TOWER HAMLETS

Meeting of the

TOWER HAMLETS HEALTH AND WELLBEING BOARD

Tuesday, 5 September 2017 at 5.30 p.m.

SUPPLEMENTAL AGENDA

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Health and Wellbeing Board Tuesday 5th September 2017	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Better Care Fund, 2017-19	

Lead Officer	Denise Radley, Corporate Director, Health, Adults & Community, Tower Hamlets Council Simon Hall, Acting Chief Officer, Tower Hamlets CCG
Contact Officers	Suki Kaur, Head of Partnership Development , Tower Hamlets CCG Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead, Tower Hamlets Council
Executive Key Decision?	No

REASONS FOR URGENCY

The report was not published five clear days in advance of the meeting due the need to submit the most up-to-date possible version of the Better Care Funding Plan (BCF Plan) to the Board. The BCF needs to be submitted to NHS England by the 11th of September which means that it cannot be deferred to the next HWBB. Prior sign off by HWBB is required for submission to NHS England.

Summary

This report seeks the endorsement of the Health and Well-Being Board for the proposed Better Care Plan for 2017-19. It covers the draft Better Care Fund Narrative Plan and its associated planning template (Appendices 1 and 2).

Following the Health and Well-Being Board's consideration of the proposed BCF plan and programme at the present meeting, the Plan and template will be submitted to NHS England for assessment.

It is anticipated that Better Care Fund resources channelled to the borough via the CCG - the so-called CCG 'minimum' - will be formally approved in early October, though plans may need to be resubmitted with further information.

Once approval of funding is given, the council and the CCG will be invited formally to adopt the BCF programme, which will be reflected in a legal agreement under section 75 of the NHS Act 2006.

Recommendations:

The Health & Wellbeing Board is recommended to:

1. Approve the draft BCF plan and planning template for 2017-19, as set out in Appendices 1 and 2, subject to final amendments.
2. Agree that final sign-off of the documents should be delegated to the relevant Chief Officers of the CCG and the Council (Simon Hall and Denise Radley).
3. Note that it is proposed to increase substantially the amount of money pooled through the BCF section 75 agreement.
4. Note the timetable for the submission of BCF plans, their scrutiny and moderation by NHS England and the finalisation of the associated Section 75 agreement, as set out in paragraph 2.11.
5. Agree that, in the event of the BCF plan and template needing to be amended and resubmitted, responsibility for overseeing its production should be delegated to the Joint Commissioning Executive, and that the final version will be submitted to the 7 November 2017 HWBB for formal ratification.
6. Note that the section 75 agreement will be submitted to council and CCG decision-making bodies for formal agreement as soon as practicable following the approval of the BCF plan by NHS England, and prior to the national deadline of 30 November 2017.

1. REASONS FOR THE DECISIONS

1.1 There is a need to review and update the Better Care Fund programme. This takes the form of the submission of a draft Better Care Plan to NHS England, together with a planning template, which sets out how the BCF will be spent, performance metrics and targets and confirms that national BCF conditions have been met. The government expects Health and Well-Being Boards to approve local Better Care Plans.

2. INTRODUCTION

2.1 The aim of the Better Care Fund (BCF) is to deliver better outcomes and secure greater efficiency in health and social care services through better integration of provision. The BCF programme needs to be agreed jointly by the council and the CCG and approved by the HWBB. The jointly agreed programme is then incorporated in a formal agreement under Section 75 of the NHS Act 2006.

2.2 The Government's intends that, by 2020, health and social care services will be more fully integrated across England. BCF plans need to set out how CCGs and local authorities are working towards fuller integration and better co-ordinated care, both via the BCF and through wider service provision. Narrative plans are expected to set out the joint vision and approach for integration, including how the activity in the BCF plan will complement the direction set in the Next Steps on the NHS Five Year Forward View.

2.3 Plans are also expected to take into account the wider context, including 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 - for example other NHS programmes, such as Integrated Personal Commissioning.

2.4 In line with the drive towards greater integration of health and social care functions, it is proposed to increase the number of functions pooled via the Better Care Fund Section 75 agreement. In 2016-17, Tower Hamlets' BCF programme comprised approximately £21 million of initiatives. The majority were funded via BCF resources channelled via the CCG - the so-called 'CCG minimum' funding. In addition, Disabled Facilities Grant resources allocated to the council were also required to be pooled, alongside the CCG 'minimum'. In addition, the CCG provided further recurrent and non-recurrent funding from its own resources for a number of initiatives.

2.5 The proposed BCF plan for 2017-19 includes the above funding sources. It also includes the Improved Better Care Fund resources allocated to the council for the three-year period, 2017-20, plus funding for a number of other existing initiatives. This increases the size of the proposed pool to approximately £45m.

2.6 As part of the BCF planning framework for 2017-19, NHSE requires four national conditions to be met (reduced from eight in 2016-17):

- That a BCF Plan, including at least the minimum contribution to the local pooled fund specified in the national BCF funding allocations, must be signed off by the Health and Wellbeing Board (HWBB), and by the constituent local authority and CCG;
- A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution;

- 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
- All areas must also implement the High Impact Change Model for Managing Transfers of Care to support system-wide improvements in transfers of care.

2.7 Narrative plans need also to describe how partners will need to continue to build on improvements locally against the following former national conditions:

- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional.

2.8 Local partners are required to develop, and agree, through the relevant Health and Wellbeing Board:

- 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
- 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 (i.e Non Elective Admissions, Residential Admissions, Reablement and Delayed Transfers of Care).

2.9 BCF plans will be approved and permission to spend the CCG minimum contribution to the BCF given once NHS England and the national Integration Partnership Board have agreed that the conditions attached to that funding have been met.

2.10 For 2017-19, following discussions at the Joint Commission Executive earlier in the year, it is proposed to increase the size of the pooled fund by incorporating a number of additional CCG and local authority initiatives. The size of the pool has also been increased by the inclusion of Improved Better Care Fund (IBCF) resources, a grant paid to local authorities 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'. In addition, the BCF Plan needs to include the Disabled Facilities Grant, a capital grant paid to the council to support people to live independently in their own homes for longer.

2.11 The timetable for the submission and sign off of the BCF Plan and planning template is as follows:

BCF Plan and template submitted for endorsement by Health and Well-Being Board	5 September 2017
Tower Hamlets Together Board	7 September 2017
BCF Plan and template submitted to NHS England	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
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

2.12 A draft of the BCF narrative and template are attached as Appendices 1 and 2. As noted above, these need to be completed and submitted to NHS England by 11 September 2017. Further work will take place over the coming weeks. The Integration and Better Care Fund planning requirements for 2017-19 are attached as Appendix 3. Appendix 4 sets out the Key Lines of Enquiry which will be used by NHS England to assess and evaluate BCF submissions.

3. COMMENTS OF THE CHIEF FINANCE OFFICER

3.1 Better Care Fund (BCF) is a combination of central government funding streams that used to flow to LBTH and the NHS. The aim of the BCF is to support the integration of health and social care and to seek to achieve the National Conditions and local objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

3.2 The 2017-19 BCF Planning Guidance was published at the end of July 2017. It is anticipated that the 2017-18 Tower Hamlets BCF programme will mostly be reflective of the 2016-17 programme. The main areas of potential change will be around incorporating other services and contracts, with the aim of improving quality and efficiency for service users.

3.3 The S.75 agreement is formed of Better Care Fund CCG Minimum (BCF), CCG additional direct funding, Disabled Facilities Grant (DFG) and the Improved Better Care Fund (IBCF). The BCF is received by the CCG and amounts to £18.17m in 2017-18, of which £7.58m relates to services commissioned by the Council. The DFG (£1.734m in 2017-18) and Improved Better Care Fund (£7m in 2017-18) are received by the Council. The CCG also has additional schemes which it funds directly. Table 1 below provides a breakdown.

3.4 It should be noted that the DFG is a capital grant with conditions. It is time limited and can only be used for specific purposes that meet capital accounting criteria. The Council has established a DFG working group, which will ensure that the conditions are adhered to.

3.5 The IBCF schemes have been drawn up by the Council, with service sustainability being the priority scheme, where additional funds are deemed to be required for sustainability, this may result in the need to review and amend other schemes funded from the IBCF monies.

Table 1: Funding Summary

	2017/18	2018/19	2019/20
BCF (CCG Minimum)**	18,165,075	18,510,211*	18,861,905*
CCG Direct Funding**	16,636,731	16,952,829*	17,274,933*
DFG (Council)	1,733,988	1,895,435	1,895,435*
IBCF (Council)	7,017,243	4,200,000	2,100,000
	43,553,037	41,558,475	40,132,273

*** These items are estimates**

**** 2018/19 and 2019/20 figures have been uplifted by inflationary 1.9%**

3.6 The 2017-18 S75 agreement in place, largely addresses the relevant financial/non-financial risks and the mitigating actions. However the risk share should be reviewed regularly and reflected in the allocation. Failure to review the risk may lead to extra base budget pressures for both the Council and the CCG.

4. LEGAL COMMENTS

Better Care Fund

4.1 The Care Act 2014 places a duty on the Council to exercise its functions by ensuring the integration of care and support provision with health provision, promote the well-being of adults in its area with needs for care and support and contribute to the prevention or delay of the development by adults in its area of needs for care and support. The 2014 Act also amended the National Health Service Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

4.2 The Government provides funding to local authorities under the Better Care Fund to integrate local services. The funding is through a pooled budget which is made available upon the Council entering into an agreement with a relevant NHS body under section 75 of the NHS Act 2006. Such agreements may be entered into where arrangements are proposed which are likely to lead to improvement in the way that prescribed NHS functions and prescribed health-related functions of the Council are exercised.

4.3 In order to receive the Better Care funding, the Government requires the Council to set out its plans for the application of those monies. The Government published a policy framework for the 2017-19 Integration and Better Care Fund programme in March 2017 which indicated that plans should be agreed by the Council's Health and

Wellbeing Board ("**HWB**"), then signed off by the Council and CCG. This is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment. The 2017-19 policy framework sets out the requirements for the plan to demonstrate how the area will meet certain national conditions.

Contracting

4.4 Pursuant to section 75 of the National Health Service Act 2006, the NHS Bodies and Local Authorities Partnerships Arrangements Regulations 2000, the s75 Agreement provides for the establishment of funds made up of contributions from the Council and NHS CCG out of which payments may be made towards expenditure incurred in the exercise of their functions; for the exercise by NHS CCG of the Council's functions and for the exercise by the Council of the NHS CCG's functions in writing. In addition, the s75 Agreement covers specific objectives in relation (including but not limited) to:

4.4.1 agreed aims and outcomes of the partnership including the Council and NHS CCG's respective legal and regulatory responsibilities, and the client groups for whom the services will be delivered under the arrangement

4.4.2 operational arrangements for managing the partnership including performance and governance structures encompassing the resolution of disputes, conditions for renewal and termination of the partnership, provision and mechanisms for annual review, the treatment of VAT, legal issues, complaints and risk sharing

4.4.3 the respective financial contributions and other resources provided in support of the partnership including arrangements for financial monitoring, reporting and management of pooled, delegated and aligned budgets

4.4.4 linking in with existing governance arrangements including the role and function of the Integrated Care Board

4.4.5 achieving best value from Service Providers and principles in connection with the management of staff; and

4.4.6 flexibilities for the Council and NHS CCG in being permitted to add relevant service provisions and deciding future budgets for existing services within the remit of the s75 Agreement.

4.5 The s75 Agreement must be consistent with the 2017-19 Better Care Fund Plan approved by HWB and entering into it formalises the arrangements agreed by the Council and NHS CCG in accordance with the statutory, regulatory and guidance frameworks.

Wellbeing Principle and Equalities Duties

4.6 The Care Act 2014 places a general duty on the Council to promote an individual's wellbeing when exercising a function under that Act. Wellbeing is defined as including physical and mental health and emotional wellbeing and in exercising a function under the Act, the Council must have regard to the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist. The wellbeing principle should therefore inform the delivery of universal services which are provided to all people in the local population, including services provided through the Better Care Fund.

4.7 The Equality Act 2010 requires the council in the exercise of its functions to have due regard to the need to avoid discrimination and other unlawful conduct under the Act, the need to promote equality of opportunity and the need to foster good relations between people who share a protected characteristic (including age, disability, maternity and pregnancy) and those who do not.

Procurement Obligations

4.8 It should be noted that the section 75 agreement does not in itself satisfy either party's obligations to subject expenditure to competition as required by the Public Contract Regulations 2015 and the general treaty principles stated in the Treaty On The Operation Of The European Union. The Section 75 agreement provides for the pooling of funds but when those funds are expended on goods works and or services these obligations will apply to that expenditure.

4.9 As detailed above the Council has many statutory functions in respect of the provision of care. Section 111 of the Local Government Act 1972 provides the ancillary power to the Council to enter into contracts in the satisfaction of any of its statutory functions. It is presumed that the CCG would be similarly empowered although this should be considered as each individual circumstance requires.

4.10 It is presumed that one of the significant advantages of the pooled budget will be the ability to jointly purchase items required by the delivery of the joint service. However, the Council must satisfy itself that its own Procurement obligations have been observed. It is notable that in the event of a defective procurement where the contract was intended to be used by both parties, both parties will be liable for the defective procurement regardless of which party was carrying out the procurement activity.

4.11 Where the Council intends to make use of a contract procured by the CCG albeit to the benefit of third parties, in the absence of taking the appropriate actions (detailed below) in order to satisfy its own procurement obligations such an arrangement would be deemed to be a single supplier purchase in the absence of competition i.e. the Council will be deemed to have just picked the CCG to provide the goods / services in the absence of a Council run competitive exercise and thereby breach its own procurement obligations.

4.12 Therefore, prior to each joint procurement exercise (or on a continuing basis by mutual agreement for example within the section 75 agreement itself) the Council should clearly appoint the CCG (where the CCG is the lead procurer) as the procurement body on behalf of the Council. Also, notices advertising contracting opportunities placed by the CCG should clearly state that the Council will be a purchaser of the goods and or services as well as the CCG and any stated estimated contract value must include the value intended to be purchased by the Council.

4.13 Many of the goods and services funded out of the pooled budget will be in Schedule 3 to the Public Contracts Regulations 2015. This means that a higher contract value threshold applies of £589,148 before the Public Contracts Regulations apply but beyond this threshold each opportunity must be advertised in Europe.

4.14 The Council also is obligated to comply with its Best Value duty in accordance with Section 3 of the Local Government Act 1999 when purchasing and delivering services. The economy element of the duty will be satisfied provided that the CCG appropriately tenders each purchase and ensures that tenders are evaluated against criteria designed to discern the most economically advantageous tender in terms of a

mix of quality and price. The evaluation criteria also need to be transparent, pre-advertised and applied equally to all tenders.

4.15 The Best Value duty is not one which may be satisfied by a third party. Therefore, the Council needs to ensure that each contract and the Section 75 agreement allows the Council sufficient scope to request information and engage in such contract monitoring activities as may be required to ensure that its part of the pooled budget is being utilised appropriately and in accordance with the duty. The contracts themselves that the CCG create also require clauses in order to support the implementation of contract monitoring in order to ensure good quality service provision.

4.16 The Council also needs to ensure that any contract meets its own social and policy commitments, such as in respect of sustainability, ethical governance and the Council's London Living Wage Licence.

5. ONE TOWER HAMLETS CONSIDERATIONS

5.1 The Better Care Fund is concerned with better integrating health and social care services to people with a diverse range of illnesses and conditions. These include people with mental health problems, people at risk of being admitted to hospital and people able to be discharged from hospital with appropriate support. It also funds services concerned with Reablement - supporting people to learn or relearn skills necessary for daily living following ill-health or disability; the adaptation of the domestic accommodation of people with disabilities to enable them to live at home, and the training of staff in the use of assistive technology.

6. BEST VALUE (BV) IMPLICATIONS

6.1 The Better Care Fund is concerned with achieving best value in the health and social care economy, by ensuring that services are provided most appropriately across the system and that the allocation of resources supports efficiency improvements, as well as better outcomes for service users. It also seeks to reduce the historic problem of financial savings in one sector being achieved at the expense of additional costs in the other, through better joint planning and shared priorities.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 The Better Care Fund has no direct implications for the environment.

8. RISK MANAGEMENT IMPLICATIONS

8.1 The section 75 agreement will specify pooled funds within the BCF, commissioning arrangements and the arrangements for risk share, including how overspends and underspends will be dealt with for each pooled fund.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 The Better Care Fund is not principally concerned with crime and disorder reduction. However, several initiatives within the Improved Better Care Fund are concerned with groups at risk of offending, or community safety issues more generally. These include the establishment of a Community Multiagency Risk Assessment Case Conference (MARAC) and an independent Antisocial Behaviour Victim Advocate; a project to support people with mental health concerns who are often at risk of coming

into contact with the police and another, which seeks to reduce the potential self-harm and harm to others caused by hoarders.

Linked Reports, Appendices and Background Documents

Appendices

- Appendix 1 - Draft BCF narrative
- Appendix 2 - Draft BCF template
- Appendix 3 - Integration and Better Care Fund planning requirements for 2017-19
- Appendix 4 - A Guide to the Assurance of Plans, including Key Lines of Enquiry which will be used by NHS England to assess and evaluate BCF submissions

Local Government Act, 1972 Section 100D (As amended)
List of "Background Papers" used in the preparation of this report

- None

Officer contact details for documents:

Steve Tennison, Senior Strategy, Policy and Performance Officer – Integration Lead
E: steve.tennison@towerhamlets.gov.uk
T: 020 7364 2567

Suki Kaur, Head of Partnership Development – CCG
E: suki.kaur1@nhs.net
T: 020 3688 2356

NOTE TO HEALTH AND WELLBEING BOARD: THIS IS A WORKING DRAFT CONTAINING A NUMBER OF OMISSIONS AND SOME TEXT THAT NEEDS TO BE UPDATED. SUCH INSTANCES ARE GENERALLY INDICATED IN THE TEXT.

Tower Hamlets Integration and Better Care Fund

Narrative Plan 2017-2019

Building on our history for a sustainable future

Local Authority	**LONDON BOROUGH OF TOWER HAMLETS**
Clinical Commissioning Groups	**NHS TOWER HAMLETS CCG**
Boundary Differences	**NA**
Date agreed at Health and Well-Being Board:	**05/09/2017**
Date submitted:	**11/09/2017**
BCF pooled budget: 2017/18	**c£45m**
BCF pooled budget: 2018/19	**£xxxxm**

Contents –

1. Introduction

Tower Hamlets CCG, the council and their partners share a vision of health and social care services as a single, interconnected system. This entails joint planning, joint commissioning, the alignment of front line health and social care services, more jointly managed services and more co-location of staff teams. It also involves working jointly to design services that address common priorities, such as relieving pressure on the hospital system, supporting people in the community wherever practicable, jointly designing services that address unmet need and ensuring that the health and social care system *as a whole* secures maximum value for money.

This Better Care Plan builds on our strong achievements to date, in which a number of key health and social care services have been more aligned and additional resources have been directed towards the achievement of joint goals - not least that of supporting people to leave hospital as soon as practicable and to remain in the community wherever possible, by providing a range of community-based services.

Under the oversight of Tower Hamlets' Health and Well-being Board, the period 2017-19 will see a step change in the degree of integration of health and social care services. This will cover both commissioning functions and operational delivery. Our ambition is reflected in the doubling of resources that we propose to pool within the section 75 agreement, relative to 2016-17. This funding will be performance managed via the Joint Commissioning Executive of the council and CCG, itself an innovation of the past year.

Over the coming period, we expect to continue to increase the proportion of resources that are pooled, and extend integrated working to new service areas. This will be underpinned by the development of a joint infrastructure, including a joint outcomes framework, the redesign of front-line services to encompass more co-location and the joint management of staff, and a shared focus on services for the whole course of life.

As elsewhere in the country, health and social care services in Tower Hamlets are working under considerable pressure. In Tower Hamlets, the population is rising rapidly, as is the number of people with complex needs, at a time when resources in the health system are broadly static and resources available to the council are declining significantly. These pressures mean that very different models of operation are required, along with changes in the manner in which care services are accessed. The development of a sustainable health and social care economy will also require substantial behavioural change among the residents of the borough, if future needs are to be met within foreseeable resource levels.

Section 2 of the plan summarises the local context. Section 3 sets out the borough's vision for health and social care integration and the approach being followed in more detail. Section 4 highlights the progress made to date. Section 5 summarises the evidence base and local priorities for integration. Section 6 summarises the schemes within the BCF plan. Section 7 summarises progress against the national conditions of the BCF, while Section 8 summarises the main funding contributions in more detail. Section 9 outlines the governance arrangements for the programme. Section 10 considers issues of risk. Section 11

addresses national metrics and Section 12 outlines the borough's approach to delayed transfers of care.

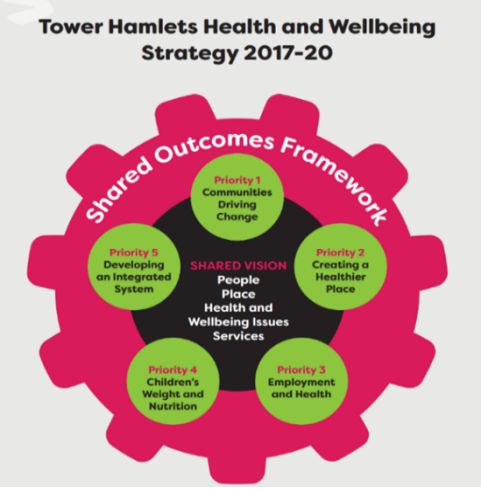
This plan was endorsed in draft by the Tower Hamlets Health and Well-Being Board on 5 September 2017 and the Tower Hamlets Together Board on 7 September 2017. These bodies include the senior representatives from the Council, the CCG, Barts Health, East London Foundation Trust, Tower Hamlets GP Care Group and the local voluntary sector.

2. Background and Context to the Plan

2.1 Our History is Important

We have a strong history of transforming health and social care in Tower Hamlets, and of primary care in particular. We are widely recognised as leaders in this area. We won CCG of the year in 2014 and have been awarded Pioneer and Vanguard status by central government. In 2017, Tower Hamlets CCG was rated 'outstanding' by NHS England. But most importantly, we have made a difference to people's health and care, and achieved better outcomes for patients who often are the most deprived, such as improved outcomes for people with diabetes, including reduced rates of unplanned hospital admissions.
We believe that a connected system of health and care organisations is good for the health of the population. Our overall vision for Tower Hamlets is to improve health and wellbeing through all stages of life (Health and Wellbeing Strategy: 2017-2020 Link Needs to be activated). We outlined our vision for integrated care across the borough more than a decade ago. The refreshed Health and Wellbeing Strategy: Towards a Healthier Tower Hamlets (2017-20) has five strategic priorities, one of which reaffirms the commitment to integration:

1. Communities Driving Change – changes led by and involving communities
2. Creating a Healthier Place – changes to our physical environment
3. Employment and Health - changes helping people with poor working conditions or who are unemployed
4. Children's Weight and Nutrition - changes helping children to have a healthy weight, encouraging healthy eating and promoting physical activity
5. Developing an Integrated System - changes which will join up services so they are easier to understand and access.



