Public Document Pack

SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Wednesday, 20th September, 2017
Time: 5.00 pm
Place: Darwin Room - Tickfield Centre
Contact: Fiona Abbott
Email: committeesection@southend.gov.uk

AGENDA

1 Apologies for Absence

2 Declarations of Interest

3 Minutes of the Meeting held on Wednesday 21st June 2017

Minutes attached.

4 Health & Wellbeing Strategy 2017-2021 Refresh Progress

Report attached.

**** **For Discussion/Decision**

5 Better Care Fund

Report attached.
Note - there are a number of additional supporting appendices with this item – the link to the documents will provided shortly

**** **For information**

6 Sustainability and Transformation Fund (STP) Briefing on current position

Report attached.

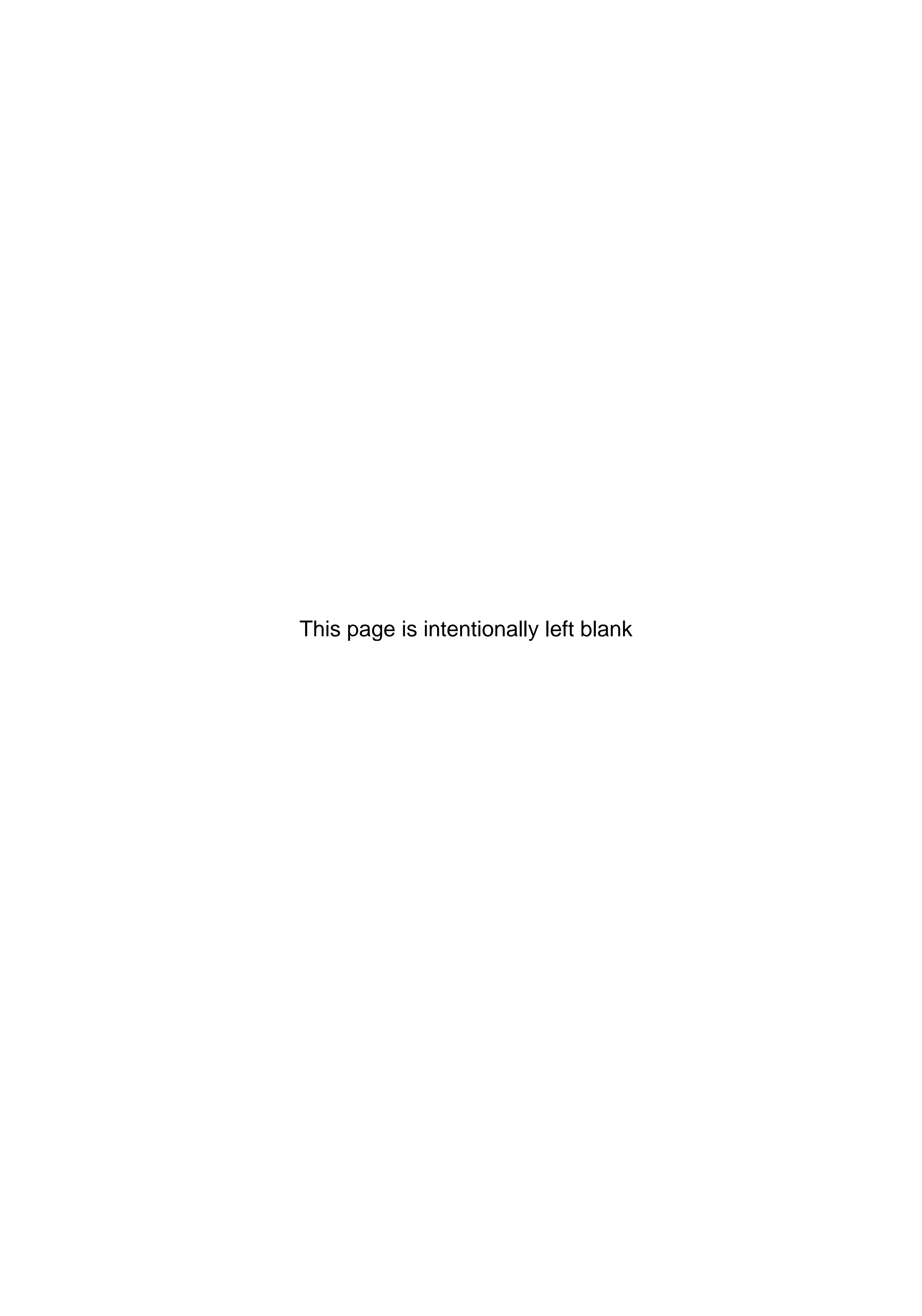
**** **A Better Start Governance Board**

7 A Better Start Southend Governance Update

Report attached.

Members:

Cllr L Salter (Chair), J Garcia-Lobera (Deputy Chair), Cllr M Davidson, Cllr J Lamb, Cllr J Moyies, Cllr C Willis, Cllr R Woodley, A Semmence, Pike, S Leftley, A Atherton, Morris, Chaturvedi, Leitch and M Freeston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SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board

Date: Wednesday, 21st June, 2017
Place: Seacole Room - Tickfield Centre

3

Present: Councillor L Salter (Chair)
Dr J Garcia-Lobera (Deputy Chair),
Councillors M Davidson, J Lamb, J Moyies, C Willis and R Woodley,
Mr I Stidston, Mr M Freeston, Ms A Semmence, Mr S Leftley, Ms A Atherton, Ms S Morris and Ms L Chidgey

In Attendance: R Walters and R Harris, Y Blucher, L Watson, L Park and N Faint.

Start/End Time: 5.00 - 6.10 pm

90 Apologies for Absence

Apologies for absence were received from Dr Chaturvedi, C Panniker, N Leitch and A McIntyre.

91 Declarations of Interest

(a) Councillor Salter – Minute 89 (A Greater Focus – Refreshing Southend's Health & Wellbeing Strategy), Minute 92 (STP Pre-Consultation Business Case) – non-pecuniary interest – husband is consultant surgeon at Southend Hospital and holds senior posts at the hospital; son-in-law is a GP; daughter is a doctor at Broomfield Hospital;

(b) Councillor Lamb – Minute 92 (STP Pre-Consultation Business Case Briefing) – non-pecuniary interest – SAVS appointed Governor at Southend Hospital NHS Trust;

(c) Councillor Davidson – Minute 92 (STP Pre-Consultation Business Case Briefing) – non-pecuniary interest – Council appointed Governor at Southend Hospital NHS Trust.

92 Minutes of the Meeting held on Wednesday 22nd March 2017

Resolved:-

That the Minutes of the Meeting held on 22nd March 2017 be confirmed as a correct record and signed.

93 A greater focus - Refreshing Southend's Health and Wellbeing Strategy

The Board considered a joint report of the Deputy Chief Executive (People) and the Interim Accountable Officer (SCCG) presenting the proposals for developing the refresh of Southend's Health and Wellbeing Strategy.

In consideration of the report the Board commended the proposals and the approach being taken to refresh the Strategy and commented as follows:-

- Ensuring that people with long term conditions and muscular skeletal conditions such as back pain and arthritis are provided the right information and we create and maintain accessible services and enabling environments;

- Dispelling some of the myths and removing the barriers preventing people from being active. This may or may not include accessing services and does not necessarily require attendance at a leisure centre or taking part in sport eg. gardening and walking;

- Co-production was essential if significant positive outcomes are to be achieved and the approach should ensure that the views of service users and the community drive the development of the strategy and outcomes;

- Other related services (e.g. planning, street scene, parks, etc) have a key role in supporting the delivery of the strategy; to achieve our strategic goals, the health and wellbeing board will need to develop effective relationships with the SBC Place Department.

Resolved:

That the key proposals detailed in paragraphs 3.7 to 3.10 of the submitted report be supported for development and progress be reviewed at the next meeting in September 2017.

94 Better Care Fund (BCF)

The Board considered a report if the BCF Programme Lead providing an update regarding the BCF for 2017/19 and the Improved BCF (iBCF) for 2017/18.

Resolved:

1. That the updates for BCF 2017/19 and the iBCF 2017/18, be noted.

2. That the priorities for setting the BCF 2017/19 plan, including the need to abide by the national BCF conditions, be approved.

3. That authority to sign-off the iBCF plan for 2017/18 be delegated to the Deputy Chief Executive (People), the Interim Accountable Officer (SCCG) in consultation with the Chair and Vice-Chair of the Health & Wellbeing Board.

4. That it be agreed that the iBCF plan 2017/18 be consulted on amongst HWB partners as outlined in Section 5 of the submitted report.

95 Suicide Prevention Strategy

The Board considered a report of the Director of Public Health presenting the draft Suicide Prevention Strategy for Southend, Essex and Thurrock – 'Let's Talk About Suicide.'

In response to a number of questions and comments the Board was informed that:

- There were a number of suicides linked to drug and alcohol use but not to the extent that was expected;
- The relevant charities and community organisations (e.g. Samaritans, MIND, etc) were involved at every level;
- The majority of people at the risk or have committed suicide were within primary care;
- The evidence suggests that there is an increasing trend in the number of older people / adults committing suicide for a range of reasons (e.g. economic factors);
- Pan-Essex Task and Finish Groups had been established and including local representation from Southend;
- Any lessons learnt or good practice from the mid-Essex and other pilot areas led by the East of England will be obtained;

The Board suggested that a local delivery / task and finish group was set up to monitor and ensure that the appropriate actions were being delivered in Southend

Resolved:

1. That the Suicide Prevention Strategy ('Let's Talk About Suicide') and associated actions be endorsed.

2. That a local Southend specific Suicide Prevention Task and Finish Group to oversee and monitor the delivery of appropriate actions be established.

96 STP Pre-Consultation Business Case Briefing

The Board considered a report of the Programme Director, Mid and South Essex Success Regime, providing an update on current thinking and the next steps for changes in local health and care.

The Board made the following comments:

- Still waiting for information detailing the evidence base supporting the STP proposals –
- Board members are advocates for the STP and given that there are genuine public anxieties about the STP it was important that Board members have the necessary information when discussing the STP with the public and other bodies/groups;
- The Safeguarding Adults Board has identified the STP as a key priority and will be seeking assurances regarding safeguarding;
- The Southend CCG will feedback views and highlighted that there was a CCG Joint Committee meeting on 7th July;

Resolved:

1. That the update and continuing opportunities to give views on the STP and developing options for service change be noted.

2. That the Board continues to participate in discussions with the Mid and South Essex SR and STP engagement and consultation programmes, which include stakeholder meetings and meetings of the Southend, Essex and Thurrock Boards.

97 Integrated Children's Services

The Board considered a report of the Deputy Chief Executive (People) providing an update of the successes and achievements delivered through the Success for All Partnership Board.

Resolved:

1. That the high level mobilisation plan and the success and achievements as delivered by Success for All, be noted.

2. That the Integrated Children’s Strategy, be noted.

98 Southend, A Better Start Briefing

The Board considered a report from the ABB Acting Programme Director providing an update on progress and the current position regarding the ABSS.

Resolved:

That the report be noted.

Chairman: ______________________

Southend Health & Wellbeing Board

Agenda Item No.
4

(Joint) Report of

Simon Leftley, Deputy Chief Executive (People), Southend-on-Sea Borough Council.

Ian Stidston, Interim Accountable Officer, NHS Southend Clinical Commissioning Group (CCG).

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to

Health & Wellbeing Board

on

20th September 2017

Report prepared by: Rob Walters – Partnership Advisor, Health and Wellbeing

For information only		For discussion	✓	Approval required	✓

Draft of Southend's refreshed Health and Wellbeing Strategy 2017-2019

Part 1 (Public Agenda Item)

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1. Purpose of Report

1.1 To review the draft Southend Health and Wellbeing (HWB) Strategy refresh 2017-2019.

2. Recommendations

2.1. That subject to amendments, the Board approves the draft HWB Strategy refresh 2017-2021 for further development.

2.2. That following development, a refined draft be electronically circulated to Board members for comment, prior to going live at the next HWB Board in December 2017.

3. Background & Context

3.1. The Health and Wellbeing Board approved a report in June 2017 (Appendix 3) which proposed that the HWB Strategy refresh 2017-2021 primarily focuses on increasing physical activity levels in Southend, in view of the profound associated benefits to both physical and mental wellbeing.

3.2. The initial draft of the refreshed strategy has been produced (Appendix 1) and is supported by draft activity mapping (Appendix 2) which, when complete, will show how other key issues are being addressed. Both documents are in development and it is proposed that subsequent refined drafts will be circulated

to the HWB Board for comment prior to the final versions going live at the next HWB Board meeting on 6th December 2017.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to the;

- Original HWB Strategy Ambitions
- Three HWB "Broad Impact Goals"

4.1 This refresh inherently addresses core health and wellbeing issues, with a primary focus of improving quality of life for local people through increasing physical activity levels. The focus will also aim to develop a model of meaningful engagement with local people, address issues of inequality and strengthen individual and community resilience. There is also an emphasis on developing a culture of self-care and the approach aligns with the NHS ONE YOU campaign: www.nhs.uk/oneyou

5. Reasons for Recommendations

5.1. To enable a greater focus on improving the physical and mental wellbeing of local people, primarily through increased levels of physical activity.

6. Financial / Resource Implications

6.1 Cost to Health Economy:

The estimated impact of physical inactivity to Southend's health economy is £21,472,753 per 100,000 population per year. (Reference; UK Active, Turning the Tide of Physical Inactivity)

7. Legal Implications

7.1. None currently identified

8. Equality & Diversity

8.1. The HWB strategy refresh aims to inherently address issues of inequality and make physical activity accessible for all

9. Background Papers

9.1 (Appendix 3) "A greater focus - Refreshing Southend's Health and Wellbeing Strategy" *-Report approved by Southend HWB Board on 21st June 2017.*

10. Appendices

Appendix 1: Be Active! Draft of Southend's HWB Strategy refresh 2017-2021

Appendix 2: Activity mapping - Draft. How are other issues being addressed

Appendix 3: (for background) **"**A greater focus - Refreshing Southend's Health and Wellbeing Strategy" -Report approved by Southend HWB Board on 21/06/17.

Appendix 4: Southend Physical Activity Strategy 2016-2021

Be active! DRAFTv5

Southend-on-Sea Health and Wellbeing Strategy Refresh 2017-2021

The potential benefits of physical activity to health are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'.

– Sir Liam Donaldson

Summary

This refresh of Southend-on-Sea's Health and Wellbeing (HWB) Strategy focusses primarily on encouraging local people to be physically active as a way of life, in order to experience an improved sense of personal health and wellbeing.

Self-care is becoming increasingly beneficial in a time of ongoing pressures on services. We are living longer and we want our lives to be as fulfilling and independent as possible. Being physically active is one simple action that can help to noticeably improve our quality of life.

The journey so far

Southend's first Health and Wellbeing Strategy launched in 2013 and included nine ambitions for the improved wellbeing of the local population. These were:

1. A positive start in life
2. Promoting healthy lifestyles
3. Improving mental wellbeing
4. A Safer population
5. Living independently
6. Active and healthy ageing
7. Protecting health
8. Housing
9. Maximising opportunities

By 2015, it was clear that the original ambitions were being addressed by the various plans and initiatives across the partnership and the Health and Wellbeing Board wanted a simple way to add value to what was already being done.

With this in mind, three "Broad Impact Goals" were introduced in 2015's HWB Strategy refresh to support the original ambitions. The Broad Impact Goals focussed on preventing ill health, addressing inequality and increasing personal responsibility and participation.

A range of measures were introduced to help support and monitor progress and:

- raise the profile of strategic HWB priorities and stimulate a more central focus for operational teams
- increase incentive and accountability for strong performance
- promote partnership working, providing opportunities for collaboration
- bring a greater awareness of the diverse operational activity across the partnership
- provide a baseline for consideration of future priority areas and effective use of resources

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Key messages

Since the original HWB strategy, there have been a number of key messages to help inform ongoing priorities:

A) Peer Challenge recommendations 2014-2015

A "Peer Challenge" review of the Health and Wellbeing Board was performed in January 2014 by the Local Government Association (LGA), with a follow up review in July 2015.

Lasting themes from the recommendations were;

A1) Less is more! -Reduce the number of issues that the Health and Wellbeing Board focuses on so that it can attend more proactively to the main issues facing the Borough (*this is in line with a wider national trend towards delivering significant improvements in a few key areas, vs. lots of less impactful activity).*

A2) Address inequality -Develop a common understanding of health inequalities and where health outcomes are poor, agree what needs to be addressed and ensure partners are addressing them together.

A3) Strengthen community engagement and resilience

B) Working Together For a Healthy Southend
Public and stakeholder engagement event, May 2015

Over 120 service users and stakeholders expressed what was important to them in relation to health and care:

B1) Mental health: Holistic view of health as both physical and mental

B2) Healthy food: Importance of good nutrition and accessibility of healthy, affordable food

B3) Importance of social connection to address isolation/loneliness

B4) Housing: Appropriate, affordable housing

B5) Value of prevention and early intervention

B6) Empower people to make positive choices

B7) Listen to and involve service users in decision making

B8) Be open and realistic with people about what can be delivered

B9) Centralise services: Promote easy/comprehensive access to information

B10) Recognise and support carers

C) HWB Strategy development session May16 (HWB Board & colleagues)

The Health and Wellbeing Board and related colleagues had an in-depth discussion in the spring of 2016 to consider which strategic issues were important to consider going forward:

C1. Outcomes: Focus on outcomes rather than services

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C2. Language and branding: think about our wording and make things more real for people i.e. 'be more active!' instead of 'increased physical activity'

C3. Data & intelligence: availability and accessibility of quality data across the system and using data intelligently to make a real difference i.e. deep dives/ analyses/ longitudinal studies.

C4. Be open with people about what is possible

C5. Consistency of message across the partnership: How does the HWB Strategy and vision influence the visions and plans of system partners?

C6. Workforce challenges – how do we address ongoing workforce needs?

D) Joint Strategic Needs Assessment (JSNA) headlines (key issues which affect our population's health and wellbeing – JSNA summary can be seen at: http://bit.ly/2wvq92y)

- Lifestyle related health challenges: excess weight; nutrition; smoking; long term conditions (LTCs).
- Life expectancy related to cancers, circulatory, respiratory and chronic diseases.
- Mental health: anxiety & depression; dementia.
- Deprivation: comparatively higher levels of deprivation and child poverty; levels of employment and skills.

Moving forward

With these important messages in mind, the refreshed Health and Wellbeing Strategy focuses primarily on increasing the number of people in Southend who are being physically active at the levels that will promote their health and wellbeing. The focus will also aim to develop a model of meaningful engagement with local people, address issues of inequality and strengthen individual and community resilience.

The compelling case for physical activity

The evidence for the health and wellbeing benefits of physical activity is compelling, not only for supporting long term physical health but also for improving mental wellbeing (see a summary of benefits and guidelines in the infographics section at the end of this publication).

Cost to the Health Economy:

The estimated impact of physical inactivity to Southend's health economy is £21,472,753 per 100,000 population per year. (Reference; UK Active, Turning the Tide of Physical Inactivity)

Human Cost:

Modelling suggests that if 75% of the Southend adult population met the Chief Medical Officer's physical activity guidelines, 6 premature deaths per month would be prevented (40-79 years old). If 100% met the guidelines, 2 premature deaths per week could be prevented.

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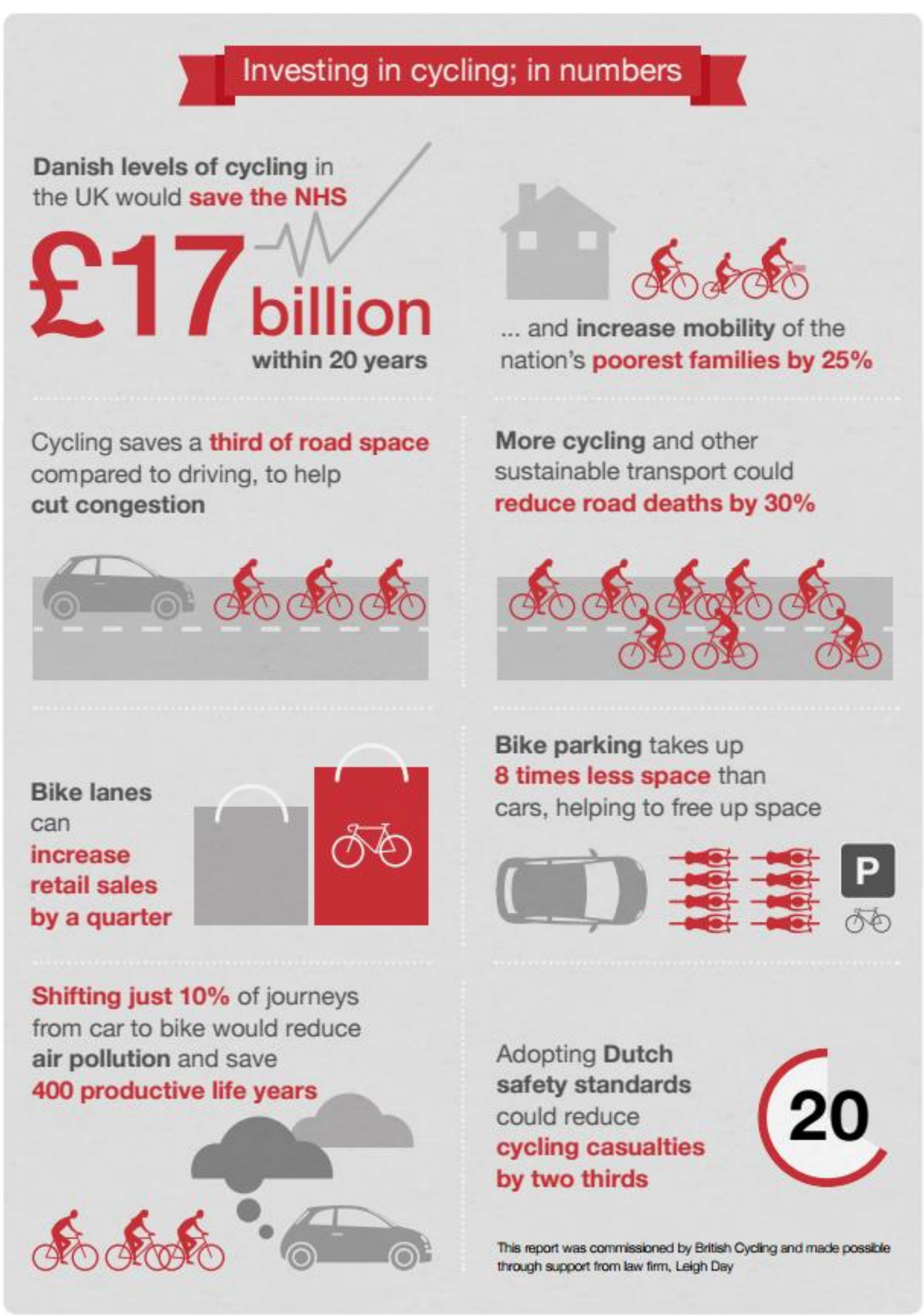
Every 5 days someone under the age of 79 from the Southend population dies a death that could have been prevented if the whole population met the Chief Medical Officer's physical activity guidelines.

The below image demonstrates the social, economic, environmental and wellbeing impacts of investing in physical activity (specifically cycling).



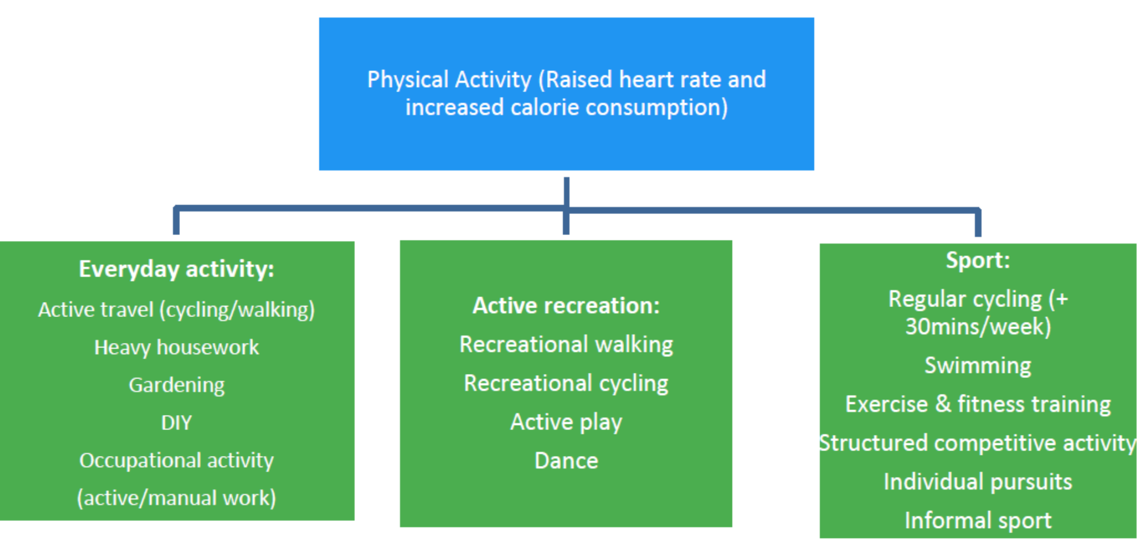
Infographic from "Benefits of investing in cycling" http://bit.ly/1w8TyGt

What is physical activity?

➔ ***Physical activity guidelines and benefits can be seen at the back of this publication.*** *These include; Birth-5 years; 5-18 years; Adults and older adults; and during Pregnancy. You may also want to view the more detailed written guidance at http://bit.ly/2asmvtp*

The Department of Health defines physical activity as all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in the gym), dancing, gardening or playing active games, as well as organised and competitive sport.

Figure 1. What constitutes physical activity



There are many ways for individuals to increase their physical activity; some people may like to include physical activity in their daily routine. For example, by getting off the bus one or two stops early or by taking the stairs instead of the lift or escalator. Others might find it useful to be social in their activity and go for a swift walk with a friend or join a running club. There are so many ways that we can be physically active.

Dispelling myths

There are of course circumstances where extra care is needed to maintain personal safety and wellbeing. For example, during pregnancy or when there are mobility considerations. However, we need to dispel any myths regarding physical activity and empower people to adopt an appropriate personalised approach to being physically active.

To support this, we need to develop routine awareness of the broad benefits of appropriate physical activity, particularly within primary and secondary care, community health, social care and the broader system, specifically supporting those with long term conditions/disabilities to build physical activity into existing care pathways e.g. pregnancy.

How are local people being helped to be active? (Case studies)

> Draft notes: Case studies will be included from several of the following:

- Organised group walks
- Ideas in Motion www.ideasinmotionsouthend.co.uk
- Workplaces- Public Health Responsibility Deal (PHRD)
- Southend Parkrun www.parkrun.org.uk/southend
- ACE Lifestyle / Fusion- Exercise Referral / Rehabilitation Classes
- Gardening/allotment projects
- Schools Sports Partnership Change4Life clubs/ Daily mile
- Community Gym

Joining together to shape our environment

The challenge to develop being physically active as a way of life cannot be addressed in isolation. This requires a broad partnership between health and care, policy makers, culture and planning, local businesses and voluntary sector partners as well as communities and individuals.

It is clear that in addition to encouraging people to be active, we also need to design our environment and infrastructure to support and stimulate a routine culture of physical activity for future populations.

As well as developing a partnership approach and suitable infrastructure, the value of fostering a culture of self-care is of central importance, in order to see a sustainable shift in our long term wellbeing and quality of life.

The developing localities work has seen that when a person has a lack of social capital such as friends and family, this can often lead to damaging behavioural patterns and dependence on professionals. We can tackle this by helping to build people's capacity.

How do we instigate change and measure progress?

Southend's Physical activity strategy 2016-2021 will be the foundation for delivering the core aims of this refreshed Health and Wellbeing Strategy. The Physical Activity Strategy contains a series of actions for delivering improved outcomes and progress will be routinely reviewed at the Health and Wellbeing Board.

Organisations can help to significantly progress these aims. For example, by engaging with the public health responsibility deal (PHRD) and supporting staff to increase their personal activity levels (particularly for those in sedentary roles), through the Making Every Contact Count (MECC) initiative and through the development of Primary Care physical activity champions.

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The focus of the HWB Strategy refresh is fully supported by Southend Health and Wellbeing Board and all partners are encouraged to enable the strategy to influence their own strategic activity, because of the profound benefits that being physically active can have on both physical and mental health.

The focus of the refreshed HWB Strategy will be formally reviewed in 2019 to ensure its ongoing relevance.

Other important issues

Increasing physical activity can profoundly improve quality of life for local people and this is the primary focus of the Health and Wellbeing Strategy refresh 2017-2021.

It is however recognised that there are a number of other important contributors to wellbeing, some of which are reflected in the above key messages, as well as in the original HWB strategy ambitions.

Appendix 1 (strategic activity mapping) shows how these other key areas are being addressed.

Conclusion

The simple focus of this refreshed strategy is an opportunity for everyone to get behind a single approach and evaluate and learn as a whole, rather than in fragments. By increasing our population's physical activity, we can improve people's quality of life while strengthening community engagement and cohesion and reducing social isolation.

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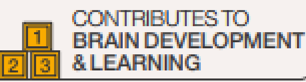
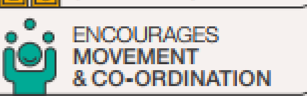
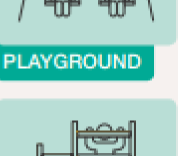
Physical activity for early years
(birth – 5 years)

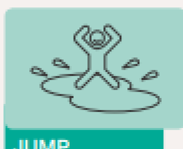
Active children are healthy, happy, school ready and sleep better

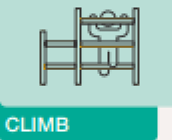


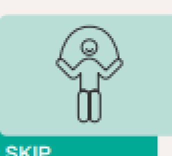


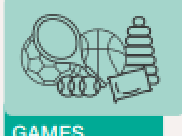
Every movement counts

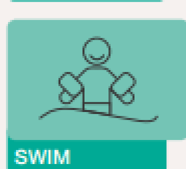


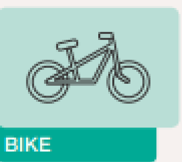












Move more. Sit less. Play together

UK Chief Medical Officers' Guidelines 2011 **Start Active, Stay Active: www.bit.ly/startactive**

Physical activity
for children and young people (5–18 Years)

BUILDS CONFIDENCE & SOCIAL SKILLS

MAINTAINS HEALTHY WEIGHT

DEVELOPS CO-ORDINATION

STRENGTHENS MUSCLES & BONES

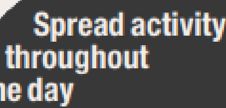
IMPROVES SLEEP

IMPROVES CONCENTRATION & LEARNING

IMPROVES HEALTH & FITNESS

MAKES YOU FEEL GOOD

Be physically active



Spread activity throughout the day

Aim for at least 60 minutes everyday

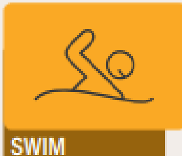
All activities should make you breathe faster & feel warmer

PLAY

RUN/WALK

BIKE

ACTIVE TRAVEL


SWIM

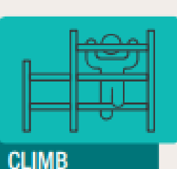
SKATE

Include muscle and bone strengthening activities 3 TIMES PER WEEK

SPORT

PE

SKIP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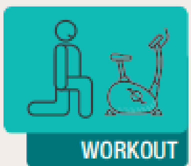
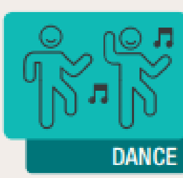

WORKOUT


DANCE

Sit less

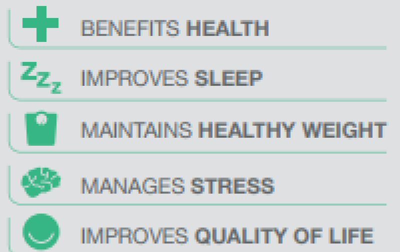
LOUNGING

Move more

Find ways to help all children and young people accumulate at least 60 minutes of physical activity everyday

UK Chief Medical Officers' Guidelines 2011 **Start Active, Stay Active: www.bit.ly/startactive**

Physical activity benefits for adults and older adults



REDUCES YOUR CHANCE OF

Type II Diabetes	-40%
Cardiovascular Disease	-35%
Falls, Depression and Dementia	-30%
Joint and Back Pain	-25%
Cancers (Colon and Breast)	-20%

What should you do?

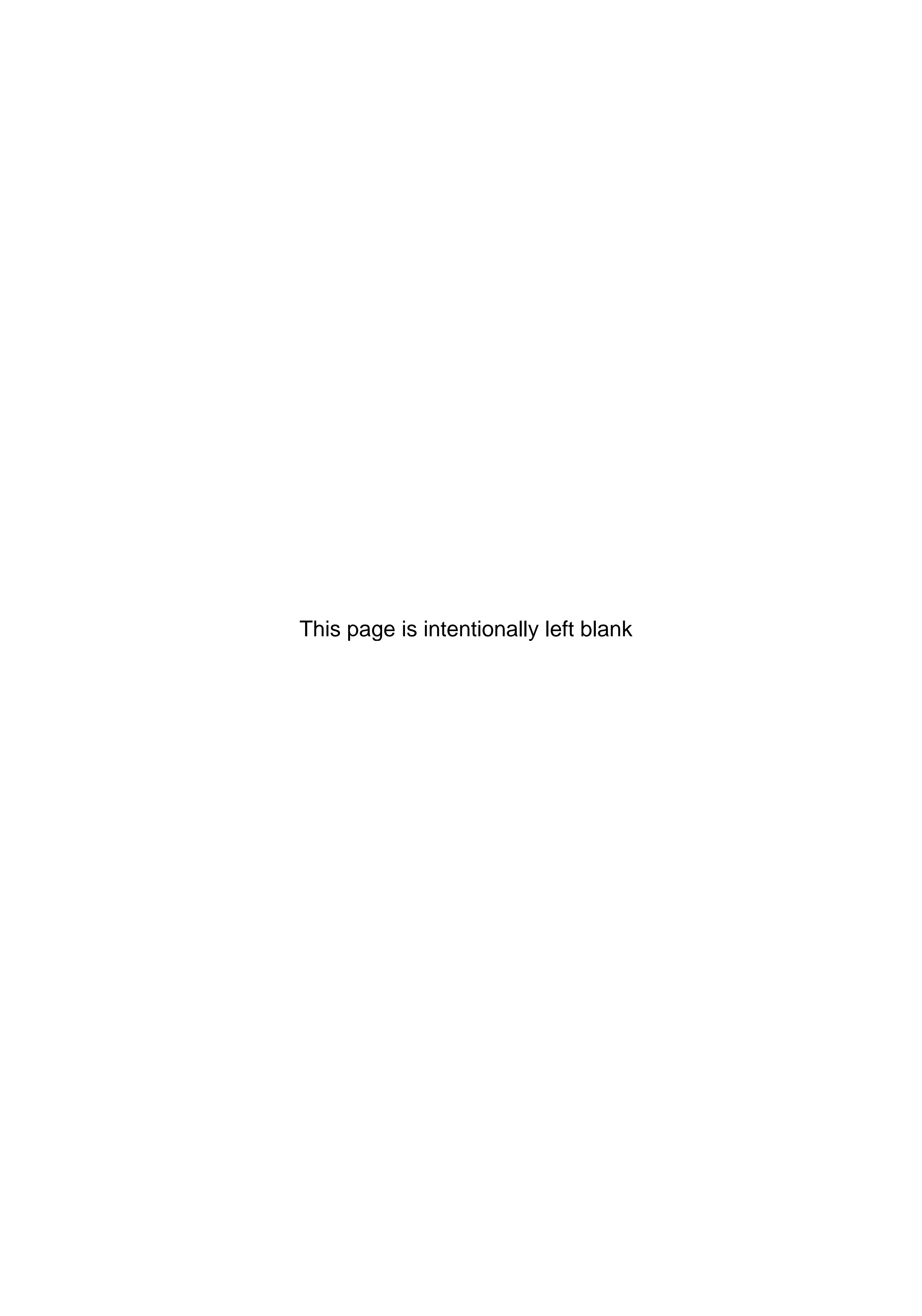
Something is better than nothing.

Start small and build up gradually: just 10 minutes at a time provides benefit.

MAKE A START TODAY: it's never too late!

