations at local level are not confirmed. Areas should input an expected allocation based on the published national allocation (£500m in 2024-25, increased from £300m in 2023-24) and agree provisional plans for 2024-25 based on this.

4. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

5. Please use the comment boxes alongside to add any specific detail around this additional contribution.

6. If you are pooling any funding carried over from 2022-23 (**i.e. underspends from BCF mandatory contributions**) you should show these as additional contributions, but on a separate line to any other additional contributions. Use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

7. Allocations of the NHS minimum contribution are shown as allocations from each ICB to the HWB area in question. Where more than one ICB contributes to the area's BCF plan, the minimum contribution from each ICB to the local BCF plan will be displayed.

8. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

6. Expenditure

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, units, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Condition 4 and is used by assurers to ensure that these 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 NHS 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 text 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 a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

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 in tab 6b.
- 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. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Expected outputs
- You will need to set out the expected number of outputs you expect to be delivered in 2023-24 and 2024-25 for some scheme types. If you select a relevant scheme type, the 'expected outputs' column will unlock and the unit column will pre populate with the unit for that scheme type.
- You will not be able to change the unit and should use an estimate where necessary. The outputs field will only accept numeric characters.
- A table showing the scheme types that require an estimate of outputs and the units that will prepopulate can be found in tab 6b. Expenditure Guidance.

You do not need to fill out these columns for certain scheme types. Where this is the case, the cells will turn blue and the column will remain empty.

6. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards eligible expenditure on social care under National Condition 4.
- 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.

7. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend on NHS commissioned out of hospital services under National Condition 4. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

8. Provider:
- Please select the type of 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.

9. 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. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

10. Expenditure (£) 2023-24 & 2024-25:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

11. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

12. Percentage of overall spend. This new requirement asks for the percentage of overall spend in the HWB on that scheme type. This is a new collection for 2023-25. This information will help better identify and articulate the contribution of BCF funding to delivering capacity.

You should estimate the overall spend on the activity type in question across the system (both local authority and ICB commissioned where both organisations commission this type of service). Where the total spend in the system is not clear, you should include an estimate. The figure will not be subject to assurance. This estimate should be based on expected spend in that category in the BCF over both years of the programme divided by both years total spend in that same category in the system.

7. Metrics

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2023-25. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2023-24.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2023-24. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2021)
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Please use the ISR Tool published on the BCX where you can input your assumptions and simply copy the output ISR:
https://future.nhs.uk/bettercareexchange/view?objectId=143133861
- Technical definitions for the guidance can be found here:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Falls
- This is a new metric for the BCF and areas should agree ambitions for reducing the rate of emergency admissions to hospital for people aged 65 or over following a fall.
- This is a measure in the Public Health Outcome Framework.
- This requires input for an Indicator value which is directly age standardised rate per 100,000. Emergency hospital admissions due to falls in people aged 65 and over.
- Please enter provisional outturns for 2022-23 based on local data for admissions for falls from April 2022-March 2023.
- For 2023-24 input planned levels of emergency admissions
- In both cases this should consist of:
    - emergency admissions due to falls for the year for people aged 65 and over (count)
    - estimated local population (people aged 65 and over)
    - rate per 100,000 (indicator value) (Count/population x 100,000)

- The latest available data is for 2021-22 which will be refreshed around Q4.
Further information about this measure and methodolgy used can be found here:
https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/6/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015/iid/22401/age/27/sex/4

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2022-23, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2023-24 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2022-23 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

4. Residential Admissions:
- This section requires inputting the expected numerator of the measure only.
- 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)
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement:
- 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 expected 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.
- Column H asks for an estimated actual performance against this metric in 2022-23. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

8. Planning Requirements

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Planning Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2023-2025 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs 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.

Better Care Fund 2023-25 Template

2. Cover

Version 1.1.3

Please Note:

- The BCF planning template is categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website and gov.uk. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
- All information will be supplied to BCF partners to inform policy development.
- 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:	Lucia Plant
E-mail:	Lucia.Plant@blackpool.gov.uk
Contact number:	01253 477107
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no please indicate when the HWB is expected to sign off the plan:	

	Role:	**Professional Title (e.g. Dr, Cllr, Prof)**	**First-name:**	**Surname:**	**E-mail:**
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Jo	Farrell	jo.farrell@blackpool.gov.uk
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Sam	Proffitt	sam.proffitt3@nhs.net
	Additional ICB(s) contacts if relevant	N/A	N/A	N/A	N/A
	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		Lucia	Plant	lucia.plant@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 e.g. housing or trusts that have been part of the process -->					

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Capacity&Demand	Yes
5. Income	Yes
6a. Expenditure	No
7. Metrics	Yes
8. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Template

3. Summary

Selected Health and Wellbeing Board: Blackpool

Income & Expenditure

Income >>

Funding Sources	Income Yr 1	Income Yr 2	Expenditure Yr 1	Expenditure Yr 2	Difference
DFG	£2,614,944	£2,614,944	£2,614,944	£2,614,944	£0
Minimum NHS Contribution	£17,939,859	£18,955,255	£17,939,859	£18,955,255	£0
iBCF	£10,875,315	£10,875,315	£10,875,315	£10,875,315	£0
Additional LA Contribution	£767,033	£767,033	£767,033	£767,033	£0
Additional ICB Contribution	£17,118,396	£17,118,396	£17,118,396	£17,118,396	£0
Local Authority Discharge Funding	£1,524,702	£2,531,005	£1,524,702	£2,531,005	£0
ICB Discharge Funding	£837,160	£1,576,394	£837,160	£1,576,394	£0
Total	**£51,677,409**	**£54,438,342**	**£51,677,409**	**£54,438,342**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

	Yr 1	Yr 2
Minimum required spend	£5,097,999	£5,386,546
Planned spend	£5,910,801	£6,245,351