We have a history of working with other health, care and community partners to organise ourselves in a way that focusses on the needs of patients and the population and we continue to build on these foundations. This began with the formation of eight networks of GP practices in 2009 which later joined together to form the GP Care Group (GPCG). We then went on to form the Tower Hamlets Integrated Provider Partnership which, subsequent to receiving Vanguard funding, relaunched as Tower Hamlets Together, with a broader perspective. It is through this partnership we are really starting to see change happen, which will be picked up later in this plan.

2.2 Our population

Tower Hamlets has an estimated resident population of 304,900 people, with an unusually young age profile. This is the first time the area's population has exceeded 300,000 since before the Second World War. The borough's population has the fourth youngest median

age in the UK, at 30.6, and nearly half of our population is aged 20-39. Only 6% (18,000) of the population is over 65. (According to GLA projections, the population will rise from 297,800 in 2016 to 364,500 in 2026.) It is expected to be the fastest growing borough in London and one of the fastest growing local authorities in England over the next ten years.

Based on the census, 31% of the population is classified as White British and 32% Bangladeshi, though this distribution varies substantially across different age groups. The White British, White Irish and Black Caribbean populations in the borough have older age profiles compared to other groups, while residents from mixed ethnic groups, the Other Black group and the Bangladeshi group are all characterised by younger age profiles, with higher proportions of children. Over one third of the Bangladeshi population is children aged under 16, compared with only 9 per cent of White British residents. Conversely, only 5% of Bangladeshi residents are aged 60 or over, compared with 16 per cent of White British residents. Given the contrasting age profiles of the two largest populations, the ethnic makeup of the population varies significantly by age. The proportion of residents that are White British rises with age: 15% of the borough's children (aged under 16) are White British compared with almost two thirds (63%) of the population aged 75 and over. More than half of the borough's children are Bangladeshi.

Headline health indicators indicate significant health inequalities between Tower Hamlets and the rest of the country. Both male and female life expectancy is shorter than the national averages (male life expectancy is 78.1 years and female life expectancy is 82.5).

Older adults are generally expected to have higher than average population growth. While residents aged 90+ are by far the smallest group in number, this group is expected to nearly double over the next decade, growing faster than any other. The population of residents in their forties, fifties, sixties, and seventies is also expected to grow faster than the average for all residents, increasing the pressure and demand on adult social care services.

Compared to London, when adjusted for age, Tower Hamlets has amongst the highest premature death rates for circulatory disease (103.3 per 100,000), cancer (150.9 per 100,000), and respiratory disease (40.4 per 100,000). These conditions typically constitute 75% of all premature deaths. Death rates vary across the borough and in general are higher in areas of higher deprivation.

Tower Hamlets has a higher rate of deaths that occur in a hospital, as opposed to other locations, (59%) than the national rate (47%). Around 1,000 Tower Hamlets residents die per year, of whom around 780 will need some form of last years of life care. Our aim is that care should focus on reversing/ stabilising or effectively managing deterioration in functional or health status, with palliative care as an integral component, in line with our shift of focus from palliative care to a wider Last Years of Life perspective.
Find out more from the Joint Strategic Needs Assessment here. Needs to be activated

2.3 Our Aims

Our principal aim for health and care services is of an integrated care system that coordinates care around the patient and delivers care in the most appropriate setting. Services will therefore:

- Empower patients, users and their carers
- Provide more responsive, coordinated and proactive care, including data sharing information between providers to enhance the quality of care
- Ensure consistency and efficiency of care.

Building upon the successes of the Waltham Forest and East London Pioneer initiative and the Tower Hamlets Vanguard UK New Care Model programme, we are also seeking to develop new models of care that that provide better outcomes for local people but in more economically sustainable ways.

The development of our integrated care strategy is within the overarching strategic framework of the borough's Health and Wellbeing Strategy, which aims to:

- Improve health and wellbeing throughout all stages of life
- Reduce health inequalities; and
- Promote independence, choice and control.

Our strategic partnerships to achieve these aims through the Better Care Fund in the period to 2020 are set out below and our local vision and approach is described in more detail in Section 3.

2.4 Our Partnerships for Health and Social Care Integration

The Care Act 2014 places a duty on Health and Social Care organisations to make evidence-based integrated care and support normal practice. Tower Hamlets' approach to health and social care integration is underpinned by strong partnership arrangements that have evolved over a number of years. The borough is currently taking a number of further steps to strengthen its partnership arrangements in line with the objective of securing integration by 2020. We recognise that as well as strengthening our partnership approach within the borough, it is also important to ensure we have strong relationships outside of Tower Hamlets, particularly as part of the Waltham Forest and East London footprint, known as WEL, and the East London Health and Care Partnership (ELHCP) as part of the STP.

(a) Health and Well-Being Board

The Health and Wellbeing Board (HWBB) sits at the apex of the borough's health and social care partnerships, and contains senior representatives from the local authority, the CCG, Barts Health, East London Foundation Trust (ELFT) and the local voluntary sector.
As noted above, one of the five strategic priorities of the refreshed Health and Wellbeing Strategy: Towards a Healthier Tower Hamlets (2017-20) is concerned with the development of an integrated health and care system.

(b) Tower Hamlets Together (THT)

The early establishment of the Tower Hamlets GP Care Group allowed for the creation of a provider partnership that encompassed partners across the health and care system, which as part of the vanguard status allowed this partnership to launch as Tower Hamlets Together (THT).

THT was established to take forward service design and secure operational arrangements for integrated health and Adult Social Care (ASC) services. This is a partnership arrangement made up of commissioners and providers of acute, community, mental health, social care and primary health services, from the following organisations:

- Barts Health NHS Trust
- East London Foundation Trust
- Tower Hamlets Council
- Tower Hamlets GP Care Group
- NHS Tower Hamlets Clinical Commissioning Group

THT attracted resources from central government through the 'Vanguard' programme, which has allowed it to establish a range of projects to improve health and care through partnerships across the borough. These initiatives complement our commissioning work streams and the BCF funding. THT members are developing close working links with wider partners including the local community, voluntary sector and hospice and have developed a Stakeholder Council for the borough, which is described later in this narrative.

THT's Vanguard status means that it has taken a lead on the development of new care models, which will act as blueprints for the health and care system nationally. The THT Board has provided a lead for strategic and operational decisions regarding health and social care integration, and has set up various sub-groups to deliver schemes or to identify operational or quality assurance issues. One of the sub groups is the Complex Adults Programme Board, which was previously known as the Integrated Care Board. This Programme Board is the working group for the delivery of the BCF.

At present, the THT Board and sub-group structure are able to make 'in principle' decisions which must then be ratified by referral to the relevant body within LBTH, the CCG, provider boards or the Joint Commissioning Executive (JCE). As outlined below, the governance and accountability structure of THT is currently under review and its role is set to be enhanced. This is to sustain and embed the partnership model following completion of the Vanguard programme in April 2018.

In June 2017, a decision was taken that the THT Board would report directly to the Health and Well Being Board. New substructures are currently being developed for particular aspects of the partnership's work, and consideration is also being given to how different organisations can best delegate responsibility and accountability to the THT Board and its sub groups, to improve the effectiveness of the partnership, whilst taking into account the autonomous nature of THT's member organisations. THT is now being regarded as the central driving force for the future of health and social care integration in Tower Hamlets, taking a whole population approach. The draft governance chart is described later in the programme governance section of this narrative.

(c) Joint Commissioning Executive (JCE)

In line with the desire of the CCG and the council to integrate health and social care commissioning functions more effectively, a Joint Commissioning Executive was established in 2016. This is responsible for the joint strategic commissioning of services in Tower Hamlets for children and young people, adults and public health.

The JCE is also responsible for coordinating the development of joint strategies for health and social care and ensuring necessary arrangements are in place to implement strategies and procure service changes. In addition, it is responsible for strategic market development and management and overseeing plans to re-commission and de-commission services, as well aligning this work with joint strategic procurement plans.

The JCE reports key decisions to the Health and Wellbeing Board and related Delivery Boards, as well as to relevant executive and governing bodies of the council and CCG. It has proven to be an effective forum for discussion and the development of shared strategic goals and operational programmes under the BCF and has decision making powers in respect of the BCF as agreed and set out in the BCF s75 agreement. It is made up of senior officers from the council and the CCG. It is not currently a formal sub-committee of the HWBB so is not able to make 'key decisions' on behalf of its component organisations. However, in line with the development of THT, its terms of reference, along with those of the Health and Well-Being Board, are currently under review.

The CCG and council are currently going through the process of jointly appointing to a Director of Integrated Commissioning. This appointment is a strong signal of how eager Tower Hamlets is to continue moving forward on our journey to integrate health and social care. Following this appointment the first task of the post holder will be to establish a Joint Commissioning Hub, which we hope to operationalise by April 2018.

(d) The Alliance Contract – TH Community Health Services (CHS)

Following the re-procurement of Community Health Services, an Alliance Contract was awarded in April 2017 to the GPCG, ELFT and Barts Health. They were also successful in bidding for the Health Visiting Service. This was an important milestone for the future of service delivery in Tower Hamlets, as organisations come together to deliver key outcomes under a central contract adopting a risk-share approach. Among the benefits of the Alliance model are that it allows for flexibility of scope and scale, and so can respond to different levels of organisational readiness and service scope.

It is important to include the Alliance contract in our context, because its scope is likely to increase over time as organisations and Alliance arrangements mature, and can weather other organisational and political change. For instance, the Alliance could take on more services, such as those commissioned/ provided by the local authority and voluntary/independent sector in the future. This future vision would complement the THT structure.

(e) Waltham Forest and East London – WEL Partnership

The case for change was developed across the three boroughs of Waltham Forest, Tower Hamlets and Newham, which in October 2013 became the WEL Integrated Care Pioneer,

and is now subsumed within the Transforming Services Together (TST) programme. Each borough within the programme has its own integrated board, reporting to the local HWBB. This ensures the inclusion of local factors within each borough's plans. However, there are many benefits to working at scale, in terms of development of enablers (for example, information sharing and governance and workforce development programmes).

The TST programme is monitored by the TST Board at the WEL level. The TST Board is made up of clinical and non-clinical executives from Tower Hamlets, Waltham Forest, Newham CCGs and Barts Health and Local authority representatives. The WEL governance structure, which mainly focuses on A&E delivery and Urgent Care delivery, including the TST Board, is undergoing a review so that its governance better reflects the emerging accountable care approach at a local borough and STP level.

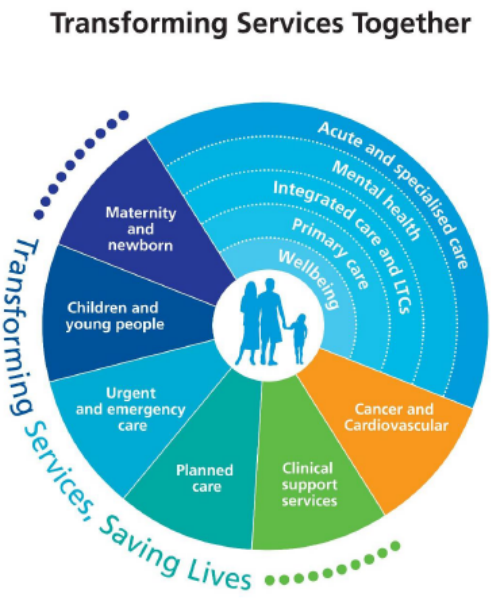
The WEL CCGs have developed and agreed strategic objectives and appropriate performance indicators. In drawing up metrics to monitor the delivery of the joint vision over the next five years WEL considered some of the key issues facing the local NHS:

- Newham and Tower Hamlets have lower than median life expectancy compared to national figures and have a higher level of potential years of life lost than the rest of the country
- There are high levels of childhood obesity
- Overall, WEL has lower than London average prevalence of health conditions, with the exception of obesity and diabetes. However, this masks a very high prevalence of common conditions in Tower Hamlets and Newham
- Vaccination rates are low in children (with the exception of Tower Hamlets)
- Use of acute services is high (bottom quartile A&E attendances), although there are lower levels of ambulatory sensitive admissions
- Providers in WEL have low Summary Hospital Mortality Indices (SHMI), low levels of falls and medication errors. There are few delays to transfers of care but trusts are in the bottom quartile for emergency readmissions
- Access to services is in need of improvement with poor access to GP services and poor patient satisfaction of both GP and acute care
- Mental health and learning disability care in WEL are delivering outcomes that are near or better than the national median.
- Community care also delivers above median outcomes in all areas except for immunisation of children (except for Tower Hamlets that performs higher than the median for immunisation).

The WEL CCGs agreed that the objectives of the five year plan should be:

- Excellent health and care services
- Integrated care
- Stable and thriving health economy
- Improvements in health and inequalities
- The same quality for mental health services as physical health.

The WEL partnership vision, upon which our STP plan is based, is a health and care service that is comprehensive and co-ordinated; where patients are put in control of their own health and well-being. We recognise the performance and quality challenges that we currently face as a system and we plan to deliver services that will be clinically safe, of the highest quality, efficient and easily accessible.



(f) Transforming Services Together (TST)

Transforming Services Together is a programme across WEL which aims to achieve the above objectives. The diagram on the left shows shared functions that focus on particular groups' needs, and cross cutting transformation programmes that reach across disease and population group boundaries.

Transforming Services Together addresses the longer-term changes that need to be made to the WEL health economy to meet the national, London-wide and local challenges and drivers. It will deliver improvements in productivity and ensure the quality of urgent and emergency care across the health economy.

The Better Care Fund is a key enabler for delivery, as it facilitates the integration of services, and the reduction in demand for acute emergency activity through better proactive care and a coordinated response to changes in individuals' needs. By pooling budgets across health and social care, it mitigates the risk of cost shifting, and allows commissioning partners to share in the benefits of greater coordination. Activity funded through the Better Care Fund will enable the delivery of this strategy.

(g) East London Health and Care Partnership – The Sustainability and Transformation Partnership

One of the new things that the Five Year Forward View (5YFV) mandated was the establishment of Sustainability and Transformation Plans (STPs) – a plan to achieve sustainability across a geographical 'footprint'. In East London this became the North East London (NEL) STP, now renamed the East London Health and Care Partnership (ELHCP). The ELHCP is still emerging, with the most recent set of plans being submitted at the end of March 2017. It has recently set up a Board with an independent chair. The STP has chosen to focus on certain areas, where it makes sense to do so over a larger footprint – such as workforce, and financial sustainability. In terms of delivery across the Waltham Forest and East London (WEL) area, Transforming Services Together (TST) has been coordinating joint activity across the Barts Health 'footprint', and in many ways a lot of what the STP seeks to achieve will be delivered through TST. Tower Hamlets' BCF-funded initiatives will dovetail with the ELHCP and TST wherever it is appropriate to do so. The transformation vision for the ELHCP is delivered through a shared framework developed for better care and wellbeing by:

- Promoting prevention and personal and psychological well being
- Promoting independence and enable access to care close to home
- Ensuring accessible quality acute services for those who need them.

2.5 Current state of the health and adult social care market

Needs Health perspective

Tower Hamlets has a wealth of organisations contributing to the health and wellbeing of our residents. Many of these are small and locally-based, such as pensioners groups, lunch clubs, with some nationally-led bodies with local bases. However, many organisations, including statutory services, whilst valuable, provide and commission more 'traditional' services. We want to work in a co-productive model with residents and partners to look at different models of meeting local needs, and building on people's support networks to maximise their independence.

The overall number of residential care and nursing home beds in the borough is low compared to other London and England authorities, with relatively low numbers of people paying for their own care from their own resources. We also have Extra Care Sheltered Housing schemes. But analysis of how we use these and whether we have the right configuration will be critical as our residents' needs change.

Tower Hamlets wishes to stimulate a diverse market for care and support offering people a real choice of services and skills. To achieve this aim, the council recognises that it needs to know how best it can influence, help and support the local market for support and related services such as employment support, community activities, advocacy, and information and advice to achieve better outcomes and value.

It is producing a Market Development Strategy underpinned by Market Position Statements (MPS) across five thematic areas (Ageing Well, Carers, Autism, Mental Health, Learning Disabilities) to initiate a new dialogue with care providers in our area where:

- Market information can be pooled and shared.
- The council is transparent about the way it intends to strategically commission and influence services in the future and how it wishes to extend choice to consumers of care and support.
- Services and workforce skills can be developed that people experiencing problems need and value.

- Developing social capital and strengthening social connectivity for people will become more significant in commissioning intentions.

The Market Development Strategy is aimed at existing and potential providers of adult social care support, including those who do not currently work in the borough and new start-up organisations. It reflects the council's intention to develop stronger and more effective partnerships between the council, people who use our services, carers and providers which will be needed to deliver the challenge of delivering the vision of ensuring our services are:

- Person led and ambitious – seeing people as individuals and focussing on the outcomes they wish to achieve
- Integrated – working in partnerships with individuals and with organisations
- Sustainable and cost effective – whilst maintaining high quality service provision which safeguards our service users and carers from harm
- More Enabling – offering greater choice for our service users and their carers, allowing them to be 'in control' of what and how services are provided and how those services contribute to meeting the outcomes that are important to them

The council is committed to stimulating a diverse, active market where innovation and energy is encouraged and rewarded, where poor practice actively discouraged and vulnerable adults remain safe. We want to have a dialogue with all providers with or desiring a presence in the borough, whether a micro provider or a national organisation.

The council and the NHS locally also commission a range of information and advice services for our local population. This can be face-to-face, telephone based advice or web based. We would want to ensure a more coordinated response.

In Tower Hamlets, people typically develop poorer health around ten years earlier than the rest of London and England, which impacts on their ability to maintain their employment. This can affect people psychologically and physically and the council, the NHS and voluntary organisations are working on programmes, such as social prescribing, apprenticeships, volunteering and pathways into employment to address this agenda. We want to do more in this area.

Overall, we are looking to adopting a strong co-productive approach with providers and people who use services, and this needs to be part of everything we do. Co-production is an opportunity to determine that local assets are available to meet local needs and enables us to focus on meeting our service user outcomes not what works best for us.

Our intention, in commissioning services and meeting needs, is to increasingly base our commissioning approaches on achieving planned outcomes. This needs to be co-produced by people who are using or may use adult social care in the future and will best be achieved by close collaboration with key services, such as public health, housing and NHS partners.

2.6 Key issues and challenges that the plan will aim to address

The Tower Hamlets Joint Strategic Needs Assessment highlights long standing issues of poorer health outcomes in the borough compared to most other parts of the country. The borough scores highly in terms of the wider determinants of poor health (income, poverty, housing, employment) and the main risk factors for health (smoking, poor diet, low levels of physical activity, problem drinking, and suchlike). Consequently, the borough's population experiences higher than average levels of illness, notably in relation to heart disease, stroke, diabetes, lung disease and lung cancer and poorer survival rates (e.g. in respect of cancer).

As set out in more detail in Section 2.2, the borough is continuing to undergo a period of rapid population growth. The services provided through the Better Care Fund closely reflect needs in the borough identified in the Joint Strategic Needs Assessment (JSNA) and other data sources.

To address these population health characteristics, health and social care organisations in the borough are taking a preventative approach, designed to reduce the prevalence of long term conditions, and promote better management of such conditions, where these exist.
As well as the burden of ill health, the high levels of need also place additional pressures on the health and social care system, where, too often, hospital care is the fallback position.
Although covering a wider range of functions than in 2016-17, this BCF Plan is built upon earlier years' plans, and shares the following themes:

- Strengthening our community, mental health and primary care teams to be more integrated and getting them to drive their own quality improvement through the primary care NIS scheme, RAID and the Extended Primary Care Teams.
- An emphasis on reducing pressures on hospitals through seven-day working by the local authority's hospital social worker team and the community equipment team service
- Strong and proactive Reablement and community equipment/assistive technology services that seek to intervene as early as practicable and thereby reduce pressures on the hospital system, and reduce the need to use of care homes.
- Wide-ranging support to carers, including Develop this

One of the key contextual differences for the period 2017-19, compared to previous BCF planning periods is the emerging sub-regional approach to health and social care services in East London, via with the East London Health and Care Partnership. Tower Hamlets will continue to engage with the STP process, while reserving its position on specific issues.

3. What is the Local Vision and Approach to Health and Social Care Integration?

3.1 Implementing our vision through partnership

This section sets out in more detail how we are implementing the local vision outlined in Section 1 and 2, above, including how we are continuing to deliver former national conditions 3-6 in the 2016-17 BCF policy framework, concerned with seven-day services; data sharing; a joint approach to assessment and care planning an agreement on any substantial impacts of changes on providers. It also the highlights the emergent interface between borough-level activity and that of the East London Health and Care Partnership, the Sustainability and Transformation Partnership for North East London.

In the introduction to this plan, it was indicated that Tower Hamlets CCG, the council and our partners share a vision of health and social care services as a single, interconnected system. This entails joint planning, joint commissioning, the alignment of front line health and social care services, more jointly managed services and more co-location of staff teams. It also involves working jointly to design services that address common priorities, such as relieving pressure on the hospital system, supporting people in the community wherever practicable, jointly designing services that address unmet need and ensuring that the health and social care system as a whole secures maximum value for money.

The Tower Hamlets Health and Well-Being Strategy for 2017-20, which has been adopted by all local partners, including the voluntary sector, includes a number of desired outcomes for a more integrated system, based on community engagement and ownership. We want more people to say that:

- They have easy access to information, advice and guidance which helps them to find what they need.
- They find it easy to get help from their GP practice and they can contact their Care Co-ordinator whenever they have any questions.
- There are different people involved in supporting them but everyone listens to what they want and helps them to achieve their goals.

To reconcile rapidly increasing needs and declining resources, health and social care providers in the borough are participating in a number of partnership arrangements. These are all seeking to develop more sustainable services through the adoption of new care models and new ways of working, sometimes involving the radical redesign of services.

This includes increasing the emphasis on preventative services; reviewing the way services are funded, in order to remove incentives that do not promote the economic sustainability of the health and social care system and looking for further ways to break down barriers between health and social care services. We are jointly designing new pathways, creating more holistic commissioning approaches and forging ahead with integrated commissioning, as the best means possible to meet the financial challenges ahead.