UK Chief Medical Officers' Guidelines 2011 **Start Active, Stay Active: http:bit.ly/startactive**

Physical activity
for pregnant women
Helps to control weight gain
Helps reduce high blood pressure problems
Helps to prevent diabetes of pregnancy
Improves fitness
Improves sleep
Improves mood
Not active?
Start gradually
Already active?
Keep going
Home
Out and about
Leisure
Throughout pregnancy
aim for
at least
150
minutes
of moderate intensity activity
every week
Do muscle strengthening activities twice a week
Every activity counts, in bouts of at least 10 minutes
No evidence of harm
Listen to your body and adapt
Don't bump the bump
UK Chief Medical Officers Recommendations 2017: Physical Activity in Pregnancy.
bit.ly/startactiveinfo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Key theme/issue	How is this being addressed? Including strategies & contributing programmes/activity/initiatives	Opportunities and actions
Ambitions from Southend's original HWB Strategy 2013-15		
1. A positive start in life		
a) Reduce need for children to be in care	**Early Help Family Support**	
b) Narrow the education achievement gap		
c) Improve education provision for 16-19s		
d) Better support more young carers		
e) Promote children's mental wellbeing	**A Better Start Southend**	
f) Reduce under-18 conception rates		
g) Support families with significant social challenges	**Early Help Family Support | A Better Start Southend**	
2. Promoting healthy lifestyles		
a) Reduce the use of tobacco	**Smoking cessation programme**	
b) Encourage use of green spaces and seafront	**Physical Activity Strategy (PAS) / Ideas in motion**	
c) Promote healthy weight		
d) Prevention and support for substance & alcohol misuse		
3. Improving mental wellbeing		
a) A holistic approach to mental and physical wellbeing	**Joint Mental Health Strategy (JMHS)**	
b) Provide the right support and care at an early stage		
c) Reduce stigma of mental illness		
d) Work to prevent suicide and self-harm	**Joint Mental Health Strategy (JMHS)**	
e) Support parents postnatal	**A Better Start Southend**	
4. A safer population		
a) Safeguard children and vulnerable adults against neglect and abuse	**Safeguarding Boards agenda**	
b) Support the Domestic Abuse Strategy Group in their work	**Community Safety Partnership**	
c) Work to prevent unintentional injuries among under 15s	**Domestic Abuse Strategy**	

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5. Living independently a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	**Transformation programme**	
6. Active and healthy ageing a) Join up health & social care services b) Reduce isolation of older people c) Physical & mental wellbeing d) Support those with long term conditions e) Empower people to be more in control of their care	**Joint commissioning programme | Multi-Disciplinary Teams** **Transformation programme**	
7. Protecting health a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	**Health screening programme**	
8. Housing a) Work together to; ○ Tackle homelessness ○ Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	**Southend Homelessness Prevention Strategy 2014-2017 http://bit.ly/2wBh5YA** **Housing Strategy 2011-2021 http://bit.ly/2gHOQSy**	

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9. Maximising opportunities		
a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment	**Joint Commissioning agenda** **Economic Development activity**	
2014-15 Peer challenge recommendations		
A1) Less is more -Reduce the number of issues that the Board is focusing on so that it can attend more proactively to the main issues facing the Borough.	**HWB Strategy refresh 2017-21, narrowed focus to increasing physical activity levels**	
A2) Address inequality -Develop a common understanding of health inequalities and where health outcomes are poor, agree what needs to be addressed and ensure partners are addressing them together.	**HWB Strategy refresh 2017-21 emphasises tackling inequality**	
A3) Strengthen community engagement and resilience	**Our Town Our Future (borough vision) programme** **Transformation programme**	
Public and stakeholder engagement event, May 2015		
B1) Mental health: Holistic view of health as both physical and mental	**Joint Mental Health Strategy**	
B2) Healthy food: Importance of good nutrition and accessibility of healthy, affordable food		
B3) Importance of social connection to address isolation/loneliness	**Transformation programme**	
B4) Housing: Appropriate, affordable housing	**Housing Strategy 2011-2021 http://bit.ly/2gHOQSy**	
B5) Value of prevention and early intervention	**A Better Start Southend**	
B6) Empower people to make positive choices		
B7) Listen to and involve service users in decision making		

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B8) Be open and realistic with people about what can be delivered		
B9) Centralise services: Promote easy/comprehensive access to information	**The Localities care model includes Multi-Disciplinary Teams for a more holistic service**	
B10) Recognise and support carers		
HWB strategy development session May 2016		
C1. Outcomes: Focus on outcomes rather than services	**Refreshed HWB Strategy 2017-2021 focuses on increasing physical activity**	
C2. Language and branding: think about our wording and make things more real for people i.e. 'be more active!' instead of 'increased physical activity'	**We have simplified the focus and language of the refreshed Health and Wellbeing Strategy 2017-2021 with the aim of making it more accessible.**	
C3. Data & intelligence: availability and accessibility of quality data across the system and using data intelligently to make a real difference i.e. deep dives/ analyses/ longitudinal studies.		
C4. Be open with people about what is possible		
C5. Consistency of message across the partnership: How does the HWB Strategy and vision influence the visions and plans of system partners?	**The HWB Strategy refresh 2017-2021, which has been fully supported by the HWB Board, encourages partners to enable the HWB strategy's aims to influence their own strategic activity.**	
C6. Workforce challenges – how do we address ongoing workforce needs?		
Joint Strategic Needs Assessment (JSNA) headlines Feb 2017		
• Lifestyle related health challenges: excess weight; nutrition; smoking; long term conditions (LTCs)	**Be Active! – Southend's HWB Strategy refresh 2017-21** **Southend's Physical Activity Strategy 2016-21** **Smoking Cessation programme**	
• Life expectancy related to cancers, circulatory, respiratory and chronic diseases.		
• Mental health: anxiety & depression; dementia.	**Joint Mental Health Strategy**	
• Deprivation: comparatively higher levels of deprivation and child poverty; levels of employment and skills		

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Southend Health & Wellbeing Board

Agenda Item No.

(Joint) Report of

Simon Leftley, Deputy Chief Executive (People),
Southend-on-Sea Borough Council.

Ian Stidston, Interim Accountable Officer, NHS Southend
Clinical Commissioning Group (CCG).

……………
to

Health & Wellbeing Board

on

21st June 2017

Report prepared by:
Rob Walters, Partnership Advisor Health and Wellbeing

For information only		For discussion	x	Approval required	x

A greater focus - Refreshing Southend's Health and Wellbeing Strategy

Part 1 (Public Agenda Item)

1. Purpose of Report

1.1. To present the proposals for developing the refresh of Southend's Health and Wellbeing Strategy.

2. Recommendations

2.1. That, subject to any amendments, the key proposals (shown in 3.7 and 3.10) be supported for development and progress be reviewed at the next Health and Wellbeing Board (HWB) meeting in September 2017.

3. Background & Context

HWB Strategy ambitions and Broad Impact Goals

3.1. Southend's first Health and Wellbeing Strategy launched in 2013 and included nine ambitions for the improved wellbeing of Southend's population.

3.2. In 2015, it was clear that the original ambitions were broadly being addressed through a range of strategic plans and initiatives across the partnership and the Board wanted a way to add value to the core activity that was already being delivered.

3.3. With this in mind, three new cross cutting "Broad Impact Goals" were introduced in 2015's HWB Strategy refresh (see Appendix 1 and 1.1) to support the original

ambitions. These focussed on the prevention of ill health; addressing inequality and developing sustainability through increased personal responsibility and participation.

A range of indicators helped to support the progress of these goals and;

- Raise the profile of strategic HWB priorities and stimulate a more central focus for operational teams
- Increase incentive and accountability for strong performance
- Promote partnership working, providing opportunities to collaborate
- Bring a greater awareness of the diverse operational activity across the partnership
- Provide a baseline for consideration of future priority areas and effective use of resources

3.4 Building the picture

As we look forward to developing a refreshed Health and Wellbeing Strategy, there have been a number of key messages to consider since the inception of the original strategy in 2013 (see below, plus short summary on Appendix 2)

Key messages to consider:

A. Peer challenge recommendations 2014-2015

A "Peer Challenge" review of the HWB was performed in January 2014 by the Local Government Association (LGA), with a subsequent follow up review taking place in July 2015.

Lasting themes within the recommendations were;

A1) Less is more: Reduce the number of issues that the Board is focusing on so that it can attend more proactively to the main issues facing the Borough.
-*This is in line with a wider national trend towards concentrating on delivering significant improvements in fewer key areas, vs. lots of activity to produce smaller outcomes.*

A2) Address inequality: Develop a common understanding of health inequalities and where health outcomes are poor, agree what needs to be addressed and ensure partners are addressing them collectively.

A3) Strengthen community engagement and resilience

Other important messages to inform our thinking:

B. Public and stakeholder engagement event, May 2015:

120+ service users and stakeholders were asked what matters to them:

B1) Mental health: Holistic view of health as both physical and mental

B2) Healthy food: Importance of good nutrition and accessibility of healthy, affordable food

B3) Importance of social connection to address isolation/loneliness

B4) Housing: Appropriate, affordable housing

B5) Value of prevention and early intervention

B6) Empower people to make positive choices

B7) Listen to and involve service users in decision making

B8) Be open and realistic with people about what can be delivered

B9) Centralise services: Promote easy/comprehensive access to information

B10) Recognise and support carers

C. Strategy development session May16 (HWB Board & colleagues)

Main points from discussions:

C1. Outcomes: Focus on outcomes rather than services

C2. Language and branding: think about our wording and make things more real for people i.e. ‘be more active!’ instead of ‘increased physical activity’

C3. Data & intelligence: availability and accessibility of quality data across the system and using data intelligently to make a real difference i.e. deep dives/ analyses/ longitudinal studies.

C4. Be open with people about what is possible

C5. Consistency of message across the partnership: How does the HWB Strategy and vision influence the visions and plans of system partners?

C6. Workforce challenges – how do we address ongoing workforce needs?

D. Joint Strategic Needs Assessment (JSNA) headlines (Appendix 3)
(Key issues which affect our population’s health and wellbeing)

- Lifestyle related health challenges: excess weight; nutrition; smoking; long term conditions (LTCs)
- Life expectancy related to cancers, circulatory, respiratory and chronic diseases.
- Mental health: anxiety & depression; dementia.
- Deprivation: comparatively higher levels of deprivation and child poverty; levels of employment and skills

3.5 Wider context

Locally, the refresh of the strategy comes at a time of transition and opportunity, with increasing collaborative integration between health and social care, NHS proposals for hospital reconfiguration and a move towards four Integrated Health and Social Care “Localities” across the borough.

The vision for the Locality approach is that a Locality is the central place where integrated health and social care interventions are delivered and co-ordinated. This is represented by a shift away from hospital centric care into community

based delivery through all system partners working in a collaborative and integrated way. Following the showcase of the East Central locality in the Sustainability and Transformation Plan (STP) pre-consultation business case, the natural next step was to pilot Locality working within East Central and develop a multi-disciplinary integrated team approach, which would undergo a period of 'testing and learning'. This was supported by the STP and East Central has been identified as a pilot area for the programme. Achievements include:

- Moderate needs Multi-Disciplinary Team (MDT) created to identify and work with people who have moderate health and care needs, i.e. those who sit between the 'adaptive' and 'dependant' elements of the transitional pathway.

- Through the Electronic Frailty Index (EFI) – a risk stratification tool – patients who would benefit from an integrated MDT approach will be identified.

Engaging Primary Care: Locality working is designed to build relationships and trust amongst professionals in order to share both the burden and joy of care and to ensure the best outcomes for the population. The integrated team is planning to provide a variety of support for Primary Care, including GPs.

It is recognised that the Localities approach can play a key part in increasing levels of physical activity, addressing inequality and developing meaningful engagement and community resilience.

Aligned to the development of the Locality approach is the integration of children's services. This work complements and supports a 'family' approach to integration. The integration of children's service journey has begun with Success for All consulting and agreeing an integration strategy for children's services. The challenge is to now develop a mobilisation plan for the strategy and align the governance structures to ensure integration opportunities are identified and realised.

3.6 The high cost of physical inactivity

"The potential benefits of physical activity to health are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'." – Sir Liam Donaldson

The case for the health and wellbeing benefits of physical activity is compelling, not only for long term improvements to physical health but also for a person's improved mental health and wellbeing (see Appendix 7 "23½ Hours" video clip: http://bit.ly/1fSDL5E)

Cost to Health Economy:

The estimated impact of physical inactivity to Southend's health economy is £21,472,753 per 100,000 population per year. (Reference; UK Active, Turning the Tide of Physical Inactivity)

Human Cost:

Modelling suggests that if 75% of the Southend adult population met the Chief Medical Officer's physical activity guidelines, 6 premature deaths per month would be prevented (40-79 years old). If 100% met the guidelines, 2 premature deaths per week could be prevented.

OR

Every 5 days someone under the age of 79 from the Southend population dies a death that could have been prevented if the whole population met the Chief Medical Officer's physical activity guidelines.

Appendix 6 demonstrates the associated social, economic, environmental and wellbeing impacts of investing in measures that support physical activity.

These challenges cannot be addressed by health and care alone. This requires a much broader partnership with colleagues from culture and planning as well as local businesses, voluntary sector partners and communities in order to shape Southend as a place which develops being physically active as a normal way of life.

In addition to a holistic organisational approach, the priority of fostering a culture of self-care and personal responsibility is of central importance, in order to see a positive shift in quality of life and sustained improvements in health and wellbeing.

It has been notable from the developing localities work how the lack of social capital such as friends and family was often a reason why people could become stuck in damaging behavioural patterns and become dependent on professionals. To avoid this, professionals need to be looking for opportunities to build people's capacity.

This is an opportunity for everyone to get behind a single approach and evaluate and learn as a whole, rather than in fragments.

3.7 Key proposals:

Having considered a broad range of key messages and following on from 2015's Broad Impact Goals, it is proposed that we develop a more focussed Health and Wellbeing Strategy refresh which primarily:

A. Increases the number of people in Southend being active at the levels that will promote their health and wellbeing

And in doing so;

B. Develops a model of meaningful engagement with local people.

C. Addresses issues of inequality and increases community resilience.

It is recognised that, as with the original strategy and its broad ambitions, there are many other areas of local importance and interest. Rather than duplicate existing work, the refreshed HWB Strategy will comprehensively map and signpost to strategic activity across the system, which addresses key areas of

importance i.e. Mental Health Strategy. This will enable the HWB Board to monitor developments and progress across a broad range of important topics.

The current Southend Physical Activity Strategy 2016-2021 (Appendix 4) will be fundamental in supporting the refreshed HWB Strategy's primary aims of improving physical activity.

Appendix 5 shows the vision of the Physical Activity Strategy.

3.8 Driving progress

The proposal is to work with the current Physical Activity Strategy Implementation Group and other relevant partnership governance and engagement routes, to develop effective system-wide commitment to drive improvements and monitor progress.

The refreshed Health and Wellbeing Strategy will align with the indicators and actions identified in the Physical Activity Strategy, (see Appendix 4, page 19) as well as supporting the ongoing development of other relevant key performance indicators (KPIs). KPI progress will be reviewed annually.

Progress, challenges and opportunities in relation to the Action Plan (Appendix 4, pages 20-23) will be reviewed with the HWB Board on a regular basis.

3.9 Consultation

Rather than being a departure from the previous priorities of the Health and Wellbeing Strategy, these refreshed proposals offer a renewed focus, to drive significant improvements by intensifying our focus on a key area, which is proved to produce significant positive outcomes in people's lives.

Engagement will continue through established and new channels, to help inform the ongoing effective development and implementation of priorities which make a difference to our local communities.

3.10 Duration

To maximise impact, it is proposed that the refreshed HWB Strategy works in line with the current Physical Activity Strategy 2016-2021, with a mid-term review of effectiveness and relevance in 2019.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- Nine HWB Strategy Ambitions (see Appendix 1)
- Three HWB "Broad Impact Goals" which add value;
    - a) Increased physical activity (prevention of ill health)
    - b) Increased aspiration & opportunity (addressing inequality)
    - c) Increased personal responsibility/participation (developing sustainability)

4.1 This proposed approach inherently addresses core themes within the current HWB Strategy, while bringing greater focus to achieving significant health and wellbeing improvements for the population of Southend through increased levels of physical activity.

5. Reasons for Recommendations

5.1. To refine the focus of the current HWB Strategy in order to drive significant improvement in the health and wellbeing of local people.

6. Financial / Resource Implications

6.1 Cost to Health Economy:

The estimated impact of physical inactivity to Southend's health economy is £21,472,753 per 100,000 population per year. (Reference; UK Active, Turning the Tide of Physical Inactivity)

7. Legal Implications

7.1 None currently identified

8. Equality & Diversity

8.1. The proposals aim to address inequality as a key priority

9. Background Papers

9.1. None

10. Appendices

Appendix 1.0 Summary on a page of HWB Strategy Refresh 2015-2016

Appendix 1.1 HWB Strategy Refresh 2015-2016

Appendix 2.0 Key messages to inform our thinking

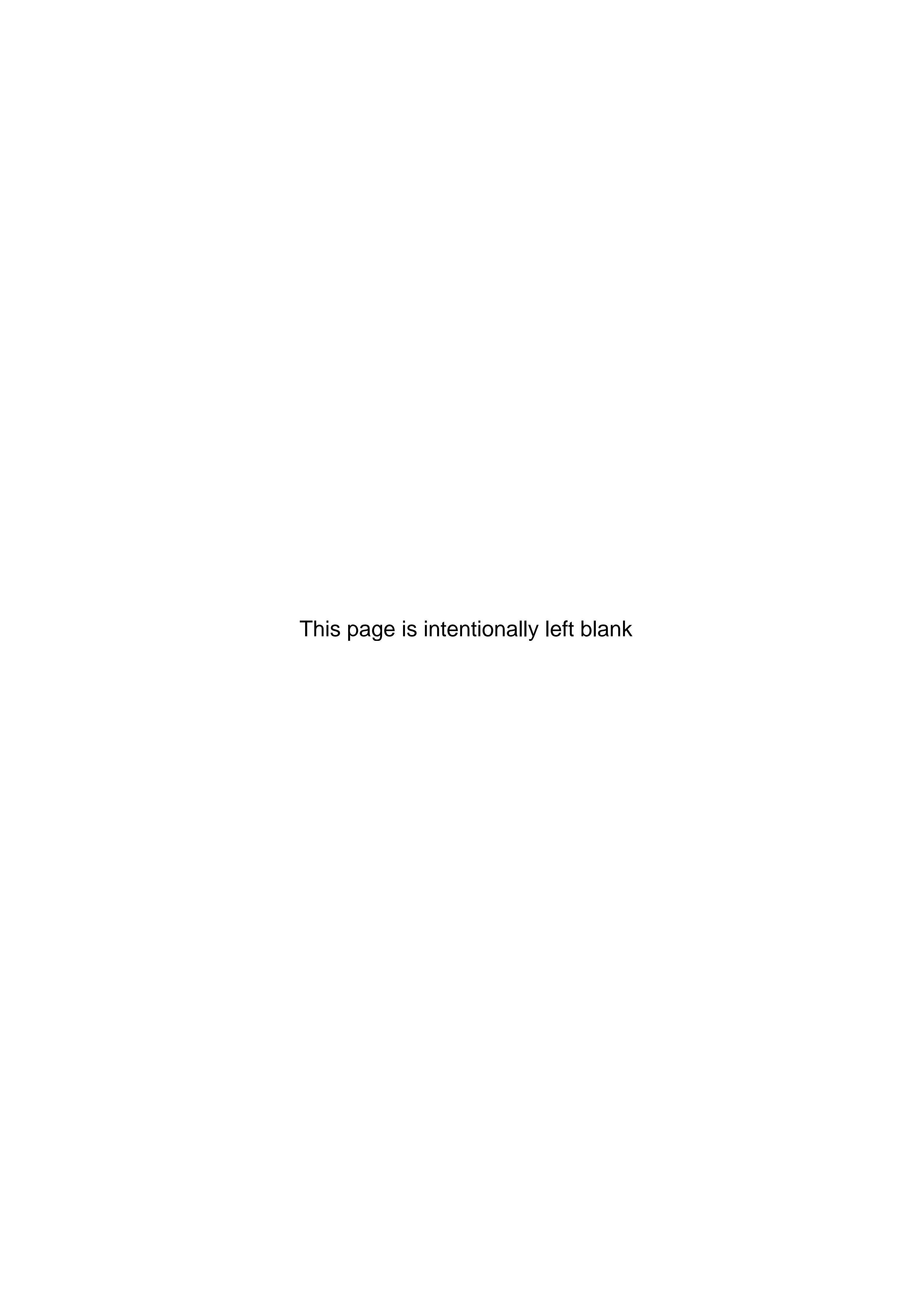
Appendix 3.0 Southend Joint Strategic Needs Assessment (JSNA) summary

Appendix 4.0 Southend Physical Activity Strategy 2016-2021

Appendix 5.0 Vision from Physical Activity Strategy 2016-21

Appendix 6.0 Info-graphic: Investing in Cycling: in numbers

Appendix 7.0 *(video clip)* "23½ hours": http://bit.ly/1fSDL5E



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Physical Activity Strategy

2016 - 2021

Southend *a healthy active borough*

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"The potential benefits of physical activity to health are huge. If a medication existed which had a similar effect, it would be regarded as a 'wonder drug' or 'miracle cure'."

Sir Liam Donaldson

Foreword

I am delighted to introduce the Physical Activity Strategy for Southend-on-Sea 2016-2021, which sets out our vision to improve the health and wellbeing of everyone in Southend by encouraging active lifestyles.

Last year I was involved in an indepth scrutiny project which looked at how we support people in the borough to achieve healthier lifestyles, with a particular focus on getting people to be more active. I was particularly struck by the amazing opportunities we have in the borough to support people to be more active in their everyday lives. I was also concerned to learn that almost a third of adults in Southend are classed as 'physically inactive'. This will be putting these individuals at a greater risk of a number of diseases, including coronary heart disease, cancer, stroke, type 2 diabetes and obesity. In addition to the impact on health and wellbeing of individuals, it is estimated that every year the health related costs associated with the low levels of physical activity in the borough are in the region of £5 million. This puts pressure on all of our budgets at a time when finances are tight and set to reduce even further over the coming years.

This strategy builds on the extensive work that was undertaken as part of the scrutiny project. We were also fortunate to have had dedicated input from the Chief Culture and Leisure Officers Association to assist us with our thinking about broader partnership working. This work enabled us to further understand our communities and how to influence people's attitudes and behaviours towards becoming more physically active.

We have used this broad range of information to inform the four key strategic aims of this strategy. These focus on: increasing levels of participation in physical activity and reducing inactivity; improving our marketing and communications about physical activity; promoting the contribution of the built and natural environment in supporting people to be active in their daily lives; and supporting the collaborative working of the Council with a wide range of partners to help people to be more active.

There is a wealth of evidence that increasing participation in physical activity can make a huge difference to people's lives. I recommend this Physical Activity Strategy to you as our first step on a journey and look forward to collaborating with you to achieve our vision to make Southend a healthy active borough.

Councillor Lesley Salter
Portfolio Holder for Adults, Health and Social Care, and
Chair of Southend Health and Wellbeing Board

1.0 Our Vision

For Southend to be a healthy active borough.

Mission

We will make participation in an active healthy lifestyle a social norm for people who live and work in Southend, and particularly for under-represented and inactive groups.

Strategic aims

To help us achieve our vision, we plan to use our influence and resources within the following key strategic aims:

- To reduce inactivity and increase participation in physical activity for everyone, giving priority to our more inactive populations. We will look at more ways for people in Southend to be more active more often at work, at home and during leisure time.
- To improve our marketing and communications about physical activity. We will increase the knowledge, awareness and understanding of people of all ages in Southend about the health benefits of physical activity, and where and how to be active.
- To promote the built and natural environment and its contribution to supporting people to be more active in their daily lives. We will promote our world class facilities and active travel network that enhance the opportunities for people to get active and stay active.
- Southend-on-Sea Borough Council will work collaboratively with a wide range of partners, including statutory organisations, businesses, the third sector and community groups, to help people to be more active. We will strengthen partnership working and make effective use of our combined resources.

In Southend we want to increase the number of people being active at the levels that will promote their health and wellbeing. We want to make physical activity a priority in people's everyday lives and that Southend is one of the most active areas in England.

2.0 Introduction

We are failing to stem the rising tide of physical inactivity across the population. We are already around 20% less active than in the 1960's and this is anticipated to increase to 35% less active by 2030, with the associated health, social and economic costs to individuals, families, communities and the country as a whole (1).

Physical inactivity is the fourth largest cause of disease and disability in the UK, with those of us who are not physically active enough being at risk of developing a number of conditions including heart disease, cancer, obesity, diabetes, depression and dementia (2).

Physical inactivity is also directly responsible for 1 in 6 deaths in the UK (3). Yet around one in four people in the UK do less than 30 minutes of activity a week and so are classified as 'inactive'(4).

Despite knowing the importance of exercise, we have not created an active society. Social, cultural and economic trends have removed physical activity out of people's daily lives. Car ownership continues to increase, we have less active jobs, and more screen based technology at home and at work. Even many features of cities and towns work against physical activity (5,6). The result is that we walk less, sit down more and allow gadgets to do the work for us.

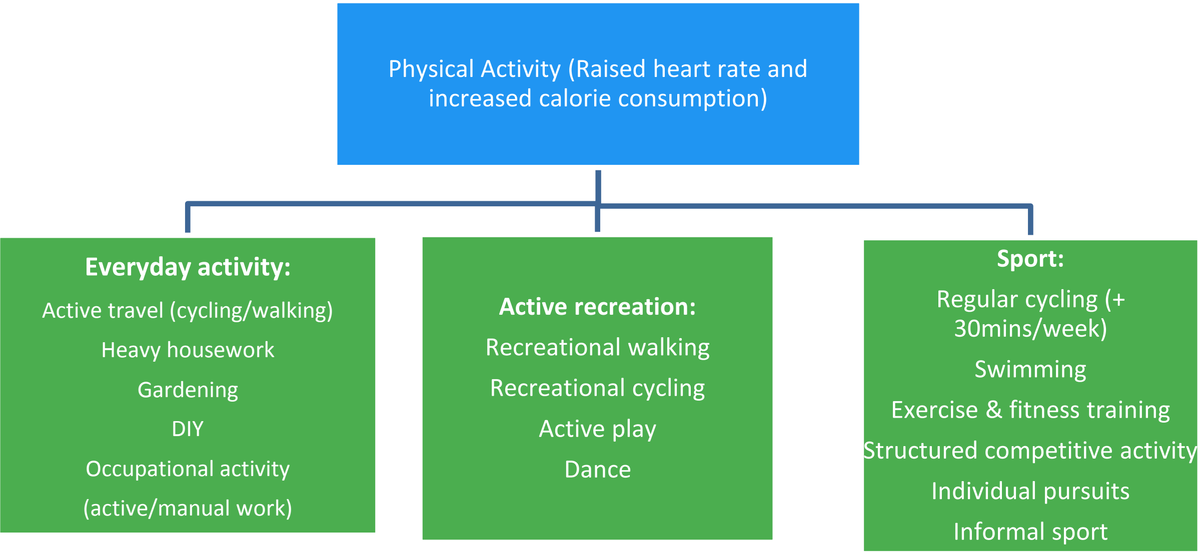
With time and commitment in short supply, helping people to be active every day is about weaving activity into our daily lives. We need to maximize our use of the many assets we already have – our parks, leisure facilities, community halls, and workspaces – as well as doing whatever exercise, dance, leisure or sport we enjoy.

2.1 Definition of Physical Activity:

Physical activity has many different definitions, but for the purposes of this strategy it includes "all forms of activity, such as everyday walking or cycling to get from A to B, active play, work-related activity, active recreation (such as working out in a gym), dancing, gardening or playing active games, as well as organised and competitive sport" (7).

Figure 1 sets out the structure of physical activity, showing how the different types of activity and their different elements all contribute towards the strategic aims set out in this strategy.

Figure 1. What constitutes physical activity



Source: Adapted from Start Active, Stay Active (2011) (Ref 7)

2.2 The case for physical activity

There is a wealth of evidence which demonstrates that an active life is essential for physical and mental health and wellbeing. Being active at every age increases quality of life and everyone's chances of remaining healthy and independent (6).

In particular, for adults undertaking at least 30 minutes of moderate intensity physical activity on at least five days a week helps to prevent and manage over 20 common serious medical conditions (7). Table 1 shows the effect of increasing physical activity on the risk of common conditions.

Table1. Effect of physical activity on the risk of common conditions

Disease	Effect of physical activity
Cardiovascular disease	20-35% lower risk of cardiovascular disease, coronary heart disease and stroke
Type 2 diabetes	30-40% lower risk of type 2 diabetes (and metabolic syndrome) in those who are moderately active compared to sedentary
Breast cancer	20% lower risk of breast cancer for adults participating in daily physical activity
Colon cancer	30% lower risk of colon cancer for adults participating in daily physical activity
Depression	20% -30% lower risk of depression for adults participating in daily physical activity
Dementia	20% -30% lower risk of dementia for adults participating in daily physical activity
Hip Fracture	36% to 68% risk reduction of hip fracture at the highest level of physical activity
Falls	30% lower risk of falls for older adults who participate in regular physical activity

Source: Adapted from Start Active, Stay Active (2011) (Ref 7)

The health improvements with physical activity are often greater than many drugs, and exercise has been called a 'wonder drug' or a 'miracle cure' (8). Table 2 provides a summary of the evidence of improvement in health with physical activity for those with chronic conditions (9).

Table 2. Evidence of improvement in health with physical activity for those with chronic conditions

Condition	Evidence for improvement
Chronic obstructive pulmonary disease	Physical activity improves cardiorespiratory health. In COPD, exercise training reduces dyspnoea symptoms and increases ability for exertion.

Heart disease and/ or Heart failure and/or Angina	Studies show clear improvements in cardiovascular health with moderate exercise. There are similar beneficial effects for sufferers of angina. Overall, exercise reduces cardiac mortality by 31%.
Hypertension (high blood pressure	Randomised controlled trials show a clear lowering of blood pressure with aerobic training. 31% of patients on average experience a drop of at least 10 mmHg with regular physical activity.
Obesity	Exercise only has a moderate effect in reducing obesity. Aerobic physical activity has a consistent effect on achieving weight maintenance. Exercise also changes the distribution of fat, by reducing the less healthy visceral [abdominal] fat.
Depression	A Cochrane review evaluated 30 trials of physical activity as a treatment for depression, showing overall 'moderate' improvement.
Peripheral vascular disease	Exercise leads to a moderate improvement in peripheral vascular disease. Improvements are seen in both pain-free walking time and distance in several studies.
Diabetes	Exercise has a statistically and clinically significant beneficial effect on glycaemic control and the metabolic state. Exercise works as a treatment modality in both type 1 and type 2 diabetes
Osteoarthritis	Physical activity improves symptoms of osteoarthritis by 22-83% and does not lead to worsening of this condition. It has benefits in reducing pain (by 25-52%), improving function, improving quality of life and mental health. Others have commented on exercise being weakly effective in osteoarthritis and leading to moderate improvement in low back pain. Exercise increases muscle strength and coordination.

Source: Exercise: The miracle cure and the role of the doctor in promoting it (2015).(Ref 9)

There are many other social, individual and emotional reasons to promote more physical activity. Being active plays a key role in brain development in early childhood (10,11) and is also good for longer-term educational attainment (12). Increased energy levels boost workplace productivity and reduce sickness absence. An active population can even reduce levels of crime and antisocial behaviour (13).

2.3 The cost of physical inactivity

It is estimated that the health costs related to physical inactivity in Southend amount to approximately £5m each year, excluding the cost of obesity (14). This equates to £3,054,673 per 100,000 population.

Table 3. Health costs of physical inactivity by disease category in Southend

Disease	Cost
Cancer lower GI	£62,231
Cancer breast	£93,462
Diabetes	£423,671
Coronary heart disease	£4,205,691
Cerebrovascular disease	£208,863
Total	**£4,993,917**

Source: Sport England Local Sport Profile 2016 (14)

2.4 Case studies and quotes from service users

Case Study:
Bob wants to stay healthy so he can play with his grandchildren into his old age – and he is praising Southend-on-Sea Borough Council for helping him to do so. The retired builder, was shocked when a health check at his local GP surgery revealed that his Body Mass Index was "through the roof". His weight was exacerbating a chronic breathing problem and he realised he needed to take some action.

On the advice of the surgery Bob had an informal meeting in The Forum with a one-to-one coach from the Council's Get Healthy Hub and he jumped at the chance to join the exercise referral and weight management programme. He was offered 12 weeks of subsidised sessions at Southend Leisure and Tennis Centre and 12 weeks of public health-funded weight management sessions.

"It was fantastic to be given this opportunity," said Bob. "Overeating is a vicious circle and I needed a push to change my lifestyle. I found the discussion groups at the weight management sessions very useful and I have also benefited at the gym from the advice of a

personal trainer for whom I paid." Bob has kept up his gym sessions beyond the initial 12 weeks, easing himself into physical activity using the recumbent exercise bikes and a cross trainer.
"The help from the Council has been a lifeline to me," he added. "I have four grandchildren, all girls aged nine, seven, six and two, and I want them to know I will be around to play with them for many years to come."

Quotes:

"I love the drumming and dancing, I can express myself and it helps to calm me" Disability Capoeira participant

"As I have long term depression, this has been wonderful for my health" Active 50+ Festival on the Pier participant

"My young person has had the best time during this course. It has been wonderful to see his self-esteem and confidence grow. These sessions have certainly helped to break down barriers with some of our young people and have demonstrated that we listen to them and what they enjoy doing. " Case Worker for an individual who attended Parkour physical activity programme.

3.0 The Context for Physical Activity

3.1 National physical activity policy

Physical activity is firmly in the national spotlight, showing an increasing drive to improve the health of the nation and tackle health inequalities. Recognition of the need to invest in preventative health is growing, focusing on staying healthy and promoting wellbeing.

Over recent years there have been numerous national reports and strategies published which provide detailed background information and evidence on the importance and impact of physical activity. These include:

Start Active, Stay Active: Department of Health, 2011 (7)
Otherwise known as the UK's Chief Medical Officers' guidelines, this report was aimed at the NHS, local authorities and a range of other organisations that develop services and advocates a partnership approach to increasing physical activity levels across the country. It lists the volume, duration, frequency and type of physical activity required for the UK population to achieve the range of benefits of being active. Its key recommendations are that:
Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments. Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes, spread throughout the day.

All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.

Adults do at least 150 minutes per week of moderate physical activity in bouts of 10 minutes.

Public Health Outcomes Framework: Department of Health 2012 (15)
This introduces the overall vision for public health as 'to improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest', and includes two key outcomes in which physical activity can play a role in increasing healthy life expectancy and reducing differences in life expectancy.
The indicators that will measure this ambition are:
2.13i Proportion of adults achieving at least 150 minutes of physical activity per week in accordance with UK CMO recommended guidelines on physical activity

2.13ii Proportion of adults classified as 'inactive'

Turning the Tide on Physical Inactivity. UK Active. 2013 (16)
This report provides the first detailed analysis of physical activity both at a national and local level and examines the rate of physical inactivity and impact on premature mortality. The report makes a number of recommendations, including that local authorities should prioritise and resource physical activity programmes to the same level as other top tier public health risks; deliver a local ambition of a 1% reduction in inactivity year-on-year for the next five years; and ensure that their green spaces are developed to make them safe, accessible and integrated into their leisure and physical inactivity strategies.

Moving More, Living More: the physical activity Olympic and Paralympic legacy for the nation. Cabinet Office 2014 (17)
In recognition of the significant opportunities that physical activity offers individuals and society, the aim of this strand of the Olympic and Paralympic legacy is to have a much more physically active nation. It presents three key areas for action:

- Active people – children, young people & families, older people, disabled people and people playing sport
- Active places – workplaces, public health settings within the NHS and travel by walking and cycling
- Active communities

Everybody Active Every Day, Public Health England 2014 (6)

This framework identifies that being active every day needs to be embedded across every community in every aspect of life, which requires creating cultural change.

To deliver this vision requires action at national and local level across four areas:

- Active society: creating a social movement
- Moving professionals: activating networks of expertise
- Active environments: creating the right spaces
- Moving at scale: scaling up interventions that make us active

Sporting Future: A New Strategy for an Active Nation. Cabinet Office. 2015 (18)
This latest strategy looks to redefine nationally what success looks like in sport by concentrating on five key outcomes:

- physical wellbeing
- mental wellbeing
- individual development
- social and community development
- economic development.

This new approach includes a new system of measurement, replacing the current Active People Survey with Active Lives. It will measure how active people are overall rather than how often they take part in any particular sport and a new set of key performance indicators will be used to test progress towards the five key outcomes.

Sport England: Towards an Active Nation Strategy 2016-2021 (19)
In response to 'Sporting Future', thus document provides the strategic direction and guidance for future investment. There is a new focus on tackling inactivity through direct investment and improving the knowledge and practice of behaviour change of the physical activity sector. The document outlines seven key areas for future investment:

- Tackling inactivity
- Children and young people
- Volunteering
- Taking sport and activity to the mass market
- Supporting sports core market
- Local delivery
- Facilities

3.2 National picture: the extent of the problem

Physical activity behaviour should be an integral habit within our daily lives.
However, national statistics from the Health Survey for England (20) identify that:
33% of men and 45% of women are not active enough for good health

19% of men and 26% of women are 'physically inactive'

21% of boys and 16% of girls aged 5-15 achieve recommended levels of physical activity

23% of girls aged 5-7 meet the recommended levels of daily physical activity, by ages 13-15 only 8% do

47% of boys and 49% of girls in the lowest economic group are 'inactive' compared to 26% and 35% in the highest

In addtion:
Only 18% of disabled adults regularly take part in sport compared to 39% of non-disabled adults (21)

Walking trips decreased by 30% between 1995 and 2013 (22)

64% of trips are made by car, 22% are made on foot and 2% are made by bike (22)

3.3 What works to increase physical activity

The evidence shows that inactivity is an entrenched problem. Positive change needs to happen at every level and should be measurable, permanent and consistent. NICE have issued evidence-based guidance to inform practice, but to achieve the desired impact it needs to be implemented on a major scale and with long-term planning.

Existing NICE guidelines include:

PH6 2007	Behaviour change: the principles for effective interventions
PH8 2008	Physical activity and the environment
PH13 2008	Promoting physical activity in the workplace
PH17 2009	Promoting physical activity for children and young people
PH41 2012	Walking and cycling: local measures to promote walking and cycling as forms of travel or recreation
PH42 2012	Obesity: working with local communities
PH44 2013	Physical activity: brief advice for adults in primary care
PH49 2014	Behaviour change; individual approaches
PH54 2014	Exercise referral schemes to promote physical activity

Much of this guidance is about maximising the potential of the many assets we already have and using streets, parks, leisure facilities, community halls, and workspaces, and thinking differently about how we commission and plan public services.

Many aspects of this guidance have also helped to inform the key areas of the vision for 'Everybody Active, Every Day' (6), but interventions need to be based on local community needs.

4.0 Physical activity profile of Southend

4.1 Southend - the place

Southend is 16 square miles in size and is one of the largest conurbations in the East of England. Excluding the London boroughs, Southend is the eighth most densely populated area in the United Kingdom, with 42.10 people per hectare compared to a national average of 16.84 per hectare (2013 mid-year population estimates).

The population of Southend is currently 177,900 (mid 2014, population estimate). Southend has an ageing population with 18.7% of people aged 65 and over, which is higher than the national average of 17.3%. The proportion aged 17 and under is 21.5%. The population is predicted to increase, the greatest increase will be in the over 65 year age group.

Deprivation in Southend is higher than average, and overall Southend is ranked as the 190th most deprived out of 363 local authorities in England, and about 21.7% (7,200) children live in poverty.

Southend has a predominantly white British population 87.03%, with a small but increasing BAME population.

Life expectancy for both men and women is similar to the England average. However, there are signficant health inequalities in the borough, with an 11.1 year gap in life expectancy for men and 10.0 years for women in the most deprived areas of Southend than in the least deprived areas.

In Southend, the adult excess weight prevalence (overweight and obese) is 66.8%, which is 2.2% higher than the national average of 64.6% and 1.2% higher than the regional average of 65.6%.

The childhood excess weight prevalence (overweight and obese) in 4-5 year olds is 21.9%, which is the same as the national average, but higher than the regional average (20.7%). For children aged 10-11 in Southend, excess weight prevalence is 32.2%, which is slightly below the national average (33.2%), but 1.5% higher than the regional average (30.7%).

Levels of physical activity in Southend
Southend currently falls below the national (57%) and regional average (57.8%) with the latest figures suggesting that just 52.1% of adults achieve at least 150 minutes of moderate activity per week in accordance with the CMO guidelines.