Adult Social Care services spend from the minimum ICB allocations

	Yr 1	Yr 2
Minimum required spend	£11,804,334	£12,472,460
Planned spend	£13,016,548	£13,753,286

Metrics >>

Avoidable admissions

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	498.0	518.0	574.0	461.0

Falls

		2022-23 estimated	2023-24 Plan
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,978.0	1,938.0
	Count	581	569
	Population	29362	29336

Discharge to normal place of residence

	2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	91.1%	60.1%	92.0%	92.5%

Residential Admissions

		2021-22 Actual	2023-24 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	531	467

Reablement

		2023-24 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.7%

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: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2023-24 Capacity & Demand Template

3. Capacity & Demand

Selected Health and Wellbeing Board: Blackpool

Guidance on completing this sheet is set out below, but should be read in conjunction with the guidance in the BCF planning requirements

3.1 Demand - Hospital Discharge

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.
Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template aligns tothe pathways in the hospital discharge policy, but separates Pathway 1 (discharge home with new or additional support) into separate estimates of reablement, rehabilitation and short term domiciliary care)

If there are any trusts taking a small percentage of local residents who are admitted to hospital, then please consider aggregating these trusts under a single line using the '**Other**' Trust option.
The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.
Estimated levels of discharge should draw on:
- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2023-24
- Data from the NHSE Discharge Pathways Model.
- Management information from discharge hubs and local authority data on requests for care and assessment.

You should enter the estimated number of discharges requiring each type of support for each month.

3.2 Demand - Community

This section collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care or short term care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 2 of the Planning Requirements.

The units can simply be the number of referrals.

3.3 Capacity - Hospital Discharge

This section collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:
- Social support (including VCS)
- Reablement at Home
- Rehabilitation at home
- Short term domiciliary care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting
- Short-term residential/nursing care for someone likely to require a longer-term care home placement

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

3.4 Capacity - Community

This section collects expected capacity for community services. You should input the expected available capacity across the different service types.
You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 7 types of service:
- Social support (including VCS)
- Urgent Community Response
- Reablement at home
- Rehabilitation at home
- Other short-term social care
- Reablement in a bedded setting
- Rehabilitation in a bedded setting

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay
Caseload (No. of people who can be looked after at any given time)
Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility
Please consider using median or mode for LoS where there are significant outliers
Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

At the end of each row, you should enter estimates for the percentage of the service in question that is commissioned by the local authority, the ICB and jointly.

Virtual wards should not form part of capacity and demand plans because they represent acute, rather than intermediate, care. Where recording a virtual ward as a referral source, pease select the relevant trust from the list. Further guidance on all sections is available in Appendix 2 of the BCF Planning Requirements.

Any assumptions made. Please include your considerations and assumptions for Length of Stay and average numbers of hours committed to a homecare package that have been used to derive the number of expected packages.	We do not currently discharge from hospital using reablement or rehabilitation at home hence the "0" figure

	Complete:
3.1	Yes
3.2	Yes
3.3	Yes
3.4	Yes

3.1 Demand - Hospital Discharge

!!Click on the filter box below to select Trust first!!

Trust Referral Source need) (Select as many as you need)	Demand - Hospital Discharge Pathway	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
(Please select Trust/s.....)	Social support (including VCS) (pathway 0)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		53	53	53	53	53	53	53	53	53	53	53	53
(Please select Trust/s.....)	Reablement at home (pathway 1)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s.....)	Rehabilitation at home (pathway 1)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		0	0	0	0	0	0	0	0	0	0	0	0
(Please select Trust/s.....)	Short term domiciliary care (pathway 1)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		74	78	76	78	78	76	78	76	77	78	73	78
(Please select Trust/s.....)	Reablement in a bedded setting (pathway 2)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		32	32	32	32	32	32	32	32	32	32	32	32
(Please select Trust/s.....)	Rehabilitation in a bedded setting (pathway 2)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		16	16	16	16	16	16	16	16	16	16	16	16
(Please select Trust/s.....)	Short-term residential/nursing care for someone likely to require a longer-term care home placement (pathway 3)												
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST		5	5	5	5	5	5	5	5	5	5	5	5
Totals	**Total:**	180	184	182	184	184	182	184	182	183	184	179	184

3.2 Demand - Community

Demand - Intermediate Care Service Type	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	24	32	30	30	30	30	30	30	30	30	30	30
Urgent Community Response	48	52	45	45	45	45	45	45	45	45	45	45
Reablement at home	39	45	42	42	42	42	42	42	42	42	42	42
Rehabilitation at home	36	42	40	40	40	40	40	40	40	40	40	40
Reablement in a bedded setting	33	35	32	32	32	32	32	32	32	32	32	32
Rehabilitation in a bedded setting	14	15	16	16	16	16	16	16	16	16	16	16
Other short-term social care	4	2	3	3	3	3	3	3	3	3	3	3

3.3 Capacity - Hospital Discharge

Capacity - Hospital Discharge Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	53	53	53	53	53	53	53	53	53	53	53	53
Reablement at Home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Rehabilitation at home	Monthly capacity. Number of new clients.	0	0	0	0	0	0	0	0	0	0	0	0
Short term domiciliary care	Monthly capacity. Number of new clients.	74	78	76	78	78	76	78	76	77	78	73	78
Reablement in a bedded setting	Monthly capacity. Number of new clients.	32	32	32	32	32	32	32	32	32	32	32	32
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	16	16	16	16	16	16	16	16	16	16	16	16
Short-term residential/nursing care for someone likely to require a longer-term care home placement	Monthly capacity. Number of new clients.	5	5	5	5	5	5	5	5	5	5	5	5