A further strand of our vision for the future of health and social care services is that people should be empowered to exercise more control over their health and wellbeing - and their care packages - and remain independent wherever possible. The borough's Health and Wellbeing Strategy makes a commitment to involve service users, carers, voluntary organisations and other service providers in shaping the services we provide. In the last year, the borough has developed a number of partnership strategies (e.g. Carers, Ageing Well, Adult Autism and an Adult Learning Disability Strategy) that will underpin our commissioning activity for the next 3-5 years. All were co-produced and this is now the agreed approach for all aspects of the commissioning cycle.

In a similar vein, the Health and Well-being Strategy also proposes a 'Health Creation' programme. In this, residents identify issues impacting on health and wellbeing and then participate in helping to develop and lead new ways of improving health and wellbeing locally. The strategy also proposes to deliver a programme across the partnership to promote a shared organisational culture that empowers people to be in control and informed about how to improve their health.

The aims of the Health and Wellbeing Strategy also accord with the principles underpinning the Care Act 2014, which place the individual at the centre of the process by which care services are determined and delivered. The local authority has introduced a practice framework, which aims to ensure that individuals are fully engaged in assessments; that issues are seen from their perspective, and that their opinions count when service needs are assessed.

In addition, the council and its health sector partners are taking active measures - not least via the Better Care Fund and Improved Better Care Fund - to address needs in community settings wherever practicable, thereby relieving pressures on local hospitals. Our model is based on the principles of care closer to home and is proactively focused on admission avoidance and speedy discharge from acute settings.

Our approach is aligned very closely with the local health and social care integration partnership, Tower Hamlets Together's, objective of delivering citizen-led care, and is reinforced by the responsibilities that the Care Act 2014 places on the council to promote wellbeing through prevention.

An additional benefit of integrated working is the opportunity to commission services jointly, reduce duplication and pool resources through multi-skilled, multi-disciplinary teams. All of these changes form part of a significant culture change that is taking place in the borough under the aegis of Tower Hamlets Together, the Tower Hamlets Health and Well-Being Board and the Joint Commissioning Executive. To support the process of change, healthcare organisations and the council are continuing to invest additional resources in learning and development, and provide tailored support to system leaders, service managers and staff teams.

As described in greater detail in Section 2, work is currently being undertaken to develop the role of Tower Hamlets Together. It is expected to become the lead partnership for integrated health and social care, under the strategic oversight of the Health and Well-Being

Board. It will also be closely linked to the Joint Commissioning Executive, which will propose the allocation of resources and the form of services provided. In its new role, Tower Hamlets Together will provide a forum in which commissioners and providers jointly address the financial challenges facing the borough and identify the most appropriate forms of service design to meet the needs of the community.

Over the last few years, a number of new developments have occurred nationally that will continue to change the way that health and care organisations work to deliver more joined-up care for patients and this translates locally for us by continuing the long standing work we have been doing with integrated care. While the STP looks at where we can do things across a wider footprint, we continue to develop integrated care with a local, Tower Hamlets focus.

We know a local focus is particularly important for primary and community care services, which aim to support those with the highest continuing needs, in a seamless way. We can deliver this by commissioning in a new way. The CCG and council have been working to develop their commissioning processes to allow greater alignment with other organisations'.

3.2 New approaches to commissioning and service redesign

Around three years ago the CCG decided that it could achieve more for patients by taking a new approach to commissioning, based on outcomes and not activity. In practical terms, this means it commissions services based on what is important to patients and service users, as opposed to traditional output-based commissioning (e.g. number of appointments). The CCG has also been exploring the potential of 'capitated budgets'. This is where organisations pool budgets and take on a shared agreement to achieve outcomes for the population, whilst sharing the risk. The East London Health and Care Partnership (STP) is currently consulting on payment reform proposals. These proposals were initiated in Tower Hamlets, through work on capitated budgets. We are aware that, in order to make the changes to health and social care, the contracting and payment models need to support us to do so.

The largest 'outcomes-based' contract developed by Tower Hamlets CCG is the CHS contract, which was put out to tender in 2014 and awarded in 2017. This is the contract known as an Alliance contract, mentioned above, through which the CCG has more ongoing involvement in co-ordination of the contract than in conventional CCG contracts. A significant part of the CCG BCF activity sits as part of this new model. The objectives set out in the new CHS Alliance Contract include:

- A Single Point of Access (SPA) for all health and social care services
- Extended "whole person care" primary care teams
- A new integrated community rehabilitation service
- A rapid access integrated frailty assessment service
- A new model for children's services, provided from one site, with the aim of developing a comprehensive integrated delivery model for children
- Specialist services for adults working across acute and community settings
- IT that works, with mobile working fully rolled out

- Piloting new ways of working (e.g. the Buurtzorg approach to community nursing and home care)
- Developing a "five partners, one way of working" culture
- Supporting staff to develop quality improvement tools and techniques, with the freedom to test creative solutions to problems
- Promoting prevention and self-care, including through social prescribing and a wellbeing hub.

In addition, the council is currently undertaking a wide-ranging review of its operational adult social care services, with a view to moving towards the alignment of social care and local health services by 31 March 2018, followed by their full integration. The initial phase of this work is being funded through the THT Vanguard. The envisaged changes will build on a number of initiatives that are funded through BCF, including the Community Health Social Work Team, as well as a number of other initiatives (e.g. the proactive use of Reablement to reduce pressure on the health system; the work of the seven-day hospital social work team and the community equipment service).

Tower Hamlets' approach towards health and social care integration encompasses much more than health and social care services, narrowly defined. Through the Health and Well-being Strategy and, in particular, the work of Tower Hamlets Together, it is concerned equally with the wider determinants of health, including housing, the environment and employment. For instance, a Population Health Strategy is being developed under the THT partnership to embed a prevention approach across the system that will focus on the wider determinants of health, with the long-term aim of reducing health inequalities.

The nationally recognised GP Care Group, with its eight GP networks across the borough, is also a key part of the borough's approach to integrated care. These networks have been evolving since 2009 and helped Tower Hamlets win the original bid to become a Multispecialty Care Provider (MCP) Vanguard site. The strong GP collegiate working arrangements provided the foundations for the new locality-based boards and Multi-Disciplinary Team ("MDT") arrangements now operating across the borough. The locality based boards are undergoing revision and are expected to become multi-agency local Health and Wellbeing Committees, with a wider remit than hitherto, that will involve not only the delivery of integrated care but also delivery of the broader population health strategy referred to above.

A further example of cross cutting work is the establishment in 2017 of a cross divisional DFG Working Group within the council, which is described in more detail in Section 6, below. During 2017-18, this Group will review the DFG programme, consider a pathway redesign for the grant and investigate the scope for greater integration of the DFG with assistive technology and other Home Care services.

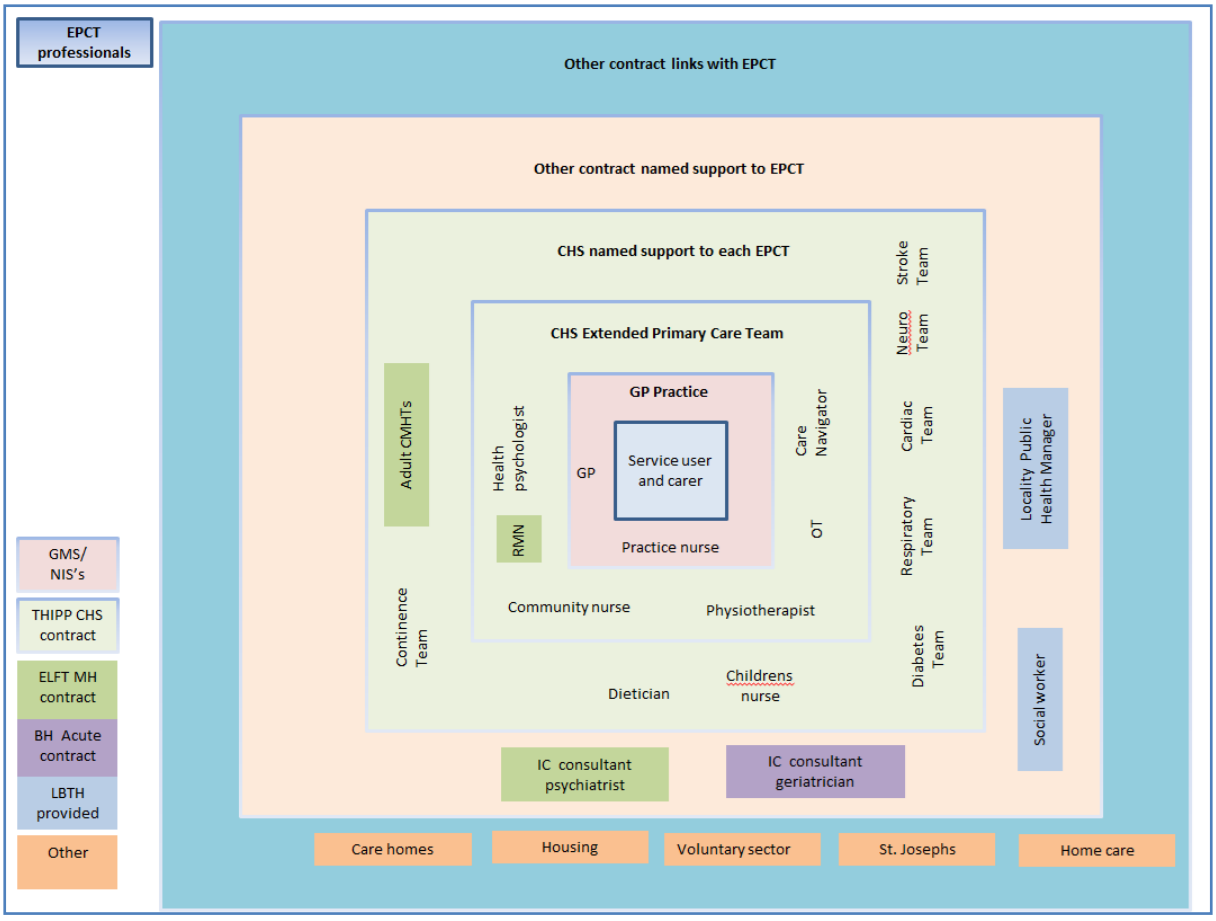
Linkages with the STP and its subsidiary structures were outlined in the previous section. The borough will engage constructively with these structures as their priorities and mechanisms for delivery become clearer. To be developed

3.2.1 ***Commissioning Innovation***

We recognise that we cannot deliver the changes and improvements we seek by doing things the way they have been done in the past. We see the providers of care for the borough's population as:

- being focused on outcomes, not inputs and outputs
- putting user involvement and experience at the heart of what they do
- working together to coordinate their services around individuals needs

Our community health services contract has been developed with these principles in mind, with a new model of care that wraps services around patient needs:



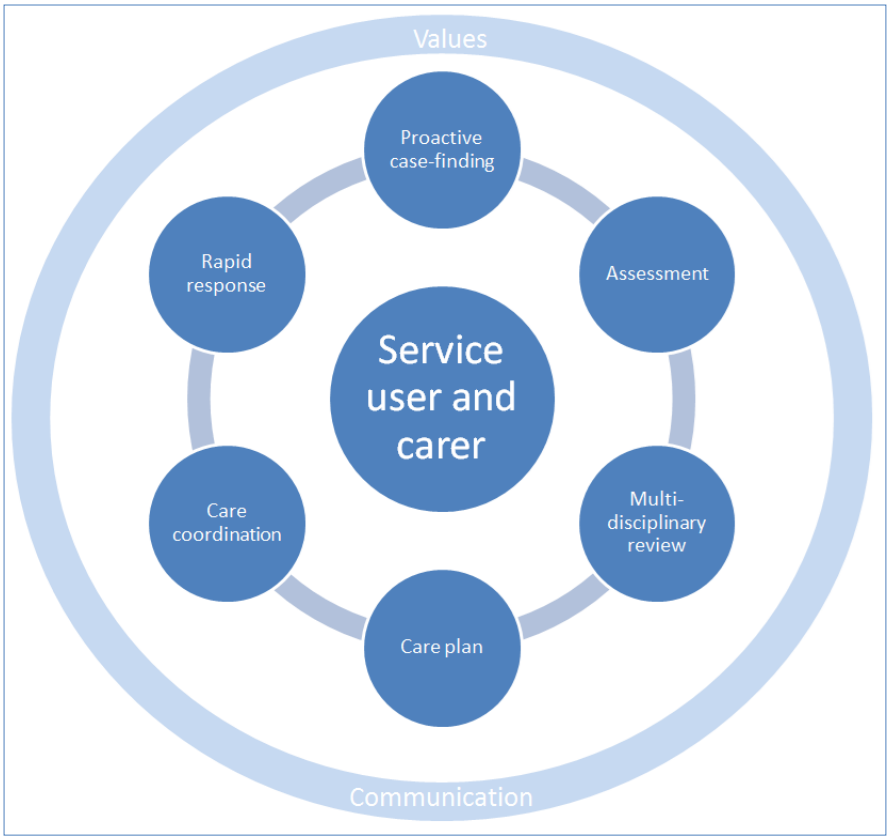
At the heart of the new model are Extended Primary Care Teams (EPCTs), locality-based services which include community nursing, occupational therapies, physiotherapy, clinical management and administration. Each EPCT has named support from specialist teams (e.g. diabetes, stroke, neuro, continence etc.), together with health psychology and mental health professionals in order to provide a whole person mental and physical health service. We are currently working together to align social care to these locality based teams going forward.

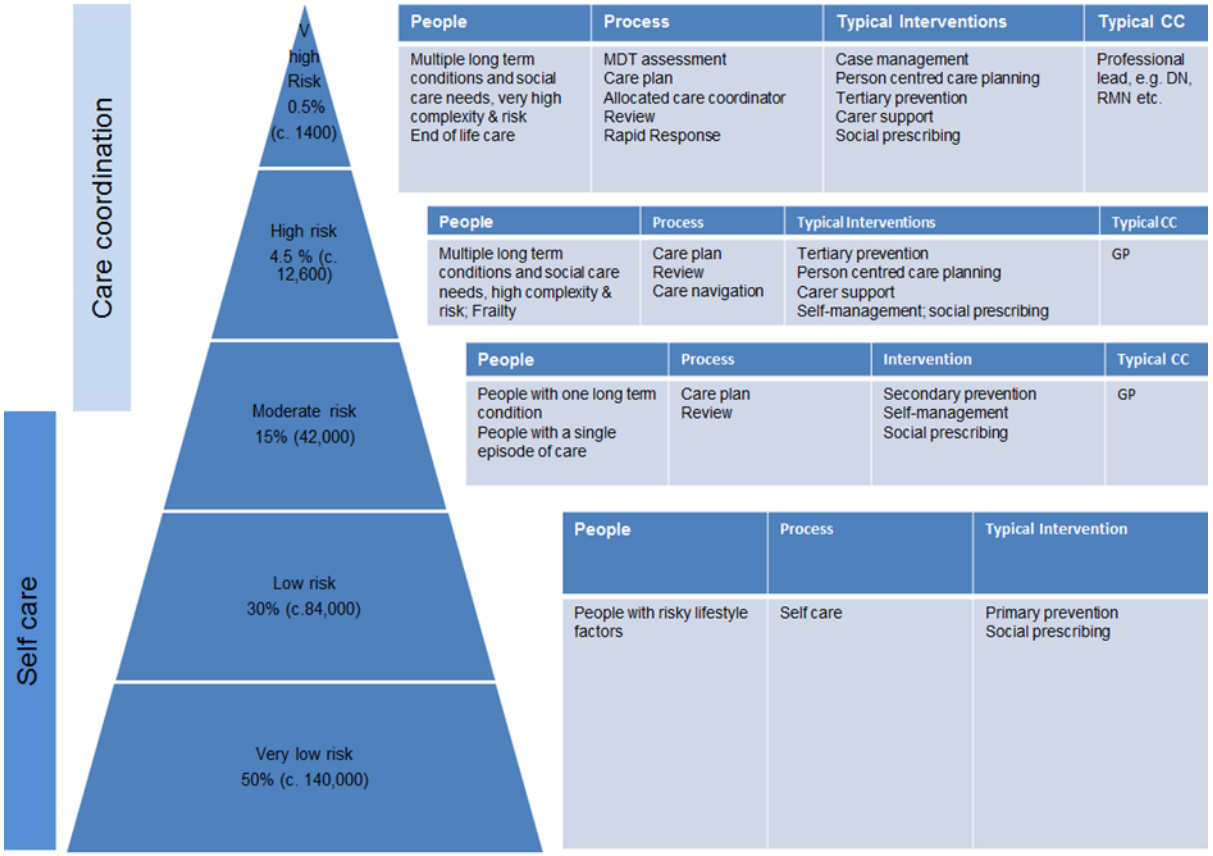
3.2.2. *Delivering health and social care integration through the Tower Hamlets Complex Adults Programme (formerly known as Integrated Care)*

The new model of care outlined above plays a key part in supporting adults with complex needs. These adults are identified in primary care and are classified under two categories:

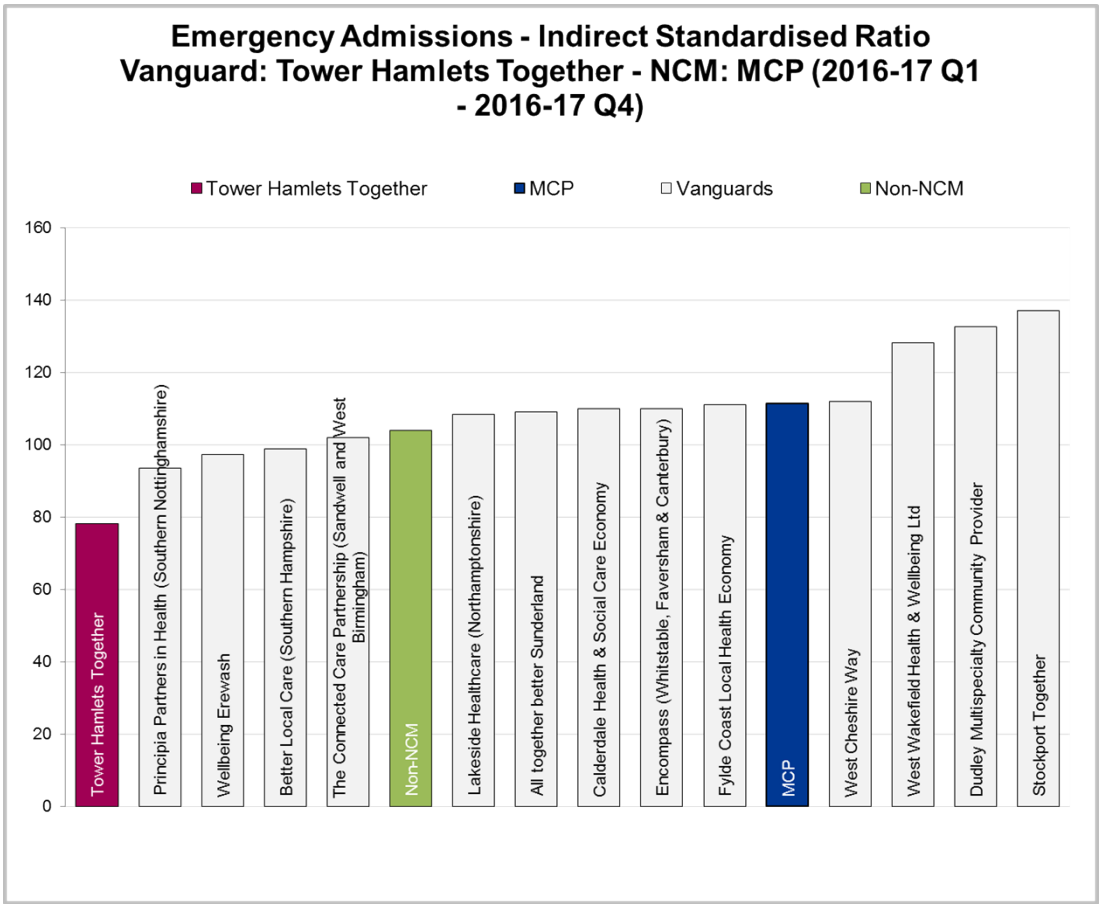
1. Complex care, which includes:
    - Patients with palliative care needs
    - Patients with dementia
    - Nursing home patients
    - A discretionary group equal to 12% of the practice's population aged ≥65 (minus the mandatory) in April 2017
2. Long term conditions, which includes patients with one or more long term conditions

The level of care provided across all partners is tailored according to individuals' needs and delivered in line with the principles shown in the diagram below:





Alongside this new model of care, we have been encouraging collaborative working through a Local Incentive Scheme (LIS). Focused on the delivery of shared outcomes, the incentive scheme rewards individual organisations for their contribution to support adults with complex needs. The shared outcomes of the scheme include key indicators, such as non-elective admissions, readmission rates and delayed transfers of care. Providers have themselves reported that this has encouraged joint working and this can be demonstrated by the dashboard below, which indicates that Tower Hamlets Together is the highest performing Multi-Specialty Community Provider (MCP) in the country against non-elective admissions.



We are seeking to build on the success of this and are in the process of agreeing the incentive scheme for 2017-18.

3.3 What difference will integrated care make to patient and service user outcomes?

Our vision for the new system is based on three aims:

1. *Empower patients, users and their carers*
   - Enable patients and service users to live independently and remain socially active
   - Establish education and self-care programmes for patients
   - Personalise care to patients' and service users' needs and preferences

2. *Provide more responsive, coordinated and proactive care*
   - Proactively manage patients' health and improve their outcomes
   - Enable high-quality care that responds to patient/service users' needs rapidly in crisis situations
   - Provide more care in the community or at home
   - Prevent avoidable admissions
   - Leverage tools and technology to deliver timely and better quality of care

3. *Ensure consistency and efficiency of care*
   - Deliver the best possible care at the minimum necessary cost

- Avoid duplication of effort in situations where patients are seen by multiple health and social care providers
- Ensure most effective possible use of clinical time and resources

We will measure benefits in a number of ways:

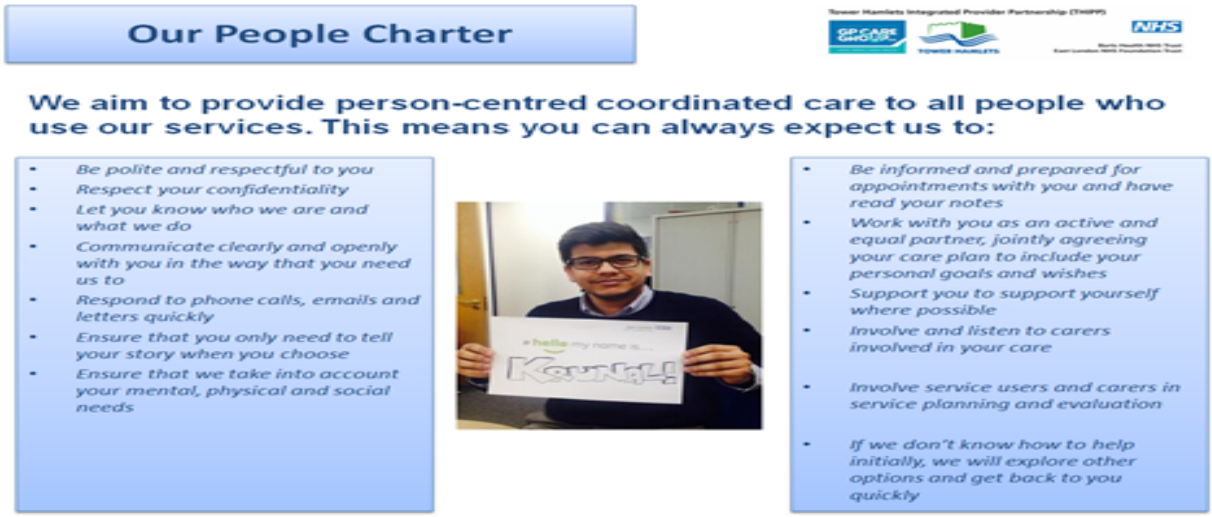
- Provider reporting: Our new community health services contract includes a number of patient and system related outcome measures and these are being monitored through our monthly alliance contract meetings
- Local Incentive Scheme (LIS) reporting: Our 2017-18 proposals are currently being finalised. This will include a series of metrics such as XXXX and reporting is expected quarterly. To be completed

3.4 Service user and public engagement

The compilation of the Tower Hamlets Health and Wellbeing Strategy itself has been underpinned by significant engagement with the local community.

