NHS
Wolverhampton
Clinical Commissioning Group

A meeting of the Wolverhampton Clinical Commissioning Group Governing Body

will take place on Tuesday 10th May 2016 commencing at 1.00 pm

LATE PAPERS

		8	Emergency Preparedness, Resilience and Response (EPRR) Mr A Smith		1 - 2
		10	Better Care Fund Submission Ms A Smith		3 - 428

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Wolverhampton CCG EPRR Work Programme

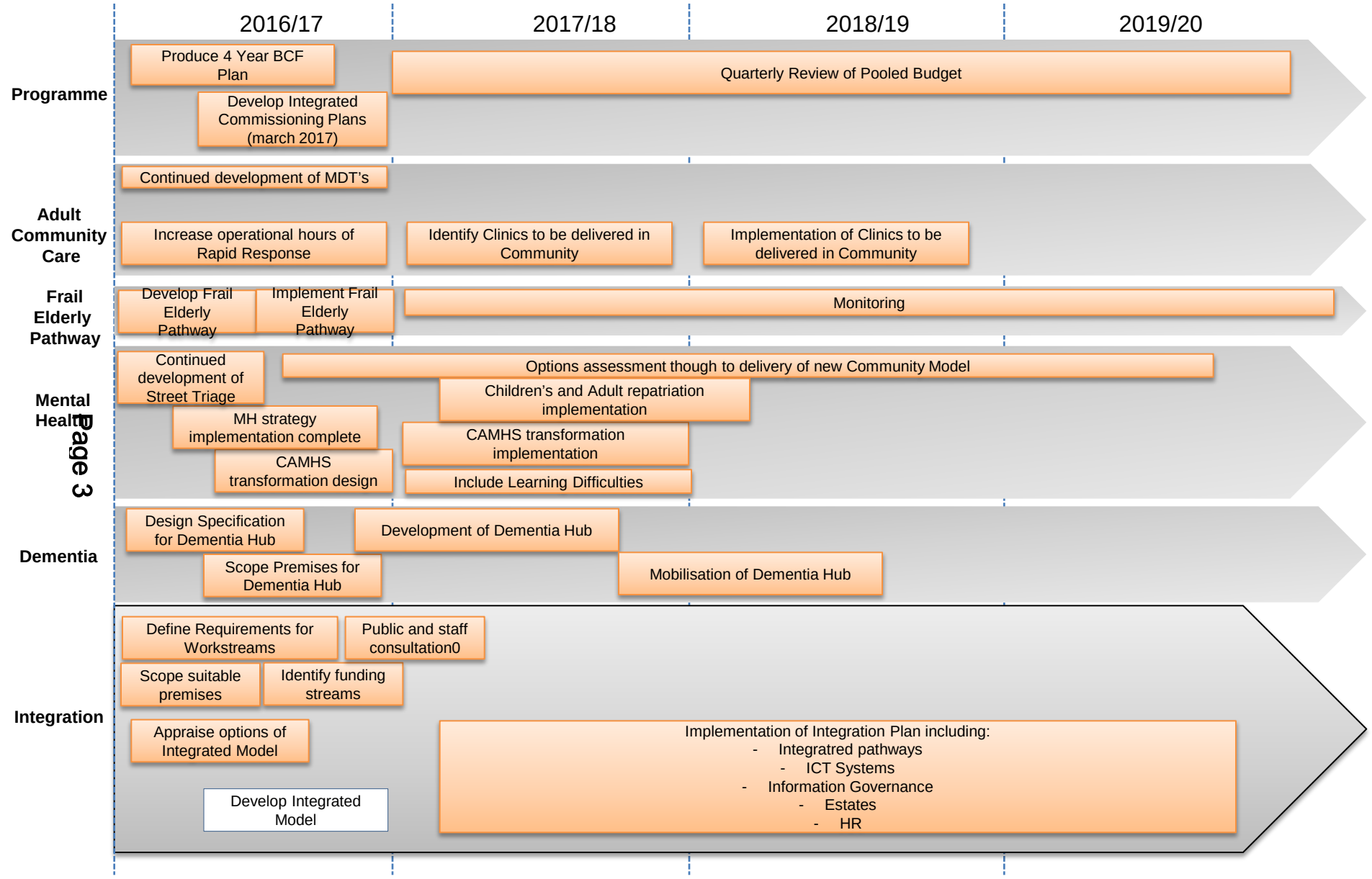
Version	1.0
Date Created	27.4.2016
Date updated	27.4.2016
Updated by	A. Smith
Approved by	M. Hastings

Priority Rating	RAG Rating
4	G
3	A
2	R
1	

Core Standards Ref	Core Area	Programme	Detail	CCG Lead Officer	Start Date	Deadline	Progress	Priority	RAG Rating
	Business Continuity	BC	1. Presentation to Execs to launch BC and identify initial priority of services across CCG	Andy Smith	12.5.16	12.5.16		1	A
		BC	2. BIA completion across critical services	Andy Smith	16.5.16	30.6.16		2	A
		BC	3. Supplier BC questionnaire distributed and evaluated by services for critical supply chain issues	Andy Smith	16.5.16	30.6.16		2	A
		BC	4. Report back to Execs with BIA results and identified areas where response exceeds capability	Andy Smith	14.7.16	14.7.16		3	A
		BC	5. Drafting initial BC plans	Andy Smith	12.8.16	16.9.16		2	A
		BC	6. Validation of initial plans through testing	Andy Smith	19.9.16	31.10.16		3	A
	Emergency Planning	EPRR Core Standards	1. Completion and submission of 2016 WCCG EPRR core Standards	Andy Smith	31.5.16	31.7.16		2	G
			2. Evaluation and review of RWT and BCPFT EPRR Core Standards submission	Andy Smith	31.7.16	31.8.16		2	G
		Review of WCCG EPRR Roles & Responsibilities against revised NHS England EPRR Framework	Briefing paper to AEO	Andy Smith		31.5.16		2	G
		Mass Casualty Planning	1. Briefing to regional workshop around CCG requirements	Andy Smith	9.5.16	9.5.16		2	G
			2. Briefing paper to AEO outlining options for Wolverhampton		31.5.16	31.5.16		2	G
		Pandemic Influenza	1. WCCG Pan Flu Plan produced and ratified	Andy Smith	1. 31.7.15	1. Completed		1	G
			2. Briefing paper to W'ton Health Protection Forum proposing W'ton Interagency approach	Andy Smith	1.4.16	31.5.16		2	G
		EPRR Plan review	1. Review of existing EPRR plans	Andy Smith	1. 1.5.16	1. 31.7.16		2	A

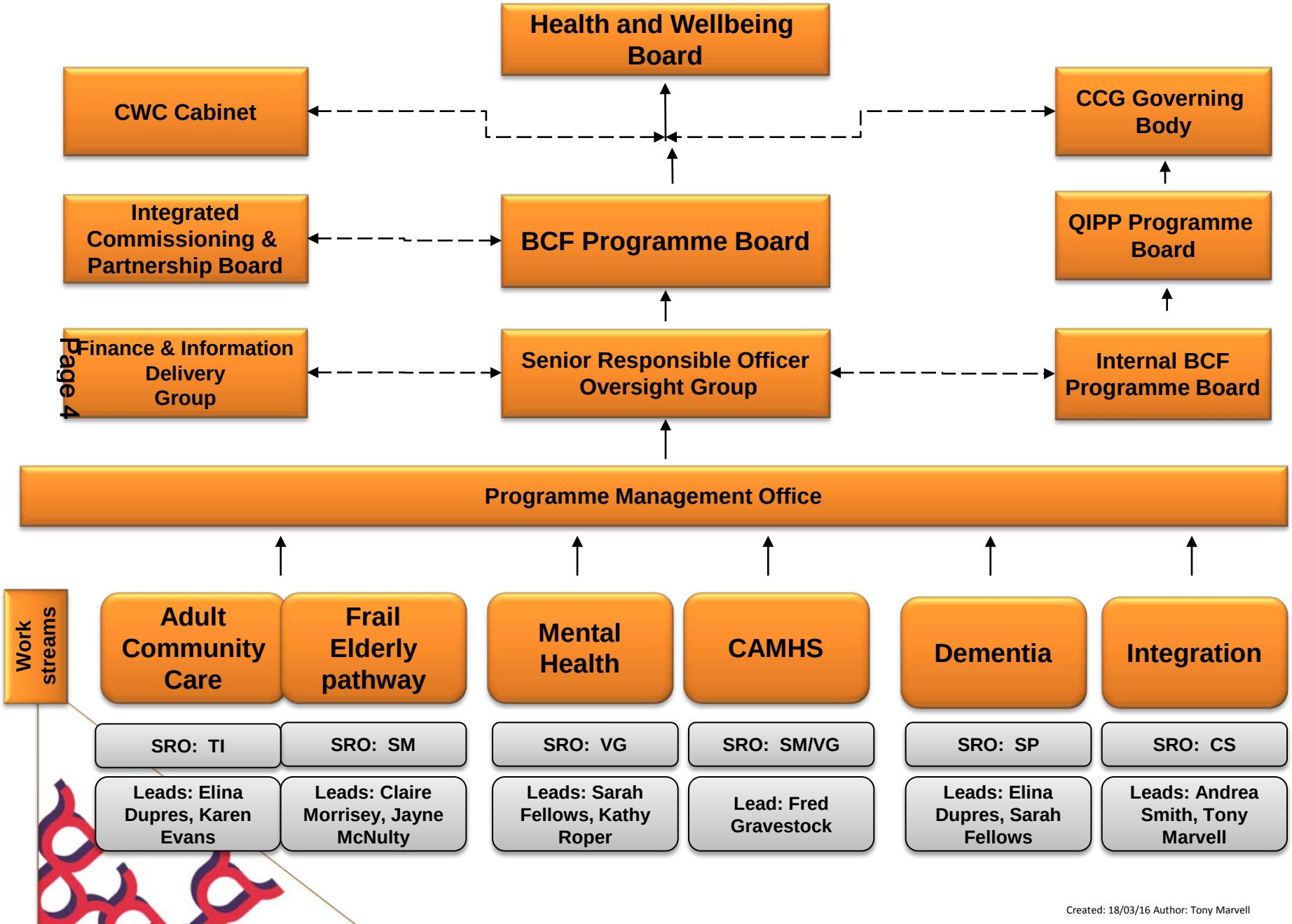
		CCG EPRR Exercise	Undertake a CCG command post exercise	Andy Smith		30.11.16		3	G
		CCG EPRR Training	Development of a CCG EPRR training Program	Andy Smith	1.4.16	30.04.16		1	A
		UCC	Support to Vocare in dovetailing their role in MI response with that of RWT	Andy Smith	1.3.16	Ongoing		1	G
	CONTEST	Prevent	1. Prevent policy to Director of Nursing for ratification and adoption	Andy Smith	1. 30.4.16 2. 12.4.16 3. 29.3.16 4. Ongoing	1. 30.4.16 2. 30.4.16 3. Ongoing 4. Ongoing		1	A
			2. Roll out of WCCG Prevent awareness training program	Andy Smith	12.4.16	30.4.16		1	A
			3. Evaluation of performance by RWT and BCPFT for Prevent	Andy Smith	29.3.16	Ongoing		2	G
			4. Participation in W'ton CONTEST Board and W'ton Channel Panel	Andy Smith	Ongoing	Ongoing		3	G
	Capacity/Surge	App Development	1. Development of an "APP" based electronic approach to manage, audit and report breaches from RWT.	Andy Smith	1. 2015	01.06.2016	Work on the app is ongoing and awaiting an IT fix from supplier currently. Preparatory work undertaken with RWT to enable early rollout once tested.	2	A
			2. Expansion of app to include messaging/incident notification, logging and incident management	Andy Smith	TBC	TBC	Scoping project once rollout of breach app is completed for best solution	4	G
	Health Protection	Health Protection	Exploration of CCG responsibilities and work undertaken to limit financial impact on CCG through contractual specification and management	Andy Smith	1.4.16	Ongoing	Given the gap in national guidance this work is important to ensure that the CCG understand its responsibilities and does not accept financial risk outside of its area of responsibility	3	A

Better Care Fund Strategic Roadmap 2016/17 – 2019/20



Created: 18/03/16 Author: Tony Marvell

Wolverhampton BCF Programme Governance Structure



Created: 18/03/16 Author: Tony Marvell

Black Country Partnership NHS
NHS Foundation Trust

NHS
Wolverhampton
Clinical Commissioning Group

Dementia Diagnosis Guidelines
Primary Care

Dementia Diagnosis – Primary Care Guidelines

Introduction

Dementia is a long term condition, which primarily affects people over the age of 65 (late on-set dementia) but can also occur in people under the age of 65 (young on-set dementia). The prevalence and incidence rises with age, such that up to 49.6% of people over the age of 90 have it some extent.

There is no single 'dementia test'. Cognitive decline, specifically memory loss alone, is not sufficient to diagnose dementia. There needs to be an impact on daily functioning related to a decline in the ability to judge, think, plan and organise. There is an associated change in behaviour such as emotional lability, irritability, apathy or coarsening of social skills.

There must be evidence of decline over time (months or years rather than days or weeks) to make a diagnosis of dementia – delirium and depression are the two most common conditions in the differential diagnosis.

'Timely' diagnosis is when the patient wants it **OR** when the carers need it.

Sub-typing dementia is important in guiding prescribing decisions. Most sub-typing can be arrived at by taking a careful history. Differentiating vascular dementia and Alzheimer's becomes more challenging in older patients and in terms of post diagnostic support may not significantly influence management. Sub-types include:

- Alzheimer's Disease – 50% of late on-set dementia cases
- Lewy Body Dementia (LBD) – second most common cause of late on-set. Often patients also have parkinsonian gait, fluctuating levels of cognitions, and can also suffer from visual hallucinations/
- Vascular Dementia (multi-infarct or arteriosclerotic) – 20% of late-onset dementia cases
- Amnesiac dementia or Korsakoff's dementia – secondary to excessive alcohol
- Mixed Alzheimer's/Vascular dementia
- Dementia in Parkinson's disease
- Dementia unspecified

Patients developing dementia often present with family, friends, carers, or neighbours reporting problems with activities of daily living, memory problems.

Sometimes patients present themselves having noticed memory problems. Health care professionals who have known the patient for a period of time may also notice that the patient's mental state is deteriorating.

Risk Factors

Non Modifiable	Modifiable
Age	Diabetes
Gender (♀>♂)	Hypertension
Genetic factors ○ Down's syndrome > 40 ○ Learning Disability > 50	Hypercholesterolemia
	Obesity
	Diet with less than 2 portions of fresh fruit or vegetables daily
	Smoking
	Alcohol
	Lack of exercise
	Lack of mental Stimulation

Symptoms

Most common symptoms are:

- Memory loss
- Loss of higher executive functions (mental arithmetic, identifying and forming patterns, ability to follow complex orders)
- Language impairment
- Sleep disturbance
- Mood disturbance
- Self-neglect
- Disinhibition

History

- How long has it been going on for?
- Is there a gradual deterioration or is it step-wise (stable, then drops, then stable)
- What problems have been noted
- Cognition, consciousness levels, hallucinations
- Any physical health problems? TIAs can contribute to vascular dementia, Parkinson's disease increases the risk of dementia, acute or sub-acute confusional state may be due to underlying infection. Malignancy is a rare but important cause of dementia-like symptoms
- Any suggestion of depression or anxiety?
- Any neurological features – seizures, dysphasia, myoclonus, etc

Diagnosis in Primary Care

People with moderate or advanced dementia who have scored poorly on whichever screening tool is used **(MMSE <20/30, GP-COG <9/15)** may be diagnosed in primary care by their GP without referral to specialist services.

GP diagnosis is suitable in the setting of moderate or advanced dementia and should be considered instead of specialist referral provided that:

- The patient and their carer/family member in attendance do not specifically request a specialist referral, despite counselling that this is not necessary;
- The GP feels confident about making the diagnosis.
- The 'default' diagnosis in this setting should be Alzheimer's Disease but Vascular Dementia or Mixed Dementia should be considered if:
    - Gait disturbance and frequent falls have occurred
    - Early unexplained urinary symptoms
    - Personality and/or mood changes, psychomotor retardation are present
    - A history (within past 3 months) or clinical evidence of past stroke

Who do we refer for brain imaging?

Brain scans are not essential for a clinical diagnosis of dementia. If a scan is justified, detailed clinical information is crucial for the radiologist.

However brain imaging is likely to be helpful in order to:

- Exclude other intracranial causes of cognitive decline or symptoms;
- Support a diagnosis of Vascular dementia

Complex Diagnosis – Referral to Specialist Dementia Services

The following subtypes of dementia should prompt specialist referral even if the dementia is moderate or advanced.

Dementia with Lewy Bodies (DLB)	Parkinsons Disease Dementia (PDD)	Fronto-temporal (inc Picks Disease, FTD *)
✓ **Parkinsonian features** ✓ **Visual hallucinations** ✓ **'Funny turns'/falls prominent in history** ✓ **Nocturnal agitation and daytime somnolence** ✓ **DLB features from International Consensus Consortium**	✓ History of Parkinson's Disease ✓ Loss of emotional control ✓ Visual hallucinations	✓ Personality change, unusual aggression ✓ Lacking insight in social situations, loss of inhibitions ✓ Development of compulsive rituals ✓ Language difficulties, word-finding problems and circumlocution ✓ Earlier onset with memory loss a late feature ✓ * FTD features from Lund-Manchester Criteria

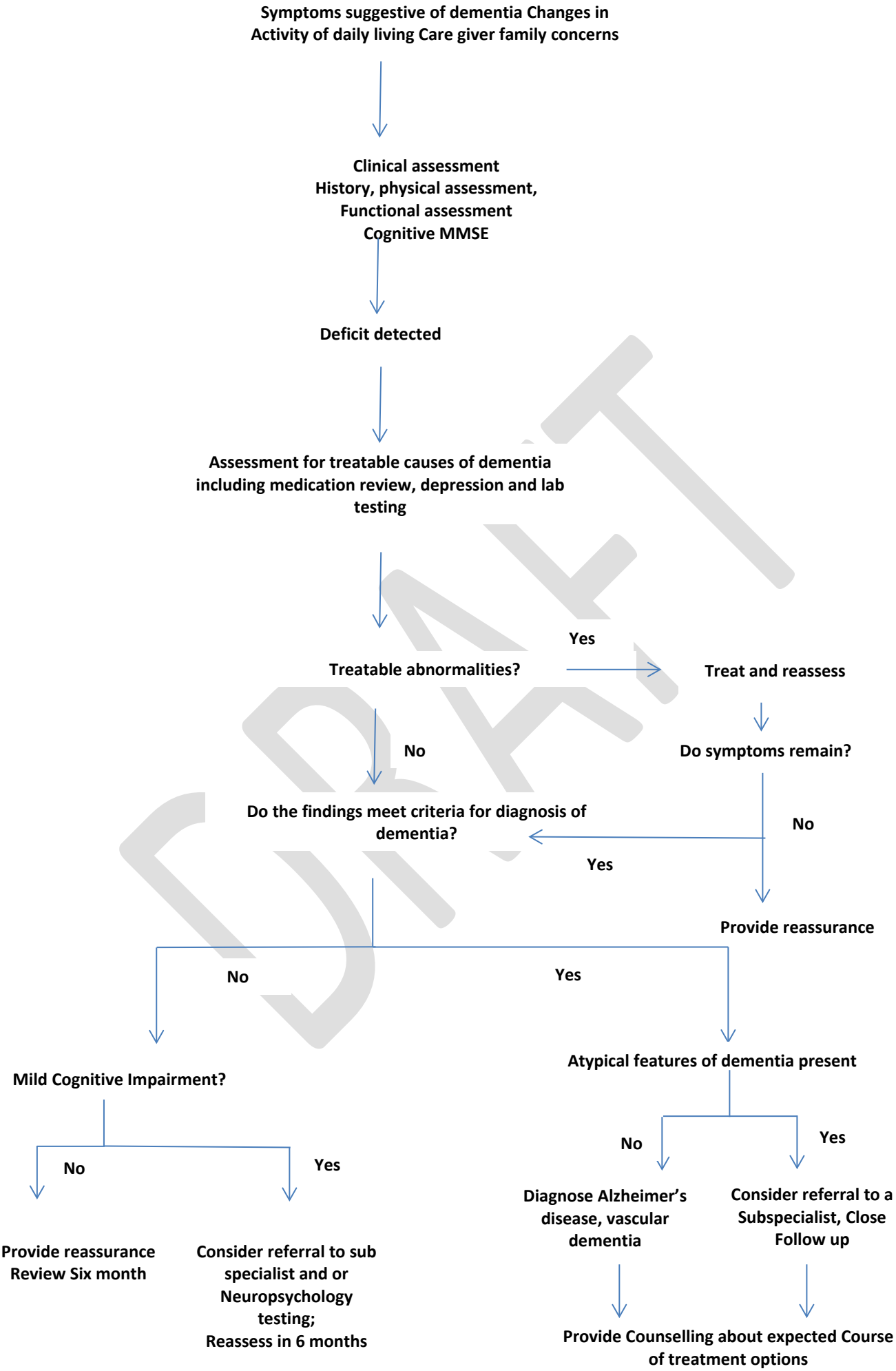
Referral in these circumstances is important

- The person with dementia is likely to need more detailed tests to help confirm the diagnosis
- The person with dementia and their carer will need different counseling and education over the likely future effects of their diagnosis
- Some drugs should not be used: acetyl cholinesterase inhibitors in FTD (risk of worsening condition, increased aggression), and antipsychotics in DLB (worsening condition).

Referral Information Required

Information to include when referring to the local Memory Clinic in the referral proforma

- Cognitive test score
- Confirmation that blood tests have been undertaken (no need to attach results)
- Confirmation that a physical examination has been done
- Any pertinent social factors including the name and contact number of a close family member or carer
- That depression and/or anxiety have been checked for and treated where necessary
- That the possibility of dementia has been discussed with the patient and carer/family member where possible


Symptoms suggestive of dementia Changes in Activity of daily living Care giver family concerns
Clinical assessment History, physical assessment, Functional assessment Cognitive MMSE
Deficit detected
Assessment for treatable causes of dementia including medication review, depression and lab testing
Treatable abnormalities?
Yes
Treat and reassess
Do symptoms remain?
No
Do the findings meet criteria for diagnosis of dementia?
No
Yes
Provide reassurance
No
Yes
Mild Cognitive Impairment?
No
Yes
Provide reassurance Review Six month
Consider referral to sub specialist and or Neuropsychology testing; Reassess in 6 months
Atypical features of dementia present
No
Yes
Diagnose Alzheimer's disease, vascular dementia
Consider referral to a Subspecialist, Close Follow up
Provide Counselling about expected Course of treatment options

Referral to: Memory Clinic Brooklands Health Centre **Date:**

Patient consent to referral: **Yes** **No** **Unable - Best Interests**

Patient Details			**GP Details**
Title:			**GP Name:**
Name:			
DOB:	**Sex: M ☐ F ☐**		**Address:**
NHS Number:			
Address:			
Postcode:			**Postcode:**
Preferred Tel Number:			
Ethnicity:			
Religion:			**Tel Number:**
Interpreter required:	**Yes**	**No**	**Fax Number:**
Do they live alone?	**Yes**	**No**	

PLEASE SEND NOK OR CARER DETAILS

NOK aware of referral:	**Yes**	**No**
NOK Name:		**NOK relationship:**
Address:		
Postcode:		
Tel Number:		

Reason for Referral/ History

Allergies: (please state if no allergies)

Please attach a copy of patient's medical summary and medication (Summary Care Record)

Investigations – Please request. (No need to wait for reports before referring)

Bloods (as per NICE CG42) *FBC / B12 & Folate / U&E / Ca / LFT / Glucose / TFT / Lipids* ☐

MRI/CT (please attach result if recently completed) ☐ **ECG** (please attach copy) ☐

Please attach cognitive test (sMMSE, 6CIT or GPCOG)

Please send or fax referrals to:

The Memory Clinic, Brooklands Health Centre, Brooklands Parade, Wolverhampton, WV1 2ND

Tel: 01902 442 391 **Fax: 01902 444 730**

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Wolverhampton City Council **OPEN DECISION ITEM**

Health and Well Being Board **Date 4 SEPTEMBER 2013**

Originating Service Group(s) **COMMUNITY**

Contact Officer(s)/ Telephone Number(s) **V GRIFFIN (55)5370**

Title **DRAFT JOINT HEALTH AND WELLBEING STRATEGY**

RECOMMENDATIONS

- That the Board notes and comments on the draft Health and Wellbeing Strategy Mark 2 and approves its publication.

1. BACKGROUND

1.1 At its meeting on 1 May 2013 the Health and Wellbeing Board agreed the priorities for the Board and its sub-groups for 2013/14 and noted progress on the JSNA / Health and Wellbeing Strategy (Mark 2). The updating of the Health and Wellbeing Strategy (Mark 2) has been coordinated by the Task and Finish Group and is now complete. The updated Strategy needs to been considered alongside the refreshed JSNA which is also on the agenda for receipt at this meeting.

2. HEALTH AND WELLBEING STRATEGY

2.1 The updated Health and Wellbeing Strategy is based on the five key priorities for the board:

- Wider Determinants of Health
- Alcohol and Drugs
- Dementia
- Mental Health
- Urgent Care

For each of these areas it commences a brief implementation plan and outlines key outcomes targets against which the plans can be performance managed.

3. FINANCIAL IMPLICATIONS

3.1 There are no financial implications associated with this report.

[MK/22082013/Y]

4. LEGAL IMPLICATIONS

4.1 There are no legal implications associated with this report.

[FD/21082013/B]

5. EQUAL OPPORTUNITIES IMPLICATIONS

5.1 An equal opportunities impact statement has been completed for the Joint Health and Well Being Strategy.

6. ENVIRONMENTAL IMPLICATIONS

6.1 There are no environmental implications associated with this report.

7. SCHEDULE OF BACKGROUND PAPERS

Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018

Ensuring good health and a longer life for all in Wolverhampton

Including the first phase implementation plan

August 2013

Foreword by Chairman of Wolverhampton's Health and Wellbeing Board

We are delighted to launch our first Health and Wellbeing Strategy for Wolverhampton. We believe this strategy is a significant step forward for the health and wellbeing of the City.

We are used to positive partnership working between Local Government and the NHS in Wolverhampton and we are also used to working hand in hand with the public. This document finds us all speaking with one voice on behalf of the new Health and Wellbeing Board in an attempt to tackle the most pressing health problems our City faces today.

Health and Wellbeing in Wolverhampton faces a number of significant challenges but we are determined to tackle these challenges by working together to achieve long term gains.

Our understanding of the issues facing Wolverhampton has been strengthened by an in depth consultation on this strategy's supporting Joint Strategic Needs Assessment with the public and our many partners.

It is important that we can measure the changes to services we intend to make and the improvements in health outcomes we hope to achieve. We have therefore included targets throughout the document. Many of these measures are ambitious and we intend to progress each of the key priorities.

We look forward to continuing to work with the public and our partners to make sure this remains a joint venture.

Councillor Sandra Samuels Chairman of the Board

1. Introduction

1.1 Overview

Welcome to Wolverhampton's Joint Health and Wellbeing Strategy. This is an overarching strategy for the city, together with an action plan for its implementation. It has been developed by leaders from across the local community working together through Wolverhampton's Health and Wellbeing Board. They have a collective focus – to improve health and wellbeing for all – so individuals and communities are able to live healthier lives, and to reduce some of the stark gaps in health experienced across the city.

1.2 Why we need a strategy

Health and Wellbeing Boards have the legal responsibility to publish a Joint Health and Wellbeing Strategy with the aim of improving the health and wellbeing in their area. This strategy provides a roadmap and gives a clear sense of direction. In developing the Health and Wellbeing Strategy, we seek to:

- Influence planning and delivery of integrated local services based on assessed needs and available assets
- Inform commissioning decisions to ensure they are focussed on the needs of service users and communities. This includes those services commissioned by the NHS England and Public Health England
- Tackle factors that impact upon health and wellbeing across service boundaries
- Influence commissioning of local services beyond health and care to make a real impact upon wider determinants of health

- Drive collective actions of NHS and local government, both commissioners and providers. Local authorities, CCGs and NHS Commissioning Board will need to have regard of the Joint Health and Wellbeing Strategy as they draw up their commissioning plans
- Engage with communities in the improvement of their own health and wellbeing
- Make best use of collective resources to achieve improved outcomes on the agreed priorities to be addressed
- Identify a robust evidence base
- Build on past work
- Link to the City Strategy –"Prosperity for All"
- Link to the Clinical Commissioning Group 'Integrated Commissioning Plan' and the vision of working closely and collaboratively with partners to deliver the 'Right Care in the Right Place at the Right Time'

1.3 Intelligence that has been used to shape the Joint Health and Wellbeing Strategy

The strategy needs to be focused on both health and wellbeing. Many factors can influence people's health and wellbeing including health issues such as heart disease caused by smoking and obesity and wider determinants such as feeling safe, being socially included and maintaining independence. The outcome priorities selected in the strategy have been chosen to reflect the full range of health and wellbeing priorities. The strategy heavily draws upon the evidence base outlined in the Joint Strategic Needs Assessment (JSNA). The JSNA is based upon the data drawn from the National Outcomes Frameworks for Health, Adult Social Care and Public Health. Data from about 120 indicators included in the national outcome frameworks has been analysed and presented to the Health and Wellbeing Board. The Health and Wellbeing Board reviewed this list of indicators and created a shortlist of outcomes where joint working can add value or which are current challenges to improving health and wellbeing in Wolverhampton. These were grouped and 2013-14 work will focus on groups 1 and 2 and detailed briefings have been produced to provide a useful evidence resource for these key health issues. The JSNA will be continually

updated to take account of the most recent versions of the outcomes frameworks in order to provide a detailed and up to date picture of health and wellbeing in Wolverhampton.

1.4 *Input from local people including the public, patients, partners and stakeholders*

Representatives of the Healthwatch, public, patients, partner organisations and other stakeholders undertook the same process as the Health and Wellbeing Board and prioritised a shortlist of outcomes. The outcome from these processes was highly compatible. Changes were made as a result of this input.

2. Strategic Direction

2.1 Our vision

Ensuring good health and a longer life for all in Wolverhampton.

2.2 Our goals

We want to improve the health and wellbeing of our most disadvantaged people and reduce inequalities in health and well-being across the city.

We want to raise the aspirations of people so they are motivated to take healthy choices to enable them to live longer, healthier and happier lives.

We want to create environments where the healthy choice is the easiest choice and support improvement in the wider determinants of health such as employment, poverty and housing that affect people's health and their ability to make healthier choices.

2.3 Our strategic priority outcomes

- ✓ Increase life expectancy
- ✓ Improve quality of life
- ✓ Reduce child poverty

2.4 Guiding Principles

The guiding principles underpinning the implementation of our Health and Wellbeing Strategy are outlined below:

- *Knowledge-led decision making* – understanding and interpreting information in all its forms – data, research and evidence, experience and expertise - and setting it within a local context is essential and will enable us to make the best possible decisions.

- *Innovation* – demand, need and expectations are increasing whilst we also face significant financial difficulties. We therefore have to think differently and do things differently. This will mean transformational change in some areas of providing services. We aim to deliver the ambitions of the strategy through being dynamic, forward-thinking and within a culture of innovation.

- *Integration* – many organisations and stakeholders will have a key part to play in successfully delivering our health and wellbeing ambitions. Some, if not all of these, are long-standing and difficult. The only way they can be tackled is through an integrated and joined-up approach across partners.

- *Outcome focused* – often strategies are full of impressive ideas that aren't measurable. It is our intention that this strategy is clearly focused on delivering outcomes and demonstrating change.

- *Value* – whether in a time of financial challenge or of plenty, we have a duty to make sure that the services we deliver or commission offer the greatest possible value in terms of quality, cost and outcome. For every initiative we implement, we aim to demonstrate the expected return in these terms of our investment.

3. Priorities Chosen by the Board

3.1 Being focussed

Wolverhampton faces considerable needs around health and wellbeing. We know this, because our JSNA process reviewed the national outcomes frameworks and highlighted 51 indicators (out of a total of 105 where we had local data) where we can be sure that Wolverhampton is performing worse than the England average. However, there is a danger that if the Health and Wellbeing Board tries to focus on all these areas of need that resource and energy will be spread too thinly to have an impact. Therefore, in the first phase, the Health and Wellbeing Board has decided to focus on a small number of priority areas.

The top five priorities identified by the Health and Wellbeing Board were:

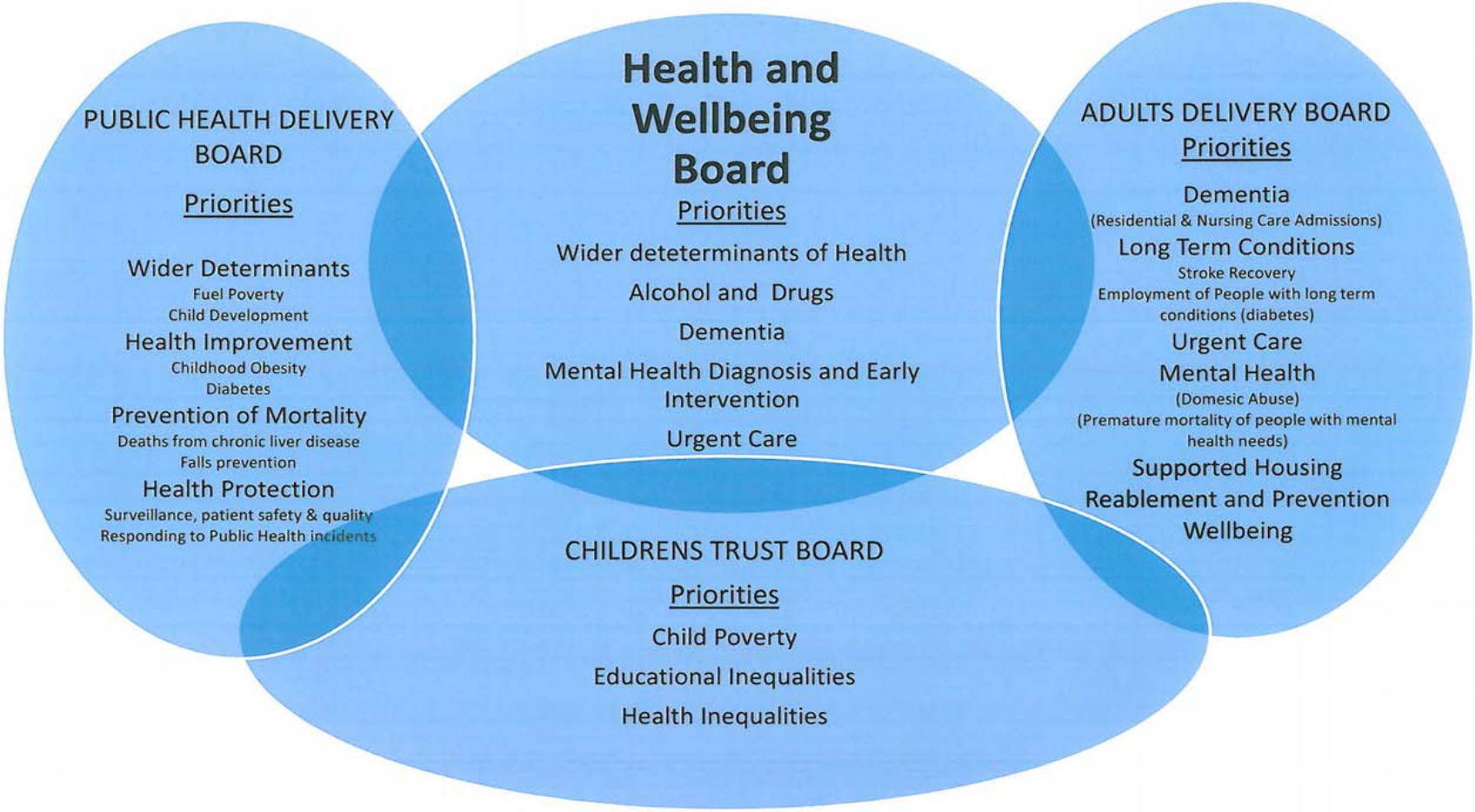
- **Wider Determinants of Health**
- **Alcohol and Drugs**
- **Dementia (early diagnosis)**
- **Mental Health (Diagnosis and Early Intervention)**
- **Urgent Care (Improving and Simplifying)**

In considering these priorities the Board identified the wider determinants of health as being a longer term priority and the other priorities as being of a short or medium term priorities. The Board has focused on those priorities which are key health issues identified in the JSNA; which are vital to the city and where, through partners working together, the Board can make a difference.