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
	100%	
	100%	
	100%	

3.4 Capacity - Community

Capacity - Community Service Area	Metric	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Social support (including VCS)	Monthly capacity. Number of new clients.	28	28	28	28	28	28	28	28	28	28	28	28
Urgent Community Response	Monthly capacity. Number of new clients.	45	45	45	45	45	45	45	45	45	45	45	45
Reablement at Home	Monthly capacity. Number of new clients.	42	42	42	42	42	42	42	42	42	42	42	42
Rehabilitation at home	Monthly capacity. Number of new clients.	40	40	40	40	40	40	40	40	40	40	40	40
Reablement in a bedded setting	Monthly capacity. Number of new clients.	32	32	32	32	32	32	32	32	32	32	32	32
Rehabilitation in a bedded setting	Monthly capacity. Number of new clients.	16	16	16	16	16	16	16	16	16	16	16	16
Other short-term social care	Monthly capacity. Number of new clients.	3	3	3	3	3	3	3	3	3	3	3	3

Commissioning responsibility (% of each service type commissioned by LA/ICB or jointly		
ICB	LA	Joint
	100%	
	100%	
	100%	

Better Care Fund 2023-25 Template

4. Income

Selected Health and Wellbeing Board: Blackpool

Local Authority Contribution		
Disabled Facilities Grant (DFG)	Gross Contribution Yr 1	Gross Contribution Yr 2
Blackpool	£2,614,944	£2,614,944
DFG breakdown for two-tier areas only (where applicable)		
Total Minimum LA Contribution (exc iBCF)	**£2,614,944**	**£2,614,944**

Local Authority Discharge Funding	Contribution Yr 1	Contribution Yr 2
Blackpool	£1,524,702	£2,531,005

ICB Discharge Funding	Contribution Yr 1	Contribution Yr 2
NHS Lancashire and South Cumbria ICB	£837,160	£1,576,394
Total ICB Discharge Fund Contribution	£837,160	£1,576,394

iBCF Contribution	Contribution Yr 1	Contribution Yr 2
Blackpool	£10,875,315	£10,875,315
Total iBCF Contribution	**£10,875,315**	**£10,875,315**

Are any additional LA Contributions being made in 2023-25? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box to clarify any specific uses or sources of funding
Blackpool	£767,033	£767,033	N/A
Total Additional Local Authority Contribution	**£767,033**	**£767,033**	

NHS Minimum Contribution	Contribution Yr 1	Contribution Yr 2
NHS Lancashire and South Cumbria ICB	£17,939,859	£18,955,255
Total NHS Minimum Contribution	**£17,939,859**	**£18,955,255**

Are any additional ICB Contributions being made in 2023-25? If yes, please detail below	Yes

Additional ICB Contribution	Contribution Yr 1	Contribution Yr 2	Comments - Please use this box clarify any specific uses or sources of funding
NHS Lancashire and South Cumbria ICB	£17,118,396	£17,118,396	N/A
Total Additional NHS Contribution	**£17,118,396**	**£17,118,396**	
Total NHS Contribution	**£35,058,255**	**£36,073,651**	

	2023-24	2024-25
Total BCF Pooled Budget	**£51,677,409**	**£54,438,342**

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

Better Care Fund 2023-25 Template

5. Expenditure

Selected Health and Wellbeing Board: Blackpool

<< Link to summary sheet

Running Balances	2023-24 Income	2023-24 Expenditure	2023-24 Balance	2024-25 Income	2024-25 Expenditure	2024-25 Balance
DFG	£2,614,944	£2,614,944	£0	£2,614,944	£2,614,944	£0
Minimum NHS Contribution	£17,939,859	£17,939,859	£0	£18,955,255	£18,955,255	£0
iBCF	£10,875,315	£10,875,315	£0	£10,875,315	£10,875,315	£0
Additional LA Contribution	£767,033	£767,033	£0	£767,033	£767,033	£0
Additional NHS Contribution	£17,118,396	£17,118,396	£0	£17,118,396	£17,118,396	£0
Local Authority Discharge Funding	£1,524,702	£1,524,702	£0	£2,531,005	£2,531,005	£0
ICB Discharge Funding	£837,160	£837,160		£1,576,394	£1,576,394	£0
Total	**£51,677,409**	**£51,677,409**	**£0**	**£54,438,342**	**£54,438,342**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum ICB Contribution (on row 33 above).

	2023-24 Minimum Required Spend	2023-24 Planned Spend	2023-24 Under Spend	2024-25 Minimum Required Spend	2024-25 Planned Spend	2024-25 Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£5,097,999	£5,910,801	£0	£5,386,546	£6,245,351	£0
Adult Social Care services spend from the minimum ICB allocations	£11,804,334	£13,016,548	£0	£12,472,460	£13,753,286	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

>> Incomplete fields on row number(s):

#NAME?

									Planned Expenditure						
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	**Expected outputs 2023-24**	**Expected outputs 2024-25**	**Units**	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding
1	Disabled Facitilites Grant-Capital	Adaptations to enable independent living	DFG Related Schemes	Adaptations, including statutory DFG grants		220	220	Number of adaptations funded/people	Social Care		LA			Local Authority	DFG
2	Phoenix Centre	Mental Health Crisis Team	Prevention / Early Intervention	Other	To Avoid Hospital Admissions				Social Care		LA			Local Authority	Minimum NHS Contribution
3	ARC inc Support Team	Residential Reablement Service	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		224	224	Number of Placements	Social Care		LA			Local Authority	Minimum NHS Contribution
4	Internal Homecare	Domiciliary care to support admission avoidance and support	Home Care or Domiciliary Care	Domiciliary care packages		5208	5208	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution
4	Internal Homecare	Domiciliary care to support admission avoidance and support	Home Care or Domiciliary Care	Domiciliary care packages		5208	5208	Hours of care	Social Care		LA			Local Authority	iBCF
5	Vitaline	Assistive technology service, including falls response. NWAS triage non injury falls	Assistive Technologies and Equipment	Assistive technologies including telecare		957	957	Number of beneficiaries	Social Care		LA			Local Authority	iBCF
5	Vitaline	Assistive technology service, including falls response. NWAS triage non injury falls	Assistive Technologies and Equipment	Assistive technologies including telecare		957	957	Number of beneficiaries	Social Care		LA			Local Authority	Additional LA Contribution
6	Keats	Day centre providing carer respite and support for people with advanced	Carers Services	Respite services		32	32	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution

7	Extra Support Service	Short term interventions for LD cases in crisis to get back on track to avoid admission to	Personalised Care at Home	Mental health /wellbeing					Social Care		LA			Local Authority	Minimum NHS Contribution
8	Coopers Way	Residential respite service for adults with learning disability	Carers Services	Respite services		79	79	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
8	Coopers Way	Residential respite service for adults with learning disability	Carers Services	Respite services		79	79	Beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
10	Primary MH Care	MH social care team	Integrated Care Planning and Navigation	Care navigation and planning					Social Care		LA			Local Authority	Minimum NHS Contribution
11	Hospital Discharge Team	Integrated hospital discharge team	High Impact Change Model for Managing Transfer of Care	Monitoring and responding to system demand and capacity					Social Care		LA			Local Authority	Minimum NHS Contribution
12	MH Day Services	Mental Health day support services	Prevention / Early Intervention	Other	Health and Wellbeing				Social Care		LA			Local Authority	Minimum NHS Contribution
13	CHC Team	Continuing Health Care social care team	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Continuing Care		LA			Local Authority	Minimum NHS Contribution
14	Additional Social Workers-neighbourhoods	Social care posts within neighbourhood team	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Local Authority	iBCF
16	Preparing for Adulthood	Dedicated autism posts to work alongside LD team	Care Act Implementation Related Duties	Other	Preparation for Adulthood Specialist Worker				Social Care		LA			Local Authority	Minimum NHS Contribution
17	Autism	Dedicated autism posts to work alongside LD team	Care Act Implementation Related Duties	Other	Autism Specialist Workers				Social Care		LA			Local Authority	Minimum NHS Contribution
21	Quality Assurance Team	QA team to monitor provider standards	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	Minimum NHS Contribution
22	Adults Equipment	Community equipment service to enable independent living	Assistive Technologies and Equipment	Community based equipment		9385	9385	Number of beneficiaries	Social Care		LA			Local Authority	Additional NHS Contribution
23	Care and Repair Contract-BCH	Handyman and repair service	Housing Related Schemes						Social Care		LA			Local Authority	Minimum NHS Contribution
24	Spending Review Original Ibcf	Uplift in provider rates	Enablers for Integration	Joint commissioning infrastructure					Social Care		LA			Local Authority	iBCF
27	Childrens Equipment	Community contract allocation	Assistive Technologies and Equipment	Community based equipment		0	0	Number of beneficiaries	Social Care		LA			Local Authority	Additional NHS Contribution
56	Richmond Fellowship	Community support and housing to support mental health patients	Integrated Care Planning and Navigation	Care navigation and planning					Mental Health		LA			Private Sector	Additional LA Contribution
28	Hub Manager	Community contract allocation	Other						Social Care		LA			Local Authority	Minimum NHS Contribution
29	Speech and Language	Community contract allocation	Other						Primary Care		LA			Local Authority	Minimum NHS Contribution
30	YOT	Community contract allocation	Other						Social Care		LA			Local Authority	Minimum NHS Contribution
30	YOT	Community contract allocation	Other						Social Care		LA			Local Authority	iBCF
30	YOT	Community contract allocation	Other						Social Care		LA			Local Authority	Additional LA Contribution

31	Care Co-ordinator Manager	Community contract allocation	Other						Social Care		LA			Local Authority	Additional NHS Contribution
32	Enhanced Primary Care and Care Homes	Development of neighbourhood care team and care home model in line	High Impact Change Model for Managing Transfer of Care	Improved discharge to Care Homes					Primary Care		NHS			NHS Community Provider	Minimum NHS Contribution
33	Out of Hospital IV therapy service	Community IV therapy service for walk in, housebound and care homes patients to avoid	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
34	Frequent Callers	More than 5 calls in a rolling 7 days results in addition to a daily highlight report	Prevention / Early Intervention	Other	To Avoid Hospital Admissions				Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
35	Intermediate Care model	Step up / step down provision for intermediate care with clinically enhanced beds	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation accepting step up and step down users		224	224	Number of Placements	Social Care		NHS			NHS Community Provider	Minimum NHS Contribution
36	Carers support workers/grants	Targeted support for patients who access primary care regularly	Carers Services	Carer advice and support related to Care Act duties		986	986	Beneficiaries	Social Care		NHS			NHS Community Provider	Additional NHS Contribution
37	Rapid Response	Step up / step down provision for intermediate care with clinically enhanced beds	Urgent Community Response						Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
38	Hospital Discharge Team	Multi-disciplinary team covering all wards in acute settings to enable discharge	High Impact Change Model for Managing Transfer of Care	Engagement and Choice					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
39	Hospital Aftercare service (existing)	Voluntary sector service providing aftercare on discharge from acute settings.	High Impact Change Model for Managing Transfer of Care	Engagement and Choice					Social Care		NHS			Charity / Voluntary Sector	Additional NHS Contribution
40	Extensive Care Service	Community frailty service providing different levels of support for walk in,	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
41	GP Plus NEL scheme	GP utilisation of care coordination to avoid non-elective admissions	Community Based Schemes	Integrated neighbourhood services					Primary Care		NHS			NHS	Additional NHS Contribution
42	Enhanced Supported Discharge	Community service providing nursing and therapy to support patient transfers	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
43	Speech & Language-BTH	Community service providing speech and language provision	Other						Community Health		NHS			NHS Acute Provider	Minimum NHS Contribution
44	Richmond Fellowship	Community support and housing to support mental health patients	Integrated Care Planning and Navigation	Care navigation and planning					Mental Health		NHS			Private Sector	Minimum NHS Contribution
45	Community End of Life Team	Community team overseeing the development of EPaCCS and national EoIC tools along	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
46	Adult Beds	Community service responsible for providing beds for housebound patients	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Community Health		NHS			NHS Acute Provider	Additional NHS Contribution
47	Community Stroke and Neuro	Service providing support for stroke and neuro patients discharged from hospital to	Community Based Schemes	Integrated neighbourhood services					Community Health		NHS			NHS Community Provider	Minimum NHS Contribution
48	Rapid Response	Step up / step down provision for intermediate care with clinically enhanced beds	Urgent Community Response						Community Health		LA			Local Authority	Additional NHS Contribution
5	Vitaline	Assistive technology service, including falls response. NWAS triage non injury falls	Assistive Technologies and Equipment	Assistive technologies including telecare		957	957	Number of beneficiaries	Social Care		LA			Local Authority	Minimum NHS Contribution
50	ICB Contribution to Adults safeguarding	Contribution towards multi-agency Safeguarding Adults board	Enablers for Integration	Integrated models of provision					Social Care		NHS			Local Authority	Additional NHS Contribution
51	Additional Homecare Hours	Domiciliary care to support admission avoidance and support	Home Care or Domiciliary Care	Domiciliary care packages		5208	5208	Hours of care	Social Care		LA			Local Authority	Minimum NHS Contribution