Local people, local staff, local care

National Voices, a coalition of health and social care charities in England, work directly with some patients, service users, carers and their families, to improve care. It is committed to ensuring that there is a patient voice in the decisions made in health-care, and provides patient leadership training, amongst other programmes, as a way of achieving this. In 2013, National Voices published work commissioned by NHS England to provide a narrative for person-centred coordinated care. Tower Hamlets continues to be committed to the delivery of this definition of Integrated Care. The THT service model and vision for community involvement is shown here.



From its outset Tower Hamlets Together (THT) committed to creating person-centred services, by working with local communities and citizens to deliver the best health and social care possible. One of the ways of doing this is through a stakeholder council involving patients, carers, staff, the voluntary and community sector and other partners. In 2016 a series of pilot workshops were run to explore the challenges and opportunities and raised a number of issues including:

- Building confidence and the ability to think beyond the traditional attitudes adopted by different types of partner is vital if we want to move towards co-production.
- There is strength in bringing together a diverse range of voices willing to use their personal, organisational and political experience and expertise collaboratively.
- There was overall agreement that the stakeholder council could play a 'critical friend' role to the Board offering an open and problem-sharing forum.

The report from the pilot workshops was presented to the Board in February and there was overwhelming support to develop it further. Subsequent discussions about governance have delayed this somewhat but in July residents, staff from all levels, voluntary and community sector representatives and other partners came together to explore themes for the community discussion about the outcomes framework currently underway. This will reconvene in early October to reflect on the results of this and provide the launch pad for the next stage of the stakeholder council.

3.4.1 ***Engagement on our Strategy***

To be completed

3.4.2 ***Engagement in the delivery of services (co-production)***

Both the CCG and council have identified funding for the delivery of discovery interviewing techniques and it is intended to use this to gather feedback and involve users and their carers in the development of the integrated care services. The council has a rewards and recognition policy under which it can make payments to service users where appropriate.

The council and CCG jointly fund the Tower Hamlets LinkAge Plus network of services for older adults across the Borough. This provides a network of older people with whom the partnership can test out ideas and plans for integrated care.

Building on that work, the CCG has conducted a range of initiatives involving patients in developing Integrated Care in Tower Hamlets including Integrated Care "conversations" alongside voluntary sector patient groups. The first one to take place was run in conjunction with the *Tower Project*, which works with children, young people and adults with disabilities. Ten participants, predominantly carers, provided feedback and engagement on plans to integrate care.

Tower Hamlets CCG is also using its website and internet content to disseminate information about Integrated Care. The Tower Hamlets CCG website is easy to navigate, interactive, and is starting to embrace the use of videos and YouTube.

The council undertakes annual service user surveys that give insight over time into service users' experiences of social care services. Data from surveys such as the National Carers' Survey help to provide the HWBB with feedback on the changes being made. More widely, the annual Local Account captures all findings from the past year's adult social care engagement activity. This provides an analysis of performance in regards to service user satisfaction in comparison to previous years.

3.5. Outcomes Framework

In 2016, Tower Hamlets Together developed a draft outcomes framework. Drawing on extensive discussion with the community, both from historic and recent engagement, staff and other partners, the outcomes are designed to provide a clear and simple way of measuring the effectiveness of service delivery and an inspiration to improve further. Following endorsement from the THT Board in January, extensive work has been undertaken to underpin the draft outcomes with a series of performance indicators to move towards capitation locally. In the summer of 2017 the New Economics Foundation was commissioned to undertake further validation, especially with those parts of the community which have not already had their say. As part of this, in July 2017, the THT Stakeholder Council - which brings together a diversity of voices, including residents, staff, the voluntary and community sector and other partners, such as the police and housing - met to explore the key areas for the validation work. Proposals for how to align the aspirations of this latest community debate with more precise performance measures will be presented to the THT Board before the end of the year. The outcomes will also be a fundamental part of the Health and Wellbeing Strategy, particularly underpinning the 'communities driving change' strand and will link closely to the borough's community plan which is currently being consulted upon.

Our Outcomes Framework…	
After using Tower Hamlets Together services we want residents to be able to say…	
Around me	I feel safe from harm in my community
	I play an active part in my community
	I am able to breathe cleaner air in the place where I live
	I am able to support myself and my family financially
	I am supported to make healthy choices
	I am satisfied with my home and where I live
	My children get the best possible start in life
My doctors, nurses, social workers and other staff	I am confident that those providing my care are competent, happy and kind
	I am able to access the services I need, to a safe and high quality
	I want to see money is being spent in the best way to deliver local services
	I feel like services work together to provide me with good care
Me	It is likely I will live a long, healthy life
	I have a good level of happiness and wellbeing
	Regardless of who I am, I am able to access care services for my physical and mental health
	I have a positive experience of the services I use, overall
	I am supported to live the life I want

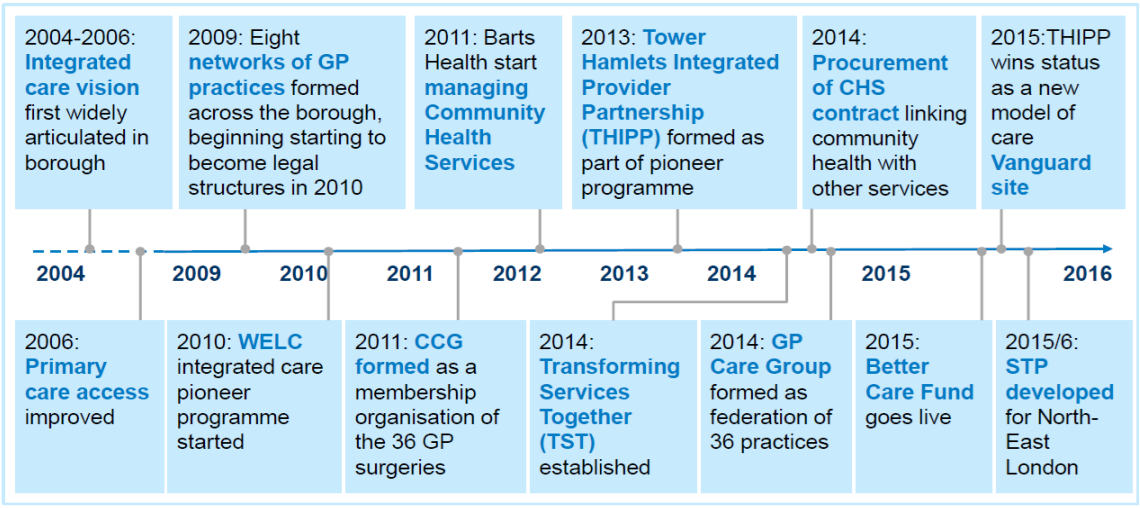
3.6 Joint Business Intelligence & Commissioning Dataset function

To be completed.

3.7 The Future: Accountable Care Systems

The timeline below illustrates some of the above mentioned developments, along with others. This section sets out the next steps for health and social care integration in Tower

Hamlets. Expand timeline.



Over the last year, with the freedom and scope for innovation that recent developments have given and our strong history of integrated care work, the CCG and the council have been thinking about how we should commission in the future. What has emerged is the concept of an Accountable Care System for Tower Hamlets, centred upon Tower Hamlets Together, which has the potential to address a number of the systemic challenges we face.

'Accountable Care System' (ACS) is an all-encompassing term that brings together a number of different elements of commissioning to facilitate a more integrated system. It offers a framework for providers to take responsibility for the cost and quality of care within an agreed budget. ACSs take many different forms, ranging from fully integrated systems to looser alliances and networks of hospitals, medical groups and other providers. What they all have in common is a defined population, a uniform payment mechanism and a clear focus on health outcomes.

In Tower Hamlets we are already working on many of the building blocks that make up an ACS, such as paying providers in a different way (capitation), commissioning based on outcomes (CHS), and facilitating greater partnership working through commissioning (CHS). The development of an ACS in Tower Hamlets will be a step-wise process, something that evolves and builds, as opposed to something that starts at one point and finishes at a pre-defined end. This is an opportunity for Tower Hamlets and the wider NHS to do what works best and build on our strengths and history.

There is not a 'top-down' mandate for this but the message from government seems clear that we have an opportunity to shape our system as and lead that change, and we want to take that opportunity now. This is different to previous changes: we are not being told specifically what to do, and it involves a new set of challenges, but, we think, wider opportunities.

In practical terms, an ACS can be established at different levels or spatial 'footprints', based on where it makes sense for organisations to work together. The level at which they are established will also define the priorities and their collective work. The ELHCP is looking at

structures that could be put in place to develop ACSs across its geography, aligned to acute provider footprints. This may mean the term ACS will be associated with work aligned to TST (see Section 2) and so on for other areas, such as Barking, Havering and Redbridge. Although not yet fully established, an ACS at TST level may focus on payments and outcomes.

3.8 What Next?

3.8.1 April 2017

As part of this journey to creating an ACS for Tower Hamlets we have started to make some changes to the ways in which we commission and the governance structures that underpin our commissioning decisions. From April 2017, the CCG will have:

- Created a new CCG Finance and Investment Committee that defines our medium and long term financial strategy and will take recommendations from the newly formed THT Board to deliver the strategy (as below);
- Finalised the CHS negotiations and gone live with the CHS alliance contract;
- Introduced a shadow capitated budget with partners.

3.8.2 By October 2017

By October 2017, we expect to have achieved the following:

- Merged the THCCG Transformation Board with the THT Board to create a reformed THT Board that will oversee the delivery of 2017-18 QIPP plans and develop the 2018-19 commissioning plans;
- Merged the THCCG PMO structure with the THT PMO structure, so that the programmes which deliver transformation are better aligned;
- Through the new PMO structure, made plans and started to embed changes to the programme boards that sit under the THT Board, looking at membership, roles and responsibilities and governance arrangements;
- Developed and launched a development programme for the new THT Board;
- Reviewed and aligned communications and engagement activities across THT.

3.8.3 What we aim to achieve by 2020

By 2020 we want Tower Hamlets to:

- Be integrated around people, with staff not hindered by organisational boundaries or bureaucracy and able to put patients' needs first;
- Be person-centred, with residents and staff collaborating together and making the right decisions, based on individual needs;
- Have a culture of trust and continuous learning, with a 'can-do' attitude across health and care services;
- Make the most of scarce resources, by allocating them according to changing population needs, and with clear accountability between clinical decisions and resource allocation;
- Have good information and data for patients and staff to help them make effective and timely decisions; and
- Be joined-up to drive improved wellbeing through partnerships with local organisations outside of the health and care system.

Despite our successes, we know there are several challenges that we need to overcome if we are to ensure the sustainability of our health system and ensure continued progress in improving health outcomes. We know, for example, that our current system remains highly fragmented with different types of providers (primary, community, social care etc.) using different systems, budgets and incentives. This all contributes to a fragmented and often confusing patient journey.

We also know that providers suffer from a lack of skilled staff, resulting in high agency spend at a time when funding is limited and while the needs of our population are growing. Like many deprived areas, a significant proportion of our population is transient and its expectations are changing, resulting in greater uncertainty regarding what is needed in the future.

Regulatory constraints from the centre also lead to a focus on meeting top-down targets rather than focussing on population outcomes. Furthermore, the current commissioning contract mechanisms are inflexible – making it difficult for commissioners to drive the change we want within an annual commissioning cycle. Many of these challenges are shared across the country and have led to recent policy changes from the centre. However, by making radical changes to commissioning and governance arrangements and reorganising jointly the way health and social care services are provided, we are confident that we will move to a genuinely accountable care system over the next three years that builds on the significant progress already through the Better Care Fund and previous partnership working.

The historical success that we have in Tower Hamlets is achieved through the hard work, innovation and ambition of our staff and clinicians. We have a high reputation and plan to continue to build on this. There is lots to be done, some of which will require new ways of working. Changes are likely to be more bottom up and iterative than they have been in the past, when change has been imposed. The future will be led through our workforce and service users.

4. Progress to Date

4.1 Tower Hamlets' BCF programme

The priorities of Tower Hamlets' BCF programme have been largely consistent since the inception of the programme. Priority themes include:

- More joint working between health and social care staff (e.g. in the areas of the community health services and hospital discharge)
- The extension of seven day working, particularly in areas where this can reduce pressure on the hospital system.
- The redesign of services to facilitate more seamless interaction with patients of the service users.
- The sustainability of social care provision in the borough.
- The empowerment of service users (e.g. through co-production).

As has been summarised above, the BCF programme is part of a wider range of initiatives and much of the improvement in outcomes (e.g. through the redesign of services and pathways) is being delivered via partnership bodies such as Tower Hamlets Together.

The BCF programme, and health and social care integration more generally, monitored, on behalf of the Tower Hamlets Health and Well-Being Board, by the THT Complex Adults Programme Board, which now reports to the THT Board. This comprises representatives of the CCG, the council, the voluntary sector and health providers.

Progress with the BCF schemes in 2016-17 and our priorities for 2017-19 are outlined in Section 6.

4.2 Progress towards an Accountable Care System

Within the borough, a number of steps are currently being taken towards the establishment of an effective Accountable Care System. In 2015-16, a joint commissioning review was undertaken on behalf of the CCG and the local authority, which identified a number of ways in which greater integration of commissioning might be effected. Now, under the aegis of the Joint Commissioning Executive, the scale of the Better Care Fund pool is being increased progressively, with more functions expected to follow in future years. In 2016-17, the size of the pooled budget was £21.4m; in 2017-18 this is being increased to approximately £45m. Even allowing for the advent of the Improved Better Care Fund, which increases the total resources available, this represents a significant increase in the value of pooled resources.

To support the enhancement of integrated service design and delivery, the council and the CCG are developing a new integrated commissioning hub as a further stage towards greater joint working and joint commissioning.

Local governance structures are also being revised to take account of these developments. The Health and Well-Being Board is now formally recognised as having strategic oversight responsibility for all health and social care activity in the borough, and the THT Board will

take on the role of overseeing the development of health and social care integration on its behalf. In addition, the CCG's programme boards are now being integrated with THT structures to provide a more accountable and inclusive system of commissioning and service improvement.

We have gained system support to build THT into a strong position to support the implementation locally of the BCF and the North East London NHS Sustainability and Transformation Plan, which is now quite advanced. In March 2017, the CCG confirmed its intention to disband its Transformation Board and delegate its functions to the THT Board. THT is at present accountable to the CCG Board for any decisions taken and the CCG has proposed amending the THT terms of reference to reflect this change in purpose, and these are expected to be revised as the borough develops an Account Care System. In addition, there is widespread support for placing THT formally under the aegis of the Health and Well-being Board and the implications of this, not least in respect of organisational governance, are currently under discussion with THT partner organisations.

In the meantime, THT and CCG sub-structures - including the Complex Adults Programme Board, concerned with overseeing the delivery of Better Care Fund initiatives - are being integrated to allow the various aspects of the health and social care agenda in the borough to be taken forward.

4.3 Fundamental Review of Adult Social Care Services

Within the council's adult social care services, a major review is currently being undertaken, funded through the THT Vanguard, with the aim of, firstly, aligning the council's services with local health services and then moving towards their integration. A draft model has been designed which proposes the following:

Phase 1 – Align (level 2) ASC services with Health in 2017/18	Phase 2 – Integrate to level 2/3 from 2018/19
An **ASC Single Point of Access** ("SPA") to provide the ASC front door.	A **Shared SPA with health** combining the ASC and community health front doors into one function
Locality based social work and occupational therapy ("OT") teams that mirror the new Extended Primary Care Teams ("EPCTs") in health; This will include and build on the ICHT pilot that is already locality based.	**Joint Locality Teams** with shared community health and ASC teams.
A **seamless, coordinated service**, covering all stages of the customer journey.	Co-located Out of Hours ("OOH") Service with the emergency duty team working alongside OOH nursing support and GP access
A **Short Term Interventions Service** that brings together reablement, telecare, assistive technology and community equipment.	An Urgent Care Hub that integrates the ASC Hospital Team with the new Urgent Care Hub to support step up / down care and to facilitate admissions avoidance and discharge to assess more

	effectively
A **Mental Health ("MH") Liaison** team to support the locality teams and provide earlier MH support	

As referred to above, a review of the Local Integrated Care Boards (to be renamed Locality Health and Wellbeing Committees) is also being undertaken. These will be reconstituted as part of the new THT governance structure and will coordinate the delivery of integrated services at the local level.

4.4 Former BCF national conditions

The borough will also continue to address the former national conditions concerning (i) 7-day services, (ii) data sharing, (iii) a joint approach to assessments and care planning and (iv) Agreement on any substantial impacts of changes on providers.

4.4.1 ***Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate***

Section 12 sets out the borough's approach to maintaining low levels of delays in transfers of care. Here it is worth highlighting two council services, which are enabled to operate on a seven-day week basis through BCF funding: the hospital social work team and the community equipment service.

- 7 Day Hospital Social Work Team: The scheme allows the council to extend the hospital discharge team at the Royal London Hospital from a Monday to Friday service to a 7-day operation. Social work staff assess and discharge patients on acute wards who are deemed medically fit for discharge at weekends and public holidays. This frees up acute beds within the hospital and uses resources more effectively. It also provides greater capacity for new admissions from A&E requiring an acute bed. The 7-day service also provides timely multidisciplinary assessments, which avoid unnecessary admissions to acute wards, and facilitates speedier discharges, by commissioning community services which permit patients to return home. In 2017-18, the scope and capacity of the Hospital Social Work Team is being enhanced by the allocation of Improved Better care Fund resources.
- Seven Day Working for Community Equipment Service Team: BCF funding is used to allow the provision of 7-day and extended hours equipment and minor adaptation delivery and installation services. The service seeks to enhance patient/service user experience and reduce pressure on the Acute Health Sector. The planned outcomes of this investment are a reduction in avoidable admissions and the facilitation of safe and early discharges, by making patients'/service users' home environments safer and making it practical for them to be cared for at home or to self-manage their support needs.

4.4.2 Better data sharing between health and social care, based on the NHS number

To follow

4.4.3 Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

The Out of Hours and Day Service continues to operate 7 days per week within Barts Health NHS Trust, with particular attention to the Royal London Hospital, the Trust's trauma centre Patients discharged from hospital to the Admission Avoidance & Discharge Services (AADS) team, who require a rehabilitation and reablement pathway, are screened while still in hospital by one of the team (a nurse or therapist), or jointly with a social worker, if care support is required on discharge. Wherever possible, this support is arranged with the Reablement team, and a therapist and/or nurse from the AADS team is allocated the following morning, with a visit made in the community within 24 hours. On-going reviews take place based on patient/service-user need and this is tailored to what the person expresses as their goals or priorities. For some, this will be a return to full independence, while for others it may be to manage activities with the least intervention possible or for their carers to feel supported in this role.

All patients are jointly reviewed with the Reablement service on a weekly basis, and there is an opportunity for a more frequent (daily) integrated discussion, if this is felt to be required by the staff visiting the person, so concerns or changes that require an increase or reduction in care are addressed promptly. There is a key worker allocated to each person from health, as well as a social worker from the team when care support visits have been arranged. This support can continue for up to six weeks, when people are either discharged if they no longer need input, or referred on to other services/long term support.

Patients in the target population will have an accountable lead professional named within their care plan. This individual will be responsible for coordinating the review of their care and will lead discussions within the MDT. They will be the first port of call for queries, and will be accessible to other professionals and care coordinators. In the majority of cases, this person will be the patient's GP.

4.4.4 Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans

To follow

5. Evidence Base and Local Priorities to Support Plan for Integration

The demographic evidence base which underpins our BCF programme is summarised in Section 2and the Joint Strategic Needs Assessment (JSNA). Our approach to health social integration and priorities are set out in Section 3.

The original priorities for the Better Care Fund in Tower Hamlets were reviewed in the course of developing the present proposed programme. The great majority of 2016-17 BCF schemes will continue to form part of the Better Care Fund, and, with a small number of exceptions, will continue to be funded from the CCG 'minimum'.

However, as has been noted previously, the borough has agreed to work towards greater integration of functions within the section 75 agreement, and, taking into account the Improved Better Care Fund, the amount pooled in 2017-18 is more than double that in the previous year.

The process of pooling of functions will continue under the scrutiny of the Joint Commissioning Executive, and it is possible for further functions will be added to the section 75 agreement in 2018-19.

The table below shows council BCF schemes (column 1); priority areas where joint commissioning frameworks are to be developed in 2017-18 (column 2); and areas that would benefit from improved joint working (column 3). It is proposed that, as the integration of commissioning becomes further developed, the functions in column 2 will tend to be pooled into the BCF under the Section 75 agreement. The functions in column 3 are not envisaged for pooling in the short term, but this will be kept under review as services develop. Needs more of a narrative, showing reasoning behind the JCE's previous decisions on increasing pooled budgets and the approach being followed by the council to determine further pooling.