In addition to the Health and Wellbeing Board's priorities the priorities of the Board's three key sub-groups have been agreed as follows:

Sub-Group	**Priority**
Adults Delivery Board	▪ Dementia (Early diagnosis and residential and nursing care admissions) ▪ Long Term Conditions (Stroke Recovery and Diabetes) ▪ Urgent Care (Reducing demand) ▪ Mental Health (Diagnosis and early intervention, domestic abuse and premature mortality of people with mental health needs) ▪ Supported Housing, Re-ablement and Prevention ▪ Wellbeing
Children's Trust Delivery Board	▪ Child Poverty ▪ Educational Inequalities ▪ Health Inequalities
Public Health Delivery Board	▪ Wider determinants of health (Fuel poverty and child development) ▪ Health improvement (Childhood obesity and diabetes) ▪ Prevention of mortality (Deaths from chronic liver disease and falls prevention) ▪ Health protection

DELIVERING THE HEALTH AND WELLBEING BOARD PRIORITIES



Priorities

The health and wellbeing priorities have been selected to provide a number of high level evidenced based priorities which are a challenge to resolve and span organisational responsibilities. The JSNA and consultation with partners provided the evidence for the priorities and the sub-groups of the Board have endorsed the priorities and added to them. The priorities are also reflected in the Clinical Commissioning Group Integrated Commissioning Plan which highlights:

- **Dementia**
- **Urgent Care**
- **Diabetes**

as its priorities.

The Board will review progress made against its priorities at each meeting and they will be reviewed and refreshed annually.

PRIORITY 1 WIDER DETERMINANTS OF HEALTH

Lead Agency: Wolverhampton City Council (Public Health Department)

Sponsor: Ros Jervis (Director of Public Health)

Project Manager: Consultant in Public Health

Partners: All agencies/departments

What is the issue?

The health and well-being of individuals and populations across all age groups is influenced by a range of social, economic and environmental factors. We, as individuals, cannot always control them and they influence and often constrain the 'choices' we make and the lifestyle we lead.

The social determinants of health have been described as 'the causes of the causes' (of ill health). They are the social, economic and environmental conditions that influence the health of individuals and populations. They include the conditions of daily life and the structural influences upon them, themselves shaped by the distribution of money, power and resources at global, national and local levels. They determine the extent to which a person has the right physical, social and personal resources to achieve their goals, meet needs and deal with changes to their circumstances. There is a clear link between the social determinants of health and health inequalities, defined by the World Health Organisation as "the unfair and avoidable differences in health status seen within and between countries".

Lack of income, inappropriate housing, unsafe workplaces and poor access to healthcare are some of the factors that affect the health of individuals and communities. Similarly, good education, inspired public planning and support for healthy living can all contribute to healthier communities. Professor Sir Michael Marmot in his Strategic Review of Health Inequalities in England, Post 2010 – 'Fair Society Healthy Lives' presented an evidence-based strategy for the reduction of

health inequalities with a focus on policies and interventions that address the social determinants of health.

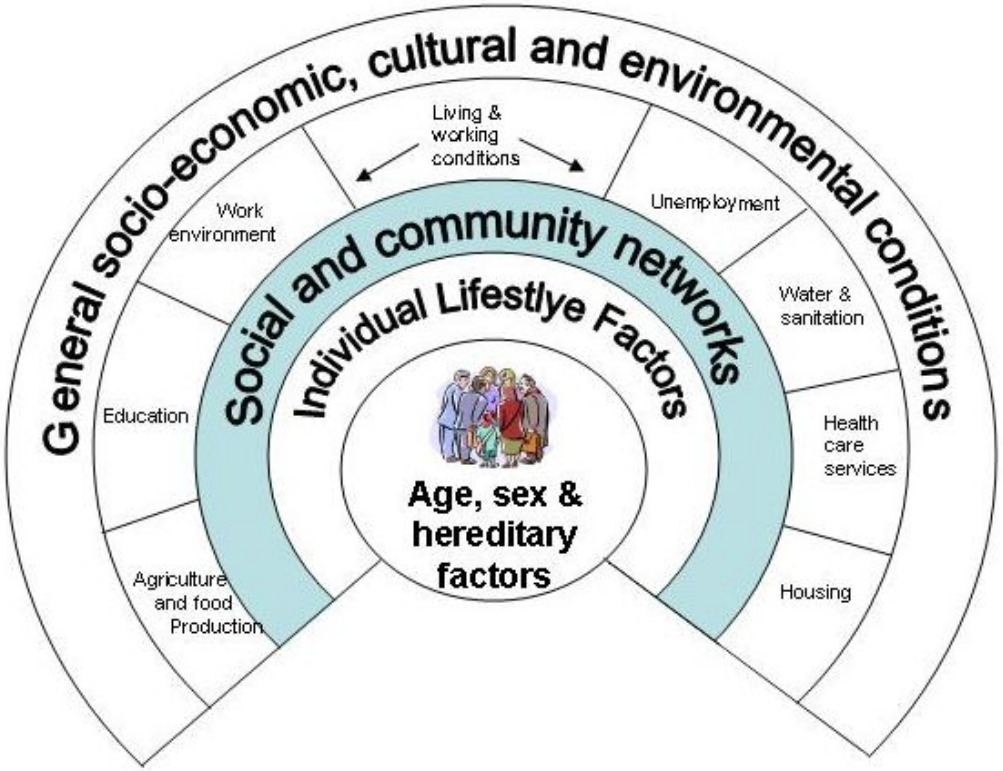
Why is it important

Addressing the contribution of the wider social determinants of health is crucial to health and wellbeing as we cannot make the large scale progress we need to make on tackling the big health issues of the 21st century, particularly on diet and weight issues, alcohol consumption, smoking, reducing health inequalities and tackling the big killers of cancer, CVD and respiratory illness, without systematic improvement across these areas. One of the difficulties in tackling health inequalities on the ground is a failure, for numerous reasons, to get a proper grip on the social determinants of health. Therefore the Health and Wellbeing Board consider this to be a key underpinning priority.

A model for the social determinants of health

A model often used to illustrate the wider determinants is the Dahlgren and Whitehead (1991) 'Policy Rainbow', which describes the layers of influence on an individual's potential for health (Figure 1). Some of these factors are fixed (core non modifiable factors), such as age, sex and genetics but there are other, potentially modifiable factors expressed in the diagram as a series of layers of influence including: personal lifestyle, the physical and social environment and wider socio-economic, cultural and environment conditions.

Figure 1: The Determinants of Health – the Policy Rainbow



The Rainbow model explained:

- In the centre of the figure, individuals possess age, sex and constitutional characteristics that influence their health and that are largely fixed.
- Surrounding them, however, are influences that are theoretically modifiable by policy. First, there are personal behaviour factors, such as smoking habits and physical activity.
- Second, individuals interact with their peers and immediate community and are Influenced by them, which is represented in the second layer.
- Next, a person's ability to maintain their health (in the third layer) is influenced by their living and working conditions, food supply, and access to essential goods and services.
- Finally, as mediator of population health, economic, cultural and environmental influences prevail in the overall society.

The size of the contribution of each of the layers to health has been estimated from research in the US as follows:

- 30% from genetic predispositions
- 15% from social circumstances
- 5% from environmental exposures
- 40% from behavioral patterns
- 10% from shortfalls in medical care

Therefore, 60% of what determines good or poor health comes from potentially modifiable circumstances of an individual's life – either directly related to the social and economic circumstances or related to behavioral patterns that will have been developed based on life experiences. Therefore taking action on improving the wider social determinants of health can have a huge impact on the health of Wolverhampton residents and impact on reducing health inequalities.

Figure 2 shows that local authorities are well placed to address these social and economic determinants of health as the services that can make a difference fall within their remit.

Figure 2: The social determinants of health and examples of local government services and activities that can make a difference

Source: adapted from Campbell F (ed.) (2010) The social determinants of heath and the role of local government. In http://publications.nice.org.uk/health-inequalities-and-population-health-phb4

What is the position and evidence in Wolverhampton?

The JSNA evidence from the various outcomes frameworks and in particular the Public Health Outcomes Framework spine charts highlights indicators relating to the wider determinants of health where Wolverhampton scores badly against national benchmarks. Children have a worse experience in a number of areas related to income deprivation and education, for example:

- 31% of children live in poverty – 10% higher than the England average
- 52% of children have a good level of development at age 5 – compared to 59% nationally
- Unauthorised absences at school are higher than average
- Amongst older age groups, 7.6% of 16- 19 year olds are not in education, employment or training – higher than the England average.

Indicators also show areas for improvement relating to adults and older people with higher rates of violent crime, more people affected by noise, higher numbers of homeless people and more households affected by fuel poverty.

However, there are other important indicators that measure the impact of social and environmental factors on the population, for example unemployment, educational attainment amongst adults, and demographic characteristics such as population structure and ethnicity. A broader measure of the wider determinants of health, the Index of Multiple Deprivation (IMD) is a composite index used to identify the most deprived areas across the country. The index combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for small population areas in England.

The IMD shows that 52% of Wolverhampton's population falls into the poorest 20% of the national spread of social deprivation – i.e. over half of Wolverhampton's population live in the poorest areas in England which impacts on life expectancy and premature mortality rates in the City.

There are also stark differences within Wolverhampton itself between those living in the most and least deprived areas of the City – all of which results in males living on average, 6 years less in the most deprived areas compared to the least deprived areas and nearly 4 years difference for females.

How does it link to other strategies and priorities in Wolverhampton?

A consideration of the health impact should be a part of all local government department strategies which address the wider determinants of health. Strategies should consider, as standard, the question: – 'How does this strategy contribute to improving the health and wellbeing of Wolverhampton residents and in particular the most disadvantaged?' All strategies should be reviewed to examine the opportunities to promote health and new strategies should include a consideration of the opportunities to improve health and wellbeing and reduce health inequalities.

Strategies that have particular impact on the wider determinants are:

- Children, young people and families plan
- Transport
- Housing
- Education /Lifelong Learning Strategies
- Employment/Economic Regeneration
- Planning
- Environment/ Trading Standards
- Parks and Leisure

What is the evidence of effective interventions?

Action in partnership, in sectors such as housing, education, transport and employment offer real opportunities to improve health and reduce the health gap. It is important that partners are aware of the opportunities that exist to improve health outcomes in many of the core functions of local government and other agencies, not only in the services

that are delivered but in the way in which services are delivered to make sure that those who need them most are receiving them. Whilst in some areas the research evidence base could be strengthened, there are opportunities for local action to tackle the wider social determinants of health in the following areas:

Examples of opportunities for local action to tackle the wider social determinants of health

Wider social determinant:	***Example of opportunity:***
Community engagement	Enhancing mechanisms for getting people engaged and involved in things that matter to them
Housing and regeneration	Working with partners who provide housing or care services to address issues such as : quality of housing, ensuring that homes are safe (injury prevention) and addressing issues of fuel poverty.
Education	Investing in early years and in the quality of schooling which provide social, health and economic returns in the future
Community safety	Reducing crime and violence
Spatial planning	Healthy places result in healthy people. Planning authorities can do a great deal to plan for healthy environments. Not just those which promote physical activity but also promote mental wellbeing by including green space and opportunities to interact with others
Food and nutrition	Planning for food resilience and ensuring availability and access to healthy food
Transport	Particularly around injury prevention, including traffic calming measures and including walking and cycling in transport plans
Children's services	Those who deliver and commission children's services make a huge contribution to the social, mental and physical wellbeing of young people, providing them with vital skills and social capital which lead to better life chances as they grow up
Leisure and cultural services	Providers and commissioners of leisure and cultural services have the potential to influence health not simply through offering activity and promoting healthy lifestyle but also in the way culture shapes an area and communities within
Employment and the work environment	Fair employment and decent working conditions are major contributors to health and well-being. Workplaces also provide opportunities for health promoting interventions

The National Institute for Health and Clinical Excellence has produced a series of public health guidance in this area and also local government public health briefings (http://publications.nice.org.uk). Briefing 4 on Health inequalities and population health outlines NICE's recommendations for local authorities and partner organisations on population health and tackling health inequalities, many of which arise from the social determinants of health.

An 'asset model' takes as its starting point the need to identify and build on the positive features of individuals and communities, utilising such capacities and capabilities as exist to further empower them. This is in contrast to the usual 'needs led' deficit approach to tackling health and wellbeing issues. Assets can operate not just at the level of the

individual but, importantly, at the level of the group, neighbourhood, community and population. For example, these assets can be social, financial, physical, environmental, educational, employment related.. Conceived of in these ways, they relate directly to the social determinants of health and can provide an alternative way of dealing with the causes of ill health by looking for positive patterns of health and strengthening those social bonds and ties that go far in sustaining health, even in the face of disadvantage. Asset mapping is being undertaken in key neighbourhoods of Wolverhampton consistently affected by wellbeing and resilience issues and this work will inform a model of good practice in taking forward an asset based approach.

What are the planned actions, timescales and leads?

The return of public health to the Local Authority has provided an opportunity to address public health outcomes, including Domain 1: Improving the wider determinants of health, through a £1 million Public Health Transformational Fund. Bids of up to £250,000 per annum are invited from council directorates in partnership with other external agencies, for example the voluntary sector, public or private sector organisations, to be ratified by the Health and Wellbeing Board. The primary aim of the fund is to support the embedding of outcomes into directorates across the council so that improving the health of the population, and addressing health inequalities through the wider determinants becomes 'usual practice'

In addition to the Transformation Fund supporting the embedding of a culture of working 'upstream', there are a series of other actions that can support this process, for example:

- Review the extent to which existing NICE guidance relating to the wider social determinants of health has been implemented in Wolverhampton
- All City Council strategies adopt a 'health impact' approach. https://www.gov.uk/government/publications/health-impact-assessment-tools
- Existing relevant strategies (see 4 above) are reviewed to assess the potential for improving the health of Wolverhampton residents and reducing inequalities

- Refresh of the JSNA to include more intelligence on the wider social determinants of health, in particular to understand the risk factors for poor health outcomes

How will progress be measured?

Key high level targets:

Before measurable changes to population health can be achieved, there will need to be some underpinning actions and more integrated working to address upstream interventions before actual benefits to the population's health are achieved. For Year 1 the key deliverables are related to the Transformation Fund, i.e:

- Successful implementation of the Public Health Transformation Fund and approval of good quality projects to address factors such as education, skills, employment, housing, social capital/social connectedness.
- Each project that is approved will have associated evaluation and success criteria agreed as part of the approval process.

Progress will be monitored quarterly through the Public Health Delivery Board.

PRIORITY 2 ALCOHOL AND DRUGS

Lead Agency: Wolverhampton City Council (Public Health Department)

Sponsor: Ros Jervis (Director of Public Health)

Project Manager: Juliet Grainger (Substance Misuse Commissioning Manager)

Partners: West Midlands Police, YOT, CCG, GPs, Pharmacists

What is the issue?

Drug and alcohol dependency is a complex health disorder with social causes and consequences. No single factor can predict whether or not a person will become addicted. The risk of addiction is influenced by a person's personality, social environment, biology and age. The more risk factors an individual has, the greater the chance that taking drugs or harmful drinking can lead to addiction with a host of consequences for an individual's health for example drug use is linked to everything from heart and respiratory problems to psychosis and seizures, while heavy drinking is known as a causal factor in more than 60 medical conditions. Added to that is the increased likelihood of suffering violence and having unprotected sex that is seen among heavy drinkers.

Nationally, numbers using drugs have fallen gradually in recent years, in both adults and children. This success has been widely welcomed, and may be due to a combination of factors from better access to treatment and health promotion campaigns to a wider cultural shift away from traditional drug use and there is a growing concern about the use of so-called legal highs – substances that mimic the effect of banned drugs.

By comparison, alcohol-related problems among adults have been getting worse on many measures. Both hospital admissions and deaths linked to drinking have increased since the early 1990s. Overall it is estimated over 1million people in England have mild, moderate or severe alcohol dependence. About a third of these will face challenges that are similar to those people who are dependent on drugs.

There isn't really such a thing as a 'typical drug user', though people dependent on heroin and/or crack cocaine are statistically more likely to be white, male, in their thirties and from a background of high social deprivation. Alcohol misuse is also more common among people from deprived backgrounds – the most deprived fifth of people are up to three times more likely to have an 'alcohol related death' - but some of the largest rises in alcohol consumption have been seen among higher income groups in the past decade. Children growing up in families where parents are dependent on drugs or alcohol are seven times more likely to become addicted as adults[i]. Despite the relatively high number of injecting drug users, England has one of the lowest rates of HIV and hepatitis C among this group thanks partly to public health programmes such as needle and syringe exchange programmes. Cannabis is the most popular drug among occasional or casual users but no causal link between current cannabis use and the future use of more problematic drugs such as heroin or crack has ever been proved. [1]

The cost to the country in dealing with the consequences of alcohol and drug problems is significant. The bill for alcohol stands at about £20 billion a year once the economic, crime and health costs are taken into account and for drugs it tops £15 billion. However, Home Office research has shown that spending £1 on drug treatment saves £2.50 in crime and health costs of drug addiction.

What is the position and evidence in Wolverhampton?

Estimates show that there are 2,135 Opiate/Crack users and 5,264 dependant drinkers aged 16 years and over. There is no official estimate for the prevalence of drug use by young people at Local Authority level. However results of the Wolverhampton Health Related Behaviour Survey show that 25% of primary school pupils and 48% of secondary school pupils said that they have had an alcoholic drink, 5% of primary school pupils said they had been offered drugs, 12% of secondary school pupils revealed that they have been offered cannabis while 6% had taken an illegal drug; 3% of them in the month before the survey.

[1] Tackling drugs and alcohol. Local government's new public health role. Local Government Association http://www.local.gov.uk/c/document_library/get_file?uuid=ef73ac40-827e-4e7f-bb27-9b19fff157c0&groupId=10171

Mortality

Alcohol abuse is one of the leading causes of premature mortality in the city. Primary care mortality data shows that between 2006 and 2010 it was the third highest contributor to years of life lost (YLL) after infant mortality and CHD. Alcohol related mortality rates have increased over the last few years.

- Alcohol is currently one of the biggest contributors to Years of Life Lost (YLL) in Wolverhampton.
- In the period 2001-2005 it ranked 5th as a cause of YLL with 4,293 years of lives lost to alcohol related liver mortality
- The latest data- 2006-2010 shows that it has moved up to 3rd with 5,221 YLL

Top 10 causes of death and top 10 sum of YLL 2006-2010

Rank	Condition	Numbers	Rank	Condition	YLL
1	CHD	594	1	Infant deaths	9000
2	Disease of the respiratory system	403	2	CHD	7006
3	Lung cancer	389	3	**Alcohol related Liver mortality**	**5221**
4	**Alcohol related Liver mortality**	**236**	4	Disease of the respiratory system	4461
5	Stroke	227	5	Accidents	4444
6	Colorectal cancer	150	6	Lung cancer	4078
7	Breast cancer	140	7	Suicide & Injury Undetermined	3231
8	Accidents	130	8	Stroke	2626
9	Diseases of the nervous system	121	9	Diseases of the nervous system	2281
10	Infant deaths	120	10	Breast cancer	2269

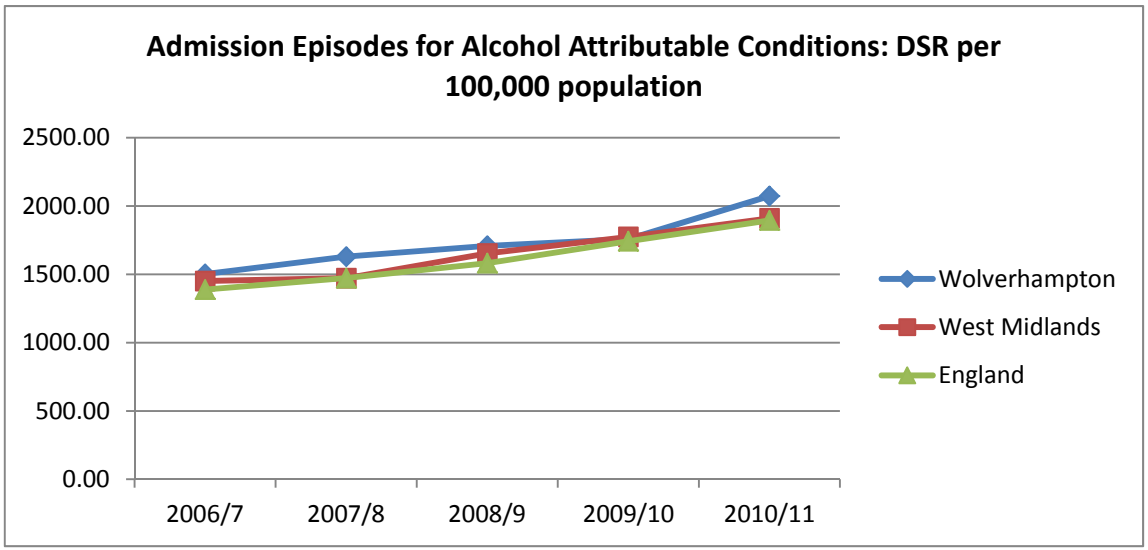
Source: Primary care mortality file

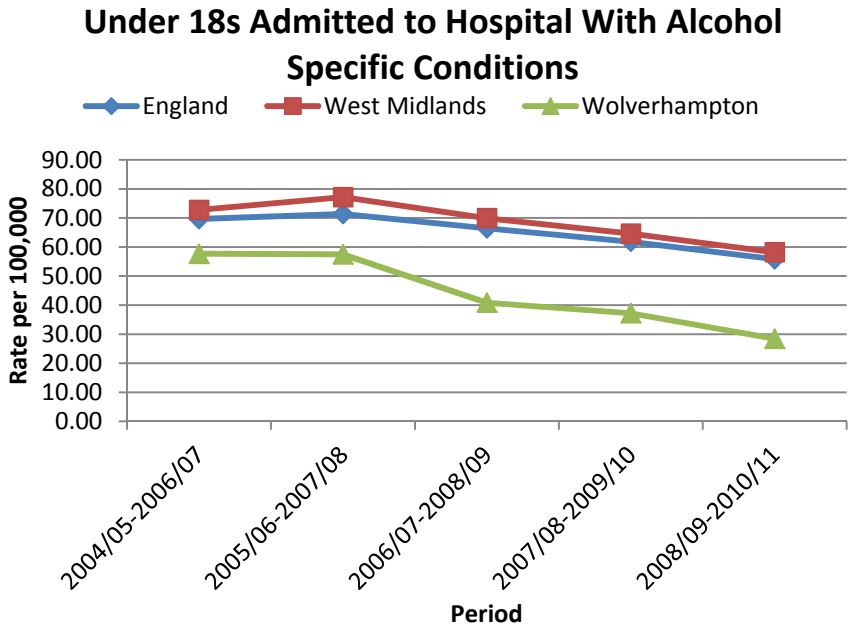
- The years of life lost annual potential for improvement shows the gap between the local value and the national average and gives an indication of the number of years of life lost that could be saved if the local value decreased to the national level.
- After infant mortality, alcohol has the biggest potential for improvement; between 2006 and 2010 494 YLL could have been saved if the rate of alcohol related mortality in Wolverhampton had been similar to the national rate.
- Alcohol related mortality has been on an upward trend over the last 17 years in Wolverhampton. In the last 3 years this trend has begun to level off, however, the gap to the national average remains almost double and rates are much higher than for the local authority comparator group, 'Centres with Industry'.
- The number of deaths related to drug use, published by the Office for National Statistics (ONS) at a national level show that there were 1,772 male and 880 female drug poisoning deaths (involving both legal and illegal drugs) registered in 2011, a 6 per cent decrease since 2010 for males and a 3 per cent increase for females.
- In 2011 the drug poisoning mortality rate was 63.8 deaths per 1 million population for males and 29.9 deaths per million population for females, both were unchanged compared with 2010.
- Deaths involving heroin/morphine decreased by 25 per cent compared with 2010, but they were still the substances most commonly involved in drug poisoning deaths (596 deaths in 2011).
- Locally the numbers are very low with only 52 deaths recorded between 1994 and 2012.

Hospital Admissions

As well as being a top cause of death, alcohol misuse also contributes to other health problems and impacts on service utilisation, in particular hospital activity. Hospital admissions for conditions related to drug use are generally lower.

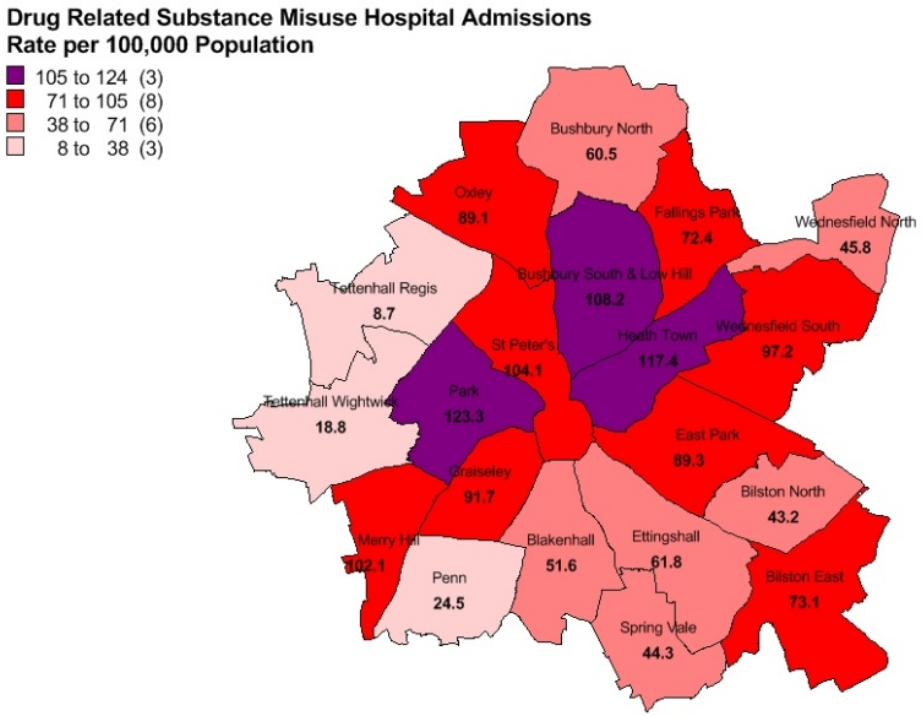
- In 2010/11, there were 2073 hospital admission episodes for alcohol-attributable hospital admissions per 100,000 population in Wolverhampton; nearly an 18% increase on the previous year.
- The rate of alcohol-attributable hospital admission episodes has seen a slow but steady increase over the past five years. However, the gap between the Wolverhampton rate and the national average is increasing.


Admission Episodes for Alcohol Attributable Conditions: DSR per 100,000 population
2500.00
2000.00
1500.00
1000.00
500.00
0.00
2006/7
2007/8
2008/9
2009/10
2010/11
Wolverhampton
West Midlands
England


Under 18s Admitted to Hospital With Alcohol Specific Conditions
England
West Midlands
Wolverhampton
Rate per 100,000
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
2004/05-2006/07
2005/06-2007/08
2006/07-2008/09
2007/08-2009/10
2008/09-2010/11
Period

- In contrast, hospital admissions for under 18s have shown an increase over the past 9 years and Wolverhampoton is significantly below the national and regional average.
- Between 2009 and 2011 there were 457 admissions related to substance misuse. This equates to a rate of 1.9 admissions per 1,000 population.
- The majority of admissions were for poisoning by narcotics. Mental health and behavioural disorders due to the use of opioids also represented a relatively high proportion of admissions.
- Between 2009 and 2012 there were 199 admissions for drug related conditions. This equates to a rate of 80 admissions per 100,000 population.

Rate of Drug Related Hospital Admissions 2009-2012



Source: Wolverhampton Public Health Department

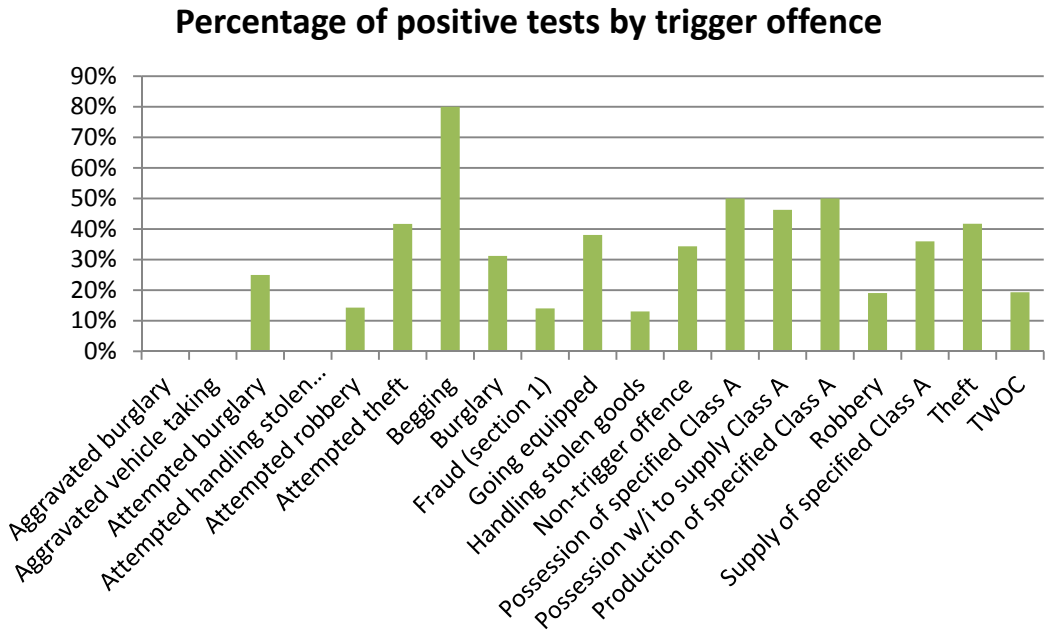
Rates of drug related hospital admissions during 2009-12 where highest in wards in the north east of the city and parts of the south west. Heath Town, Park and Bushbury South and Low Hill had the highest rates of admissions.

Services need to continue to engage people from the identified wards into treatment and reduce the risk of hospital admissions.

Crime

Alcohol has been identified as a factor in violent crime nationally and drug use tends to go hand in hand with acquisitive crime such as theft, shoplifting and robbery. However it is difficult to get an accurate picture of the extent of these crimes across the city because there is no consistent way of determining if an offence was fuelled by alcohol and/or drugs. Over half of young people and approximately a third of adults who come into substance misuse treatment every year in Wolverhampton come through criminal justice pathways.

- Any crime that the police deem to have been influenced by alcohol or where the offender may have been intoxicated is recorded with an 'alcohol Involved' marker.
- During 2011/12 there were 701 such crimes out of a total of 18,084 crimes recorded in Wolverhampton. The majority of these were assaults. This equates to just 4% of crimes in Wolverhampton.
- While this is an illustration of the role of alcohol in violent crime, it is thought that this figure does not give an accurate picture and is a significant underestimate of the actual number of crimes involving alcohol. As a guide, national estimates suggest that 55% of violent crimes are committed whilst the offender was under the influence of alcohol.
- Wolverhampton keeps a data base of people presenting to A&E after an assault and it shows that a proportion of assaults are committed when either the offender or the victim are intoxicated.
- Between February 2010 and January 2013 there were 1,234 attendances to A&E for assault related injuries. 54% of them were alcohol involved. 47 (7%) of the alcohol related assaults were domestic violence.
- The drug intervention programme which is a critical part of the government's strategy for tackling drug addiction gives the local police force powers to perform a drug test on any offender committing a 'trigger offence'.
- During the financial year 2011-12 there were 1,898 Wolverhampton residents who had tests successfully completed at Wolverhampton and Wednesbury police stations. 679 or 36% had a positive result. The chart below shows the test results for each trigger offence.



- This shows the link between drug use and certain types of offences. Offenders arrested for begging, production and/or possession of specified substances, possession with intent to supply, theft, and attempted theft and going equipped to steal had the highest probability of testing positive.
- Approximately 4% of drug offences were committed by young people under the age of 18.

Child Protection

Alcohol and drug abuse can affect an individual's ability to be a good parent to their children and this has an impact on social care and child protection.

- Wolverhampton Children's Social Care takes referrals from various sources for a wide range of issues affecting young people including substance misuse.

- In the 12 month period ending February 2013, there was a total of 3,406 referrals to children's social care, 144 (4.2%) were for substance misuse related issues. 92% of referrals moved on to receive an initial assessment while a small number were signposted to other services or no further action was taken.
- Of the 1,465 adults in drug treatment in 2011/12, 40% were parents or had some other contact with children. Similarly of the 759 adults in alcohol treatment, nearly 40% were parents or had contact with children.
- Parental substance misuse can be a factor to a child becoming looked after by the Local Authority. The number of looked after children in Wolverhampton has seen a significant increase over the past few years. It is currently not known how many of these involved substance misuse but a local case file audit of looked after children undertaken by Dartington Social Research Unit in conjunction with Children's Services, estimated approximately a quarter.

How does it link to other strategies and priorities in Wolverhampton?

Children and Young People's Plan (2011/14)

Action on alcohol and drugs will aim to:

- prevent children and young people from coming into contact with alcohol and drugs
- make sure there are effective young people's substance misuse services
- identify and address "hidden harms" and child protection issues that may be present in the children of substance misusers.

Safer Wolverhampton's Priorities

- Substance misuse is a priority for SWP

Taking action on alcohol and drugs will support reductions in crime and anti-social behaviour.

Wolverhampton's City Strategy (2011-2026)

Area 2: We are working to *Empower People and Communities* by
- doing things earlier and preventing things from happening

Area 3: We are working together to *Re-invigorate the City* by
- improving the city centre

Wolverhampton Alcohol Strategy 2011-2015

Priorities seek to improve alcohol treatment services and tackle alcohol related crime and disorder, including domestic violence and anti-social behaviour and the impact alcohol has on communities, children, young people and families.

- Supporting a whole community approach to changing alcohol habits
- Developing a well-managed -night time economy
- Combating alcohol related crime and disorder and increase community safety due to alcohol misuse
- Improving health and alcohol treatment services in Wolverhampton

What is the evidence of effective interventions?

There is a wide range of evidence of effective interventions for drugs and alcohol. However, there is a strong focus on ensuring that individuals can recover from dependency, primarily: -
Strategy 2010- Reducing Demand, Restricting Supply, building Recovery: supporting people to live a Drug free Life

The Strategy sets out the Government's approach to tackling drugs and addressing alcohol dependence, both of which are key causes of individual, family, societal and community harm. It sets out a fundamentally different approach to

preventing drug use in communities, and for drug and alcohol dependency, with the goal of recovery as its foundation. It sets out a whole system approach to commissioning recovery focused services. In relation to alcohol, the strategy aims to ensure that people who are alcohol dependent are provided with treatments, interventions in a holistic way (addressing any housing, employment or other social issues as well as the alcohol problem) which gives the best opportunity for recovery.

The Strategy describes the following "best practice outcomes":

1. Freedom from dependence on drugs or alcohol
2. Prevention of drugs related deaths and blood borne viruses
3. A reduction in crime and re-offending
4. Sustained employment
5. The ability to access and sustain suitable accommodation
6. Improvement in mental and physical health and wellbeing
7. Improved relationships with family members, partners and friends, and
8. The capacity to be an effective and caring parent

<u>NICE Guidance, e.g.</u>

- NICE Public Health Guidance 24- Alcohol-use Disorders: Preventing the Development of Hazardous and Harmful Drinking, (June 2010)
- NICE CG 100 - Alcohol Use Disorder: Diagnosis and Clinical Management of Physical Complications (June 2010)
- NICE CG 115 – Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol
- NICE PH guidance 43, Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection, December 2012

Models of Care

- MoCAM Models of Care for Alcohol Misusers, provides best practice guidance for local health organisations in delivering a planned and integrated local treatment system for adult alcohol misusers. MoCAM outlines the activities and services which should be commissioned. Services should be delivered on a stepped model of care, starting with the provision of advice and information and moving to in-patient detoxification or residential services.
- Models of Care for treatment of adult drug misusers (NTA, 2006)

High Impact Changes for Alcohol

The Department of Health highlights seven practical measures, which if implemented at a local level have been identified as making the biggest difference to tackling alcohol related harms, including

- Improve the effectiveness and capacity of specialist treatment (community and hospital settings)
- Appoint an alcohol health worker (in hospital settings)
- Alcohol IBA – provide more help encourage people to drink less

What are the planned actions, timescales and leads?