52	Health Inequalities	Social care posts across Adult Social Care	Enablers for Integration	Integrated models of provision					Community Health		NHS			NHS	Additional NHS Contribution
53	ARC rehabilitation GP support	Residential Reablement Service	Bed based intermediate Care Services (Reablement,	Bed-based intermediate care with rehabilitation (to support discharge)		224	224	Number of Placements	Social Care		NHS			Local Authority	Additional NHS Contribution
54	Discharge to assess	Where people who are clinically optimised and	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		LA			Private Sector	Local Authority Discharge
55	Discharge to assess	Where people who are clinically optimised and	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs					Social Care		NHS			Private Sector	ICB Discharge Funding
41	GP Plus NEL scheme	GP utilisation of care coordination to avoid non-elective admissions	Community Based Schemes	Integrated neighbourhood services					Primary Care		NHS			NHS	Minimum NHS Contribution

Further guidance for completing Expenditure sheet

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2023-25 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Assistive technologies including telecare 2. Digital participation services 3. Community based equipment 4. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Independent Mental Health Advocacy 2. Safeguarding 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Carer advice and support related to Care Act duties 3. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level social support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. New governance arrangements 7. Voluntary Sector Business Development 8. Joint commissioning infrastructure 9. Integrated models of provision 10. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Short term domiciliary care (without reablement input) 4. Domiciliary care workforce development 5. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services (Reablement, rehabilitation in a bedded setting, wider short-term services supporting recovery)	1. Bed-based intermediate care with rehabilitation (to support discharge) 2. Bed-based intermediate care with reablement (to support discharge) 3. Bed-based intermediate care with rehabilitation (to support admission avoidance) 4. Bed-based intermediate care with reablement (to support admissions avoidance) 5. Bed-based intermediate care with rehabilitation accepting step up and step down users 6. Bed-based intermediate care with reablement accepting step up and step down users 7. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups.
12	Home-based intermediate care services	1. Reablement at home (to support discharge) 2. Reablement at home (to prevent admission to hospital or residential care) 3. Reablement at home (accepting step up and step down users) 4. Rehabilitation at home (to support discharge) 5. Rehabilitation at home (to prevent admission to hospital or residential care) 6. Rehabilitation at home (accepting step up and step down users) 7. Joint reablement and rehabilitation service (to support discharge) 8. Joint reablement and rehabilitation service (to prevent admission to hospital or residential care) 9. Joint reablement and rehabilitation service (accepting step up and step down users) 10. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Urgent Community Response		Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
14	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.

15	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
16	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
17	Residential Placements	1. Supported housing 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Short-term residential/nursing care for someone likely to require a longer-term care home replacement 7. Short term residential care (without rehabilitation or reablement input) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Workforce recruitment and retention	1. Improve retention of existing workforce 2. Local recruitment initiatives 3. Increase hours worked by existing workforce 4. Additional or redeployed capacity from current care workers 5. Other	These scheme types were introduced in planning for the 22-23 AS Discharge Fund. Use these scheme decriptors where funding is used to for incentives or activity to recruit and retain staff or to incentivise staff to increase the number of hours they work.
19	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Scheme type	Units
Assistive Technologies and Equipment	Number of beneficiaries
Home Care and Domiciliary Care	Hours of care (Unless short-term in which case it is packages)
Bed Based Intermediate Care Services	Number of placements
Home Based Intermeditate Care Services	Packages
Residential Placements	Number of beds/placements
DFG Related Schemes	Number of adaptations funded/people supported
Workforce Recruitment and Retention	WTE's gained
Carers Services	Beneficiaries

Better Care Fund 2023-25 Template

6. Metrics for 2023-24

Selected Health and Wellbeing Board: Blackpool

8.1 Avoidable admissions

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2022-23 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	316.2	328.9	360.9	412.0	The target has been set based on the number of avoidable admissions in 2022/23 and has been provided by the ICB.	The Rapid Response Team includes 2 Qualified Social Workers and works 7 days 8am-8pm, to avoid hospital admissions and readmissions. it provides crisis support and urgent care following requests directly from A+E to avoid hospital admission. Neighbourhood hubs work as multi-disciplinary teams within local
	Number of Admissions	524	545	598	-		
	Population	138,381	138,381	138,381	138,381		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Indicator value	498	518	574	461		

>> link to NHS Digital webpage (for more detailed guidance)