Included within the Better Care Fund Level 4	**Joint Commissioning Frameworks Level 3**	**Improved joint working Level 2**
Column 1	Column 2	Column 3
LinkAge Plus	Mental Health services	Children's Services
Reablement Team	Older People's Mental Health Team	Public Health
Community Health Team (Social Care)	Learning Disability services	Drug and Alcohol Action Team (DAAT)
7 Day Hospital Social Work Team	Hostels and homeless commissioning/ELFT homelessness project/Groundswell/HealthE1	Acute Emergency Care/Acute Planned Care
Community Equipment Services	Social Care services included within the Ageing Well strategy- e.g. Residential Care, Extra Care, Home Care, Day Care for Older	Continuing Healthcare

	People	
Care Act Implementation	Single Point of Access (Vanguard)/LBTH Information, Advice and Advocacy (IMHA &IMCA)	Personalisation (Direct Payments/Personal Health Budgets)
Carers Support		Safeguarding (Children and Adults)
Disabled Facilities Grant		Transitions
Local Authority Integration Support (Enablers)		Monitoring and measuring patient/service user experience
Community outreach service (Dementia)		
Dementia café		
Social worker input into the memory clinic		
Improved BCF		

Add text on local financial context for the BCF Plan

6. Better Care Fund Plan

In 2017-18, we are using the Better Care Fund programme as a platform for developing closer joint working between Tower Hamlets Council and the CCG. The development of integrated commissioning within the borough is reflected in the increased scope of the section 75 agreement, which is now considerably broader than in 2016-17.

The Table below sets out the schemes and associated budgets that have been incorporated into the 2017-19 BCF. The Tower Hamlets Joint Commissioning Executive (JCE) gave agreement to expand the 2016-17 Fund to enable associated areas of investment and activity to be brought together under a series of new Joint Commissioning Frameworks.

Table needs 2018-19 column

Pooled Fund	BCF Scheme	Lead Commissioner	Provider	BCF Allocation 2017-18 CCG 'minimum' needs to be uprated by 1.79% (1.9% for 18-19) (£)
Pooled Fund Hosted By London Borough of Tower Hamlets	LinkAge Plus	Council	VCS	650,000
	Reablement Team	Council	Council	2,413,871
	Community Health Team (Social Care)	Council	Council	895,500
	7 Day Hospital Social Work Team	Council	Council	1,230,800
	Community Equipment Services	Council	Council	TBC
	Care Act Implementation	Council	Council	733,000
	Carers Support	Council	Council	697,000
	Disabled Facilities Grant	Council	Council	1,733,988
	Local Authority Integration Support (Enablers)	Council	Council	208,000
	Community outreach service (Dementia)	Council	VCS	25,000
	Dementia café	Council	VCS	55,000
	Social worker input into the memory clinic	Council	Council	50,000
	Improved BCF	Council	Council	8,700,000
Total				TBC
Pooled	Extended Primary Care Team	CCG	ELFT	13,232,000

Fund hosted by	Integrated Clinical and Commissioning Quality Network Incentive Scheme	CCG	GP Care Group	4,461,313
	RAID	CCG	ELFT	2,106,420
	Adult autism diagnostic intervention service	CCG	ELFT	330,000
	Mental Health Recovery College	CCG	ELFT & VCS	210,000
	~~Falls prevention~~	~~CCG~~	~~ELFT~~	~~TBC~~
	Community Geriatrician Team	CCG	Barts Acute	110.000
	Personalisation (IPC programme)	CCG	VCS	212,000
	Psychological Support for People with Long Term Conditions (Previously Mental Health Personal Commissioning)	CCG	ELFT	150,000 (TBC)
	St Joseph's Hospice	CCG	St Joseph's	2,029,248
	Voices Survey	CCG	St Joseph's	£30,000
	Age UK Last Years of Life	CCG	VCS	£91,500
	Barts Acute Palliative Care Team	CCG	Barts Acute	959,086
	Discharge to Assess	CCG	THT	TBC
	Age UK Take Home and Settle	CCG	VCS	114,000
	CVS Commissioning Development Programme	CCG	THCVS	70,000
	Single Incentive Scheme	CCG	THT	500,000
			Total	TBC
			BCF total	**TBC**

6.1 Schemes Continuing from 2016-17

- **Community Health Team (Social Care)** - The team provides assessment, support and care navigation to a targeted group of people at medium or high risk of hospital admission, using co-ordinated, person-centred and Multi-Disciplinary Team (MDT) approaches. It promotes the wellbeing and independence of those living with long term conditions and assesses and supports Carers of people with long term conditions. The team has contributed to the reduction of unplanned admissions and readmissions to hospital, by maintaining patients in the community for longer and delaying admission to

long term care. A brief QA audit around Safeguarding Adults indicated that CHT (SC) is able to decrease risk for service users by timely and effective MDT working. The team is now working with over 400 service users who are on the ICP in the very high risk cohort, plus those who are undergoing active neuro-rehabilitation. It works closely with hospitals to plan and implement timely and safe hospital discharges (the hospital social work team carries this out for other Adult Social Care teams). There are also two named social workers linked to pilot Neighbourhood Care Team (Buurtzorg) and the CHT (Social Care) Development Team Manager is part of the Operational Design Group. The team's Operational Manager is actively involved in GP-led strategic planning regarding End of Life/Palliative Care. CHT (SC) has also been working closely with health partners around Continuing Health Care. This is essential in ensuring MDT good practice in completing Decision Support Assessments. It has led on planning and implementing CHC Legal training, along with the council's Learning and Development Team and Health Partners. In 2017-2018, the above work is expected to continue. In addition, the team is planning to increase its work at the local (via IBCF) and to increase social work and management capacity to support Continuing Health Care work, including at CHC Eligibility Panel (again, via IBCF). It will also participate in the development of the End of Life/Palliative Care offer to LBTH residents and champion this area of work. A Palliative Care social work post is also being created within the team.

- **Out of Hours 7 Day Hospital Team** - The scheme has enabled the council to extend the work of the Hospital Discharge Team at the Royal London Hospital from a Monday to Friday to a 7-day service. Social work staff are available at weekends and on public holidays to assess and discharge patients on acute wards who are deemed medically fit for discharge. This has freed up acute beds within the hospital, and allowed for resources to be used more effectively. It has also provided greater capacity for new admissions from A&E requiring an acute bed. The service has worked to prevent hospital admissions, support early diversion, reduce discharge delay, reduce re-attendance, and save ED staff time. The Service specifically prevents unnecessary hospital admission (social admission) for particularly the elderly frail patients into acute beds. The Out of Hours social workers within the Acute Assessment Unit (AAU) and ED respond to referrals within the hour, commission support and discharge patients whose do not have a clinical need to be in hospital. Achievements in 2016- 17:
    - The service continues to improve in the area of Delayed Transfers of Care, patient flow has been increased and trolley rates reduced. We have not needed to divert patients elsewhere or resort to escalation beds in the last 12 months.
    - The need for Non-Elective admissions has been reduced and the team has worked, proactively with staff in the Emergency Department to prevent unnecessary admissions.
    - Patient experience has been improved, by preventing unnecessary admissions and/ or facilitating prompt discharges.
    - Reablement support has been used as a preventative approach for patients presenting to the A&E and the pre-admission wards, in order to support them in regaining their independence and prevent the need for long term care and support.

  Proposed future changes for service in 2017-18 include becoming more proactive, reaching more wards and targeting more complex discharges and frequent hospital attenders. It is intended also to link in with the Community Health Teams, GPs and to be able to divert patients back to their GP practice and Multidisciplinary Teams in the

community. The aim is for the service to be scaled up and rolled out to all patients in acute and general wards, including supporting out-of-borough patients at weekends where possible.

- **Reablement Team**- the service has helped people with illness or disability cope better by learning or re-learning skills necessary for daily living. This service is now being reviewed to be jointly delivered with the Rehabilitation service to become the Reablement and Rehabilitation service. To be developed
- **Assistive Technology** (AT) – The project seeks to integrate the use of assistive technology into mainstream health and social care provision, to enable residents to live independently in their own homes. It uses a range of training and communication methods to raise staff awareness, giving them the knowledge, confidence and support to prescribe appropriate assistive technology equipment for their service users. The project also provides training and support on the use of AT equipment to health and social care staff in 19 operational teams across 9 locations. In 2016-2017, there were 26 formal training sessions, involving a total of 178 staff: 124 from health and 54 from social care. For the period April-June 2017, there have been 4 sessions, involving 30 staff (4 health and 26 social care). The project runs pilots to test specific pieces of equipment, or to evaluate equipment for specific client groups. These have included:
  - Working with our Independent Travel Training Team using smart phone apps and GPS technology.
  - Pill dispenser pilot working with District Nurses.
  - Part of a Pressure Ulcer pilot using a grant from THT.
  - A pilot to assess the use of monitoring equipment to understand how service users are coping with their support plans.

  The project was shortlisted for an Innovation Award by the Local Government Chronicle, and received a bronze award at the Innovation and Efficiency Awards 2017. In terms of future developments, the project will be investigating equipment that combines Telecare and telehealth capabilities.
- **Social Worker Input into Diagnostic Memory Clinic** - The social worker offers community assessments under the Care Act (2014); carers' assessments; organises provision of packages of care; signposting, and advice information and support to patients at a relatively early stage of Dementia. The post holder is based in the Diagnostic Memory Clinic Team (East London Foundation Trust) which supported the integration of these services. The inclusion of social care in the DMC provides a truly integrated model of care throughout the dementia pathway in Tower Hamlets. Access to social care in the Diagnostic Memory clinic helps improve service users' 'journey' at a vulnerable and anxiety-provoking time in their lives. The Scheme will continue to provide an earlier assessment of service users in need of some support through social care and earlier signposting to other non-statutory agencies for those not in need of social care input. Providing frontline social care input creates efficiencies, by reducing the number of referrals made directly to the Adult Social Care (Assessment and Intervention Team). In 2015-2016 user satisfaction was 97.5% positive of all the survey responses received.
- **Dementia Café & Community Outreach Service** – The Dementia Café provides an inclusive peer support service, 4 times a month including structured programme of activities, and promotes understanding of dementia for service users with mild to moderate dementia and their carers. This funding has supported a range of provision in

BME communities, such as awareness training, case finding and work to support people to understand dementia, break stigma and access services. The Community Outreach Service/ BME Inclusion service help to increase the proportion of people from Bangladeshi and other BME communities with dementia receiving a formal diagnosis, and in particular, when they are in the early stages of the condition. It identifies and supports hard to reach individuals with dementia and their carers to access services. (90 % of service users and carers indicate positive engagement.) The service provides a supportive community outreach service which is integrated with other dementia services and projects already up and running in Tower Hamlets. In 2017-18, we are exploring how to meet the existing outcomes using a different methodology, building on a recent innovative pilot that works through schools, using a multigenerational model.

- **Adult Autism and Diagnostic Intervention Service**- The Adult Autism Diagnostic and Intervention service (ASD service) supported the alignment of autism services in Tower Hamlets with the aims of the National Autism Strategy. East London Foundation Trust was commissioned to deliver a dedicated autism diagnostic team for adults, provision of a post diagnostic brief intervention programme and assist service users to access employment and training opportunities. Text to be updated
- **Community Equipment Service** - Community Equipment Services in Tower Hamlets include:
  - Community equipment service
  - Tele care service
  - Assistive Technology (see above)
  - Sight and Hearing

  The Community Equipment Service procures stores, delivers, installs, maintains, collects, cleans and recycles daily living, paediatric, moving & handling and sensory impairment equipment, and carries out minor adaptations and alterations to property. In 2016-17, BCF resources were used to allow for seven day working by the community equipment service team. This helped ensure a reduction in avoidable admissions, the facilitation of safe and early discharges and made patients'/service users' home environments safer, so that they could be cared for or self-manage their support needs. The investment in a 7-day service was expected to increase output of deliveries and installations by approximately 30% of current activity and achieve a minimum of 30 additional deliveries and installations of equipment over a seven day week. It has supported timely discharges and enabled complex care to be delivered at home to approximately 500 more patients and service users over a year. Out of these additional 500 patients, the majority received their standard non-urgent equipment items within or below the national benchmark of 7 days. A 95% target was set for people needing same day provision, 24 hours and 48 hours. BCF was also used to supplement resources to allow increased demand for community equipment to be met. For 2017-18, we are pooling all health and social community equipment budgets in the central BCF fund. This will allow the service to be looked at in its totality. The resources for seven day working and to meet additional demand will be rolled forward as part of this.
- **Carers** - A range of support is provided to carers. This includes preventative services, from whole-population measures aimed at promoting health, to more targeted interventions aimed at improving skills or functioning for one person or a particular group. Carers benefit from support to help them develop the knowledge and skills to care effectively and look after their own health and wellbeing. The primary support

service available to all carers is the Carers Centre. This was accessed by approximately 1,300 carers in 2016/17. It provides information, advice and advocacy service for carers and refers people with eligible needs to the local authority for statutory carers' assessments. Care packages, including respite services for carers are also available to carers following an assessment. The support provided to carers also includes peer support services, like dementia cafés and emotional support and stress management classes. The council is currently co-producing what the carers' services should include from 2018 onwards. This redesign includes an ambitious intention to review and improve carer support and services across health and social care to ensure carers have a better journey and are recognised as equal and expert partners of care. Text to be updated

- **Care Act Implementation** - A number of posts will continue to be funded to ensure the local authority is managing the demands and pressures experienced in Adult Social Care. These posts include operational support, strategic commissioning and workforce development. Text to be updated
- **Personalisation -** It is a fundamental part of our vision that care and support are personalised to patients' and service users' needs and preferences to support patients to feel more empowered and resilient, this will be a core part of the work under the BCF. Tower Hamlets is a demonstrator site for Integrated Personal Commissioning, and 2017-18 will see the expansion of personal health budgets and joint budgets with social care for people with learning disabilities, mental health needs and multiple long term conditions. The targets for 2017-18 are 1,500 personalised care and support plans, with the offer of a personal health budget, resulting in 300 personal health budgets or joint budgets. In 18/19 the expectation is that we will achieve 3,000 personalised care and support plans and 600 personal health budgets or joint budgets.
- To follow:
  Extended Primary Care Team
  Integrated Clinical and Commissioning Quality Network Incentive Scheme
  RAID
  Mental Health Recovery College
  Falls prevention
  Community Geriatrician Team
  Psychological Support for People with Long Term Conditions (Previously Mental Health Personal Commissioning)
  Discharge to Assess
  Age UK Take Home and Settle
  Single Incentive Scheme

6.2 Improved Better Care Fund

The size of the pooled budget has also been increased by the inclusion of the Improved Better Care Fund. The IBCF resources available to the borough are set out in the table below.

Tower Hamlets	2017-18 Additional funding for adult social care (£m)	2018-19 Additional funding for adult social care (£m)	2019-20 Additional funding for adult social care (£m)
2015 Spending Review	1.6	7.7	12.8
2017 Budget	7.0	4.2	2.1
Total	8.7	11.9	14.9

IBCF is being used by the council to address a number of high priority needs, including demographic pressures, safeguarding and ethical care and to meet inflationary pressures within the care system.

To strengthen the stability and sustainability of the provider market, it is also proposed to increase nursing home provision in the borough. This will complement already agreed uplifts in care funding to improve the quality of residential/nursing provision and wider support in the community, such as enhancing home care linked to hospital discharge and improving reablement approaches in day support. Work will continue with providers during the autumn of 2017 through a number of 'summits', in which further needs and different approaches may be identified. A contingency provision has been earmarked to finance these.

Building on the above theme, further investment of approximately £1.4m in a full year is being made that will benefit health services in the borough. This includes provision to enhance capacity and skills in the Community Health Social Work team to increase the number of people it is able to support on the integrated care pathway. It also includes the enlargement of the Hospital Social Work Team to get more people home quickly and safely and reduce the need for residential placements. In addition, the IBCF is being used to fund social work support to strengthen the continuing healthcare process, with a view to developing a new joint service model in the medium term.

A number of initiatives are being funded that are designed to address unmet need in mental health services. These include projects targeted young people transitioning from children's services to adults' and working with people at risk of anti-social behaviour. For instance, a Community Multi-Agency Risk Assessment Case Conference, MARAC, is being established, along with an Independent Anti-Social Behaviour Victim Advocate post. A scheme for people at risk of self-neglect and self-harming behaviours is also being funded.

A number of areas of unmet need and services experiencing demand pressures will also be supported via IBCF. Initiatives include a project to reduce isolation among vulnerable older people. Additional resources are also being directed to the reablement service to address rising demand, and a significant sum has been allocated to commission additional support to address assessment and review backlogs in adult social care. Finally, the IBCF is being used to support the implementation of a number of adult social services transformation reviews.

6.3 Disabled Facilities Grant

Disabled Facilities Grant (DFG) plays an important part in Tower Hamlets' approach to integrated care. Expenditure of the 2017-18 DFG has been agreed with the local Housing Authority and will centre on meeting our duties to provide adaptations and facilities in the homes of disabled people, as set out in the Housing Grants, Construction and Regeneration Act, 1996.

The local authority provides services to clients requiring adaptations through its Occupational Therapist service and Home Improvement Agency. It works closely with Registered Providers which own the majority of social housing in the borough. The tenants of the borough's Registered Providers account for around 75% of DFG expenditure. This spend reflects the relatively low level of owner occupied housing in the borough.
Since the integration of DFG into the Better Care Fund, a cross divisional DFG Working Group has been set up within the council to review the DFG programme, consider a pathway redesign for DFG and the DFG's integration with assistive technology and other Home Care services. The Working Group is also currently giving consideration to how it can make better use of the flexibility allowed in DFG spending by the Regulatory Reform (Housing Assistance)(England and Wales) Order 2002 . It is proposed to set aside £300,000 of the DFG allocation for this purpose in 2017-18.

Areas for potential development in 2017-18 are:

- a joint training and development programme to ensure the key people in the health and social care system understand best practice in prescribing equipment through the DFG
- the exploration of further uses of assistive technology
- to extend the excellent OT work concerning children with autism into the adults programme, in order to ensure safety and independence
- the exploration of new ways of working (e.g. the use of trusted assessors).

6.4 Other New Functions within the Pooled Budget

The following functions have been incorporated within the pooled budget for the first time:

- **LinkAge Plus -** This is a preventative service which provides Tower Hamlets residents aged 50 and over universal access to community outreach; a wide range of physical and social activities; information and advice, including signposting and onward referrals and a range of health-related services.
- **Specialist Palliative Care (St Joseph's Hospice) -** St Joseph's Hospice provides high quality, efficient and effective specialist palliative support for last years, months and days of Life care. It uses a multi-disciplinary approach to care, with access to the full multi-disciplinary team, as defined by NICE Supportive and Palliative Care Guidelines. It provides advice and support to nurses, doctors, GPs and other members of the wider health and social care team and care to the patient and their carer/family.
- **VOICES2 Survey -** This survey provides an annual measure of carers' experiences that can be monitored over time, and compared with the national average and other CCGs' results. It identifies factors in both positive and poor experience and enables this

information to be used to improve services. It also identifies gaps in the system and areas for improvement.

- **Age UK Last Years of Life -** This initiative works closely with hospitals and GPs in Tower Hamlets to engage socially isolated people, who may traditionally be reluctant to accept help and support - particularly from the statutory sector; It signposts and refers people into support services provided by the NHS, the council and the voluntary sector. The service undertake this needs assessments in order to understand people's requirements in their last years of life. It provides a befriending service and practical help in the home that is not covered by social services. It also provides support to carers, enabling them to have short term 'care-free' time and provides holistic support (e.g. therapeutic services). It also provides preventative services to protect the health and wellbeing of both cared for people and their carers through befriending, practical and emotional support.
- **Barts Acute Palliative Care Team -** The Palliative Care Team gives specialist advice about symptom control as well as psychological and social support to patients, families, carers and staff. In the early stages of illness, palliative care may be provided alongside other active treatments. For patients at the end of their life the service aims to provide appropriate end of life care to ensure comfort and dignity in death. Families, partners and carers may also need expert support in bereavement.
- **AADS Service - Discharge to Assess – To follow**
- **Age UK Take Home and Settle – To follow**
- **Tower Hamlets CVS Development Programme -** Objective is to build the capacity of the sector to respond to the changing commissioning landscape in health and social care to become partners in the delivery of improved health and well-being for the residents of Tower Hamlets. Capacity building aimed at 4 distinct areas:

  1. THCVS Priorities for Commissioning Intentions financial year 2017-18
  - Support the VCS consortium during its first year of delivery, seeking other opportunities &
  - private investment
  - Developing sustainable funding platform for strategic work
  - Supporting governance via the existing H&WB Forum
  - Building membership, quality insuring & improvement
  - Building relationships with commissioners/ & the private sector

  2. Continue to support the H&WB Forum & provide a strategic voluntary sector presence & leadership as currently, including to the health and wellbeing board and THT
  - Running 4 X Forum and 4 X Steering Group meetings
  - Re-run Leadership in Health workshop
  - Representation on Health & Wellbeing Board & Subcommittee
  - Representation on THT Board & Subcommittees
  - 20 HWB Bulletins / year

  3. Delivering training and support to increase VCS capacity
  - 4X Health development workshops annually
  - 1:1 support to 10 organisation's per quarter – re income diversification etc.

4. Continue to support best practice in commissioning

- Re-run NCVO commissioning Masterclass
- Prioritise Impact/Outcomes monitoring training
- Work with statutory partners to strengthen co-production
- Explore best practice around service co-design.

7. National Conditions

7.1 National Condition 1: Jointly Agreed Plan

This plan has been jointly agreed by the Tower Hamlets CCG and Tower Hamlets Council. It has been endorsed by Tower Hamlets Together Board and the Tower Hamlets Health and Well-Being Board. The local housing authority has been involved via the Disabled Facilities Grant Working Group. Approximately £300,000 of the borough's DFG allocation will be used to support new ways of working in conjunction with the Community Equipment Service. The use of the IBCF has been agreed between the council and the CCG and endorsed by the Health and Well-Being Board. Provider partners have endorsed the proposals through the Tower Hamlets Together Board.

7.2 National Condition 2: Social Care Maintenance

Planned spend on social care from the CCG minimum for 2017-18 and 2018-19 is equal to the amounts confirmed in the planning template (£7,524,476 in 2017-18 and £7,667,441 in 2018-19). In addition, the CCG is contributing from its own resources to one small social care project, the Social Worker Input to the Memory Clinic, as it did in 2016-17. The proposed funding is regarded as sustainable from the point of view of the local health and care system as a whole, and is not expected to have any adverse effect on the stability of the system. Indeed, much of the expenditure on social care is designed to support the financial and operational stability of local health services.

Most of the social care initiatives funded through BCF will have a direct or indirect impact on health services in the borough. These include the funding of the Reablement Team, the Community Health Team (Social Care), the Seven Day Hospital Social Work Team, the Seven Day Community Equipment Service, the Assistive Technology Team, the Dementia Café, Social Worker Input into the Memory Clinic, the BME Inclusion Service the planned investment in Carers and the Adult Autism Diagnostic Intervention Service. Much of the investment via the Disabled Facilities Grant also complements health provision in the borough.