The latest figures also highlight that 29.2% of adults in Southend are classed as 'physically inactive' and undertake less than 30 minutes of at least moderate intensity physical activity per week (compared to 27.7% nationally and 25.9% regionally).

4.2 Southend: assets and opportunities for physical actvity

Southend has a wealth of assets that present opportunities to support everyone in the borough to be more physically active. These include:

Southend Pier – a local icon, the longest pleasure pier in the world which stretches 1.33 miles out into the Estuary providing perfect conditions for walking.

Seafront – Southend has 7 miles of seafront, with eight beaches. 4 of the beaches have been ranked 'excellent' in the prestigious Blue Flag awards.

Three Shells Lagoon – a planned seafront development to construct an artificial lagoon to provide a safe swimming area.

4 Local Authority owned leisure centres including 3 public swimming pools –
Chase Sports and Fitness Centre, Belfairs Swim Centre, Shoeburyness Leisure Centre and Southend Leisure and Tennis Centre including Southend Swimming and Diving Centre at Garon's Park. The centre is a World Class diving facility and was used by the British Olympic Diving Team as their pre-games training site for the 2012 London Olympics. The leisure operator is required to deliver sports development across the Borough, increasing physical activity opportunities for a range of target groups. Exercise referral is delivered at Southend Leisure and Tennis Centre and currently provides tailored exercise programmes for those referred from their GP with long term conditions or at high risk of long term conditions .

Cycling Town - 3 years as a Cycle Town has left a legacy of improved cycling infrastructure and additions to the national cycling network such as the Prittlebrook Cycle Path and the seafront cycle route. There is also improved cycle parking at all schools, colleges and the university, many workplaces, the town centre, parks and sports centres and local shopping areas.

Ideas in Motion – a distinct brand and website to promote sustainable transport options including walking and cycling.

Shared space infrastructure for traffic calming and to encourage walking and cycling. This includes the award-winning City Beach and Victoria Gateway Plaza.

Water sports - seven miles of seafront provide ideal conditions for water sports including sailing, wind surfing, kite surfing, jet skiing, kayaking as well as swimming and the seaside favourite –paddling.

Parks and Green Spaces – over 1,000 acres of parkland and green space which includes 5 Green Flag Award winning parks and offers various physical activity opportunities including multi-use game areas, children's play areas and outdoor gym equipment.

18 hole 'pay and play' public golf course at Belfairs Park. There is also a 9-hole Pitch 'n' Putt course.

283 acres of public pitches, courts and greens: bowling greens, cricket squares, football and rugby pitches, croquet lawns, pitch and putt, basketball courts, cricket nets, tennis court and a synthetic turf pitch, as well as a variety of school sports facilities.

Private and community provision including: 75 acres of private sport and leisure facilities, there are number of private leisure providers across the town which include private gyms and fitness centres, sports clubs, dance schools, martial arts clubs.

Effective volunteer workforce supporting delivery of many physically active sport and leisure activities.

A Better Start National Lottery funded programme supporting system transformation to shift focus towards prevention in children 0-3 years. Increasing physical activity can support focused outcomes for social and emotional development in the targeted wards.

Two School Sports Partnerships provide a range of sport and physical activities in school settings across the borough, the partnership also provides continuing professional development oportunities for teachers in sports and physical activity.

Active Southend is a community network of physical activity and sport providers. The organisation funded solely by external funding grants delivers a range of projects to increase physical activity levels in the borough. Examples of these programmes include: walking football for older people, dodgeball for young adults and a disability focused multi-sport/activity project.

External Funding the Council is proactive in identifying funding opportunities to support sporting and physical activity initiatives – these include the Active Women project funded by Sport England over three years to provide sporting and physical activity opportunities for women in six wards across the town in community locations. The Council has also worked in partnership with other organisations to draw in funding for a range of activities such as disability cycling and dodgeball.

4.3 Links with other local strategies

The main local drivers for change are:

In-depth Scrutiny 2014-15. How the Council assists and excites individuals and community groups to achieve healthier lifestyles – envisages a town:

- where people engage with each other through activity
- whose people live longer more active lives
- with reduced inequalities in life expectancy and improved quality of life

Southend Health and Wellbeing Strategy – has nine ambitions for the Southend populations health and wellbeing, including:

- a positive start in life
- promoting healthy lifestyles
- improving mental wellbeing
- living independently
- active and healthy ageing

Southend-on-Sea Health & Wellbeing Strategy 2015 - 2016 Refresh
Introduction of three broad impact goals, including: 'increased physical activity'

Southend-on-Sea Health System Strategic Plan 2014-19 - has a focus on prevention and introduces five system objectives including:

- our children to have the best start in life
- encourage and support local people to make healthier choices
- reduce the health gap between the most and least wealthy

Southend Children and Young People's Plan 2015/16 – has six priority areas including: 'supporting young people and families to live healthy lifestyles'

Southend Local Transport Plan 3 Strategy Document 2011 – 2026 – aims to tackle health inequalities by increasing the number of adults and children who walk and cycle for work, education and leisure

Southend Parks and Green Spaces 2015 – 2020 – recently published and aims to provide recreation and sports facilities to encourage active, healthy lifestyle and increase participation in sport and leisure

Southend Sport & Leisure Strategy 2013 – 2020 - aims to provide a framework for sports and leisure provision; in particular focusing on increasing participation in sport and leisure as well as promoting the health and social inclusion benefits of sport and leisure to encourage lifelong participation.

5.0 Delivering the strategy

5.1 Implementation, monitoring and evaluation

This five year strategy highlights the importance of increasing physical activity levels for the health and wellbeing of the population and identifies the key measures that will be needed within Southend to achieve increased levels of activity.

Whilst all agencies, working in partnership, have a role to play, effective leadership and coordination of effort is needed. The action plan will be led and monitored by a Southend Physical Activity Strategic Partnership consisting of officers from appropriate teams across the Council and the organisations that have been involved in developing the strategy. The Strategic Partnership will report its progress to the Active Southend Network, which consists of a much wider range of organisations and individuals that have a role to play in delivering activity across the borough.

The Strategic Partnership will report its progress on an annual basis to the Southend Health and Wellbeing Board which will have oversight of the implementation of the plan.

It is proposed that the two physical activity indicators in the Public Health Outcomes Framework, are used as the headline key performance indicators to monitor the overall outcome of the physical activity strategy. These two indicators will be updated on an annual basis through the Active Lives Survey.

KP1: By 2021, achieve at least a 2.5% increase in adults being active for 150 mins per week
Baseline (2014): 52.1% Target: 54.6%
(Baseline 2014: England 57%, East of England 57.8%)

KPI 2: By 2021, achieve at least a 2.5% decrease in adults not being active for at least 30 mins/week
Baseline (2014): 29.2% Target: 26.7%
(Baseline 2014: England 27.2%, East of England 25.9%)

A number of other KPIs will be developed as part of further detailed action planning work. This strategy will also contribute to a number of other Public Health Outcomes Framework indicators including:

PHOF 0.1 Life Expectancy/Healthy Life Expectancy
PHOF 0.2 Inequalities in Life Expectancy/Healthy Life Expectancy
PHOF 1.09 Sickness absence
PHOF 2.12 Excess weight in adults
PHOF 2.24 Injuries due to falls in people aged 65 and over

5.2 Southend Physical Activity Strategy Action Plan

Action	Description	Timescale/ issues/ requirements	Lead	Outcome/Output	Impact of Action / What does success look like	Progress
1	Complete physical activity / physical inactivity needs assessment to identify at risk populations	On-going	Public Health / Planning	Completed needs assessment A detailed understanding of the main groups at risk from physical inactivity	Improved intelligence of most inactive populations in Southend and how we access them. This will be used to inform future commissioning and marketing approaches	
2	Set up a multi-agency Southend Physical Activity Strategic Partnership to deliver this strategy to complement the operational work of Active Southend	June 2016	Public Health/ Culture	An effective mechanism for engaging key strategic partners	Multi-agency group to deliver the action plan. System-wide responsibility for increasing physical activity	
3	Develop guidance for providers to utilise physical activity as a method of delivering social value within new and existing contracts	October 2016	Public Health and other commissioning and Procurement teams	Guidance document produced Providers delivering activities which enhance social value	Improved social value of SBC procurements and spend. More physical activity related social value commitments by providers	
4	Include a Physical Activity related action in each service plan across SBC	March 2017	All SBC Departments	Further develop SBC as a Public Health organisation	All relevant SBC services supporting increased physical activity levels in a variety of ways	
5	Include a "Public Health Impact" subheading for consideration within all board papers (Southend on Sea Borough Council)	March 2017	All SBC Departments	Consider the public health implications of all policy and strategic decisions	Public Health impact considered within all decision making	

6	Continue the implementation of the Parks and Open Spaces Strategy and Sports & Leisure Strategy	On-going	Culture / Public Health	Increased opportunities to be physically active	Ensure that the strategies have maximum impact to increase physical activity	
7	Work with partners to develop a marketing plan for physical activity to maximise impact This will include existing websites and campaigns e.g. - Active Southend, SHIP - Leisure Provider Marketing Plan - Public Health England campaigns such as Change4Life (children and families) and One You (adults 18+ - Rio Olympics and other national and international events	On-going	Public Health/ Culture/ Communications	Increased awareness & accessibility of local Physical Activity opportunities	Increased awareness of existing and new opportunities (both privately and public funded), to be physically active amongst the Southend-on-Sea population	
8	Develop and implement Active Southend work plans to increase community based physical activity opportunities	On-going - Annual	Culture / Public Health	Improve the offer of physical activity opportunities across the Borough	Increased number of externally funded physical activity programmes in Southend	
9	Mobilisation of the new Lifestyle Hub contract including the health trainer service that can support access to physical activity opportunities. The service will support physical activity programmes including; Exercise Referral, Postural Stability, Dance for Health and Social Prescribing	October 2016	Public Health	Improve pathways to physical activity opportunities, delivery of good quality motivational interviewing and support to increase physical activity.	Increased number of inactive people entering physical activity interventions	

10	Increase active and sustainable travel through the Ideas in Motion campaign	On-going	Sustainable Transport	Creation of an environment that supports active travel	Increased number of people travelling in an active and sustainable way	
11	Work in partnership to review & Implement new guidance from • "Building the foundations: Tackling obesity through planning and development" re: physical activity elements of designing physical activity into towns as part of tackling obesity • Sport England's "10 Principles of Active Design"	March 2017	Planning/ Public Health	Creation of environments that support physically active lives	Improved consideration of the impact of planning and development design on population physical activity levels	
12	Develop locally relevant 'Southend Active' Design Guidance based on National Guidance including maximising section 106 impact	March 2017	Planning/ Public Health	Creation of environments that support physically active lives	Improved consideration of the impact of planning and development design on population physical activity levels	
13	Use 'Southend Active' guidance to influence other regeneration and new build projects to reduce barriers to physical activity, including improving perceived safety of areas.	On-going	Planning/ Public Health	Creation of environments that support physically active lives	Improved consideration of the impact of planning and development design on population physical activity levels	
14	Optimise the Queensway development to be an exemplar site "designing for people and physical activity"	March 2017	Planning/ Public Health	Creation of environments that support physically active lives	Best practice examples for other developments (both in and out of the borough) to follow, improving physical activity levels of tenants	
15	Deliver Continuing Professional Development for relevant health,	On-going	Public Health	Increased knowledge of the benefits of physical activity	Increased number of brief interventions and	

	education, and social care professionals re: benefits and importance of physical activity, adjustments for special populations (diabetes, asthma) and local services and facilities			& dangers of sedentary behaviour and opportunities available for service users.	signpost/referral into physical activity opportunities	
16	Delivery of Making Every Contact Count to deliver physical activity brief interventions across all appropriate public facing organisations including NHS (incoming standard NHS contract for brief interventions?)	On-going	Public Health / Lifestyle Hub Provider	Increased number of good quality brief interventions for physical activity. Increased referral into physical activity services	Increased number of brief interventions and signpost/referral into physical activity opportunities	
17	Engage with businesses to explore innovative physical activity opportunities and increase sign up to physical activity pledges for the Public Health Responsibility Deal amongst Southend-on-Sea Organisations	On-going	Public Health	Improved staff health and wellbeing in Southend-on-Sea businesses.	Increased number of employees in Southend-on-Sea supported to be physically active in the workplace	
18	Social Marketing for new lifestyle hub including Physical Activity	On-going	Public Health/ Lifestyle Hub Provider	Increased awareness & accessibility of the lifestyle hub & associated services	Increased awareness of physical activity opportunities	
19	Further develop settings based approaches to increase physical activity and reduce sedentary behaviours e.g. Public Health Responsibility Deal, Healthy Schools, Healthy Early Years, School Sports Partnerships	On-going	Public Health	Opportunities for physical activity are increased	Increased opportunities to be physically active in early years settings, schools and workplaces	
20	Develop a network of physical activity champions in primary care	On-going	Public Health/Southend CCG	Each Southend practice has a physical activity champion	Increased knowledge of benefits of physical activity and pathways to support increased physical activity levels	

6.0 References

1. Ng SW, Popkin B (2012). Time Use and Physical Activity: a shift away from movement across the globe. Obesity Reviews 8, 659-80

2. Murray et al. (2013). UK health performance: findings of the Global Burden of Disease Study 2010. The Lancet 381: 997-1020

3. Lee IM, et al. (2012). Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. The Lancet 380: 219-29

4 Health and Social Care Information Centre (2013). Health Survey for England 2012. Volume 1: Chapter 2 – Physical activity in adults. Leeds: Health and Social Care Information

5. Rind E, Jones A, Southall H (2014). How is post-industrial decline associated with the geography of physical activity? Evidence from the Health Survey for England. Social Science Medicine 104: 88-97

6. Public Health England (2014). Everybody Active,Every Day. An evidence based approach to physical activity.

7. Department of Health. Start Active, Stay Active (2011). A report on physical activity for health from the four home countries Chief Medical Officers

8. Chief Medical Officer (2009). Annual report 2009, Department of Health

9. Academy of Medical Royal Colleges (2015). Exercise: The miracle cure and the role of the doctor in promoting it.

10. Maude P (2010). Physical literacy and the young child. In: Whitehead M, editor. Physical literacy throughout the lifecourse. p. 100-16. Oxon: Routledge

11. Ginsburg KR (2007). The importance of play in promoting healthy child development and maintaining strong parent-child bonds. Pediatrics 119:182-91.

12. Hillman CH,et al (2014). Effects of the FITKids Randmised Controlled Trial on Executiv Control and Brain Function. Pediatrics 119:182-91
13. Laureus Sport for Good Foundation (2011). Teenage Kicks: the value of sport in youth crime. London: Laureus Sport for Good Foundation.
14. Sport England (2016). Local Sport Profile for Southend-on-Sea.
15. Department of Health (2012). The Public Health Outcomes Framework for England 2013-2016.
16. UK Active (2013). Turning the Tide on Physical Inactivity.
17. Cabinet Office (2014). Moving More, Living More. The Physical Activity Olympic and Paralympic Legacy for the Nation.
18. Cabinet Office (2015). Sporting Future: A New Strategy for an Active Nation.
19. Sport England. Towards an Active Nation Strategy 2016-2021.
20. Health and Social Care Information Centre (2012). Health Survey for England.
21. Sport England. Active People Survey 8. April 2013 - April 2014.
22. Department for Transport. National Travel Survey 2013.

Appendix 1 Chief Medical Officer (CMO) Physical Activity Guidelines 2011

In July 2011, The Chief Medical Officers (CMOs) of England, Scotland, Wales and Northern Ireland published new guidelines for physical activity. The report emphasised the importance of physical activity for people of all ages and also highlights the risks of sedentary behaviour. The recommendations for different age groups are as follows:

EARLY YEARS (under 5s)

Physical development involves providing opportunities for babies and young children to be active and interactive and to improve their skills of coordination, control, manipulation and movement. Children should be supported in developing an understanding of the importance of physical activity.

Physical activity should be encouraged from birth, particularly through floor-based play and water-based activities in safe environments.

Children of pre-school age who are capable of walking unaided should be physically active daily for at least 180 minutes (3 ours), spread throughout the day.

All under 5s should minimise the amount of time spent being sedentary (being restrained or sitting) for extended periods (except time spent sleeping).

CHILDREN AND YOUNG PEOPLE (5–18 years)

All children and young people should engage in moderate to vigorous intensity physical activity for at least 60 minutes and up to several hours every day.

Vigorous intensity activities, including those that strengthen muscle and bone, should be incorporated at least three days a week.

All children and young people should minimise the amount of time spent being sedentary (sitting) for extended periods.

ADULTS (19–64 years)

Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

Alternatively, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous intensity activity.

Adults should also undertake physical activity to improve muscle strength on at least two days a week.

All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

OLDER ADULTS (65+ years)

Older adults who participate in any amount of physical activity gain some health benefits, including maintenance of good physical and cognitive function. Some physical activity is better than none, and more physical activity provides greater health benefits.

Older adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more – one way to approach this is to do 30 minutes on at least 5 days a week.

For those who are already regularly active at moderate intensity, comparable benefits can be achieved through 75 minutes of vigorous intensity activity spread across the week or a combination of moderate and vigorous activity.

Older adults should also undertake physical activity to improve muscle strength on at least two days a week.

Older adults at risk of falls should incorporate physical activity to improve balance and co-ordination on at least two days a week.

All older adults should minimise the amount of time spent being sedentary (sitting) for extended period.

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Southend Health & Wellbeing Board

Agend
Item No

5

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Ian Stidston, Interim Accountable Officer, Southend CCG

to

Health & Wellbeing Board

on

20 Sep 2017

Report prepared by:
Nick Faint BCF Programme Lead

For discussion	X	For information only		Approval required	

Better Care Fund

2017/19

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is as follows;

1.1 To update members of the Health and Wellbeing Board (HWB) regarding the Better Care Fund (BCF) for 2017/19;

1.2 To note the BCF plan 2017/19 submission made to NHS England on 11th Sep 2017 following sign off from the Deputy Chief Executive (People) (Southend-on-Sea Borough Council 'SBC') and the Interim Accountable Officer (Southend Clinical Commissioning Group 'SCCG') in conjunction with the Chair and Vice Chair of HWB.

2 Recommendations

HWB are asked to;

2.1 note the update for BCF 2017/19;

2.2 note the Southend BCF plan for 2017/19 that was submitted to NHS England on 11th Sep 2017;

3 Background & Context

3.1 The BCF for 2016/17 was established between SCCG and SBC from 1 April 2016. It is underpinned by a legal Section 75 Agreement between the two organisations that sets out the proposed schemes to be funded, the required

flows of income into the pooled budget and the distribution back to the scheme / organisational leads.

3.2 Throughout the course of 2016/17 HWB has reported quarterly BCF activity to NHS England. The most recent return made to NHS England (31 May 2017) continued the theme of reporting that the Southend system continues to operate in challenging financial and operational circumstances but that integrated mitigations and projects are beginning to have an impact, key issues being reported were;

3.2.1 Non-elective admissions are higher than the previous year but the trend is starting to decrease;

3.2.2 Admissions to residential care is stable and is being robustly managed within the context of transforming adult social care;

3.2.3 Delayed Transfers of Care (DToC) performance is good but still presents a significant challenge to both health and social care; and

3.2.4 Reablement (those still at home 91 days after discharge) is on track and stable.

4 Southend BCF 2017/19

National

4.1 The Policy Framework was published in March 2017 (see Appendix A). Due to the General Election 2017 the publication of the technical planning guidance, which enables a BCF submission, was delayed until 4th July 2017, see Appendix B.

4.2 The summary points for the BCF Policy Framework are;

4.2.1 The planning cycle will move from annual to biennial (once every two years) to align with NHS planning requirements;

4.2.2 Local areas will be invited to graduate from BCF which will provide areas with greater autonomy;

4.2.3 National conditions will reduce from eight to four; (1) plans to be jointly agreed; (2) NHS contribution to adult social care is maintained in line with inflation ; (3) commissioning of out of hospital services; and (4) Managing Transfers of Care;

4.2.4 As a result of the 2015 Spending review and 2017 spring budget additional funding has been allocated to local authorities via the BCF to enable a focus on managing transfers of care and sustaining the social care market place, this is known as improved Better Care Fund (iBCF); and

4.2.5 Metrics to measure performance will continue to focus on non-elective admissions; admissions to residential care homes; reablement; and DToC;

Local

4.3 Since March 2017 SCCG and SBC have agreed the following principles that will be followed whilst setting the BCF 2017/19 plan, these are;

4.3.1 BCF fund is largely committed to existing community health and integrated social care activity;

4.3.2 The existing section 75 agreement will be amended to accommodate 2017/19 BCF plan and the iBCF element;

4.3.3 All national conditions will be met, consistent with approach 2016/17; and

4.3.4 Both SCCG and SBC will contribute the mandated funds to the BCF pool. This will be the same as 2016/17 with an anticipated uplift set and agreed by both DCLG and DoH.

4.4 At June 2017 HWB members delegated powers for the Deputy Chief Executive (People) SBC, the Interim Accountable Officer SCCG and the Chair and Vice-Chair HWB to sign off the BCF 2017/19 plan.

5 Southend BCF 2017/19

5.1 On 11th Sep 2017 the Southend BCF plan for 2017/19 was submitted to NHS England according to the planning policy and technical planning guidance (Appendix A and B respectively).

5.2 The plan (at Appendix C) summarises the vision that Southend has in terms of delivering an integrated health and social care model via the Locality approach, reviews the 2016/17 activity and presents a plan with supporting evidence that demonstrates how the locality approach will be implemented.

5.3 The plan confirms agreement to the 4 national conditions.

5.4 Further, the plan outlines the associated financial elements for Southend BCF 2017/19.

6 Southend improved BCF 2017/18

6.1 The Planning Policy at Appendix A outlines the national conditions associated with BCF. One of these conditions is that local areas are responsible for managing transfers of care.

6.2 To enable local areas to manage transfers of care a new grant for adult social care (iBCF) was announced as part of the Government’s Spending Review 2015 and the Spring Budget 2017.

6.3 The iBCF will be paid direct to Local Authorities via a Section 31 grant from the Department for Communities and Local Government. Conditions attached to the grant are outlined below.

6.4 The grant conditions are;

6.4.1 Grant is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market.

6.5 A recipient local authority must:

6.5.1 pool the grant funding into the local Better Care Fund, unless the authority has written Ministerial exemption;

6.5.2 work with the relevant Clinical Commissioning Group(s) and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

6.5.3 provide quarterly reports as required by the Secretary of State.

6.6 The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

6.7 To support the planning for the allocation of iBCF the Government published a High Impact Change model which supports the requirements for meeting the national condition re 'Managing Transfers of Care'. The High Impact Change model outlines 8 step changes that should be considered and planned against to ensure local areas are able to manage more efficiently transfers of care.

6.8 iBCF allocation for Southend are; 2017/18 - £3.99M; 2018/19 - £5.429M (indicative); and 2019/20 - £6.744M (indicative);

6.9 via the Locality Transformation Group (LTG) the iBCF plan was developed. LTG meets monthly and is attended by SBC, SCCG, SEPT and SUHFT. The group is chaired by the Director of Strategy, Commissioning & Procurement; and

7 National Assurance of the BCF plan

7.1 NHS England have delegated responsibility for assuring plans to regional level whilst maintaining responsibility for moderation.

7.2 During the period 11th Sep – 22nd Sep plans will be assured by regional representatives from both local government and NHS England.

7.3 From 22nd Sep plans will be moderated at both regional and national level with letters confirming either an 'approved', 'approved with conditions' or 'not approved' status on 3rd Oct 2017. Assurance guidance and timetable can be found at Appendix D.

8 Health & Wellbeing Board Priorities / Added Value

8.1 The BCF contributes to delivering HWB Strategy Ambitions in the following ways

8.2 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.

8.3 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

8.4 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

9 Reasons for Recommendations

9.1 As part of its governance role, HWB has oversight of the Southend BCF 2017/19.

10 Financial / Resource Implications

10.1 None at this stage

11 Legal Implications

11.1 None at this stage

12 Equality & Diversity

12.1 The BCF plan should result in more efficient and effective provision for vulnerable people of all ages.

13 Appendices

Appendix A – 2017 – 19 Integration and Better Care Fund (Policy Framework)	
Appendix B – BCF technical planning guidnace	
Appendix C – Southend BCF 2017/19 plan (narrative and financial)	
Appendix D – National Assurance	

HWB Strategy Ambitions

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

Agenda
Item No.

Southend Health & Wellbeing Board

Joint Report of
Simon Leftley, Corporate Director for People, SBC
Melanie Craig, Chief Officer, Southend CCG

to

Health & Wellbeing Board

on

01 August 2016

Report prepared by:
Jacqui Lansley, Joint Associate Director of Integrated Care Commissioning
Nick Faint, BCF Project Manager

For discussion	X		For information only	X		Approval required

Locality Approach for Southend

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 Provide Health & Wellbeing Board (HWB) with a briefing and update regarding the formation of commissioning Localities for health & social care in Southend on Sea; and

1.2 Demonstrate how an integrated complex care co-ordination service might fit with the Locality approach;

2 Recommendations

HWB are asked to;

2.1 Discuss and note the locality approach to be adopted and that it will be based on 4 Localities in Southend on Sea.

3 Background

3.1 The vision for the Locality approach is that a Locality is the central place where integrated health and social care interventions are delivered and co-ordinated, this represents a shift away from the hospital and into the community.

3.2 Each Locality will utilise existing (or new) NHS / Council estate to provide primary, community and social care services working in a multi-disciplinary team environment and a complex care service for a risk stratified cohort of

patients and carers. Further, the locality approach is aligned to the Essex Success Regime.

3.3 A complex care co-ordination service has been developed and is currently subject to approval. The service has been developed so that it is aligned to the Locality approach. It will support primary care and community services in ensuring patients receive the right care at the right time and in the right place.

3.4 The Locality approach and integrated services that exist within are aligned to the actions from the pre board discussion items held by HWB regarding Mental Health, Community Recovery Pathway and Integrated Childrens service.

3.5 During the course of quarter 1 2016 / 2017 the Joint Associate Director of Integrated Care Commissioning led an engagement process with the members of the Clinical Executive Committee SCCG to introduce the detail behind the Locality approach and the complex care service. The team has also engaged with system leaders from both commissioners (SCCG and the Council) and providers (SBC, SUHFT and SBC) in developing the Locality approach.

The proposed model

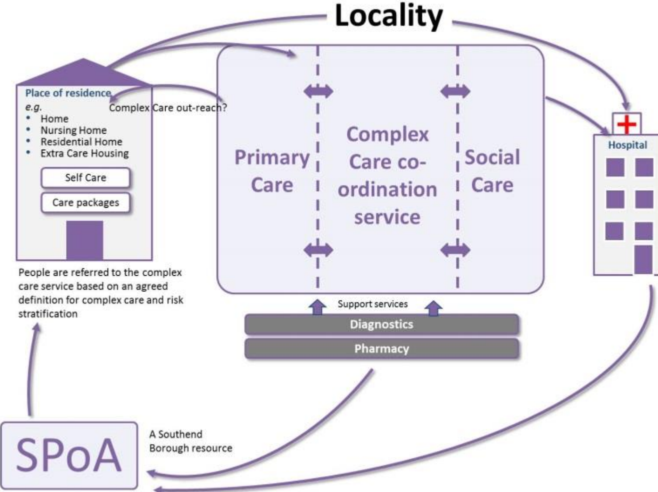
3.6 A number of factors have driven the move towards integrated care provision across Southend-on-Sea. Published in October 2014 by NHS England, The NHS five Year forward view (5YFV) sets out a positive vision for the future based around seven models of care.

3.7 To further help support the transition towards commissioning integrated care, it was agreed in May 2016 (see Appendix 1a & b) that the number of localities within Southend is 4 (four) which work around circa 50,000 residents or patients, as recognised as best practice by the Essex Success Regime.

3.8 Under this new care model outlined in the 5YFW, GP group practices will expand bringing nurses and community services, hospital specialists and others to provide integrated out-of-hospital care. These practices will shift a majority of outpatient consultations and ambulatory care to out-of-hospital settings. To support the 5YFV approach, most recently, the Essex Success Regime has highlighted the requirement for health and care economies to join-up and address problems systematically, rather than in isolation.

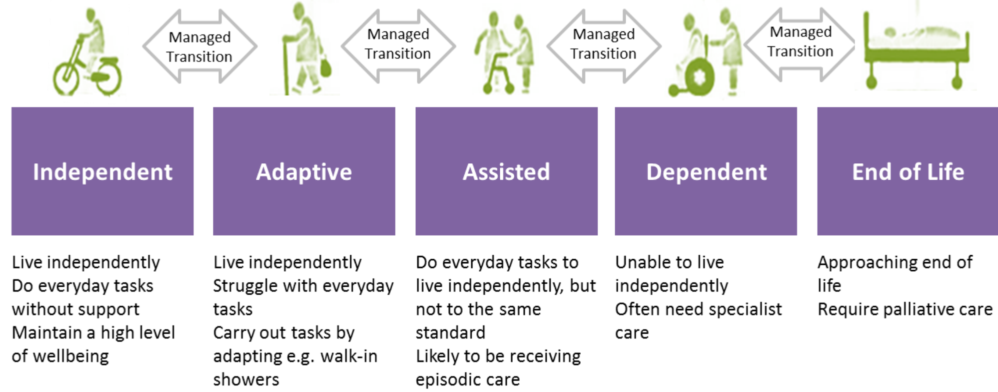
3.9 The drive for matrix working between health and care services has given rise to the opportunity to develop Localities (as demonstrated in the diagram below), where a combination of primary, community and social care can co-locate or integrate.

The Locality approach

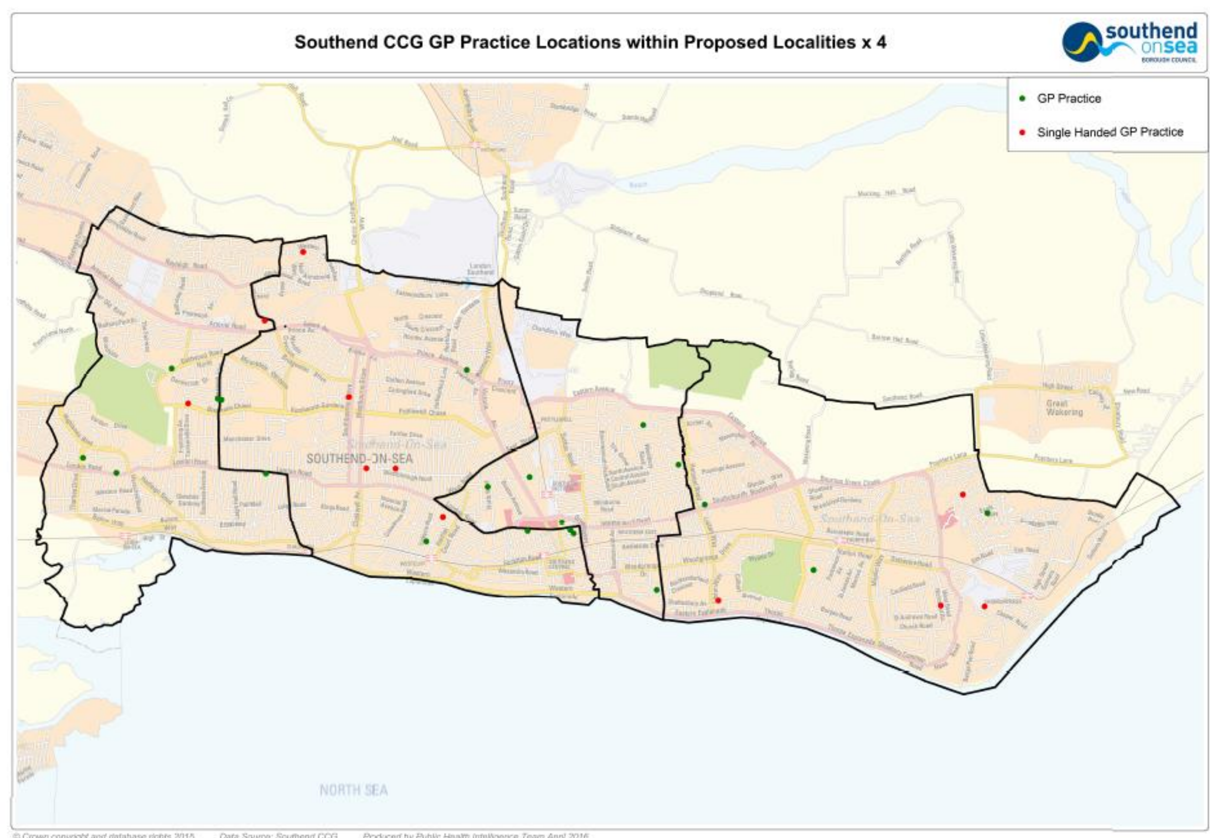


3.10 Closely aligned to a Locality approach is the transitional pathway through which patients will be assessed. Patients with complex care needs – measured through a combination of a frailty index and integrated health and social care data – are those with multiple long term conditions. The best place for the provision of health and social care to these patients should not be the hospital but through the Locality.

The transitional pathway



3.11 The 4 Localities for Southend are represented below;



Timeline for implementation

3.12 The agreed Locality approach will be implemented across Southend through a staged approach;

3.12.1 There will be a period of testing, which includes; the clustering of GP practices into a Locality framework; the further development of MDTs; the co-location of SPoR and the Access team; and locating a social care worker at a GP practice to embed the way in which health and social care work together.

3.12.2 Implementation of full locality approach, alignment with wider transformation programmes such as Adult Social Care redesign and community health services.

3.13 The four Localities are expected to be fully operational by April 2017.

Complex Care Co-ordination service

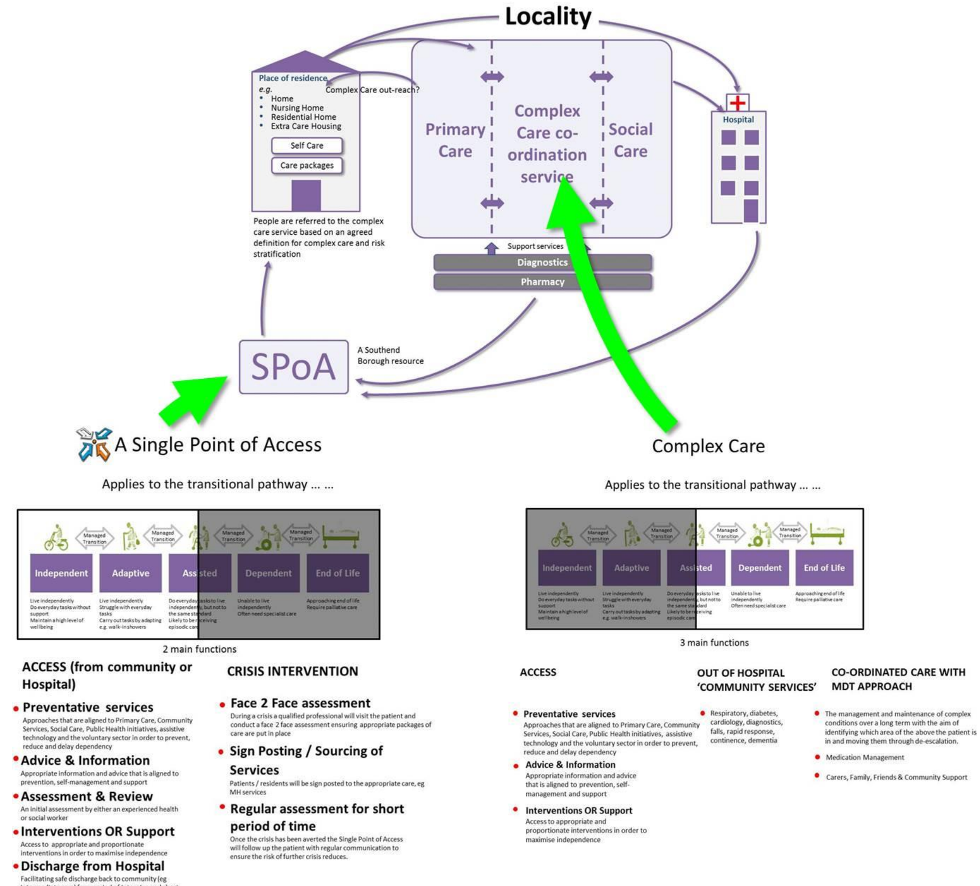
3.14 Within each locality there will be the provision of primary, community and social care. The complex care service will be delivered to support these services ensuring that ‘complex care’ patients have their care co-ordinated and delivered so as to avoid unnecessary interactions within the system.

3.15 The aim / vision of the complex care service is to provide those identified with complex care needs with a service that co-ordinates their health and social care provision based upon existing services and need. Their care is currently provided in an uncoordinated and inconsistent manner which is not tailored to

the specific needs of the patients nor is it most efficient use of resources. The aim of the service is to ensure care needs are assessed, care plans are co-designed through an established MDT approach and care is delivered in a co-ordinated way.

Alignment with the Locality Approach

3.16 The diagram below provides an over view of the complex care co-ordination service and how this interfaces with the Locality Approach and the transitional pathway.



3.17 A complex care co-ordination service will be in operation from 1st October 2016 across the borough of Southend to provide a co-ordination of existing health, social care and community services for an identified and risk stratified complex care cohort.

The next steps – transformation of Community Services

3.18 Following the implementation of the Locality approach we will undergo a process of consultation and engagement with commissioners, providers and patient groups to redesign community services so that they are fully aligned to the complex care co-ordination service and patient needs.

4 Health & Wellbeing Board Priorities / Added Value

The BCF contributes to delivering HWB Strategy Ambitions in the following ways

4.1 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.