A key strand will be to support the prevention agenda to provide a whole community approach to changing alcohol habits in Wolverhampton as driven through the alcohol strategy action plan.
Planned actions centre on ensuring that specialist treatment services are available and that "recovery" is achieved for individuals in a holistic way, encompassing, for example, housing, employment and other key factors.
A new integrated recovery focused substance misuse service (alcohol, drugs and young people's services) has been commissioned and procured. 'The service has been operational since 1 April 2013. The new model of service delivery will begin on 1st July 2013.
A single point of contact (SPOC) will be provided for referrals into drugs, alcohol and young people's substance misuse services to ensure quick and appropriate access into services.

A children's and young people's substance misuse service, including transition services for those aged 18-25 years old, if it is deemed that adult substance misuse provision is not appropriate.
The service will include alcohol and drugs pharmacological and psychosocial interventions (including identification and brief advice for hazardous and harmful drinkers) provided in the community. This is in addition to a drugs and alcohol service at New Cross hospital (provided through a hospital liaison nurse service).

Community and enterprise provision will be the vehicle for providing wrap around support and driving recovery. In addition to pharmacological and psychosocial interventions, a key strand of the service will be providing help and support to ensure individuals can address any social problems they may have (for example housing issues) and access employment and training. This is important as wider problems often impact on individual's substance misuse and affect their chances of recovery.

How will progress be measured?

Key high level targets:

Reduction in 3 year average alcohol related mortality rates per 100,000 all ages population from a baseline of 19.6 in 2008 – 2010.

Improvement to the top quintile of performance nationally for:

- Percentage of drug users in treatment who complete treatment and do not represent within 6 months (OPIATES)
- Percentage of drug uses in treatment who complete treatment and do not represent within 6 months (NON-OPIATES)

In addition quarterly monitoring and review meetings will be held with the provider and a suit of performance indicators have been established (some of which are performance related (PBR) and these will be used to identify and measure progress with Wolverhampton Alcohol Strategy and this will be the focus of monitoring meetings.

PRIORITY 3 DEMENTIA

Lead Agency: Wolverhampton City Council (Community)

Sponsor: Anthony Ivko (Assistant Director, Older People and Personalisation)

Project Manager: Steve Brotherton (Head of Older People's Commissioning)

Partners: All agencies/ Departments

What is the issue?

Dementia can affect anyone whatever their gender, ethnic group, age or class, however it is particularly prevalent in the population aged 65 years and over and with a growing aging population the number of people with dementia is set to significantly increase. Raising awareness of dementia across all sectors and the importance of delivering a person centred response is critical to making a real difference to the health and well-being of individuals and their families.

What is the position and evidence in Wolverhampton?

- There are 3000 people living with dementia in Wolverhampton
- This figure is forecast to rise by 44% over the next 20 years, representing an increase of 75 people per year
- Only 40% of people with dementia in Wolverhampton are on a GP dementia register
- It is predicted that the number of people diagnosed with an early onset dementia is underestimated by three times (Dementia UK 2007)
- One third of people with dementia are living in care homes (1000 people in Wolverhampton) with two thirds of the care home population at any one time made up of people with dementia (Alzheimer's Society 2007)

- Conversely, two thirds of people with dementia are living independently in their own homes (2000 people in Wolverhampton
- 40% of people in hospital have dementia; the excess cost is estimated to be £6 M per annum in the average General Hospital; co morbidity with general medical conditions is high; people with dementia stay longer in hospital, have poorer quality outcomes and one third of people with dementia admitted to hospital never return home (Alzheimer's Society, 2009)
- In a national survey of 1000 GPs only 47% said they had sufficient training to diagnose and manage dementia; 58% said they felt confident about giving advice about management of dementia-like symptoms (National Audit Office, 2010)
- Alcohol-related dementia is under-recognised and may account for up to 10% of all dementia cases –around 70,000 people in the UK. (British Journal of Psychiatry); 300 people in Wolverhampton
- An Alzheimer's Society Report in 2007 estimated the annual cost of dementia for the United Kingdom at more than £17 billion, or £25,000 per person (Alzheimer's Society 2007). Applying these figures to Wolverhampton gives a total annual cost of dementia to the Wolverhampton economy of £75 million pounds (3000 people X £25,000 per person). The Kings Fund predicts that the cost of dementia in England will rise to £34.8 billion by 2026 (Kings Fund 2008).

The following table gives a more detailed breakdown on the projected population of people with dementia in Wolverhampton:

POPPI (2011): Wolverhampton People with Dementia Population Projection

Age	2009	2015	2020	2025	2030
65-69	133	145	142	149	165
70-74	264	264	295	289	306
75-79	488	493	504	562	556
80-84	757	778	825	848	966
85+	1301	1520	1739	2034	2323
Total	**2943**	**3200**	**3505**	**3883**	**4315**

How does it link to other strategies and priorities in Wolverhampton?

The response to dementia in Wolverhampton has been developed through a partnership approach involving all key stakeholders, including Wolverhampton Clinical Commissioning Group, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, and Wolverhampton Public Health. This response is underpinned by the following:

- The Living Well in Later Life Strategy 2012-15 sets the direction for services for older people, focussing on prevention, aiming to improve the quality of life & independence of older people, and increasing participation in service planning & community activities. It targets the 20% of older people who are most at risk of entering the downward spiral of isolation and ill health, include people with dementia
- The Joint Dementia Strategy (2011) was co-produced through a series of workshops, attended by over three hundred people, and a range of consultation events. It adopts a person centred philosophy that recognises people with dementia as people first and foremost who have the same rights as everyone else to lead healthy, happy and fulfilling lives. The strategy focuses on the delivery of five key priorities: Good Quality Early Diagnosis and Intervention; Improved Quality of Care in General Hospitals; Living Well with Dementia in Care Homes; Reduced Use of Antipsychotic Medication; Improved Support for Carers
- The Joint Reablement Forward Plan (2011-2013) outlines the commissioning intentions with regard to reablement activity, emphasising the need to focus on the person and their individual circumstances as presented at every stage across all pathways
- The following outcomes frameworks:

    - *NHS Outcomes Framework 2013/14*
        - Enhancing quality of life for people with dementia
        - Estimated diagnosis rate for people with dementia
        - A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life

- *Adult Social Care Outcomes Framework 2013/14*
  - Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services
  - Proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation services
  - Permanent admissions to residential and nursing care homes
  - When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence
  - Delayed transfers of care from hospital, and those which are attributable to adult social care
  - People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual

- *Public Health Outcomes Framework for England, 2013-2016*
  - Increased healthy life expectancy
  - Reduced differences in life expectancy and healthy life expectancy between communities

There are further local and national strategies that have informed the local response:

- NICE Quality Standard 1 for Dementia
- NICE Quality Standard 30. Supporting People to live well with dementia(2013)
- NICE Quality Standard 13. End of life care for adults
- NICE Clinical Guideline 42. Dementia: supporting people with dementia and their carers in health and social care
- NICE: Support for commissioning dementia care (2013)
- The Adult Social Care: Choice Framework (2013)
- Caring for our future: reforming care and support (2012)
- Living well with dementia: a national dementia strategy (2009)

- Care Quality Commission: Position statement and action plan for older people, including people living with dementia
- Improving quality of life for people with long term conditions (2012)
- Whole System Demonstrator Programme: Telehealth and Telecare (2011)
- Prime Minister's Challenge on Dementia
- Think Local; Act Personal

What is the evidence of effective interventions?

- To improve awareness and education, Worcester University Association of Dementia Studies has delivered two training modules to external market and public sector providers. These modules have concentrated on developing dementia leaders (hire and fire positions) and champions (front line worker position) with each organisation required to nominate a representative for each of these modules. These two people are then tasked to go back to their organisation and deliver person centred changes that improve the health and well-being of people with dementia
- To improve quality, Bradford University School of Dementia have carried out a dementia care map of local care homes across the City. An Action Plan with the aim of improving well-being was delivered to the home and a follow up map completed six months later to check progress
- To improve in-patient experience and outcomes, a dementia ward has been developed at New Cross hospital in addition to an outreach service to other wards
- To improve quality, Dementia Care Matters have carried out an evaluation of the wards at New Cross hospital and made a quality and cost comparison with the University Hospital in Birmingham
- To improve community based resources, six dementia cafés have been established across the City, one café for Asian elders and one café for African Caribbean elders
- To raise public awareness, two Prime Minister Challenge conferences were held to launch the development of a dementia friendly City, including people with dementia as key note speakers, banks, building societies, retailers and faith groups

What are the planned actions, timescales and leads?

The following Action Plan has been agreed by Adult Delivery Board:

Action	Timeframe	Assigned Lead Organisation/Individual/s
Common Assessment Framework (CAF) – Project to commence 01 September 2013		
To establish a CAF project group	Within 30 days	Black Country Partnership Foundation Trust
To agree in principle a multi-agency CAF approach	Within 60 days	
To review CAF processes and understand its potential application for dementia	Within 60 Days	
To agree and deliver a CAF paper with recommendations to Adult Delivery Board	Within 90 Days	
Information Sharing Protocols – Project to commence 01 September 2013		
To review City wide information sharing protocols	Within 90 days	Wolverhampton City Council
Dementia Pathway - Project to commence 01 September 2013		
Through the multi-agency Joint Dementia Strategy Steering Group formulate and agree a revised pathway for dementia	Within 90 days	Joint Commissioners
Reablement – Project to commence 01 September 2013		
To establish a dementia reablement project group	Within 30 days	Wolverhampton City Council
To develop a reablement approach for people with dementia	Within 60 days	"
To agree and deliver a multi-agency reablement paper with recommendations to Adult Delivery Board	Within 90 days	"
Home as a Hub – Project to commence 01 September 2013		
To establish a dementia hub project group	Within 30 days	Wolverhampton Clinical Commissioning Group
To agree the scope of services in a dementia hub	Within 60 days	"
To agree and deliver a multi-agency dementia hub paper with recommendations to Adult Delivery Board	Within 90 days	"
Refresh of Joint Dementia Strategy		
To deliver a refreshed Joint Dementia Strategy & Implementation Plan	By 31 March 2014	Joint Commissioners

How will progress be measured?

Progress will be measured against the following statements where people living with dementia in Wolverhampton are able to say:

- *'I was diagnosed early*
- *'I understand, so I make good decisions and provide for future decision making'*
- *'I get the treatment and support which are best for my dementia and my life'*
- *'Those around me and looking after me are well supported'*
- *'I am treated with dignity and respect'*
- *'I know what I can do to help myself and who else can help me'*
- *'I can enjoy life I feel part of a community'*
- *'I'm inspired to give something back'*
- *'I am confident my end of life wishes will be respected'*
- *'I can expect a good death'*

In terms of integrated working, three core areas have been highlighted as critical in order to enhance the experience and outcomes for people with dementia:

1. Information Access and Care Planning: Grounded in in a commitment to ensure that timely information is available and managed safely across the system, ensuring that people with dementia only need to tell their story once
2. Home as the Hub of Service: Grounded in a commitment to ensure that living at home and retaining independent living is regarded as a default outcome consideration, including the development of early intervention; prevention & rehabilitation and community based opportunities, making 'home' a positive and realistic alternative for people with dementia
3. Developing the Community Capacity to Care: Grounded in a commitment to deliver a whole city approach, including developments with commercial sector partners to ensure a full range of life opportunities are available for people with dementia.

All of this will be evaluated by identifying:- reduced costs in health & social care; a shift in public expenditure from intensive to preventative services; increased numbers of older people engaged in local groups and networks; increased satisfaction of older people with their quality of life; reduction in health inequalities.

PRIORITY 4 MENTAL HEALTH

Lead Agency: Wolverhampton City Council (Community)

Project Sponsor: Viv Griffin (Assistant Director – Health, Wellbeing and Disability)

Project Manager: Sarah Fellows

Partners: All agencies

What is the issue?

It is acknowledged that at least one in four people will experience a mental health difficulty at some point in their life and that one in six adults and one in ten children in England under 16 years have a mental health difficulty at anyone time. It is also understood that half of those with lifetime mental health difficulties experience symptoms by the age of 14 *(No Health without Mental Health, 2011)*. We now know that mental illness is the largest disease burden upon the NHS, up to 23% of the total burden of ill health and the largest cause of disability within the United Kingdom *(No Health without Public Mental Health, Royal College of Psychiatry 2010)*, and that mental ill health often starts before adulthood and continues through life.

There are significant personal, social and economic costs, with particular risks from birth, into childhood and as young people move into adulthood and as they enter periods of physical and psychological change and development. It is also understood that physical health is inextricably linked to mental health. Poor mental health is associated with obesity, alcohol and substance misuse and misuse and smoking, and with diseases such as cardio-vascular diseases and cancer, *(No Health without Public Mental Health, Royal College of Psychiatry 2010).*

Mental health is a vital element therefore of the of the quality of life, physical health, emotional and social well-being and economic success and educational achievement of individuals, families and communities, and a key contributing factor in reducing the impact/s of physical ill-health, unemployment, homelessness, drug and alcohol misuse and crime.
It has been identified that the costs of mental health problems to the economy in England have been estimated at £105 billion - in comparison, the total costs of obesity to the UK economy are £16 billion a year and £31 billion for cardiovascular disease , and that in 2010/11, £12 billion was spent on NHS services to treat mental disorder, equivalent to 11% of the NHS budget and that treatment costs are likely to double in the next 20 years as by 2026, the number of people in England who experience a mental disorder is projected to increase by 14%, from 8.65 million in 2007 to 9.88 million (*No Health without Public Mental Health, Royal College of Psychiatry 2010).*

The cross–departmental mental health strategy '*No Health Without Mental Health' (2011)*, describes mental health as *'everyone's business'* and details the Government's aim to '*mainstream*' mental health within England, to establish and develop parity of esteem between mental and physical health, and to improve outcomes for all building and developing on previous National and Local priorities and work programmes in terms of improving existing services for people with mental health problems and addressing the wider and underlying causes of mental ill health. This includes an emphasis on the importance of promoting good mental health and intervening early, particularly in childhood and teenage years to prevent mental illness from developing and to reduce the impact of mental health difficulties when they do occur. The Strategy takes a life course approach therefore, recognising the importance of good maternal and parental mental health, protecting and promoting well-being and resilience through early and developmental years, and into adulthood and then on into our later years.

Addressing the impact and burden of mental ill health is a priority nationally and locally therefore, and mental health services have developed in Wolverhampton in keeping with national policy guidance in recent years –including improved access to psychological therapies (IAPT), an Early Intervention in Psychosis Service for those aged 14 years, integrated approaches to delivering health and social care, and the development of teams and services locally that were compliant with the model/s described within National Service Framework for Mental Health: modern standards and service models *(Department of Health, 1999)* – it is timely to now place a focus upon mental health promotion and prevention, intervening early when mental ill health occurs.

It is imperative therefore, the Wolverhampton our Health and Well-being Strategy is able to describe and deliver a cross agency programme of priorities that can meet the mental health promotion and early intervention needs of our population, while recognising and responding to the unique characteristics of the people that live in our City. To do this we will need to work together to reduce the impact of the stigma of mental ill-health, to deliver improved outcomes for people with mental health difficulties, - for example in terms of housing and employment - and provide focused interventions for people that fall into the most vulnerable groups, such as those from Black and Minority Ethnic communities, communities with high levels of deprivation and people who are unemployed, people who experience physical ill-health, people with co-occurring conditions, children and young people who are transitioning to early adulthood and / or have parents or carers with poor mental health, people without stable family and / or social support, people who are subject to / at risk of abuse and bullying and people leaving care.

It is important to continue to improve access to services therefore but also to develop an approach that provides mental health promotion initiatives, and particularly to imbed this approach within early and school years where the impact of these initiatives is understood to be potentially higher in terms of improving life term outcomes such as improved mental health, improved educational outcomes, improved employment, and reduced levels of anti-social behaviour, crime including violent crime, and reduced suicide *(No Health without Public Mental Health, Royal College of Psychiatry 2010)*.

We must aim therefore to deliver a range of mental health promotion interventions across the life span to prevent mental illness, promote well-being, improve emotional health and well-being, and increase resilience in individuals, families and communities. Improving and strengthening resilience is a key concept in terms of developing protective versus risk factors with specific interventions such as parenting programmes, improved maternal care and mental health promotion programmes for employers, schools and colleges, and all-age communities and groups. It is important to provide interventions which apply across the life course that protect health and well-being and promote resilience to adversity, with early and appropriate intervention if mental health difficulties occur. Strategies to promote parental mental health and effectively treat parental mental illness are also important as are targeted approaches to support the mental health needs of Older People including interventions to prevent and treat dementia, and to promote good mental health and well-being in later life, including, recognising and promoting the contributions older people make to families and communities, and to develop reablement initiatives as part of this plan to allow people who have been affected by

disability or ill-health to move to a position of increased self-support and self-management, improving self-esteem and self-efficacy and facilitating greater levels of social inclusion. This approach is a key strategic priority for the Joint Commissioning Unit in terms of helping people with mental health difficulties to recover and engage in a more active role within their families and communities, whilst increase their personal autonomy and self-direction.

What is the position and evidence in Wolverhampton?

A detailed needs analysis of Wolverhampton prevalence data in 2010 identified the following key factors.

- QOF data of psychotic registers reported the prevalence to be comparable with national data at (0.7%)
- QOF depression registers reported a similar prevalence (5.5%) to national predictions
- Low-level depression was thought to be more prevalent among Wolverhampton adults since 2.4% of the population (5,615 people) were claiming incapacity benefit (IB) on the grounds of mental health, which equated to 42% of those claiming the benefit. This is slightly higher than the regional average (39.5%), and the national average (41%)
- QOF indicators for mental health were slightly below the national achievement levels
- The average suicide rate in Wolverhampton was 11.6, compared with the national average of 8.3. There was also a large discrepancy between different wards in Wolverhampton, which further highlights the health inequality in the city
- The percentage of people with a long term limiting illness in Wolverhampton (21%) was slightly higher compared to West Midlands (19%) and also above the England average (18%).

The Wolverhampton Community Mental Health Profile 2010/11(Department of Health 2013) has identified the following:

- Wolverhampton has slightly higher than average directly standardised rate for hospital admissions for mental health (Local Value 184, National Average 172)
- Significantly lower than average directly standardised rate admissions for Alzheimer's disease and Dementia (Local Value 49, National Average 80)
- Wolverhampton has lower than average proportion of referrals for IAPT (Improving Access to Psychological Therapies Local Value 53.2, National Average 60.1)

- Slightly lower than average numbers of people receiving care and support as part of the on Care Programme Approach, rate per 1,00 population (Local Value 5.8, National Average 6.4)
- Higher than average contacts with mental health services per 1,000 population (Local Value 413, National Average 313)
- Lower than average in year bed days for mental health, rate per 1,000 population, (Local Value 184, National Average 193)
- Significantly higher than average contacts with Community Psychiatric Nurses, rate per 1,000 population (Local Value 274, National Average 169)

Key drivers for the current Mental Health Commissioning Strategy include the 6 priorities of 'No Health without Mental Health' (Dept. Health 2012), which are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Services have been configured and aligned from 2012 to provide IAPT (Integrated Access to Psychotherapy) as part of the Primary Care facing Well-Being Service and a strong emphasis is placed upon providing psychological therapies across all elements of the service model as a whole in keeping with national drivers.

In addition in February 2012 a Needs Analysis of CAMHS prevalence data revealed the following key factors:

- When comparing local use of services against a national prevalence tool utilisation of services last year suggests that there is an under use of universal and targeted services, an over use of specialist services and a significant increase in the use of in-patient hospital provision.

- Over the fiscal years 2011/12 and 2012/13 the requirement for hospital admissions rose by over 100%. The purpose of 75 % of in-patient admissions was to prevent harm to self.

- The Crisis Support and Home Treatment Service is providing support and treatment to significantly more females than males – most recent data tells us that 35% of referrals to this service were following acts of deliberate self-harm. In addition there is an increase in females in school years 11 and 12 accessing the Multi Agency Support teams for support.

- The Crisis Support and Home Treatment Service has also experienced a significant increase in requests for specialist assessment out of hours (an increase of 273%) as well as planned telephone support out of hours (an increase of 294%).

- Overall the Crisis Support and Home Treatment Service have received experienced a 25% increase in routine referrals.

- From April 2012 to date there have been 149 admissions to the paediatric wards at New Cross Hospital of children and young people who have engaged in acts of self-harm.

- Public Health data identifies that in 2011 there were no suicides of people aged under 18 years that were resident in the City. In 2012 there are known to have been 3 incidents of suicide in the under 18 age group, the youngest being a child aged 13 years. Each incident is the subject of a serious case review.

- Referrals into services regarding the mental health of teenage mothers, children and young people in contact with criminal justice services and referrals from substance misuse services into children and young people's mental health services are not consistent with national prevalence data for these high risk groups, suggesting under representation within mental health services. This includes data regarding referrals into mental health services for those classed as 'children in need' and looked after children. Only 17% of the looked after children population are known to children's and young people's mental health services currently.

- Prevalence data suggests that as many of 10% of young people aged 18-25 years are currently accessing adult mental health services. Specialist teams within children's and young people's mental health services have reported difficulties referring young people into adult mental health services, with poor use of transition protocols / processes, and differing criteria regarding referral into adult mental health service provision.

- The School Census Spring 2012 in Wolverhampton shows that the school age population is more diverse than the ethnicity of the City as a whole. Specialist teams and multi-agency support teams are being accessed by predominantly white British families. Children and young people from Black and Minority Ethnic groups are significantly underrepresented in the data regarding children and young people accessing mental health and psychological support services in the City.

All of the above information has been used to inform the development of the Wolverhampton Emotional and Psychological Well-Being Strategy for Children and Young People however it should be noted that within Adult and Children and Young People's Mental Health Services and Commissioning a strong emphasis should now be placed upon Public Mental Health to provide a focus upon providing mental health promotion and prevention for the whole population of our City, including hard to reach groups and people who have established mental health conditions.

How does it link to other strategies and priorities in Wolverhampton?

This Mental Health Priority links to a number of other strategies, initiatives and priorities. These include:

- Mental Health Strategy Re-fresh (including CAMHS Strategy, i.e. Strategy for the Emotional, Social and Psychological Well-Being of Children and Young People
- NHS Outcomes Framework 2013/14
- Social Care Outcomes Framework 2013/14
- QIPP
- No Health Without Mental Health (2011)
- No Health Without Public Mental Health (2011)

- Dementia Strategy
- Children and Young People's Plan

What is the evidence of effective interventions?

The Joint Commissioning Panel for Mental Health *'Guidance for Commissioning Public Mental Health Services' (JCP-MH, 2012)*, identifies that mental well-being is associated with a wide range of improved outcomes in health, education and employment, as well as reduced crime and antisocial behaviour such as, better physical health, longer life expectancy, reduced inequalities, healthier lifestyles, improved social functioning and better quality of life. The guidance also suggests that Public Mental Health should form a key part of the strategic plans of Health and Well-being Boards, and that this should involve:

- Strong data intelligence which details the current and future mental and physical health needs of the local population and both an assessment of the risk factors for mental disorder and the protective factors for well-being in the local population.
- A Health and Well-Being Board Mental Health 'champion'.
- A Strategic Plan to deliver appropriate interventions to promote well-being, prevent mental disorder, and provide early and pro-active treatment for mental disorder, ensuring that people with increased risk of mental disorder and poor well-being are proportionately prioritised in delivery of interventions ('proportionate universality').
- Strong collaboration and partnership working across all agencies to ensure a combination of initiatives that will address the broad range of social, cultural, economic, psychological and environmental factors at all stages of the life-course.

The JCP-MH guidance also highlights a wide-ranging body of good evidence to suggest the efficacy of public mental health interventions to reduce the burden of mental disorder, enhance mental well-being, and support the delivery of a broad range of outcomes relating to health, education and employment and further identifies that although current spending on prevention and promotion is less than 0.001% of the annual NHS mental health budget investment in the promotion of mental well-being, prevention of mental disorder and early treatment of mental disorder results in significant economic savings - including in the short term - across health, social care and criminal justice areas.

The JCP-MH guidance suggests that preventing disease can occur as follows:

- Primary prevention, which aims to **prevent ill health** by focusing upon the wider determinants of illness and utilises approaches that target the majority of the population
- Secondary prevention, which involves the **early identification** of health problems and early intervention to treat and prevent their progression
- Tertiary prevention, which involves working with people with mental ill health to **promote recovery and prevent or reduce the risk of relapse**

The JCP-MH guidance also suggests that promoting health can occur as follows:

- Primary promotion involves promoting the health and well-being of the **whole population**
- Secondary promotion involves targeted approaches to groups that have or are at risk of **developing poor health** and well-being
- Tertiary promotion targets groups with **established health problems** to help promote their recovery and prevent relapse.

The table below describes suggested Public Mental Health Interventions adapted from the JCP-MH Guidance, the outcomes of the NHS Confederation / New Economics Foundation, 'Five Ways to Well-being' (2011) and the five key outcomes of Every Child Matters / The Children's Act (2004) and the stakeholder involvement required:

Mental Health Promotion	Mental Health Prevention	Early Intervention	Five Ways to Well-Being / Outcomes from 'every Child Matters'	Key Stakeholders
• Starting Well • Developing Well • Living Well • Working Well	• Mental Disorder and Dementia • Health Risk Behaviour including alcohol and	• Treatment of Mental-Disorder and sub-threshold Mental Disorder	• Connect • Be Active • Take Notice • Keep Learning	• Public Health England • Universal and Primary Care Services • Secondary and Tertiary

Mental Health Promotion	Mental Health Prevention	Early Intervention	Five Ways to Well-Being / Outcomes from 'every Child Matters'	Key Stakeholders
• Ageing Well	substance misuse • Inequality • Discrimination and Stigma • Suicide and self harm • Violence and Abuse including bullying	• Promotion of physical health and prevention of health risk behaviour in those developing mental disorder • Promotion of recovery through early intervention • Recognition of Mental Disorder	• Give • Stay Safe • Keep Healthy	Care Services • Substance Misuse Use Services • Local Authorities • Social Care Providers • Education establishments • Housing Providers • Criminal Justice Services • Third Sector and Community Organisations • Faith groups • Environmental Planners

The JCP-MH Guidance (2012) suggests a number of ways that evidence supports that Public Mental Health promotion and prevention can reduce the impact and burden of mental ill-health and disorder. These include:

- 'Promote well-being and resilience with resulting improvements in physical health, life expectancy, educational outcomes, economic productivity, social functioning, and healthier lifestyles'.
- 'Prevent mental disorder, health risk behaviours and associated physical illness, inequalities, discrimination and stigma, violence and abuse, and suicide and deliver improved outcomes for people with mental disorder as a result of early intervention approaches'.
- 'Prevent mental disorder in childhood which leads to poorer outcomes and inequalities in adulthood, higher levels of unemployment and lower earnings, higher risk of crime and violence and higher risk of adult mental disorder'.

- ‘Prevent mental disorder during adulthood which leads to poorer outcomes and inequalities poorer educational achievement, higher risk of homelessness higher unemployment, higher rates of debt problems, increased suicide and self harm levels, increased health risk behaviours, including poor diet, and less exercise.’
- Deliver ‘economic savings by reducing the costs of mental disorder through prevention and improved outcomes as a result of early intervention, economic savings associated with improved well-being, such as reduced welfare dependency, reduced use of health and social care services, less crime and greater social cohesion.’
- Deliver ‘economic savings resulting from reduced health risk behaviour and subsequent physical illness.’
- Deliver ‘economic benefits associated with improved well-being due to improved educational outcomes, higher employment rates, and greater economic productivity.’
- Deliver ‘improved resilience and ability to cope with adversity, reduced emotional and behavioural problems in children and adolescents, reduced levels of mental disorder in adulthood reduced suicide risk, better general health, less use of health services and reduced mortality in healthy people and in those with established illnesses’.
- Deliver ‘improved educational outcomes, healthier lifestyle and reduced health risk behaviour including reduced smoking and harmful levels of drinking, increased productivity at work, reduced absenteeism and reduced burnout, higher income, stronger social relationships, increased social/community participation, reduced antisocial behaviour, crime and violence.’

Local initiatives should therefore focus upon identifying risk and protective factors for mental well-being, such as identifying high risk groups and developing and supporting initiatives to access employment / higher economic status, increase social net works and engagement and opportunities for education and physical activity, and developing emotional and social literacy life skills, including developing skills in relation to communication, problem solving and resilience. Different levels of emotional and cognitive resilience or ‘capital’ include:

- Emotional and cognitive: includes optimism, self-control and positive personal coping strategies
- social: includes networks and resources that enhance trust, cohesion, influence and cooperation for mutual benefit within communities
- Physical health

- Environmental: includes features of the natural and built environment which enhance community capacity for well-being
- Spirituality: incorporates a sense of meaning, purpose and engagement as well as religious belief for some. ‘

There is a compelling case, therefore to deliver a robust plan to provide a range of mental health promotion and prevention interventions across a ‘life course’ approach to improve the mental health and well-being of our resident population, to identify and target risk factors and develop and promote protective factors, working in partnership across agencies to reduce the burden of mental ill-health across upon a range of personal, social, familial and economic outcomes.

What are the planned actions, timescales and leads?

The planned actions, timescales and leads are described in the table below:

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
1. Re-fresh / revisit the mental health data within the JNSA	To provide strong data intelligence which details the current and future mental and physical health needs of the local population, including levels of unmet need and both an assessment of the risk factors for mental disorder and the protective factors for well-being in the local population across the life span	By October 2013	PHE and SF
2. Promote good / positive mental health and well-being	Including universal proportionality i.e. targeted well-being promotion to facilitate recovery of those at risk of developing mental health difficulties and those with mental health difficulties. Sign up to ‘Time to Change’ campaign to tackle stigma locally	By October 2013	PHE and SF and MG and Education Lead

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
	Develop Resilience Strategy for Wolverhampton as part of CAMHS Strategy and Adult Strategy re-fresh, which will deliver targeted mental health promotion interventions within schools and the wider community and utilise simple telehealth options where possible. Align with 'Five Ways to Well-Being' and Stay Safe Keep Healthy outcomes of 'every Child Matters'	By January 2014	
3. Address health risk behaviour in those with mental health difficulties and / or those at risk of developing mental health difficulties	Work with Public Health England to co-ordinate approaches for identified target audiences regarding: • Alcohol • Cannabis (skunk) • Tobacco • Obesity	By January 2014	PHE and SF and MG
4. Describe Early Intervention Care Pathways from Universal to Primary and Secondary Care for all care clusters in Adult Mental Health, i.e. 0-3, 4-8, 10-17, and 18-21, and diagnostic groups in CAMHS	• As part of CAMHS Strategy and Adult Strategy re-fresh, develop Early Intervention Care Pathways for all care clusters • Work with GPs and Provider Leads • Align with NICE Guidance • Identify pathways for key target groups	Drafts by April 2014	SF, MG SS and Provider Leads

Priority Area	Set of High Level Action / Outputs	Timescales	Lead/s
5. Re-fresh Care Programme Approach Policy across all agencies to promote reablement across all care clusters, and prevent relapse and re-admission/s where possible	• As part of CAMHS Strategy and Adult Strategy re-fresh • Work with GPs and Provider Leads • Align with NICE Guidance	Draft by April 2014	SF, MG SS and Provider Leads
6. For all of the above describe pathways for hard to reach groups.	• As part of CAMHS Strategy and Adult Strategy re-fresh. To include engagement initiatives for people from BME Groups, Looked After Children, people who are homeless, unemployed, are living with physical health difficulties and /or living in areas of socio-economic deprivation and people who are Disabled and /or have a Learning Difficulty	By January 2014	SF, MG SS and Provider Leads

How will progress be measured?

Progress will be measured via a dashboard developed by the Mental Health Strategy Steering Group and reported to the JCU Development and Delivery Group, Adult Delivery Board and Health and Well-Being.

The Dashboard will include a number of KPIs including:

- Access to Early Intervention Services
- Access to Psychological Therapies
- Numbers of people moving to recovery who are receiving Psychological Therapies
- Numbers of people entering employment
- Delivery of Mental Health Promotion initiatives
- Numbers of people leaving care and hospital and entering reablement / intermediate care

PRIORITY 5 URGENT CARE

Lead Agency: Wolverhampton City Clinical Commissioning Group

Project Sponsor: Richard Young (Director of Strategy and Solutions)

Project Manager: Rox Modiri

Partners: Local Authority, Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, West Midlands Ambulance Service, South Staffordshire Clinical Commissioning Group

What is the issue?

Urgent and Emergency Care has been highlighted in the press both locally and nationally due to the extreme pressure that the entire system is under. The focus of attention has been on the pressures felt by the Emergency Department and the ambulance service, however the entire system has experienced increased activity and patients experiencing longer waits to be seen and treated and Wolverhampton is no exception.

What is the position and evidence in Wolverhampton?

The Joint Urgent and Emergency Care Strategy Board has been developed with partners from WCCG, SES&SP CCG, RWT, WCC and WMAS coming together to undertake a review of urgent and emergency care in Wolverhampton, develop an urgent and emergency care strategy and a commitment to work with our patients to develop a cohesive and sustainable way forward. In order to deliver the strategy but also to manage the wider Urgent & Emergency Care system, the Strategy Board will morph into the Urgent & Emergency Care Board. The board will continue to include health and social care leads who are both clinicians and managers but will also widen the membership by including patients, public health and mental health trust and communication representatives.

How does it link to other strategies and priorities in Wolverhampton?

Taking the views of our patients and stakeholders, and the extreme pressure the system is under, a cohesive vision for urgent and emergency care has been developed.

"Our vision is for an improved, simplified and sustainable 24/7 urgent and emergency care system that supports the right care in the right place at the right time for all of our population. Our patients will receive high quality & seamless care from easily accessible, appropriate, integrated and responsive services. Self-care will be promoted at all access points across the local health economies and patients will be guided to the right place for their care and their views will be integral to the culture of continuous improvement."

Urgent and Emergency Care Strategy Objectives:

- Improved Assessment and Discharge
- Managing Patient Expectation by clinicians working together
- Standardising and Improving Quality in Urgent Care by ensuring services are high quality and clinically robust
- Improve Timely Access to Services by improving access and operating hours
- Encourage Self-Care (wherever possible) by communicating with our patients
- Use of Risk Stratification by managing patients who are at high risk of admission into hospital
- Improved Communication by using technology and promotional campaigns
- Seamless and Consistent Urgent Care Services by ensuring all providers are managed through a system approach
- Explore and Develop Alternative Solutions by ensuring new solutions to improve quality within the system are identified, considered and delivered

Expected Benefits of Strategy:

- Appropriate reduction of ED attendances by 2016 by ensuring our pathways are correct
- Appropriate reduction in Emergency Admissions by 2016
- Patients arriving at ED by ambulance will be assessed by a nurse within 15 minutes.
- The sustainable delivery of the 95% ED target will be achieved 98% of the time
- An increase in Primary Care appointments by April 2015
- An increase in Mental Health Practitioners within the ED to improve urgent care provision for patients in crisis by April 2014

Wolverhampton Surge Planning Group –
The Surge Planning Group provides resilience support to the current Urgent & Emergency Care system by advising on tactical changes to manage surges in activity across Wolverhampton. The primary focus is on the urgent care system, the impact of pressure on those services and the decisions that need to be taken to alleviate the immediate pressures. This group will work to deliver the A&E Recovery Plan and will be overseen by the U&EC Board.

What is the evidence of effective interventions?