All the investment in social care services via BCF has been agreed between the council and the CCG as being consistent with the priorities of this plan.

7.3 National Condition 3: NHS-Commissioned Out-of-Hospital Services

See attached planning template confirming funding committed to out of hospital services is above minimum allocation.

7.4 National Condition 4: Managing Transfers of Care

Narrative concerning eight High Impact Changes to be added after Task and Finish Group meeting to complete action plan. Meeting booked for w/c 28th Aug.

8. Overview of Funding Contributions

The planning template shows how the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose. Further details are provided in Sections 6 and 7. Among other things, specific funding has been allocated to the following areas:

- Implementation of Care Act duties
- Funding dedicated to carer-specific support
- Funding for Reablement
- Disabled Facilities Grant

This has been agreed with relevant stakeholders and is in line with the National Conditions.

In addition, the Improved Better Care Fund has not been offset against the contribution from the CCG minimum and will be spent entirely on additional activity. Plans for the use of IBCF money address all of the purposes set out in the grant determination, namely: 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.

9. Programme Governance

9.1 Governance Arrangements

The overarching governance and accountability arrangements for integrated care in Tower Hamlets in 2017-18 are set out below.

Responsibility for the strategic development and resourcing of the BCF Plan and programme is undertaken by the Joint Commissioning Executive (JCE) of the CCG and the local authority. This is the 'Partnership Board' as defined in the BCF Section 75 agreement. The JCE also oversees the quarterly monitoring returns to NHS England and the Department for Communities and Local Government for the Better Care Fund and Improved Better Care Fund respectively.

The BCF programme is overseen and driven on behalf of the Health and Well-Being Board by a joint Complex Adults Programme Board (CAPB). The CAPB includes representatives from:

- CCG and local authority commissioners
- Provider colleagues from social care, acute, community, mental health and primary care
- Voluntary sector

As noted in Section 2, the role and membership of the CAPB is currently under review, as part of the wider development of health and social care partnership arrangements in the borough, in which it is proposed that Tower Hamlets Together will become the formally acknowledged health and social care integration partnership for the borough, under the Health and Well-Being Board. From 2017, it is anticipated that the CAPB will be chaired by a Tower Hamlets Together Board member.

Under the proposals currently being developed, the CAPB will become a formal sub-committee of the Tower Hamlets Together Board, which in turn will be a formal sub-structure of the Health and Wellbeing Board.

The THT Complex Adults Programme Board oversees:

- Delivery of commissioned Integrated Care services
- Implementation of Integrated Care, including the Better Care Fund

The governance arrangements are set out in the diagram below.

INSERT DIAGRAM

9.2 Management arrangements to support joint working

The management of the delivery of the Better Care Fund programme is as follows:

- Work streams within the Better Care Fund for service delivery are managed by the lead provider or providers for that function,

- The provision of Community Health Services is delivered by Tower Hamlets Together through the Alliance contract referred to in Section 2.

The Complex Adults Programme Board will receive the following management information:

- An integrated care dashboard, which will be refreshed in 2017-18
- Reports on individual schemes will be made on an exception basis, for example, as new developments are implemented. In addition, providers are required to produce recovery plans where delivery is off track.

Under the proposed new partnership arrangements, the CAPB's main route for the escalation of issues will be to the Tower Hamlets Together Board, and thence, as appropriate, to the Joint Commissioning Executive, the Health and Well-Being Board or the formal decision-making processes of relevant partner organisations.

The process of exception reporting to the CAPB, described above, together with regular financial monitoring and individual organisations' management and performance management arrangements are together intended to ensure that schemes perform effectively, and that effective remedial action can be taken quickly, if necessary.

In addition, during 2017, the council and the CCG are taking further steps to strengthen local integrated commissioning arrangements, through the recruitment of a new joint post Director of Integrated Commissioning. This is expected to be followed by the establishment of a Joint Commissioning Hub. To be developed

Benefits Realisation and Capturing and sharing learning
To be developed

We will measure benefits in three ways:

- Provider reporting: Our providers update the Complex Adults Programme Board bi-monthly. This picks up delivery progress and risks, and gives assurance on implementation
- Integrated Care Dashboard: Covers BCF metrics and a wide suite of further locally agreed metrics, designed to measure progress in meeting our integrated care objectives
- Patient Experience Metric: We are developing innovative metrics of patient experience with Picker and DoH as part of the Pioneer programmes.

Through Tower Hamlets Together, the borough has placed particular emphasis on sharing good practice and innovation with other areas, regionally and nationally. In addition, the council and the CCG have responded positively to requests for information and speakers from bodies, such as NHS England, and other health and social care networks. To be developed further, with examples

10. Assessment of Risk and Risk Management

As in 2016-17, Tower Hamlets' approach to risk sharing has been developed with the following principles:

- That risk for service budgets within the pooled fund sits with the providers of those services (see Section 75)
- The construction of a risk and reward pool between all THT partners and the CCG and council

The following table sets out the perceived most important risks and the actions that will be taken to address them.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Unexpected shifts in care costs not accounted for in BCF Planning to either LBTH or CCG.	2	4	8	KPIs allow early identification of shifts in pressure. The S75 agreement will have robust monitoring and evaluation procedures via the Complex Adults Programme Board and the Joint Commissioning Executive. The Better Care Fund Working Group and DFG Working Group monitors shifts in demand.
Failure to identify a high quality	2	3	6	Clear expectations set out in the process so that quality is achieved.

provider				Robust process underpinned with clear KPIs, deliverables and specification
One of the providers withdraws from the process	1	4	4	Ensure there is strong PMO support to ensure momentum Contracts do not allow for withdrawal before review period. Robust Commissioning Frameworks to manage risk.
Patient/client specific information is not able to be shared and this leads to fragmented care and lack of integrated working.	2	4	8	The following needs to be checked and updated INEL Information Sharing Agreement in place. SSISSA available for specific sharing. Patient/service user consent to share information forms used in ASC and health. Robust Information Governance in place (IG Toolkit compliant) Caldicott Guardian Seeking full signed consent as a matter of routine best practice from every patient/service user who is within the integrated care services. Currently applying for s251 approval and working with the Pioneer programme at the Department of health Review Client Information Sharing Agreement Form in ASC to ensure is legally compliant.
Achievement of DTOC metric	3	4	12	Monthly monitoring of KPIs for early identification of DTOC

put at risk due to people requiring specialist provision commissioned by NHS England remaining in hospital which will lead to delayed transfers of care (DTOC)				Joint Working Group oversees DTOC performance and regular updates are provided to Joint Commissioning Executive.
Risk BCF Plans will not be agreed between LBTH and CCG	1	5	5	Strong governance structures already exist between the two organisations through the Tower Hamlets Health and Wellbeing, the Joint Commissioning Executive Board and the Complex Adults Programme Board. These Boards will regularly review the planning and implementation of the BCF Plan.

Risk and reward pool – Local Incentive Scheme

Text to follow

11. National Metrics

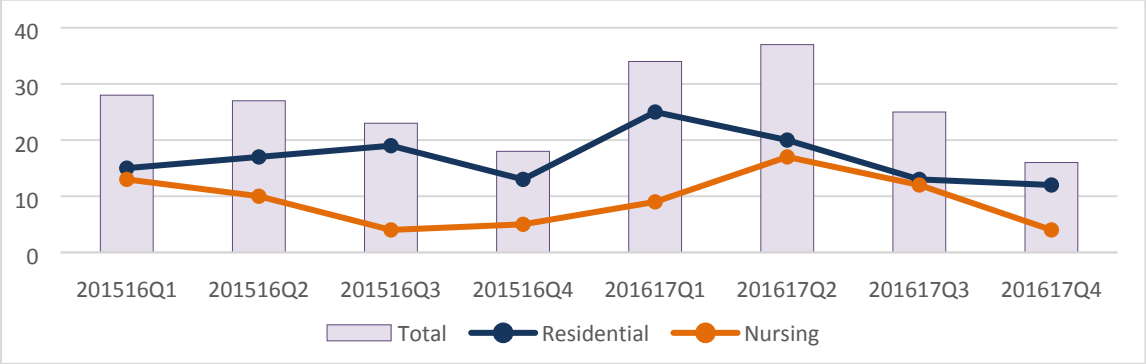
- **Non Elective Admissions** To be updated

A target has been set for general and acute NEA and included in the submission template. Section xx provides a list of BCF schemes which support the reduction of NEA. Needs to be developed

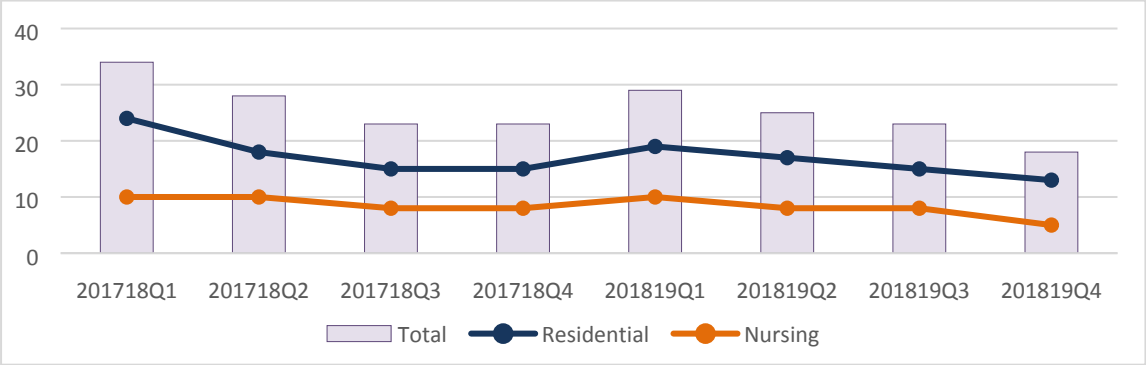
- **Admissions to Residential and Care Homes**

The tables below set out Tower Hamlets' admissions to residential and nursing care homes for people aged 65 and over. (Actuals are shown in the first table and forecasts for 2017-19 in the second.)

	201516Q1	201516Q2	201516Q3	201516Q4	201617Q1	201617Q2	201617Q3	201617Q4
Residential	15	17	19	13	25	20	13	12
Nursing	13	10	4	5	9	17	12	4
Total	**28**	**27**	**23**	**18**	**34**	**37**	**25**	**16**



	201718Q1	201718Q2	201718Q3	201718Q4	201819Q1	201819Q2	201819Q3	201819Q4
Residential	24	18	15	15	19	17	15	13
Nursing	10	10	8	8	10	8	8	5
Total	**34**	**28**	**23**	**23**	**29**	**25**	**23**	**18**

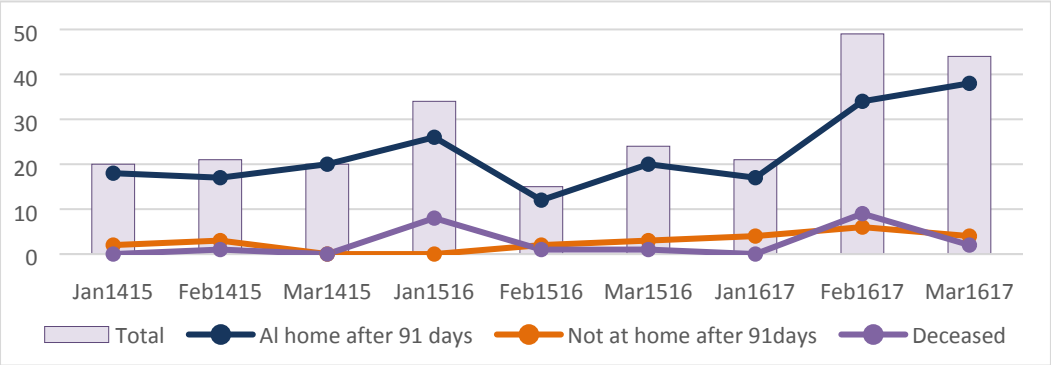


Under our prevention agenda, and with the support of BCF and IBCF resources, an Improvement Board has been set up to plan and manage the demand for residential and nursing care homes for people aged 65+. One of the key measures adopted as part of this plan has been a delegation of resources to the 'front door', with the intention of managing demand at the point of contact through more effective utilisation of equipment and adaptations, along with reablement services. This is reflected in the increased usage of reablement services in 2016-17 referred to above (cf ASCOF 2B 91 days indicator). The forecasts are ambitious but are considered achievable with the current improvement plans and additional support for coming years of 2017-18 and 2018-19 as per the tables above. Community Health Teams have begun engaging with high-risk integrated care patients with the aim of co-ordinated support to maintain independence. The reablement service continues to support the independence of service users.

- **Effectiveness of Reablement**

The tables below sets out performance to the end of March 2017 against the national metric.

	Jan1415	Feb1415	Mar1415	Jan1516	Feb1516	Mar1516	Jan1617	Feb1617	Mar1617
Al home after 91 days	18	17	20	26	12	20	17	34	38
Not at home after 91days	2	3	0	0	2	3	4	6	4
Deceased	0	1	0	8	1	1	0	9	2
Total	**20**	**21**	**20**	**34**	**15**	**24**	**21**	**49**	**44**



The overall number of people being supported with reablement services following a hospital discharge has increased significantly. This is in part a reflection of changes in policy and practice and an increase of staffing resources allocated towards supporting people leaving hospital. In the final quarter of 2015-16, 73 people received a reablement service following discharge from hospital. In quarter 4 of 2016-17 the corresponding figure was 114 people supported by reablement. The volume increased (by 56%). 78% of the cohort were still at home after the 91 day period, compared to a target of 82%. To a considerable extent this reduction in performance is a reflection of the substantial increase in the number of people supported.

Targets have been set for 2017-18 and 2018-19 of 80.0% and 83.1% respectively. These targets are considered achievable in the light of past years' performance. Improved Better Care Fund resources, are being invested in the reablement service to reduce waiting times,

and this is expected to have the effect of increasing the effectiveness of the support given to people leaving hospital.

- **Delayed transfers of care (DTOC) plan**

Section to be developed and updated

Tower Hamlets has a local action plan for managing delayed transfers of care, which includes stretching targets for their reduction. It should be noted that within Tower Hamlets, figures on the DTOC measure, as defined within the BCF guidance, are already relatively low compared to comparator boroughs. However, given we have a large tertiary trust which includes hyper acute stroke, and trauma services, hospital flow is impacted significantly by the challenges connected to managing patients whose homes are outside the borough, and even outside London. Therefore, our significant plans address both issues, but this is not reflected in the Borough metric.

Tower Hamlets' plan is within the context of the A&E Delivery Board plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community. The CCG has invested along with its partners in the STP area, via operational resilience monies, in a number of effective schemes to manage the system at points of highest pressure. This builds upon the recurrent investment the CCG has made over the last three years which is enshrined within the Better Care Fund and associated strategy. As such, reductions in emergency admissions, A&E attendances, all of which have a significant impact on DTOC, are reflected in CCG operational plans.

DTOC are a particular measure connected to the local incentive scheme, therefore acting as a local risk sharing agreements with respect to DTOC. Providers of services will be rewarded for the delivery of services in line with existing guidance and best practice. In the event of non-delivery, the commissioner is able to use this scheme to manage risk and make decisions on any additional investment, or changes in the existing portfolio to drive delivery. In agreeing our plans for System resilience and delayed transfers of care, Tower Hamlets CCG and council have engaged with our local acute and community trusts (Barts Health), and Mental Health Trust (East London Foundation Trust). All partners sit on the System Resilience Group, Urgent Care Working Group, A&E Delivery Board and are full members of the Tower Hamlets Together Board for the Better Care Fund. The GP Care Group, Barts Health and ELFT also hold an Alliance Contract for community services as mentioned above. The A&E Delivery Board has led on the implementation of national guidance and best practice, including the eight 'high impact interventions' that were agreed by ECIP. In addition there has been engagement with the independent and voluntary sector providers locally including the funding of such initiatives as "Take Home and Settle" with Age UK.

A DTOC target rate has been set of 330 per 100,000. We aim to reach this target following work undertaken in the last 12 months and work which is planned to happen as discussed in this narrative. 560/100,000 was the borough's original target. We are hopeful in achieving this ambition, based on performance in Q1 of 319. Performance is already low when compared to other areas. Our view is that a statistically significant reduction from this low baseline would not be achievable. The pressure on DTOC in Tower Hamlets is largely driven

by out of borough DTOCs, due to Barts Health's status as a major tertiary trust. DTOC driven by local flow issues (the focus of the BCF) are relatively low compared to other areas.

Please refer to the attached – DTOC Trajectory and Plan Assurance (add plan)

- **Delivery of 7 day services to support DTOC**

Rapid Assessment Interface Discharge

Rapid Assessment Interface and Discharge (RAID) is a service open to all patients with mental health and drug and alcohol problems over the age of 16 presenting at the Royal London Hospital and all associated Barts Health sites in Tower Hamlets. The service offers a comprehensive range of mental health specialties within one multi-disciplinary team. The role of this team is to provide clinical support and supervision in mental health interventions, alongside formal and informal training for general acute hospital staff. The model emphasises rapid response, with a target time of one hour within which to assess referred patients who present to A&E and 24 hours for seeing referred patients on inpatient wards. This focus on prompt assessment and intervention is intended to improve patient experience and outcomes, support diversion and discharge from A&E and facilitate early discharge from inpatient wards. The RAID service is available 24 hours a day. There is evidence of an overall decrease in length of stay for patients with mental health and drug and alcohol problems since the introduction of RAID. This is largely driven by a reduction in bed usage for non-elective patients, especially for those with dementia, substance misuse and severe mental illness. It is estimated that this saved approximately 2833 bed days in the 2014/15 financial year. The occupied bed days data for 2016/2017 shows that when patients with mental health problems are referred to RAID they are being discharged at a faster rate evidenced by the trend line which is going down. RAID sees patients with more complex needs who would have otherwise stayed much longer in hospital. The data shows a saving of at least 1778 OBDs a year (an average saving of 1 OBD per patient when you exclude April 2016) and at most 4400 OBDs a year (an average saving of 2.5 OBD if you include April 2016).

Integrated Community Health Team

The integrated community health team provides health and social care input to housebound patients over the age of 18. The service offers a comprehensive range of specialities within one multi-disciplinary team, including nursing, therapies, social care, mental health and case management. There is also specialist input from a community geriatrician and palliative care nurse. The teams are divided into 4 localities across the borough. The focus of the service is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and providing personalised, co-ordinated care in the community. The emphasis is upon improving patient experience and outcomes, supporting self-care, preventing A&E attendances and hospital admissions and facilitating timely discharge from inpatient wards. The service is available 24 hours a day (between 8pm-8am, this is comprised of nursing provision only).

On average, across the four locality teams in March 2015, the service reported:

Responding to 98% of rapid response referrals within 2 hours

Providing input/putting in place packages of care for 97% of urgent referrals within 24 hours

Providing input/putting in place packages of care for 96% of routine referrals within 5 days

The model for community health services changed with the Tower Hamlets Community Health Services Alliance Contract. The community health teams will be remodelled into Extended Primary Care Teams with a focus of supporting self-care and improving health and well-being. The operation of a multidisciplinary Rapid Response Team, consisting of nursing, therapy and social work elements responds within two hours to put in place packages of care. Since April 2017, data shows that this service prevents ED attendance or admission in approximately 90% of patients referred to the team. The Rapid Response Team also works closely with the Physician Response Unit, which is operated by Barts Health.

There is a social care component integrated with the Community Health Team. Fundamental to the overall design of the wrap around approach within the GP networks, this scheme seeks to extend the involvement of social care functions on a spectrum of integration with Community Health Teams over time. The focus of this scheme is primarily related to preventing the highest risk groups from requiring health interventions, particularly acute and secondary health services, and supporting them in the community, providing care and support closer to home. Targeting the 'frequent flyers' in the health economy, this provides the last resort to health management in the community. The extension of the scheme allows more people to be supported lower down the spectrum of risk to prevent more costly interventions arising. Learning points from this pilot team has been incorporated into the high level plan for Adult Social Care integration with Health. The plan for 2017-2018 it to align social care services with the existing community health teams in preparation for integration in 2018-2019.

Hospital Social Work Team

Through the BCF programme, the Hospital Social Work Team at the Royal London Hospital continue to operate seven day working and extended hours (9am – 8pm daily), with the aim of facilitating rapid discharge of patients who are fit to leave the hospital. As well as hospital based social work staff, the proposals include additional Brokerage staff and Reablement staff to complement weekend discharge and provide a whole system approach. The Hospital Social Work Team also seeks to help reduce further attendances and admissions to hospital by supporting people in the home and other settings.

The focus of this scheme is about preventing people from being admitted to hospital in the first instance, leading to reduced bed days. In addition, through good quality discharge arrangements, people are safely discharged at weekends where they will have previously waited until the following week, or discharged without input from social care, or the carer not being involved in the discharge planning. This will ensure that any carers are fully involved in the discharge, preventing breakdown of care; support is in place in the home (or in step down arrangements) to meet needs preventing relapse and beds are freed up in a planned way over the course of seven days rather than five.

Social workers are based in Acute Assessment Unit (AAU) and the plan for 2017-2018 is for social workers to be proactive in case-finding on all hospital wards. This will lead to efficiencies in assessment turnaround times and improved multi-disciplinary working. The Team also works closely with the Community Health Team to identify people who are frequent visitors to hospital, via the Integrated Care Pathway list. The plan for 2017-2018 is for people on the

Integrated Care Pathway to be more quickly identified redirecting them back home to their GP locality under the care and support of their MDT. Develop this

Rehabilitation and Reablement

Reablement, traditionally provided by the local authority, and Rehabilitation, provided by health services are so closely aligned that the pathway for people leaving hospital and requiring support to return to baseline or maintain their level of independence can be inconsistent and involve duplication across the system. Under the plan for Adult Social Care integration with health services, the two functions will be aligned during 2017-2018 and integrated in 2018-2019. The focus of this scheme is on preventing, reducing and delaying health and care needs from taking root, by offering a spectrum of bringing joint expertise to bear on individual cases, but also espousing the ethos of each other's expertise within specific cases to get the best outcomes for individuals. Getting people back in control of their situations will reduce the call on health services, enable self-management of conditions far more and enable Carers to support individuals appropriately.