4.2 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

4.3 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

5 Reasons for Recommendations

5.1 As part of its governance role, HWB has oversight of the Locality approach.

6 Financial / Resource Implications

6.1 None at this stage

7 Legal Implications

7.1 None at this stage

8 Equality & Diversity

8.1 The Locality approach should result in more efficient and effective provision for vulnerable people of all ages.

9 Appendices

Appendix 1a & b – Options appraisal for Southend Locality approach	Appended separately

HWB Strategy Ambitions

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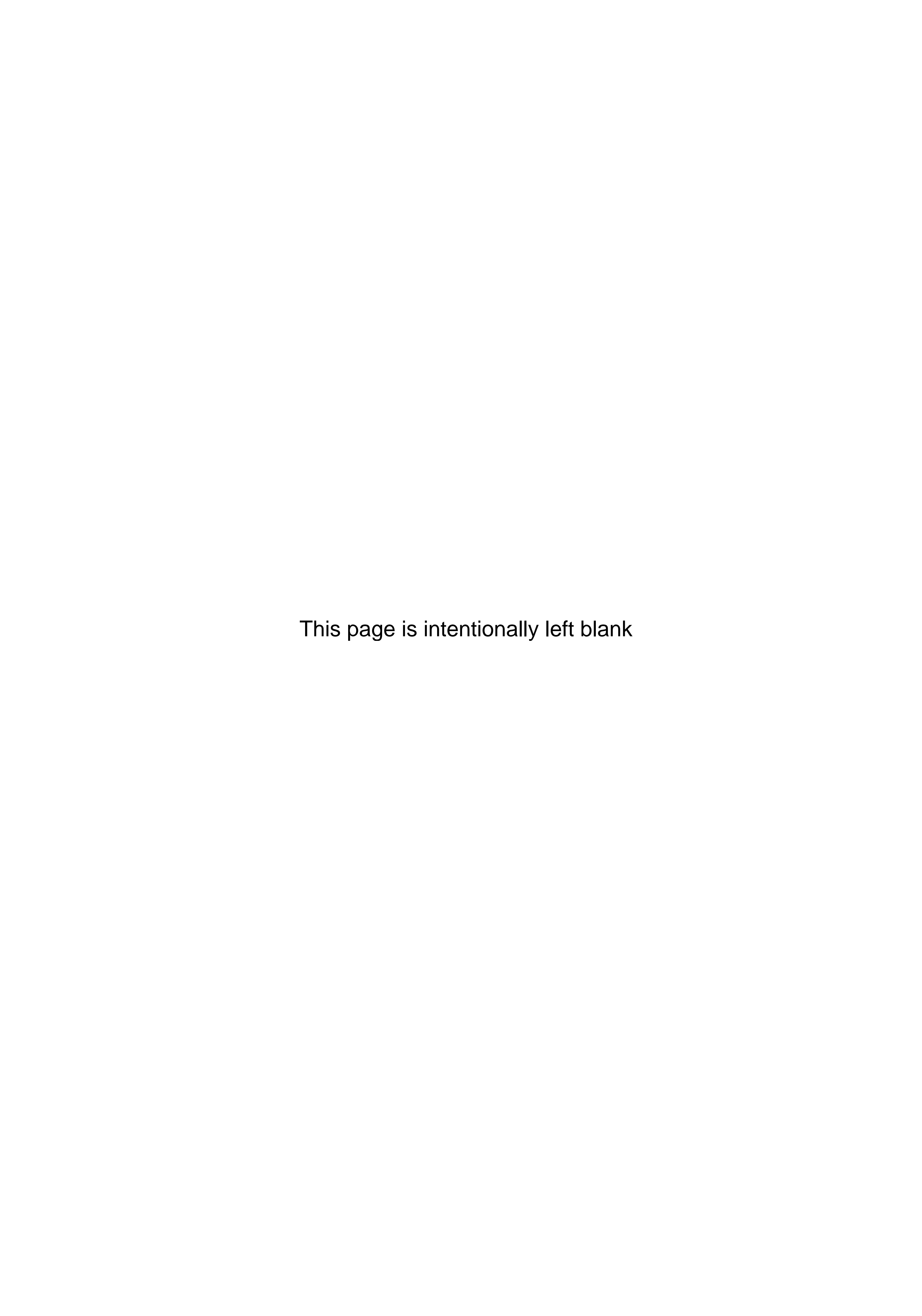
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Integration and Better Care Fund planning requirements for 2017-19

The Better Care Fund

NHS England Publications Gateway Reference 06945

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Introduction

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund (BCF) in 2017-18 and 2018-19. This was developed in partnership with the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS) and NHS England. The framework forms part of the NHS England Mandate for 2017-18. It requires NHS England to issue these further detailed requirements to local areas on developing BCF plans for 2017-18 and 2018-19.

2. The BCF provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group (CCG) allocations, the Disabled Facilities Grant (DFG) and funding paid directly to local government for adult social care services – the Improved Better Care Fund (IBCF). The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the IBCF grant to local authorities (LAs) and will be included in local BCF pooled funding and plans.

3. This BCF planning requirements document supports the core NHS Operational Planning and Contracting Guidance for 2017-19.[2] It is being published jointly with DH and DCLG in order to disseminate it directly to LAs.

4. The legal framework for the Fund derives from the amended NHS Act 2006 (s. 223GA), which requires that in each area the CCG(s) transfer minimum allocations (as set out in the Mandate) into one or more pooled budgets, established under Section 75 of that Act, and that approval of plans for the use of that funding may be subject to conditions set by NHS England. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

5. The DFG and IBCF Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003.

6. The NHS Act 2006 also gives NHS England powers to attach additional conditions to the payment of the CCG minimum contribution to the Better Care Fund to ensure that the policy framework is delivered through local plans. These powers do not apply to the DFG and IBCF.

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[1] https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019

[2] https://www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

Policy requirements

7. Key changes to the policy framework since 2016-17 include:

    - A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
    - The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.

8. The four national conditions require:

    i. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
    ii. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
    iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
    iv. All areas to implement the High Impact Change Model for Managing Transfer of Care[3] to support system-wide improvements in transfers of care.

9. The reduction in national conditions is intended to focus the conditionality of the BCF, but does not diminish the importance of the issues that were previously subject to conditions. These remain key enablers of integration. Narrative plans should describe how partners will continue to build on improvements locally against these formal conditions to:

    - Develop delivery of seven day services across health and social care;
    - Improve data sharing between health and social care; and
    - Ensure a joint approach to assessments and care planning.

10. In addition, local authorities now benefit from the additional funding for social care announced in the Spring Budget 2017. This was provided for the purposes of:

    - Meeting adult social care needs;
    - Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
    - Ensuring that the local social care provider market is supported.

11. Annex B of the policy framework sets out the Government's ongoing policy requirements in relation to the former national conditions. Areas should note that the High Impact Change Model for Managing Transfers of Care includes seven day integrated working to support discharge.

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

Further integration of health and social care

12. The 2015 Spending Review set out the Government's intention that, by 2020, health and social care will be more fully integrated across England. BCF plans must set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both within the BCF and in wider services. Narrative plans should set out the joint vision and approach for integration, including how the work in the BCF plan complements the direction set in the Next Steps on the NHS Five Year Forward View[4], the development of Sustainability and Transformation Partnerships (STPs), the requirements of the Care Act (2014) and wider local government transformation in the area covered by the plan. This could also include alignment with work through Transforming Care Partnerships or other NHS programmes such as Integrated Personal Commissioning.

Planning requirements

13. Local partners will need to develop a joint spending plan that meets the national conditions. In developing BCF plans for 2017-19, local partners will be required to develop, and agree, through the relevant HWB(s):

    i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions; and how their BCF plans will contribute to the local plan for integrating health and social care; and

    ii. A completed planning template, demonstrating:
        - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
        - A scheme-level spending plan demonstrating how the fund will be spent; and
        - Quarterly plan figures for the national metrics.

14. Plans will be assured and moderated regionally. Recommendations for approval of BCF plans will be made following moderation at NHS regional level of assurance outcomes by NHS England and local government and cross regional calibration of outcomes to ensure consistent application of the requirements nationally.

15. Overall plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met. For the first time BCF plans will be agreed for a two year period. Arrangements for refreshing or updating plans for 2018-19, for instance to take account of progress against metrics, will be set out in separate operating guidance, which will be published later in the year.

16. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

[4] https://www.england.nhs.uk/five-year-forward-view/

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level
Confirmation of funding contributions	BCF planning template (spreadsheet). CCGs should ensure consistency between the figures recorded in the BCF planning template and their core financial returns	Assured regionally by relevant NHS teams and local government assurers following collation and analysis nationally
National conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through the BCF planning template	Assured regionally by relevant NHS teams and local government assurers, with regional moderation involving the LGA and ADASS at NHS regional level
Scheme level spending plan	Submitted to NHS England regional / DCO teams through the BCF planning template	Assured regionally by relevant NHS teams and local government assurers following collation and analysis nationally.
National Metrics	Submitted through UNIFY and through the BCF planning template	Collated and analysed nationally, with feedback provided to relevant NHS teams and local government assurers for regional moderation and assurance process

Confirmation of funding contributions

17. Under the Mandate for 2017-18, NHS England is required to ring-fence £3.582 billion for 2017-18 rising to £3.65 billion in 2018-19 within its overall allocation to CCGs to establish the BCF. For 2017-18, the remainder of the £5.128 billion fund will be made up of the £431 million DFG, and a new £1.115 billion grant allocation to local authorities to fund adult social care, first announced in the 2015 Spending Review: the IBCF. The Spring Budget 2017 included a significant increase in IBCF allocations. For 2018-19, the remainder of the £5.617 billion fund will be made up of the £468 million DFG and £1.499 billion IBCF grant to local authorities.

18. NHS England has published allocations for CCG contributions to the BCF at individual HWB level for 2017-18 and (indicatively) for 2018-19, along with the

detailed formulae used, on its website.[5] The IBCF and DFG monies are paid to local authorities directly under Section 31 of the Local Government Act 2003, with grant conditions requiring that the funding is pooled in the BCF.

19. The Government has attached conditions for the new IBCF grant to local authorities (see below). It is subject to the joint NHS England and local government assurance process.

20. As soon as plans for use of the IBCF funding have been locally agreed, IBCF funding can be spent through the pooled budget in line with the grant conditions.

	2017-18 (millions)	**2018-19 (millions; indicative)**
Minimum NHS ring-fenced from CCG allocation	£3,582	£3,650
Disabled Facilities Grant	£431	£468
Additional funding paid to local authorities for adult social care (IBCF)	£1,115	£1,499
Total	£5,128	£5,617

21. All local partners will need to confirm mandatory and any additional funding contributions to all plans to which they are a partner. This will include confirming that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework, relevant grant conditions and the guidance below. This confirmation will be collected nationally through the BCF Planning Return. Detailed instructions on completing this are included in the guidance section of the return template.

Direct Grant to Local Government – the Improved Better Care Fund.

22. This funding, totalling £1.115 billion in 2017-18 and £1.499 billion in 2018-19, will be paid directly to LAs as a direct grant under Section 31 of the Local Government Act 2003 for adult social care[6]. The following grant conditions, detailed in the Grant Determination, apply to the entire IBCF allocation (i.e. the original grant announced in 2015 and the additional funding announced in the 2017 Spring Budget).

[5] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[6] The Liverpool City Region, consisting of six local authorities, Liverpool, Halton, Knowsley, Sefton, St Helens and Wirral, is participating in a pilot programme to test a new model for retention of business rates locally. As a result, the allocation of funding for the Improved Better Care Fund will not be paid as a grant to these authorities, but instead, the pilot areas will be required to pool their allocation from locally raised business rate income that has been retained.

23. The grant conditions for the IBCF require that:

> Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.
>
> A recipient local authority must:
>
> a) pool the grant funding into the local Better Care Fund, unless an area has written Ministerial exemption;
>
> b) work with the relevant Clinical Commissioning Group and providers to meet national condition four (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and
>
> c) provide quarterly reports as required by the Secretary of State.
>
> The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans for spending the grant have been locally agreed with Clinical Commissioning Groups involved in agreeing the Better Care Fund plan.

24. The BCF planning template will be populated with the provisional grant allocation for each HWB area. This funding does not replace, and must not be offset against, the NHS minimum contribution to adult social care.

25. Areas must agree, within their BCF Plans, how this money will be spent, ensuring that the grant conditions are met. In May 2017, DCLG confirmed the department's requirements on quarterly reporting for the IBCF. Updates on progress in implementing the High Impact Change Model for Managing Transfers of Care will be included within the monitoring of national condition four.

26. DH and DCLG have made clear in their letter of 28 March to LA chief executives that there are three purposes of this funding, one of which is to reduce pressures on the NHS. When areas agree this local investment, it will therefore contribute to meeting the ambition in the 2017-18 NHS England Mandate for NHS organisations to reduce delayed transfers of care (DToC) to occupying no more than 3.5% of hospital bed days by September 2017. In order to meet this, daily delays need to fall to around 4,000 in September 2017. This would in turn meet the ambition to free up the 2,000-3,000 hospital beds across England set out in Next Steps on the NHS Five Year Forward View.

27. The funding can be allocated across any or all of the purposes outlined above as the LA and CCG(s) best determine to meet local pressures and reduce delayed transfers. No fixed proportion needs to be allocated across the purposes, nor should the funding be restricted to funding the changes in the High Impact Change Model.

28. DCLG has also required LAs to certify (via their Section 151 officer) that spending of the additional money provided at the 2017 Spring Budget will be additional to previous plans for adult social care spending. The IBCF is allocated over three years (until 2019-20) and is intended to support sustainable approaches to stabilising the social care market and relieving pressure on the NHS. The Government has committed to improve social care and bring forward proposals for consultation.

29. The Government has announced a package of measures to address DToC across the health and social care system. This package includes:

- A dashboard showing how areas are performing against a range of metrics across the NHS-social care interface;
- Targeted CQC reviews to examine performance in the areas with the worst outcomes across these metrics, with a view to supporting them to improve;
- Considering a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care; and
- Guidance on implementing a Trusted Assessor model.

Disabled Facilities Grant

30. Following the approach taken in previous years, the DFG continues to be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people to live independently in their own homes for longer, and to take a joined-up approach to improving outcomes across health, social care and housing. Innovation in this area could include combining DFG and other funding sources to create fast-track delivery systems, alongside information and advice services about local housing options. In 2016-17, the housing element was strengthened through the national conditions, with local housing authority representatives required to be involved in developing and agreeing BCF plans. This has been retained for 2017-19.

31. As in previous years, DFG will be paid to upper-tier authorities. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate DFG from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

32. In 2017-19, in two-tier areas, decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county council to district councils (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. During these discussions, it will be important to continue to ensure that local needs for aids and adaptations are met, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. Where some DFG funding is retained by the upper tier authority, plans should be clear that:

- The funding is included in one of the pooled funds as part of the BCF;
- The funding supports a strategic approach to housing and adaptations that supports the aims of the BCF; and
- The relevant lower-tier authorities agree to the use of the funding in this way.

33. All areas are required to set out in their plans how the DFG funding will be used over the two years. Since 2008-09, the scope for how DFG funding can be used has been widened to support any LA expenditure incurred under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO). This enables authorities to use specific DFG funding for wider purposes.

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

Care Act 2014 Monies

35. The BCF minimum allocation to CCGs includes funding to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal or family carers will be supported by LAs and the NHS. Further guidance and details of the exact breakdown has been set out in the Local Authority Social Services Letter, sent by DH to Directors of Adult Social Services.

Former Carers' Break Funding

36. The CCG minimum allocation to the BCF also includes, as in 2016-17, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes. In doing so, local areas may wish to make use of An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing, an NHS England resource that promotes and supports joint working between Adult Social Care services, NHS commissioners and providers, and third sector organisations.

Reablement Funding

37. The CCG minimum allocation to the BCF also includes, as in 2016-17, £300m of NHS funding to maintain current reablement capacity in LAs, community health services, and the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

National conditions

38. Local partners will be required to include a clearly articulated plan for meeting each national condition in their BCF narrative, as set out in the policy framework and operationalised by the guidance contained in this document, as well as in the scheme details entered in the planning template. This should include clear links to other relevant programmes or streams of work in place locally to deliver these priorities. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning template. More details on each condition are set out below

National condition one: A jointly agreed plan

Narrative plans

39. The BCF plan should build on approved plans for 2016-17 and demonstrate that local partners have reviewed progress in the first two years of the BCF as the basis for developing plans for 2017-19. Local providers must be involved in the development of plans. This includes NHS trusts, social care providers, voluntary and community service partners and local housing authorities.

40. The narrative plan will also need to demonstrate that local partners have collectively agreed the following:

    i. The local vision and model for sustainable systems and better co-ordinated care through the integration of health and social care – showing how services will be transformed to meet the Government's vision to move towards more fully integrated health and social care services by 2020, as set out in the policy framework and how the plans support a shift to a more community based, preventative approach to care and the role the BCF plan in 2017-19 plays in that context;
    ii. A coordinated and integrated plan of action for delivering the vision, supported by evidence;
    iii. A clear articulation of how they plan to meet each national condition, including the national commitment for each local area to free up its share of 2,000-3,000 hospital beds across England; and
    iv. An agreed approach to performance and risk management, including financial risk management and, where relevant, risk sharing and contingency.

41. In all cases these elements can be demonstrated and referenced from existing plans or initiatives. Where a plan makes reference to other documents, the information being referenced should be made clear and contextualised and, in the interests of transparency, narrative plans should be coherent as standalone documents.

42. The policy framework describes the Government's expectation that areas continue to make progress against the national conditions from the 2016-17 BCF that have now been removed. These are set out in Annex B of the policy framework. Narrative plans should briefly describe how areas will continue to make progress against these former conditions, referencing other plans where appropriate.

43. Local partners should consider how the activities in their BCF plan will address health inequalities in the area in line with duties in the Health and Social Care Act 2012 and reduce inequalities between people from protected groups in line with the Equality Act 2010. Local strategies for reducing inequalities across the constituent organisations can be referenced where appropriate, but the narrative plan should give an overview of any priorities and investment to address health inequalities or to address inequalities for people with protected characteristics under the Public Sector Equality Duty in the Equality Act 2010.

Managing Risk

44. All plans must set out the approach to managing risk locally. This should include financial risks that impact on the delivery of the BCF plan as well as delivery risks. The assurance process will no longer involve separate assessments on plan quality and risk to delivery. Instead, all narrative plans must include an assessment of key risks to plan delivery, the approach to managing these risks and a risk log, setting out mitigations consistent with the level of risk in the plan. Assessment of risk should be consistent with wider assessments by partner organisations, provider market and strategic challenges set out in the plan's evidence base, such as market position statements, Joint Strategic Needs Assessment and other external assessments – for example from the Care Quality Commission.

45. Plans can include links to organisational risk logs as part of the plan-level risk mitigation. Further information can be found in the local plan development, sign-off and assurance section of this document.

National condition two: NHS contribution to social care is maintained in line with inflation

46. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition that the NHS contribution to adult social care is maintained in line with inflation. This condition gives effect to the commitment in the Spending Review to continue to maintain the NHS minimum mandated contribution to adult social care to 2020. This contribution to social care can be used to support existing adult social care services, as well as investment in new services. Maintaining existing services is essential in managing demand, maintaining eligibility and avoiding service cuts. Furthermore, in the light of the acute funding pressures on adult social care, HWBs need to be able to review the schemes funded through the BCF and reallocate resources in order for local authorities to continue to meet their adult care statutory duties.

47. In 2017-18 and 2018-19, the minimum contribution to adult social care will be calculated using the figure agreed through the 2016-17 plan assurance process as a baseline, uprated for each subsequent year in line with the CCG minimum contribution. This means that the minimum required contribution will rise by 1.79% in 2017-18 and 1.90% in 2018-19. Local areas will have the opportunity to query the baseline used for this calculation if they believe that it is not an accurate reflection of the CCG minimum allocation for social care in 2016-17. Grounds for this could include that:

- The baseline in the planning template includes non-recurrent payments. In this case, all partners must agree that the funding in question was not intended to be part of the baseline; and
- The baseline is not correct due to mis-coded spend lines.

48. Areas need to query their baseline with the Better Care Support team by 31 July 2017. Agreement to any changes to the baseline, and resultant minimum required contributions, will be made by the Integration Partnership Board. Further details are at **Appendix 4**.

49. Areas can agree larger contributions if they wish. Any area proposing increases to social care funding from the CCG minimum contribution significantly above inflation should provide supporting evidence to set out the reasoning and benefits to the wider system of this increase. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution or a smaller increase in 2018-19, provided the contribution is greater than, or equal to the minimum requirement for 2018-19 published in the planning template.

50. The BCF planning template will be pre-populated with the required minimum contribution to social care from CCG minimum contributions in each year. In setting the level of contribution to social care, localities should ensure that any change does not destabilise the local health and social care system as a whole. This will be assessed compared to 2016-17 figures through the regional assurance process.

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

51. The policy framework establishes that a minimum of £1.018 billion of the CCG contribution to the BCF in 2017-18, and £1.037 billion in 2018-19, will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, while supporting local integration aims. Each CCG's share of this funding will be set out in allocations and will need to be spent as set out in the national condition. This should be achieved in one of the following ways:

    - Where areas do not plan for reductions in non-elective admissions (NEAs) beyond the CCG operational plans they may use the full allocation to fund NHS-commissioned out-of-hospital services. These services should have a clear evidence base and are expected to lead to reductions in acute activity and unplanned admissions. This could include a wide range of services including community nursing, therapeutic and adult social care, to be determined locally. Funding from the ring-fenced out-of-hospital spend can be used to pay for health related activity to meet national condition four (managing Transfers of Care), although funding from other parts of the CCG contribution can also be used. CCGs and local authorities should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan; or

    - If a local area is planning additional NEA reductions, it must consider putting part of its ring-fenced funding for NHS-commissioned services into a contingency fund equal to the value of the planned reductions in NEAs. In the event that NEA activity is higher than the metric in the BCF plan, an

appropriate amount can be withheld from the fund and used to cover the additional cost of unplanned admissions to the CCG, with the balance spent on NHS-commissioned out-of-hospital services.

52. Where local partners agree to use a contingency fund the default approach should be to base this on the 2015-16 payment-for-performance approach, as set out at **Appendix 2**. Any risk share agreement linked to National Condition 3 should relate solely to funding from the ring-fenced funding for out-of-hospital services from the CCG minimum contribution and should not result in any part of the minimum transfer of funding to maintain social care being held 'at risk'.

53. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS-commissioned out-of-hospital services from the spending plan.

Risk shares and financial contingency not linked to national condition three.

54. Areas can agree local approaches to risk sharing or creating contingency reserves to cover costs incurred if preventative approaches are not successful. In designing these schemes, local systems must ensure that the financial position of CCG(s) or the LA(s) are not compromised. Any risk share agreement involving an LA should not result in any part of the minimum transfer of funding to maintain social care being held 'at risk'.

National condition four Implementation of the High Impact Change Model for Managing Transfers of Care.

55. National condition four requires health and social care partners in all areas to work together to implement the High Impact Change Model for Managing Transfers of Care. BCF plans should set out how local areas are implementing the model, which was agreed by local government and health partners in December 2015 and republished in April 2017[7]. This model sets out eight broad changes that will help local systems to improve patient flow and processes for discharge and so help reduce delayed transfers. It provides a framework to assess local services and offers practical options to support improvements. The changes cover:

- Early discharge planning;
- Monitoring patient flow;
- Discharge to assess;
- Trusted assessors;
- Multi-disciplinary discharge support;
- Seven day services;
- Focus on choice (early engagement with patients and their families/carers); and;
- Enhancing health in care homes.

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

56. Areas should agree a joint approach to funding and implementing these changes, building on existing successful local practice and tailored to local circumstance. If one or more of the changes are in the process of being implemented, plans should set out the target date for implementation. Where one or more of the changes is funded from budgets that are not included in the BCF, this should be set out in the narrative plan. Areas should set out a coherent and comprehensive set of measures to manage transfers of care. Where all parties in an area have agreed to a variation on the model or not to implement one of the changes (for example if an existing, successful, approach would be duplicated by elements of the eight change model); the plan should briefly explain the rationale for this and provide assurance that a comprehensive approach to managing transfers of care and meeting their obligations on DToC reductions is in place. All partners, including relevant A&E Delivery Boards, should be involved in agreeing the approach.

57. The Better Care Support Team will monitor progress against implementation of the model through the BCF reporting mechanisms.

58. The High Impact Change Model includes implementation of Enhanced Health in Care Homes. This approach is being demonstrated through the New Care Models Vanguard Programme. More details and guidance can be found in the Enhanced Health in Care Homes Framework'[8].

59. In addition to the High Impact Change Model, National Partners have produced a number of guides that areas can draw on in developing plans, including:

- Quick guides on:
    - 'Improving hospital discharge into the care sector'[9];
    - 'Discharge to Assess'[10];
    - 'Better use of care at home'[11];
    - Supporting Patients' Choices to Avoid Long Hospital Stays[12].
- 'a Simple Guide to the Care Act and Delayed Transfers of Care'[13] published by ADASS, the LGA and NHS England; and
- The BCF resource on Delayed Transfers of Care, available through the SCIE website[14].

Scheme-level spending plan

60. A scheme-level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:

[8] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf
[9] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-Improving-hospital-discharge-into-the-care-sector.pdf
[10] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf
[11] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-better-use-of-care-at-home.pdf
[12] http://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-supporting-patients-choices.pdf
[13] http://londonadass.org.uk/wp-content/uploads/2015/11/DToC-Simple-Guide-Final.pdf
[14] http://www.scie.org.uk/integrated-health-social-care/better-care/guides/delayed-transfers-of-care/

- Area of spend;
- Scheme type;
- Commissioner type;
- Provider type;
- Funding source;
- Total 2016-17 investment (if existing scheme); and
- Total 2017-18 investment and indicative 2018-19 investment.

61. Detail on scheme-level spending plans will be collected nationally through a BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

National metrics

62. The BCF policy framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

    a. Non-elective admissions (General and Acute);
    b. Admissions to residential and care homes[15];
    c. Effectiveness of reablement; and
    d. Delayed transfers of care;

63. Information on all four metrics will continue to be collected nationally. The table below sets out a summary of the information required and where this will be collected. Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

Metric	Collection method	Data required
Non-elective admissions (General and Acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly HWB level activity plan figures for 2017-18, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 metrics
Admissions to residential and care homes	• Collected through nationally developed high level BCF Planning Return	Annual metric for 2017-18 and 2018-19
Effectiveness of reablement	• Collected through nationally developed high level BCF Planning Return	Annual metric for 2017-18

[15] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.

Metric	Collection method	Data required
Delayed transfers of care	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly metric for 2017-18. Each HWB area must submit their agreed DToC metrics by 21 July 2017 alongside their first quarterly return for IBCF spending

Non Elective Admissions (NEAs)

64. The detailed definition of the NEA metric is set out in the Planning Round Technical Definitions[16]. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG-level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for meeting targets to reduce NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

65. Areas that are planning additional reductions in non-elective activity beyond those in CCG operating plans should clearly identify these in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved. Where an additional reduction is planned, partners should consider placing an appropriate amount of the ring-fenced allocation intended for NHS-commissioned out of hospital services into a contingency reserve as per national condition three.

Delayed Transfers of Care

66. The NHS England Mandate for 2017-18 sets a target for reducing Delayed Transfers of Care (DToC) nationally to 3.5% of occupied bed days by September 2017. This equates to the NHS and Local Government working together so that, at a national level, delayed transfers of care are no more than 9.4 in every 100,000 adults (i.e. equivalent to a DToC rate of 3.5%). This joint achievement would release around 2,500 hospital beds. This is a system wide obligation and responsibility for delivery is not limited to the BCF. Nevertheless, it is expected that activity in BCF plans will contribute to meeting it.

67. Each CCG and NHS Trust is already agreeing a trajectory to meet this requirement and maintain it for the remainder of 2017-18. This will reflect agreements between NHS Improvement and NHS England for each area.

68. Each Local Authority is now being required to agree a target for reducing social care attributed DToCs in 2017-18 as part of BCF planning.

69. In both cases, DToC levels will need to be reported in the quarterly BCF returns.

[16] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

70. Ministers are clear that the health and social care system should work together to achieve reductions in DToC and that the agreed trajectory for doing so should reflect ambitious targets for reducing delays attributed to both NHS organisations and social care.

71. In drafting BCF narrative plans, areas should set out how CCGs, LAs, NHS providers of acute, community and mental health bed-based services and providers of social care will work together to achieve the local, agreed ambition for DToC. In setting the DToC metric in the BCF planning template, areas should describe how the schemes and services commissioned will contribute to the system-wide DToC ambition agreed for each system. This will include activity in relation to national condition four to implement the High Impact Change Model for Managing Transfers of Care and use of the BCF where appropriate. Ministers have set out an expectation that the target reduction in delayed transfers should involve an equal reduction in DToCs from both social care and the NHS nationally. Metrics should be agreed locally and should reflect challenging but realistic ambitions to reduce NHS and social care attributable delays to free up 2,500 hospital beds based on the indicative reduction levels published by DH[17]**.** The locally agreed reduction in both NHS and social care attributable delays should be reported in the BCF plan.

72. Each area should therefore set a metric that reflects the target agreed by a) the CCG(s) in support of the reduction in DToC in the NHS mandate and b) the Local Authority in support of the reduction in social care attributed DToC set out by Ministers on 3 July 2017. Where the metrics or contribution to them from either social care or the NHS are not sufficiently ambitious, a more stretching metric may be set as part of the assurance process as a condition of approval for the plan.

73. Government will consider a review, in November, of 2018-19 allocations of the social care funding provided at Spring Budget 2017 for areas that are poorly performing. This funding will all remain with local government, to be used for adult social care.

74. The BCF DToC metric in plans for 2017-18 and 2018-19 will continue to be calculated as total delayed days per 100,000 population. The BCF plan should link to the wider activity plans for reductions and ensure that ambitions set for the BCF plan are in line with the targets agreed locally for daily delays by relevant CCGs. Both metrics calculate the number of delayed days, so the BCF metric should reflect the CCG targets locally.

75. In order to verify that trajectories for reducing DToCs are consistent with the ambition in the NHS Mandate as soon as possible, areas must submit their provisionally agreed BCF DToC metrics for 2017-18 and 2018-19 to the Better Care Support Team on 21 July 2017, at the same time as their first quarterly reporting return for the IBCF.

[17] https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions

Reporting of metrics

76. The detailed definitions of all metrics are set out at the end of this document. HWBs will be required to set challenging but realistic plans in relation to each metric. The national requirement to agree and report a local metric has been removed, but areas are still of course able to agree local metrics, where this will support improved performance. Areas will be able to review metrics for 2018-19 as part of any plan refresh at the end of 2017-18.

Local plan development, sign off and assurance

77. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice.

78. The assurance of plans will be streamlined into one stage, with an assessment of whether a plan should be approved, not approved, or approved with conditions. Plans should be submitted by 11 September 2017, having been approved or set to be approved by the relevant HWB(s). All plans will be subject to regional assurance and moderation. Judgements on potential support needs through the planning process, will be 'risk-based'. The IBCF funding can be spent as soon as the LA and CCG(s) agree.

79. BCF plans will be submitted and assured in the following way:-

80. The BCF submission will consist of a narrative plan, including a description of how the national conditions will be met, the alignment of the plan with the area's approach to integration of health and social care, assessment of risks in the local system and how the planned activity will help to address these. Areas should also complete and submit the BCF Planning Return, detailing the technical elements of the planning requirements. This will include funding contributions, a scheme-level spending plan, national metric plans, and any local risk-sharing agreement linked to NEAs under national condition three. At this point, local areas will also be asked to confirm that plans have been agreed between the LA and CCGs for spending IBCF grant to provide stability and capacity in local care markets. Plans should be agreed by the HWB.

81. CCGs should ensure that these returns mirror their operational planning returns for 2017-18 and 2018-19, submitted through central UNIFY and finance return templates. This will include some of the same data – including funding contributions and baseline NEA metrics agreed in the CCG operational plans and targets for reductions in DToCs should be consistent with the targets agreed by CCGs with NHS England. There will be a national reconciliation process to ensure the data provided matches in all cases. If any additional NEA metrics are planned as part of the BCF, these should be entered in the planning template.

82. Areas are asked to send copies of both the planning template and narrative plan to the relevant DCO team, copied to england.bettercaresupport@nhs.net. The Better Care Support Team will collate data from the planning template to assist regional assurance. Narrative plans will not be assured nationally, but will be used for identifying promising approaches to integration, wider trends to inform

our support offer (including development of benchmarking and support tools) and policy making.

83. The assurance process, including reconciling any data issues, will be a joint NHS England and local government process. NHS England assurance will take place within NHS England's Director of Commissioning Operations (DCO) teams and regional NHS England finance teams. NHS England will seek input from NHS Improvement regional teams at agreed points in the assurance process, to provide feedback on the quality and ambition of plans from a provider perspective. Local government has been funded to carry out assurance via regional local government leads. BCMs and the Better Care Support Team will work with these teams to ensure they are fully briefed on the requirements of the BCF for 2017-19 and have capacity in place to participate in the process. A set of consistent key lines of enquiry (KLOE) have been produced to support the assurance process and will be available to local areas as a guide in developing plans. The assurance document sets out the main planning requirements for the BCF, and associated KLOEs. The document is intended to clarify the minimum requirements for a local Better Care Plan to be assured and the NHS funding elements approved.

Moderation, calibration and plan approval

84. Plan assurance will include moderation at NHS regional level, led by Better Care leads for each region, with appropriate representation from Regional NHS and local government.

85. Following moderation, the Better Care Support Team will co-ordinate a cross-regional calibration exercise to provide assurance to the Integration Partnership Board and NHS England that plans have been assured in a consistent way across England. The national team will provide data on assurance outcomes and facilitate the cross-regional discussion in order to agree a consistent approach nationally. Advice on approval will be provided to the Integration Partnership Board, which is jointly chaired by DH and DCLG, with representation from partners including the LGA, ADASS and NHS England.

86. The minimum elements of the funding have different legal bases:

- The CCG minimum contribution to the fund is governed by the amended NHS Act 2006 (s. 223GA). The Act gives NHS England powers to approve spending and set conditions on this money. NHS England will approve plans for spend from the CCG minimum in consultation with DH and DCLG as part of overall plan approval.

- The DFG and IBCF Grants are subject to grant conditions set out in grant determinations made under Section 31 of the Local Government Act 2003. LAs are legally obliged to comply with grant conditions and the IPB will confirm, following assurance that it is content that the conditions are met in BCF plans.

87. Formal approval of BCF plans and authorisation for CCGs to use the CCG minimum element of the BCF will be given by NHS England under s.223GA (4) of the NHS Act 2006, following agreement with the Integration Partnership Board that all conditions, including the conditions of grant for the IBCF and DFG

are met. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved, the Better Care Support Team may implement a programme of support, with partners, to help areas to achieve approval as soon as possible or consider placing the area into formal escalation.

88. Following formal approval, CCG funding agreed within BCF plans must be transferred into one or more pooled funds established under section 75 of the NHS Act 2006. If a plan is not approved, the area should not proceed with the signing of a Section 75 agreement in relation to NHS monies. Consideration will be given by the regional assurance panel, working with the Better Care Support Team, as to whether further support should be provided or whether the area should enter formal escalation.

Assurance categories

89. Assurers will check that plans meet all key lines of enquiry, including that they:

- Meet all national conditions;
- Have agreed a spending plan for the IBCF grant;
- Set out a vision and progress towards fuller integration of health and social care by 2020; and
- Have in place a robust approach to managing risk to plan delivery, including adequate financial risk management arrangements, proportionate to the level of risk in the system.

90. Assessment of the overall risk in the plan will be based on:

- The overall quality of the plan, based on the compliance with the national conditions, degree to which key lines of enquiry have been met and quality of the narrative plans overall;
- An assessment of whether the plan has adequately assessed and addressed risks to successful delivery; and
- The current performance, capacity and financial position of the local health and social care system in relation to plan delivery, using information from NHS England, NHS Improvement and local government.

91. Based on this assessment, the plan will be classified as Approved, Approved with Conditions or Not Approved. Following assurance, a moderation exercise will be carried out to ensure that the planning requirements have been applied consistently across each NHS region. This exercise must include representatives from DCO teams, NHS finance and local government. Following assurance, and moderation, the Better Care Support Team will co-ordinate a cross-regional calibration exercise with assurers. This exercise will help areas to make sure that they are assuring plans in a way that is consistent with other parts of the country. This may result in some regions needing to re-visit judgements for particular areas.

92. If an agreed plan is not submitted by the deadline, the Better Care Support Team will work with the local BCM to agree appropriate support for the area to agree a plan promptly. Areas will be expected to take up this support. If it appears that a plan is unlikely to be agreed locally within a reasonable timeframe, escalation will be considered.

93. If, following moderation, a plan is not approved or is approved with conditions, more in-depth support will be agreed for the area in consultation with the BCM, the regional assurance panel and Better Care Support Team. In some instances, the conditions imposed may be the provision of further information or clarifications, but in instances where there are more substantial conditions to meet, areas will be expected to access the support on offer in order to meet the conditions specified. All areas will be expected to submit a compliant plan by the date set by the regional moderation panel.

94. The three assurance categorisations are as follows:

<table>
<tr><th>Category</th><th>Description</th></tr>
<tr><td>Approved</td><td>• Plan agreed by HWB
• Plan meets all requirements and KLOEs, including locally agreed targets for reducing NHS and social care attributed delays which achieve each area's share of the national commitment to free up 2,000-3,000 hospital beds.</td></tr>
<tr><td>Approved with conditions</td><td>• National conditions one, two or three are met
• Most but not all remaining planning requirements met, – i.e. one or more KLOEs not satisfied; for example:
  • Narrative plan (vision, approach to risk management) needs improvement; or
  • National condition four not fully met
  • Not all metrics agreed

• Progress is being made (including on national condition) and, provided feedback is incorporated, there is confidence that a compliant plan can be produced
• Assurance panel are confident that the area can agree a plan</td></tr>
<tr><td>Not approved</td><td>• One or more of the following apply:
  • Plan is not agreed
  • One or more of national conditions 1-3 not met,
  • No local agreement on use of the IBCF
  • DToC ambition is not in line with the targets agreed with NHS England (for CCGs) and/or necessary to achieve expected reductions (for Local Authorities).</td></tr>
</table>

Plans approved with conditions.

95. If a plan is approved with conditions following moderation and this categorisation is agreed by the IPB and NHS England, the area will receive authorisation to enter into a formal Section 75 agreement and the CCG authorised to release money from the BCF ring-fence. The notification will make clear:

- The planning requirements that were not met, the actions required to receive full approval, and the date by which this should be done; and
- Escalation action and powers of direction/clawback will be used in the event that these conditions are not met by the date specified.

96. Areas that receive an Approved with Conditions classification should address all unmet requirements and resubmit their plan to their BCM by the date specified.

97. The overall assurance process is illustrated in the schematic at **Appendix 3**. More detailed guidance for those involved in assurance has been developed and published to aid local areas.

Escalation and use of Direction Powers

98. In the event that:
- Signatories to a plan are not able to agree and submit a draft plan or:
- The Health and Well-being Board do not approve the final plan; or
- Regional assurers rate a plan as 'not approved'.

The Better Care Support Team, in collaboration with the relevant Better Care Manager, will commence an escalation process to oversee the prompt agreement of a compliant plan.