8.2 Falls

		2021-22 Actual	2022-23 estimated	2023-24 Plan	Rationale for ambition	Local plan to meet ambition
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	Indicator value	1,906.5	1,978.0	1,938.0	ICB METHODOLOGY 1. Use 2018 local authority population projections (65+) for the 2022-23 outturn (2022) 2023-24 (2023) and 2024-25 (2024) population denominators 2. Maintain 'adjustment' factor aligned to indirect standardisation throug the model. 3. Blackpool rate of 1906 is classed as	Vitaline, Technology Enabled Care Service, has successfully provided a 'falls pick up' service for over 20 years in Blackpool. This has recently been expanded to include NWAS Diverts of uninjured fallers, whereby NWAS will alert Vitaline of a faller call in the 'stack' and Vitaline will respond. If a successful fall is achieved then Vitaline stand down NWAS. Building on this
	Count	560	581	569		
	Population	29,362	29362	29336		

Public Health Outcomes Framework - Data - OHID (phe.org.uk)

8.3 Discharge to usual place of residence

*Q4 Actual not available at time of publication

		2022-23 Q1 Actual	2022-23 Q2 Actual	2022-23 Q3 Actual	2021-22 Q4 Plan	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	91.2%	92.2%	91.5%	99.0%	ICB METHODOLOGY 1. Use 2022-23 quarterly figures as the denominator in subsequent years 2. Performance has been deteriorating - therefore target an improvement to the national average of 92.6% by te end of 2023-24 3. Then target the 2021-22 performance of 92.73% by the end of 2024-25 with a straight line trajectory between these	Patient care is assessed throughout admission with those no longer meeting the criteria to reside supported in the identified discharge pathway. On admission patients may have lived in their own home and have had little support, upon discharge after the triage process within the Transfer of Care hub, it may be necessary to support the patients in different ways eg a package of care or a
	Numerator	3,528	3,529	3,517	478		
	Denominator	3,867	3,827	3,844	483		
		2023-24 Q1 Plan	2023-24 Q2 Plan	2023-24 Q3 Plan	2023-24 Q4 Plan		
	Quarter (%)	91.1%	60.1%	92.0%	92.5%		
	Numerator	3,521	3,504	3,536	3,513		
	Denominator	3,865	5,827	3,843	3,798		

8.4 Residential Admissions

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
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	531.1	465.1	434.0	467.0	Based on previous years and adjustments.	The stretch target has been set taking into account performance pre COVID-19 and current operating pressures in the system e.g. lack of capacity in the care at home sector. Blackpool Council and the ICB have several existing integrated care pathways, aligned to a focus on promoting independence and supporting people in the community, rather than residential care settings. The neighbourhood care teams (PCNs) are based around GP practices, to provide care and support for people to maintain their independence for as long as possible. There is a focus on care coordination, supporting patients with goal setting and coaching, to evolve the model on from a focus solely on medical interventions. Health and wellbeing support workers are supporting the input of specialist clinicians by, for example, supporting patients with prescribed rehab
	Numerator	151	135	126	137		
	Denominator	28,433	29,029	29,029	29,336		

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 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2021-22 Actual	2022-23 Plan	2022-23 estimated	2023-24 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	81.9%	80.0%	81.1%	80.7%	Episodes of home-based reablement continued to decrease in 2022-23 due to flexing in-house services to meet demand for crisis care and hospital discharge due to the decline in capacity in wider care market. The discharge to assess model has also changed the way in which reablement has been commissioned due to the majority of inpatients returning home with a commissioned package of homecare. These episodes of reablement do not include where discharge to assess has been used to provide care at home services via our inhouse provider which incorporates reablement, as well as vitaline telecare via discharge to assess which also provides reablement via discharge to assess. The capacity and demand template provides figures for combined in-house capacity.	We will continue to invest in our reablement and rehab services using the funding available. Episodes of inpatient reablement/rehabilitation remain similar to last year and there are no plans to change this provision at present.
	Numerator	86	60	73	67		
	Denominator	105	75	90	83		

Please note that due to the demerging of Cumbria information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- Actuals and plans for Cumberland and Westmorland and Furness are using the Cumbria combined figure for all metrics since a split was not available; Please use comments box to advise.
- 2022-23 and 2023-24 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2021-22 estimates.

	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through
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 all partners from ICB(s) in accordance with ICB governance rules, and the LA; been submitted? *Paragraph 11* Has the HWB approved the plan/delegated approval? *Paragraph 11* 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? *Paragraph 11* Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned? Have all elements of the Planning template been completed? *Paragraph 12*	Expenditure plan Expenditure plan Narrative plan Validation of submitted plans Expenditure plan, narrative plan
	PR2	**A clear narrative for the integration of health, social care and housing**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integration of health, social care and housing services including DFG to support further improvement of outcomes for people with care and support needs *Paragraph 13* • The approach to joint commissioning *Paragraph 13* • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered *Paragraph 14* - Changes to local priorities related to health inequality and equality and how activities in the document will address these. *Paragraph 14* The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5. *Paragraph 15*	Narrative plan
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? *Paragraph 33* • Does the narrative set out a strategic approach to using housing support, including DFG funding that supports independence at home? *Paragraph 33* • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils? *Paragraph 34*	Expenditure plan Narrative plan Expenditure plan