Admission Avoidance and Discharge Service (AADS) including D2A

A pilot for a discharge to assess model was funded in 2015/16. Further operational resilience funding has been provided from September 2016 to March 2018 for the Admission Avoidance & Discharge Service (AADS) which incorporates the discharge to assess model for patients at the Royal London Hospital. The community service operates 7 days per week from 8am-6pm with up to 6 weeks input. The team takes a proactive and responsive approach to discharge; aiming to triage patients within 2 hours of referral. Most patients who received the service have been admitted to wards on the 11th and 14th floors at RLH. Since July 2017, patients who are expected to return to their usual place of residence and have had a positive checklist and are awaiting a continuing health care assessment (DST) and expected to return to their usual place of residence can have this assessment completed at home. Between September 2016 and May 2017, over 200 patients have benefited from the discharge to assess model and received a care package via AADS. On average, over 20% of patients require no or reduced social care input at the end of the 6 weeks with AADS.

Approval and sign off

An earlier draft of this plan was endorsed by the Tower Hamlets Health and Well-Being Board on 5 September 2017 and the Tower Hamlets Together Board on 7 September 2017. The final draft of the plan, as submitted to NHS England, was signed off on behalf of the HWBB by Simon Hall, Acting Chief Officer of Tower Hamlets Clinical Commissioning Group and Denise Radley, Corporate Director, Health, Adults & Community, Tower Hamlets Council.

In the event that a second submission of the plan is required, it is envisaged that it will be agreed for submission by the Joint Commissioning Executive on behalf of the Health and Well-being Board and formally ratified by the HWBB at its meeting on 7th November.

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Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: Guidance

Overview

This template is to be read and used in conjunction with the BCF Policy Framework document and the BCF Planning Requirements document which provides the background and further details on the planning requirements for 2017-2019.

The purpose of this template is to collect the BCF planning information for each HWB which includes confirmation of National Conditions, specific funding requirements, scheme level financial information and planning metrics for the period 2017-2019.

This template should also be aligned to the BCF narrative plan documents for the BCF schemes being planned for 2017-2019 by the HWB.

Note on entering information into this template

1. Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:
Yellow: Data needs inputting in the cell
Blue: Pre-populated cell
2. All cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000
3. This template captures data for two years 2017-19

Data needs inputting in the cell

Pre-populated cell

Note on viewing the sheets optimally

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

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

Checklist (click to go to tab)

1. This sheet helps identify the data fields that have not been completed. All fields that appear as incomplete should be complete before submission for plan-assurance.
2. It is sectioned out by sheet name and contains the description of the information required, cell reference (hyperlinked) for the question and the 'checker' column which updates automatically as questions within each sheet are completed.
3. The checker column will appear “Red” and contain the word “No” if the information has not been completed. Clicking on the corresponding “Cell Reference” column will link to the incomplete cell for completion. Once completed the checker column will change to “Green” and contain the word “Yes”
4. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
5. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Complete Template'.
6. Please ensure that all boxes on the checklist tab are green before submission.

Summary (click to go to tab)

1. This sheet summarises the key planning information provided on the template to be used for review and plan-assurance.
2. Print guidance: By default this sheet has been set up to print across 4 pages, landscape mode and A4.

1. Cover (click to go to tab)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Please enter the following information on this sheet:
- Several area assurance contact roles have been pre-populated for you to fill in, please enter the name of that contact and their email address for use in resolving any queries regarding the return;
- Please add any further area contacts that you would wish to be included in official correspondence. Please include their job title, and their email address.
3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all 5 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. HWB Funding Sources (click to go to tab)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2017-19. It will be pre-populated with the minimum CCG contributions to the BCF, the DFG allocations and the iBCF allocations. These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

2. This sheet captures the various funding sources that contribute to the total BCF pool for the Local Area. The DFG, iBCF and CCG minimum funding streams are pre-populated and do not need re-entering.
Please enter the following information on this sheet:
- Additional contributions from Local Authorities or CCGs: as applicable are to be entered on this tab on the appropriate sections highlighted in "yellow".
- Additional Local Authority contributions: Please detail any additional Local Authority funding contributions by selecting the relevant authorities within the HWB and then entering the values of the contributions. Please use the comment boxes alongside to add any specific detail around this additional contribution.
- Additional CCG contributions: Please detail any additional CCG funding contributions by selecting the relevant CCGs. Please note, only contributions assigned to a CCG will be included in the 'Total Additional CCG Contribution' figure.
- Funding contributions narrative: Please enter any comments in the "Funding Contributions Narrative" field to offer any information that could be useful to further clarify or elaborate on the funding sources allocations entered including any assumptions that may have been made.
- Specific funding requirements: This section requests confirmation on the specific funding requirements for 2017-19. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for further details. These are mandatory conditions and will need to be confirmed through the planning assurance process. Please select "Yes" where the funding requirement can be confirmed as having been met, or "No" to indicate that the requirement is unconfirmed. Where "No" is selected as the status, please provide further detail in the comments box alongside to indicate the actions being taken or considered towards confirming the requirement.

3. HWB Expenditure Plan (click to go to tab)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and utilised to analyse the BCF plans nationally and sets the basis for future reporting and to demonstrate how the national policy framework is being achieved.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme. In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this tab please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple lines.

2. Scheme Name:
- This is a free field. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop down list that best represents the type of scheme being planned. A description of each scheme is available at the end of the table (follow the link to the description section at the top of the main expenditure table).
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.

4. Area of Spend:
- Please select the area of spend from the drop down list by considering the area of the health and social system which is most supported by investing in the scheme.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.

5. Commissioner:
- Identify the commissioning entity for the scheme based on who commissions the scheme to the provider. If there is a single commissioner please select the option from the drop down list.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns alongside.

6. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

7. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list.
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines.

8. Scheme Duration:
- Please select the timeframe for which the scheme is planned for from the drop down list: whether 2017-18, 2018-19 or Both Years.

9. Expenditure (£) 2017-19:
- Please enter the planned spend for the scheme (Based on the duration of the scheme, please enter this information for 2017-18, 2018-19 or both)

This is the only detailed information on BCF schemes being collected centrally for 2017-19 but it is expected that detailed plans and narrative plans will continue to be developed locally and this information will be consistent across them.

4. HWB Metrics (click to go to tab)

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2017-19. The BCF requires plans to be set for 4 nationally defined metrics.
This should build on planned and actual performance on these metrics in 2016-17.

1. Non-Elective Admissions (NEA) metric planning:
• The NEA plan totals are pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2017-19. This is to align with the wider CCG Ops planning for this metric
• If the BCF schemes are aiming for additional NEA reductions which are not already built into the CCG Operating Plan numbers for NEAs, please select “Yes” to the question “Are you planning on additional quarterly reductions”. This will make the cells in the table below editable. Please enter the additional quarterly planned NEA reductions for 2017-19 in these cells.
• Where an additional reduction in NEA activity is planned for through the BCF schemes, an option is provided to set out an associated NEA performance related contingency reserve arrangement (this is described in the Planning Requirements document). When opting to include this arrangement, please select “Yes” on the NEA cost question. This will enable any adjustments to be made to the NEA cost assumptions (just below) which are used to calculate the contingency reserve fund. Please add a reason for any adjustments made to the cost of NEA
• Further information on planning further reductions in Non-Elective Activity and associated contingency reserve arrangements is set out within the BCF Planning Requirements document.

2. Residential Admissions (RES) planning:
• This section requires inputting the information for the numerator of the measure.
• Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
• The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from ONS 2014 based subnational population projections.
• The annual rate is then calculated and populated based on the entered information.
• Please add a commentary in the column alongside to provide any useful information in relation to how you have agreed this figure.

3. Reablement (REA) planning:
• This section requires inputting the information for the numerator and denominator of the measure.
• Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
• Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
• The annual proportion (%) Reablement measure will then be calculated and populated based on this information.
• Please add a commentary in the column alongside to provide any useful information in relation to how you have agreed this figure.

4. Delayed Transfers of Care (DToC) planning:
• Please refer to the BCF Planning Requirements 17/19 when completing this section.
• This section captures the planned Delayed Transfers Of Care (delayed days) metric for 2017/19
• Please input the delayed days figure for each quarter.
• The total delayed days and the quarterly rate is then calculated based on this entered information
• The denominator figure in row 95 is pre-populated (population - aged 18+, 2014 based SNPP). This figure is utilised to calculate the quarterly rate.
• Please add a commentary in the column alongside to provide any supporting or explanatory information in relation to how this metric has been planned.

5. National Conditions (click to go to tab)

This sheet requires the Health & Wellbeing Board to confirm whether the national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2017-19. Please refer to the BCF Policy Framework and BCF Planning Requirements docments for 2017-19 where the BCF national conditions are set out in full. Please answer as at the time of completion.
On this tab please enter the following information:

1. Confirmation status for 2017/18 and 2018/19:
For each national condition please use the 2017/18 column to select ‘Yes' or ‘No’ to indicate whether there is a clear plan set out to meet the condition for 2017/18 and again for 2018/19. Selecting ‘Yes’ confirms meeting the National Condition for the Health and Well Being board as per the BCF Policy Framework and Planning Requirements for 17/19

2. Where the confirmation selected is ‘No’, please use the comments box alongside to indicate when it is expected that the condition will be met / agreed if it is not being currently. Please detail in the comments box issues and/or actions that are being taken to meet the condition, when it is expected that the condition will be met and any other supporting information.

CCG - HWB Mapping (click to go to tab)

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

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Planning Template v.14.6b for BCF: due on 11/09/2017

Better Care Fund 2017-19 Planning Template

Sheet: Checklist

[<< Link to the Guidance tab]

Incomplete Template

1. Cover

	Cell Reference	Checker
Health and Well Being Board	C10	Yes
Completed by:	C13	Yes
E-mail:	C15	Yes
Contact number:	C17	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	Yes
Area Assurance Contact Details	C22 : G31	Yes

Sheet Completed:	Yes

2. HWB Funding Sources

	Cell Reference	Checker
Are any additional LA Contributions being made on 2017/18? If yes please detail below	C35	Yes
Are any additional LA Contributions being made on 2018/19? If yes please detail below	D35	Yes
Local authority additional contribution:	B38 : B40	Yes
Gross Contribution (2017/18)	C41	No
Gross Contribution (2018/19)	D41	No
Comments (if required)	F38	N/A
Are any additional CCG Contributions being made on 2017/18? If yes please detail below;	C62	No
Are any additional CCG Contributions being made on 2018/19? If yes please detail below;	D62	No
Additional CCG Contribution:	B65	No
Gross Contribution (2017/18)	C65	No
Gross Contribution (2018/19)	D65	No
Comments (if required)	F65	N/A
Funding Sources Narrative	B83	N/A
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? (2017/18)	C91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? (2017/18)	C93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? (2017/18)	C94	Yes
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? (2017/18)	C95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? (2017/18)	C96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? (2017/18)	C97	Yes
6. Is the iBCF grant included in the pooled BCF fund? (2017/18)	C98	Yes
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? (2018/19)	D91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? (2018/19)	D93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? (2018/19)	D94	Yes
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? (2018/19)	D95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? (2018/19)	D96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? (2018/19)	D97	Yes
6. Is the iBCF grant included in the pooled BCF fund? (2018/19)	D98	Yes
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? Comments	E91	Yes
2. i) In areas with two tiers of local government, can you confirm that the full amount of Disabled Facilities Grant will be passed to local housing authorities? Comments	E93	Yes
2. ii) In areas with two tiers of local government, can you confirm that relevant district councils have agreed how Disabled Facilities Grant will be spent in line with ambitions in the BCF to support integrated approaches to health, social care and housing? Comments	E94	Yes
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? Comments	E95	Yes
4. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	E96	Yes
5. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	E97	Yes
6. Is the iBCF grant included in the pooled BCF fund? Comments	E98	Yes

Sheet Completed:	No

3. HWB Expenditure Plan

	Cell Reference	Checker
Scheme ID	B18 : B267	No
Scheme Name	C18 : C267	Yes
Scheme Type (see table below for descriptions)	D18 : D267	No
Sub Types	E18 : E267	Yes
Please specify if 'Scheme Type' or 'Sub Type' is 'other'	F18 : F267	No
Area of Spend	G18 : G267	No
Please specify if 'Area of Spend' is 'other'	H18 : H267	No
Commissioner	I18 : I267	No
if Joint Commissioner % NHS	J18 : J267	No
if Joint Commissioner % LA	K18 : K267	No
Provider	L18 : L267	No
Source of Funding	M18 : M267	No
Scheme Duration	N18 : N267	Yes
2017/18 Expenditure (£000's)	O18 : O267	Yes
2018/19 Expenditure (£000's)	P18 : P267	Yes
New or Existing Scheme	Q18 : Q267	Yes

Sheet Completed:	No

4. HWB Metrics

	Cell Reference	Checker
4.1 - Are you planning on any additional quarterly reductions?	E18	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q1 (2017/18)	F20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q2 (2017/18)	G20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q3 (2017/18)	H20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q4 (2017/18)	I20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q1 (2018/19)	J20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q2 (2018/19)	K20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q3 (2018/19)	L20	Yes
4.1 - HWB Quarterly Additional Reduction Figure - Q4 (2018/19)	M20	Yes
4.1 - Are you putting in place a local contingency fund agreement on NEA?	E24	Yes
4.1 - Cost of NEA (2017/18)	E30	Yes
4.1 - Cost of NEA (2018/19)	E31	Yes
4.1 - Comments (2017/18) (if required)	F30	N/A
4.1 - Comments (2018/19) (if required)	F31	N/A
4.2 - Residential Admissions : Numerator : Planned 17/18	H48	Yes
4.2 - Residential Admissions : Numerator : Planned 18/19	I48	Yes
4.2 - Comments (if required)	J47	N/A
4.3 - Reablement : Numerator : Planned 17/18	H57	Yes
4.3 - Reablement : Denominator : Planned 17/18	H58	Yes
4.3 - Reablement : Numerator : Planned 18/19	I57	Yes
4.3 - Reablement : Denominator : Planned 18/19	I58	Yes
4.3 - Comments (if required)	J56	N/A
4.4 - Delayed Transfers of Care : Planned Q1 17/18	I65	Yes
4.4 - Delayed Transfers of Care : Planned Q2 17/18	J65	Yes
4.4 - Delayed Transfers of Care : Planned Q3 17/18	K65	Yes
4.4 - Delayed Transfers of Care : Planned Q4 17/18	L65	Yes
4.4 - Delayed Transfers of Care : Planned Q1 18/19	M65	Yes
4.4 - Delayed Transfers of Care : Planned Q2 18/19	N65	No
4.4 - Delayed Transfers of Care : Planned Q3 18/19	O65	No
4.4 - Delayed Transfers of Care : Planned Q4 18/19	P65	Yes
4.4 - Comments (if required)	Q64	N/A

Sheet Completed:	No

5. National Conditions

	Cell Reference	Checker
1) Plans to be jointly agreed (2017/18)	C14	Yes
2) NHS contribution to adult social care is maintained in line with inflation (2017/18)	C15	Yes
3) Agreement to invest in NHS commissioned out of hospital services (2017/18)	C16	Yes
4) Managing transfers of care	C17	Yes
1) Plans to be jointly agreed (2018/19)	D14	Yes
2) NHS contribution to adult social care is maintained in line with inflation (2018/19)	D15	Yes
3) Agreement to invest in NHS commissioned out of hospital services (2018/19)	D16	Yes
4) Managing transfers of care	D17	Yes
1) Plans to be jointly agreed, Comments	E14	Yes
2) NHS contribution to adult social care is maintained in line with inflation, Comments	E15	Yes
3) Agreement to invest in NHS commissioned out of hospital services, Comments	E16	Yes
4) Managing transfers of care	E17	Yes

Sheet Completed:	Yes

Planning Template v.14.6b for BCF: due on 11/09/2017

Summary of Health and Well-Being Board 2017-19 Planning Template

Being Board:

Tower Hamlets

Data Submission Period:

2017-19

Summary

<< Link to the Guidance tab

2. HWB Funding Sources

	2017/18 Gross Contribution	2018/19 Gross Contribution
Total Local Authority Contribution exc iBCF	£1,733,988	£1,895,435
Total iBCF Contribution	£8,657,393	£11,907,381
Total Minimum CCG Contribution	£19,141,806	£19,505,500
Total Additional CCG Contribution	£0	£0
Total BCF pooled budget	**£29,533,187**	**£33,308,316**

Specific Funding Requirements for 2017-19	2017/18 Response	2018/19 Response
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

3. HWB Expenditure Plan

Summary of BCF Expenditure (*)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£0	£0
Community Health	£0	£0
Continuing Care	£0	£0
Primary Care	£0	£0
Social Care	£0	£0
Other	£0	£0
Total	**£0**	**£0**

Summary of BCF Expenditure from Minimum CCG Contribution (***)	2017/18 Expenditure	2018/19 Expenditure
Acute	£0	£0
Mental Health	£0	£0
Community Health	£0	£0
Continuing Care	£0	£0
Primary Care	£0	£0
Social Care	£0	£0
Other	£0	£0
Total	**£0**	**£0**

→

Summary of NHS Commissioned Out of Hospital Services Spend from MINIMUM BCF Pool (**)	2017/18 Expenditure	2018/19 Expenditure	
Mental Health	£0	£0	
Community Health	£0	£0	
Continuing Care	£0	£0	
Primary Care	£0	£0	
Social Care	£0	£0	
Other	£0	£0	
Total	**£0**	**£0**	*Below Ringfenced Spend*
NHS Commissioned OOH Ringfence	£5,439,558	£5,542,910	

Additional NEA Reduction linked Contingency Fund	2017/18 Fund	2018/19 Fund
NEA metric linked contingency fund held from the ringfenced local allocation for NHS OOH spend	£0	£0

BCF Expenditure on Social Care from Minimum CCG Contribution	2016/17	2017/18	2018/19
Minimum Mandated Expenditure on Social Care from the CCG minimum		£7,524,476	£7,667,441
Planned Social Care expenditure from the CCG minimum	£7,392,156	£0	£0
Annual % Uplift Planned			
Minimum mandated uplift % (Based on inflation)		**1.79%**	**1.90%**

4. HWB Metrics

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
Total HWB Planned Non-Elective Admissions	5,546	5,605	5,602	5,479	5,595	5,774	5,768	5,678	**22,232**	**22,816**
HWB Quarterly Additional Reduction Figure	0	0	0	0	0	0	0	0	**0**	**0**
HWB NEA Plan (after reduction)	5,546	5,605	5,602	5,479	5,595	5,774	5,768	5,678	**22,232**	**22,816**
Additional NEA reduction delivered through the BCF									**£0**	**£0**

4.2 Residential Admissions

		Planned 17/18	Planned 18/19
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	**Annual rate**	585	499

4.3 Reablement

		Planned 17/18	Planned 18/19
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	**Annual %**	80.0%	83.1%

4.4 Delayed Transfers of Care

		Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	**Quarterly rate**	341	341	339	324	2	0	0	2

5. National Conditions

National Conditions For The BCF 2017-19	Does your BCF plan for 2017/18 set out a clear plan to meet this condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this 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

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;
Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)
Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)
Source of Funding = CCG Minimum Contribution

***Summary of BCF Expenditure from Minimum CCG contribution** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' form the minimum CCG contribution that have been provided by HWBs in their plans (from the 4. HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other
Source of Funding = CCG Minimum Contribution

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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Health and Well Being Board	**Tower Hamlets**
Completed by:	Suki Kaur & Steve Tennison
E-Mail:	Suki.kaur1@nhs.net & Steve.Tennison@towerhamlets.gov.uk
Contact Number:	0203 688 2356 & 020 7364 2567
Who signed off the report on behalf of the Health and Well Being Board:	Denise Radley & Simon Hall

	Role:	Title and Name:	E-mail:
Area Assurance Contact Details*	Health and Wellbeing Board Chair	Vacant	Vacant
	Clinical Commissioning Group Accountable Officer (Lead)	Jane Milligan	jane.milligan1@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	Simon Hall	simonhall2@nhs.net
	Local Authority Chief Executive	Will Tuckley	Will.Tuckley@towerhamlets.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Denise Radley	Denise.Radley@towerhamlets.gov.uk
	Better Care Fund Lead Official -	Steve Tennison	Steve.Tennison@towerhamlets
	LA Section 151 officer	Zena Cooke	Zena.Cooke@towerhamlet.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->	Better Care Fund Lead Official - CCG	Suki Kaur	suki.kaur1@nhs.net

***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'

Incomplete Template

	No. of questions answered
1. Cover	6
2. HWB Funding Sources	24
3. HWB Expenditure Plan	6
4. HWB Metrics	28
5. National Conditions	12

Please go to the Checklist for further details on incomplete questions - Link here

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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:

Tower Hamlets

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
Tower Hamlets	£1,733,988	£1,895,435
Lower Tier DFG Breakdown (for applicable two tier authorities)		
Total Minimum LA Contribution exc iBCF	**£1,733,988**	**£1,895,435**

Are any additional LA Contributions being made in 2017/18 or 2018/19? If yes please detail below	Yes	Yes

Local Authority Additional Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Tower Hamlets		
Total Local Authority Contribution	**£1,733,988**	**£1,895,435**

Comments - please use this box clarify any specific uses or sources of funding

iBCF Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
Tower Hamlets	£8,657,393	£11,907,381
Total iBCF Contribution	**£8,657,393**	**£11,907,381**

CCG Minimum Contribution	2017/18 Gross Contribution	2018/19 Gross Contribution
NHS Tower Hamlets CCG	£19,141,806	£19,505,500
Total Minimum CCG Contribution	**£19,141,806**	**£19,505,500**

Are any additional CCG Contributions being made in 2017/18 or 2018/19? If yes please detail below	<Please Select>	<Please Select>

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	**£29,533,187**	**£33,308,316**

Funding Contributions Narrative

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:

Tower Hamlets

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	£29,533,187	£33,308,316	
Local Authority Contribution balance exc iBCF	£1,733,988	£1,895,435	
CCG Minimum Contribution balance	£19,141,806	£19,505,500	
Additional CCG Contribution balance	£0	£0	
iBCF	£8,657,393	£11,907,381	
Running Totals	**2017/18**	**2018/19**	
Planned Social Care spend from the CCG minimum	£0	£0	*Below Minimum Mandated Spend*
Ringfenced NHS Commissioned OOH spend	£0	£0	*Below Ringfenced Spend*

		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
		<Please Select>			<Please Select>		<Please Select>			<Please Select>	<Please Select>	<Please Select>			<Please Select>

Selected Health and Well Being Board:

Tower Hamlets

Data Submission Period:

2017-19

3. HWB Expenditure Plan

<< Link to Guidance tab

Link to Summary sheet

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Selected Health and Well Being Board:

Tower Hamlets

Data Submission Period:

2017-19

3. HWB Expenditure Plan

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Selected Health and Well Being Board:

Tower Hamlets

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Selected Health and Well Being Board:

Tower Hamlets

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Selected Health and Well Being Board:

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Selected Health and Well Being Board:

Tower Hamlets

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Selected Health and Well Being Board:

Tower Hamlets

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Selected Health and Well Being Board:

Tower Hamlets

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Selected Health and Well Being Board:

Tower Hamlets

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2017-19

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Selected Health and Well Being Board:

Tower Hamlets

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Selected Health and Well Being Board:

Tower Hamlets

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2017-19

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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

Selected Health and Well Being Board:

Tower Hamlets

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	£29,533,187	£33,308,316	
Local Authority Contribution balance exc iBCF	£1,733,988	£1,895,435	
CCG Minimum Contribution balance	£19,141,806	£19,505,500	
Additional CCG Contribution balance	£0	£0	
iBCF	£8,657,393	£11,907,381	
Running Totals	**2017/18**	**2018/19**	
Planned Social Care spend from the CCG minimum	£0	£0	*Below Minimum Mandated Spend*
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Tower Hamlets

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Tower Hamlets

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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
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

Selected Health and Well Being Board:

Tower Hamlets

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3. HWB Expenditure Plan

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	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				
	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:

Tower Hamlets

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	**5,546**	**5,605**	**5,602**	**5,479**	**5,595**	**5,774**	**5,768**	**5,678**	**22,232**	**22,816**

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 **	£5,439,558	£5,542,910

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)

would expect the value of the contingency fund to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: xxxx insert allocation document

*** 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	542.7	498.0	585.0	498.9	Demand for services is significantly growing at Tower Hamlets, we are working and monitoring closely for the next two years under prevention and early intervention and with IBCF additional resources to provide care at home making it more personal.
	Numerator	96	89	108	95	
	Denominator	17,688	17,871	18,462	19,041	

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 %	79.5%	82.7%	80.0%	83.1%	Tower Hamlets has been working towards facilitating increased reablement / rehabilitation services for people discharged from hospital (Actual 60% increase in 2016-17 as compared to 2015-16) which has an impact on the overall performance. it is also important to note that this is a very volatile indicator because of small numbers and clients deceasing following reablement has a negative impact.
	Numerator	58	62	96	108	
	Denominator	73	75	120	130	

4.4 Delayed Transfers of Care

		16-17 Actuals				17-18 plans				18-19 plans				Comments
		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	
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	756.7	702.3	436.8	447.0	340.5	340.5	339.5	324.0	2.4	0.0	0.0	2.4	
	Numerator (total)	1,793	1,664	1,035	1,087	828	828	826	806	6			6	
	Denominator	236,952	236,952	236,952	243,152	243,152	243,152	243,152	248,836	248,836	248,836	248,836	253,993	

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.