99. The purpose of escalation is to assist areas to reach agreement on a compliant plan. It is not an arbitration or mediation process. Senior representatives from all local parties who are required to agree a plan, including the HWB chair, will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward.

100. The escalation process will involve the following steps.

1. Trigger - following failure to submit a plan, or a decision not to approve a plan during assurance	The Better Care Support Team in consultation with the BCM will consider whether a plan should be escalated. If escalation commences, a formal letter will be sent, setting out the reasons for escalation, consequences of not agreeing a plan and informing the parties of next steps, including date and time of the Escalation Panel
2. Escalation Panel	The Escalation Panel will be jointly chaired by DCLG and DH senior officials with representation from: • NHS England • LGA/ADASS • Better Care Support Team Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer/s from LA The Escalation Panel meeting is the opportunity to use national and local insight to consider the planned approach being put forward by the parties to the BCF plan to deliver a compliant plan and agree actions and next steps, including whether support is required. It is expected that in line with the principle of 'no surprises', issues will have been raised through ongoing relationships with Better Care Managers, NHS England regional offices and local government regional peers.

3. Formal letter and clarification of agreed actions	The local area representatives will be issued with a letter, summarising the 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 Panel, an update on what support will be made available will be included.
4. Confirmation of agreed actions	The Better Care Manager will track progress against the actions agreed and ensure that a locally agreed plan is submitted within the agreed timescale for regional assurance. Any changes to the timescale must be formally agreed with the Better Care Support Team.
5. Consideration of intervention options	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • Agreement that the panel will work with the local parties to agree a compliant plan • Appointment of an independent expert to make recommendations on specific issues and support the development of an agreed plan – this might be used if the local parties cannot reach an agreement on certain issues. • Appointment of an advisor to develop a compliant plan, where the panel does not have confidence that the area can deliver a compliant plan 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.

101. The Escalation Panel members will consider all relevant information, including financial and performance issues. This could include:

- Wider financial context, such as whether the LA has taken sufficient action to protect its funding for social care – including, but not limited to, making use of precepting powers, the balance of financial risk between parties and appropriate use of reserves;
- Whether all financial commitments mandated in the BCF have been met, including passporting of Care Act funding, funding for social care managed reablement and carers' breaks;
- Whether the agreed transfer to social care from CCG minimum contributions represents a real terms maintenance of allocations. This will also include consideration of transfers prior to the establishment of the BCF

102. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DH and DCLG ministers, (as required under the 2017-18 NHS Mandate), with the final decision then taken by NHS England. In accordance with the legal framework set out in section 223GA of the NHS Act 2006 (as amended by the Care Act 2014), NHS England powers are only applicable to the minimum contribution from CCG budgets set out in the policy framework.

103. 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. A BCF plan will not be approved, however, if the IBCF or DFG grant conditions are not met. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

Timetable

104. The submission and assurance process will follow the timetable below

Milestone	Date
Publication of Government Policy Framework	31 March 2017
BCF Planning Requirements, BCF Allocations published	4 July 2017
Planning Return template circulated	w/e 7 July 2017
First Quarterly monitoring returns on use of IBCF funding from Local Authorities.	21 July 2017
Areas to confirm draft DToC metrics to BCST	21 July 2017
BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local authorities). All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	11 September 2017
Scrutiny of BCF plans by regional assurers	12 – 25 September 2017
Regional moderation	w/c 25 September 2017
Cross regional calibration	2 October 2017
Approval letters issued giving formal permission to spend (CCG minimum)	From 6 October 2017
Escalation panels for plans rated as not approved	w/c 10 October 2017
Deadline for areas with plans rated approved with conditions to submit updated plans.	31 October 2017
All Section 75 agreements to be signed and in place	30 November 2017
Government will consider a review of 2018-19 allocations of the IBCF grant provided at Spring Budget 2017 for areas that are performing poorly. This funding will all remain with local government, to be used for adult social care.	November 2017

Graduation from the Better Care Fund

105. The policy framework describes the approach that will be taken from 2017-18 to graduation from the BCF – the process for enabling areas that have integrated their health and social care commissioning or provision, to the extent that they exceed, and will continue to exceed, the requirements of the BCF.

106. Areas that graduate will no longer be required to submit BCF plans and quarterly returns, with the exception of evidencing ongoing compliance with funding contributions and national conditions, which can be demonstrated through annual self-certification. The footprint for graduates can be a single Health and Wellbeing Board area or more than one – for example a devolution deal area or STP geography if the relevant HWB(s) agree.

107. Areas (as defined above) will be able to put themselves forward for graduation over the next two years. Requests to graduate from the Fund will be considered through graduation panels that will take place at regular intervals over the period of the programme. The panels will include central government departments, NHS and local government stakeholders (LGA and ADASS). The sessions will focus on helping areas to both challenge their assumptions and readiness to move on from the BCF, and also to provide advice on where the proposal could develop further.

108. Panels will consider:

- The key enablers to integration, common to all systems;
- A self-assessment of local leadership, accountability and joint vision for integration;
- How integration supports better outcomes for populations, including performance against key metrics (including DToC reductions) and assessing the use of own management data; and
- Agreement of a clear, measurable and transparent objectives and milestones for fuller integration by 2020.

109. There were 17 first wave Expressions of Interest to graduate from the BCF. The short-list (who will go through graduation panels in the Autumn), is being finalised.

Appendix one - Specification of Better Care Fund metrics

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

Outcome sought	A reduction in the number of unplanned acute admissions to hospital.
Rationale	Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.
Definition	**Description**: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population. Numerator: Number of specific acute non-elective spells in the period. Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency. Number of specific acute hospital provider spells for which: • Der_Management_Type is ‘EM’ and ‘NE’ **Where** ‘EM’ = Emergency and ‘NE’ = Non-Elective Please refer the Joint Technical definitions for Performance and Activity (2017/18-2018/19) and see Appendix A- SUS Methodology for details of derivations and Appendix B for full list of Treatment Function Code categorisation. **Denominator:** ONS mid-year population estimate for all ages (mid-year projection for population
Source	Secondary Uses Service tNR (SEM) - SUS tNR is derived from SUS (SEM) and not the SUS PbR Mart. For more details see Joint Technical definitions for Performance and Activity (2017/18-2018/19). Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)
Reporting schedule for data source	Collection frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing of availability: data is available approximately 6 weeks after the period end.
Historic	From 2017/18, total number of specific acute non elective spells replaces non elective (general and acute) episodes metric

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

Outcome sought	Reducing inappropriate admissions of older people (65+) in to residential care
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by NHS Digital **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate Office for National Statistics (ONS) mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: NHS Digital - SALT: http://content.digital.nhs.uk/socialcarecollections2016) Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)
Reporting schedule for data source	Collection frequency: Annual (collected Apr-March) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2014/15 following a change to the data source. The transition from Adult Social Care Combined Activity Return (ASC-CAR) to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was redefined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population." More details about the change can be found on page 18 of the 2014-15 data report.

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

Outcome sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Rationale	Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from SALT collected by NHS Digital. **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from SALT collected by NHS Digital Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework: (NHS Digital - SALT: http://content.digital.nhs.uk/socialcarecollections2016)
Reporting schedule for data source	Collection frequency: Annual (although based on 2x3 months data – see definition above) Timing of availability: data typically available 6 months after year end.
Historic	Data first collected 2011-12 (currently five years data final available (2011-12, 2012-13, 2013/14, 2014/15 and 2015/16) **Resubmitted 2014/15 SALT data** - as part of the extensive SALT validation process for the 2015/16 submission, councils have also had the opportunity to resubmit their 2014/15 return. The 2014/15 data in the current release is the resubmitted data. Due to the known data quality issues of the original data, Adult Social Care Outcomes Framework (ASCOF) scores previously published in the 2014/15 publication should no longer be used.

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

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.
Definition	Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	DToCs (NHS England, http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (ONS, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/subnationalpopulationprojectionsforengland/2014basedprojections)
Reporting schedule for data source	Collection Frequency: Numerator collected monthly (aggregated to quarters for monitoring). Denominator is annual. Timing: data is published approximately 6 weeks after the period end.
Historic	Data first collected Aug 2010

The Baseline used for each metric is the latest period available prior to the collection period in the plan for each metric. For example for monthly/quarterly measures the baseline will be the corresponding period of the previous year where this is available. I.e. the baseline for NEA and DToC metrics in 2017/18 will be the corresponding quarter in 2016/17.

Appendix two – Requirements for contingency in national condition three

1. All CCGs must ring-fence a proportion of their overall BCF allocation to invest in NHS-commissioned out of hospital services. These allocations are set out in CCG financial planning templates for 2017-18 and 2018-19.

2. National condition three requires that all areas should consider holding back part of this ring-fenced funding in contingency, linked to performance against any **additional metrics to reduce Non elective admissions agreed in the BCF plan.**

3. The 'HWB metrics tab of the BCF Planning Template will be pre populated with the area's non elective admissions target, taken from CCG operating plans for 2017-18 and 2018-19, mapped to HWB areas. Each area should consider setting an additional NEA reduction metric linked to their BCF plan. Metrics should be stretching, but proportionate. The national condition only applies to risk share agreements linked to these additional metrics on NEAs. Areas are free to agree risk shares linked to other schemes within the BCF, but these do not form part of the national condition.

4. As in 2016-17, the default model for calculating the value of the contingency fund should be the Payment for Performance mechanism for 2015-16. Areas that did not meet their NEA activity reduction targets in 2016-17 should actively consider agreeing an additional reduction metric. Where a metric is set, a contingency fund should be considered. Arrangements made as part of this condition should:

   - Cover the full risk to the CCG of not achieving the reduction based on the tariff for NEAs. In other words the value of the risk share should be equivalent to the cost of the emergency admissions that the plan seeks to avoid.
   - Hold this amount, from the ring-fenced allocation for NHS-commissioned out of hospital services, in a contingency fund outside of funds pooled in the BCF.
   - Release money into BCF pooled funds based on performance against the additional NEA metric. Areas should agree, in advance, how this money will be spent.
   - Agree frequency of payment and baselines locally across the two years of the BCF plan.

5. Assurance of plans will include an assessment of whether CCGs are financially protected if investment in out of hospital services does not result in planned additional reductions in emergency admissions.

6. The value of the contingency fund should calculated based on the number of additional reductions in non-elective admissions, multiplied by the value of these admissions, based on national reference costs for a non-elective admission. Again, areas can agree a local costing, but must set out their reasoning in their plan. As in 2015-16 areas can measure performance quarterly, releasing funding into the BCF based on performance in the previous quarter, commencing with quarter 4 (January to March) 2016-17.

Example

7. A Health and Wellbeing Board has a target, based on CCG core operational plans to reduce NEAs to 50,000 in 2017-18 and 49,000. As part of their Better Care fund plan, the LA and CCGs agree a further reduction metric of 1000 admissions avoided in both 2017-18 and 2018-19. The amount held back in each year is calculated based on the national tariff of £1490 per admission.

Year	A: Target level of NEAs – operational plan	B: Agreed reduction through BCF plan	C: Target level of NEAs – BCF plan	Funds held in contingency (Column B x £1490)
2017-18	50,000	1,000	49,000	£1,491,000
2018-19	49,000	1,000	48,000	£1,491,000

The quarterly reduction targets are therefore

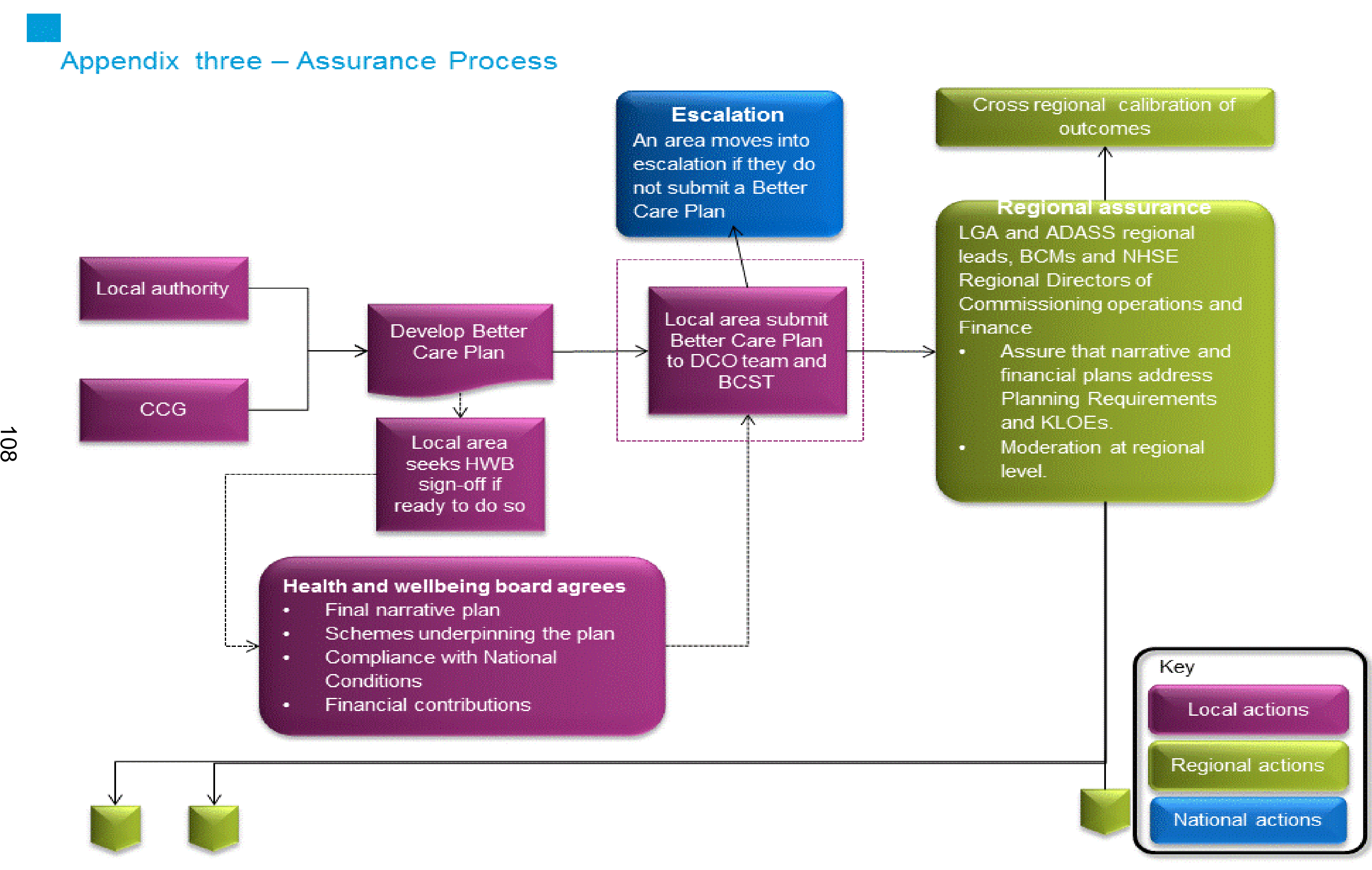
	Q4 2016-17	Q1 2017-18	Q2 2017-18	Q3 2017-18
CCG baseline (quarterly)	12,500	12,500	12,500	12,500
CCG baseline (cumulative)	12,500	25,000	37,500	50,000
BCF stretch target (quarterly)	12,250	12,250	12,250	12,250
BCF stretch metric (cumulative)	12,250	24,500	36,750	49,000
Money held in contingency from CCG minimum (quarterly)	£372,750	£372,750	£372,750	£372,750

8. If the target is wholly or partly met, funding should then be released from the fund, in this case on a quarterly basis; up to the total amount held in contingency. Payment released in each quarter should be calculated based on the cumulative performance against target. Examples are below.

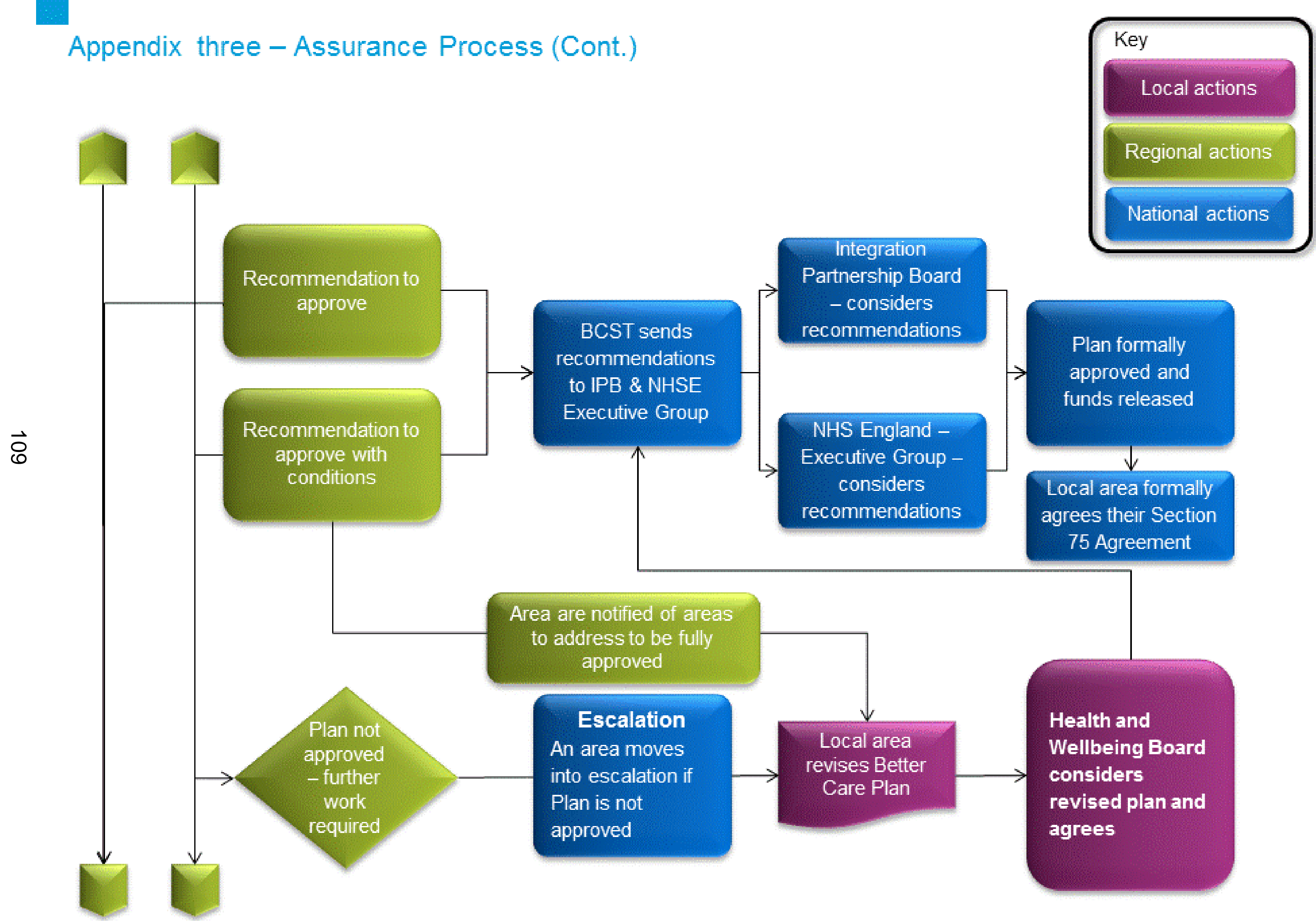
9. Areas should agree how money released from the fund should be spent. The released funds should remain within the pooled fund but can be spent on any activities that are consistent with the aims of the local plan, including social care.

	Q4 2016-17	**Q1 2017-18**	**Q2 2017-18**	**Q3 2017-18**
CCG baseline	12,500	12,500	12,500	12,500
BCF stretch target (quarterly)	12,250	12,250	12,250	12,250
BCF stretch target (cumulative)	12,250	24,500	36,750	49,000
Actual performance (quarterly)	12300	12,200	12,500	12,250
Actual performance (cumulative)	12,300	24,500	37,000	49,250
Money released from contingency reserve (quarterly)	£298,200	£447,300	£0	£372,750
Money released from contingency reserve (cumulative)	£298,200	£745,500	£745,500	£1,118,250

Appendix three - Assurance diagram



Appendix three – Assurance Process (Cont.)



Appendix four – Querying baseline for social care maintenance contributions

1. Required contributions to social care from CCG minimum contributions will be calculated for each Health and Well-being Board area based on inflation level increases to assured contributions in 2016-17 BCF plans. These figures will be pre-populated in the planning template for each HWB area.

2. The use of this baseline to calculate the minimum required contribution is agreed policy and we expect that the contribution in each HWB area will be equal to, or greater than, these figures for each area in 2017-18 and 2018-19. If local planners believe that this baseline is not correct, they will be able to query it. The grounds for doing so include:
   - The baseline in the planning template includes non-recurrent payments. In this case, all partners should agree that the funding in question was not intended to be part of the baseline.
   - The baseline is not correct due to mis-coded spend lines.

Process

3. Areas should inform their Better Care Manager (BCM) if they believe that the baseline for maintaining social care spend for 2016-17 is wrong by 31 July 2017, setting out their reasoning and any supporting documents. Areas must confirm that both the relevant CCG(s) and LA(s) agree that the baseline is not correct and certification should be provided from the chief executive in the relevant LA and the Accountable Officer(s) of relevant CCGs.

4. The query and supporting evidence will be reviewed by the Better Care Support Team with the Better Care Manager. Recommendations for amending a baseline will be made to the Integration Partnership Board (IPB). If the IPB agrees to amend a baseline, areas will be notified as soon as possible. All decisions will be made before 25 August 2017.

5. Where local planners believe that the baseline, as set out in the assured 2016-17 planning template, is wrong due to mis-coding; they should identify specific schemes that were coded wrongly and set out the reasons for changing the scheme classification or the value of the scheme.

6. Where a payment that has been included in the baseline for 2016-17 that was intended to be a non-recurrent payment, an area will need to provide details and demonstrate that there was mutual understanding that the payment was a one off. Government policy is that spending on social care services from CCG minimum contributions should be maintained in real terms through the period of the Spending Review. Areas must demonstrate therefore that
   - The payment was not part of the 2015-16 contribution to social care.
   - The payment was clearly intended to be to alleviate short term pressures or for specific, one-off purposes.
   - That both the CCG and the LA agreed at the time that this was the case.

Appendix five - Quarterly reporting from local authorities to DCLG in relation to the Improved Better Care Fund

This appendix replicates the reporting requirements issued by DCLG to local authorities confirming the reporting requirements attached the additional funding for the IBCF confirmed in the Spring Budget 2017.

Overall we are expecting to see a narrative report for the relevant quarter about how you are using the additional funding announced at Spring Budget 2017 to deliver the purposes of the grant, in meeting adult social care needs generally, reducing pressures on the NHS (including DToC) and stabilising the care provider market.

One of the grant conditions is to work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19. We expect the Better Care Fund will pick up reporting with regard to this however as the Planning Requirements are not yet published, we are asking for this information in your Q1 return. We will confirm whether this is necessary for additional quarters.

Quarter 1 (April – June 2017)

A. *For Q1 you should provide a scene-setting narrative and then consider and address the following questions which will form the basis of further quarterly reports:*

- *How has this money affected decisions on budget savings that may otherwise have been required?*
- *What initiatives / projects will this money be used to support? Please describe briefly their objectives / expected outcomes. You will be expected to comment on progress in later quarters.*
- *Have you engaged with your care providers in the light of this funding? If yes, what action have you taken? If no, outline your plans for engaging with your care providers.*
    - *What were your unit average costs for home care (per contact hour) and care home provision age 65+ (per client per week, excluding full cost payers, 3rd party top ups and NHS FNC) in 2016-17?*
    - *On the same basis, at what level are you setting costs for 2017-18?*

B. *What impact do you anticipate – in comparison with plans made before this additional funding was announced – on:*
    - *Number of home care packages – provide figures*
    - *Hours of home care provided – provide figures*
    - *Number of care home placements – provide figures*

C. *Please provide any further information you wish us to be aware of, and use whatever further specific metrics you consider appropriate for your area; for example this might include on reablement, timeliness of assessments, carers, staff capacity etc. You will be expected to update these each quarter.*

D. *The grant determination requires you to work with the relevant CCG and providers to meet NC4 of the Integration and Better Care Fund. NC4 states that*

all areas should implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in transfers of care. Please set out, from the local authority's perspective, what progress is being made to implement the High Impact Change Model with health partners and the intended impact on the performance metrics, including Delayed Transfers of Care.

Quarters 2 (July – Sept 2017) and 3 (Oct – Dec 2017)

A. A narrative report for the quarter which follows up the information you provided at Q1, including updates and progress reports on the initiatives / projects and further information you identified at Sections A and C in Q1.

B. Report actual impact of additional funding on:

- *Number of home care packages – provide figures*
- *Hours of home care provided – provide figures*
- *Number of care home placements – provide figures*

C. Update on additional metrics you identified at Section C in Q1.

D. [To be confirmed.] Update on progress.

Quarter 4 (January – March 2018)

A. A final report which provides a self-assessment against the information provided at Q1 including final updates and progress reports on the initiatives / projects and further information you identified at Sections A and C in Q1. This should include final comparative data on unit costs for home care and care home provision for end of year.

B. report on actual impact of additional funding on:

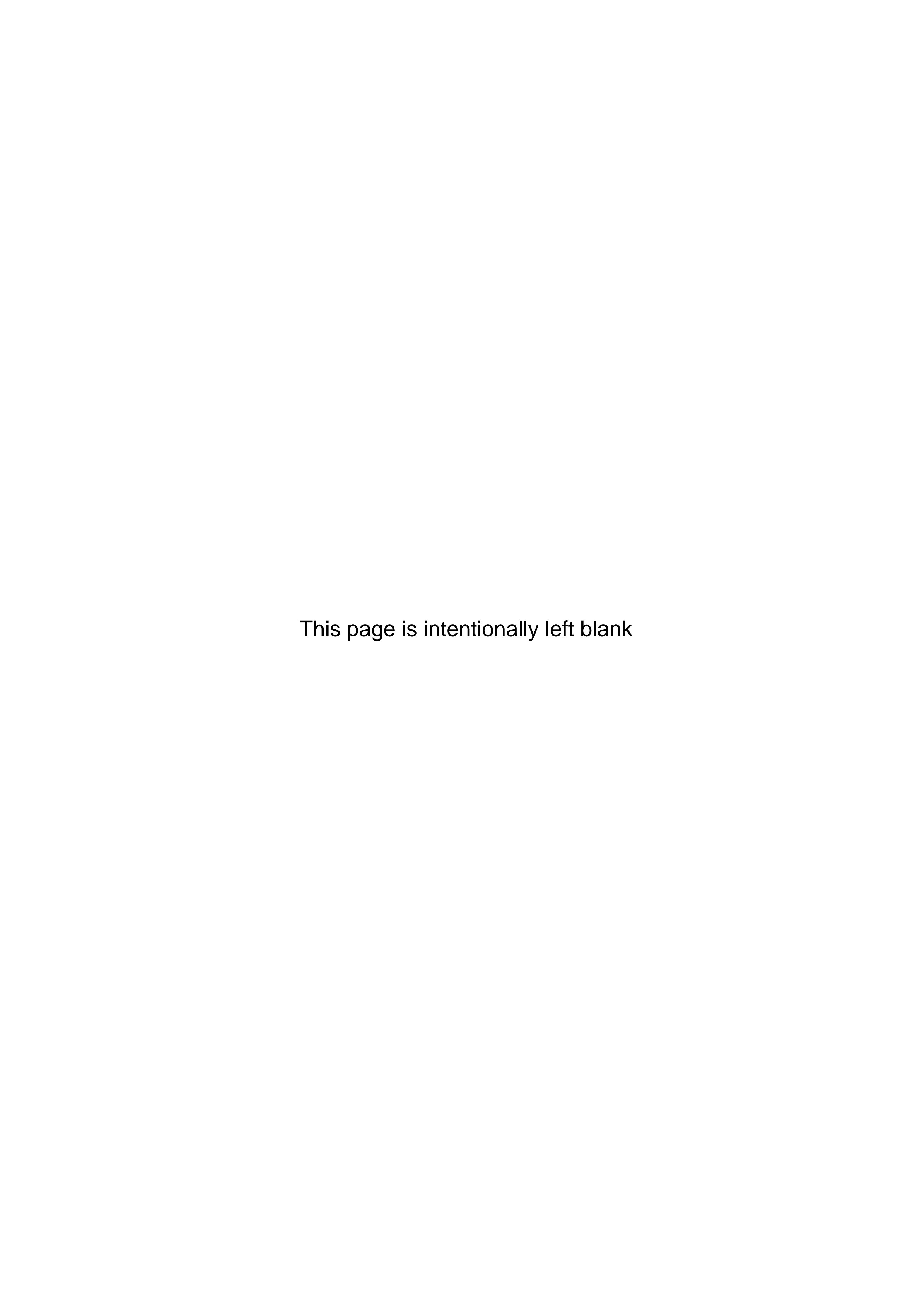
- *Number of home care packages – provide figures*
- *Hours of home care provided – provide figures*
- *Number of care home placements – provide figures*

C. Final report on additional metrics you identified at Section C in Q1.

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

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

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



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Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Area	**Southend on Sea**
Constituent Health and Wellbeing Boards	**Southend Health and Wellbeing Board**
Constituent CCGs	**Southend Clinical Commissioning Group**

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Appendices

Appendix A - HWB report (Aug 2016) re Localities

Appendix B - Southend JSNA (Feb 2017)

Appendix C - Southend Local Account (2015-16)

Appendix D - Southend Public Health Report (2015)

Appendix E - Southend HWB Strategy – a greater focus

Appendix F - CCG list of commissioned community services

Appendix G - Adult Social Care BCF list of integrated services

Appendix Gi - Transforming Adult Social Care (May, June, July 2017)

Appendix H - iBCF plan 2017-18

Appendix Hi - iBCF plan - timescales

Appendix I - NHS England approval for Southend iBCF (Aug 2017)

Appendix J - Southend DToC Submission (July 2017)

Appendix K - Southend Integrated Discharge Model (Apr 2017)

Appendix L - Southend Integrated Discharge Model update (Aug 2017)

Appendix M - Southend BCF – high level plan 2017-19

Appendix N - Southend BCF RAID (Aug 2017)

Appendix O - Report to HWB re progress to date (Mar 2017)

Appendix Oi - Appendix A to Report to HWB re progress to date (Mar 2017)

Appendix P - John Bewick OBE ‘Southend – what next?’

1 Introduction / Foreword

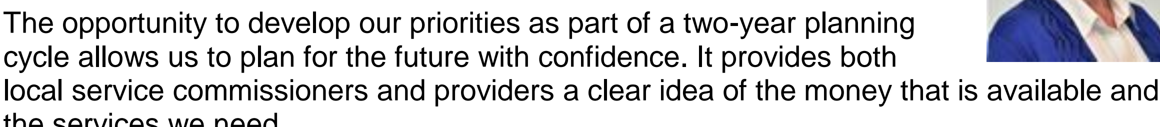
Introduction

Southend on Sea (Southend) is delighted to present our Better Care Fund (BCF) plan for 2017-19. The plan presented in this document builds on our approved plan for 2016-17 and aims to demonstrate and assure the national bodies that local partners have reviewed progress during the course of the last 2 years and used this information to develop the plan for 2017-19.

Our plan is complemented by the financial planning submission and the associated appendices which provide further evidence of our robust and proven planning process and ability to deliver.

Our plan has been developed and completed in accordance with the NHS Five Year Forward View1, the BCF Policy Framework2 and the BCF Technical Planning Guidance3.

Foreword from Cllr Lesley Salter, Chair HWB



I am pleased to present the Better Care Fund plan for 2017-19, which sets out how Southend's senior leaders in health and social care will continue to prioritise the health and wellbeing our local residents.

The opportunity to develop our priorities as part of a two-year planning cycle allows us to plan for the future with confidence. It provides both local service commissioners and providers a clear idea of the money that is available and the services we need.

The challenges in Southend are significant and demand for services continues to increase. We know there are still inequalities in health across the borough and we continue to face difficulties in recruiting and maintaining the diversely skilled workforce we need. Our local hospital services are also undergoing change through the Sustainability and Transformation Plan (STP) for mid and south Essex, and this process has meant residents are facing change on an unprecedented scale.

However, there are also many positives for Southend as we look to the future. The borough has an enviable and innovative track record in health and social care integration, through bringing services and a diverse range of professionals together we now have GPs, social workers and community-based health staff working as integrated teams, piloting new ways of working and learning from each other's experiences and successes.

Our progress will be reflected in this plan and we will also set out our stall for the future. We will explain how we will continue the good work of recent years and demonstrate our local vision and model for the integration of health and social care. We will show just how far we have come.

You will see how we have jointly developed a coordinated and integrated plan of action to deliver our vision and that this meets with the national requirements for integrated health and social care services. The Health and Wellbeing Board (HWB) is aligned to this work and has an agreed approach to performance and risk management that includes local finances.

Our plan is a summary of all the excellent work that has been delivered and is underway in Southend. The plan has been submitted by the Health and Wellbeing Board by all partners,

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[1] NHS Five Year Forward View

[2] 2017 / 19 Integration and Better Care Fund Policy Framework

[3] 2017 / 19 Integration and BCF planning requirement

including providers, commissioners and voluntary sector partners. In summary, I am delighted to submit the *Southend-on-Sea Better Care Fund Plan*.

Cllr Lesley Salter

Chair Health & Wellbeing Board

2 What is the local vision and approach for health and social care integration?

The local vision for health and social care services

*'To create a **health and social care economy** in which the population can access **optimal care** and enable **urgent care** to be delivered with maximum **efficiency and effectiveness'***

Health and Social Care economy; Southend will adopt a system wide view and understand impacts across all key constituents.

Optimal Care and Urgent Care; right care at the right time in the right setting to minimise need to use acute resources.

Efficiency and Effectiveness; a focus on both cost and quality of care, not one at the expense of the other. The current scope of focus and solutions should have positive impact on broader acute care setting and the overall health economy

Our vision is underpinned by focusing on the following areas:

- Risk stratification
- Joint commissioning
- Improvement of the community MDTs
- Improvement of the Single Point Of Referral
- Pilot seven day access to services
- Reducing admissions to acute care
- Integrated care records
- Acute Hospital sector challenges

Alignment of vision with national and regional requirements

2.1 The vision and Southend BCF plan for Southend is aligned to;

2.1.1 NHS England's 5 Year Forward View, in which greater engagement with patients, carers and citizens is encouraged so that there can be promotion of well-being and the prevention of ill-health;

2.1.2 The 2017-19 Integration and Better Care Fund Policy Framework and the 2017-19 Integration and BCF planning requirements. Our vision and BCF plan confirms the 4 national conditions set out in the BCF planning guidance;

2.1.3 Both regional and local initiatives, for example the STP (which is focused on acute reconfiguration and financial stability of acute service as well as all community physical and mental health services) and the transformation of Primary care;

2.2 Our BCF plan is aligned with the Joint Service Needs Assessment (JSNA) to ensure that our localities have access to equal, fair and speedy services. We work as a system between Southend Borough Council (SBC or 'the council'), Southend Clinical Commissioning Group (SCCG or 'the CCG') and Southend Public Health to achieve the priorities laid out in the JSNA.

2.3 Our BCF plan is aligned to our HWB strategy. The ambition for HWB in Southend is that everyone living in Southend has the best possible opportunity to live long, fulfilling, healthy lives.

2.4 Our BCF plan is aligned with our on-going challenges in Southend which enables the plan to focus on five "big ticket" priority areas. These are;

2.4.1 Mental Health

2.4.2 Complex Care

2.4.3 Integrated Children's Services

2.4.4 Physical Activity levels

2.4.5 Primary Care Access

Engagement

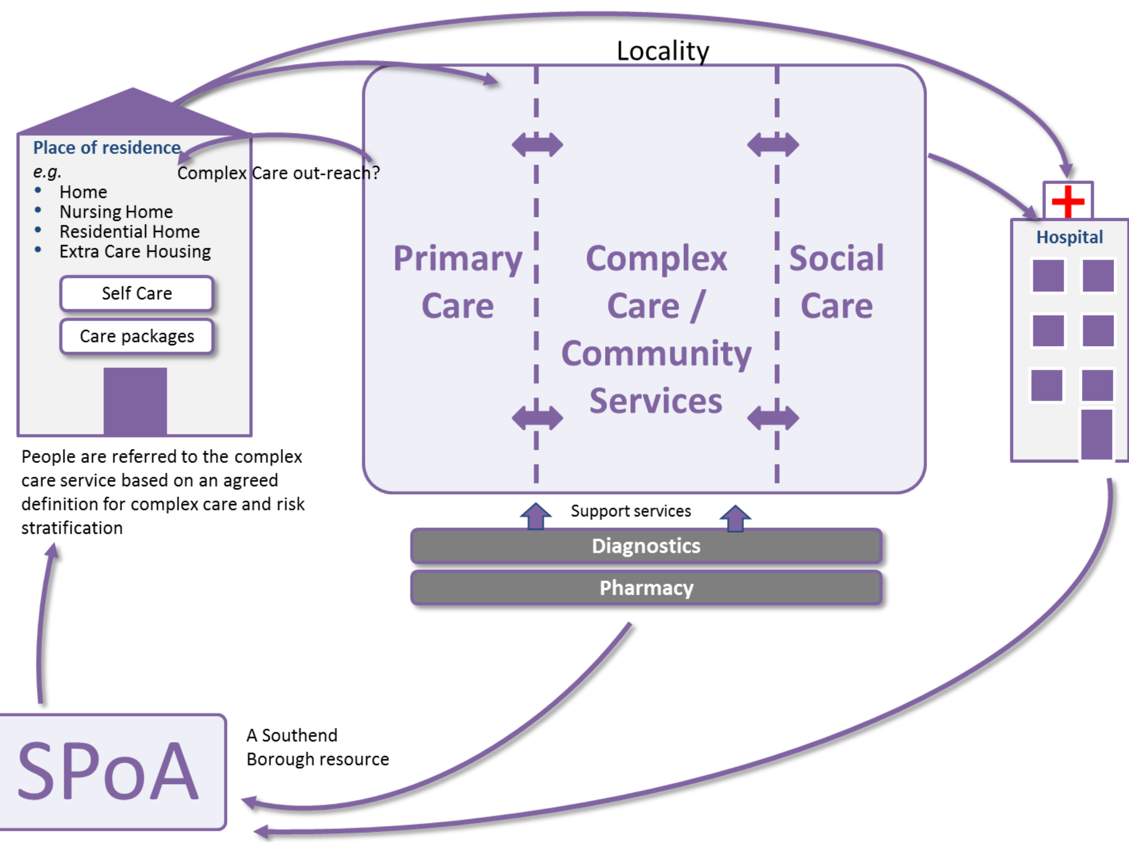
2.5 It is vital that our BCF plan is informed by a good understanding of patients' experience of services and their expectations and perceptions of the health and social care services in the area.