What are the planned actions, timescales and leads?
TBC

How will progress be measured?
TBC

Appendix 1 – Health and Wellbeing Board shortlisted outcomes – spine chart

Key:

- Significantly better than England average
- Not significantly different from England average
- Significantly worse than England average
- No significance can be calculated

Regional Key:

National average
Wton LA peers
Worst — Best
25th Pecentile 75th

	Indicator	Local Number	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Group 1	Alcohol related admissions per 100,000 2008-09	4628	1715.9	1582.7	2856.4		784.3
	Alcohol related mortality all ages 2007-09	164	22.3	10.4	33.6		2.2
	Children in Poverty 2010	17365	30.8	20.9	57.0		3.9
	Year R obesity rates 2009-10	333	12.2	9.8	14.7		5.4
	Year 6 obesity rates 2009-10	659	24.7	18.7	28.6		10.7
	Obesity rates in adults 2006-08 (estimated)	n/a	27.3	24.2	32.9		13.2
	% employed with long term conditions						
	% employed with long term conditions (Mentally ill and LD)						
Group 2	Male disability free life expectancy 1999-2003	n/a	58.3	61.7	50.4		71.5
	Female disability free life expectancy 1999-2003	n/a	60.8	64.1	54.0		71.3
	Incidents of domestic abuse						
	Circulatory disease mortality under 75 2007-09	639	85.2	70.5	122.1		37.9
	Prevalence of diabetes 2009-10	13886	6.9	5.3	7.9		3.3
	Infant mortality rates 2007-09	65	6.5	4.7	10.6		0.7
	Perinatal mortality rates 2007-09	123	12.1	7.6	14.7		2.0
Group 3	Child development at 2 years						
	Good development at age 5 2010	n/a	52.1	55.7	41.9		69.3
	Mortality rate for people with mental illness						
	Permanent admissions to residential and nursing homes per 100,000 2009-10	340	180.0	160.0	315.0		25.0
	An indicator on recovery from stroke						
	Early cancer diagnosis stages 1 and 2						
Group 4	Under 18 conception rates 2007-09	788	56.3	40.3	69.4		14.6
	Homeless households 2009-10	339	3.4	1.9	8.3		0.1
	Maternal smoking prevalence 2009-10	626	20.5	14.5	31.4		4.5
	Fractured proximal femur emergency admission rates 2008-09	n/a	130.0	98.0	141.2		0.0
	Access to green space 2005	n/a	29.2	87.5	12.4		97.3

[i] Tackling drugs and alcohol. Local government's new public health role. Local Government Association, January 2013. http://www.local.gov.uk/c/document_library/get_file?uuid=ef73ac40-827e-4e7f-bb27-9b19fff157c0&groupId=1017

Care Closer to Home - Recommendations to Influence Commissioning Intentions for 2016/17

You Said	We Did
• Access to services need to be easier and quicker 24/7, with single points of access where possible • One multi professional care plan for all professionals to access, assessments should take place before and during acute care and post discharge. Discharge should be supported by an appropriate care plan (complied pre-discharge) and a follow up visit/phone call where possible • Services need to be more integrated, where possible, community based and spread across the borough, one person such as community worker to co-ordinate all health and social care needs • Information and communication is also key, help to self-care where possible • Advice and ongoing support for patients and carers to be provided by community groups and third sector organisations	**Community Neighbourhood Teams** An integrated model of care called Community Neighbourhood Teams are currently under development. The development of Community neighbourhood teams is part of a large programme of work being delivered under the umbrella of the Better Care Fund. The programme consists of all health and social care organisations in Wolverhampton who have agreed to work together better together to ensure safe, high quality and financially sustainable services for the residents of Wolverhampton. By adopting a more integrated approach it is aimed to prevent people having unnecessary stays in hospital and improve health and social care outcomes for everyone in Wolverhampton. The delivery of Community Neighbourhood Teams is underpinned by the following underlying principles: • Services should be accessible, convenient and responsive • Patients should receive high quality care which is centred on their social, physical and health needs rather than the needs of professionals and organisations. • Patients should be empowered to manage their own care and self-care. • Services should be local wherever possible • Services should be centralised where necessary (to ensure clinical safety). • Care should be seamless across health and social care. • Information and communications should be centred on the patient not the organisation/professional. • High quality care should be accessible quickly regardless of the time or day of the week Community Neighbourhood teams will be wrapped around localities locality based and aligned around a number of GP practices and their

populations providing a single point of access for both healthcare professionals and patients.

The different functions of the community neighbourhood team include:

- Rapid Response which provides an urgent response (within two hours of referral to service) for assessment, diagnostics and support to safely manage patients in their own home and avoid unnecessary admissions to hospital.
- Intermediate Care which helps facilitate discharge from hospital, and offers care and support services to enable you to maintain or regain the ability to live independently in your own home or avoid premature admission to residential care.
- Risk Stratification/Case Management - Community matrons will work closely with GP practices to risk stratify and identify patients who are have either complex needs or at risk admission who would benefit from case management or would benefit from joint health and social care multidisciplinary team discussion..

Joint health and social care management plans will be developed which will be accessible by both primary and secondary care services.

Patients will have a named care co-ordinator who will facilitate and co-ordinate the care plan.

The long term plan for the community neighbourhood teams is to shift to delivering seven day services.

Future plans entail working closely with the voluntary sector to ensure patients and carers are appropriately supported in the community and developing a frail elderly pathway.

As the community neighbourhood teams become embedded the longer term plan is to review services to identify areas/access clinics (including acute setting clinics) that could be shifted and centred and run around CNT localities/GP practices

Integrated MSK Community Services

Currently in the process of procuring an integrated MSK community service with the overall aim of providing a multi-disciplinary team approach for the care of people with a musculoskeletal condition.

The overall aims and objectives of this service are:

- To act as a single point of access for patients with a musculoskeletal condition to include orthopaedic, rheumatology, physiotherapy, pain management and orthotics.
- To include the specialist triage of musculoskeletal referrals to ensure patients are seen in the right place by the right person at the right time and actively manages inappropriate referrals through education and support
- To reduce the need for patients to attend secondary care, thus promoting care closer to home and right care, right place, right time
- To educate patients on their condition and empower patients to self-manage where appropriate
- To increase knowledge of the service across primary/community care to enable signposting of patients to the service, and other support services as appropriate
- To adopt a multidisciplinary approach to ensure an holistic approach is undertaken when developing treatment plans

Review of Community Services

Review of all community services being undertaken over the next two to three years to ensure services are providing value for money and are meeting patients' needs and are delivering outcomes required.

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This Unit of Planning covers the population of Wolverhampton and concerns the commissioning and delivery of health and social care, comprising the statutory organisations of Wolverhampton Clinical Commissioning Group, Wolverhampton City Council, Black Country Partnership Foundation Trust and The Royal Wolverhampton NHS Trust.

In 5 years time we will have a streamlined health economy with reduced reliance on the acute sector and increased capacity in primary and community care with accessible high quality services. By 2018/19 significant progress will have been made towards making sure that within the available resources, people in Wolverhampton will receive

the right care, in the right place, at the right time

Outcome Ambition 1 : To decrease Potential Years of Life Lost (PYLL) from causes amenable to healthcare by 13.2% in 5 years

Outcome Ambition 2: To improve the health related quality of life for people with long term conditions by 1.7% in 5 years

Outcome Ambition 3: To reduce avoidable admissions to hospital by 15% in 5 years

Outcome Ambition 4: To increase the proportion of older people living independently at home following discharge from hospital by at least 5% in 5 years

Outcome Ambition 5: To increase the number of people having a positive experience of hospital care by 5% in 5 years

Outcome Ambition 6: To increase the number of people having a positive experience of out of hospital care by at least 9.6% in 5 years

Outcome Ambition 7: To have parity in weekend mortality (no higher than any other day in the week) in our hospital

Primary Care Development to include: Workforce development; improve IT and Estates; enhance productivity; improve integrated working with other sectors.

Community Care Development: to include Community Nursing Service and Telecare and Telehealth provision.

Better Care Fund: To act as catalyst for whole system change which includes collaboration for health and social care planning and service delivery; prevention focus; person centred care

Reconfiguration of Urgent and Emergency Care System to include streamlining of services; highly responsive urgent care system; emergency patients directed to emergency centre with relevant expertise and equitable 7 day access.

Modernisation Programme to include shift of activity to the community and implementation of enhanced recovery and discharge planning projects

Specialised services: To collaborate and engage with West Midlands partners to align with the national direction of travel.

Mental Health: Focused on parity of esteem and early intervention to prevent people from entering secondary and tertiary services wherever possible and provide an integrated system of assessment and intervention with social care partners to enable recovery, promote independence and prevent relapse.

Tackling Health Inequalities: to work with health and social care partners to analyse key problems, set common goals, identify, implement and measure high impact interventions including preventative measures

Governance arrangements

- Coordinated through HWBB
- Clinically driven and designed for clinical expertise and decision-making
- Combined with the rigour of Programme Management
- Commissioning cycle approach

Success criteria

- Achievement of Outcome Ambition Targets
- Integrated Quality Assurance across the system
- Sustainability and Financial Stability
- Reduction in Health Inequalities

System values and principles

- Respect and value; listen and engage with local people
- Work proactively and in partnership
- Ensure clear accountability and transparency
- Act in fairness and with equity
- Focus on Quality and Innovation
- Prevention: Promote health and wellbeing
- Productivity: monitor the effectiveness of our services ensure the best use of our resources

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Our priorities

A stronger economy

Stronger communities

A confident capable council

City of Wolverhampton Council's Corporate Plan 2015/16

Our mission:
Working as one to serve our city

Objective: To work in collaboration to improve the region of the Midlands

Accountable Officer: Managing Director

Why is this important to Wolverhampton?

Greater collaboration in the West Midlands and the Midlands as a whole will benefit the city of Wolverhampton in the following ways:

- Greater economic growth
- Improve job prospects and skills training for residents
- Allow access to enhanced funding opportunities from central government
- Improve the movement of people and freight across the Midlands and the rest of the country

What are our key policies and strategies?

There are a number of key policies and strategies which relate to our objective. These include:

- Regional transport strategies and policies
- Skills Commission work
- Economic Growth Strategy

What will we do to achieve this?

Action Description	Lead Officer
• Develop the West Midlands Transport Strategy for approval by the Integrated Transport Authority	Managing Director
• Create a Combined Authority for the West Midlands	Managing Director
• Create a prospectus for the West Midlands	Managing Director
• Prepare a proposal for central government to approve a deal for the West Midlands Combined Authority to help develop the economic growth potential of the region	Managing Director
• Deliver the City of Wolverhampton Interchange (train station) as the gateway to the Black Country and Birmingham/Coventry	Managing Director
• Deliver an effective and coordinated consultation and communication plan to support the development of a West Midlands Combined Authority	Managing Director

How will we monitor our progress?

We will achieve the following key milestones:

- Parliamentary approval for the West Midlands Combined Authority, giving the body legal status.
- The 'deal' the West Midlands Combined Authority is able to achieve with central government.
- Prospectus agreed by Leaders for launch by July 2015.
- Have a transport strategy for the West Midlands approved by the Integrated Transport Authority by December 2015.
- Deliver a Wolverhampton Interchange by 2019.

Cover photography courtesy of the Express & Star

Our Corporate Plan

Working as one to serve our city

Place Stronger Economy

Delivering effective core services that people want

Keeping the city clean

Keeping the city moving

Improving the city housing offer

An environment where new and existing businesses thrive

Developing a vibrant city

Supporting businesses, encouraging enterprise and attracting inward investment

People develop the skills to get and keep work

Improving our critical skills and employability approach

People Stronger Communities

People live longer, healthier lives

Promoting and enabling healthy lifestyles

Promoting independence for older people

Promoting independence for people with disabilities

Adults and children are supported in times of need

Safeguarding people in vulnerable situations

Strengthening families where children are at risk

People and communities achieve their full potential

Challenging and supporting schools to provide the best education for children and young people

Enabling communities to support themselves

Keeping the city safe

Confident, Capable Council Stronger Organisation

Future Council - stronger council ready and able to deliver change

Future Customer	Future People	Future Performance	Future Works	Future Practice	Future Money	Future Space

Equality Objectives

Objective: Keeping the City Clean

Accountable Officer: Service Director for City Environment

Why is this important to Wolverhampton?

A clean city is a better place to live, work and visit and will attract investment and create job opportunities.

Maintaining and improving our streets and green spaces will create pride in our city and improving the quality of our local environment brings environmental, economic, social and health benefits. It can lead to a positive impact on well-being, quality of life and community cohesion where people take responsibility and care for their local area.

What are our key policies and strategies?

There are a number of documents which support keeping the city clean, including:

- Regeneration Compliance and Regulatory Policy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Undertake a comprehensive spring clean of the city and launch campaigns to combat littering and dog fouling	Head of Public Realm
• Promote use of the report-it app to identify rubbish hot spots and deploy area response teams to clear them	Head of Public Realm
• Engage with local residents through social media and traditional means to establish a community cleansing champion scheme	Head of Public Realm
• Introduce a new improved approach to managing the public realm in the City Centre	Head of Public Realm
• Improve air quality in the city by reducing the emissions from the council's vehicle fleet	Head of Operational Services

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Amount of emissions from the council's vehicle fleet	2,977,284 kgs	2,947,511 kgs
• Percentage of customers satisfied with street cleaning	53%	55%
• Percentage of customer street cleaning enquiries responded to within set time frame	94%	94%

Objective: Keeping the City Moving

Accountable Officer: Service Director for City Assets

Why is this important to Wolverhampton?

A safe, efficient and effective Transportation network supports economic development, social and regeneration aspirations and Environmental objectives of the city.

Our transportation networks are major assets, which need to be properly maintained and developed to allow the safe and efficient movement of people and goods across the city and wider region.

Our transportation network needs to support all modes of transport including car, bus, coaches, rail, tram, cycling and walking.

What are our key policies and strategies?

There are a number of documents which support keeping the city moving, including:

- West Midlands Local Transport Plan
- Black Country Core Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Establish plans for an effective transportation network to support development across the city	Transportation Manager
• Progress the £20 million scheme to extend the Midland Metro line into the new Wolverhampton Interchange	Transportation Manager
• Progress delivery of the £20 million Wolverhampton Interchange as a regional transport hub involving the redevelopment of Wolverhampton Train Station	Transportation Manager
• Improve traffic flows in the city by implementing a new Urban Traffic Control (UTC) system	Urban Traffic Control Manager
• Invest £0.4 million in the city's highways network to improve safety and operations	Transportation Manager
• Improve the co-ordination of works on the highway to avoid unnecessary delays to users	Urban Traffic Control Manager
• Promote and encourage walking, cycling and public transport to reduce the number of car journeys	Transportation Manager

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of people killed or seriously injured (KSI) in road traffic accidents	75	73
• Number of uses of cycle routes	69,888	70,857
• Percentage of traffic light faults responded to within 2 hours	90%	100%
• Total length of cycle network	23km	26km

Objective: Improving the City Housing Offer

Accountable Officer: Service Director for City Assets

Why is this important to Wolverhampton?

Improving the quality and supply of housing is crucial to support current and future residents who will have a fundamental role to play in the city's future.

This includes supporting people who are considered as vulnerable households and building new housing to support the growing economy and regeneration agendas.

What are our key policies and strategies?

There are a number of documents which support improving the city housing offer, including:

- Housing Strategy
- Homelessness Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Stimulate the private housing market to encourage a wider range of housing to reflect the full range of needs	Head of City Housing
• Deliver and support projects that will see the creation of 650 new homes in the city	Head of City Housing
• Prepare a strategy to develop various housing estates such as the Heath Town estate	Head of City Housing
• Provide a support service to prevent vulnerable people from becoming homeless	Head of City Housing
• Improve the private rented sector in the city	Head of City Housing
• Deliver plans to tackle the issues of long term empty properties and bring 200 houses back into use	Head of City Housing
• Support households in vulnerable situations to get into long term housing solutions	Head of City Housing

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of additional homes provided (net) (as part of the New Build programme)	677	650
• Number of affordable homes completed	145	115
• Number of homes improved to meet the statutory housing standard	291	300
• Number of vacant dwellings returned to occupation or demolished	200	200
• Number of homes improved to meet the decent home standard	1755	540
• Number of households accessing housing options services	3110	3110
• Number of landlords accredited through the Midland Landlord Accreditation Scheme (MLAS)	191	200

Objective: Developing a Vibrant City

Accountable Officer: Service Director for City Economy

Why is this important to Wolverhampton?

To attract and retain high value businesses and a skilled workforce, the city needs to develop a distinct and attractive offer. This means securing further inward investment and growth funds into our three main economic growth areas. We need to address viability gaps, support collaborations and joint ventures, as well as develop inspiring places that support the creative and learning sectors. This will allow them to flourish, generate vibrancy, footfall and in turn stimulate the retail sector.

The provision of an excellent cultural offer is an essential part of ensuring we have a strong visitor economy. Our heritage and leisure facilities support improved footfall and the economic development of our city.

What are our key policies and strategies?

There are a number of documents which support developing a vibrant city, including:

- Black Country Strategic Economic Plan
- Black Country Core Strategy
- Wolverhampton City Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Enhance and expand our city marketing approach with partners to raise our external profile and attract new investment into the city	Service Director City Economy
• Start construction on key city centre schemes such as the Wolverhampton Interchange and progress key opportunities at Westside and Southside	Head of City Development
• Begin the £10 million refurbishment of the civic halls complex to enhance its national position	Service Director City Economy
• Enable development of the Springfield Brewery site for specialist vocational and educational provision in construction and manufacturing as part of a thriving canalside quarter	Head of City Development
• Secure further growth opportunities in the M54 Junction 2 strategic growth area including working with occupiers to maximise opportunities for city businesses and residents	Head of City Development
• Commence implementation of £10.9 million programme to deliver new housing, retail, culture and leisure improvements in Bilston Urban Village	Head of City Development

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Total amount of investment in the city	£61.9 million	£519.7 million
• Number of businesses located in the city's main economic growth areas	3,775	3,964
• Number of jobs created in the city's main economic growth areas	51,500	54,075
• Number of visitors to the city's main cultural venues	New measure	Baseline to be established

Objective: Supporting Businesses, Encouraging Enterprise and Investment

Accountable Officer: Service Director for City Economy

Why is this important to Wolverhampton?

As the public sector shrinks, the city is increasingly dependent on private sector investment and business rates. We need to do all we can to create new job opportunities and address the low wage economy, which significantly contributes to poverty and ill health. This means attracting new businesses who will bring new jobs, and support existing businesses to survive, adapt and grow.

What are our key policies and strategies?

There are a number of documents which will help us support businesses, encourage enterprise and investment, including:

- Black Country Strategic Economic Plan
- Black Country Core Strategy
- Wolverhampton City Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Maximise EU and UK external funding to deliver business, enterprise and inward investment support	Service Development Manager
• Develop a targeted programme of activity to enhance the profile of the city to potential investors	Head of Enterprise and Skills
• Improve the Black Country Growth Hub to provide a one-stop-shop for targeted effective business support	Head of Enterprise and Skills
• Introduce a City Procurement Charter to enhance opportunities for local businesses to supply public bodies	Head of Enterprise and Skills
• Increase the number of successful social and community enterprises across the city	Head of Economic Inclusion

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of business start-ups supported	New measure	Baseline to be established
• Number of businesses surviving after first five years	34.6%	36.9%
• Number of small and medium (SME) businesses supported	Small: 1420 Medium: 305	Small: 1450 Medium: 315

Objective: Improving our Critical Skills and Employability Approach

Accountable Officer: Service Director for City Economy

Why is this important to Wolverhampton?

With a global shift towards a knowledge economy, it is critical for the city to meet the needs of existing and future employers, and equip local people to successfully compete for and progress in work. Although it is improving, the city still has one of the worst unemployment levels in the country. Too many people face barriers that mean they are likely to remain workless or trapped in a low wage economy. We therefore need to strengthen all stages of the journey - from taking the first steps in obtaining advice to securing employment.

What are our key policies and strategies?

There are a number of documents which support improving our critical skills and employability approach, including:

- Black Country Strategic Economic Plan
- Black Country Core Strategy
- Wolverhampton City Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Implement a City Skills and Employability Programme with all providers following the completion of the independent Wolverhampton Skills and Employment Commission	Service Director City Economy
• Build on the 'outstanding' Adult Education Service to focus on supporting people to obtain the skills needed for the world of work	Head of Adult and Cultural Learning
• Develop the role of the council as a leading employer in the city by maximising apprenticeships, traineeships and work experience opportunities	Head of Enterprise and Skills
• Further develop an innovative recruitment approach with new and existing employers to maximise employment opportunities for people in the city	Head of Enterprise and Skills
• Provide co-ordination and facilitation across the city's leading organisations that prepare people for the world of work, particularly in the city's most deprived areas	Head of Economic Inclusion
• Introduce an improved approach to make it easier for people in the city to access a range of critical employability support	Head of Economic Inclusion

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of people accessing the creative economy, learning, training or volunteering opportunities	New measure	Baseline to be established
• Number of residents supported through education, training, employment or enterprise	New measure	Baseline to be established
• Number of residents in key deprived areas supported though education, training, employment or enterprise	New measure	Baseline to be established

Objective: Promoting and Enabling Healthy Lifestyles

Accountable Officer: Service Director for Public Health and Wellbeing

Why is this important to Wolverhampton?

Infant mortality, smoking, poor diet, a lack of physical activity and alcohol misuse is having a major impact on life expectancy in the city. Tackling the issues in these areas will improve quality of life and reduce the time spent with illness prior to death.

What are our key policies and strategies?

There are a number of documents which support promoting and enabling healthy lifestyles, including:

- City Strategy
- Health and Wellbeing Strategy
- Alcohol Strategy for Wolverhampton
- Obesity Call to Action
- Infant Mortality Action Plan

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Introduce specific programmes to increase the number of women who stop smoking during pregnancy	Consultant in Public Health
• Kick-start a whole school 'Stop Smoking' and smoking prevention programme across the city	Consultant in Public Health
• Roll out a local smoke-free campaign for the city to help people stop smoking and improve the environment	Consultant in Public Health
• Launch a range of focused health programmes across the city to drive up physical activity levels	Head of Healthier Place
• Develop a programme to support businesses and organisations to be healthy workplaces. Start with the council, the University of Wolverhampton and the Royal Wolverhampton NHS Trust	Head of Healthier Place
• Support GPs to spot when their patients are starting to have problems with alcohol	Consultant in Public Health
• Investigate why alcohol related emergency admissions are still on the increase	Consultant in Public Health

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Percentage of mothers smoking at the time of delivery	18.7% (2013/14)	To reduce
• Percentage of individuals achieving targeted weight loss through a weight management programme	39.9% (2013/14)	To increase
• Rate of alcohol related emergency admissions (under 75 years per 100,000 population)	782 (2012/13)	To reduce

Objective: Promoting Independence for Older People

Accountable Officer: Service Director for Older People

Why is this important to Wolverhampton?

Older people of Wolverhampton have a right to protection and support so that their life chances can be improved and they can be safe in their homes.

What are our key policies and strategies?

There are a number of documents which support promoting independence for people for older people, including:

- Information and Advice Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Develop a network of advice centres that can provide financial health checks for older people across the city to support financial independence and stability	Head of Welfare Rights
• Develop an offer to community associations to support vulnerable older people	Head of Commissioning Older People
• Develop services closer to home for older people that optimise independence	Head of Assessment and Care Management
• Shift the balance of care to support more older people at home	Head of Libraries
• Develop integrated reablement services work with partners, to prevent and delay the need for high intensity support	Head of Assessment and Care Management
• Achieve 'Dementia Friendly' city status to ensure Wolverhampton is a welcoming place for older people with dementia	Head of Commissioning Older People

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of new users of Telecare services	New measure	500
• Number of financial health checks undertaken	New measure	2000
• Number of carer assessments	1124	1350
• Rate of permanent admissions to care homes for older people (per 100,000 population) (ASCOF 2A(2))	650	638
• Percentage of older people who have received reablement services who remain in their own home six months after discharge from those services	83.2%	84.0%

Objective: Promoting Independence for People with Disabilities

Accountable Officer: Service Director for Disability and Mental Health

Why is this important to Wolverhampton?

It is important that clients in contact with Disability or Mental Health Services are enabled to live their lives as independently as possible and that they have choice and control over the services that they receive.

We must also manage the demand for services so that the services can be more efficiently provided within the available resources.

What are our key policies and strategies?

There are a number of documents which support promoting independence for people with disabilities, including:

- Mental Health Commissioning Strategy
- Learning Disability Joint Commissioning Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Embed Special Educational Needs and Disability (SEND) reforms to ensure that each individual has a personalised plan	Head of All Age Disability
• Transform the transition pathway from children's services to adult services for young people with disabilities to promote their independence	Head of All Age Disability
• Reduce the number of adults with mental ill health in residential nursing care to enable them to have more independent living	Head of All Age Disability
• Promote the independence of adults with learning difficulties with a care plan	Head of All Age Disability
• Enable vulnerable adults to live more independently	Head of All Age Disability

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Percentage of Education, Health and Care Plans (EHCP) converted	25%	35%
• Percentage of disabled children in year 9 that have a Transition Plan	100%	100%
• Rate of adults aged 18-64 in contact with Mental Health Services who are in permanent residential or nursing care (per 100,000 population)	33.9	14.3
• Number of adults aged 18-64 in contact with Mental Health Services who have been resettled from permanent residential care into community based services	New measure	35
• Rate of adults aged 18-64 in contact with Learning Disability Services who are in permanent residential or nursing care (per 100,000 population)	109.4	96.4
• Number of new supporting living placements created for people with learning disabilities	New measure	50

Objective: Safeguarding People in Vulnerable Situations

Accountable Officer: Strategic Director of People

Why is this important to Wolverhampton?

Vulnerable children and adults in the city have a right to protection and support so that their life chances can be improved and they can be safe in their homes.

What are our key policies and strategies?

There are a number of documents which support safeguarding people in vulnerable situations, including:

- Domestic Violence Protocol

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Take practical steps to ensure that Child Sexual Exploitation (CSE) is understood and prioritised across the city	Head of Safeguarding and Quality
• Promote a 'whole family' approach across the council to demonstrate and achieve positive sustained change	Strategic Director People
• Work across the partnerships to improve understanding of safeguarding priorities	Head of Safeguarding and Quality
• Introduce and embed an integrated model of support for domestic violence across social care	Strategic Director People
• Develop a Multi-Agency Safeguarding Hub (MASH) in Wolverhampton	Strategic Director People

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Proportion of children identified as been at risk of Child Sexual Exploitation (CSE) whose level of risk has reduced	New measure	60%
• Percentage of referrals to Children's Social Care where domestic violence is an identified factor	38.4%	40%
• Percentage of referrals to Adults Safeguarding where domestic violence is an identified factor	10.4%	12%
• Proportion of people who use social services who feel safe	74.8%	75.5%

Objective: Strengthening Families Where Children are at Risk

Accountable Officer: Service Director for Children and Young People

Why is this important to Wolverhampton?

Targeting effective early help and support to vulnerable families at the earliest point works. It will strengthen families, keep children and young people safe and improve their life chances.

What are our key policies and strategies?

There are a number of documents which support strengthening families where children are at risk, including:

- Children, Young People and Families Plan
- Wolverhampton Youth Justice Board Plan
- Early Help Plan
- Looked After Children Sufficiency Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Work together to keep children safe and in stable families	Service Director for Children and Young People
• Work with the whole family to demonstrate and achieve positive sustained change	Heads of Early Help
• Ensure families get swift and co-ordinated access to the right services	Service Director for Children and Young People
• Improve the engagement and achievement of young offenders and care leavers in education, training, employment or enterprise	Service Director for Children and Young People
• Deliver quality services through ensuring we have a stable, skilled and effective workforce	Service Director for Children and Young People

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of families who have been identified and with whom work has commenced as part of the second phase of the Troubled Families programme	New measure	483
• Percentage of young people engaged in education, training, employment or enterprise	Young offenders: 46% Care leavers: 67%	Young offenders: 55% Care leavers: 70%
• Rate of Looked After Children (LAC) (per 10,000 population)	138	112

Objective: Challenging and Supporting Schools to Provide the Best Education

Accountable Officer: Director of Education

Why is this important to Wolverhampton?

Education outcomes across the city are unacceptably poor and limit the children's life chances and wellbeing of Wolverhampton citizens, as well as the longer term development and prosperity of the city.

The city is also experiencing demographic change and the local authority has a duty to ensure there are sufficient school places to meet the city's need. There is therefore a pressing need to raise expectations, secure rapid school improvement and ensure there are sufficient school places and resources to support children's learning.

What are our key policies and strategies?

There are a number of documents which support challenging and supporting schools, including:

- School Improvement and Governance Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Strategically lead education services and ensure that the council is well informed about the quality of school provision in the city, including the analysis of performance data	Director of Education
• Maintain an excellent working relationship with all schools so that early support and advice can be offered when required	Head of School Standards
• Identify issues in maintained schools and offer appropriate levels of challenge to those identified as at risk, holding them to account for school improvement and implementing formal powers of intervention where necessary	Head of School Standards
• Maximise available funding and resources to support school improvement activity and quality learning environments, including Building Schools for the Future and Local Education Partnership resources	Head of School Planning and Resources
• Ensure there are sufficient school places to meet demand in the city and that there is fair access for all	Head of School Planning and Resources

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Percentage of schools judged by OFSTED to be 'good' or 'outstanding'	68%	78%
• Percentage of pupils achieving level 4 in combined Reading, Writing and Maths at Key Stage 2	78%	80%
• Percentage of pupils achieving 5 A* - C Grades including English and Maths	46.4%	54%
• Percentage of maintained primary and special schools with uncommitted balances greater than 8% of budget share	40%	20%
• Percentage of maintained secondary schools with uncommitted balances greater than 5% of budget share	12%	0%

Objective: Enabling Communities to Support Themselves

Accountable Officer: Strategic Director of People

Why is this important to Wolverhampton?

Supporting local communities to continue to develop local support for local communities is a key role for the council to build resilience in the city.

What are our key policies and strategies?

There are a number of documents which support enabling communities to support themselves, including:

- Advice and Information Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Develop the Wolverhampton Information Network (WIN) across the city to have locally accessible information advice points to support self-help and independence	Head of Libraries
• Trial the use of creative initiatives to support the development of sustainable and self-reliant communities	Head of Healthier Place
• Develop an asset based approach with the community to develop a network of support	Head of Libraries
• Transform the role of libraries to better support communities to access quality information and advice	Head of Libraries
• Strengthen the work of Community Hubs and Community Association	Head of Welfare Rights

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Number of unique hits on the Wolverhampton Information Network (WIN)	14,040	19,040
• Number of listings on the Wolverhampton Information Network (WIN)	550	688

Objective: Keeping the City Safe

Accountable Officer: Service Director for Public Health and Wellbeing

Why is this important to Wolverhampton?

Reducing crime and improving feelings of safety in Wolverhampton is important in enhancing the experiences of those who live, work and visit the city. Year on year reductions in crime and improved feelings of safety will contribute towards creation of a stable economic climate; attracting inward investment, and supporting a vibrant night time economy.

What are our key policies and strategies?

There are a number of documents which support keeping the city safe, including:

- Crime Reduction, Community Safety and Drugs Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Work with partners to reduce the risk of people being radicalised and spot those who might be enticed into terrorism	Head of Community Safety
• Trial use of new legal powers to tackle anti-social behaviour and assess the impact of this	Head of Community Safety
• Work with partners to reduce gang-related crime	Head of Community Safety
• Tackle relationship-based violent crimes which are more likely to harm women and girls	Head of Community Safety
• Work together with partners such as the Fire Service, Police and other agencies, to target earlier support to those in need	Strategic Director People

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Rate of recorded crime (per 100,000 population)	6,686	To reduce
• Rate of young people involved in violent crime (with injury) (per 10,000 population aged 10-17)	Victims: 361 Offenders: 275	Victims: To reduce Offenders: To reduce
• Number of referrals made to Channel Panel (Prevent Agenda)	21	To increase

Objective: Confident, Capable Council

Accountable Officer: Managing Director

Why is this important to Wolverhampton?

A Confident, Capable Council will underpin the delivery of the council's Corporate Plan and create a better, stronger council ready and able to deliver the change the city needs.

The programme will transform the way the council does its day to day business by changing and strengthening council-wide management practices, corporate controls and establishing efficient processes in its core internal services. In short, this means that we will transform the council into a modern business organisation and become a customer service focussed organisation; all of which will lead to a better experience for the customer.

What are our key policies and strategies?

There are a number of documentss which support being a Confident, Capable Council, including:

- Medium Term Financial Strategy
- Customer Services Strategy
- ICT Strategy

Please visit our **Policy Portal** for more information.

What will we do to achieve this?

Action Description	Lead Officer
• Develop more creative approaches to maximising income streams for the council	Director of Finance
• Secure a 'clean bill of health' from the external auditors on the statement of accounts and value for money	Director of Finance
• Maximise the benefit to the city through the council's procurement activities	Director of Finance
• Improve the way we make our decisions and secure value for money for our residents, by ensuring we have robust internal controls and governance processes in place	Director of Governance
• Improve facilities for customers, modernise and use our frontline buildings as best we can, keeping only those we need and saving money from those we do not	Strategic Director of Place
• Ensure our land and buildings directly benefit residents, offer value for money and are well managed	Service Director of City Assets
• Ensure that our customers can contact us and access our key services in a way and at a time that suits them through increased use of innovative digital channels	Head of Customer Service
• Enhance the customer experience when contacting the council to ensure that we exceed the expectations they have of us	Head of Customer Service
• Transform the council into a modern business organisations using ICT to maximise the customer experience and enable service efficiencies	Head of ICT
• Develop our workforce to ensure we have the right people, with the rights skills, in the right place at the right time	Head of Transformation
• Ensure we use evidence to inform our decisions, monitor performance and address problem areas as soon as possible	Head of Transformation
• Make sure that our customers, service users and members of the public are informed about council performance and can influence the decisions we make	Head of Transformation

Objective: Confident, Capable Council

Accountable Officer: Managing Director

How will we monitor our progress?

Measured by	2014/15 Baseline Data	2015/16 Target
• Percentage of council tax collected	95.0%	95.0%
• Percentage of business rates collected	96.5%	96.7%
• Percentage of spend with suppliers whose address includes a WV postcode	28.58%	31.08%
• Cost per square meter of our operational property portfolio	New measure	Baseline to be established
• Percentage of customers satisfied with the customer service they received from the council	70%	70%
• Percentage of calls to Customer Services resolved at 1st contact	61%	70%
• Percentage of completed website transactions	New measure	Baseline to be established
• Percentage of our eligible workforce who have a current appraisal	73.4%	100%
• Number of workings days lost per Full Time Equivalent (FTE) to sickness absence	New measure	Baseline to be established
• Percentage of Freedom of Information (FOI) requests responded to within the statutory timeframe	94.9%	97%

Measured by	2014/15 Baseline Data	2015/16 Target
• Percentage of Subject Access requests responded to within the statutory timeframe	82.5%	85%
• Percentage of customers who feel informed about council performance	New measure	Baseline to be established
• Percentage of employees who are aware of the council's corporate priorities and understand how they contribute to them	44%	80%

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JOINT STRATEGIC NEEDS ASSESSMENT

FOCUS ON OUTCOMES

Contents

1 What is the Joint Strategic Needs Assessment (JSNA)?

The Joint Strategic Needs Assessment is a process that identifies the current and projected health and wellbeing needs of the local population. It is a key building block in enabling the understanding of the needs of local people. It contains collective intelligence about local health and wellbeing need, and forms a key element of the Shadow Health and Wellbeing Board's overall understanding of health and wellbeing.

The Joint Strategic Needs Assessment is designed to underpin the commissioning priorities and strategic plans of the Local Authority and local NHS. Specifically it will be used to inform the Joint Health and Wellbeing Strategy that is currently being developed.

Joint Strategic Needs Assessments

- Must take account of the current and future health and social care needs of the entire population.

- Look beyond needs to examine local assets, including the local community itself, to meet identified needs.

- Explore inequalities in the local area and the factors that influence them such as poor housing, worklessness or crime and how these impact on health and wellbeing outcomes across the community

- Should adopt an 'outcomes-based approach', considering what will improve the outcomes that matter most to their populations. It should be informed by information and indicators from the national outcomes frameworks for the NHS, Adult Social Care, Public Health (and at clinical commissioning group level, the Commissioning Outcomes Framework), and identify desired outcomes to drive their joint health and wellbeing strategy. The Health and Wellbeing Board is the place where the national outcomes frameworks come together, supporting a primary focus on local priorities.

- There should be a focus on the things that can be done together. These will be identified by the Health and Wellbeing Board working together with local partners and understanding the added value of pooling resources (including people) in order to achieve a greater impact across the local system, to deliver improvements in health and wellbeing outcomes for the whole community, as well as to avoid duplication or bureaucracy.

- Joint Health and Wellbeing strategies should prioritise the issues requiring the greatest attention, avoiding the pitfalls of trying to take action on everything at

once. They will not contain a long list of everything that might be done, they will focus instead on key issues and actions that make the biggest difference.