Planning Template v.14.6b for BCF: due on 11/09/2017

Sheet: 5. National Conditions

Selected Health and Well Being Board:

Tower Hamlets

Data Submission Period:

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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 condition?	Does your BCF plan for 2018/19 set out a clear plan to meet this condition?	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	

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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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Department for Communities and Local Government

NHS England

Department of Health

Integration and Better Care Fund planning requirements for 2017-19

The Better Care Fund

NHS England Publications Gateway Reference 06945

CONTENTS

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.

[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.

[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:

Category	Description
Approved	• 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.

Approved with conditions	• 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

Not approved	• 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).

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

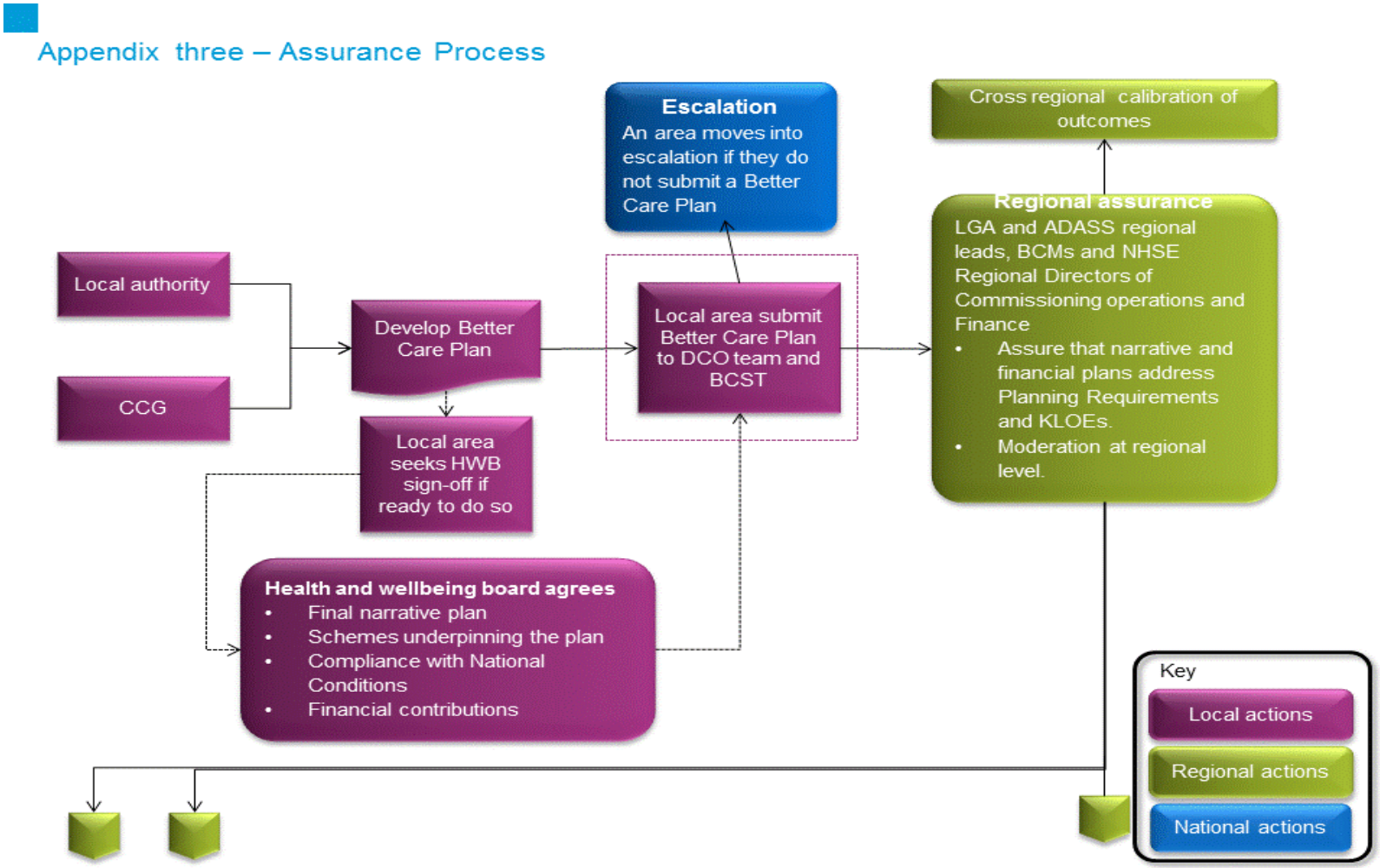
	Q4 2016-17	**Q1 2017-18**	**Q2 2017-18**	**Q3 2017-18**
CCG baseline (quarterly)	12,500	12,500	12,500	12,500
CCG baseline (cumulative)	12,500	25,000	37,500	50,000
BCF stretch target (quarterly)	12,250	12,250	12,250	12,250
BCF stretch metric (cumulative)	12,250	24,500	36,750	49,000
Money held in contingency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

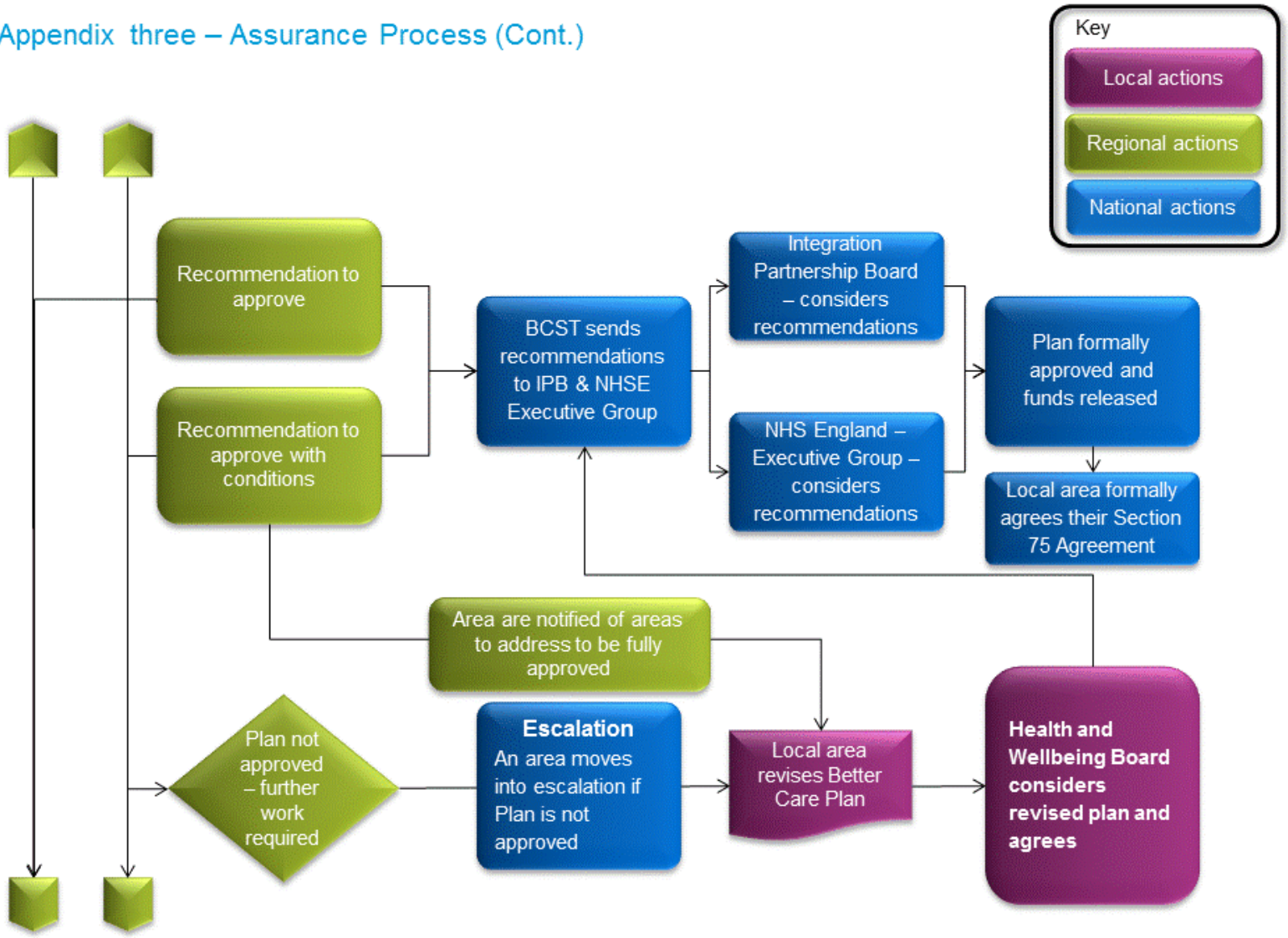
9. Areas should agree how money released from the fund should be spent. The released funds should remain within the pooled fund but can be spent on any activities that are consistent with the aims of the local plan, including social care.

	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.

<u>Quarter 1 (April – June 2017)</u>

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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Better Care Fund 2017-19

A guide to assurance of plans

Draft v5

The Better Care Fund

Contents

BCF 17/19 – Guide to assuring BCF plans

Introduction and context

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

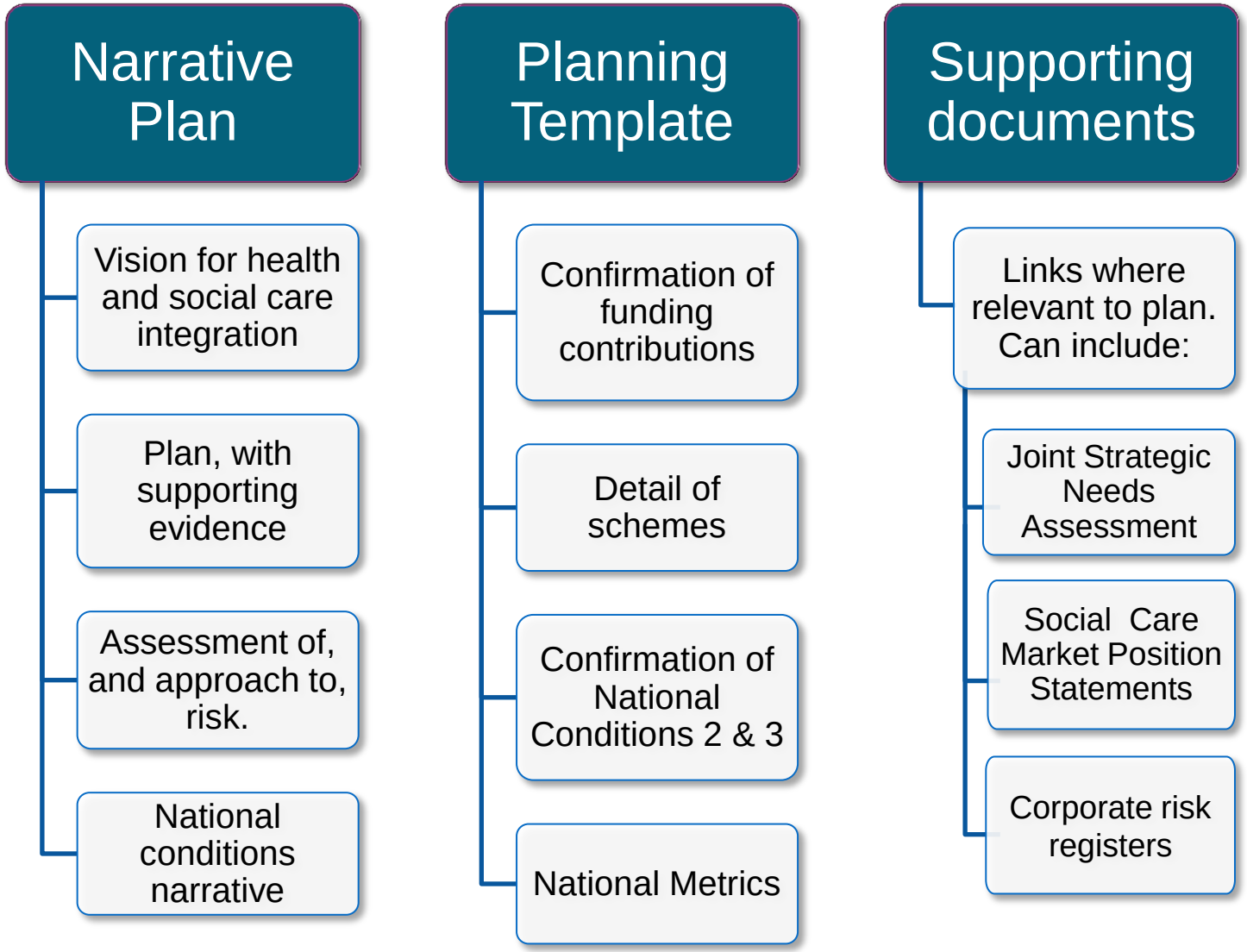
Each Better Care Fund Plan should consist of

- 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



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.

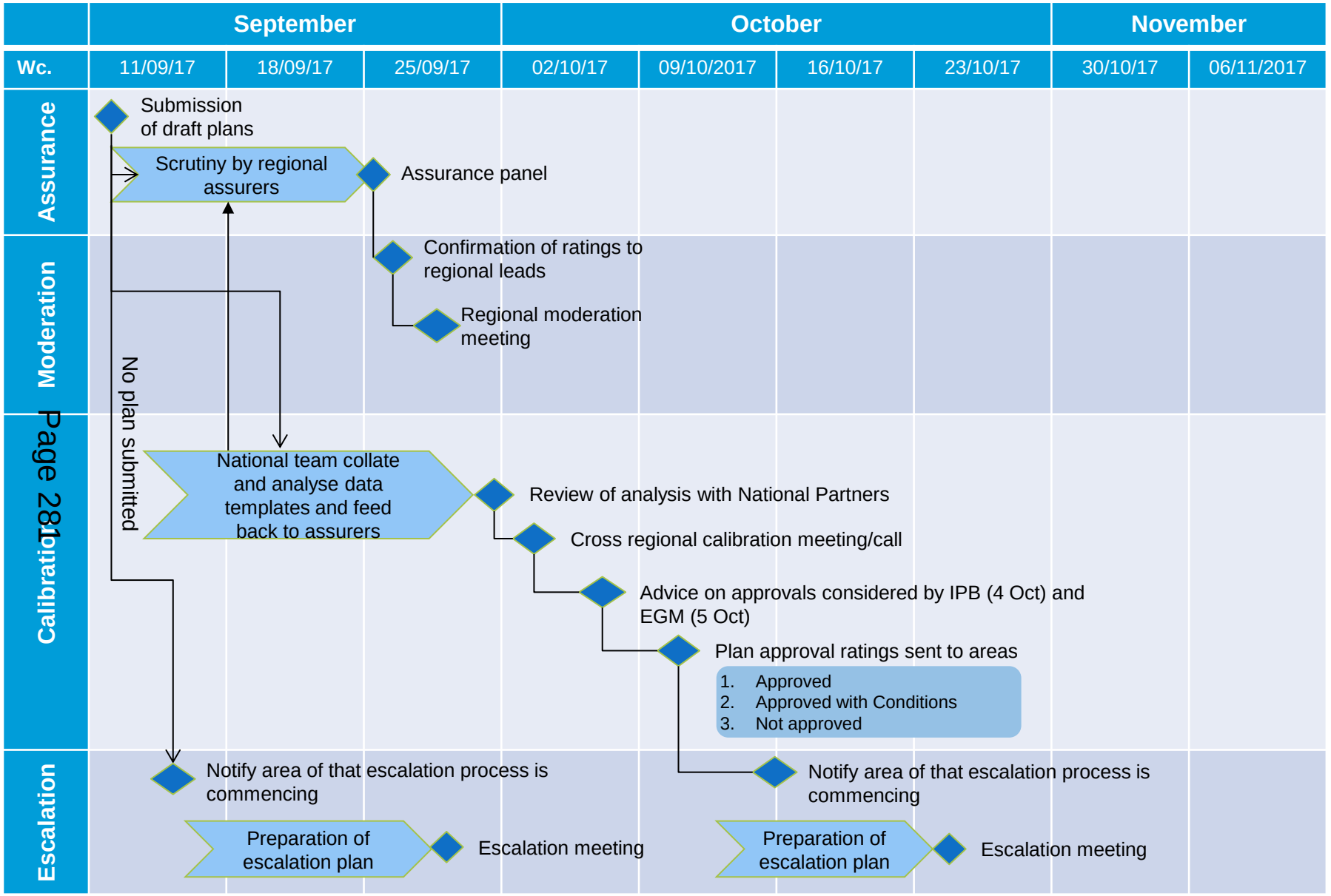
Assurance categorisation and follow up actions

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

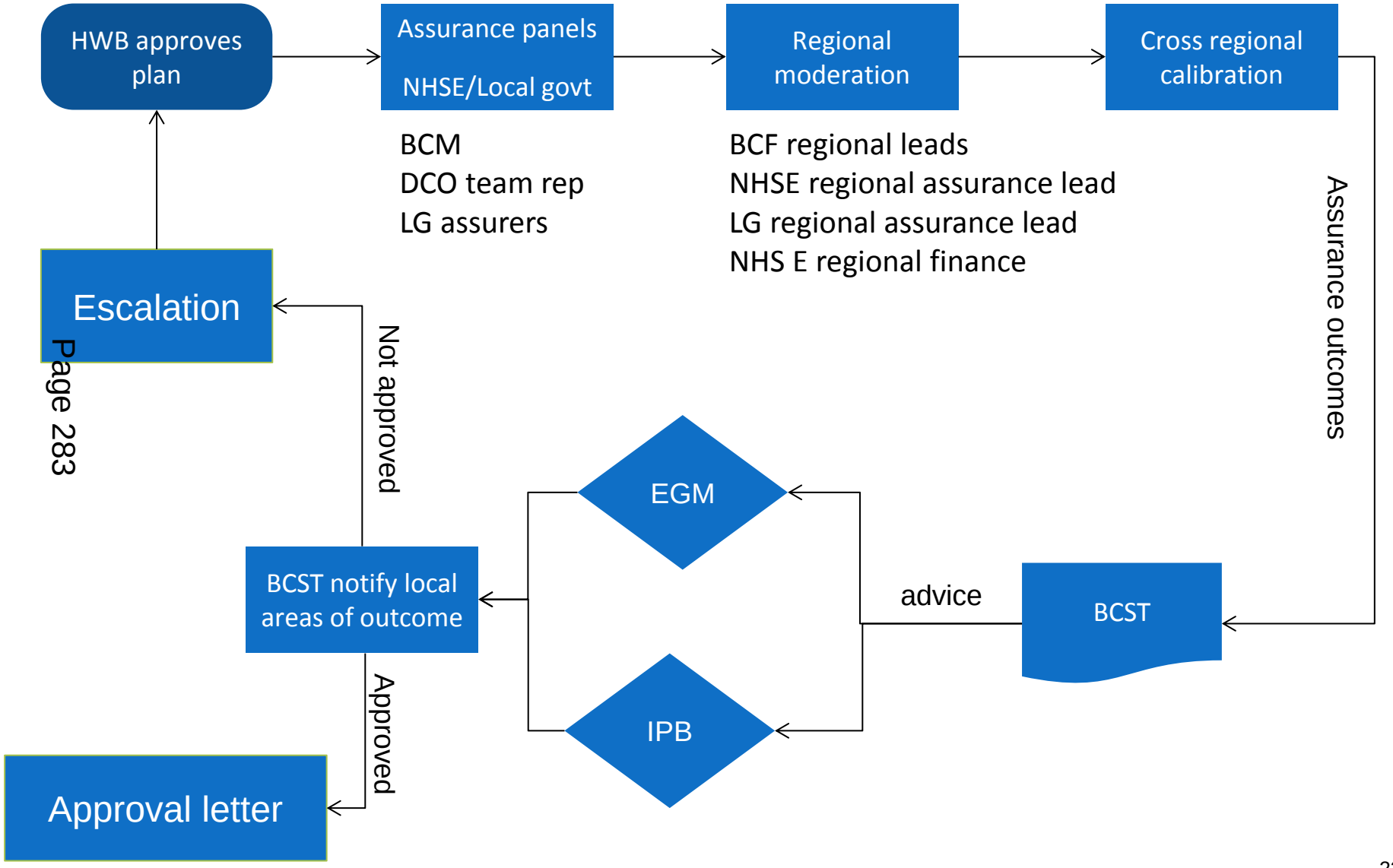
Overview of assurance, moderation and calibration



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.