2.6 Over the past year our activities have been focused on implementing our new approaches to patient and public engagement and further developing the tools and channels that we will use.

2.7 We have attended dozens of events to engage face to face with members of the public across a range of different topics and issues. In May 2017 we held an engagement event to help develop the Locality approach for Southend. The event was a great success and attended by more than 150 people.

The Model

2.8 The agreed model that has been developed to deliver the Southend vision is known as the Locality approach and is demonstrated below.



The changes

2.9 The changes, as a result of implementing the agreed model, that we will continue to deliver for 2017–19 will build upon the successes from previous years and further develop the Southend vision for integrated health and social care. The changes that patients and residents will experience in terms of interacting with services will include;

2.9.1 **Locality model.** The completion of a 'Locality' approach where the locality is the central place that integrated health and social care interventions are co-ordinated. This change will represent a shift away from hospital into the community. The completion of the Locality approach will be aligned to the provision of both social care and primary care services working in a Multi-Disciplinary Team (MDT) environment. Appendix A provides a full description of the Locality model and the developing health and social care model.

2.9.2 **Complex Care.** The continued development of the complex care coordination service. In Jan 2017 the pilot service was commissioned. Through risk stratification we identify a cohort of patients with complex care needs. Once identified we design a service that co-ordinates their care needs and provides a holistic health and social care plan thus reducing demand on primary care and presentations at A&E. The service was commissioned as a pilot and will come to an end in March 2018. Our plan is to evaluate the service and commission on a permanent basis.

2.9.3 **End of Life pathway redesign.** Our emerging plans for the transformation of community services are forward looking and include the development of a pathway model focusing on complex care and frailty through from initial identification of risk and/or need to end of life. Through this model we will enhance advice, support and advocacy empowering people to take control and make choices.

2.9.4 **Adult Social Care (ASC) redesign.** ASC redesign is an important element to the locality approach and the delivery of integrated health and social care in Southend. ASC is currently leading a transformational project across the whole social care and health system which will turn around culture and mind-set, develop alternatives, develop engagement, communicate a compelling vision, and embed the narrative that supports this transformational change programme of work.

2.9.5 **Disabled Facilities Grant (DFG).** Through the BCF we aim to ensure the outcomes derived from the capital spend associated with the DFG are aligned and in support of those outcomes we derive from our integrated care commissioning activity for the cohort of patients identified with complex needs.

Alignment with Sustainability and Transformation Plan

2.10 NHS England's requirement for health and social care systems to draft a blueprint for the implementation of the five year forward view is otherwise known as Sustainability and Transformation Plans (STPs). The Southend system has agreed a local footprint for our STP and has aligned it with the Essex Success Regime (ESR).

2.11 The plans for the Mid & South Essex STP continue to develop with a focus on acute reconfiguration and financial stability for acute services. For the STP to succeed system leaders have agreed the need for the STP to be aligned with the plans to integrate health and social care within the community. The BCF plan will support the capacity for the acute services to be reconfigured.

2.12 To achieve the alignment close working relationships (between system leaders and organisations) have been formed alongside formal governance routes to ensure both the STP and BCF plans are working in partnership.

3 Background and context to the plan

Local Demographics and future challenges

3.1 In February 2017 Southend Public Health published an updated Joint Strategic Needs Assessment (JSNA) – Appendix B. The JSNA looks at the Borough of Southend and the demographics. It clearly articulates the challenges that our residents face from an early life through to older people. In Summary;

3.1.1 The population of Southend is in the region of 180,000. By 2021, this is expected to rise by a further 7%. Deprivation in Southend is higher than average and about 23.5% children live in poverty. Life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend. This is worse than the average for England.

3.1.2 The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity and alcohol have a negative impact on the health of the local population. There are also high levels of mental ill-health within Southend.

Current State of the health and adult social care market

3.2 The state of the social care market in Southend is improving. As a system we are continually looking for ways to invest and support the market but the specific challenges are around recruitment and retention and workforce development. We have over 100 care homes in Southend providing over 2,000 residential care beds. A significant proportion of residents are privately funded which provides challenges to the council to find care for state funded residents. The huge number of care homes provides challenges to the system in terms of consistency and quality of care.

3.3 During the course of the past year we have invested in domiciliary care by re-contracting with care providers and aligning the care being provided to the locality approach. We have also begun to invest in residential care homes (Gold Standard Framework) through supporting and training staff to improve quality of care.

3.4 Via the iBCF we also plan to enhance our investment in the voluntary sector which will help support and develop the social care provider market.

3.5 The Southend Local Account 2015-16 provides a comprehensive detailed account of the social care market in Southend. Please refer to Appendix C for the Local Account.

4 Progress to date

Summary

4.1 The progress made to integrate health and social care is significant. A recent report to HWB (Mar 2017), as evidenced in Appendix O and Oi, demonstrates the progress made at all levels of the system, which include leadership, operational and system leadership.

4.2 Described in detail at Appendix O and Oi our BCF plan for 2016-17 supported and drove our activities to integrate health and social care. As we now enter the planning phase for 2017-2019 our BCF plan will focus on further reductions in non-elective admissions, maintaining the performance for residential care admissions achieved in the previous 2 years against a backdrop of transformational change and continuing to deliver strong DToC performance.

4.3 To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the STP.

4.4 Southend HWB have recently commissioned an options appraisal to evaluate the 'what next' in terms of health and social care integration for Southend. This represents an exciting challenge for our system and one that our system partners are embracing.

4.5 Via the national BCF team support was sought though the LGA offer and a ‘what next’ report was commissioned. In June 2017 John Bewick OBE was commissioned to meet with both system and senior leaders of Southend. The report, at Appendix P, provides a very helpful independent analysis of our journey towards integration and provides very helpful areas to focus on for the period 2017-19. These area are due for ongoing discussion at both HWB and operational level and will be complete by Dec 2017.

Successes in Southend

4.6 There are many examples that evidence the success of integration of health and social care in Southend. Since the inception of our BCF planning some of these successes include;

4.6.1 Data sharing. It is well recognised in Southend that accurate commissioning, case finding and risk stratification for integrated health and social care services forms the platform for an integrated service provision. During the early history of the Pioneer programme Southend led a work stream to ensure that data across health and social care could be linked and shared.

4.6.2 Transforming Care Partnership. A pan Essex partnership has been formed to develop a plan that will change local services in a way that will make a real difference to the lives of children, young people and adults with a learning disability and / or autism who display challenging behaviour, including those with a mental health condition. Our plans will include things like improving community services so that people can live near their family and friends, and making sure that the right staff with the right skills are in place to support and care for people with a learning disability. Our plans will be a 'living' document which will continue to be developed in partnership with the service users, their friends, family and carers as well as charities and other groups.

4.6.3 Integrated commissioning team. In April 2015 an integrated commissioning team was formed from resource from both SBC and SCCG. The team are responsible for health and social care services in Southend for adults, the elderly and frail, mental health, dementia and children's. Commissioned services include Child and Adolescent Mental Health Services (CAMHS) and a complex care co-ordination service.

4.6.4 Locality approach. In May 2016 it was jointly agreed that 4 localities would be formed across Southend and that the locality would be the central place where integrated health and social care interventions are delivered and co-ordinated.

4.6.5 Single Point of Referral (SPoR) co-location with Southend Access. In July 2016 the SPoR and the Access team co-located at SBC to ensure that professionals who were referring patients into a health and social care system had the opportunity to refer through a single front door. Phase 1 of the project included co-locating two well established health and social care teams into one team. Working in partnership with our providers Phase 2 includes a review of activity and a redesign of service specification.

4.6.6 Complex Care co-ordination service. In January 2017 a complex care service commenced operations which would co-ordinate existing community based health and social care services around an individual with complex needs. New resource has begun to work with patients in Southend to ensure that the support and care patients receive is integrated and seamless.

4.6.7 Mental Health strategy and dementia services. Mental Health services face significant demand in Southend which is forecast to increase. An Essex wide (including Southend and Thurrock) Mental Health strategy has recently been agreed, this strategy provides the direction for mental health services and the challenge to develop a Southend specific implementation plan will now be addressed. Strategically, dementia services for Southend have recently been remodelled following a period of staff and community engagement and will now incorporate an enhanced service that is fully integrated within existing health, social care and community assets. From a performance perspective SCCG is historically and continues to be top of the league for East of England CCGs when diagnosing dementia.

4.7 Serious Illness Conversation. From November 2016 until May 2017 Southend were part of an NHS England pilot to support primary care in having ‘serious illness conversations’ with patients who were considered to be at ‘End of Life’. The pilot was led by Clatterbridge Cancer Care NHS Trust and involved 18 Southend GPs in the initial stages. Over the course of 6 months over 200 conversations were had across the pilot. The pilot is currently at evaluation stage with a view to rolling out the training across community health providers and primary care.

4.7.1 Other examples include DToC performance, jointly commissioned services, GP home visits in each West Central locality and re contracting with domiciliary care providers on a locality basis

5 Evidence base and local priorities to support plan for integration

Evidence base supporting the case for change

5.1 Data and information derived from the Director of Public Health for Southend's Annual Public Health Report 2015 (Appendix D) and additional sources including the Health and Wellbeing Strategy (Appendix E) and current JSNA (Appendix C) highlight the key health and social care challenges facing the system of Southend. The above reference appendices also provide the detailed evidence base that underpins our BCF plan. Paragraph 5.2 provides the high level evidence base;

5.2 The local priorities for Southend, as evidenced through the above referenced documents are;

5.3 **Primary Care.** Through joint partnership arrangements SCCG and the council have worked with NHS England to identify gaps and variation in primary care services. Locally, there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years.

5.4 **Ageing population.** Southend has an ageing population. We know the incidence and prevalence of ill health and disease increases with age and have identified a number of conditions, population groups and specific interventions where we believe more effective collaboration and coordination between partners will improve outcomes for local people and reduce costs to the health and social care economy. The key issues identified are:

5.4.1 **Older people**; residents at risk of falls and / or at risk of social isolation are included in this cohort. Southend has an ageing population, many of whom do not have family or a local network to support them as they age. These issues are similar for those ageing people who are living with long-term conditions, in particular; cardio vascular disease, respiratory and asthma.

5.4.2 **Older people with mental health and / or dementia**; mental health and dementia amongst older people increasing in parallel with national indicators. Our services to treat this cohort of patients require transformation to ensure the services are much more community based and integrated with primary care, community health services and social care.

6 Better Care Fund plan

Disabled Facilities Grant

6.1 Southend BCF will allocate £1.299M (2017-18) and £1.405M (2018-19) in capital to the council for use under the DFG guidance.

6.2 The services funded under the DFG are currently operated from in-house resource following the cessation of our contract with our private sector provider and the recommendation of an independent review.

6.3 The transition of private sector provider to in-house provider will be complemented with review the outcomes we are currently achieving with the use of the DFG. The aim of which will be to align the DFG spend to influence outcomes associated with families and those residents with complex care needs.

Commissioning, maintaining and transforming community services

6.4 Southend BCF will allocate £6.401M (2017-18) and £6.522M (2018-19) in revenue to SCCG for use to commission, maintain and transform community services.

6.5 During 2017-18 we will maintain the existing community services with our providers which will include services such as our SPoR, tissue viability, leg ulcers, the community element of stroke services, continence, intensive dementia support and occupational therapy. For a list of these services please refer to Appendix F.

6.6 During 2018-19 our plan is to design transformation programme which will change our existing service delivery model to a locality approach which is aligned to the health and social care delivery models outlined in the Five Year Forward view. The Locality approach is outlined below;

Locality approach

6.7 SCCG's approach within the BCF for 2017-19 to transforming community services for the benefit of Southend residents is through an integrated 'locality approach'. A locality will provide comprehensive integrated out of hospital care for provision, co-ordination and signposting ensuring that the shift is taken away from the hospital. This locality approach may not necessarily be a physical location but will use existing council and health estate and provide services in a range of different ways.

6.8 The approach will be to recognise the locality and not the hospital as the main location where health and social care takes place. The new model will establish the 'home' accessing services with the locality as a more efficient location for quality and value focused health and social care.

6.9 There will be a focus on retraining the workforce to enhance their roles in delivering whole person care that enhances self-management and independence.

6.10 The locality approach will also enhance retention and recruitment of clinical staff particularly district nurses, practice managers and GPs.

6.11 Through adopting the locality approach residents of Southend will see a benefit through improved outcomes as follows;

6.11.1 The integrated health and care system designed to ensure proactive prevention and early intervention, breaking the cycle of reactive care provision;

6.11.2 To family carers and the health and social care workforce;

6.11.3 Robust predictive modelling and risk stratification identifying patients at risk of decline for enrolment into the complex care service before their health deteriorates.

6.11.4 Each complex care patient has a care plan tailored to their individual needs, with different programmes designed for different needs e.g. diabetic programme, chronic heart failure programme;

6.11.5 Care takes place at convenient locations for the patient, with significant locality based care with support for transportation to ensure high levels of compliance with treatment programmes

6.11.6 Breaking down barriers between organisations and removing silo working will deliver improvements in the care patients receive, increasing quality and patient experience

6.11.7 Full authority over care decisions, and full clinical and financial accountability to ensure incentives are aligned to drive better outcomes for patients

6.11.8 By delivering enhanced quality outcomes for patients by ensuring that those delivering care have the appropriate skills and competency to do so.

6.11.9 Reduced unplanned attendances at Accident and Emergency

6.11.10 Decreased inpatient admissions and re-admissions and specialist utilisation (including reduced outpatient appointments)

6.11.11 Shortened inpatient length of stay (enhanced recuperation and rehabilitation care in appropriate settings

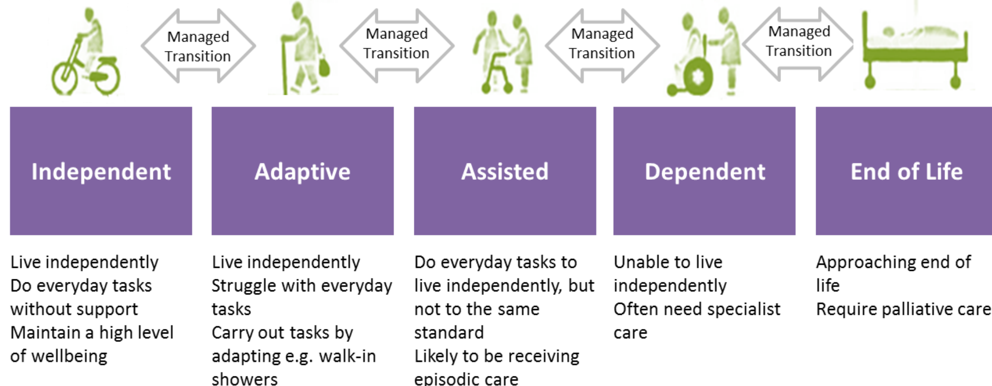
6.11.12 Reduced proportion of deaths in hospital (and increased provision of end-of-life care at home/ in hospices, aligned with patient choice)

6.11.13 Release of GP time to address other patient groups

6.12 Following a detailed analysis of demand, demographics and workforce it has been agreed that four localities are appropriate for Southend. A map of Southend shown in Localities can be found at Appendix A.

6.13 Residents will be risk stratified according to the ‘transition pathway’ outlined below. Patients with complex care needs – measured through a combination of a frailty index and integrated health and social care data – will most likely be those with multiple long term conditions. The best place for the provision of health and social care to these patients should not be the hospital but through the locality. Co-production and self-management, facilitated by technology, needs to be the location for higher acuity health and social care.

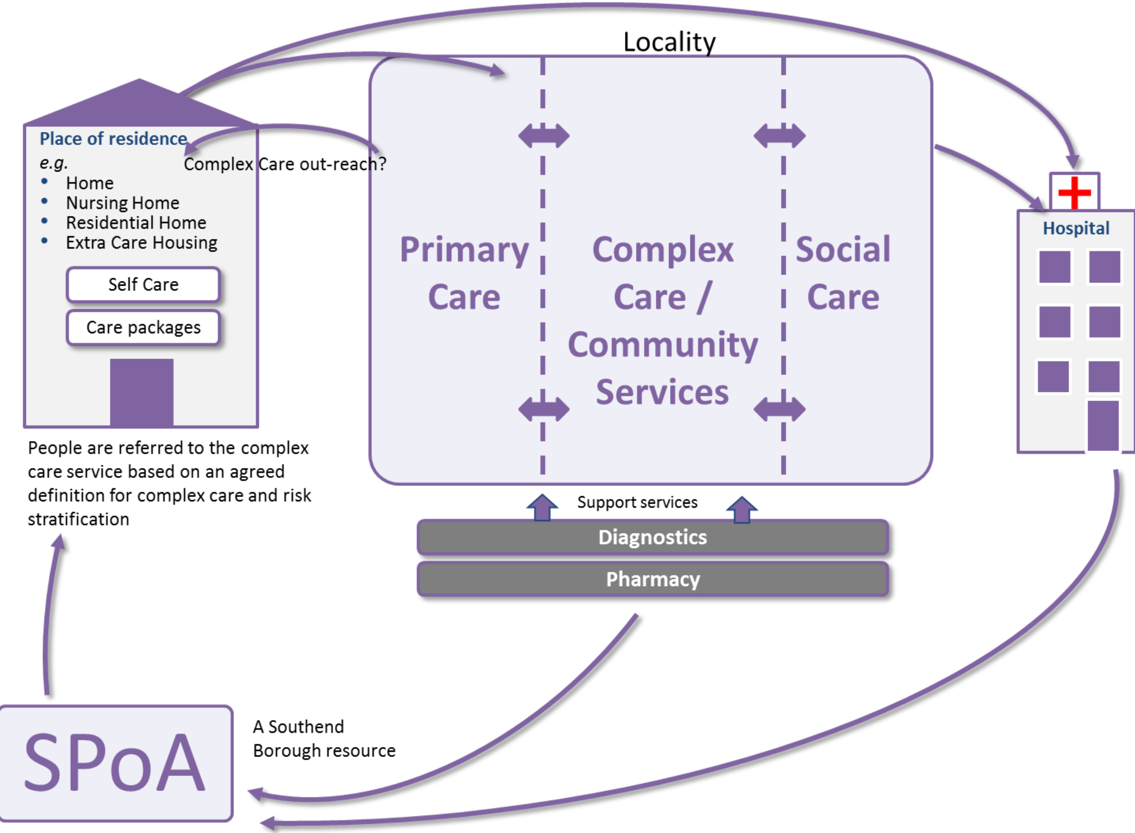
The transitional pathway



6.14 Led by our integrated commissioning team and by working in partnership with Primary Care providers, community service provision, our hospital provider, social care providers we have designed a model that is based on a locality approach and will deliver complex care services from within each locality.

6.15 Through working with adult social services we have designed a robust front door for both health professionals and residents to access health and social care information advice and a crisis service.

The proposed model

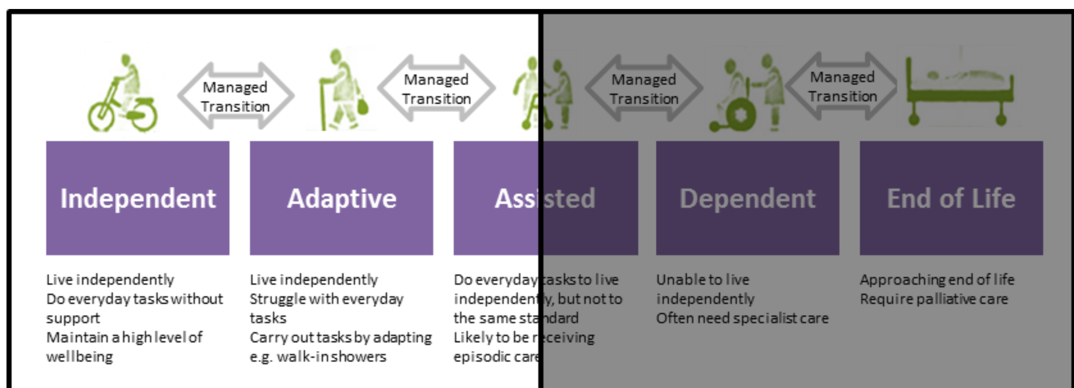


6.16 The SPoA focuses on;

6.16.1 Access to services; focused on preventative measures, advice and information; assessment and review; interventions or support; and discharge from hospital;

6.16.2 Crisis intervention; focused on face 2 face assessment, sign posting and the regular assessment for a short period of time following a period of care.

6.17 The SPoA targets those individuals who sit within the transitional pathway as outlined below;



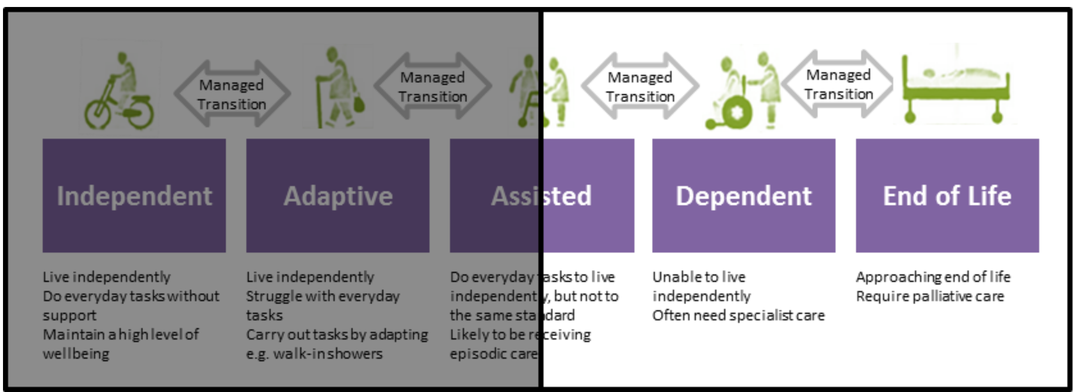
6.18 Complex Care / community services works in an MDT environment co-locating teams of professionals which will include GPs, community nurses, care co-ordinators, therapies, social workers, pharmacists, voluntary sector, mental health practitioners, dieticians and Long Term Condition nurses, facilitated through an integrated IT solution and delivering care according to standardised pathways and a task orientated approach. The main focus for the complex care element is;

6.18.1 Access to services; focused on preventative measures, advice and information or support;

6.18.2 Out of hospital community services focused on moderate frailty; respiratory, diabetes, cardiology, diagnostics, falls, rapid response, continence and dementia; and

6.18.3 Co-ordinated care with an MDT approach; focused on the management and maintenance of complex conditions over a long term with the aim of identifying which area of the transition pathway the patient is in and moving them through de-escalation; medication management; and carers, family, friends and community support.

6.19 The complex care service targets those individuals who sit within the transitional pathway as outlined below;



Outcomes

6.20 The provision of community services and transformation to a locality approach is measured through the following performance metrics;

6.20.1 Non elective hospital admissions;

6.20.2 Delayed Transfers of Care; and

6.20.3 Reablement;

6.21 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

The Locality approach – progress to date

6.22 The process to implement the Locality approach is a complex and lengthy journey which challenges the relationship between commissioner and provider and also challenges the workforce to think and act differently. Progress to date has been encouraging but it is recognised that there is still much to do. The following list are all achievements in implementing the locality approach;

- **Feb 2016.** HWB (informal session) discussed Health and Social Care integration and the model for implementation; Community Recovery Pathway;
- **May 2016.** Southend agreed 4 Localities in Southend; West; West Central; East Central; and East;
- **June 2016.** STP assigns East Central as the STP pilot locality for 'urban deprived';
- **June 2016.** Co-location of SPoR and Access team;
- **July 2016.** Senior stakeholders and executives meet to discuss integrated locality teams;
- **Aug 2016 – Dec 2016.** Nominated integrated locality team meetings to design and build and also develop relationships for East Central;
- **Sep 2016.** Essex Partnership University NHS Trust (EPUT) commit resource to lead Locality approach
- **Jan 2017 - present** (some of the activity)
  - Moderate needs MDT commences in East Central, currently running on a weekly basis
  - Social Care conduct community asset mapping for Southend
  - Check-in with senior stakeholders and executives to sponsor work
  - Social Workers aligned to Localities and GPs
  - Community nursing teams aligned to Localities and GPs
  - Re tendering and contracting with Domiciliary Care providers on a Locality basis

- Complex Care 'go live' – additional resource in system to support Locality approach
- Transformation of primary care led to development of a business case to support extended access and triaging
- Commenced West Central to be next Locality for development of integrated team

Provide, maintaining and redesign social care

6.23 Southend BCF will allocate £4.274M for (2017-18) and £4.355M for (2018-19) in revenue to the council for use to provide, maintain and redesign social care.

6.24 During 2017-19 we will maintain social care services which will include services such as our SPoR, community social work assessments, a discharge to assess model, dementia services and the Falls service. A full list of services can be found at Appendix G.

6.25 Whilst we maintain services we will develop a plan which will redesign our existing service delivery model (as outlined below) and be aligned to the locality approach and the Southend health and social care integrated vision, outlined above;

Redesign of Adult Social Care (ASC)

6.26 ASC redesign is an important element to the redesign and delivery of integrated health and social care in Southend. ASC is currently leading a transformational programme across social care and health system which is turning around culture and mind-set, developing alternatives, developing engagement, communicating a compelling vision, and developing and embedding the narrative that supports this transformational programme of work.

6.27 The redesign of social care is changing the approach to adults, families, carers and the community. Using strengths-based assessments and care planning, Social Care is focusing on individual abilities and community assets, rather than an approach that overly focuses on deficits and services to meet need. The approach is empowering and is facilitating the adult to take control of their own live rather than being told what is best for them.

6.28 Social workers are learning to take a preventative approach, as part of a Multi-Disciplinary Team (MDT), to their practice in community settings. The vision is for social workers, alongside their health colleagues, to have a strong understanding of their local community and engage wholly with Southend residents to maximise independence, inclusion and reduce marginalisation.

6.29 By adopting a collaborative and preventative approach to our practice we are minimising admissions into long term residential care, admissions into hospital and minimising the need for large domiciliary care packages. Social Care is creating a robust multi-disciplinary front-end adult social care team where advice, information and signposting to the wider community and universal services can minimise the long term dependency on health and social care services.

6.30 The plan is for social care to ensure that individuals are regularly reviewed to ensure that their needs are being met in the most empowering way. These teams will be developed into a highly skilled and adaptable workforce, which can respond to the changing needs of individuals and the communities, so adults and their carers can receive support and guidance at the right time and in the right way.

Outcomes

6.31 This project will be measured through the following performance metrics;

6.31.1 Residential care admissions;

6.31.2 Delayed Transfers of Care; and

6.31.3 Reablement.

6.32 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

The Redesign of social care – progress to date

6.33 At Appendix Gi there are three of the most recent transforming adult social care newsletters, these provide a detailed sense of the progress to date in transforming adult social care.

Reablement & Care Act

6.34 Southend BCF will allocate £1.475M (for 2017-18) and £1.503M (for 2018-19) in revenue to the council for use to provide, reablement services and continue with the requirements of the Care Act.

6.35 During 2017-19 we will continue to commission reablement services which will include services such as our Single Point of Referral (SPoR), Stroke early supported discharge pathway, discharge to assess and home again services.

6.36 The strategic objective of this scheme is to maintain social care and reduce hospital admissions through funding reablement services with the aim of improving social care discharge management and admission avoidance including developing existing reablement services.

6.37 The funding will be used to facilitate seamless care for patients on discharge from hospital, to promote ongoing recovery and independence and to prevent avoidable hospital admissions.

6.38 Reablement complements the work of intermediate care services and aims to provide a short term, time limited service to support people to retain or regain their independence at times of change and transition. It is intended to promote the health, wellbeing, independence, dignity and social inclusion of the people who use the service.

6.39 The service provider works in partnership with the service users, their families and carers in assessing problems and needs, goal setting, planning and implementing reablement programmes. In order to meet the objectives, reablement requires service providers to develop and skill their workers to be able to motivate and encourage service users and in some cases to take risks.

6.40 Patients who have had a hospital stay and are assessed as benefitting from a period of reablement to assist them in gaining as much independence as possible. Also people who remain within the community, requiring support to live at home and have not ‘gone near’ a hospital or long-term care placement. It is anticipated that referrals of individuals living in the community will contribute towards a reduction in the number of individuals being admitted to hospital.

Outcomes

6.41 This project will be measured through the following performance metrics;

6.41.1 A reduction in avoidable admissions to hospital

6.41.2 Facilitate timely hospital discharges

6.41.3 Prevention and maximising independence

6.41.4 Recovery and enablement services.

6.41.5 Community rehabilitation and reablement.

6.41.6 Processes to minimise delayed discharge

Improved Better Care Fund (iBCF)

6.42 Southend BCF will allocate £3.988M (for 2017-18) and £5.428M (for 2018-19) in revenue to the council for use in accordance with the grant conditions as set out in the BCF planning guidance.

6.43 The plan for 2017-18 (see Appendix H) and agreed by NHS England on 3rd August 2017 (see Appendix I) was developed in accordance with the high impact change model and each element of the step change model is underdevelopment. It is our ambition that each of the planned investments will have been made by the end of Q3 2017-18.

6.44 Some of the investments are being considered and developed, a timeline for the implementation of the high impact change model has been developed and is available at Appendix Hi. The timeline notes that each step change is at various different levels of development, for example the integrated discharge pathway is being piloted at Southend Hospital. Please refer to Appendix K for an outline to the project and Appendix L for an update as at Aug 2017.

6.45 Other projects are at a similar level of development whilst others required further scoping. For example, the Trusted Assessor requires a partnership approach to be developed between Essex County Council, a neighbouring CCG, our local CCG and the council.

6.46 Investment, aligned to the grant conditions for iBCF, will be in social care. These investments will be made to support a whole system transformational change approach which will include community groups, health and social care. Using a strength-based approach we will focus on individual abilities and family and community assets, rather than an approach that overly focuses on deficits and services to meet need. Our model is empowering and facilitates the individual in taking control of their own lives rather than being told what is best for them. Health, social care and partners will take a preventative approach to practice in a community setting. This investment will include (but will not be limited to) supporting training, enhancing capacity, capital investment and technology to support prevention.

6.47 The plan for 2018-19 will build upon the successes evaluated from 2017-18 and will continue to invest in areas that are identified as challenging to the Southend system. The plan for 2018-19 will also be in accordance with any published guidance from either NHS England or the Local Government Association (LGA).

6.48 At this point in time we expect for our iBCF plan for 2018-19 to be focused on delivering the locality approach, supporting the social care market and relieving system pressures.

7 Risk

7.1 The RAID log for Southend BCF (Appendix N) provides a detailed analysis of the key risks identified for 2017-19. It has been developed in conjunction with the Council's Corporate Risk Officer and the CCG's Head of Corporate Governance and agreed with key partners via the Locality Transformation Group (LTG). The risks are reviewed on a monthly basis by the BCF Pooled Fund Manager with oversight by the LTG on a bi-monthly basis.

7.2 The majority of services within the BCF Plan are currently operational, and risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the HWB on the recommendation of the LTG. These plans will include robust programme plans for each project, including key milestones, impacts and risks.

7.3 To deliver the vision in Southend's BCF plan, under the direction of the HWB, the council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which determines the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment has been undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks.

7.4 The total value of the BCF in Southend is £17.439M (for 2017-18) and £19.216M (for 2018-19), which includes iBCF contribution, and for both years (2017-19) no amount of the BCF is described as 'at risk'.

7.5 The council and the CCG, working with its providers Southend University Hospital NHS Foundation Trust (SUHFT) and Essex Partnership University NHS Foundation Trust (EPUT), have agreed to assume strategic responsibility for the whole health and social care system economy. They accept collective responsibility for overspends, working together, and with providers, to pre-empt or minimise their occurrence.

7.6 The HWB has specifically considered performance against the total emergency admissions target set locally for 2017-19 and determined that in the light of the solid performance in the last year, together with the close working with the STP in the context of agreeing a new contract with SUHFT, no "at risk" contingency is required in 2017-19. Accordingly, the whole BCF funding will in 2017-19 be invested in NHS out of hospital services.

7.7 The HWB remains closely involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. Section 75 performance reports for each BCF scheme will continue to be provided to the Locality Transformation Group and to the HWB.

7.8 The issue of treatment of overspends in the BCF schemes has also been agreed and the HWB have agreed that the BCF for 2017-18 should again be fixed at the agreed value of the Pooled Fund. A decision is to be taken for 2018-19. The effect of this is that any expenditure over and above the value of the fund will fall to the Council or the CGG depending on whether the expenditure is incurred on the social care functions or health care related functions.

7.9 The Section 75 Agreement stipulates that Financial Contributions in each Financial Year will be paid to the fund monthly in advance receivable on the first day of the month.

7.10 In terms of management arrangements, the Section 75 agreement stipulates that, if during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the LTG within 21 days. The LTG, where appropriate in consultation with the HWB, will then consider whether it needs to agree the action plan in order to reduce expenditure.

8 National Conditions

Plans jointly agreed

8.1 This plan, submitted on 11th September 2017, has been signed off on behalf of the HWB by both the Chair, the Vice Chair, the Director Adult Social Care (DASS), SBC and the Accountable Officer (AO), SCCG. Operationally, commissioners and providers have signed off this plan.

8.2 HWB will formally receive this BCF plan on 20th September 2017.

8.3 Our iBCF plan (Appendix H) for 2017-18 was formally approved on 3rd August 2017, see Appendix I for the approval letter.

8.4 Through the governance process outlined in Section 10 we have engaged with health and social care providers to fully understand the impact of the fund. We continue to work proactively with our providers which includes Southend's voluntary sector to mitigate any negative impacts and build on positive impacts.

8.5 Our Director for Adult Operations and Housing is part of the BCF delivery group and is also responsible for the DFG. We have, therefore, ensured housing authority representatives have been involved in the development of the BCF plan.

8.6 Through the BCF we aim to ensure the outcomes derived from the capital spend associated with the DFG are aligned and in support of those outcomes we derive from our integrated care commissioning activity for the cohort of patients identified with complex needs.

8.7 We continue to invest in our workforce to understand the cultural and workforce impact of the changes our BCF plans to implement. We have engaged a system facilitator to work with an appointed Leadership 4 Change team to address the workforce on two fronts.

8.7.1 Firstly, our Leadership 4 Change team have attended residential courses which are enabling a cohesive approach to system leadership. This team is then responsible for integrating the learning into our workforce.

8.7.2 Secondly, with the support of our system facilitator we are conducting a gap analysis of our workforce needs which will then support the design of a transformation programme.

Maintain provision of social service

8.8 The total amount from the BCF allocated for supporting adult social care services, and agreed locally, is £4.274M (2017-18) and £4.355M (2018-19). This budget will be allocated to maintain and support the provision of social care services. This agreed approach is aligned with the BCF Policy Framework 2017-19 and consistent with the DoH guidance to NHS England on the funding transfer from NHS to social care in 2013/14.Full details, which include a comparison of approach and spend, are provided in Section 6.

8.9 The total amount from the BCF allocated for supporting adult social care services has been maintained in real terms compared to 2016-17. In 2016-17 a total of £4.199M was allocated and in 2017-18 a total of £4.274M, 2018-19 £4.355M has been allocated, this represents an increase of 1.79% (2017-18) and 1.89% (2018-19). The

increase in spend will not destabilise but help support and maintain services provided throughout 2017/19.

8.10 The Department of Health (DoH) and LGA recently published the local apportionment of the £138m set aside for Care Act Duties. The apportionment to Southend is consistent with national directive and planning guidance and this plan confirms both its identification and allocation within the BCF.

8.11 We are currently waiting for the apportionment of the carer specific funding. We can confirm that our plan will be aligned with the BCF national conditions and await further national guidance.

8.12 We are committed to extending our support to carers in recognition of the vital role they play in the cared for person's well-being and in line with the duties under the Care Act. We have used the national models available to estimate the number of carers not currently known to the council and we are using this information to establish what the increase in carers' assessments is likely to be. We are committed to:

8.12.1 Identifying the carers who are not currently known to the council

8.12.2 Increasing and developing the workforce in response to the increasing demand.

8.12.3 Investing in staff training of both health and social care staff to ensure that the staff have the skills to recognise the impact of the caring role on the carer as well as ensuring the carer has a self-directed service.

8.12.4 Ensuring that there is accessible advice and information available to carers to support them in their caring role

8.12.5 Increasing the availability of respite provision to enable carers to have a break from their caring role.

8.13 We will allocate an agreed amount to carer specific services.

Agreement to invest in NHS commissioned out of hospital services

8.14 For 2017-19 and aligned with national conditions and the SCCG operational plan Southend BCF plans to deliver a reduction in non-elective admissions. At end of Q4 2016-17 non elective YTD admissions had reduced by 1.2% (from Q1 to Q4 2016-17).

8.15 Our HWB have decided to not pool any funding at risk and that the BCF plan would commit funding for out of hospital community services upfront.

Agreement on local action plan to reduce delayed transfers of care (DToC)

8.16 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 9.2 delayed days per day per 100,000 population between Feb 2017 and Apr 2017[4]; by comparison the national target is approx. 9.4 delayed days per day for every 100k of population.

[4] NHS Social Care interface dashboard published 4th July 2017

8.17 A target for DToC has been agreed and submitted to NHS England (see appendix J). The process was led by both SCCG and the council and engaged providers who have an impact on DToC. We recognise that whilst our DToC performance is extremely good there are always areas for improvement. Subsequently, the agreed targets will support either sustaining our excellent performance or a further decrease in DToC.

8.18 The plan (see Appendix H) was developed in accordance with the high impact change model and each element of the step change model is underdevelopment. It is our ambition that each of the planned investments will have been made by the end of Q3 2017-18.

8.19 Some of the investments have been made, for example the integrated discharge pathway is being piloted at Southend Hospital. Please refer to Appendix K for an outline to the project and Appendix L for an update as at Aug 2017.

8.20 Other projects are at a similar level of development whilst others required further scoping. For example, the Trusted Assessor requires a partnership approach to be developed between Essex County Council, a neighbouring CCG, our local CCG and the council.