The Joint Strategic Needs Assessment is not a document it is a process. There will be publications sharing the intelligence collected and methods used through the process. This is the first publication of the Joint Strategic Needs Assessment process.

The JSNA is also a key resource to be used for commissioning and all local organisations' commissioning plans should make reference to the needs identified in the JSNA.

2 JSNA process phase 1 – collating data on the outcome frameworks

The Department of Health has published three national outcome frameworks: NHS, Adult Social Care and Public Health. In addition, the Department of Health highlight that the development of an outcomes strategy for children and young people's health and wellbeing would support a co-ordinated approach in this area and therefore a children's outcome framework has been developed locally to respond to this.

For each of the outcomes on each of the outcome frameworks, where possible, data has been collated on the local position, the national position (including average and range of values) and the position of comparable local authorities. The data is presented in the form of 'spine charts' which summarise Wolverhampton's position (a circle) compared to the national average (the solid middle line) and the best and worst values in England.

However, in order to tell the story of the health and wellbeing needs contained in the outcomes frameworks spine charts and to identify opportunities for improving the health of Wolverhampton residents, a summary has been prepared as Appendix 1.

Appendix 1 – What Do the Outcome Framework Spine Charts tell us about health issues in Wolverhampton?

The spine charts are presented in the following Appendices

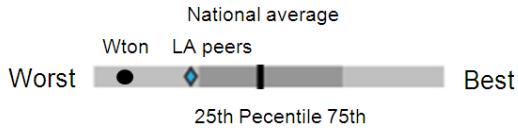
Appendix 2 – NHS Outcome Framework spine chart

Appendix 3 – Adult Social Care Outcome Framework spine chart

Appendix 4 – Public Health Outcome Framework spine chart

Appendix 5 – Children's Outcome Framework spine chart

Spine charts present the data in the format below:



The colour of Wolverhampton's data circle gives further information in relation to how Wolverhampton's value compares with the national average. For further information on interpreting spine charts, see Appendix 6.

3 JSNA process phase 2 – identifying Health and Wellbeing Board outcomes

The Health and Wellbeing Board focusses on outcomes where joint work can add value. Therefore a long list of outcomes is created by identifying outcomes that appear on more than one outcome framework. In addition the outcomes on the Public Health Outcome Framework identified as wider determinants are included because they require joint working with wider partners. This collection of outcomes will be referred to as the Health and Wellbeing Outcomes Framework (HWBOF).

Appendix 7 - Health and Wellbeing Outcome Framework at a glance

For each of the outcomes identified, data has been collated, where possible, on the local position, the national position (including average and range of values) and the position of comparable local authorities.

Appendix 8 – Health and Wellbeing Outcome Framework spine chart

4 JSNA process phase 3 – Identifying the Health and Wellbeing Board shortlist

The Health and Wellbeing Board reviewed the HWBOF to develop a shortlist. They focussed on:

- Outcomes where Wolverhampton performed significantly worse than England (those marked as red on the spine chart). A decision was made to include all these outcomes in the shortlist.

- Outcomes where no data was available, using local knowledge to judge if these should be a priority in Wolverhampton. A decision was made to include those outcomes which stakeholders considered represented important local health issues for Wolverhampton.

- Outcomes they considered important that were not included in the Health and Wellbeing spine chart. A decision was made to include some additional outcomes.

A major reference point was the importance of the wider social determinants of health as major factors that underpin and shape the 'choices' that individuals make and which in turn influence the health outcomes that they experience, for example, education, unemployment, housing, experience of crime. This shortlist was then prioritised using a voting system.

5. JSNA process phase 4 - Stakeholder Engagement

The Health and Wellbeing Board engaged a wide range of stakeholders in ratifying this shortlist.

Appendix 9 – List of stakeholders who were invited to contribute, the method of engagement and the numbers that engaged

As a result the prioritised shortlist was reviewed and changes made including:

- New outcomes added
- Outcomes given higher priority
- Discrimination of priority for outcomes ranked equally by HWB
- A separate list of outcomes developed identified by one stakeholder.

Appendix 10 – Changes made as a result of stakeholder engagement

The revised shortlist was then prioritised into 6 groups with 7 outcomes in each group.

Appendix 11 – Health and Wellbeing Board shortlisted outcomes
Appendix 12 – Health and Wellbeing Board shortlist spine chart

6 JSNA process next phases

The Health and Wellbeing Outcome Framework will be reviewed annually. The outcomes included in this framework may change due to changes in the nationally defined Public Health, NHS and Adult Social Care Outcome Frameworks.

Spine charts for the Health and Wellbeing, Public Health, NHS and Adult Social Care and Children's Outcome Frameworks will be re-produced annually using the most up-to-date data available.

This data will be reviewed by the Health and Wellbeing Board and as a result the shortlist of outcomes may change both in which outcomes are included and the priority of these outcomes. Stakeholders will be involved in these reviews.

The groups of outcomes will be considered in turn. In 2013-14 work will focus on group 1 and 2. In future years work will focus on the remaining groups in order.

For each outcome in groups 1 and 2 an outcome briefing has been produced containing a:

- Description of the outcome
- Needs profile
- Equity profile (age, gender, ethnicity, geography, disability)
- Review of the evidence base
- Service mapping
- Gaps in terms of need and equity
- Recommendations for action based on national good practice, local asset building, expert development and social marketing.

The Health and Wellbeing Board have developed a prioritisation framework which they will apply to the proposed actions Identified in the outcome briefings.

Appendix 13 – Health and Wellbeing Board prioritisation framework

The prioritisation framework will give each proposed action a score which will enable the proposed actions to be ranked. The Health and Wellbeing Board will need to decide a threshold that proposed actions will need to meet to be included in their strategy.

The briefings including the proposed actions that meet the threshold will form the basis of the Health and Wellbeing Strategy.

Glossary

ASCOF	The **Adult Social Care Outcome Framework** provides a broad, transparent and outcome focussed approach to presenting information on what adult social care has achieved.
COF	The **Children's Outcome Framework** is a locally developed framework including relevant outcomes from NHSOF and PHOF and additional outcomes considered relevant.
HWBOF	The **Health and Wellbeing Outcome Framework** is a locally developed framework which identifies the indicators on the national frameworks which benefit from joint working and therefore are the focus of the SHWB and JHWS.
JSNA	The **Joint Strategic Needs Assessment** is a process that identifies the current and projected health and wellbeing needs of the local population.
JHWS	The **Joint Health and Wellbeing Strategy** drives the collective actions of the NHS and local government, both commissioners and providers, and engages communities in the improvement of their own health and wellbeing.
NHSOF	The **National Health Service Outcome Framework** provides a national level overview of how well the NHS is performing, it provides an accountability mechanism between the Secretary of State for Health and the proposed NHS commissioning board and it acts as a catalyst for driving quality improvement and outcome measurement throughout the NHS.
PHOF	The **Public Health Outcome Framework** sets out the desired outcomes for public health and how these will be measured. The framework concentrates on two high-level outcomes to be achieved across the public health system. These are increased healthy life expectancy and reduced differences in life expectancy and healthy life expectancy between communities
SHWB	The **Shadow Health and Wellbeing Board** is the key partnership for improving the health and wellbeing of Wolverhampton residents. It was formed in response to the Government's agenda for radical reorganisation of how health services are delivered and managed in England. The board will be in shadow form until April 2013, when it will become a statutory body. It involves representation from councillors, LA strategic directors, Director of Public Health, Clinical Commissioning Groups and LINk.
Spine Chart	Are a way of presenting local data in the context of national benchmarks. A guide of how to interpret spine charts can be found in Appendix 12.

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All Age Disability and Mental Health Provision

Engagement on Mental Health Prevention Services in Wolverhampton.

Engagement REPORT

October 2015 – December 2015

WOLVERHAMPTON CITY COUNCIL
January 2016

CONTENTS

1.0: Methodology

An engagement exercise was undertaken over an eight week period. Commencing on Monday 5th October 2015 and ending on Friday 27th November 2015. The engagement was carried out following good practice guidelines as set out in Wolverhampton City Council Engagement Guidance. The engagement activity also respects the principles outlined in the Wolverhampton Compact. However additional comments were submitted after the closing date and requests were made for events so the timescale was extended until the end of December.

An engagement plan was drawn up prior to the activities commencing. The engagement plan outlines the activity that will take place, sets out the approach that will be taken to consult and includes consideration of the following:

- Timescale
- methods
- Who will be involved, what they will be engagment on and when the engagment will run
- The person(s) who will lead on the required actions

A variety of different methods for collecting people's views were utilised. A short questionnaire was produced and circulated to a number of key mental health providers in Wolverhampton. These questionnaires were e mailed out to the key providers who were asked to circulate the information to any users of the services, carers or staff who either use or work within the services. An offer was also made for visits to be made to any key service user or carer groups that were running during the consultation process.

People were also able to call a dedicated phone line or email to submit comments or ask for additional information.

1.1: People invited to participate

Any organisations and providers who worked within the prevention field closely with users of the services were contacted initially by e mail and asked if they would support the consultation. A covering letter and short questionnaire were attached to the email and people were asked to contact the service for further information.

The organisations were also asked to contact the service if they would like someone from the Commissioning team to attend a meeting where service users would be in attendance or support an event where further views could be sought.

1.2: Organisations invited to respond to the engagement:

- African Caribbean Community Initiative (ACCI)
- Positive Action for Mental Health (PAMH) and self support groups through Wolverhampton Voluntary Sector Council
- Positive Participation
- RAMA Men's group
- Rethink
- The Epic Café through Creative Support
- Mind Out
- Mental Health Social Care Team

1.3: Questionnaires

A questionnaire was drawn up and circulated to the organisations who were invited to participate in the consultation. In total 84 questionnaires were returned by the response deadline and a further 24 were sent in after the deadline and these comments were also included. In total 108 questionnaires were returned.

1.4: Events

Organisations who were invited to participate in the process were asked if they would like someone to attend one of their regular meetings and meet with the existing users of the prevention services. Two organisations Rethink and Positive Participation contacted the Participation Officer and asked her to attend one of their regular meetings. In total the views of a further 22 people were noted at these two events.

1.5: Total Number Consulted

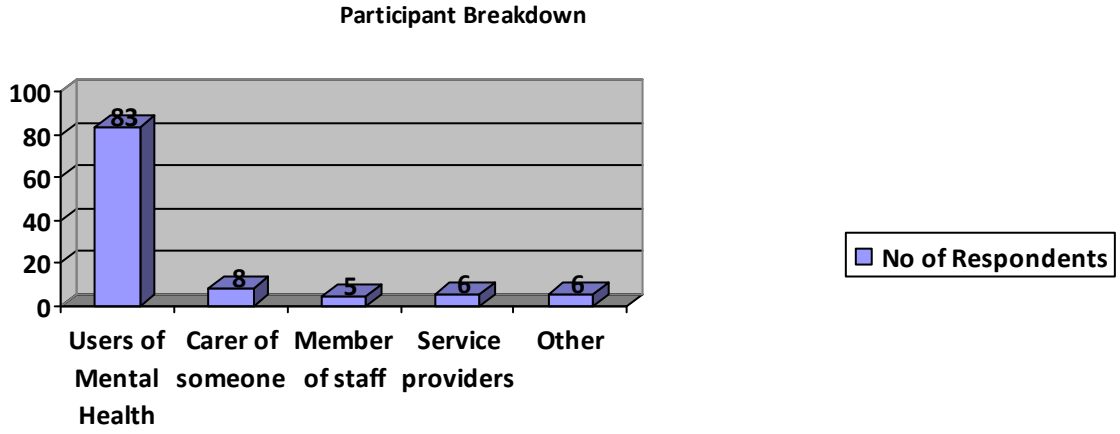
Mechanism	Number that Attended	Date
Positive Participation Meeting at Blakenhall healthy Living Centre	**15**	**Monday 23 November 2015**
Rethink Meeting at Merridale Lodge, Merridale	**7**	**Friday 4 December 2015**
Paper Questionnaires	**108**	
Total Number Consulted	**130**	

In total 130 people engaged in the process. There were 108 questionnaires returned either through the post or hand delivered into the Commissioning Team.

1.5.1: Participant Breakdown

The following information has been taken from the 108 questionnaires returned as all of the people who attended the groups were existing users of the prevention services.

83 (76%) were users of mental health services, 8 (7%) were a carer of someone who uses mental health services, 5 (5%) were a member of staff working within mental health services, 6 (6 %) were service providers and 6 (6%) respondents selected other, of which 2 were residents at The Haven, One was a former users of the services, 2 were asylum seekers and one was a service user.

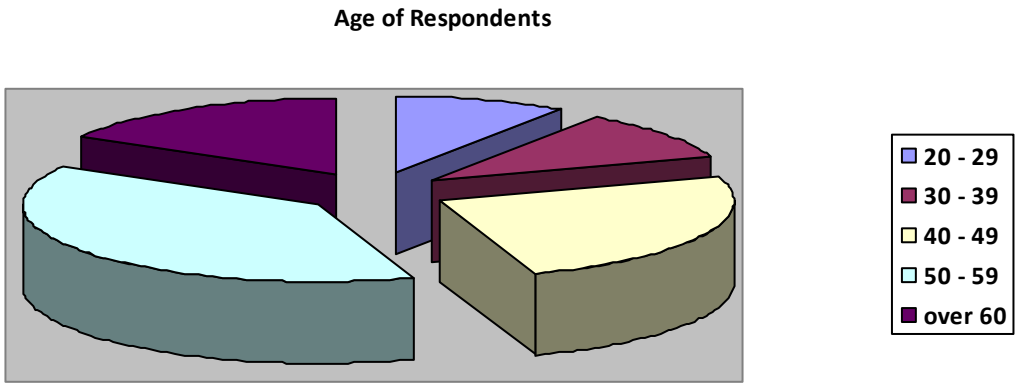


1.6: Demographic Information of Participants from the questionnaires

Demographic and equalities information is collected from participants throughout consultation activity. There is a legal requirement for local authorities to show that they have paid due regards to the Public Sector Equality Duty, created by Section 149 of the Equality Act 2010. The broad purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities. As well as adhering to legal requirements; the Council has its own commitment to equalities and wants to ensure the services it provides are equally accessible and fair to all of Wolverhampton's diverse communities. We can only do this if we know how different communities feel about different issues. Although we encourage people to share information with us, participation, in full or in part is optional and all personal information shared is kept confidential.

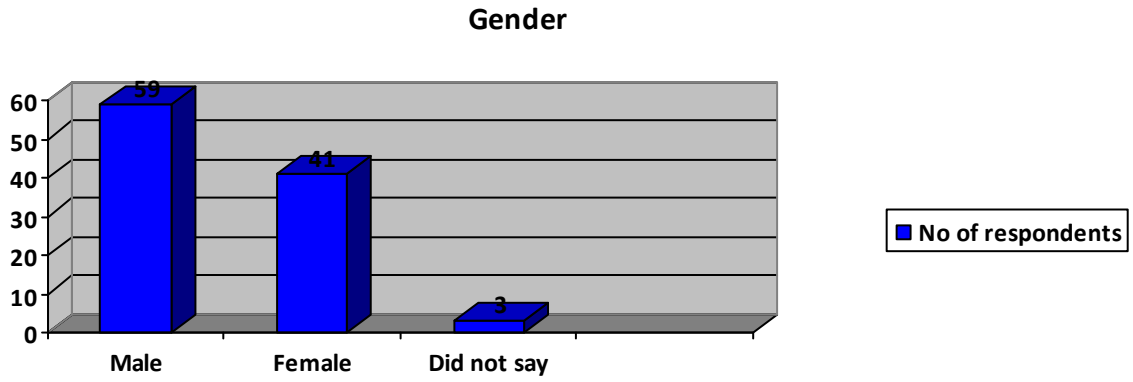
1.6.1: Age

A total of 96 respondents completed this question and there were 12 people who did not respond to this question. 9 (9%) people who responded were aged between 20 – 29; 10 (10%) people who responded were aged between 30 – 39; 24 (25%) people who responded were aged between 40 – 49; 37 (39%) people who responded were aged between 50 – 59 and 16 (17%) people who responded were over 60.



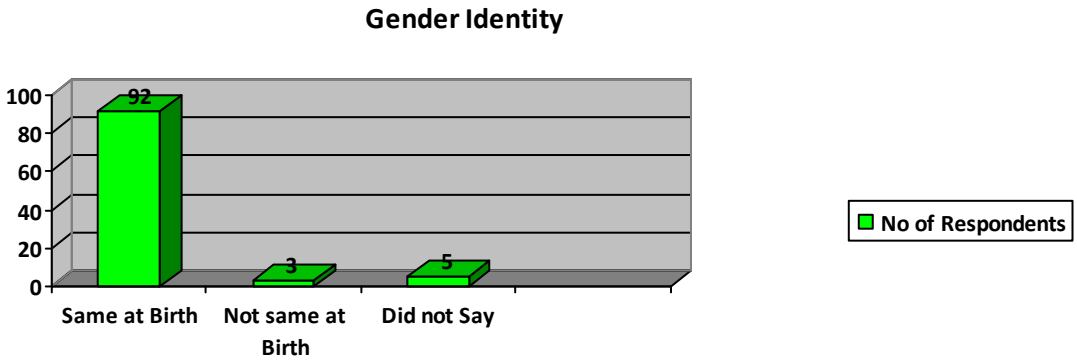
1.6.2: Gender

5 (5%) respondents skipped this question, 59 (54%) respondents were male and 41(38%) were female and 3 (3%) people preferred not to say



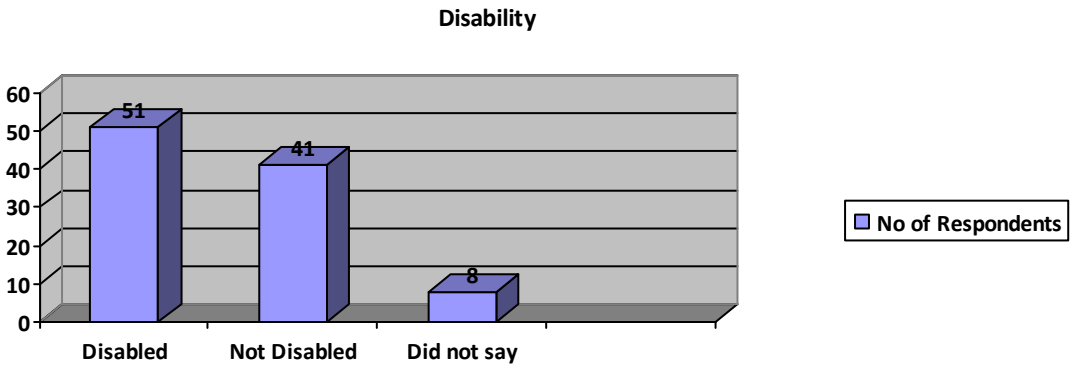
1.6.3: Gender Identity

8 (7%) respondents skipped this question, 92 (85%) respondent's said their gender was the same as assigned at birth, 3 (3%) respondents said their gender was not the same as assigned at birth and 5 (5%) respondents preferred not to say.



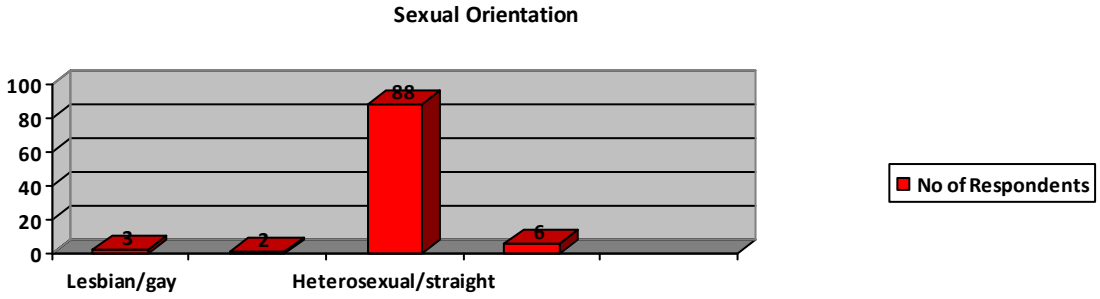
1.6.4: Disability

8 (7%) respondents skipped the question, 51(48%) of respondents considered themselves to be disabled, 41 (38%) said they were not disabled and 8 people (7%) preferred not to say.



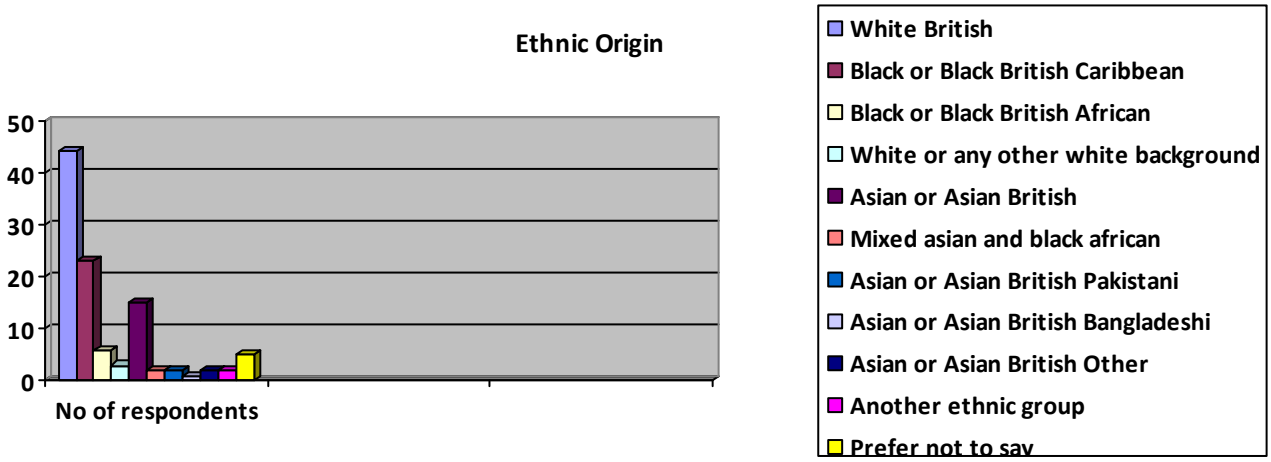
1.6.5: Sexual Orientation

9 respondents skipped this question (8%), 3 people (3%) were lesbian/gay female, 2 people (2%) were bisexual and 88 people (81%) were heterosexual/straight, no people (0%) were unsure and 6 people (6%) preferred not to say.



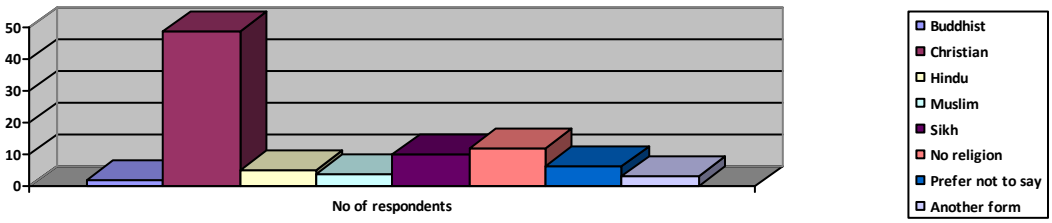
1.6.6: Ethnic Origin

3 people (3%) skipped this question, 44 people (41%) were white british, 23 people (22 %) were black or black british caribbean, 6 people (6 %) were black or black british African, 3 people (3 %) were white or any other white background, 15 people (14 %) were Asian or Asian british, 2 (2%) people were mixed Asian and black African and 2 people (2 %) were Asian or Asian british Pakistani, 1 person (1%) was Asian or Asian British Bangladeshi, 2 people (2%) were Asian or Asian British from any other Asian background, 2 people (2 %) were from another ethnic group and 5 people (5 %) said that they would prefer not to say.



1.6.7: Religion

17 people (15%) skipped this question, 2 people (2%) were buddhist, 49 people (45 %) were Christian, 5 people (5%) were Hindu, 4 people (4 %) were muslim, 10 people (9%) were sikh, 12 people (11%) said they were from another religion, 6 people (6 %) preferred not to say and 3 people (3%) said another form of religion.



2.0: Background to the engagement on the Mental Health Prevention Services

Wolverhampton City Council is proposing changes to the Mental Health prevention services in 2016. This is to improve the local services.

2.1: Current Mental Health Prevention Service Providers and Models

Wolverhampton's Mental Health Prevention Services are currently delivered through a number of providers across the City. These providers are:

Provider	Overview of service
Hear Our Voice C/O Wolverhampton Voluntary Sector Council	A safe space to empower service users to share and explore experiences and a Magazine
Positive Participation	To improve and prevent mental ill health among south Asian adults (male and female) through the provision of a culturally sensitive community support service.
Wolverhampton Voluntary Sector Council Empowerment Team	Responsible for establishing and developing new and existing user led self-support groups with a view to them becoming independent of the Empowerment Service
Rethink	To provide a safe space offering community support and a range of opportunities for adults who have experienced or are experiencing mental ill health and enabling them to sustain good mental health

2.2: Proposed Service Changes

It is proposed that reshaping of the mental health prevention services takes place and that a new service specification is drawn up by April. Stakeholders will be involved and consulted in the process. A tender will be issued later in the year and providers will be invited to submit a tender for the new service, Consortium bids will be welcomed.

3.0: Feedback Summary (Questionnaires)

The following is an overview of the feedback received through the engagement process. Further detail can be found throughout this report. A full written transcript of all feedback is available by request.

3.1: Mental Health Prevention Services that people were aware of:

- ACCI (19 respondents)
- Phoenix Social Group Wednesfield (13 respondents)

- RAMA group and I see AB at the Men's Well Being Group at the one to one sessions in town (9 respondents)
- Penn Hospital (8 respondents)
- Wolverhampton Voluntary Sector Council Self Support Groups for people with mental health issues: Mental Health Empowerment Team, Autism support, LGBT, Hear Our Voice (6 respondents), hand in hand (6 respondents) gender matters, Peoples Group (6 respondents) Phoenix Self Support Group, Positive Action for Mental Health
- The Hub Epic café (5 respondents)
- Creative support – previous users (at boot factory) (4 respondents)
- Wolverhampton Healthy minds (4 respondents)
- Steps to Health (3 respondents)
- Wellbeing Service (3 respondents)
- WEAD (2 respondents)
- Peoples Group (2 respondents)Aquarius,
- St Chads Church in Wolverhampton (2 respondents)
- Emergency team – out of hours phone number, various support groups
- Rethink.
- RAS team – listening service only
- Wolverhampton Advocacy services
- Counselling Services
- The Haven
- Active Minds
- Recovery House including outreach workers
- Peoples group supported by MH empowerment
- Phoenix group Self-support by MH empowerment
- St Mary's Church in Wolverhampton
- Outreach workers form Recovery House.
- GP
- Hearing Voices Group
- Inspiring futures
- Base 25
- Wolverhampton Voluntary Sector Council.
- Blakely Green House (supported living)
- Social inclusion team – drop in sessions
- I go to a group that was organised by the community inclusion team.
- Blakenhall Centre
- Bilston Centre
- St Marks

3.2: Elements that people felt were important in any mental health preventative services in Wolverhampton in priority order?

Location	78 (1st)
Culturally sensitive	69 (2nd)
Age Appropriate	55 (3rd)

Promoted widely	55 (3rd)
Gender sensitive	50 (5th)
Using social media	33 (6th)

3.2.1:The following were identified as additional important elements of a prevention service

Accessible

- Accessibility (eg to people with learning impairments or physical or sensory impairment
- Design of building/facility
- People friendly and supportive Services
- Location needs to be somewhere quiet so people can feel safe also needs to be local where people don't have to travel too far the cost of travelling people are losing their free bus passes

Inclusive safe environment

- Sexual Orientation
- Being reassured about privacy and feeling safe in venue /area
- Environment needs to be secure and friendly
- There should be a trusting relaxed atmosphere ,
- Kindness and inclusive services
- People allowed to make own choices both culture wise and language wise
- Been comfortable and able to open up in a trusting reliable atmosphere

Promotion/Communication

- Using a variety of advertising media and support tools
- Communication
- Information and promotion to those without computers
- For services to be more widely known and promoted in GP's waiting rooms.

Access to range of services

- Easy access to support when need it and when you become unwell
- Rapid Access, simple access criteria, short intensive programme.

Appropriate staff

- Counselling
- Support of Mental Health Empowerment Team to help run groups
- Seeing same psychiatrist every time, having staff at drop in
- CPN
- Trained staff (Culturally trained and appropriate)
- Where you can receive appropriate help and support and some where you feel safe and welcome
- Mental Health and Physical Health as one

- The most important element is having workers who have a genuine interest in helping people with Mental Health problems – who the service users themselves feel are genuinely helping them.

Translation Services and Funding

3.3: The following were identified as improvements that could be made to the Mental health prevention services in Wolverhampton.

Information

- More information on all of the services that are available in Wolverhampton
- More information on the role, remit and how to access services in Wolverhampton.
- It feels like there have been so many changes to services that people are not aware of the services that are available to people in Wolverhampton
- More leaflets and information about all the preventative services that are available.

Promotion

- More promotion of all services
- Better advertising of services in particular voluntary and community services as they come and go in current economic climate (sometimes with no or unsatisfactory services replacements) no info about what else is available.
- Promote the Mental Health Directory widely and make it available in print not just on line.
- More education for children and young people in schools also the faith communities
- Staff training in A and E and other service areas on mental health conditions.
- Use social media to promote awareness and reduce stigma
- More preventative services and more promotion of services needed.
- More information needs to be given out by GP's and providers about services and self referral options.

Tiered stages/processes between services

- Need a stepped stages tiered process between services for example crisis services and self support groups.
- Develop close working protocols between these services as people with mental health are constantly changing and have periods of well being and periods of crisis.
- Need triage at Penn Hospital
- It is under what is preventative and what is local authority – statutory social care and what is statuary health care, it appears as though the local authority and the foundation trust take all the money to finance services for non-preventative services to plug gaps higher un the chain
- Better networking between services a better understanding of how groups work with different client groups so we can share good practice. More opportunities for service users to meet up with other service users ie events and trips
- To have better connections between all the people who run the preventative services.

- It is unclear what is a preventative service and what is local authority and what is statutory.

Consistency in treatment

- Consistency in treatment in services.
- Inconsistency as some services you can self refer but some you cannot and it is not clear which are which.

Clarify the remit of teams

- Clarify the remit of teams for example The RAS (Referral Assessment Team) cannot help with depression and anxiety only for people in crisis or many psychiatric services.

Role of GP's in prevention

- Out of hours GP services as they play a key role in prevention. They can often be the first port of call but many of them do not have the knowledge or awareness of services.
- Often GP's just seen to give out Tickets to Recovery for Healthy Minds CBT Services for any condition no matter on the severity and so there needs to be a tiered system.
- More info to GP's and service professionals about the more esoteric services for improved mental health like walking groups, craft groups, talking groups, website
- GPS need to be educated about Mental health services as they are supposed to be the gateway to services
- Combination and package of services required for people for example medication from the GP, talking therapies and then self support groups.
- To have more information about services and for it to be widely available such as flyers and leaflets in GP surgeries.
- Have meetings with the GP's to tell them what services are available as GP's are supposed to be the gateway to services.

Access and referrals to services

- Saturday, Sunday and out of hours availability of all services.
- Quicker access to Mental health services and hospital admissions (in terms of pathways)
- Reduce waiting times for services in particularly therapy services for people regarded as at risk of self-harm
- Problems accessing Health Minds very long waiting times and difficult to contact.
- Short waiting list if any emergency and crisis particularly at New Cross Hospital
- More possibilities for self-referral to non-therapy services and in variety of ways,
- Change the system as you are always starting from the very beginning as a new assessment even if you have had previous support from services.
- Easier access to help should a relapse happen. At the current time you have a few sessions and then after so many sessions you are dismissed.
- More counselling and shorter waiting lists

- Access to Mental Health and emotional health services needs to be more widely accessible, and more attention needs to be paid to those that need to be seen at home, due to their phobias and anxieties, that stop them attending appointments and unfortunately the slip through the net
- On-going support for as long as any individual needs it
- There should be a group for people discharged from Mental health services and there should be a place to go.
- Reduce waiting times as the current times to get initial contact is far too long
- More possibilities for self referral to non-therapy services and in a variety of ways.
- Shorter waiting list for therapy services for people regarded as at risk of self-harm.
- Quicker access to mental health services and hospital admissions
- Waiting to have critical contact is far too long.
- The current waiting time for counselling is over 6 months.

Social Opportunities

- More social opportunities with mental health self-management techniques built in.
- More activities (pool, table tennis, day trips, accessing activities in the community
- Have our own buildings so we can have our own things such as pool table and other games, give extra money so they can do more things with them
- Buddying system for people who want join a non health services/social service group or activity
- Training exercise gym open weekends and some holidays.
- More recreational activities more free holidays for service users
- I would like more computer access and day trips out and activities
- More social opportunities with mental health self-management techniques built in.
- More and better information about diet, sleep, hygiene, stress reduction techniques and more advertising of useful tools.
- More outings, activities and functions to keep groups interesting.

General well being

- More and better information about diet, sleep hygiene, stress reduction techniques, and more advertising of these useful tools
- Do not disregard the person's views just because the person seeing me decides I am Meet more often and more leisure facilities provided.
- better when I don't feel the same

Funding of services and cuts to services

- More funding to make services help more people
- More drop ins, more health services more money spent on it,
- More staff to support the self support groups as they were withdrawn from the groups, such as peoples groups and the council run groups.
- More preventative services, more promotion of the services needed, services must not be closed
- More services to enable people with mental health to get help

- It would help if places of HELP were not SHUT DOWN under government cuts and try and keep good services open
- Increase number of centres, people are worried about centres closing, they don't want to end up on their own
- More carers meetings and more rehabilitation services to help me cope with life changes
- Bring back day services and service user groups at Corner House
- People worry about centres closing so they need help with these situations so they do not end up in crisis.

Services for people in crisis

- More beds and triage in Penn Hospital when people are ill and less cuts to good services.
- Translation services so I can make myself better understood (language appropriate)
- More leaflets and information about all the preventative services that are available especially in times of mental health crisis. It seems like you are a number in the system and help is limited then you are abandoned and you end up going backwards. There should be on-going support for as long as any individual needs the support.

Staffing

- When people are discharged there should be more groups around and to have trained in mental health staff on site for example trained workers.
- Trained staff

Other general comments

- As a service provider we gather views of service users and take them up with statutory bodies, responses are required to issues members have raised
- The RAMA Group needs their own centre
- We need an Asian men's drop in
- Counselling
- Less closed policy as after so many sessions you are dismissed.
- Better access
- Make sure you do not close ACCI because this is the only service in Wolverhampton for Black people.
- Earlier intervention as recent research has shown that bullying at school makes a person prone to depression.

4.0: Consultation Summary (Events)

4.1 Summary of comments at the Positive Participation Event on 23.11.15

- Some of the participants had had a poor experience when they presented in crisis at Penn Hospital. In one instance a person was left for 10 hours in crisis with no support.
- Penn Hospital do not accept self referrals when you present in crisis and often the police are called to you if you dial 111 for help.
- Penn Hospital needs a triage system as there is no clear pathway in and out of services for people who present in crisis and there needs to be staff trained in mental health.
- Individuals often have to rely on family and friends when they are unwell.