NC2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	**PR4**	**A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home**	Does the plan include an approach to support improvement against BCF objective 1? *Paragraph 16* Does the expenditure plan detail how expenditure from BCF sources supports prevention and improvement against this objective? *Paragraph 19* Does the narrative plan provide an overview of how overall spend supports improvement against this objective? *Paragraph 19* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objctive and has the narrative plan incorporated learnings from this exercise? *Paragraph 66*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan
Additional discharge funding	**PR5**	**An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.**	Have all partners agreed on how all of the additional discharge funding will be allocated to achieve the greatest impact in terms of reducing delayed discharges? *Paragraph 41* Does the plan indicate how the area has used the discharge funding, particularly in the relation to National Condition 3 (see below), and in conjunction with wider funding to build additional social care and community-based reablement capacity, maximise the number of hospital beds freed up and deliver sustainable improvement for patients? *Paragraph 41* Does the plan take account of the area's capacity and demand work to identify likely variation in levels of demand over the course of the year and build the workforce capacity needed for additional services? *Paragraph 44* Has the area been identified as an area of concern in relation to discharge performance, relating to the 'Delivery plan for recovering urgent and emergency services'? If so, have their plans adhered to the additional conditions placed on them relating to performance improvement? *Paragraph 51* Is the plan for spending the additonal discharge grant in line with grant conditions?	Expenditure plan Narrative and Expenditure plans Narrative plan Narrative and Expenditure plans
NC3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	**PR6**	**A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time**	Does the plan include an approach to how services the area commissions will support people to receive the right care in the right place at the right time? *Paragraph 21* Does the expenditure plan detail how expenditure from BCF sources supports improvement against this objective? *Paragraph 22* Does the narrative plan provide an overview of how overall spend supports improvement against this metric and how estimates of capacity and demand have been taken on board (including gaps) and reflected in the wider BCF plans? *Paragraph 24* Has the intermediate care capacity and demand planning section of the plan been used to ensure improved performance against this objective and has the narrative plan incorporated learnings from this exercise? *Paragraph 66* Has the area reviewed their assessment of progress against the High Impact Change Model for Managing Transfers of care and summarised progress against areas for improvement identified in 2022-23? *Paragraph 23*	Narrative plan Expenditure plan Narrative plan Expenditure plan, narrative plan Expenditure plan Narrative plan
NC4: Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	**PR7**	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift to the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution? *Paragraphs 52-55*	Auto-validated on the expenditure plan

Agreed expenditure plan for all elements of the BCF	**PR8**	**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?**	Do expenditure plans for each element of the BCF pool match the funding inputs? *Paragraph 12* Has the area included estimated amounts of activity that will be delivered, funded through BCF funded schemes, and outlined the metrics that these schemes support? *Paragraph 12* Has the area indicated the percentage of overall spend, where appropriate, that constitutes BCF spend? *Paragraph 73* Is there confirmation that the use of grant funding is in line with the relevant grant conditions? *Paragraphs 25 – 51* Has an agreed amount from the ICB allocation(s) of discharge funding been agreed and entered into the income sheet? *Paragraph 41* Has the area included a description of how they will work with services and use BCF funding to support unpaid carers? *Paragraph 13* Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement? *Paragraph 12*	Auto-validated in the expenditure plan Expenditure plan Expenditure plan Expenditure plan Expenditure plan Narrative plans, expenditure plan Expenditure plan
Metrics	**PR9**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	Have stretching ambitions been agreed locally for all BCF metrics based on: - current performance (from locally derived and published data) - local priorities, expected demand and capacity - planned (particularly BCF funded) services and changes to locally delivered services based on performance to date? *Paragraph 59* Is there a clear narrative for each metric setting out: - supporting rationales for the ambition set, - plans for achieving these ambitions, and - how BCF funded services will support this? *Paragraph 57*	Expenditure plan Expenditure plan

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Karen Smith, Director of Adult Social Services / Director of Health and Care Integration, Lancashire and South Cumbria Integrated Care Board (ICB)
Relevant Cabinet Member:	Councillor Neal Brookes, Cabinet Member for Adult Social Care
Date of Meeting:	18 October 2023

INTEGRATED JOINT CAPITAL RESOURCE USE PLAN 2022/23 AND 2023/24

1.0 Purpose of the report

1.1 To note the Integrated Joint Capital Resource Use Plans for 2022/23 and 2023/24 as shared with the Health and Wellbeing Board for information.

2.0 Recommendation(s)

2.1 To note the Lancashire and South Cumbria Integrated Care Board Capital Resource Use Plan for 2022/23 attached at Appendix 7a.

2.2 To note the Lancashire and South Cumbria Integrated Care Board Capital Resource Use Plan for 2023/24 attached at Appendix 7b.

3.0 Reason for recommendation(s)

3.1 The recommendation is in line with statutory guidance.

3.2 Is the recommendation contrary to a plan or strategy approved by the Council? N/a

3.3 Is the recommendation in accordance with the Council's approved budget? N/a

4.0 Other alternative options to be considered

4.1 N/a

5.0 Council priority

5.1 The relevant Council priority is both:

- 'The economy: Maximising growth and opportunity across Blackpool'

- ‘Communities: Creating stronger communities and increasing resilience’

6.0 Background and key information

6.1 The National Health Service Act 2006, as amended by the Health and Care Act 2022 (the amended 2006 Act) sets out that an Integrated Care Board (ICB) and its partner NHS trusts and foundation trusts :must before the start of each financial year, prepare a plan setting out their planned capital resource use must publish that plan and give a copy to their integrated care partnership, Health and Wellbeing Boards and NHS England may revise the published plan - but if they consider the changes significant, they must re-publish the whole plan; if the changes are not significant, they must publish a document setting out the changes.

In line with the amended 2006 Act, Integrated Care Boards are required to publish these plans before or soon after the start of the financial year and report against them within their annual report.

The template for the 2023/24 plan was provided by NHS England, with a requirement to submit this to NHSE alongside the finance system and provider planning templates by the final plan submission date of 30 March 2023 which was done to the deadline specified.

6.2 Does the information submitted include any exempt information? No

7.0 List of appendices

7.1 Appendix 7a: Lancashire and South Cumbria Integrated Care Board Capital Resource Plan 2022/23.
Appendix 7b: Lancashire and South Cumbria Integrated Care Board Capital Resource Plan 2023/24.