9 Overview of funding contributions

Minimum funding contributions met

9.1 Southend can confirm that the minimum funding requirements for the BCF plan are as per below. These include the following;

		2017-18	**2018-19**
9.1.1	SCCG contribution	£12.151M	£12.382M
9.1.2	Disabled Facilities Grant	£1.299M	£1.405M
9.1.3	Care Act 2014 and reablement	£1.475M	£1.503M
9.1.4	Carers Break funding	£0.200M	£TBCM
9.1.5	Protection of social services	£4.274M	£4.355M
9.1.6	iBCF	£3.998M	£5.428M

9.2 Section 6 to this plan demonstrates how each element of the funding contributions will be used.

Additional funding contributions

9.3 No funding has been allocated from either the council or SCCG, in addition to the minimal funding requirements.

Local Agreement on funding arrangements

9.4 Both the BCF planning return and this plan have been signed off by the Chair and Vice Chair of HWB, the DASS at SBC, and the AO SCCG.

9.5 SCCG Clinical Executive Committee (CEC) have requested to review the BCF plan. A meeting is planned for 14th September 2017, after which any comments will be noted and fed into the plan.

9.6 There are 4 key changes to the funding contributions, these are;

9.6.1 CCG contribution. This has changed from £11.937M (2016-17) to £12.151M (2017-18) and £12.382M (2018-19).

9.6.2 DFG. This has changed from £1.193M (2016-17) to £1.299M (2017-18) and £1.405M (2018-19). The additional capital resource funding requirement has been agreed by both the council and SCCG.

9.6.3 Care Act 2014 and reablement. This has changed from £1.450M (2016-17) to £1.475M (2017-18) and £1.503M (2018-19).

9.6.4 Protecting social services. This has changed from £4.199M (2016-17) to £4.274M (2017-18) and £4.355M (2018-19). The additional funding is consistent with the Department for Health guidance to NHS England on the funding transfer from NHS to social care.

9.6.5 The impact of these changes on services has been assessed and no impact is envisaged.

10 Programme Governance

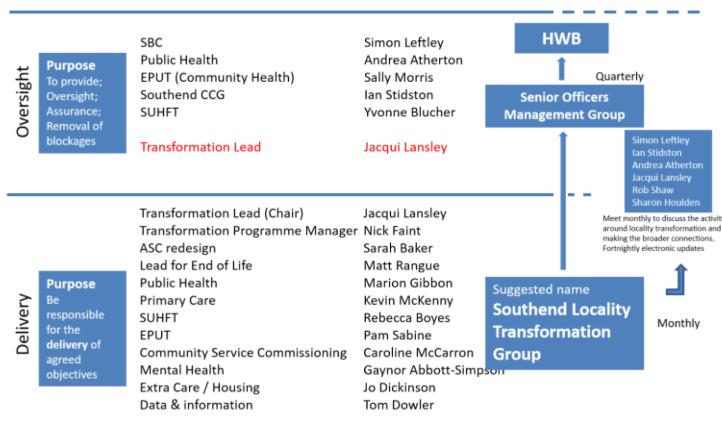
Governance

10.1 We regularly review the BCF governance structure to ensure that it is robust and able to cope with the demands of health and social care integration. Prior to February 2016 the BCF governance structure was as per diagram 1 below. Following a detailed review of the structure to ensure it was aligned with our revised BCF plan for 2016-17 and wider transformational activity (for example STP) the governance structure was amended as per diagram 2. Additionally, we took the opportunity to appoint a transformation lead who will ensure the BCF activity for 2016-17 and going forward is aligned with wider transformation and makes the broader connections.

10.2 A governance review was recently undertaken with the objective of ensuring that our current governance structure (outlined in diagram 2) was robust and able to deliver the BCF plan for 2017-19. The outcome of the review was that our current arrangements were sufficient and more than able to meet the requirements of our transformational activity.

Diagram 1 (Governance structure pre Feb 2016)

Diagram 2 (Governance structure post Feb 2016)



10.3 Responsible for the BCF delivery is HWB. With multi organisational representation the HWB receives regular reports from the BCF programme to assure financial and operational performance. HWB meet 5 times per annum.

10.4 Responsible for the operational delivery of BCF is the Southend Locality Transformation Group (SLTG). With multi organisational representation the LTG meets monthly. The LTG reports to HWB.

10.5 To work through the day to day delivery of BCF we have appointed a Transformational Lead who is supported by a BCF programme team. The BCF programme team is responsible for developing, managing and monitoring performance, risk, plan and finances. The BCF programme team report directly to LTG.

10.6 A detailed BCF programme plan has been developed (see Appendix M) alongside a BCF RAID log (see Appendix N).

11 National Metrics

11.1 The agreed targets for non-elective admissions, residential care home admissions, reablement, Delayed Transfers of Care and patient engagement is detailed in the BCF planning template submitted in support of the narrative plan.

11.2 Our agreed targets will be delivered through the following activities, each aligned with individual BCF projects;

11.2.1 transforming community services to a locality;

11.2.2 redesigning social care;

11.2.3 discharge to assess service;

11.2.4 overnight support service;

11.2.5 reablement services;

11.2.6 working closer with care homes;

11.2.7 a complex care co-ordination service;

11.2.8 redesigning our end of life pathway;

11.3 We are confident that our track record of delivery (outlined below), delivery and governance structure provides the appropriate assurance that our planning for 2017-19 has been undertaken and undergone a rigorous planning process;

11.3.1 Delivered a reduction in non-elective admissions. Detailed analysis has been undertaken regarding our performance for 2016-17 and our success has been assigned to the commissioning of a number of services that are aligned to delivering services within the community. Our plan for 2017-19 is a continuation of our plan for 2016-17.

11.3.2 Delivered a reduction in residential care admissions. Detailed analysis has been undertaken regarding our performance for 2016-17 and our success has been assigned to a revised approach to panel review, the implementation of a discharge to assess model and closer management of the discharge pathway.

11.3.3 Delivered a reablement metric that shows that a significant percentage of those (over the age of 65) discharged from hospital are still at home 91 days after discharge. Detailed analysis has been undertaken regarding our performance for 2016-17 and our success has been assigned to closer management of the reablement services, the implementation of a discharge to assess model and closer management of the discharge pathway.

11.4 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 9.2 delayed days per day for every 100k of population (Feb 2017 – Apr 2017); by comparison the national target is approx. 9.4 delayed days per day for every 100k of population.

11.5 A target for DToC has been agreed and submitted to NHS England.

Measuring the successful development of each Locality

11.6 The locality approach in Southend has been designed according to a number of factors which include demand, demographics and workforce. Each locality are, therefore, different. For example, the issues that face East Central differ from those that face West; East Central have predominantly deprived areas with large differences for health inequalities, there are huge mental health issues which have led to high rates of substance misuse and challenges for healthy lifestyles. West have a mixture between a predominantly ageing and frail population and an affluent population who commute to London and work in the financial sector.

11.7 The challenge to measure the successful development of each locality is significant. A locality dashboard for each locality will be developed with a mixture of KPIs and outcomes. Each dashboard will specifically measure the success of pilots such as the moderate needs MDT and the complex care service. Early indications show that the complex care service is having a positive impact on A&E attendances and admissions whilst from a qualitative perspective narratives reflecting patient's stories have been developed.

11.8 The plans to measure the effectiveness of our moderate needs MDTs are also in development; we have recently engaged with University of Essex to begin the process of formally evaluating our MDTs.

11.9 Whilst the challenge to measure patient outcomes is significant the challenge to monitor workforce, recruitment and retention will be tougher. Workforce issues in Southend are well publicised but via the HWB a strategy is being developed to ensure a system approach is adopted to ensure we fully address. The locality dashboard will be developed to measure this aspect.

Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: 1. Cover Sheet

<< Link to the Guidance tab

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Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

Health and Well Being Board	**Southend-on-Sea**
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Who signed off the report on behalf of the Health and Well Being Board:	Cllr Lesley Salter, Chair HWB

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Please add further area contacts that you would wish to be included in official correspondence -->			

***Only those identified will be addressed in official correspondence**

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

Complete Template

No. of questions answered

1. Cover	6
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4. HWB Metrics	31
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Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 2. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

2. HWB Funding Sources

<< Link to the Guidance tab

Local Authority Contributions exc iBCF		
Disabled Facilities Grant (DFG)	2017/18 Gross Contribution	2018/19 Gross Contribution
Southend-on-Sea	£1,299,530	£1,405,687
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	**£1,299,530**	**£1,405,687**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution	**£1,299,530**	**£1,405,687**

Comments - please use this box clarify any specific uses or sources of funding

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Southend-on-Sea	£3,988,630	£5,429,039
Total iBCF Contribution	**£3,988,630**	**£5,429,039**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Southend CCG	£12,151,359	£12,382,235
Total Minimum CCG Contribution	**£12,151,359**	**£12,382,235**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	No	No

Additional CCG Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Additional CCG Contribution	**£0**	**£0**

Comments - please use this box clarify any specific uses or sources of funding

	2017/18	2018/19
Total BCF pooled budget	**£17,439,520**	**£19,216,961**

Funding Contributions Narrative
Southend BCF confirms that the minimum funding requirements as specified in the national planning guidance have been met.

Specific funding requirements for 2017-19	Response	Response	If the selected response for either year is 'No', please detail in the comments box
1. Is there agreement about the use of the Disabled Facilities Grant and are arrangements in place for the transfer of DFG funds to the local housing authority?	Yes	Yes	
2. In areas with two tiers of local government:			
i) Are there plans to pass down the full amount of Disabled Facilities Grant from the county to each of the district authorities?			
ii) If a portion of the DFG funding has been retained by the county, have the relevant district councils agreed to this approach? If applicable, please detail in the comments box how the retained portion of DFG will be spent to support integrated approaches to health, social care and housing.			
3. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	Yes	
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	Yes	
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	Yes	
6. Is the iBCF grant included in the pooled BCF fund?	Yes	Yes	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 3. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Southend-on-Sea

Data Submission Period:
2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£5,750,213	£5,859,468
Ringfenced NHS Commissioned OOH spend	£6,401,146	£6,522,767

Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme
1	DFG	4. DFG - Adaptations			Social Care		Local Authority			Local Authority	Local Authority Contribution	Both 2017/18 and 2018/19	£1,299,530	£1,405,687	Existing
2	High Impact Model	9. High Impact Change Model for Managing Transfer of Care	9. Other	see appendix H to the plan	Other	system wide investment	Local Authority			Local Authority	Improved Better Care Fund	2017/18 Only	£1,488,630		New
3	iBCF Social Care	14. Residential placements	6. Other	sustaining the social care market	Social Care		Local Authority			Local Authority	Improved Better Care Fund	Both 2017/18 and 2018/19	£2,400,000	£5,429,039	New
4	Reablement, including supporting the care act	16. Other		Reablement, including supporting the Care Act	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£1,475,955	£1,503,997	Existing
5	Protecting Social Care	16. Other		protecting social care	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	Both 2017/18 and 2018/19	£4,274,258	£4,355,471	Existing
6	CCG Schemes	16. Other		community health services	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	Both 2017/18 and 2018/19	£6,301,146	£6,522,767	Existing
7	Carers Break funding	3. Carers services	1. Carer advice and support		Other	system wide investment	CCG			Charity / Voluntary Sector	CCG Minimum Contribution	2017/18 Only	£100,000		New
8	Carers Break funding	3. Carers services	1. Carer advice and support		Other	system wide investment	Local Authority			Charity / Voluntary Sector	Improved Better Care Fund	2017/18 Only	£100,000		New

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	2017/18	2018/19
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£5,750,213	£5,859,468
Ringfenced NHS Commissioned OOH spend	£6,401,146	£6,522,767

		Expenditure													
		Scheme Descriptions Link >>													
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

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Running Balances	**2017/18**	**2018/19**
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Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
Additional CCG Contribution balance	£0	£0
iBCF	£0	£0
Running Totals	**2017/18**	**2018/19**
Planned Social Care spend from the CCG minimum	£5,750,213	£5,859,468
Ringfenced NHS Commissioned OOH spend	£6,401,146	£6,522,767

		Expenditure													
		Scheme Descriptions Link >>													
Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

[<< Link to Guidance tab]

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
Local Authority Contribution balance exc iBCF	£0	£0
CCG Minimum Contribution balance	£0	£0
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Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
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Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Link back to the top of the sheet >>

Scheme Type	Description	Sub type
1. Assistive Technologies	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	1. Telecare 2. Wellness services 3. Digital participation services 4. Other
2. Care navigation / coordination	A service to help people find their way to appropriate services and support and thus also 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. This is often as part of a multi-agency team which can be on line or use face to face care navigators for frail elderly, or dementia navigators etc. . This includes approaches like Single Point of Access (SPoA) and linking people to community assets.	1. Care coordination 2. Single Point of Access 3. Other
3. Carers services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	1. Carer advice and support 2. Implementation of Care Act 3. Respite services 4. Other
4. DFG - Adaptations	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.	
5. DFG - Other Housing	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	
6. Domiciliary care at home	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.	1. Dom care packages 2. Dom care workforce development 3. Other
7. Enablers for integration	Schemes that build and develop the enabling foundations of health and social care 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 commisisioning infrastructure includes any personnel or teams that enable joint commissioning.	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Other

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

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Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
BCF Pooled Total balance	£0	£0
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Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Scheme Type	Description	Sub Types
8. Healthcare services to Care Homes	Improve the availability and quality of primary and community health services delivered to care home residents. Support the Care Home workers to improve the delivery of non-essential healthcare skills. This includes provider led interventions in care homes and commissioning activities eg. joint commissioning/quality assurance for residential and nursing homes.	1. Other - Mental health / wellbeing 2. Other - Physical health / wellbeing 3. Other
9. High Impact Change Model for Managing Transfer of Care	The 8 changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system.	1. Early Discharge Planning 2. Systems to Monitor Patient Flow 3. Multi-Disciplinary/Multi-Agency Discharge Teams 4. Home First/Discharge to Access 5. Seven-Day Services 6. Trusted Assessors 7. Focus on Choice 8. Enhancing Health in Care Homes 9. Other
10. Integrated care planning	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. For Multi-Disciplinary Discharge Teams and the HICM for managing discharges, 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.	1. Care planning 2. Integrated care packages 3. Review teams (reviewing placements/packages) 4. Other
11. Intermediate care services	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 delivered by a combination of professional groups. Services could include Step up/down, Reablement (restorative of self-care), Rapid response or crisis response including that for falls.	1. Step down 2. Step up 3. Rapid/Crisis Response 4. Reablement/Rehabilitation services 5. Other
12. Personalised healthcare at home	Schemes specifically designed to ensure that a person can continue to live at home through the provision of health related support at home. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term and end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in the Personalised Healthcare at Home scheme type.	1. Other - Mental health /wellbeing 2. Other - Physical health/wellbeing 3. Other
13. Primary prevention / Early Intervention	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.	1. Social Prescribing 2. Other - Mental health /wellbeing 3. Other - Physical health/wellbeing 4. Other

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

3. HWB Expenditure Plan

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Link to Summary sheet

Running Balances	**2017/18**	**2018/19**
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Expenditure

Scheme Descriptions Link >>

Scheme ID	Scheme Name	Scheme Type (see table below for descriptions)	Sub Types	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Scheme Duration	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New/ Existing Scheme

Scheme Type	Description	Sub Types
14. Residential placements	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.	1. Supported living 2. Learning disability 3. Extra care 4. Care home 5. Nursing home 6. Other
15. Wellbeing centres	Wellbeing centres provide a space to offer a range of support and activities that promote holistic wellbeing or to help people to access them elsewhere in the community or local area. They can typically be commissioned jointly and provided by the third sector.	
16. 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.	

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 4. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Southend-on-Sea

Data Submission Period:
2017-19

4. HWB Metrics

<< Link to the Guidance tab

4.1 HWB NEA Activity Plan

	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 17/18**	**Total 18/19**
HWB Non-Elective Admission Plan* Totals	**5,433**	**5,338**	**5,220**	**5,025**	**5,180**	**5,236**	**5,236**	**5,122**	**21,015**	**20,775**

Are you planning on any additional quarterly reductions?	No

Please only record reductions where these are over and above existing or future CCG plans. HWBs are not required to attempt to align to changing CCG plans by recording reductions.

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction										
HWB NEA Plan (after reduction)										
HWB Quarterly Plan Reduction %										

Are you putting in place a local contingency fund agreement on NEA?	No

	2017/18	2018/19
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/contingency fund **	£3,453,072	£3,518,680

Cost of NEA as used during 16/17***	£1,490	Please add the reason, for any adjustments to the cost of NEA for 17/18 or 18/19 in the cells below
Cost of NEA for 17/18 ***		
Cost of NEA for 18/19 ***		

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	**Total 17/18**
Additional NEA reduction delivered through BCF (2017/18)						
		Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	**Total 18/19**
Additional NEA reduction delivered through BCF (2018/19)						
HWB Plan Reduction % (2017/18)						
HWB Plan Reduction % (2018/19)						

The CCG Total Non-Elective Admission Plans are taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 10/07/2017

* This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

** Within the sum subject to the condition on NHS out of hospital commissioned services/contingency fund, for any local area putting in place a contingency fund for 2017/18 or 2018/19 as part of its BCF

*** Please use the following document and amend the cost if necessary: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/577083/Reference_Costs_2015-16.pdf

4.2 Residential Admissions

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	669.7	696.6	613.9	603.2	Targets for residential admissions have been provisionally set but remain subject to confirmation following the outturn of 2017-18 and a detailed analysis of ASC transofrmation activity
	Numerator	228	240	215	215	
	Denominator	34,043	34,452	35,023	35,646	

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 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a Residential Admissions rate for these two Health and Well-Being Boards.

4.3 Reablement

		15/16 Actual	16/17 Plan	17/18 Plan	18/19 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	87.4%	86.0%	88.0%	88.0%	Targets for reablement have been provisionally set but remain subject to confirmation following the outturn of 2017-18 and a detailed analysis of ASC transofrmation activity
	Numerator	90	86	88	88	
	Denominator	103	100	100	100	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				
		Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	Comm
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	653.5	723.9	966.1	823.3	823.3	824.7	747.2	715.9	855.2	864.2	864.2	839.1	The detailed planning has not b prior to the submission of this p have been provisionally set an standards set via the BCF plan
	Numerator (total)	928	1,028	1,372	1,179	1,179	1,181	1,070	1,033	1,234	1,247	1,247	1,220	
	Denominator	142,008	142,008	142,008	143,197	143,197	143,197	143,197	144,298	144,298	144,298	144,298	145,397	

Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year using the 2014 based Sub-National Population Projections for Local Authorities in England;
https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures for Cornwall and Isles of Scilly and Bournemouth and Poole has been combined to form Cornwall & Scilly and Bournemouth & Poole respectively to create a DTOC rate for these two Health and Well-Being Boards.

nents
peen completed for 2018-19 plan. The targets for 2018/19 d aligned to the national DToC nning guidance

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2017-19

5. National Conditions

<< Link to the Guidance tab

National Conditions For The Better Care Fund 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this	Does your BCF plan for 2018/19 set out a clear plan to meet this	If the selected response for either year is 'No', please detail in the comments box issues and/or actions that are being taken to meet the condition.
1) Plans to be jointly agreed	Yes	Yes	
2) NHS contribution to adult social care is maintained in line with inflation	Yes	Yes	
3) Agreement to invest in NHS commissioned out of hospital services	Yes	Yes	
4) Managing transfers of care	Yes	Yes	

CCG to Health and Well-Being Board Mapping for 2017-19

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	90.2%	87.9%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	7.0%	8.5%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.3%	0.5%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.2%	3.0%
E09000002	Barking and Dagenham	08W	NHS Waltham Forest CCG	0.0%	0.1%
E09000003	Barnet	07M	NHS Barnet CCG	91.0%	92.5%
E09000003	Barnet	07P	NHS Brent CCG	1.9%	1.7%
E09000003	Barnet	07R	NHS Camden CCG	0.9%	0.6%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	06N	NHS Herts Valleys CCG	0.0%	0.1%
E09000003	Barnet	08H	NHS Islington CCG	0.2%	0.1%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.5%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.4%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	93.7%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.6%
E09000004	Bexley	07N	NHS Bexley CCG	93.5%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.4%	1.5%
E09000004	Bexley	08A	NHS Greenwich CCG	7.6%	8.8%
E09000004	Bexley	08L	NHS Lewisham CCG	0.1%	0.1%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	91.9%	53.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.8%	24.3%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	3.0%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.4%	18.8%
E08000025	Birmingham	05P	NHS Solihull CCG	15.2%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	86.7%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.5%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.4%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%

E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.9%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.6%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.3%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.9%

E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.6%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	22.2%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.9%	57.9%
E08000032	Bradford	02T	NHS Calderdale CCG	0.2%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.2%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.2%	2.4%
E09000005	Brent	07P	NHS Brent CCG	89.9%	86.5%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.9%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.7%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000005	Brent	08E	NHS Harrow CCG	5.8%	4.0%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.5%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.1%
E06000023	Bristol, City of	11E	NHS Bath and North East Somerset CCG	0.1%	0.0%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.4%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.7%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.7%	95.1%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.1%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.3%	35.3%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.0%	59.7%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.4%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.3%	0.7%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.7%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.1%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.0%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	14L	NHS Manchester CCG	0.7%	2.1%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.9%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.5%	98.9%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.3%	0.3%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.7%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.0%	96.7%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.8%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.2%	0.3%
E09000007	Camden	07P	NHS Brent CCG	1.3%	1.9%

E09000007	Camden	07R	NHS Camden CCG	84.0%	89.2%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	5.8%	4.8%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.3%	3.1%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.3%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.0%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.2%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.3%	1.9%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.4%	50.4%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.5%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	1.9%	1.2%

E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.9%	69.3%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.3%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.4%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	1.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.8%	72.7%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.0%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.9%
E09000001	City of London	08Y	NHS West London (K&C & QPP) CCG	0.0%	0.1%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.2%	52.6%
E06000047	County Durham	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	46.1%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.4%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.6%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.4%	93.3%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.9%	2.8%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.5%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Morecambe Bay CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.2%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.0%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.0%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.4%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.3%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	2.0%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.2%	35.9%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.3%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.2%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.1%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.0%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.1%	80.6%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.5%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.3%	0.3%

E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.4%	0.5%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.2%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.2%

E10000009	Dorset	11J	NHS Dorset CCG	52.5%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.3%	0.6%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.8%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	3.9%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.7%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000009	Ealing	07W	NHS Ealing CCG	86.8%	90.7%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.8%	3.0%
E09000009	Ealing	08E	NHS Harrow CCG	0.4%	0.3%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.7%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	4.8%	3.6%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.7%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.0%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.5%	8.1%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.5%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.1%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.7%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.6%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.8%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.5%
E09000010	Enfield	07X	NHS Enfield CCG	95.4%	90.8%
E09000010	Enfield	08D	NHS Haringey CCG	7.7%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.2%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.3%	11.6%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.7%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.3%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.6%
E10000012	Essex	06T	NHS North East Essex CCG	98.6%	22.6%
E10000012	Essex	08N	NHS Redbridge CCG	3.0%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.3%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.4%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.1%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	38.9%	97.9%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.8%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%

E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.1%	4.2%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.7%	89.7%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.2%	4.7%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.4%	94.4%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.6%
E09000012	Hackney	08H	NHS Islington CCG	4.4%	3.6%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.6%
E06000006	Halton	01J	NHS Knowsley CCG	0.2%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	1.0%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%

E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.1%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.4%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.4%	87.7%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.7%
E09000013	Hammersmith and Fulham	08X	NHS Wandsworth CCG	0.1%	0.2%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.7%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	16.0%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.4%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.5%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.3%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.8%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.1%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.4%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.5%
E09000014	Haringey	07R	NHS Camden CCG	0.6%	0.5%
E09000014	Haringey	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.8%	91.5%
E09000014	Haringey	08H	NHS Islington CCG	2.4%	2.0%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.6%	4.8%
E09000015	Harrow	07W	NHS Ealing CCG	1.2%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	89.7%	84.4%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.5%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.8%	2.0%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.5%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.5%	99.5%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	3.3%	2.8%
E09000016	Havering	08F	NHS Havering CCG	91.7%	96.4%
E09000016	Havering	08M	NHS Newham CCG	0.1%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.6%	0.7%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.0%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.9%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.4%	0.1%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.6%	0.1%

E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.8%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.8%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.3%	1.9%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	89.9%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%

E09000018	Hounslow	07W	NHS Ealing CCG	5.7%	7.8%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.7%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.2%	86.8%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.6%	3.9%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.6%	5.2%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.5%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.3%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.6%
E09000019	Islington	08H	NHS Islington CCG	89.4%	88.7%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.0%	5.2%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	1.0%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	63.8%	93.1%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.2%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.9%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.2%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	12.9%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.2%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.3%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.4%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.5%	98.6%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.6%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.1%	1.3%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.7%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.7%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.7%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	98.9%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.0%	0.8%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.8%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.8%
E09000022	Lambeth	07R	NHS Camden CCG	0.1%	0.1%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.8%	0.5%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	85.9%	92.6%
E09000022	Lambeth	08R	NHS Merton CCG	1.1%	0.6%

E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%

E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.3%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	99.0%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.5%	11.8%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Morecambe Bay CCG	99.8%	12.9%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.1%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.0%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.2%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.4%	31.7%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	43.0%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.4%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.3%	2.0%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.3%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.7%	2.7%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.4%	39.9%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.6%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.7%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.9%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.4%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.2%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.1%	1.9%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.3%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	91.8%	92.4%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.8%	3.8%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.3%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.0%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.5%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.8%	19.6%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.3%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.7%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.4%	96.3%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.2%	4.4%
E06000032	Luton	06P	NHS Luton CCG	97.3%	95.6%

E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	14L	NHS Manchester CCG	90.9%	95.5%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01W	NHS Stockport CCG	1.6%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.1%	1.6%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%

E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.9%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	1.0%	1.6%
E09000024	Merton	08R	NHS Merton CCG	87.5%	81.1%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.6%	10.8%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.2%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.3%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.6%	95.1%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.1%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.5%	0.3%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.6%	97.7%
E09000025	Newham	08N	NHS Redbridge CCG	0.3%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.7%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.7%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.8%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.9%	25.4%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.6%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.2%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.2%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.1%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.6%	1.5%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.0%	96.3%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.4%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.5%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.2%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%

E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.7%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%

E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.7%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	84.9%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	1.0%	0.7%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.6%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	95.3%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.0%
E06000018	Nottingham	04M	NHS Nottingham West CCG	4.3%	1.2%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.3%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.3%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.6%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.6%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.0%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.0%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.6%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.6%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	90.5%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.4%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.5%	1.4%
E08000004	Oldham	14L	NHS Manchester CCG	0.8%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.6%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.1%	1.8%
E10000025	Oxfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.6%	0.2%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.8%	96.3%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.1%	3.7%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.2%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.6%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.6%	36.2%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.8%	60.6%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%

E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.8%	0.7%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.4%	99.0%

E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	4.9%	7.0%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.5%	1.4%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	91.7%	90.5%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.6%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.5%	96.6%
E08000005	Rochdale	14L	NHS Manchester CCG	0.6%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.9%	1.0%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	1.0%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.8%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.4%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.7%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	11.9%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.3%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.9%	1.4%
E08000006	Salford	14L	NHS Manchester CCG	0.9%	2.2%
E08000006	Salford	01G	NHS Salford CCG	94.0%	94.8%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.2%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.1%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	3.0%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.7%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.0%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.7%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.3%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.8%
E08000014	Sefton	01V	NHS Southport and Formby CCG	96.9%	41.8%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.4%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.6%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.3%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.1%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.8%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.1%	6.5%
E06000039	Slough	09Y	NHS North West Surrey CCG	0.0%	0.1%
E06000039	Slough	10T	NHS Slough CCG	96.6%	93.1%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	1.9%	6.2%

E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.4%	0.6%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05L	NHS Sandwell and West Birmingham CCG	0.0%	0.1%
E08000029	Solihull	05P	NHS Solihull CCG	83.6%	92.1%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.3%	0.4%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%

E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.5%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	5.0%	8.9%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.1%	88.7%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.2%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.2%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.7%	99.5%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.5%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.7%	4.6%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.7%	95.4%
E09000028	Southwark	07R	NHS Camden CCG	0.4%	0.3%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.2%	1.4%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.7%
E09000028	Southwark	08L	NHS Lewisham CCG	2.0%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.4%	88.7%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.1%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.3%
E08000013	St. Helens	02E	NHS Warrington CCG	0.0%	0.1%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.7%	1.2%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	92.0%	14.6%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.0%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.1%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.3%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.7%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	14L	NHS Manchester CCG	1.1%	2.2%
E08000007	Stockport	01W	NHS Stockport CCG	95.0%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.3%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.4%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.9%	98.6%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.4%	0.6%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.3%	16.4%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.4%	0.6%

E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.1%	0.4%
E10000029	Suffolk	07H	NHS West Essex CCG	0.1%	0.0%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.1%	29.7%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.9%	0.9%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.2%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.1%

E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	17.0%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.5%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.6%	0.2%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.3%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.4%	29.4%
E10000030	Surrey	08P	NHS Richmond CCG	0.6%	0.1%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.8%
E10000030	Surrey	10C	NHS Surrey Heath CCG	98.9%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	8.5%	1.1%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.4%	3.3%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.4%	6.7%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	85.6%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.2%	0.3%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.2%	98.3%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.7%	1.4%
E08000008	Tameside	14L	NHS Manchester CCG	2.3%	5.9%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.7%	2.2%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.7%	2.9%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.1%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.3%
E06000034	Thurrock	08F	NHS Havering CCG	0.2%	0.3%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.2%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.4%	0.3%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.9%	0.9%
E09000030	Tower Hamlets	08H	NHS Islington CCG	0.1%	0.1%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.5%
E08000009	Trafford	14L	NHS Manchester CCG	2.7%	6.9%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	02A	NHS Trafford CCG	95.6%	92.8%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.9%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.5%	98.1%

E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.6%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.2%
E08000030	Walsall	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.1%	0.0%
E08000030	Walsall	05Y	NHS Walsall CCG	92.7%	90.6%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.4%	1.3%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.2%	1.6%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.6%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.9%	0.5%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	3.0%	3.2%
E09000032	Wandsworth	08R	NHS Merton CCG	2.9%	1.7%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.8%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.3%	93.1%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.3%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	96.9%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.3%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.2%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.2%	21.5%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.2%	45.5%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.7%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.2%	66.4%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.3%	23.5%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	8.7%	7.5%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.7%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.1%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.6%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	1.9%
E09000033	Westminster	07R	NHS Camden CCG	3.0%	3.4%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	80.4%	71.2%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.1%
E09000033	Westminster	08K	NHS Lambeth CCG	0.1%	0.2%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.4%	23.2%
E08000010	Wigan	00T	NHS Bolton CCG	0.2%	0.2%
E08000010	Wigan	01G	NHS Salford CCG	0.9%	0.7%
E08000010	Wigan	01X	NHS St Helens CCG	3.8%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%

E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.8%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.4%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.5%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.8%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.2%	0.6%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.2%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	96.8%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.8%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.1%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.6%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.1%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.3%	1.3%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.6%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.2%	0.1%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.4%
E06000041	Wokingham	10W	NHS South Reading CCG	11.5%	9.5%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.4%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.6%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.5%	3.6%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.8%	93.2%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.4%	0.5%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.5%	1.3%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	49.0%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.4%	18.7%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.2%	99.9%

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Better Care Fund 2017-19

A Guide to Assurance of Plans

August 2017

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BCF 17/19 – Guide to assuring BCF plans

Introduction and context

Gateway: 06945

Introduction and purpose of document

- This document outlines the process for assurance of BCF plans for 2017-18 and 2018-19 and provides guidance for Better Care Managers and Regional Leads as well as assurers. As in 2016/17, plans will be assured regionally. Assurance will be co-ordinated by the Better Care Managers (BCMs) but decisions will be jointly made between NHS and local government assurers.
- Assurance of plans in 2017 will take place in one stage, after which plans deemed to meet the requirements set out in the Policy Framework and Planning Requirements will be put forward for approval. Plans rated 'approved with conditions' will be given permission to enter into s75 agreements on condition that any outstanding requirements are met by the date specified in the notification
- Final decisions on plan approval will be agreed by NHS England and the Integration Partnership Board (IPB) [1]. These decisions will be based on the moderated recommendation of the regional assurance panel
- This pack sets out
    - The stages and timetable for the assurance process,
    - Approach to ensuring consistent application of the National Conditions and requirements and:
    - A set of areas for assurance, underpinned by Key Lines of Enquiry.
- The pack also describes the roles of different partners in the assurance process.

[1]The IPB is a joint board that oversees government activity to deliver integrated health and social care. It is jointly chaired by the Department for Health and The Department for Communities and Local Government, with senior officials from HM Treasury, the Cabinet Office, the Local Government Association, ADASS, NHS England and NHS Improvement.

Context: BCF Planning 2017-19

Each Better Care Fund Plan should consist of:

- A jointly agreed narrative plan including details of how they are addressing the national conditions; how their BCF plans will contribute to the local plan for integrating health and social care and an assessment of risks related to the plan and how they will be managed. A narrative plan template is available.
- A BCF planning template that includes:
  - Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;
  - A scheme-level spending plan demonstrating how the fund will be spent;
  - Quarterly plan figures for the national metrics.

The Better Care Fund for 2017/18 and 2018/19 has four National Conditions:

- That a BCF Plan, including the minimum of the pooled fund specified in the Better Care Fund allocations, should be signed off by the HWB itself, and by the constituent local authorities and CCGs, and with involvement of local partners;
- A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in 2017/18 and 2018/19, in line with inflation;
- That a specific proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement.
- Implementation of the High Impact Change Model for Managing Transfers of Care

Context: BCF planning documents

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BCF 17/19 – Guide to assuring BCF plans

Requirements that need to be assured in BCF plans: *Planning Requirements and Key Lines of Enquiry (KLOE)*

Planning requirements and key lines of enquiry

This section sets out the content to be covered in Better Care Fund plans for 2017-19. This should be read in conjunction with the BCF Policy Framework for 17-19 published by the Department of Health and Department of Communities and Local Government, and the BCF Planning Requirements 2017-19' published by NHS England, the Department of Health and the Department for Communities and Local Government.

The 'Key Lines Of Enquiry' (or KLOEs) set out here are intended as a guide to local areas in developing their plans, as well as to the teams that will be carrying out the assurance of BCF plans for 2017-19. They are organised under the core planning requirements set out in the documents referenced above. They provide guidance on interpretation of the requirements for BCF plans and the key areas for assurers to verify. The KLOEs set out in this document will provide a single, transparent set of expectations for local areas in approaching BCF planning. The key lines of enquiry have been reduced in number from 2016/17 and all plans are required to meet these in order to be approved.

By the end of the assurance process all plans will need to demonstrate that they are meeting, or have plans in place to meet, the planning requirements in order to be approved and for authorisation to spend the CCG minimum element of the Better Care Fund. Plans that are 'Approved with Conditions' will be given permission to spend but must address the remaining issues identified by the assurance panel.

Answering Key Lines of Enquiry

The approach to BCF planning for 2017-19 seeks to simplify the requirement for local areas, while still ensuring that the conditions of access to the fund are met and local plans for furthering the integration of health and social care services through the BCF are in place.

The Planning requirements and supporting KLOEs can be demonstrated through the Narrative Plan, Planning Template and, where appropriate links to supporting documents, with a clear statement of the specific section or figures being referenced. Areas are encouraged to avoid structuring plans purely to answer these assurance questions. Instead, plans should present a narrative and supporting information that sets out how the joint plan for commissioning services under the Better Care Fund will produce more integrated working and improve services, along with a description of what will be commissioned and how the national conditions are met.