- There are restrictions related to access to services and this can cause people to feel very stressed.
- There is not enough information so people do not have knowledge of all of the current services in Wolverhampton as there have been so many changes in recent years.
- Wolverhampton Commissioners do not respond to feedback given from Service users when they consult about services.
- Services cannot cope with the number of people who are accessing them.
- Healthy Minds does not help people and often people keep going back and forth in and out of this service
- People benefit from holistic therapies like Positive Participation as many Asian people do not speak or read or write English. Need for culturally sensitive services.
- It is difficult to know how to access services and there is not clear pathway in and out of services.
- There needs to be a combination of talking therapies and groups for people to attend.
- All GP's are not aware of any other services and so we need to educate GP's as they can often just give out tablets and tickets for recovery (Healthy Minds).
- Clarify the tickets to recovery process so that everyone is aware of the eligibility and suitability criteria.
- GP's are often keen to prescribe medication however for many people appropriate talking therapies would be more suitable eg Punjabi talking therapy services
- Long waiting lists to access 'talking therapies.'
- People really valued the work of support groups such as Positive Participation and one to one counselling and therapy but there needs to be more awareness and how to access these services.
- Concerns were raised about what services were available for them beyond the age of 65 as they can get very anxious and stressed if they think that they are going to have to leave the groups that they currently access.
- It would be helpful to have transport provided between mental health support services.
- Accessible services outside working hours that can manage all levels of mental health needs from mild to moderate to severe and enduring.
- People do not all know about The Hub and the staff do not specifically speak Asian languages and there is not a confidential space available.
- Regular trips, listening services, one to one and counselling in own languages would prevent people from going into crisis.
- As soon as people are referred to services they need access immediately as waiting times cause people to go into crisis.
-

4.1.1: Additional summary of comments relating to prevention services documented by staff at Positive Participation after the event

- Culturally sensitive staff and services to represent Asian people and their needs.
- Ideally prevention services should encompass access to parking, private consultation rooms and be based within a community setting for access to wider services eg fitness suite, library, computers and canteen for general well being.
- Reduction in waiting times for services
- Concerns about which services older Asian adults are supposed to access.
- There is a mix of service users from a range of cultural backgrounds who attend the group.
- There are lots of barriers to accessing the prevention services and no clear pathway.

- Interpretation
- Single point of access
- Privacy
- Talking psychological therapies in a range of languages

4.2 Summary of comments at the Rethink Event.

- Reduce waiting times for key services such as Healthy Minds tier system as I was waiting for over a year and a half.
- When you ring the number given for Healthy Minds it is always engaged and this can add to your stress levels if you have to keep trying
- There is not enough counselling and there are long waiting lists for essential services.
- People are passed from service area to service area and there needs to be a clear pathway.
- People go through the same journey over and over again and this makes them feel far worse in themselves.
- If you have on-going mental health issues you can fall in and out of crisis and you need a triage at Penn Hospital as there is a Triage system for physical disabilities at A and E but not at Penn Hospital.
- Casualty is not suitable for people with mental health problems as they are treated poorly.
- GP's are frustrated as they cannot sign post you services as many of them are full.
- If you have a GP who is very holistic in their approach then this can be seen as prevention.
- Some GP's are very good and knowledgeable and others are not and there is inconsistency.
- Some services are self referral and some you just cannot but we are not sure which is which.
- I am not mild enough to suit the doctor but I am not severe enough for A and E so where do I go for help and support.
- Self referral to GP for depression.
- Mixed to referral to sign post elsewhere and be sign posted.
- You can fall between gaps if you live on the outskirts of Wolverhampton.
- The support groups help lift you up then they stop then you fall back down as you often access 6 weeks therapy then you are left and there is nothing it is not consistent.
- Groups are not for everyone and you need individual services staying in a home environment. When you're feeling unwell you cannot use phones as they disable you.
- Rethink Services are not promoted proactively.
- Why do you have to wait to get to Crisis Point to get information.
- It is on an ad hoc basis if you get to hear about services or not there needs to be more promotion.
- We just do not know about the services that are available for people in Wolverhampton and how to access them and the criteria for each service and confusion about the different tiers of services
- The Rapid Assessment Service (RAS Team send you straight back down to well being. It would be helpful if someone from the RAS team could come out to see you.

- Medication can be prevention however some different types of medication interact with each other.
- No knowledge or awareness of self referral or services or changes in services.
- A friend suffering with bi polar was only offered access to a self support group led by WVSC. A support group is not good and will not help a person in Crisis. There needs to be something else.
- Complex split into North/South City Rethink and Willows Crisis team under complex care.
- No awareness of prevention services many people ask where do people go?
- Mental Health Directory we have no awareness of this online. There do not seem to be any printed copies and so it is not helpful if you do not have any computers.
- More out of hours support people to come round in the middle of the night and at weekends.
- Assessment in the home and signpost phone calls can be difficult to make when you are in crisis.
- More support workers at school to start the prevention work and awareness early,
- Acknowledge that family and friends are a lifeline and offer them more support.
- We need people to understand that you can have a good day and a bad day and GP's and professionals need to understand this and cannot just look at how you present on the day.
- There is a difference between younger GP's as I feel that they are better than the older GP's and there are inconsistencies in the way that you are treated by a GP. There are more celebrities and more promotion of mental health issues in the press but this can sometimes be negative as celebrities can afford to have lots of support.
- I had a psychiatrist who did not understand the idea of a spectrum of conditions relating to mental health.
- Cannot see a psychiatrist as there are so many people waiting to see them and so much pressure on them and they have long waiting times.
- Medical staff need experience and knowledge of lots of other conditions.
- You need ABC Action Before Crisis and symptoms you can look out for and call this number.
- There are more difficult clients with complex needs who are falling through the net. As they are moved around then they are in Crisis.

5.0: Concluding comments

Wolverhampton City Council would like to thank everyone who contributed to this engagement exercise.

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Appendix A

Mental Health Provision

Consultation on proposed options for the future for

Recovery House

CONSULTATION REPORT

November 2015 – February 2016

CITY OF WOLVERHAMPTON COUNCIL

CONTENTS

1.0: Methodology

A formal consultation exercise was undertaken over a twelve week period. Commencing on Monday 16th November 2015 and ending on Friday 5th February 2016. The consultation was carried out following good practice guidelines as set out in the City of Wolverhampton Council Engagement Guidance. The consultation also respects the principles outlined in the Wolverhampton Compact.

A consultation plan was drawn up prior to the consultation commencing. The consultation plan outlines the consultation activity that will take place, sets out the approach that will be taken to consult and includes consideration of the following:

- Timescale for consultation
- Consultation methods
- Who will be consulted and when
- The person(s) who will lead on the required actions

A variety of different methods for collecting people's views were utilised. People were able to engage with a short survey available online on Survey Monkey. Consultation packs were distributed to service users through by post and via staff from the Outreach Service. Staff were sent consultation information packs by email, as were stakeholders.

The consultation packs included a cover letter, consultation information pack, consultation questionnaire and a freepost envelope (if distributed by post).

People were also able to call a dedicated phone line, email or submit comments by post.

Four public meetings were held over the consultation period. Two meetings were held with affected members of staff.

A press release was issued on 17th November 2015 and the consultation subsequently promoted on social media, advertising the consultation and mechanisms for taking part.

Information pertaining to the consultation and mechanisms for participation are also uploaded to http://www.wolverhampton.gov.uk/article/4047/Current-consultations

1.1: People invited to participate

93 people who had used the service over the last 12 months were invited to give feedback through the circulation consultation materials. 19 members of staff who will be affected by the proposals were invited to participate, along with 39 stakeholders and 21 mental health self-support groups. 17 copies of paper questionnaire were requested and supplied. In total a minimum of 189 people were invited to participate.

1.2: Questionnaire

A questionnaire was uploaded onto Survey Monkey asking participants 14 questions. Six questions related to the proposed options for the future of the service, the other nine

collected useful information to support the equality analysis and demographic information of respondents.

The Recovery House survey was available at www.surveymonkey.com/r/recovery-house 32 responses were received through this mechanism. Paper questionnaires were available upon request, 20 people completed and returned paper versions.

1.3: Consultation Meetings

Six consultation meetings were, two meetings with staff and four public meeting were held. Morning, afternoon and evening sessions were organised to enable people with commitments at different times of the day to attend. A total of 36 people attended consultation meetings.

1.4: Total Number Consulted

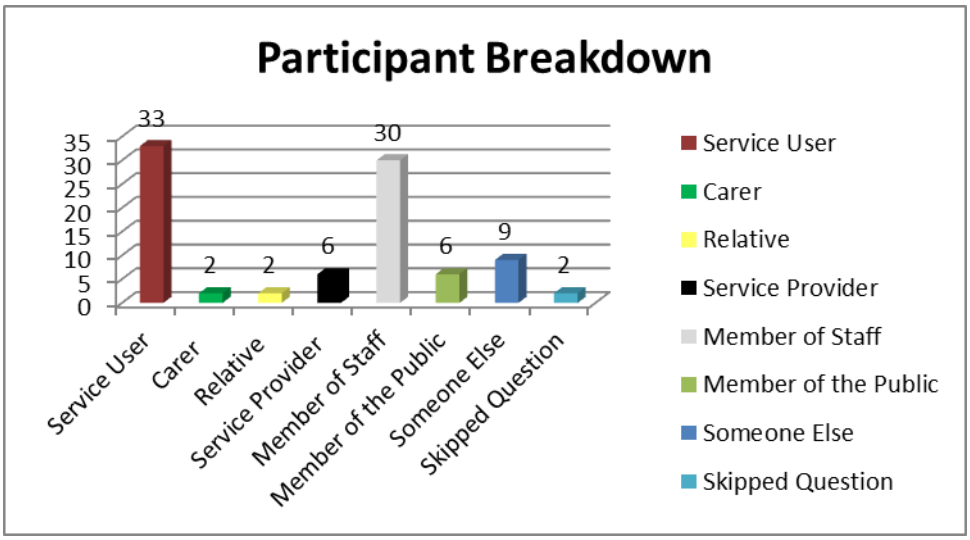
Mechanism	Number that Attended	Date
Brickklin Community Centre (Staff)	**6**	**Monday 23rd November 2015**
Brickkiln Community Centre (Staff)	**8**	**Thursday 26th November 2015**
Committee Room 1	**5**	**Thursday 3rd December 2015**
Brickkiln Community Centre	**1**	**Thursday 3rd December 2015**
Committee Room 2	**1**	**Thursday 3rd December 2015**
Committee Room 3	**15**	**Friday 15th January 2016**
Survey Monkey	**32**	**Throughout consultation period**
Paper Questionnaires	**20**	**Throughout consultation period**
Letters Received	**2**	**Throughout consultation period**
Total Number Consulted	**90**	

In total 90 people engaged in the consultation process. Of the people invited to participate the total number that participated represents 48% of those invited.

1.5: Participant Breakdown

33 (37%) were service users, two (2%) were relatives of a services user, two (2%) were carers, six (7%) respondents identified themselves as service providers, 30 (33%) were members of staff, six (7%) identified themselves as a member of the public, two people (2%) skipped the question and nine (10%) selected ‘someone else’ and stated they were; a resident of the local area, a concerned person, a Mental Health Social Worker, Complex Care Team, a Band 4 NHS service user and a Community Psychiatric Nurse.

Question 1: Are You…	Survey Monkey	Questionnaire	Staff Meetings	Public Meetings	Other	Total
Service User	7	17		8	1	33
Carer	1			1		2
Relative	1	1				2
Service Provider	4			2		6
Member of Staff	11	1	14	3	1	30
Member of the Public				6		6
Someone Else	7			2		9
Skipped Question	1	1				2



1.6: Demographic Information of Participants

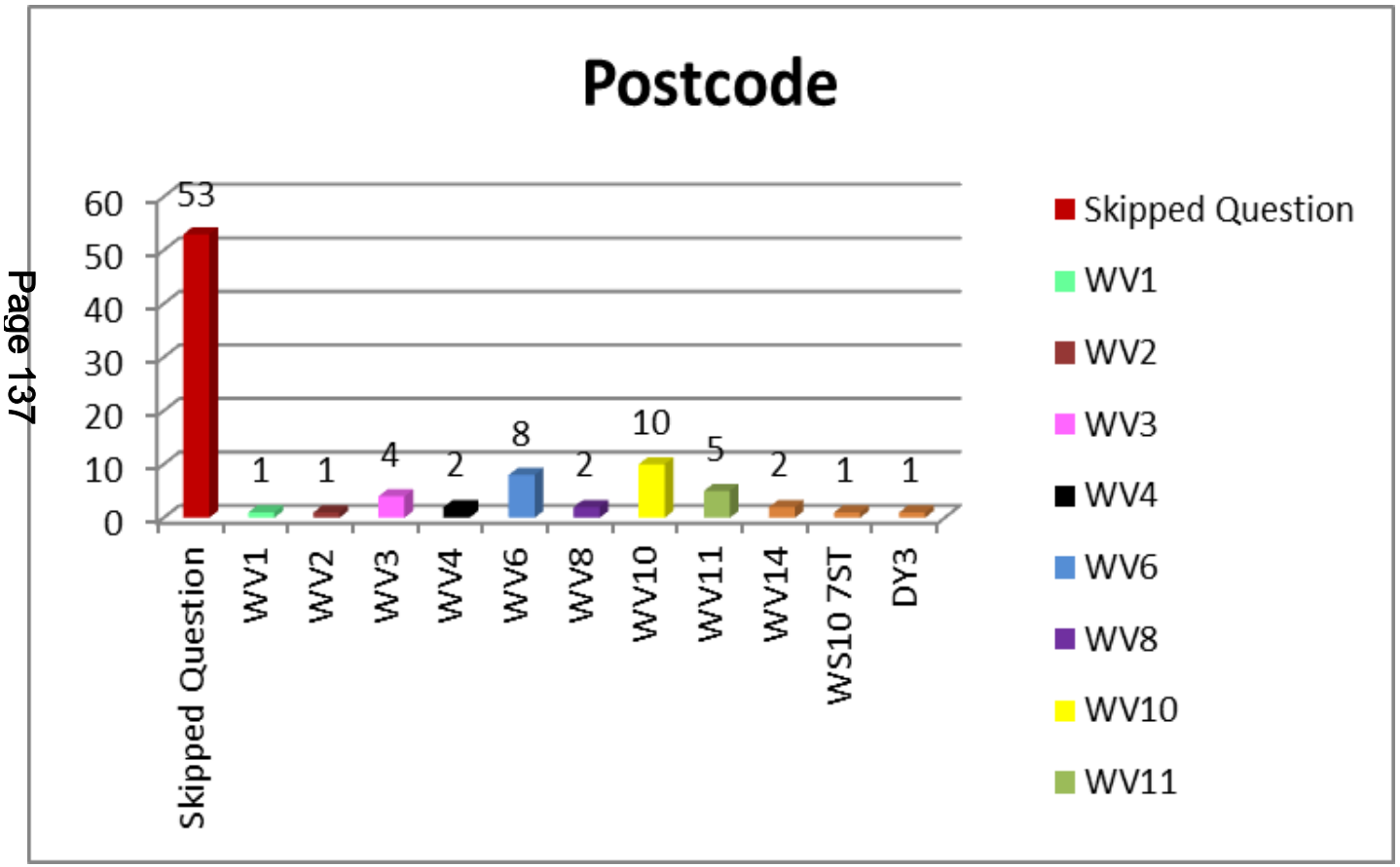
Demographic and equalities information is collected from participants throughout consultation activity. There is a legal requirement for local authorities to show that they have paid due regards to the Public Sector Equality Duty, created by Section 149 of the Equality Act 2010. The broad purpose of the equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities. As well as adhering to legal requirements; the Council has its own commitment to equalities and wants to ensure the services it provides are equally accessible and fair to all of Wolverhampton's diverse communities. We can only do this if we know how different communities feel about different issues. Although we encourage people to share information with us, participation, in full or in part is optional and all personal information shared is kept confidential.

1.6.1: Service Used

Use of the services provided through Recovery House and the Outreach Support Team was identified 79 times. A total of 44 respondents had used/referred to Recovery House and 35 respondents had been supported by the Outreach Team.

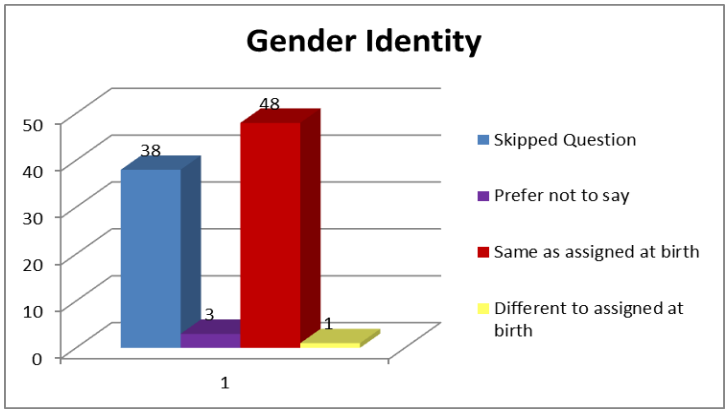
1.6.2: Geographic Location

53 (59%) respondents skipped the question, two (2%) people were from out of area and 35 (39%) people lived in Wolverhampton.



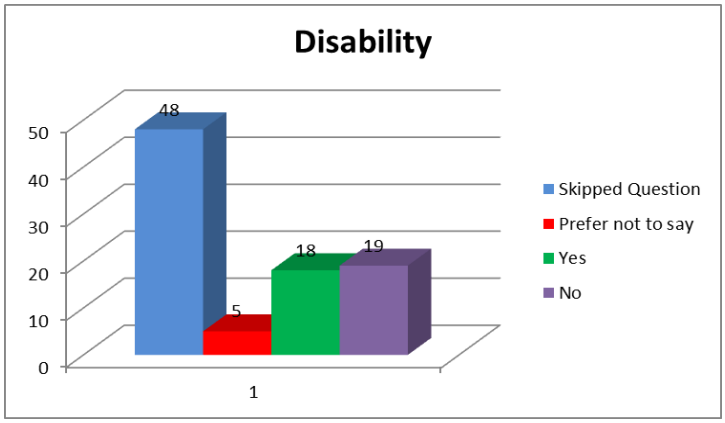
1.6.3: Gender Identity

Three (3.3%) participant's said they preferred not to say if their gender was the same as assigned at birth. 48 (53.3%) of people had the same gender identity, one person (1.1%) said their gender identity was different to assigned at birth and 38 people (42.2%) skipped the question.



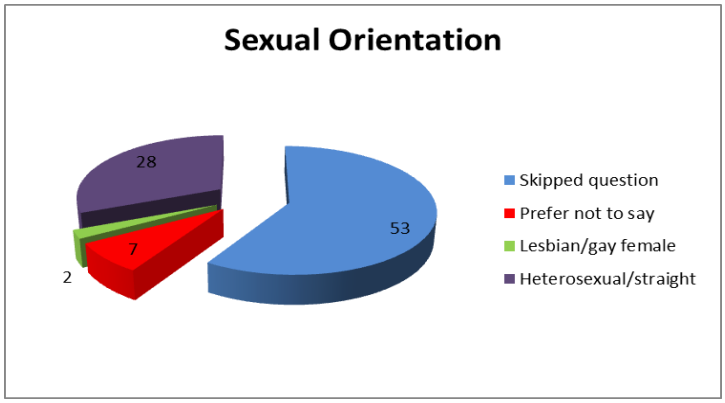
1.6.4: Disability

Eighteen (20%) of respondents considered themselves to be disabled, 19 (21%) said they were not. 48 people (53%) skipped the question and five (6%) preferred not to say.



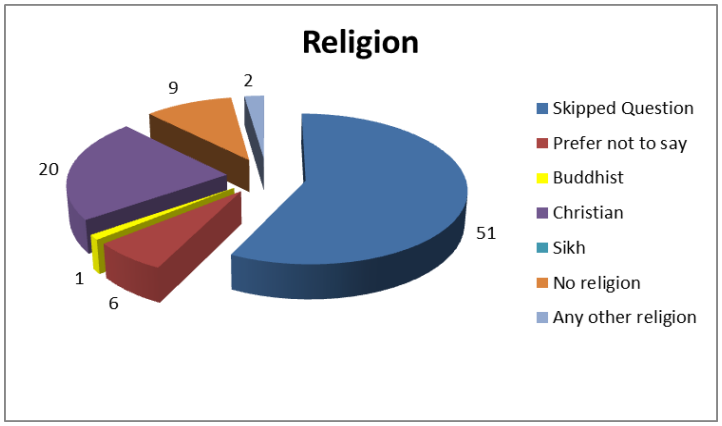
1.6.5: Sexual Orientation

Fifty three people (59%) chose to skip this question, whilst seven people (8%) said they preferred not to say. Two were (2%) lesbian/gay female and 28 people (31%) are heterosexual/straight.



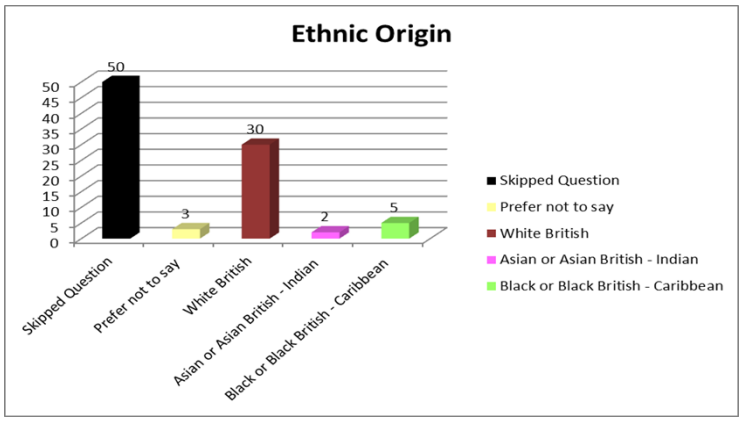
1.6.6: Religion

Twenty (22%) people identified themselves as Christian, two people (2%) identified with another religion and stated Wicca/pagan and catholic. Nine (10%) were of no religion. 51 people (57%) skipped the question, one person (1%) was a Buddhist and one person (1%) was Sikh whilst six (7%) people said they prefer not to say.



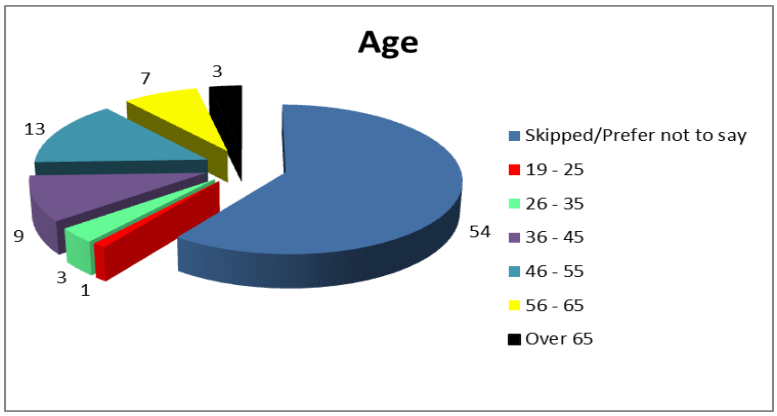
1.6.7: Ethnic Origin

Fifty people (56%) skipped this question and three (3%) preferred not to say. The top three responses were: 30 people (33%) were White British, two people (2%) was Asian or Asian British – Indian and five (6%) were Black or Black British – Caribbean.



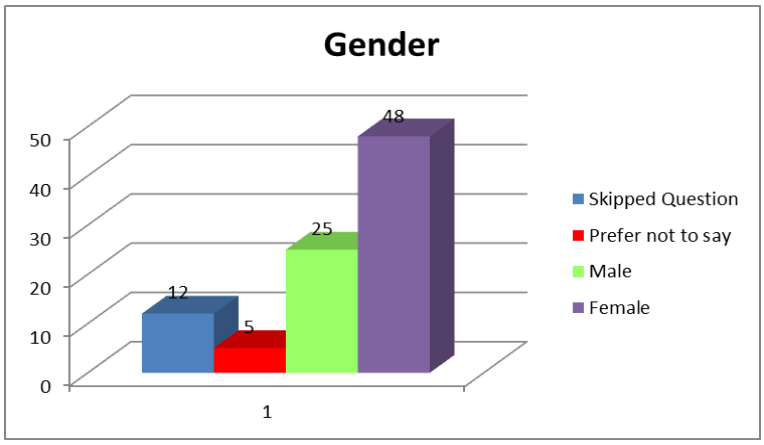
1.6.8: Age

No feedback was received from the 16 – 18 years age group. 54 people (60%) skipped this question. One respondent (1.1%) was aged 19 – 25, three respondents (3.3%) were aged 26 – 35 years, nine (10%) were aged 36 – 45, 13 (14.4%) were aged 46 – 55, seven (7.8%) respondents were aged 56 – 65 and three (3.3%) people were aged over 65.



1.6.9: Gender

Twelve people (13%) skipped this question and five people (6%) preferred not say. Twenty five (28%) respondents were male and 48 (533%) were female.



2.0: Background

Recovery House is a four bed crisis house which offers urgent and planned interventions for people with acute mental health needs. The service includes an Outreach Support Team.

To improve service delivery to this client group, the City of Wolverhampton Council's objective is to deliver a service which supports the resettlement programme. The programme aims to reduce the number of clients living in residential and nursing home settings, and supporting them to live more independently in the community.

A four bed unit is no longer a cost effective model for either partner. Based on 2014 – 15

activity and financial data, it is estimated that the average cost of each bed per week is £2,300.

The City of Wolverhampton Council is facing an unprecedented budget challenge. To address this, budgets across the council have been assigned spend reduction targets. The local authority needs to make a saving on this service as part of the Medium Term Financial Strategy.

Wolverhampton CCG is separating from the current joint funding arrangements for the different elements of the service, and has indicated that they intend to source crisis beds from an alternative provision.

2.1: Recovery House

The Recovery House service has been delivered in partnership with health partners since 2000. Wolverhampton's Clinical Commissioning Group (CCG) currently invests in the service in partnership with the City of Wolverhampton Council.

The service is a short term provision for people with mental health needs leaving hospital to provide support in readiness for living in a more independent setting, and/or for individuals in need of a period of assessment, reablement or a short break.

The service was restructured in May 2014 which resulted in a continuation of a four bed crisis unit and an Outreach Support Team.

2.1.1: The Outreach Support Team

Outreach support is available seven days per week between the hours of 10 am and 8 pm; community support may be available outside of these hours if identified as required and community outreach support provides practical social care support tailored to meet individual's needs in their local community.

2.2: Proposed Options for the Future of the Service

The City of Wolverhampton Council has considered a range of options for the future of Recovery House and those who use the service.

2.2.1: Option 1 - Do Nothing

Although all ways forward must be considered, doing nothing is not an option. The local authority needs to make a saving on the funding allocated to this service as part of the Medium Term Financial Strategy. Additionally, Wolverhampton CCG is separating from the current partnership arrangement for the different elements of the service and intend to source step down beds from an alternative resource. Without joint funding the service would not be able to continue to be delivered as it is currently.

2.2.2: Option 2 - Promoting Independence Model

The house itself would no longer be registered with the Care Quality Commission (CQC) as residential accommodation. The facility would continue to have capacity for four

people who would have a more secure and longer term tenancy through an external housing provide until they are ready to live in a more independent setting. The support would be provided by the Community Outreach Service.

The Community Outreach Service would also provide support to people living in their own homes in the local community. Staff who are not delivering the Community Outreach Service would be located with the Community Mental Health Service to support other people who are moving into the community from nursing or residential care settings.

The staff team would be reduced over a period of time as the number of people resettled in the community increases.

2.2.3: Option 3 – Complete Decommissioning of the Service

This option would involve the withdrawal of all funding for the service delivered at Recovery House and the Community Outreach Team.

2.2.4: Option 4 – Outreach Team Only

This option would involve decommissioning the Recovery House building so it is no longer used for service delivery and handing it over to the Corporate Landlord. An enhanced Outreach Team would have increased capacity to support the Social Work Team in the resettlement and transition programmes for people moving out of long stay residential and nursing settings.

The staff team would be reduced over a period of time as the number of people resettled in the community increases.

3.0: Consultation Feedback Summary

The following is a summarised overview of the feedback received through the consultation. Further detail can be found throughout this report. A full written transcript of all feedback is available by request.

3.1: Experience of current services

28 people who filled in the questionnaire shared their experience of Recovery House and/or the Outreach Team. Of that number only two people shared negative experiences. One felt that their stay at Recovery had worsened an existing neck, arm and back problem. The other felt that there were limited scheduled activities and a lack of signposting to other opportunities such as education. Additionally, hey felt that the treatment options weren't flexible and consulting time was limited.

Overall respondents felt that it is a flexible and responsive service which is delivered in an informal environment where they are treated with dignity. It was noted that service is preventative and 22 out of the 36 referrals received in the last 12 months were for people in acute crisis which would have required hospital admission otherwise.

3.1.1: Recovery House

It is felt that Recovery House provides holistic care and assists with promoting independence and the development of life-skills such as cooking, shopping and money management. Staff assist with move on and furnishing properties. Overall those that responded felt that they delivered good care, emotional support, reablement and respite 24 hours a day, seven days a week which support recovery.

Respondents feel that the service prevents self-harm, suicide, delayed discharge and hospital admission. It allows safe discharge from hospital, relocation back home and prevented clients being sent out of area. The service has enabled clients with children to be kept close to them and has been able to monitor and support clients that self-neglect.

However it was acknowledged that there is a prevalence of users of the residential service who are experiencing housing crisis/issues. A lack of suitable housing and the length of time it takes to find appropriate accommodation is seen as a contributory factor. It was noted that the residential element of the service is not suitable for people with disabilities.

3.1.2: The Outreach Team

It is felt that the Outreach Team provides on-going support which helps clients who are unable to leave the home due to acrophobia or who have been resettled. The outreach service helps clients to attend appointments, introduces them to other services and self-help groups.

3.1.3: Other feedback

It is felt that Recovery House should not be looked at in isolation but holistically with other mental health provision across the city. It was fed back that the remodelling exercise in May 2014 had had a positive effect and had the most impact on the planned elements such as; supporting people out of nursing homes, supporting the reablement agenda and supporting service users into supported living and more independent settings. The Integrated Panel ensures that nursing homes specify why individuals are there and their planned next steps which has improved step up and step down. It is felt a step up and step down replacement service needs to be in place before a closure is considered.

Staff feel that they build good, sustainable relationships with current and former service users which allows maintenance of wellbeing and prevents crisis. They fed back that a residential placement is always utilised as a last resort if outreach support is not possible or is unsuitable. They feel that the resettlement programme had slowed down turnover as clients stay longer which increases cost. Staff at Recovery House feel that they plug gaps and take the pressure of other services as well as identifying safeguarding concerns with other providers.

Staff queried how we would continue to assess resettlement clients for independent living, carry out urgent crisis assessments and administer medication if the service did

not continue. Additionally they expressed concern regarding the pressure on social workers to resettle people from nursing homes and felt that often these decisions are being made with no evidence base. The staffing ratio, roles and base going forwards was also queried. It is felt the staff team are highly skilled, experienced and trained and it would be a shame to lose their expertise.

It was fed back that there is difficulty accessing secondary mental health services, however, the CCG report that they commission more activity and invest more money in services than previously. A respondent felt there is a lack of public health and other health service provisions. Additionally, the CCG fund a lot of out of area beds which at times is unavoidable but which can have negative impact on service users. It was noted that since the Section 75 agreement had come to an end, the pathways into the service have changed. It was questioned if Recovery House is able to provide the intensive support required to people that are acutely unwell. Health colleagues report that they have experienced difficulty placing people who are unwell in Recovery House because of the nature of the building and the service it provides.

It was pointed out that if a service is stopped then the pressure is felt elsewhere. An attendee felt that Recovery House closing would lead to increases in Section 136, increased homelessness and people waiting to be admitted to hospital where there are already bed shortages. It is believed that there is pressure on acute beds which it is felt would be made worse if Recovery House was to close.

3.2: Preferred Options

Respondents were able to choose more than one of the proposed options available. 55 selections were made through the questionnaire, letter or email. Additionally 41 comments were noted as to the reasons for the options selected. Top three selections were Do Nothing, followed by the Promoting Independence Model and then Outreach Team only.

Eight respondents said they did not wish to choose any of the options, although one intimated that they did not want Recovery House to close. Two people said they were not sure about a preferred option. They said the reasons for this was because they were not sure what is happening with the services currently and the other respondent said they were unsure of what the options are.

One respondent queried how the proposed options will replicate the current benefits to clients and carers.

3.2.1: Option 1 – Do Nothing

24 people who completed the questionnaire or sent in feedback chose the ‘Do Nothing’ option. A petition was received on 3rd December 2015 containing 46 signatures along with a letter for the Cabinet Member for Adults Cllr Mattu. Overall the vast majority of those who attended consultation meetings also did not want the service to change and gave the following reasons. They felt:

- the service should be left as it is and kept open

- there should be more provision
- the £2,300 per bed per week figure was questionable
- the other options available are unsuitable for future needs
- This is a need for this type of service for people in crisis or vulnerable people
- it would be a travesty to close it
- the service is well used and is an invaluable asset to the city.

3.2.2: Option 2 – Promoting Independence Model

12 people who completed the questionnaire chose the Promoting Independence Model. One person felt that money would be better spent in promoting care in own home and sorting out the root problems of people. However concern was expressed by one respondent at the proposed staff reduction once clients were resettled in the community.

3.2.3: Option 3 – Complete Decommissioning of the Service

One person who completed the questionnaire chose the option of the complete decommissioning of the service. They felt the current cost is far too expensive and is unsustainable.

3.2.4: Option 4 – Outreach Team Only

Eight people who completed the questionnaire chose option four, the following reasons were given.

- The fourth option is best so can still have a service
- I agree to Option 4 as long as services will be provided to people like myself
- Agree with Option 4.

3.2.5: Other Responses

Eight people who completed the questionnaire said they did not wish to choose any of the options. Two people were unsure and nine skipped the question.

3.3: Alternative Suggestions

The staff team at Recovery House have submitted an Option 5 through the consultation. A summary of this option can be found in 3.3.1 and further detail can be found in 4.0.

Other alternative suggestions received during the consultation are as follows:

- Make football supporters or the football team pay for policing on match days instead of the tax payer. The money saved could go towards financing mental health projects.
- Faster turnover of clients which would make money or be given a bigger property to house and support more people.
- Increase council tax by 2% for the social care needs of mental health service users.

- Volunteers to man Recovery House.
- Charging service users who have the ability to contribute
- Ring fence for this vital service.
- Step down from wards to re-enable return home with a maximum of two weeks of planned care. Crisis or respite use but done in a controlled manner i.e. care planned and fixed time frame as an alternative to inappropriate hospital admissions.
- 1) Supported housing at Recovery House with a progressive individual plan leading to independent living. 2) Those with lower support needs can be supported via outreach in their own homes.
- De-register the service with Care Quality Commission (CQC)
- Explore other options such as the Mental Health and Learning Disability Trust or specialist housing associations
- A cost benefit analysis exercise be undertaken to establish the best option(s) going forwards
- Additional support online to that already provided such as sexual abuse/trauma for those who won't attend conventional services.
- Sheltered housing to provide the same support at a lower cost.
- A better building for the same amount of funding could mean the service could be offered to more people with a static critical mass of staff.
- Rented units that can be utilised as and when required for residential placements
- Training to ensure a common framework of independence is used from a service user's activity.

3.3.1: Summary of Option 5

Option 5 relies on the continuation of a jointly funded service. It proposes to maintain links with health partners through weekly hospital visits to identity suitable referrals and/or begin in reach to support faster discharge.

Option 5 proposes a staffing reduction from a current team of 18.5 full time employees to a team of 13. Current staffing costs are approximately £634,260 per year, the proposed reduction in staffing brings this cost down to approximately £451,709. Option 5 offers a saving of approximately £182,551 whilst retaining both the residential element of the service and intensive outreach support.

The service would maintain the ability to administer medication and provide an immediate response to assessment and admissions. The staffing ratio would enable the service to continue to offer 24 hour residential support and continue to support the resettlement project.

4.0: Option 5

The staff team at Recovery House have submitted an Option 5 through the consultation. The following detail is taken from the proposal.

There is no question that the service currently offered is expensive however, there is currently no data available to evidence what costs would have been associated with the

referrals received if the Recovery House had not been available. It would be questionable as to whether there would have been any service available at all to some of the recent admissions due to associated risks and current capacity in the supported housing schemes.

It is also acknowledged that previous links within the Black Country Foundation Partnership Trust (BCFPT) have been eroded and systems need to be re-established to ensure that a more effective and proactive 'step down' and 'alternative to admission' is available. This could be easily achieved by early intervention and identification and point of admission if not achieved before. Currently health colleagues rarely contact or refer into the service until there is a bed crisis within the hospital and frequently the referrals are not appropriate however, the service regularly helps to alleviate bed pressures and blockages.

It is recommended that a continued joint service be provided as simply as visiting the hospitals on a weekly basis to identify any possible suitable referrals and/or commence in reach to support a quicker discharge.

A merger of the Community Inclusion Team and Recovery House following a restructure in May 2014 resulted in an increase of staff within the service which is not a true reflection of the baseline staff that would be required to deliver the majority of the services currently delivered: residential, outreach and maintenance support.