8.0 Financial considerations

8.1 None.

9.0 Legal considerations

9.1 None.

10.0 Risk management considerations

10.1 None.

11.0 Equalities considerations and the impact of this decision for our children and young people

11.1 None.

12.0 Sustainability, climate change and environmental considerations

12.1 None.

13.0 Internal/external consultation undertaken

13.1 None.

14.0 Background papers

14.1 None.

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Appendix 7a

Lancashire & South Cumbria

ICS Total **QE1**

CDEL		Total			Narrative on the main categories of expenditure
		Plan Months 1-12	Expenditure Months 1-3	Budget Months 4-12	Period covered
					M1 - M12
Provider	Operational Capital	110,539	12,142	98,397	Main areas of spend include backlog maintenance (£11m), Routine maintenance (£15m), Equipment (£14m), IT (£16m), Fleet and Vehicles (£12m) and various new build schemes (£34m). Sources of funding £6.4m of RAAC Plank remiedial works funded by PDC. £2.7m pre-approved emergency loan funding. Remainder is self financed.
ICB	Operational Capital	3,117	0	3,117	Primarily Gp IT (£2.9m).
	Total Op Cap	**113,656**	**12,142**	**101,514**	
Provider	Impact of IFRS 16	9,121	0	9,121	New equipment leases (£3m), new vehicle leases (£3.5m) and new building leases (£1.4m). Remainder is lease re-measurements
ICB	Impact of IFRS 16	0	0	0	
Provider	Upgrades and NHP Programmes	9,060	1,158	7,902	£1m NHP and £8m pathology collaboration. Pathology scheme still awaiting approval.
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)	51,918	1,175	50,743	Elective recovery (£30m), CDC (£7m), Frontline digititisation (£1.6m)
Provider	Other (technical accounting)	2,294	573	1,721	PFI capital charges (residual interest)
	Total system CDEL	186,049	15,048	171,001	

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Joint capital resource use plan – 2023/24

REGION	**North West**
ICB / SYSTEM	**NHS Lancashire and South Cumbria ICB**

Introduction

Figures based on M11 forecast outturn and exclude the impact of IFRS16.

In 2022/23 the ICB incurred capital expenditure of £212m; £209m in providers and £3m in primary care. This was funded by £95m of trust internal resources, £23m of approved loans and lease liabilities and £94m of national Public Dividend Capital (PDC) funding. Of the £94m PDC funding £19m was spent on community diagnostic centres and a further £24m went to supporting recovery of elective activity.

The key priorities for 2023/24 are the completion of the elective recovery and community diagnostic centre schemes as well as the eradication of Reinforced Autoclaved Aerated Concrete (RAAC) from Trust premises. Further priorities are the implementation of electronic patient record systems where these are not currently present or fit for purpose as well as reducing backlog maintenance in Trust estates. Funding is also anticipated for the development of the business case to develop the Royal Preston and Lancaster Royal Infirmary sites as part of the New Hospital Program.

Assumed Sources of Funding for 2023/24

As shown in Annex A, the total capital programme for 2023/24 is £184.6m. Excluding the impact of IFRS 16 the plan is £174m with the funding for this being as follows:

- Trust own resources £107m
- Pre-approved loan funding £1m
- PDC £63m
- Primary care £3m

This is considered to be low risk as all the funding has been confirmed.

Overview of Ongoing Scheme Progression

In 2023/24 several large schemes which started in previous years will continue the main ones being:

- Elective Recovery £25m
- Community Diagnostic Centres £10m
- Eradication of RAAC £3m
- Front line digitisation £15m
- New Hospitals Programme (NHP) - ongoing development of the business case

Risks and Contingencies

The main risk to capital plans in 2023/24 is the risk of inflation creating an in-year pressure on budgets. The risk will be managed through tight monitoring of spend in-year. Given the ICB and provider track records of spending within capital allocations the risk is considered as low risk.

Business Cases in 2023/24

They main business case expected to be submitted in 2023/24 is for a new Electronic Patient Records (EPR) system at Blackpool Foundation Trust with £14.8m planned to be spent in 2022/23 (£23.4m in total). Work will also continue on the NHP business case with £1.2m planned to be spent in year.

Cross System Working

Northwest Ambulance Service NHS Trust (NWAS) operates across all ICBs in the Northwest region and as such the capital expenditure incurred by them directly impacts these systems.

The ICB works closely with Cheshire and Merseyside ICB on capital plans for Southport and Ormskirk Hospitals NHS Trust.

Capital Planning & Prioritisation

Community Diagnostic Centres and Elective Recovery schemes represent a prioritisation process that was operated by the system.
EPR funding has been directed towards those organisations with the lowest digital maturity.
Capital funding was allocated between providers based on their need to replace existing assets by using depreciation as the basis allocating funding.

Lancashire and South Cumbria Integrated Care Board

Annex A – NHS Lancashire and South Cumbria ICB 2023/24 CAPITAL PLAN

	CDEL	Lancashire and South Cumbria ICB £000	Blackpool Teaching Hospitals NHS Foundation Trust £000	East Lancashire Hospitals NHS Trust £000	Lancashire and South Cumbria NHS Foundation Trust £000	Lancashire Teaching Hospitals NHS Foundation Trust £000	Northwest Ambulance Service NHS Trust £000	University Hospitals of Morecambe Bay NHS Foundation Trust £000	Total Full Year Plan £000
Provider	Operational Capital		21,139	14,011	14,353	22,370	23,787	19,215	114,875
ICB	Operational Capital	3,113							3,113
	Total Op Cap		21,139	14,011	14,353	22,370	23,787	19,215	117,988
Provider	Impact of IFRS 16		0	4,970	0	362	4,672	0	10,004
ICB	Impact of IFRS 16	504							504
Provider	Upgrades & NHP Programmes		0	0	0	880	0	350	1,230
Provider	National Programmes (diagnostics, Front line digitisation, Mental Health, TIF)		22,748	4,924	1,408	12,708	0	10,667	52,455
Provider	Other (technical accounting)		0	2,375	1	0	0	0	2,376
	Total system CDEL	3,617	43,887	26,280	15,762	36,320	28,459	30,232	184,557