Key Lines of Enquiry: national conditions (1 of 2)

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Templates / reference documents
National condition 1: jointly agreed plan (Policy Framework)	**1. Has the area produced a plan that all parties sign up to, that providers have been involved in, and is agreed by the health and well being board?** **2. In all areas, is there a plan for DFG spending? And, in two tier areas, has the DFG funding been passed down by the county to the districts (in full, unless jointly agreed to do otherwise)?**	1. Are all parties (Local Authority and CCGs) and the HWB signed up to the plan? 2. Is there evidence that local providers, including housing authorities and the VCS, have been involved in the plan? 3. Does the Narrative Plan confirm that, in two-tier areas, the full amount of DFG Money has been passed to each of the Districts (as councils with housing responsibilities), or; where some DFG money has been retained by the Upper Tier authority, has agreement been reached with the relevant District Councils to this approach?	✓Planning Template ✓Narrative plan
National condition 2: Social Care Maintenance (Policy Framework)	**3. Does the planned spend on Social Care from the BCF CCG minimum allocation confirm an increase in line with inflation* from their 16/17 baseline for 17/18 and 18/19** **1.79% for 2017/18 and a further 1.90% for 2018/19*	4. Is there an increase in planned spend on Social Care from the CCG minimum for 17/18 and 18/19 equal to or greater than the amount confirmed in the planning template? 5. If the planned contributions to social care spend from the BCF exceed the minimum, is there confidence in the affordability of that contribution? 6. In setting the contribution to social care from the CCG(s), have the partners ensured that any change does not destabilise the local health and care system as a whole? 7. Is there confirmation that the contribution is to be spent on social care services that have some health benefit and support the overall aims of the plan? NB this can include the maintenance of social care services as well as investing in new provision	✓Planning Template ✓Narrative plan

Key lines of enquiry: national conditions (2 of 2)

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Templates / reference documents
National condition 3: NHS commissioned Out of Hospital Services (Policy Framework)	**4. Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	8. Does the area's plan demonstrate that the area has committed an amount equal to or above the minimum allocation for NHS commissioned out-of-hospital services and this is clearly set out within the summary and expenditure plan tabs of the BCF planning template? 9. If an additional target has been set for Non Elective Admissions; have the partners set out a clear evidence based process for deciding whether to hold funds in contingency, linked to the cost of any additional Non Elective Admissions that the plan seeks to avoid? 10. If a contingency fund is established; Is there a clear process for releasing funds held in contingency into the BCF fund and how they can be spent?	✓Planning Template ✓Narrative plan
National condition 4: Implementation of the High Impact Change Model for Managing Transfers of Care	**5. Is there a plan for implementing the high impact change model for managing transfers of care?**	11. Does the BCF plan demonstrate that there is a plan in place for implementing actions from the high impact change model for managing transfers of care? Does the narrative set out a rationale for the approach taken, including an explanation as to why a particular element is not being implemented and what is approach is being taken instead? 12. Is there evidence that a joint plan for delivering and funding these actions has been agreed? 13. If elements of the model have already been adopted, does the narrative plan set out what has been commissioned and, where appropriate, link to relevant information?	✓Planning Template ✓Narrative plan

Key lines of enquiry: narrative plan

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Templates / reference documents
Local vision for health and social care	**6. A clear articulation of the local vision for integration of health and social care services?**	14. Does the narrative plan articulate the local vision for integrating health and social care services, including changes to patient and service user experience and outcomes, and a strategic approach to housing, social care and health, cross-referenced and aligned to other plans impacting on integration of health and social care such as STPs or devolution deals? 15. Is there an articulation of the contribution to the commitment to integrate health and social care services by 2020 in line with the intent set out in the 2015 spending review and the BCF policy Framework? 16. Is there a description of how progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework?	✓Narrative plan ✓Other local plans that contribute to integration (e.g. STP) ✓Joint strategic needs assessment
Plan of action to contribute to delivering the vision for social and health integration	**7. Does the BCF plan provide an evidence-based plan of action that delivers against the local needs identified and the vision for integrating health and social care?**	17. Is there a robust action plan that addresses the challenges of delivering the vision, including: • Quantified understanding of the current issues that the BCF plan aims to resolve • Evidence based assessment of the proposed impact on the local vision for integrating health and social care services through the planned schemes and joint working arrangements	✓Narrative plan
Approach to programme delivery and control	**8. Is there a clear, jointly agreed approach to manage the delivery of the programme, identify learning and insight and take timely corrective and preventive action when needed?**	18. A description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF plan? 19. A description of how the plan will contribute to reducing health inequalities (as per section 4 of the Health and Social Care Act) and to reduce inequalities for people with protected characteristics under the Equality Act 2010? 20. Does the narrative plan have a clear approach for the management and control of the schemes? including as a minimum: • Benefit realisation (how will outcomes be measured and attributed?) • Capturing and sharing learning regionally and nationally • An approach to identifying and addressing underperforming schemes	✓Narrative plan

Key lines of enquiry: risk and funding

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Templates / reference documents
Management of risk (financial and delivery)	**9. Is there an agreed approach to programme level risk management, financial risk management and, including where relevant, risk sharing and contingency?**	21. Have plan delivery and financial risks, consistent with risks in partner organisations, been assessed in partnership with key stakeholders and captured in a risk log with a description of how these risks will be proportionally mitigated or managed operationally? 22. If risk share arrangements have been considered and included within the BCF plan, is there a confirmation that they do not put any element of the minimum contribution to social care or IBCF grant at risk? 23. Is there sufficient mitigation of any financial risks created by the plan if a risk share has not been included?	✓Narrative plan ✓Market Position Statement ✓Organisational risk logs
Funding contributions: **1. Care Act,** **2. Carers' breaks,** **3. Reablement** **4. DFG** **5. iBCF**	**10. 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 and this is appropriately agreed with the relevant stakeholders and in line with the National Conditions?**	24. For each of the funding contributions, does the BCF evidence: • That the minimum contributions set out in the requirements have been included? • How the funding will be used for the purposes as set out in the guidance? • That all relevant stakeholders support the allocation of funding? • The funding contributions are the mandated local contributions for: • Implementation of Care Act duties • Funding dedicated to carer-specific support • Funding for Reablement • Disabled Facilities Grant? 25. Does the planning template confirm how the minimum contribution to Adult Social Care and the funding for NHS Commissioned Out of Hospital Services will be spent? 26. Does the BCF plan set out what proportion of each funding stream is made available to social care and that the improved Better Care Fund has not been offset against the contribution from the CCG minimum? 27. Is there agreement on plans for use of IBCF money that meets some or all of the purposes set out in the grant determination?	✓Planning Template ✓Narrative plan

Key lines of enquiry: metrics

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Templates / reference documents
Metrics – Non Elective Admissions	**11. Has a metric been set for reducing Non Elective Admissions?**	28. Does the narrative plan include an explanation for how this metric has been reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19? 29. Has a further reduction in Non Elective Admissions, additional to those in the CCG operating plan, been considered?	✓Planning Template
Metrics – Non Elective Admissions (additional)	**12. If a metric has been set for a further reduction in Non Elective Admissions, beyond the CCG operating plan target, has a financial contingency been considered?**	30. Has the metric taken into account performance to date and current trajectory and are schemes in place to support the target? See also National Condition 3.	✓Narrative plan ✓Planning Template
Metrics Admissions to residential care homes	**13. Has a metric been set to reduce permanent admissions to residential care?**	31. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of BCF schemes on performance in 2017-19?	✓Planning Template
Metrics – Effectiveness of Reablement	**14. Has a metric been set for increasing the number of people still at home 91 days after discharge from hospital to rehabilitation or reablement?**	32. Does the narrative plan include an explanation for how this metric will be reached, including an analysis of previous performance and a realistic assessment of the impact of the reablement funding allocation for health and social care and other BCF schemes on performance in 2017-19?	✓Planning Template

Key lines of enquiry: delayed transfers of care

Planning requirement area	BCF Planning Requirements (the confirmations for these requirements will be collected and analysed centrally)	KLOEs to support assurance of the planning requirements (these KLOEs underpin the assurance for the planning requirements but will not be collected/analysed centrally)	Templates / reference documents
Metrics Delayed Transfers of Care	**15. Have the metrics been set for Delayed Transfers of Care?**	33. Have all partners agreed a metric for planned reductions in delayed transfers of care across the HWB that is at least as ambitious as the overall HWB target for reductions of DToC by November 2017? 34. Is the metric in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DTOC template? 35. If the local area has agreed changes in attribution from those set out in the template is there a clear evidence base and rationale for those changes? 36. Does the narrative set out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan? 37. Have NHS and social care providers been involved in developing this narrative?	✓Planning Template ✓Narrative plan ✓Related schemes and models impacting DTOC beyond BCF ✓A&E improvement plans
Integrity and completeness of BCF planning documents	**16. Has all the information requested in the DTOC and planning templates been provided and are all the minimum sections required in the narrative plan elaborated?**	38. Have the DTOC template, Planning template and Narrative plans been locally validated for completeness and accuracy as per the planning requirements? (Better Care Support Team will carry out central data validation)	✓DTOC template ✓Planning Template ✓Narrative plan

BCF 17/19 – Guide to assuring BCF plans

Assurance approach and process

Assurance overview

Stage	Aims	Who is involved	Decision maker

Assurance of submissions	• Assess whether the planning requirements are met.
	• Agree whether plans should be
	    • Approved,
	    • Approved with Conditions, or
	    • Not approved.
		• Co-ordinated by regional assurance teams (DCO teams and local government assurers, supported by Better Care Managers).
		• Better Care Support Team (data validation and summary)
			Regional/sub regional assurance panel

Moderation of assurance outcomes	• Scrutinise assurance outcomes and comments across NHS region to ensure consistency of approach	• Co-ordinated by Better Care regional leads in DCO teams • Regional assurance leads (NHS England (taking on board NHS Improvement views) and local government) • NHS regional finance reps	Regional moderation panel
Submission of assured plan ratings and summary template to the Better Care Support team			
Cross regional calibration	• Scrutinise assurance outcomes between regions to ensure consistency of approach	• Co-ordinated by Better Care Support Team, with Better Care regional leads and regional assurance leads	Regional moderation panel
Submission of assured plan ratings and summary template to the Better Care Support team			

Management of the assurance process: assurance panels

Regional assurance will be co-ordinated by BCF Regional Leads and Better Care Managers, working with Directors of Commissioning Operations (DCO) teams, in partnership with local government assurance teams. NHS regional staff (including finance staff) and BCMs will be responsible for ensuring that regional assurers have access to appropriate information and guidance to assure plans and that arrangements are in place for joint agreement by NHS and local government of assurance outcomes and feedback to local areas.

Regional Leads for the Better Care Fund, with support from BCMs will

- Agree the process for assuring and moderating plans in line with the guidance and timetable, using the key lines of enquiry and other nationally available materials.
- Agree how DCOs and NHS regional assurers will work with local government regional colleagues to assure plans, and put in place a timetable for delivery before 31 July 2017**.** This should include an opportunity for NHS and local government assurers to discuss and agree plan status once plans have been scrutinised.
- Ensure that assurers are fully aware of their roles and equipped to provide adequate assurance of plans
- Ensure that assurance panels are arranged in time to meet milestones in the planning requirements and that local Better Care Fund planning leads have arrangements in place for agreement and approval of plans locally.
- Agree a mechanism to resolve differences in plan ratings between different assurers.

Lead local government Chief Executives and Directors of Adult Social Care should put in place appropriate additional regional capacity by **31/07/2017** to ensure local government regions are able to fully participate in the assurance process (utilising national BCST resources where required)

Management of the assurance process: regional moderation

- Arrangements should also be made by BCF regional leads and Better Care Managers for moderation of plan outcomes at NHS regional level.

- Moderation should be completed by the dates set out in the Planning Requirements and should ensure that a consistent approach to plan assessment has taken place across each NHSE region.

- Moderation should include input from:
  - Local government representatives: DASS and/or Chief Executive
  - NHS England DCO (taking on board views from NHS Improvement regional teams)
  - NHS England regional finance representatives
  - Better Care Managers

- Moderation should ensure that the requirements of the policy framework and planning requirements have been applied consistently across the region. The meeting should agree a final set of plan ratings after each of the two rounds of assurance. The moderation panel should consider whether the local DToC metrics are consistent with the agreed targets and that any changes in attribution at local level are well evidenced and have a clear rationale.

- Ratings should be recorded on the template provided and communicated to the national Better Care Support Team by **27 September 2017**.

Management of the assurance process: Cross regional calibration

- The Better Care Support team will co-ordinate a teleconference between regional assurance leads to allow regions to moderate scores across England. Once moderated plan outcomes are communicated to the Better Care Support team, a national level analysis of plan outcomes will be produced and provided to national partners and to NHS England regions.
- Following this, regions should review and benchmark their ratings against others. This process is the mechanism that the national Better Care Support team use to provide assurance to departments and NHS England that the conditions of the Fund have been applied consistently across England.
- This exercise will be used to ensure that plans are assured in a way that is consistent with other parts of the country. The calibration meeting will not examine individual HWB level assessments, but will examine overall approach and trends.
- This may result in some regions needing to re-visit judgements or comments for particular areas if it is apparent that different approaches have been taken regionally.
- As in 2016/17, decisions to put forward plans for approval by the IPB and NHS England, will be made by regions and the approach and representation at moderation and calibration will be for regions to make.

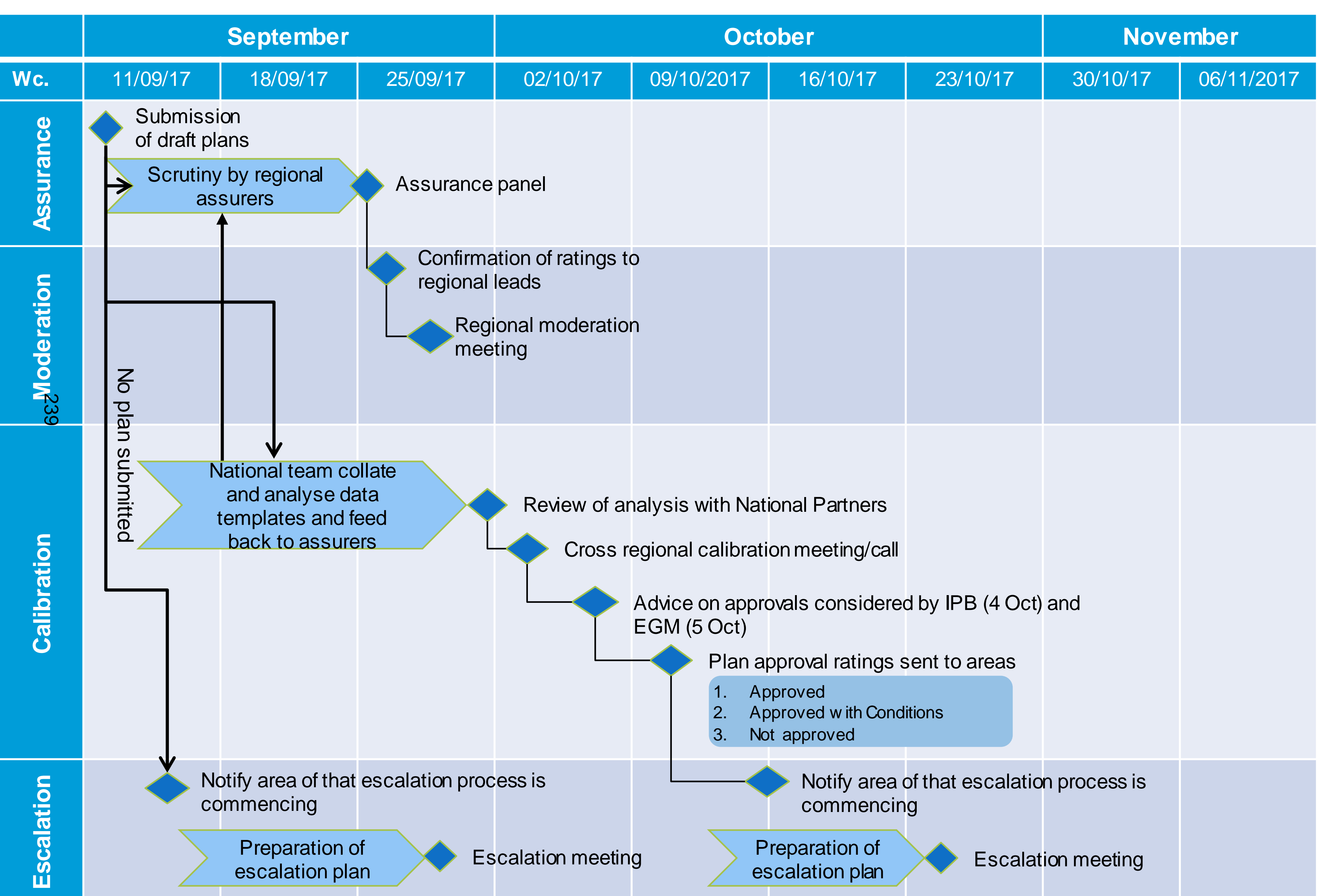
Assurance categorisation and follow up actions

Rating	Overview	Criteria	Next steps
Approved	• Plan agreed by Health and Wellbeing Board • Plan meets all requirements	• All planning requirements and KLOEs met • National Conditions met (including that the plan is agreed by the HWB)	• Plan is put forward for approval by NHS England following consultation with the IPB. • NHS England will write to these areas giving permission to enter a s75 agreement spend from the ring-fence in the CCG budget

Approved with conditions	• Principal conditions (including National Conditions 1,2 & 3 met
	• Meets most planning requirements
		• Principal conditions (including National Conditions 1,2 & 3 and DTOC metric) are met
		• Not all planning requirements met, – i.e. one or more KLOEs not satisfied; for example:
		    • Narrative plan (vision, approach to risk management) needs improvement; or
		    • National Condition 4 not fully met
		    • Not all Metrics not agreed
		• Progress is being made (including on National Condition 4) and, provided feedback is incorporated, there is confidence that a compliant plan can be produced
		• Assurance panel are confident that the area can agree a plan by November
			• NHS England will write to areas giving permission to enter a s75 agreement spend from the ring-fence in the CCG budget
			• Provide formal feedback to areas on actions needed to gain approval and timescale.
			• Area and BCM to consider any support required
			• Area to implement improvements prior to submitting a revised plan to their HWB.

Not approved/ not submitted	• One or more minimum funding contributions not included or • Plan is not locally agreed. • Plan is not submitted	• Several planning requirements not met including: • One or more of National Conditions 1, 2 or 3 not met. • Little or no progress towards agreement on National Condition 4. • Metrics are not set or not accompanied by plan • Plan is not submitted • DToC ambition is not in line with the targets agreed with NHS England (for CCGs) and/or necessary to achieve expected reductions (for Local Authorities).	• Provide feedback to areas on actions needed to deliver a compliant plan • Area and Better Care Support Team notified • If a plan is not submitted, BCST to arrange escalation panel meeting in w/c 25 September • If a plan is submitted but not approved, BCST to arrange escalation panel w/c 23 October • Support provided to area to produce an escalation plan

Overview of assurance, moderation and calibration



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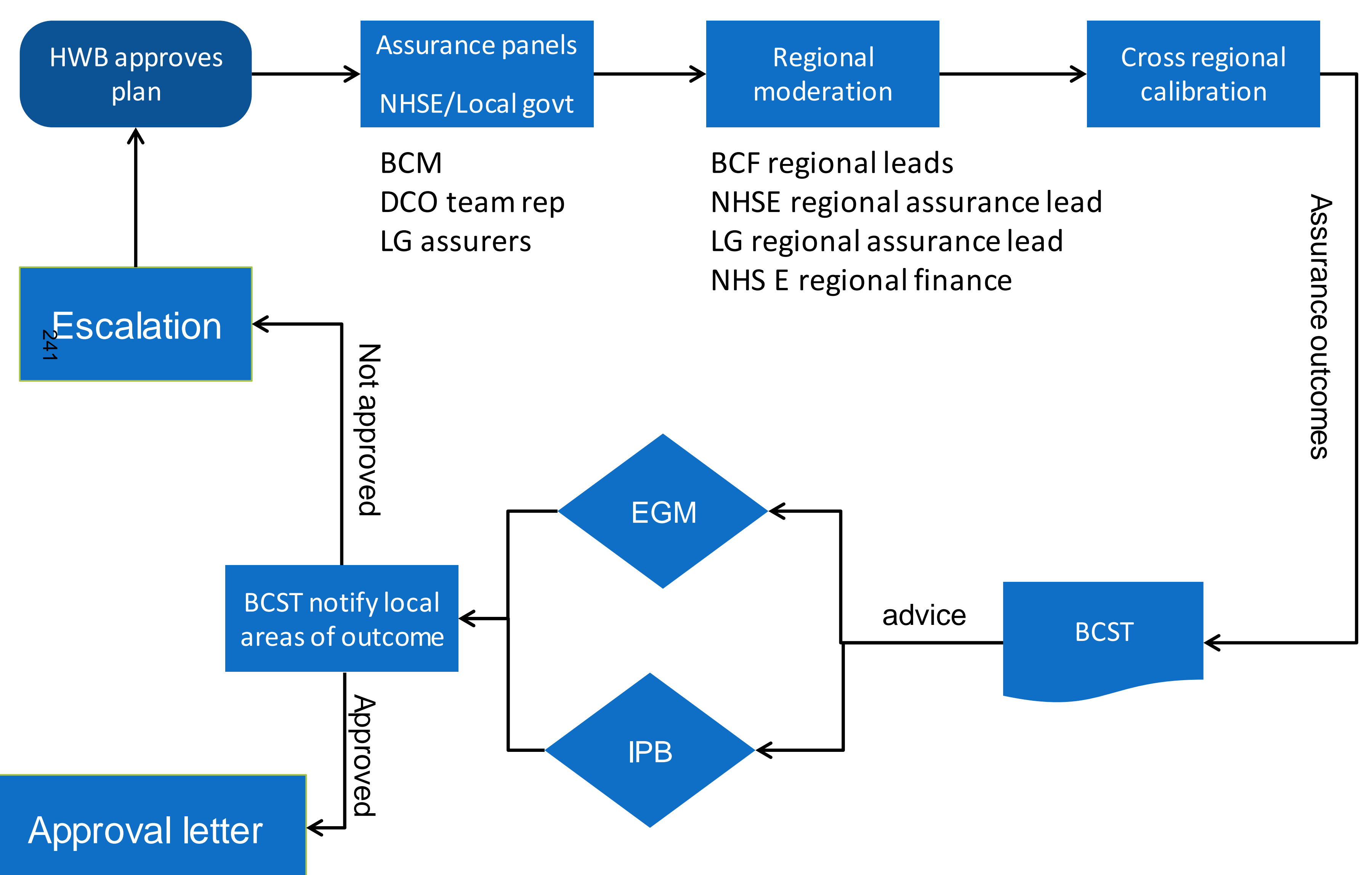
BCF 17/19 – Guide to assuring BCF plans

Responsibilities and Accountabilities for BCF Assurance

BCF assurance: process and accountability



BCF assurance: roles and responsibilities

NHS England Directors of Commissioning Operations (DCOs) and BCF Regional Leads

- Work with local government (LG) regional leads and BCMs to agree and deliver the approach to assurance, supported by Better Care Managers
- Ensure that the BCF assurance template is completed for each Health and Wellbeing Board within their area
- To coordinate and submit regional level returns providing an overview of plan assurance outcomes for each HWB in the region

Regional local government leads (Directors and/or Chief Executives)

- To oversee the LG input to BCF plan assurance and moderation, working with DCOs, BCMs and NHS England regions
- To ensure that additional operational capacity is provided to LG leads to deliver the approach to assurance and moderation from a local government perspective

Better Care Managers (BCMs)

- To provide additional capacity to DCOs and LG regional leads as agreed to support the overall approach to assurance and moderation across both health and social care

NHS England regional leads and NHSE regional finance leads

- To work with LG regional leads to provide a moderated view of BCF plans which aligns with wider moderation of NHS plans, taking on views of NHSI colleagues.

The Better Care Support Team

- To develop a consistent framework for assurance and moderation agreed by partners
- To develop a HWB level BCF assurance template to aid consistency
- To support the cross regional calibration exercise to establish a national picture of plan assurance
- To advise IPB and NHS England EGM on approval of plans
- To lead and co-ordinate the escalation process

BCF 17/19 – Guide to assuring BCF plans

Appendix: Escalation overview

The escalation process and statutory powers

The purpose of escalation is to assist areas to reach agreement on a compliant plan. Senior Representatives from all parties required to sign up to a plan will be asked to attend an Escalation Panel meeting to discuss concerns and identify a way forward.

In the eventuality that:

- signatories to a plan are not able to agree and submit a draft plan, or:
- The Health and Well-being Board do not approve the final plan; or
- Regional Assurers decide that a plan does not meet the planning requirements:

The Better Care Support Team, in collaboration with the relevant Better Care Manager, will commence an escalation procedure to oversee prompt agreement of a compliant plan.

A guide to escalation will be issued to all those asked to enter the escalation process.

Escalation arrangements

- Representatives from the area (HWB chair, local authority chief executive (or DASS) CCG accountable officer) will be required to be present their escalation plan to the escalation panel (senior officials from DH, DCLG, NHSE and LGA

Outcomes

- Agreed escalation plan proposal:
  - set timelines for delivery and monitoring by the BCM and, if appropriate, external support to develop plan
- No agreed proposal:
  - Direct development of an alternative proposal
  - Appoint an independent expert to support development of a plan
  - Appoint an independent contractor to develop a plan, using NHS powers of direction

Follow up

- BCST will monitor progress on agreed outcomes
- Revised plans will be assured and approved once submitted.

6

Southend Health and Wellbeing Board

Mid and South Essex
Sustainability and Transformation Partnership (STP)

Our Future NHS – update on current progress towards consultation

Summary

The Mid and South Essex STP is finalising a business case for potential service changes over the next five years, including proposals to reconfigure some hospital services.

The business case will be scrutinised by national NHS regulators, such as NHS England and NHS Improvement, as well as reviewed by the East of England Clinical Senate. Once the assurance process is complete, the five CCGs in Mid and South Essex will lead, on behalf of the STP, a full public consultation on these proposals in order to ensure that local views continue to influence the plans and future implementation.

- The STP is currently finalising the draft pre-consultation business case, in preparation for a comprehensive assurance review by the regional office of NHS England.
- At this stage, the pre-consultation business case may go through some further changes before being submitted to a national committee of NHS England (the Investment Committee)
- In the meantime, the STP will continue to work with local partners to prepare for consultation in the following ways:
    - Sharing draft versions of the consultation document with partners and service users to improve on style, content and design in preparation for publication
    - Designing with partners and service users the associated materials to support consultation, including online feedback survey, short versions of the consultation document and other support materials that may be required.

    - Setting a comprehensive programme of meetings and workshops to ensure meaningful discussion and feedback. This will include attending existing groups and committees, such as Health and Wellbeing Boards and local authority scrutiny committees.

- We are aiming to start public consultation at the end of October 2017. We have an opportunity to present our case and consultation plans to the national committee of NHS England on 4 October.

Background

Over the last eighteen months, we have been listening to what local people think about emerging proposals to make improvements to secure our future NHS in mid and south Essex.

We have talked extensively about the current pressures and rapidly rising demands; there is a broad consensus locally on the need to change. We also talked about the potential for doing things differently and how we could do much more for patients by joining services together.

People consistently tell us that the top priorities for change were *access to GP services* and *developments in community care.* We agree, and one of the main aims of the sustainability and transformation partnership (STP) that we have published is to invest in and develop these areas.

One aspect of the STP focuses on the three hospitals in the footprint and how working together as one group presents many opportunities. As a result of listening to people, we narrowed down to five from over 100 possible ways to organise services across our three hospitals. From these five, we identified two options for more detailed development, but we continued to listen to local people and this changed our thinking significantly.

Hospital services in Basildon, Chelmsford and Southend

- Over the months, we have discussed the likely benefits of consolidating some more specialised services across the three hospitals in mid and south Essex, together with the possibility of separating emergency inpatients from planned operations. We looked at options where one hospital, possibly Basildon, would provide the most serious emergency treatment.

- The implications for local A&E services became the main focus of public attention during the spring and early summer of 2017

- We described how, under our initial proposals, each hospital would retain its A&E department, but that patients with serious, life-threatening conditions are likely to have better chances of survival and recovery if they went straight to a very specialist hospital by ‘blue light’ ambulance.

A significant change in our thinking

- During the engagement period, we heard clear concerns from a range of stakeholders about proposals for all 'blue light' ambulances going to Basildon

- Our clinicians have been working to address these concerns by developing revised proposals which would see ambulances continue to convey patients to their nearest A&E, as now. Once seen by doctors in the local A&E, stabilised, diagnosed and treated, patients would then either be: discharged; referred for follow-up treatment; admitted locally for further tests and treatment; or transferred if needed to a specialist team, which could be in a different hospital for some patients.

- We wrote to all partners, staff and local groups on 20 July, to explain the change in thinking.

- Clinicians are continuing to finalise proposals for how we could improve local services at each hospital, including the local A&E; and how we could still improve patient care and outcomes in some specific specialised services.

- These recommendations are now being finalised as part of the pre-consultation business case and will present a list of specific proposals for consultation.

Our opportunity to secure funding for hospital change

- The emerging proposals are likely to involve an overall increase in bed capacity at the three hospitals.

- There would be a need to expand facilities at all three hospitals in mid and south Essex, for which we currently estimate a requirement to invest approximately £118m in the hospitals'' infrastructure.

- Alongside the pre-consultation business case, we are progressing with a bid for capital funding from the Department of Health. Should this be approved within the next few months, it does not guarantee that our hospitals would receive the money as any proposed changes are subject to public consultation, and could change.

General direction of proposals for consultation

The overall strategic direction has been the subject of local discussions for the last eighteen months. It was first published in outline on 1 March 2016 and in more detail in November 2016.

For further information, please visit our website and download a public summary of the plan entitled, *10 things you should know about your local health and care plan*
www.successregimeessex.co.uk

We will be taking this forward in the forthcoming consultation with further discussion on:

- Self-care programmes to support people to stay well for longer
- Locality based joined up health and care services to extend the range of expertise and care in the community, including a shift from hospital to community where possible
- Integrated services to provide support at the earliest possible stage to reduce the risk of serious illness, with priority development in complex care, frailty and end of life.
- Development of urgent and emergency care pathways, including integrated 111, out of hours and ambulance services.
- Integration and development of mental health services with primary, community and acute hospital care

General direction of proposals for hospital reconfiguration

The three main hospitals in Basildon, Chelmsford and Southend are now working together as a group and this offers opportunities to improve patient care by taking advantage of a greater scale for some services.

Some key features of the emerging proposals are:

- The majority of hospital care will continue to available locally, including a local A&E with enhanced services
- A small number of people may have to travel further if they need to stay in hospital for certain specialised treatments or surgery.
- Some planned inpatient care would be separated from emergency inpatients, where this would improve quality, access and efficiency, such as fewer cancelled operations and shorter waiting times.
- Over time, some hospital services could be moved, along with the funding, to new services in the community run by GP partnerships and other health and care services.

The consultation programme will discuss with local people:

- the range of services to be provided at each of the three local hospitals

- which particular specialised services are proposed for new arrangements and hospital locations
- how each hospital would have an enhanced emergency service, and how patients could be treated, stabilised and transferred to a specialist team, if that was what was needed.

The consultation document will include details of proposals for specific services, to include:

- enhanced emergency care at all three hospitals
- the addition of specialised stroke services to the network of stroke care across the three hospitals and in the wider community
- complex respiratory services
- specialised renal services
- specialised vascular surgery (for arteries and veins)
- trauma and orthopaedics (e.g. fractures, hip and knee replacements)
- cardiology (heart treatment)
- complex urology
- complex gynaecology
- complex general surgery

Timetable for progress towards consultation

Action	Dates
Finalise pre-consultation business case, draft consultation document and draft consultation plan to be shared with key partners, including local authority leaders, Service User Advisory Group and lead public representatives	September 2017
Draft consultation document and plans to be shared with local authority scrutiny committees	September 2017
Updated draft documents to be made public	October 2017
Stakeholder briefing event to discuss progress and listen to views	Mid October 2017 (TBC)

Co-production of consultation materials and planning for meetings	Sept – Oct 2017
Possible launch of consultation	End October 2017
Possible close of consultation	End January 2017
Post consultation outcomes analysis	End February 2017
Decision-making process	March 2017

If you would like further information, or would like to register an interest in being part of the preparations for consultation, please contact us at england.essexsuccessregime@nhs.net

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MEETING **Health & Wellbeing Board**	AGENDA ITEM
MEETING DATE **20 Sept 2017**	REPORT NUMBER
SUBJECT **A Better Start Southend (ABSS) Programme update**	
REPORT AUTHOR **Michael Freeston, acting Programme Director**	
PRESENTED BY **Michael Freeston**	

SUMMARY
The effective progress reported to the last H&WB in June has continued. The coproduction space in the SAVS building has been officially opened and is being used by parents and stakeholders to develop the programme's activities in partnership with the ABSS team. The financial review being undertaken by Big Lottery Fund has progressed to a point where two outstanding payments totalling £1.2m have now been received. The Service Design process to coproduce new activities in the areas of Breastfeeding Peer Support and Introducing Nutritious Foods has now begun with a range of sector specialists, service providers and parents all contributing.

RECOMMENDATIONS
Board members are asked to note progress and the current position.

1) GOVERNANCE

Following a successful quarterly review meeting in August and further progress on all aspects of the strategic and financial review, the Big Lottery Fund has transferred £1.2m of outstanding payments to the Partnership. Sarah Gibbs (BLF Finance Director) reported how pleased BLF were with recent progress. They share our view that ABSS is now on a firm footing with strong engagement from all partners and stakeholders, has a clear focus and sense of purpose. They agreed our priorities for the next phase should be on implementing new programmes through the service design process, extending links to universal providers across the borough and securing strong data management and evaluation arrangements.

At its August meeting the Partnership Board approved in principle use of the Liquid Logic data management system. With Southend Borough Council moving ahead with the use of this system for its social care and Early Help provision ABSS will be able to share relevant information in a safe and secure manner.

Appointments update

a) Programme Manager:

Two candidates were interviewed for the role of Programme Manager; Deborah Payne has accepted the role on a secondment bases from EPUT.

b) Director A Better Start Southend:

From the 20 applications two candidates were interviewed. The panel consisted of Kate Billingham (BLF advisor), Michaela Howell (Director ABS Bradford) Simon Leftley, Andrea Atherton, Jackie Dale (HR Manger Pre-school Learning Alliance) and myself. Candidates also spent an hour with parents. Their valuable feedback informed the panel's decision making.

The panel felt unable to offer the post to either candidate. Both were strong in a number of areas but tended to lean toward the operational side of management rather than demonstrating the necessary strategic leadership required for this role. This has led to a review of the focus and requirements of the role to reflect more closely the evolution of the programme around the enhanced healthy child programme. The revised role will be promoted more from a public health perspective on a rolling basis and potential candidates will be invited for an informal discussion about the role and our expectations before progressing to the formal application process.

This longer term approach is possible because the programme team is now well established and functioning effectively. The Director role continues to be covered by the Director of Quality Improvement for the Pre-school Learning Alliance. BLF have agreed proposals to extend the secondment of Deborah Payne from EPUT into the Programme Manager role until March 2018 and a further 90 days of James Boxer on a consultancy basis in the Project Manager role.

This core team will review the operational arrangements required by the Programme for the next phase of development and delivery. This review was to be undertaken once the new Director was in place but it is now felt that a delay pending that appointment is now viable.

c) Independent Chair.

No applications were received for this role by the deadline. This matter was discussed at the quarterly meeting with BLF and consideration may now be given to remunerating this role. As a result, a similar rolling process of appointment will now be applied to the search with initial, informal discussions with potential candidates being held in advance of the formal application process.

2) PROGRAMME UPDATE

a) Office Move

The Programme Office moved to its new home in the SAVs office on Alexandra Street on 1st August and an opening event is to be held on 19th September. The creation of a coproduction space where stakeholders can contribute to the process of service design, delivery and evaluation is a tremendous step forward for the programme.

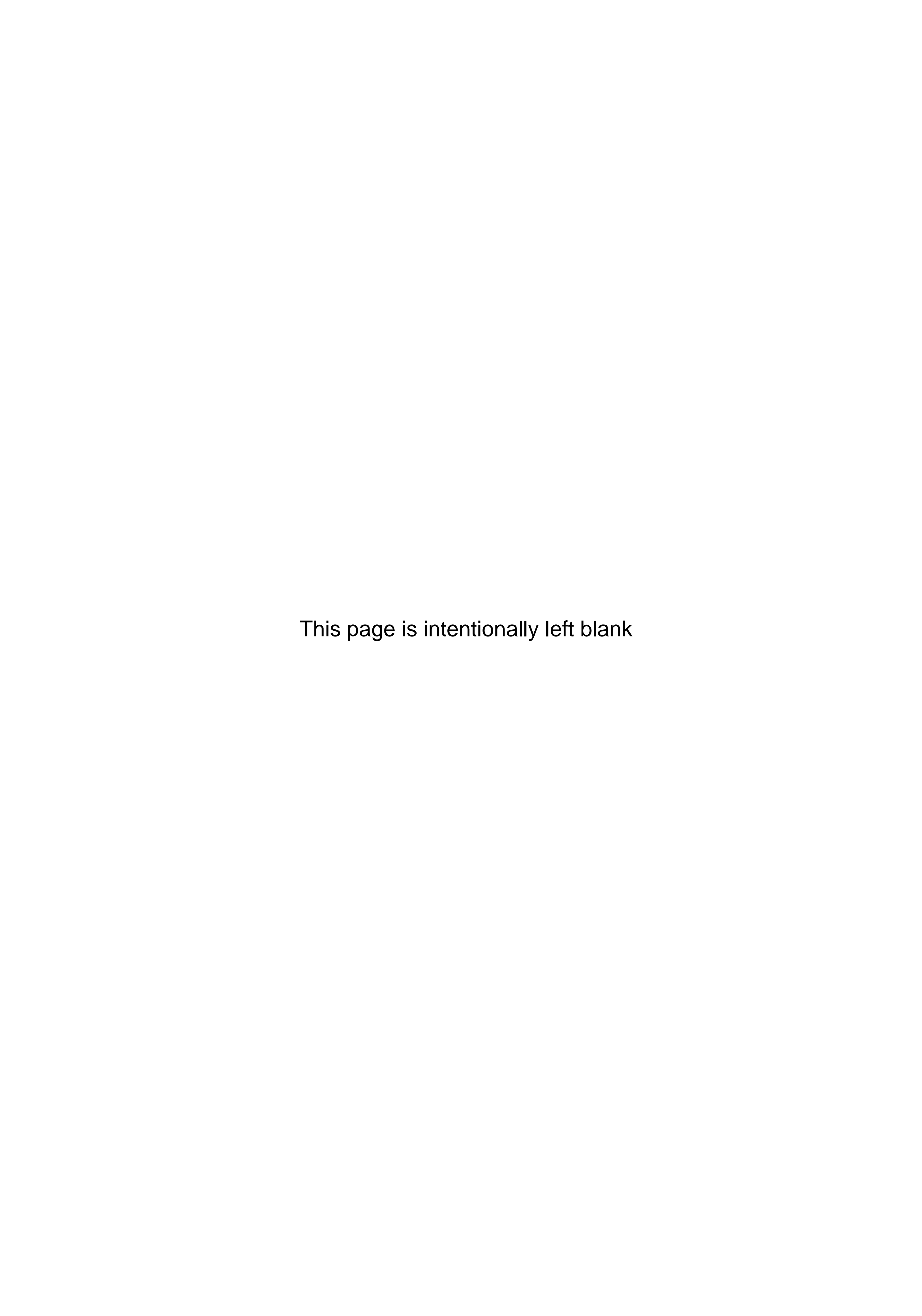
b) Strategic Operations Group (SOG)

The review of the programme will be completed by October. This will steer the direction of the programme into its next phase. The review has been informed by research undertaken by Activmob to establish family perceptions of healthy eating in the Borough. Interviews took place with parents at children's centres, foodbanks local parks. Discussions focused on general lifestyles, behaviours, access to nutritious ingredients, prevalence of take away food outlets etc. The findings will be presented to a stakeholder event on 11th September; a verbal update can be provided at the H&WB on the key issues raised and proposals for future development within the ABSS programme and beyond.

3) PROJECT SERVICE DESIGN

The first two proposed new programmes to be considered by the Programme have begun their journey through service design. A range of subject experts, providers, academics and parents contributed to an initial consideration of *infant feeding* and *breastfeeding peer support* programmes. A series of task and finish groups have been established to carry forward the work, aiming for implementation through an approved provider in February 2018.

Following on from a cross-system Perinatal Mental Health mapping exercise facilitated by MABIM (Mothers and babies in Mind), a gap was highlighted around capacity to work with mothers with mild to moderate perinatal mental health illness. It was agreed by the perinatal mental health steering group that the most appropriate way of filling this gap was to employ a specialist health visitor with a background or interest in mental health. The proposal was taken to the ABSS partnership board as an innovation based project and was formally signed off to progress to service design immediately. We anticipate that the role will provide specialist support to clinical staff working within universal services, deliver face to face support in the home and community to a small caseload of mothers, and will develop innovative community based programmes alongside IAPT (Improved access to psychological therapies) to provide a time related, clinical intervention to support mental health needs of these mothers. The programme will seek to measure the long term impact of these interventions on both the maternal mental health and parent-infant relationships.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