Current Staffing Resource

1 FTE Registered Manager – Grade 7 = £46,116
6 FTE Team Leaders – Grade 6 = £221,271
5 x Night Social Care Workers – Grade 5 = £156,783
6.6 FTE Social Care Workers – Grade 5 (6 @ 37hrs + 1 @ 25.9 hrs.) = £210,090

Total Approximate Cost = £634,260

Based on rough calculations the current staffing budget could be reduced from a current team of approximately 18.5 FTE employees to a team of 13 as detailed below.

Option 5 – Staffing Resource

1 FTE Registered Manager – Grade 7 = £46,116
3 FTE Team Leaders – Grade 6 = £110,982
5 Night Social Care Workers – Grade 5 + 10% night working allowance = £169,184
4 FTE Social Care Workers – Grade 5 = £125,427

Total Approximate Cost = £451,709

Saving of £182,551

Option 5 would be able to offer a significant saving of £182,551 whilst still retaining both the residential element of the service and the intensive outreach support. The service would offer 2 qualified, experienced members of staff on duty at all times inclusive of a

team leader on duty between the hours of 8 am – 9 pm. This would enable continued administration of medication and immediate response to assessment and admissions. This staffing ratio would enable the service to continue to offer the high intensity 24 hour residential support with minimal exclusion to service users due to the potential risks associated with lone working. This would also enable the service to continue to effectively support the resettlement project.

5.0: Experience of current services

Participants were invited to share their experience of the services that they receive(d) or the person they care for currently use at Recovery House or through the Outreach Support Team. Twenty eight people provided feedback.

5.1: Positive Experiences

Twenty six respondents shared positive experiences of Recovery House and/or the Outreach Team. Overall respondents see the service as a lifeline and feel that it is a flexible and responsive service which is delivered in an informal environment where they are treated with dignity. *"Recovery House has literally been a life saver for me on several occasions. Having their support available has stopped me severely harming or committing suicide. Outreach has been useful at other times. Both have provided continuity of care at difficult times and being able to relate to staff when in crisis is invaluable."*

It was felt that Recovery House provides holistic care and assists with promoting independence and the development of life-skills such as cooking, shopping and money management. Staff assist with move on and furnishing properties. It is felt they deliver good care, emotional support, reablement and respite 24 hours a day, seven days a week which supports recovery. *"I found it was very good and very helpful. I got on very well with the staff. I went shopping and to drop-ins. I learnt a lot of new things. The staff taught me about cooking and also about food and to go on buses. I moved into Recovery House from Harper House and now live in my own house."*

The service prevents self-harm, suicide, hospital admission and a breakdown of care arrangements. *"I have used Recovery House on several occasions. Each time I have had good care and it has enabled me to return to home life and not return to hospital or end up killing myself. The staff are generally great and helpful."* It allows safe discharge from hospital, relocation back home and prevented clients being sent out of area. The service has enabled clients with children to be kept close to them and has been able to monitor and support clients that self-neglect. *"When I was initially admitted to hospital there were no NHS beds in the country and I was placed in Bristol. This made it impossible for my children to stay in touch with me."*

It is felt that the Outreach Team provides on-going support which helps clients who are unable to leave the home due to acrophobia or who have been resettled. The outreach service helps clients to attend appointments, introduces them to services and self-help groups. *"The service has helped me get to appointments and I have been lonely so I have asked them for help."*

5.2: Negative Experiences

Two respondents shared negative feedback. One felt that their stay at Recovery House had worsened an existing neck, arm and back problem which resulted in them experiencing pain. The respondent said that they now considered themselves as disabled after their stay at Recovery House. A respondent felt there are limited scheduled activities or signposting to other opportunities. Additionally they felt the treatment options and consultation times were inflexible. *"However, the inflexibility of their treatment options and limited consulting time make this part of the service look pressured from within; less than load of the client register dictating the outcomes."*

6.0: Views expressed on the proposals

6.1: Detailed comments

Some respondents used this section to reiterate the value placed on the service and the need for the service in the city. "*Although I usually like independence there are times when I just need to be cared for and someone to keep you safe."* The calculation of £2,300 per bed per week was queried particularly when compared to costs applied by other similar organisations. *"Whilst he service may appear expensive, does the intensive short term cost of enablement/maintenance then reduce lifetime costs?"* One respondent felt that none of the proposed options are suitable as a replacement for the existing or future needs of clients and their families. An attendee queried whether the CCG were able to remove their funding from the service without consultation? It was suggested that consultation should have took place earlier to shape the options. An attendee felt that the proposals were not joint/integrated and were not robust. It was felt that a step up, step down facility needed to be in place before a closure.

Concern was expressed regarding the potential loss of a local step up, step down community mental health resource due to resource constraints. Additionally it was felt that the loss of this resource would leave unsatisfactory alternative options for vulnerable people such as a P3 hostel or the Wulfrun Hotel which it was said used by prostitutes. They felt the implications of travelling out of area would impact negatively on clients. *"Some will have further to go if they are in real need of help. Especially if they have no car. Also they will have to get used to new personnel and surroundings which will already add to the stress they are in."* Additionally they felt that the CCG had made decisions and plans which undermined a joint approach and the consultation, and also meant that complex issues and models are not being explored.

Relatives feel that a residential service is necessary when someone becomes unwell as their life style may contributing to the problem, additionally they felt that it is important that their loved one be removed from home when in crisis to enable them to be supported in a different environment and then returned home. Environment is seen as very important to wellbeing and recovery; however it was noted that if clients remain too long in a service it can deskill them. Others felt that resettlement in the community and support in the home was not always appropriate. *"And as far as I'm concerned condemning someone to live alone in their own house is not independence but purgatory. It might be cheap, it might be cheap but it's purgatory."*

An attendee felt that GP's provide little support and that people need help to sort out the root problem and chronic loneliness is an issue for many. It was suggested that there is need for more advocacy provision in the city and better promotion of existing services. An attendee felt that people were not receiving mental health support in the community. It was queried how the £600 million national additional funding for mental health and crisis intervention would be spent locally.

6.1.1: Option 1 - Do Nothing

Overall Option One – Do Nothing was the favoured option with those that participated. It was felt by the majority that the service should be kept open as it is a unique service for people in crisis. It provides support 24 hours a day, seven days a week in a safe environment which is appropriate for building relationships and learning new skills. *"When in crisis going to a small informal place such as Recovery House is much less stressful than inpatient psychiatric services and ultimately leads to a speedier recovery."* It is felt that service aids recovery and is relied on by other organisations. *"I believe that the residential beds are frequently used and are an invaluable asset to both WCC and BCPFT."* It is felt that closure of Recovery House would be a loss to the city and may but strain on other resources. It was suggested that the service should be expanded and provide more beds. *"My preferred option or better option would be to expand it to more beds. I'm sure they are needed."*

6.1.2: Option 2 – Promoting Independence Model

Option Two – the Promoting Independence Model was the second favourite option amongst participants. *"Money would be better spent promoting care in their own home, sorting out the root problems of people."* However, concern was expressed regarding to intention to reduce staff numbers once clients have been resettled in the community as it focusses on existing clients and had not considered new clients coming through the service.

6.1.3: Option 3 - Complete Decommissioning

Option Three – Complete Decommissioning of the service was the least favoured option and was only endorsed by one participant who felt the current cost was far too expensive and unsustainable.

6.1.4: Option 4 – Outreach Team Only

Option 4 – Outreach Team Only was the third popular of the options. Participants felt that at least there would be some level of provision. *"The fourth option is the best so can still have a service."*

7.0: Case Studies

The following case studies have been supplied by Recovery House staff to highlight the varied and complex nature of the work undertaken by the service.

7.1: Case Study One

October 2015 - 17.30 pm. Telephone call received from Home Treatment Team (HTT) Penn Hospital for an urgent assessment for admission to Recovery House. Doctor on call is looking for a bed for a female patient for around three days. Recovery House initiated a prompt response. Staff arrived at the hospital at approx. 18.20. HTT brief - Patient known to Mental Health Services and has a diagnosis of Schizophrenia with a history of relapse in mental health resulting in paranoia and delusional beliefs. Patient sat in Hospital reception. HTT had conducted a visit to the home at tea time. She reported to them her husband had hit her. Husband admitted he had hit her and should she remain in the house he would do it again. HTT transported her to hospital for a place of safety as they felt should she remain there was a high risk of the situation escalating. Nurse stated the patient has a history of allegations towards her husband and family and believes the allegations are part factual/part illness. During the assessment she stated she wanted to report the incident to the Police and was worried about her two dependent children. Nurse stated she had raised a safeguarding regarding her welfare earlier today. Documented evidence on risk assessment Safeguarding raised for children August 2014 which was investigated and case closed. Nurse stated they were waiting on the Emergency Duty Team (EDT) for advice. Patient rang the Police during the assessment and reported the incident to the Police who took the relevant details with a plan to visit to take a statement.

Outcome:

Dr on Call felt the patient did not require a hospital admission. No beds available. Patient asked if Recovery House was another hospital /institution as she would not be happy to go. Staff explained we are a four bed “house type” Social Services residential establishment staffed 24 hours per day which she accepted. She was admitted to Recovery House at 20.00 hrs. Police attended and took her statement whilst supported by staff as she felt frightened and anxious. Safeguarding application made for the children the same night.

Patient remained at Recovery House for 24 hours until her mother collected her to take her to stay with her. Staff liaised with HTT throughout the process to ensure she continued to have a place of safety. Safeguarding investigated.

7.2: Case Study Two

October 2015 - Recovery House were called to attend an urgent assessment at Penn Hospital by the Home Treatment Team (HTT) at the request of the on call Doctor. Assessment completed at 19.30 pm, two staff in attendance. During the car journey back to Recovery House a call was received from a colleague regarding concern for one of our clients. The young person had telephoned and sounded distressed stating she had taken an overdose of sleeping pills. She informed them of the area she was in but not an address.

Staff turned the car around and drove to the area she stated she was in. She was found on a street corner crying and refused to get into the car and threatened to run off should staff telephone the Police. Following reassurance she agreed to return to Recovery

House. Staff telephoned colleague to call an ambulance during our journey back. On a safe return to Recovery House paramedics arrived and transported her to hospital for further investigations. She returned during the early hours of the morning where night staff sat with her offering her reassurances. This continued the following day as she had stated she felt very upset and about what she had done.

Outcome:

The person is under the Transition Service from the Looked after Children Team to Adults with a view to independent living. Work is continuing with this individual.

City of Wolverhampton Council would like to thank everyone who contributed to this consultation exercise.

TERMS OF REFERENCE

Project/Programme Name:	Mental Health
Prepared by:	BCF PMO
Date Amended:	01.04.16

Role	Name	Organisation	Contact Details
Senior Responsible Officer (SRO)	Steven Phillips	BCPFT	Steve.phillips@bcpft.nhs.uk
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Programme Team Member	Ann Beach	CWC	ann.beach@wolverhampton.gov.uk
Programme Team Member	Jason Viola-Davis	WCCG	j.viola-davis@nhs.net

Total MH Budget	£8,350	Total MH Demographic Growth Target	
Total Ring-Fenced MH Budget	£0	Total MH BCF Target	
Actual MH Budget Total	**£8,350**	**Total MH Budget Available to Spend (Actual Budget MINUS BCF Target)**	**£8,350**

Mental Health Project Plan - Critical Path

KEY	C/F Milestone	Slippage predicted	Dependency	**Last Updated**	**27.04.16**
	Late	On Target	Delivered	**National Conditions**	(3) 7 day services (5) joint assessment/care planning

Related KLOES:	C2vi; C3iv; C3ii; C3iii; C6iv
National Metrics	Non-Elective Admissions (NEL's) Delayed Transfers of Care (DTOCS)

Reporting Period		j													Finance Quarter 2												Finance Quarter 3												Finance Quarter 4											
	Quarter																																																		
	Period	Report 1				Report 2					Report 3				Report 4				Report 5					Report 6				Report 7					Report 8					Report 9				Report 10					Report 11					Report 12			
	Month	April				May					Jun				Jul				Aug					Sep				Oct					Nov					Dec				Jan					Feb					March			
Projects	Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52

Nos

Reablement & 1St Avenue

- Assertive Outreach job descriptions finalised
- HR consultation started
- Appeals Panel decisions shared
- At Risk letters issued to staff
- Interviews held
- Re-structure implemented
- Identify estate needs for AO Team
- AO team re-located
- Agree location & requirements
- AO team operational
- Source short term 24 hour emergency 2 bed accommodation with care support
- Spec agreed
- Award contract
- 2 bed crisis support accommodation operational
- Start tender
- Agree terms

1

- Liaise with Wolverhampton Homes re 1st Ave property
- Transfer of 1st Ave to registered social landlord completed
- Registered social landlord identified
- 1st Avenue (3 unit) supported living operational
- identify clients
- Confirm 3 Clients for 1st Ave
- Develop service spec for supported living care provider
- Start tender
- Contract awarded

Steps to Independence

- Identify 14 Clients for Accommodation 'S'
- ISF mechanisms agreed
- Start assessment & reablement activity
- 14 clients confirmed for accommodation'S'
- Begin comms liaison with members/officers for Accomm 'S'
- Accommodation 'S' (14 units) operational
- Detail Design Input started for 'My Place Woodhayes'
- Spec for My Place (Woodhayes) care support developed
- Identify 14 Clients for My Place Woodhayes
- Provider support tender process started → On stream July 2017
- Start assessment & reablement activity → On stream July 2017
- CASSH funding secured
- Detail Design input started
- Identify 14 Clients for Tap Works project → On stream Dec 2017
- Tap Works wider scheme out for tender
- Plans submitted (LDO process)
- Start assessment & reablement activity → On stream Dec 2017
- Developer for Tap Works selected
- Plans approved (LDO process)

3 Prevention

- Stakeholder consultation started
- Consultation feedback analysed and summarised
- Single joint prevention service operational
- Tender process started
- Contract awarded
- Existing contracts cease
- Service spec for new prevention model finalised

4 Community Recovery Service

- 16/17 AMHP funding secured
- AMHP resource into acute wards

5 Urgent MH Pathway

- 16/17 Street Triage Car (STC)funding secured
- Dedicated STC AMHP opportunity developed
- AMHP operational in STC
- Start Dementia focus work/training for STC staff
- Review existing Crisis Concordat with service users and carers
- Crisis Concordat Review Completed
- Crisis Concordat review planning started
- Crisis Concordat updated
- Revised Crisis Concordat implemented
- Agree a Section 12 /AMHP process
- Implement Section 12 /AMHP process agreement

BCF Mental Health Implementation Plan

Programme RAG

On Target

Date Last Updated **27.04.16**

#	Milestone	Owner	Update/ Mitigation/ Risk to Completion	Status	Planned Start	Planned Dur	Actual Start	Actual Dur	% Done
Reablement & 1st Avenue									
1	**Assertive Outreach job descriptions finalised**	Lesley Brazier/Suzanne Gwilt	**21.04.16** The JD&PS were finalised on 18.04.16 and forwarded to HR (Jo Farley) for consideration	Complete	2	1	2	1	100%
2	Service Development Meeting held to work on details of the new service design model	Lesley Brazier/Suzanne Gwilt	**21.04.16** Meeting arranged for 15.04.16 cancelled. Further meeting planned for w/c 25.04.16 to determine operating times, office accommodation requirements etc	Slippgage	2	1	2	2	50%
3	Meet with Dave Auger (UNISON) to discuss proposed restructure, including proposed ring fences/assimilation /recruitment process.	Lesley Brazier/Suzanne Gwilt	**21.04.16** Meeting set up with UNISON (Dave Auger) for Wednesday 27 April with June, Lesley and HR (Jas Manku)	Slippgage	2	2	2	2	45%
4	**Formal HR group consultation begins with employees and relevant TU's.**	Lesley Brazier/Suzanne Gwilt	**21.04.16** Email sent out to all RH workers for staff consultation briefing on 4 May at the civic centre 1200 – 13 00 hrs again with June, UNISON (Dave Auger) and HR (Jas Manku)	Slippgage	3	2	4	2	33%
5	2 week window to forward comments/suggestions/ring fence & assimilation challenges.	Lesley Brazier/Suzanne Gwilt	**21.04.16** 2 weeks slippage as Staff consultation briefing now on 4 May at the civic centre 1200 – 13 00 hrs (week 5)	Slippgage	3	2	5	2	0%
6	Issue consultation information to employees and TU's	Lesley Brazier/Suzanne Gwilt	**21.04.16** Slippage of 1.5 weeks. Will now go out end of week 4 start of week 5	Slippgage	3		5		0%
7	Manager conducts individual 1-1 consultation with staff	Lesley Brazier/Suzanne Gwilt	**21.04.16** Slippage of 2 weeks. Will now start week 5	Slippgage	3	2	5	2	0%
8	Deadline for submission of comments/ suggestions.	Lesley Brazier/Suzanne Gwilt		Slippgage	5		7		0%
9	Deadline for submission of ring fence and assimilation	Lesley Brazier/Suzanne Gwilt		Slippgage	5		7		0%
10	Deadline for submission of voluntary redundancy requests.	Lesley Brazier/Suzanne Gwilt		Slippgage	5		7		0%
11	**HR consultation ended**	Lesley Brazier/Suzanne Gwilt		Slippgage	5		7		0%
12	Panel meets to consider written submissions to challenge	Lesley Brazier/Suzanne Gwilt		Slippgage	6		8		0%
13	**Panel decisions confirmed to individuals.**	Lesley Brazier/Suzanne Gwilt		Slippgage	6		8		0%
14	Meet with TU's and respond to consultation process and	Lesley Brazier/Suzanne Gwilt		Slippgage	7		9		0%
15	Notify staff of SMR approval.	Lesley Brazier/Suzanne Gwilt		Slippgage	8		10		0%
16	Issue at risk letters to staff subject to priority ring fenced	Lesley Brazier/Suzanne Gwilt		Slippgage	8		10		0%
17	**Start HR Restructure**	Lesley Brazier/Suzanne Gwilt		Slippgage	8		10		0%
18	Interviews for G6 & G5 posts	Lesley Brazier/Suzanne Gwilt		Slippgage	8	3	10	3	0%
19	Implement re-structure proposals - assimilations/ring	Lesley Brazier/Suzanne Gwilt		Slippgage	11	3	13	3	0%
20	**Restructure implemented**	Lesley Brazier/Suzanne Gwilt		Slippgage	14		16		0%
21	**Identify estate needs for AO Team**	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
22	Determine location requirements	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
23	Determine IT and office space requirements	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
24	Determine access and parking requirements	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
25	**Agree infrastructure & location for AO Team**	Lesley Brazier/Suzanne Gwilt		On Target	5				0%
26	Start re-location planning	Lesley Brazier/Suzanne Gwilt		On Target	5	9			0%
27	End re-location planning	Lesley Brazier/Suzanne Gwilt		On Target	14				0%
28	**AO team re-located**	Lesley Brazier/Suzanne Gwilt		On Target	14				0%
29	**Assertive Outreach Operational**	Lesley Brazier/Suzanne Gwilt		On Target	15				0%
30	**Source short term 24 hour emergency 2 bed accommodation with care support**	Jacqui McLaughlin	**21.04.16** Ongoing exploratory work taking place to identify accommodation and provision. Considering market testing exercise	Slippgage	1	4	1	4	20%
31	Liaise with providers to identify accommodation	Jacqui McLaughlin	**21.04.16** No accommodation sourced at end of week 3	Slippgage	1	4	1	4	20%
32	**Agree Specification**	Jacqui McLaughlin		On Target	5	2			0%
33	**Start tender**	Jacqui McLaughlin		On Target	7				0%
34	Utilise procurement framework processes	Jacqui McLaughlin		On Target	7	10			0%
35	**Agree terms (e.g. outcomes, costs, contract duration etc)**	Jacqui McLaughlin		On Target	17				0%
36	Complete all tender negotiations	Jacqui McLaughlin		On Target	17	3			0%
37	**Award contract**	Jacqui McLaughlin		On Target	20				0%
38	Complete operational arrangements	Jacqui McLaughlin		On Target	20	5			0%
39	**2 bed crisis support accommodation operational**	Jacqui McLaughlin		On Target	26				0%
40	Liaise with Wolverhampton Homes re 1st Ave property	Jacqui McLaughlin	**21.04.16** First meeting with Wolverhampton homes undertaken they want to visits the property.	On Target	1		1		20%
41	Start discussions with property services and Wolverhampton Homes to transfer 1st Avenue	Jacqui McLaughlin	**21.04.16** WH need to visit and undertake and complete a business case. Alison Fowler from Asset magnet involved.	On Target	1	6	1	6	15%
42	**Registered social landlord identified**	Jacqui McLaughlin		On Target	7	1			0%
43	Begin property transfer processes	Jacqui McLaughlin		On Target	8	14			0%
44	End property transfer processes	Jacqui McLaughlin		On Target	22	1			0%
45	**Transfer of 1st Ave to registered social landlord completed**	Jacqui McLaughlin		On Target	23	2			0%
46	Complete operational arrangements	Jacqui McLaughlin		On Target	25				0%

Programme RAG					Planned		Actual		%
On Target	Date Last Updated	27.04.16							
#	Milestone	Owner	Update/ Mitigation/ Risk to Completion	Status	Start	Dur	Start	Dur	Done
47	**Identify 3 Clients**	Lesley Brazier/Suzanne Gwilt	**21.01.16** 3 potential people have been identified for possible shared tenancy. Discussions have started with one, plans are in place to visit for another and contact should be made with the third shortly	On Target	6	6			0%
48	Complete assessment of need reviews	Lesley Brazier/Suzanne Gwilt		On Target	6	6			0%
49	Agree future support plan arrangemnets	Lesley Brazier/Suzanne Gwilt		On Target	13				0%
50	**Develop service spec for supported living provider**	Jacqui McLaughlin		On Target	7	5			0%
51	Agree service specification	Jacqui McLaughlin		On Target	13				0%
52	**Start Tender**	Jacqui McLaughlin		On Target	14				0%
53	Procurement processes started	Jacqui McLaughlin		On Target	14	8			0%
54	Procurement processes completed	Jacqui McLaughlin		On Target	23				0%
55	**Contract awarded**	Jacqui McLaughlin		On Target	24				0%
56	**1st Avenue (3 unit) operational**	Kathy Roper/June Pickersgill		On Target	26				0%
	Steps to Independence								
57	**Scheme S (14 bed low/medium level needs, step down to**	Jacqui McLaughlin		On Target					0%
58	**Identify 14 clients and their associated needs**	June Pickersgill /Lesley Brazier	**21.04.16** The process mapping exercise across all supported housing accommodation, nursing and residential placements to assist with identifying who can possible move on from current accommodation/placement is underway with a completion date of 25.04.16.	On Target	1	27	1	27	5%
59	Negotiate care & rent cost models with provider	Jacqui McLaughlin		On Target	3				0%
60	Negotiate access support delivery timescales with provider	Jacqui McLaughlin		On Target	3				0%
61	Develop draft service specification that includes client needs &	Jacqui McLaughlin		On Target	3				0%
62	**Start client assessment & reablement activity**	June Pickersgill /Lesley Brazier	**21.04.16** Meeting arranged with Firsbrook manager to discuss progress of reablement planning	On Target	3	23			0%
63	Develop support plans with clear timescales that enable	June Pickersgill /Lesley Brazier		On Target	3	4			0%
64	Timescales for individual client moves into Scheme S identified	June Pickersgill /Lesley Brazier		On Target	7				0%
65	On-going reablement activity underway	June Pickersgill /Lesley Brazier		On Target	7	16			0%
66	**Start communication activity with Members**	Kathy Roper		On Target	6	6			0%
67	Develop a comms plan that includes councillors and officers	Kathy Roper		On Target	6	1			0%
68	Brief ward councillors and officers	Kathy Roper		On Target	7	5			0%
69	**Support delivery arrangements (activity, timescales and**	Kathy Roper/Jacqui McLaughlin		On Target	12	4			0%
70	ISF mechanisms explored	June Pickersgill /Lesley Brazier		On Target	16	6			0%
71	**ISF mechanisms agreed**	June Pickersgill /Lesley Brazier		On Target	22				0%
72	First client moved into Scheme S	June Pickersgill /Lesley Brazier		On Target	22				0%
73	Other clients move into Scheme S	June Pickersgill /Lesley Brazier		On Target	22	4			0%
74	Last Client moved into Scheme S	June Pickersgill /Lesley Brazier		On Target	26				0%
75	**Project S (14 units) operational**	Kathy Roper/ June Pickersgill		On Target	27				0%
76	**Scheme My Place Woodhayes (14 bed low/medium level needs, step down from hospital/step up from community)**	Kathy Roper		On Target	1	70	1	70	5%
77	**Detail health and social care design input completed for MY Space Woodheyes**	Kathy Roper/Jacqui McLaughlin	**21.04.16** Planning application was successful project group to be established	Complete	1		1	1	100%
78	**Identify 14 Clients and their associated needs for MY Place units**	June Pickersgill /Lesley Brazier	**21.04.16** The process mapping exercise across all supported housing accommodation, nursing and residential placements to assist with identifying who can possible move on from current accommodation/placement is underway with a completion date of 25.04.16.	On Target	1	16	1	16	5%
79	Develop support plans with clear timescales that enable	June Pickersgill /Lesley Brazier		On Target	1	16	1	16	5%
80	**Start client assessment & reablement activity**	June Pickersgill /Lesley Brazier		On Target	9				0%
81	On-going reablement activity underway	June Pickersgill /Lesley Brazier		On Target	9	20			0%
82	**Developer starts on-site build**	Kathy Roper/Jacqui McLaughlin		On Target	19				0%
83	**Service specification for care support at MY Place developed**	Kathy Roper/Jacqui McLaughlin		On Target	22				0%
84	Timescales for individual client moves into My Place Scheme	Kathy Roper/Jacqui McLaughlin		On Target	25	4			0%
85	Focussed client reablement activity linked to identified	June Pickersgill /Lesley Brazier		On Target	29	41			0%
86	**Start tender for care provision**	Kathy Roper/Jacqui McLaughlin		On Target	27				0%
87	Procurement processes started	Kathy Roper/Jacqui McLaughlin		On Target	27	32			0%
88	Procurement processes completed	Kathy Roper/Jacqui McLaughlin		On Target	52	7			0%
89	**Provider support contract awarded**	Kathy Roper/Jacqui McLaughlin		On Target	52	8			0%
90	Complete operational arrangements	June Pickersgill /Lesley Brazier		On Target	52	16			0%
91	**Scheme My Place Woodhayes (14 units) operational**	Kathy Roper/June Pickersgill		On Target	52	17			0%
92	**Scheme Tap Works (14 bed low/medium level needs, step down from hospital/step up from community)**	Kathy Roper/Jacqui McLaughlin		On Target	1		1	1	0%
93	**Tap Works wider scheme out for tender**	Kathy Roper/Jacqui McLaughlin	**21.04.16** This looks like it's too early as planning hasn't been agreed yet	On Target	1		1	1	85%
94	**Developer for Tap Works selected**	Kathy Roper/Jacqui McLaughlin		On Target	9				0%
95	**Detail Design input started**	Kathy Roper/Jacqui McLaughlin		On Target	13				0%
96	**Plans submitted (LDO process)**	Kathy Roper/Jacqui McLaughlin		On Target	22				0%
97	**Identify 14 Clients for Tap Works project**	June Pickersgill /Lesley Brazier		On Target	27				0%

Programme RAG					Planned		Actual		%
On Target	**Date Last Updated**	**27.04.16**							
#	Milestone	Owner	Update/ Mitigation/ Risk to Completion	Status	Start	Dur	Start	Dur	Done
98	Develop support plans with clear timescales that enable	June Pickersgill /Lesley Brazier		On Target	27	8			0%
99	**Start assessment & reablement activity**	June Pickersgill /Lesley Brazier		On Target	32				0%
100	On-going reablement activity underway	June Pickersgill /Lesley Brazier		On Target	32	40			0%
101	**Plans approved (LDO process)**	Kathy Roper/Jacqui McLaughlin		On Target	35				0%
102	**Tap Works stakeholder consultation started**	Kathy Roper	**21.04.16** Meeting with Social work teams arranged for 27th April to start stakeholder involvement	On Target	1		1	1	80%
103	Event(s) held	Kathy Roper	**21.04.16** Consultation on site development being led by Housing Strategy, meetings held with the tenants and residents group	On Target	1	11	1	11	15%
104	Feedback analysed and summarised	Kathy Roper		On Target	12	2			0%
105	**Service specification finalised and agreed**	Kathy Roper		On Target	14				0%
106	**Tender process started**	Kathy Roper		On Target	14				0%
107	Procurement processes started	Kathy Roper		On Target	14	16			0%
108	Procurement processes completed	Kathy Roper		On Target	30				0%
109	**Contract awarded**	Kathy Roper		On Target	31				0%
110	Complete operational arrangements	Kathy Roper		On Target	31	8			0%
111	**Existing contracts cease**	Kathy Roper		On Target	39				0%
112	**Single joint prevention service operational**	Kathy Roper		On Target	40				0%
	Community Recovery								
113	**16/17 AMHP funding secured**	Sarah Fellows / June Pickersgill	Funding secured - TASK CLOSED	Complete	1		1	1	100%
114	**AMHP resource into acute wards confirmed**	Sarah Fellows / June Pickersgill	Funding secured - TASK CLOSED	Complete	2		2	1	100%
	Urgent Care Pathway								
115	**16/17 Street Triage Car (STC)funding secured**	Sarah Fellows	Funding secured - TASK CLOSED	Complete	1		1	1	100%
116	**Dedicated STC AMHP opportunity developed**	Sarah Fellows / June Pickersgill	PID COMPLETED FOR SRG - TASK CLOSED	Complete	1		1	1	100%
117	SRG Funding secured	Sarah Fellows		On Target	1	16	1	16	20%
118	AMHP Recruitment completed	Sarah Fellows / June Pickersgill		On Target	17				0%
119	**Start Dementia focus work/training for STC staff**	Sarah Fellows / June Pickersgill		On Target	9				0%
120	Liaise with dementia work stream leads and agree appropriate	Sarah Fellows/ Kathy Roper		On Target	9	8			0%
121	Deliver dementia focussed training to STC team	Sarah Fellows/ Kathy Roper		On Target	17	4			0%
122	**Agree a Section 12 /AMHP process with BCPFT**			On Target	5				0%
123	Liase with all relevant parties to get agreement	Sarah Fellows / June Pickersgill		On Target	5	6			0%
124	**Implement Section 12 /AMHP process agreement**	Sarah Fellows / June Pickersgill		On Target	12				0%
125	**AMHP operational in STC**	Sarah Fellows / June Pickersgill		On Target	22				0%
126	**Crisis Concordat Review Planning started**	Kathy Roper		On Target	1	4	1	4	20%
127	**Review existing Crisis Concordat with service users and carers**	Sarah Fellows / Kathy Roper		On Target	5	1			0%
128	Organise stakeholder events	Kathy Roper		On Target	6	3			0%
129	Hold stakeholder events	Sarah Fellows / Kathy Roper		On Target	9				0%
130	**Crisis Concordat Review Completed**	Sarah Fellows / Kathy Roper		On Target	10	2			0%
131	Summary analysis completed and shared for comment	Sarah Fellows / Kathy Roper		On Target	12	2			0%
132	**Crisis Concordat updated**	Sarah Fellows / Kathy Roper		On Target	14				0%
133	**Revised Crisis Concordat implemented**	Sarah Fellows / Kathy Roper		On Target	14				0%
				On Target					
				On Target					
				On Target					
				On Target					
				On Target					
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				On Target					
				On Target					

Mental Health - Action Log

LAST UPDATED **27.04.16**

ID No.	Detail of action	Action to resolve/decision made	Raised by	Owner	Baseline Date	Revised Date	Date Completed	Status	Comments & Updates
4	Crisis Concordat	Review the existing Crisis Concordat key principles with service users/ carers and front line staff	Ann Beach	Sarah Fellows/ Kathy Roper	**31.03.16**		26.04.16	**Closed**	**26.04.16** **Agreed that this work could be carried out at the BCF Stakeholder meeting already set up for 09.05.16** **• KR to draft an outline ploan with AB that follows the already agreed agenda plan for the event.** **Action Closed**
7	BCPFT Consultant rotas	Share flow chart being prepared by Dr Viswanathan with work stream members when available	Ann Beach	Sarah Fellows	**31.03.16**			**Open**	**24.04.16** **C/Fwd from 02.03.16: Dr. Viswanathan agreed to prepare a flow chart** **• Update required at next meeting**
9	Mental Health Liaison	Share details of BCPFT's amended specification and current model with work stream members	Ann Beach	Julian Wenham / Wayne Jasmin	**22.03.16**		26.04.16	**Closed**	**26.04.16** **Sarah to add wording to the SPA/MLS service specification that describes** **• acceptance of referrals from 'appropriate professionals' instead of the routes currently specified.** **• acceptance of reasonable efforts to acquire patient consent as enough for a response/involvement in cases of crisis.** **Action Closed**
11	Mental Health Liaison	Consider how processes can be 'flexed' to reduce the number of MHA assessment requests which is currently higher than the national average	Ann Beach	All	**22.03.16**	**30.06.16**		**Open**	**26.04.16** **Sarah/Lesley to agree a date to meet to look at HSCIC site and refresh existing data** **• Update required at next meeting**
15	Co-location of AMHP's	Develop a revised social care model (recovery, assertive outreach and MHIT services) that aligns to the existing BCPFT model once it has been shared	Ann Beach	June Pickersgill / Lesley Brazier	**11.05.16**			**Open**	**26.04.16** **• Report about the review of EDT is due to be taken to the council's PLT in May 2016** **• June to update at next meeting**
16	Co-location of AMHP's	Ensure full implementation of the revised social care model can be achieved by September 2016	Ann Beach	June Pickersgill / Lesley Brazier	**30.09.16**			**Open**	**26.04.16** **• Sept confirmed as revised date for Bank holiday & weekend co-location of AMHP / support worker** **• Work ongoing to begin HR consultation in May 16**
23	OA CMHT options paper	Paper that was due be presented at ERG in Dec 15 will now be Jan 15	Kira Bradbeer	Dr Viswanathan	**31.01.16**	**30.06.16**		**Open**	**26.04.16** **SF confirmed this options paper will be submitted to ERG in June 2016** **• Sarah to update progress again in May**
24	BCPFT RAS requirements for GP Referral and pre-response Patient Consent	BCPFT to update the group about how the existing referral processes can be flexed to include direct social work professional referral and remove the requirement forpre-response patient consent	Ann Beach	Julian Wenman	**31.05.16**			**Open**	**26.04.16** **Agreed specific text will be added to the service spec to address these sissues** **• See response to action 9**
25	Risk log entries	Add risks identified to MH risk log	Ann Beach	Lesley Brazier / Suzanne Gwilt	**15.04.16**		14.04.16	**Closed**	**26.04.16** **All identified risks added to MH Risk Log** **ACTION CLOSED**
26	NHS Commissioning Guidance	Check the new commissioning guidance in relation to 'responsible owners' and potential impact areas (e.g. Section 117 etc)	Ann Beach	Sarah Fellows / Kathy Roper	**03.05.16**			**Open**	**26.04.16** **Sarah confirmed the new guidance from 01.04.16 has impacts for CCG responsibility in relation to continuation of funding for new out of area in-patient, nursing and residential placements.**
27	Daily A&E call	Check current and intended future status of A&E daily call. (Noted that BCPFT will shortly have 2 staff on duty 7/7 for a fixed term of 1 year	Ann Beach	Sarah Fellows / June Pickersgill	**03.05.16**		26.04.16	**Closed**	**26.04.16** **Sarah understands the daily call is not currently happening.** **Action Closed**
29	SRG Funded AMHP post	Determine whether this post can also cover the Older Adult wards at Penn and act as liaison person with the Older Adults social work team	Ann Beach	June Pickersgill / Lesley Brazier	**03.05.16**		26.04.16	**Closed**	**26.04.16** **Agreed this postholder will also act as coordinator/liaison with the OA teams** **Action closed**

30	Section 117 Guidance	Share and seek agreement for revised Section 117 Guidance	Ann Beach	June Pickersgill	**03.05.16**			**Open**	**<u>26.04.16</u>** **• Lesley to share latest guidance and flow chart with Sarah and Julian** **• Sarah to meet with Steve Phillips, Melvena and Julian** **• BCPFT to consider any staff training requirements** **• June to begin launch event planning**
31	Preventative Services	Review existing preventative services and develop a revised model for the future.	Ann Beach	Sarah Fellows / Kathy Roper	**15.07.16**			**Open**	**<u>26.04.16</u>** **• Kathy confirmed report shared. Consultation to start very soon for two specific contracts and last for 6 weeks** **• Sarah to discuss phased funding approach with Kathy** **• Discussions started with Ian Darch about a single provider or main provider who can manage smaller providers.**
32	Joint Funding Panels	Read the revised terms of reference for the Single Referral Forum which will now operate every alternate Monday .	Ann Beach	All	**19.04.16**		26.04.16	**Closed**	**<u>26.04.16</u>** **Documents and Panel meeting dates shared by Lesley.** **Action Closed**
34	ACCI meeting	Invite Julian Wenman to the next CCG meeting with ACCI	Ann Beach	Sarah Fellows	**27.04.16**			**Open**	**<u>26.04.16</u>** **New action**
35	Dementia options paper	Share the options paper submitted to CCG commissioning committee with Julian Wenman	Ann Beach	Sarah Fellows	**27.04.16**			**Open**	**<u>26.04.16</u>** **New action**
36	Epic Café	Arrange for CPN to liase with and attend the Epic Café (MH hub)	Ann Beach	Julian Wenman	**30.05.16**			**Open**	**<u>26.04.16</u>** **New action**
37		Identify impacts on the hub of changes to Recovery House staff involvement.	Ann Beach	Kathy Roper / Lesley Brazier	**30.05.16**			**Open**	**<u>27.04.16</u>** **• Lesley has arranged to discuss the potebtial impacts with June P and Suzanne Gwilt ASAP** **• Lesley to update at next meeting**
38	Complaint about proposed Recovery House changes	Share notes/ responses already written	Ann Beach	Sarah Fellows	**27.04.16**			**Open**	**<u>26.04.16</u>** **New action**
39	Data Mapping	Set up a meeting with all key participants from CCG, CWC, and BCPFT to identify the information that will need to be shared as part of integrated working arrangements	Ann Beach	Ann Beach	**06.05.16**			**Open**	**<u>26.04.16</u>** **New action**
40	MHA Assessment	Share details of the recent challenge to the legality of an MHA detention with Julian	Ann Beach	Lesley Brazier	**29.04.16**			**Open**	**<u>27.04.16</u>** **Lesley shared details of the MHA section 2 case challenge with Julian .** **• Julian to look into training implications for the Trust and update at next meeting**
41									

Risk ID Code	Raised By	Date Identified	Description (Cause / Event)	Impact	Mitigations Considered / In Place	Target Resolution Date	Risk Owner	Probability score	Impact score	Original PI Score	Probability score	Impact score	Current PI Score	Status	Comments
MH1	Lesley Brazier	12.04.16	There is a risk that due to urgent cost pressures a gap in service of upto 8 weeks will occur as a result of Go Live time differences between the launch of the Assertive Outreach Team (01.07.16) and the 1st Avenue 3 person supported living unit (30.09.16)	**medium**	• Ensure that stakeholder communication about access to other like provision is robust and timely	15.06.16	Lesley Brazier / Suzanne Gwilt	5	2	**10**	5	4	**20**		
MH2			There is a risk that							**0**			**0**	Open	
MH3										**0**			**0**		
MH4										**0**			**0**		
MH5										**0**			**0**		
MH6										**0**			**0**		
MH7										**0**			**0**		
MH8										**0**			**0**		
MH9										**0**			**0**		
MH10										**0**			**0**		
MH11										**0**			**0**		
MH12										**0**			**0**		
MH13										**0**			**0**		
MH14										**0**			**0**		
MH15										**0**			**0**		
MH16										**0**			**0**		
MH17										**0**			**0**		
MH18										**0**			**0**		
MH19										**0**			**0**		
MH20										**0**			**0**		

Mental Health Workstream - Issues Log												Date last Updated	27.04.16
Issue ID Code	Project/ Workstream	Author	Date Identified	Where Identified	Issue Description	Impact (High, Medium, Low)	Issue Owner	Target Resolution Date	Status	Comments	Date Last Updated	Result of Issue	
MH 1						High			Open				
MH 2													
MH 3													
MH 4													
MH 5													
MH 6													
MH 7													
MH 8													

Mental Health - Monthly Highlight Report 2016/17

Filter Mth	Month	RAG	Update (Summary of Activity)	Next Steps (Planned Activity for the next 4 weeks)	Risks (Please confirm is this is logged on Datix and if so include Datix UI number)
1	April (11.03.16 - 15.04.17)	On Target	Liaison with Wolverhampton Homes regarding the future status of the property at 1st Avenue (existing Recovery House) is underway as is social care work to identify 3 suitable clients to live there in supported tenancies	● Identify the first of the three clients for 1st Avenue and start any necessary re-ablement activity ● Confirm Wolverhampton Homes willingness to become the landlord for 1st Avenue	● it may not be possible to identify a suitable client within the time period ● Wolverhampton Homes may not be willing to become the landlord for 1st Avenue
		On Target	Work to develop a specification, source and commission a 2-bed unit with care support has started	● Complete draft specification and progress work to source suitable 2-bed crisis accommodation	
		On Target	SRG funding for 1 FTE AMHP resource for 1 year has been secured. This resource will work closely with BCPFT ward and other staff.	● Notify all relevant parties and ● Advertise 12 month fixed term AMHP post ● Interview for 12 month fixed term AMHP post	
	April (16.04.16 - 20.05.17)				
2	May				

BCF Programme Report high light report - April 2016

Work stream RAG	Month	Status	BCF PMO	Reporting period:
			Green	
			Achievements/Highlights This Period	Next Steps (Planned Activity for the next 4 weeks)
Green	April	On Target	Liaison with Wolverhampton Homes regarding the future status of the property at 1st Avenue (existing Recovery House) is underway as is social care work to identify 3 suitable clients to live there in supported tenancies	● Identify the first of the three clients for 1st Avenue and start any necessary re-ablement activity ● Confirm Wolverhampton Homes willingness to become the landlord for 1st Avenue
		On Target	Work to develop a specification, source and commission a 2-bed unit with care support has started	● Complete draft specification and progress work to source suitable 2-bed crisis accommodation
		On Target	SRG funding for 1 FTE AMHP resource for 1 year has been secured. This resource will work closely with BCPFT ward and other staff.	● Notify all relevant parties and ● Advertise 12 month fixed term AMHP post ● Interview for 12 month fixed term AMHP post

Programme RAG	BCF Mental Health Implementation Plan		On Target Delayed Late Closed		Planned		Actual		%
	Date Last Updated 14.04.16				Planned		Actual		%
#	Milestone	Owner	Update/ Mitigation/ Risk to Completion	Status	Start	Dur	Start	Dur	Done
Reablement & 1st Avenue									
1	**Assertive Outreach job descriptions finalised**	Lesley Brazier/Suzanne Gwilt		On Target	2	1	2	1	50%
2	Service Development Meeting held to work on details of the new service design model	Lesley Brazier/Suzanne Gwilt		On Target	2	1	2		20%
3	Meet with Dave Auger (UNISON) to discuss proposed restructure, including proposed ring fences/assimilation /recruitment process.	Lesley Brazier/Suzanne Gwilt	**21.04.16** Meeting set up with UNISON (Dave Auger) for Wednesday 27 April with June, Lesley and HR (Jas Manku)		2	1	2		20%
4	**Formal HR group consultation begins with employees and relevant TU's.**	Lesley Brazier/Suzanne Gwilt	**21.04.16** Email sent out to all RH workers for staff consultation briefing on 4 May at the civic centre 1200 – 13 00 hrs again with June, UNISON (Dave Auger) and HR (Jas Manku)	On Target	3				0%
5	2 week window to forward comments/suggestions/ring fence & assimilation challenges.	Lesley Brazier/Suzanne Gwilt		On Target	3	2			0%
6	Issue consultation information to employees and	Lesley Brazier/Suzanne Gwilt		On Target	3				0%
7	Manager conducts individual 1-1 consultation	Lesley Brazier/Suzanne Gwilt		On Target	3	2			0%
8	Deadline for submission of comments/ suggestions.	Lesley Brazier/Suzanne Gwilt		On Target	5				0%
9	Deadline for submission of ring fence and assimilation challenge process	Lesley Brazier/Suzanne Gwilt		On Target	5				0%
10	Deadline for submission of voluntary redundancy requests.	Lesley Brazier/Suzanne Gwilt		On Target	5				0%
11	**HR consultation ended**	Lesley Brazier/Suzanne Gwilt		On Target	5				0%
12	Panel meets to consider written submissions to challenge assimilations/ring fence proposals and comments/ suggestions.	Lesley Brazier/Suzanne Gwilt		On Target	6				0%
13	**Panel decisions confirmed to individuals.**	Lesley Brazier/Suzanne Gwilt		On Target	6				0%
14	Meet with TU's and respond to consultation process and thereafter any further changes to be made to the restructure to be circulated to staff at feedback meeting.	Lesley Brazier/Suzanne Gwilt		On Target	7				0%
15	Notify staff of SMR approval.	Lesley Brazier/Suzanne Gwilt		On Target	8				0%
16	Issue at risk letters to staff subject to priority ring fenced recruitment and displaced staff.	Lesley Brazier/Suzanne Gwilt		On Target	8				0%
17	**Start HR Restructure**	Lesley Brazier/Suzanne Gwilt		On Target	8				0%
18	Interviews for G6 & G5 posts	Lesley Brazier/Suzanne Gwilt		On Target	8	3			0%
19	Implement re-structure proposals - assimilations/ring fence/recruitment/redundancy	Lesley Brazier/Suzanne Gwilt		On Target	11	3			0%
20	**Restructure implemented**	Lesley Brazier/Suzanne Gwilt		On Target	14				0%
21	**Identify estate needs for AO Team**	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
22	Determine location requirements	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
23	Determine IT and office space requirements	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
24	Determine access and parking requirements	Lesley Brazier/Suzanne Gwilt		On Target	1	4	1	4	20%
25	**Agree infrastructure & location for AO Team**	Lesley Brazier/Suzanne Gwilt		On Target	5				0%
26	Start re-location planning	Lesley Brazier/Suzanne Gwilt		On Target	5	9			0%
27	End re-location planning	Lesley Brazier/Suzanne Gwilt		On Target	14				0%
28	**AO team re-located**	Lesley Brazier/Suzanne Gwilt		On Target	14				0%
29	**Assertive Outreach Operational**	Lesley Brazier/Suzanne Gwilt		On Target	15				0%
30	**Source 2 bed accomm with care support**	Jacqui McLaughlin		On Target	1	4	1	4	20%
31	Liaise with providers to identify accommodation	Jacqui McLaughlin		On Target	1	4	1	4	20%
32	**Agree Specification**	Jacqui McLaughlin		On Target	5	2			0%
33	**Start tender**	Jacqui McLaughlin		On Target	7				0%
34	Utilise procurement framework processes	Jacqui McLaughlin		On Target	7	10			0%
35	**Agree terms (e.g. outcomes, costs, contract duration etc)**	Jacqui McLaughlin		On Target	17				0%
36	Complete all tender negotiations	Jacqui McLaughlin		On Target	17	3			0%
37	**Award contract**	Jacqui McLaughlin		On Target	20				0%
38	Complete operational arrangements	Jacqui McLaughlin		On Target	20	5			0%
39	**2 bed crisis support accommodation operational**	Jacqui McLaughlin		On Target	26				0%
40	Liaise with Wolverhampton Homes re 1st Ave property	Jacqui McLaughlin		On Target	1		1		20%
41	Start discussions with property services and Wolverhampton Homes to transfer 1st Avenue	Jacqui McLaughlin		On Target	1	6	1	6	15%
42	**Registered social landlord identified**	Jacqui McLaughlin		On Target	7	1			0%
43	Begin property transfer processes	Jacqui McLaughlin		On Target	8	14			0%
44	End property transfer processes	Jacqui McLaughlin		On Target	22	1			0%
45	**Transfer of 1st Ave to registered social landlord completed**	Jacqui McLaughlin		On Target	23	2			0%
46	Complete operational arrangements	Jacqui McLaughlin		On Target	25				0%
47	**Identify 3 Clients**	Lesley Brazier/Suzanne Gwilt		On Target	6	6			0%

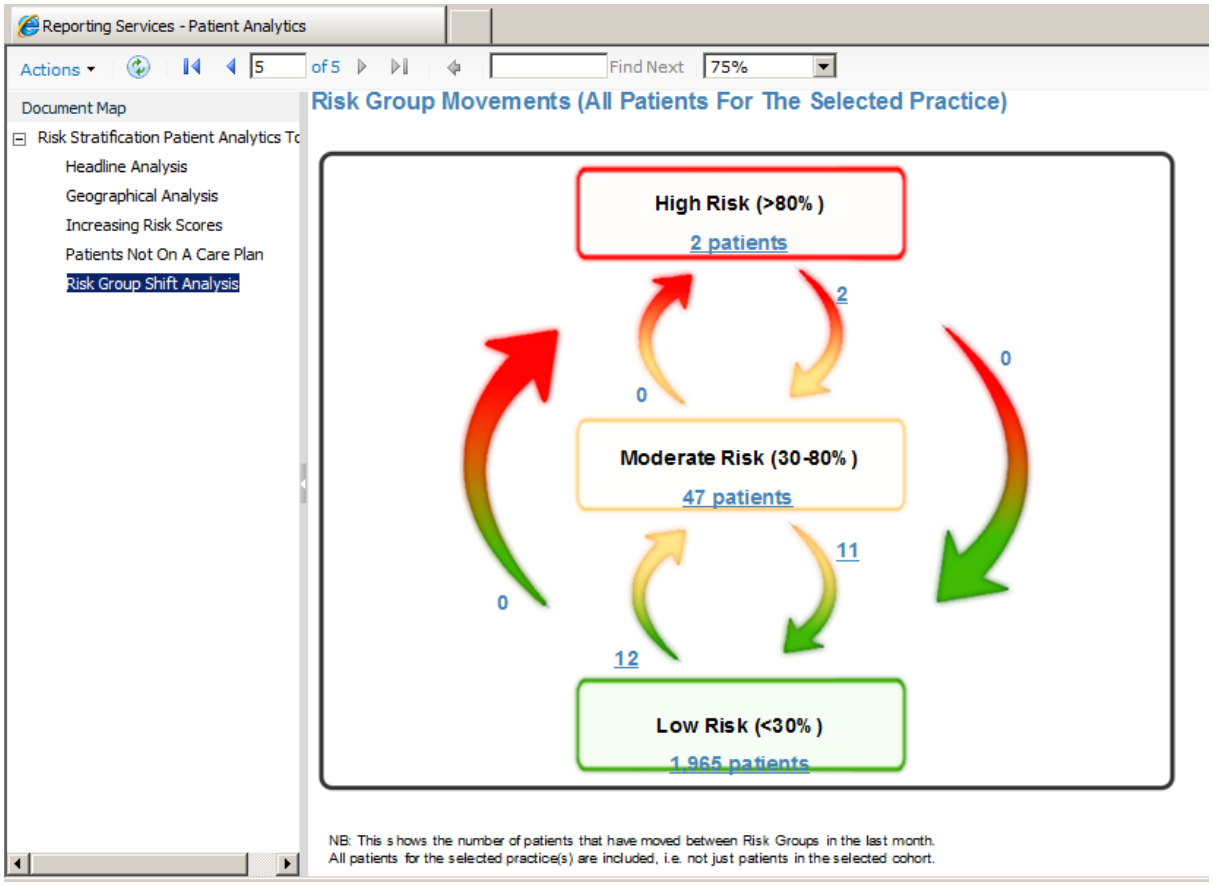
Programme BAG			Delayed		Planned		Actual		%
	Date Last Updated 14.04.16		Late						
			Closed		Planned		Actual		%
#	Milestone	Owner	Update/ Mitigation/ Risk to Completion	Status	Start	Dur	Start	Dur	Done
48	Complete assessment of need reviews	Lesley Brazier/Suzanne Gwilt		On Target	6	6			0%
49	Agree future support plan arrangemnets	Lesley Brazier/Suzanne Gwilt		On Target	13				0%
50	**Develop service spec for supported living provider**	Jacqui McLaughlin		On Target	7	5			0%
51	Agree service specification	Jacqui McLaughlin		On Target	13				0%
52	**Start Tender**	Jacqui McLaughlin		On Target	14				0%
53	Procurement processes started	Jacqui McLaughlin		On Target	14	8			0%
54	Procurement processes completed	Jacqui McLaughlin		On Target	23				0%
55	**Contract awarded**	Jacqui McLaughlin		On Target	24				0%
56	**1st Avenue (3 unit) operational**	Kathy Roper/June Pickersgill		On Target	26				0%
	Steps to Independence								
57	**Scheme S (14 bed low/medium level needs, step down to own tenancies)**	Jacqui McLaughlin		On Target					0%
58	**Identify 14 clients and their associated needs**	June Pickersgill /Lesley Brazier		On Target	1	27	1	27	5%
59	Negotiate care & rent cost models with provider	Jacqui McLaughlin		On Target	3				0%
60	Negotiate access support delivery timescales with provider	Jacqui McLaughlin		On Target	3				0%
61	Develop draft service specification that includes client needs & staff skills sets for forensic users (e.g. arsonists)	Jacqui McLaughlin		On Target	3				0%
62	**Start client assessment & reablement activity**	June Pickersgill /Lesley Brazier		On Target	3	23			0%
63	Develop support plans with clear timescales that enable identified clients to move to new supported living units within specified time periods	June Pickersgill /Lesley Brazier		On Target	3	4			0%
64	Timescales for individual client moves into Scheme S identified	June Pickersgill /Lesley Brazier		On Target	7				0%
65	On-going reablement activity underway	June Pickersgill /Lesley Brazier		On Target	7	16			0%
66	**Start communication activity with Members**	Kathy Roper		On Target	6	6			0%
67	Develop a comms plan that includes councillors and officers	Kathy Roper		On Target	6	1			0%
68	Brief ward councillors and officers	Kathy Roper		On Target	7	5			0%
69	**Support delivery arrangements (activity, timescales and costs) agreed with provider**	Kathy Roper/Jacqui McLaughlin		On Target	12	4			0%
70	ISF mechanisms explored	June Pickersgill /Lesley Brazier		On Target	16	6			0%
71	**ISF mechanisms agreed**	June Pickersgill /Lesley Brazier		On Target	22				0%
72	First client moved into Scheme S	June Pickersgill /Lesley Brazier		On Target	22				0%
73	Other clients move into Scheme S	June Pickersgill /Lesley Brazier		On Target	22	4			0%
74	Last Client moved into Scheme S	June Pickersgill /Lesley Brazier		On Target	26				0%
75	**Project S (14 units) operational**	Kathy Roper/ June Pickersgill		On Target	27				0%
76	**Scheme My Place Woodhayes (14 bed low/medium level needs, step down from hospital/step up from community)**	Kathy Roper		On Target	1	70	1	70	5%
77	**Detail health and social care design input completed for MY Space Woodheyes**	Kathy Roper/Jacqui McLaughlin		On Target	1		1	1	90%
78	**Identify 14 Clients and their associated needs for MY Place units**	June Pickersgill /Lesley Brazier		On Target	1	16	1	16	5%
79	Develop support plans with clear timescales that enable identified clients to move to new supported living units within specified time periods	June Pickersgill /Lesley Brazier		On Target	1	16	1	16	5%
80	**Start client assessment & reablement activity**	June Pickersgill /Lesley Brazier		On Target	9				0%
81	On-going reablement activity	June Pickersgill /Lesley Brazier		On Target	9	20			0%
82	**Developer starts on-site build**	Kathy Roper/Jacqui McLaughlin		On Target	19				0%
83	**Service specification for care support at MY Place developed**	Kathy Roper/Jacqui McLaughlin		On Target	22				0%
84	Timescales for individual client moves into My Place Scheme	Kathy Roper/Jacqui McLaughlin		On Target	25	4			0%
85	Focussed client reablement activity linked to identified timetable for	June Pickersgill /Lesley Brazier		On Target	29	41			0%
86	**Start tender for care provision**	Kathy Roper/Jacqui McLaughlin		On Target	27				0%
87	Procurement processes started	Kathy Roper/Jacqui McLaughlin		On Target	27	32			0%
88	Procurement processes completed	Kathy Roper/Jacqui McLaughlin		On Target	52	7			0%
89	**Provider support contract awarded**	Kathy Roper/Jacqui McLaughlin		On Target	52	8			0%
90	Complete operational arrangements	June Pickersgill /Lesley Brazier		On Target	52	16			0%
91	**Scheme My Place Woodhayes (14 units) operational**	Kathy Roper/June Pickersgill		On Target	52	17			0%
92	**Scheme Tap Works (14 bed low/medium level needs, step down from hospital/step up from community)**	Kathy Roper/Jacqui McLaughlin		On Target	1		1	1	0%
93	**Tap Works wider scheme out for tender**	Kathy Roper/Jacqui McLaughlin		On Target	1		1	1	85%
94	**Developer for Tap Works selected**	Kathy Roper/Jacqui McLaughlin		On Target	9				0%
95	**Detail Design input started**	Kathy Roper/Jacqui McLaughlin		On Target	13				0%
96	**Plans submitted (LDO process)**	Kathy Roper/Jacqui McLaughlin		On Target	22				0%
97	**Identify 14 Clients for Tap Works project**	June Pickersgill /Lesley Brazier		On Target	27				0%

Programme BAG			Delayed		Planned		Actual		%
	Date Last Updated 14.04.16		Late						
			Closed		Planned		Actual		%
#	Milestone	Owner	Update/ Mitigation/ Risk to Completion	Status	Start	Dur	Start	Dur	Done
98	Develop support plans with clear timescales that enable identified clients to move to new supported living units within specified time periods	June Pickersgill /Lesley Brazier		On Target	27	8			0%
99	**Start assessment & reablement activity**	June Pickersgill /Lesley Brazier		On Target	32				0%
100	On-going reablement activity underway	June Pickersgill /Lesley Brazier		On Target	32	40			0%
101	**Plans approved (LDO process)**	Kathy Roper/Jacqui McLaughlin		On Target	35				0%
	Prevention								
102	**Tap Works stakeholder consultation started**	Kathy Roper		On Target	1		1	1	20%
103	Event(s) held	Kathy Roper		On Target	1	11	1	11	15%
104	Feedback analysed and summarised	Kathy Roper		On Target	12	2			0%
105	**Service specification finalised and agreed**	Kathy Roper		On Target	14				0%
106	**Tender process started**	Kathy Roper		On Target	14				0%
107	Procurement processes started	Kathy Roper		On Target	14	16			0%
108	Procurement processes completed	Kathy Roper		On Target	30				0%
109	**Contract awarded**	Kathy Roper		On Target	31				0%
110	Complete operational arrangements	Kathy Roper		On Target	31	8			0%
111	**Existing contracts cease**	Kathy Roper		On Target	39				0%
112	**Single joint prevention service operational**	Kathy Roper		On Target	40				0%
	Community Recovery								
113	**16/17 AMHP funding secured**	Sarah Fellows / June Pickersgill	Funding secured - TASK CLOSED	On Target	1		1	1	100%
114	**AMHP resource into acute wards confirmed**	Sarah Fellows / June Pickersgill	Funding secured - TASK CLOSED	On Target	2		2	1	90%
	Urgent Care Pathway								
115	**16/17 Street Triage Car (STC)funding secured**	Sarah Fellows	Funding secured - TASK CLOSED	On Target	1		1	1	100%
116	**Dedicated STC AMHP opportunity developed**	Sarah Fellows / June Pickersgill		On Target	1		1	1	100%
117	SRG Funding secured	Sarah Fellows		On Target	1	16	1	16	20%
118	AMHP Recruitment completed	Sarah Fellows / June Pickersgill		On Target	17				0%
119	**Start Dementia focus work/training for STC staff**	Sarah Fellows / June Pickersgill		On Target	9				0%
120	Liaise with dementia work stream leads and agree appropriate training mechanisms	Sarah Fellows/ Kathy Roper		On Target	9	8			0%
121	Deliver dementia focussed training to STC team	Sarah Fellows/ Kathy Roper		On Target	17	4			0%
122	**Agree a Section 12 /AMHP process with BCPFT**			On Target	5				0%
123	Liase with all relevant parties to get agreement	Sarah Fellows / June Pickersgill		On Target	5	6			0%
124	**Implement Section 12 /AMHP process agreement**	Sarah Fellows / June Pickersgill		On Target	12				0%
125	**AMHP operational in STC**	Sarah Fellows / June Pickersgill		On Target	22				0%
126	**Crisis Concordat Review**			On Target	5				0%
127	**Review existing Crisis Concordat with service users and carers**	Sarah Fellows / Kathy Roper		On Target	5	1			0%
128	Organise stakeholder events	Kathy Roper		On Target	6	3			0%
129	Hold stakeholder events	Sarah Fellows / Kathy Roper		On Target	9				0%
130	**Crisis Concordat Review Completed**	Sarah Fellows / Kathy Roper		On Target	10	2			0%
131	Summary analysis completed and shared for comment amendment	Sarah Fellows / Kathy Roper		On Target	12	2			0%
132	**Crisis Concordat updated**	Sarah Fellows / Kathy Roper		On Target	14				0%
133	**Revised Crisis Concordat implemented**	Sarah Fellows / Kathy Roper		On Target	14				0%

Aristotle Risk Stratification – Software Summary

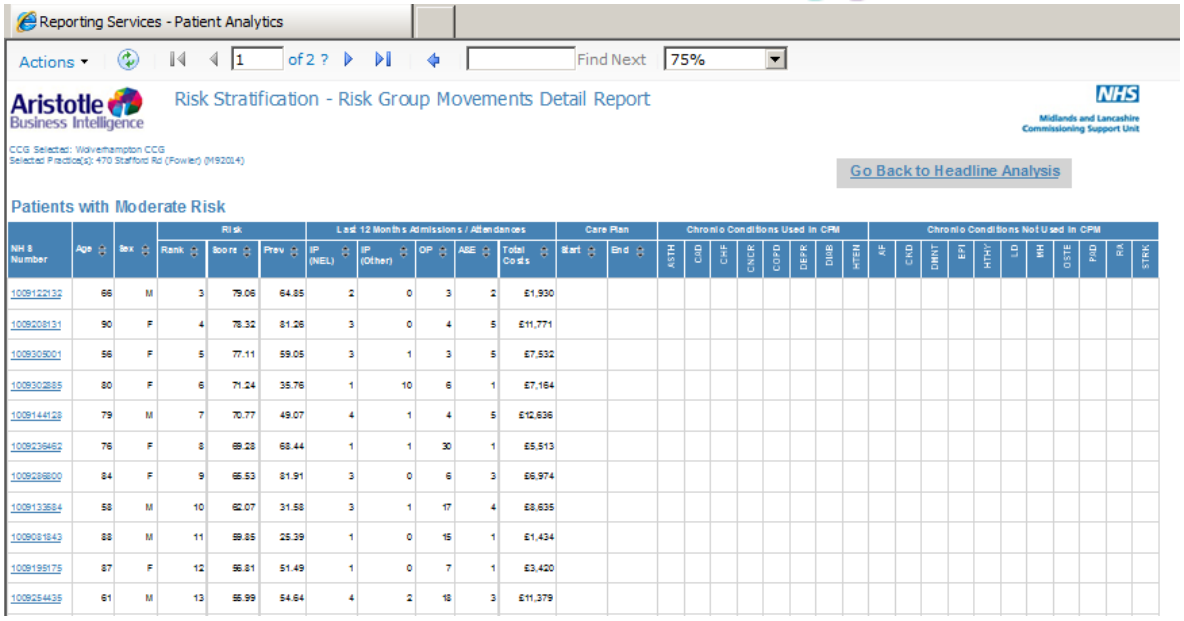
Below is a summary of the key functionality that will be most useful for Risk Stratification of patients as part of the Better Care Fund initiative.

Risk Group Movements

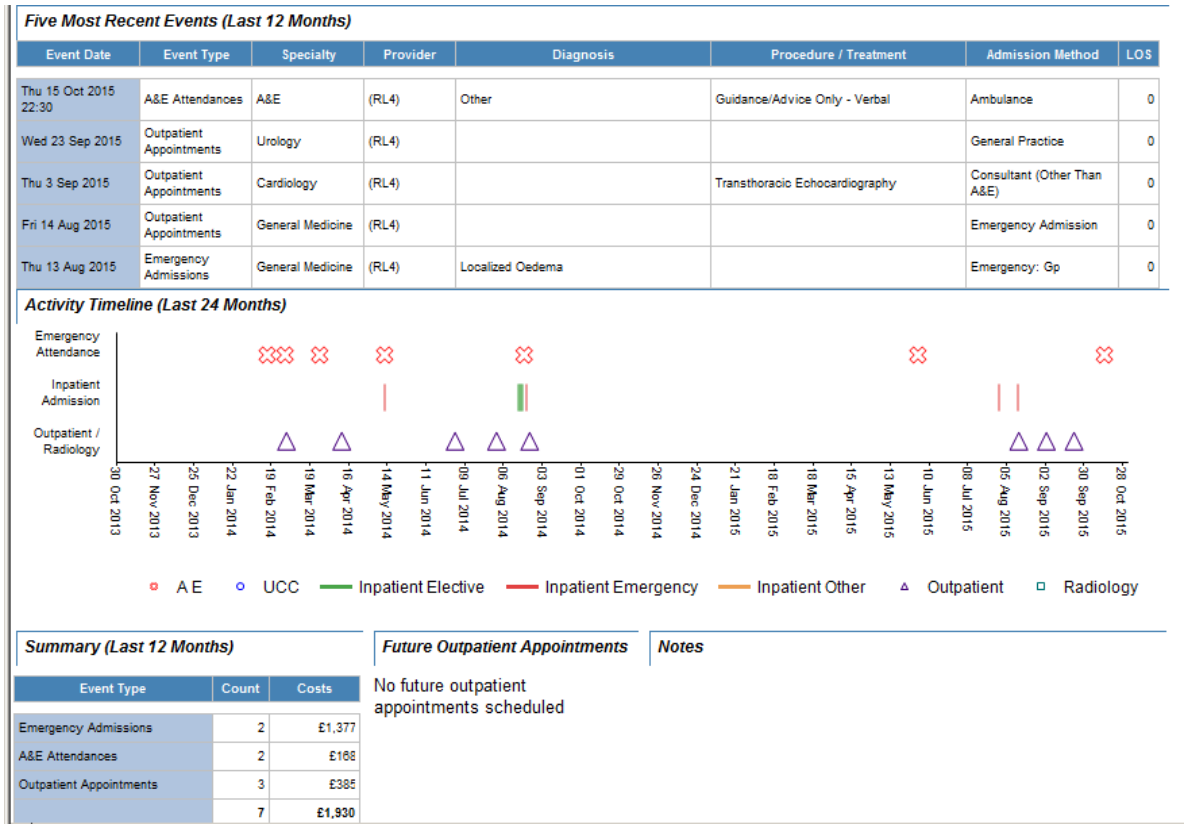


This report shows the movement between Risk Groups for single or multiple GP Practices. Note that the movement between the groups and total numbers are constantly moving to take into account patient risk score ratings, migration and mortality.

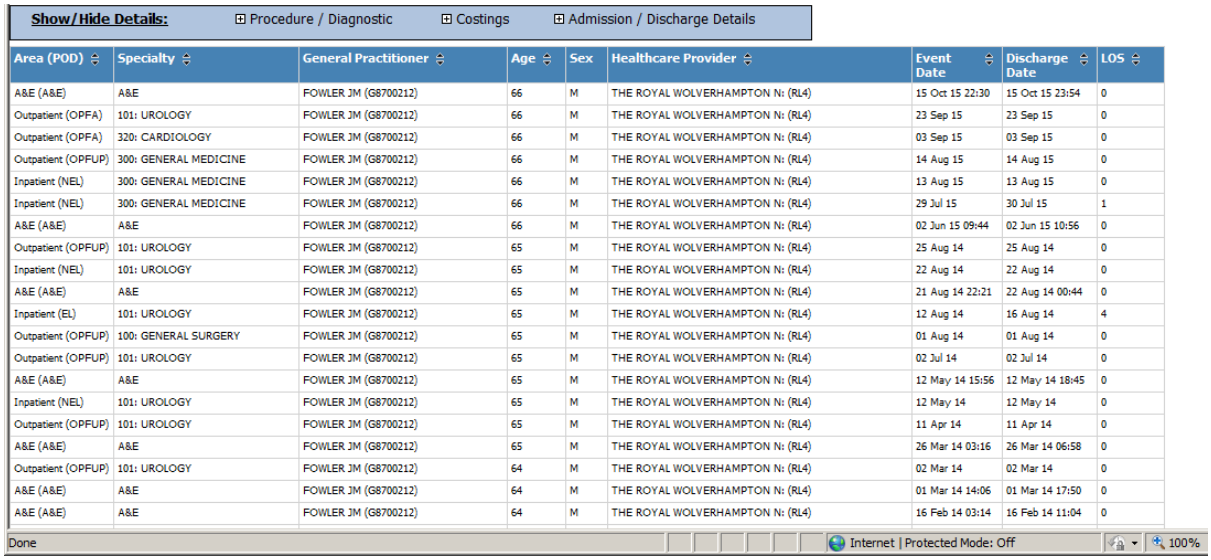
Each number is a hyperlink which enables the user to drill down into more detail as shown on the next page to view a list of patients.



More detail can be obtained in a Patient Profile view for individual patients by clicking the NHS Number hyperlink:



For even more granular information to help explain risk score ratings a Patient Activity report can be opened and expanded with additional information around Procedure / Diagnostic, Costings, Admissions / Discharge Details.



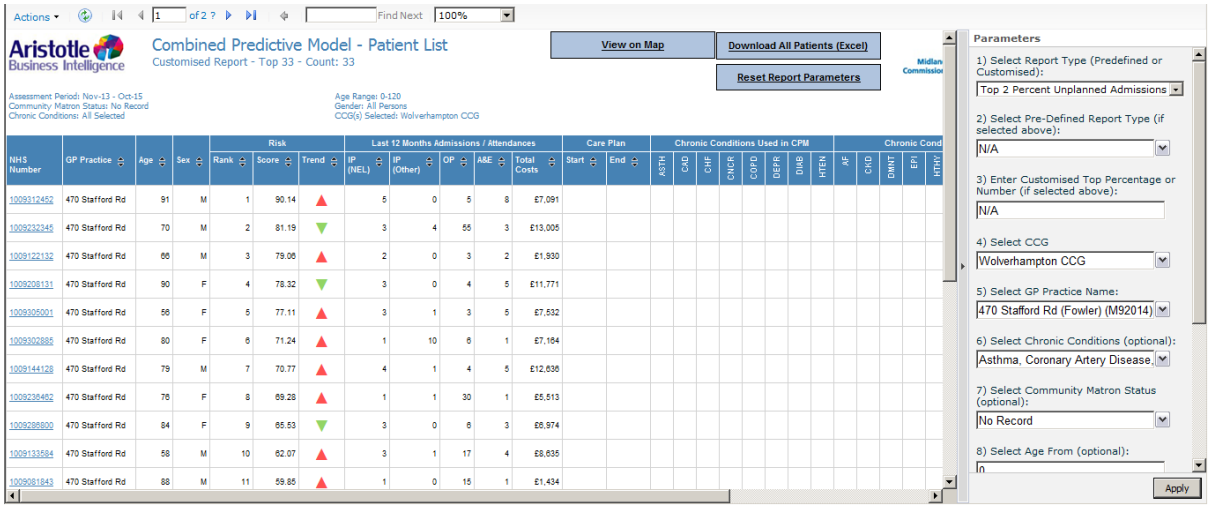
Show/Hide Details: ⊞ Procedure / Diagnostic ⊞ Costings ⊞ Admission / Discharge Details

Area (POD)	Specialty	General Practitioner	Age	Sex	Healthcare Provider	Event Date	Discharge Date	LOS
A&E (A&E)	A&E	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	15 Oct 15 22:30	15 Oct 15 23:54	0
Outpatient (OPFA)	101: UROLOGY	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	23 Sep 15	23 Sep 15	0
Outpatient (OPFA)	320: CARDIOLOGY	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	03 Sep 15	03 Sep 15	0
Outpatient (OPFUP)	300: GENERAL MEDICINE	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	14 Aug 15	14 Aug 15	0
Inpatient (NEL)	300: GENERAL MEDICINE	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	13 Aug 15	13 Aug 15	0
Inpatient (NEL)	300: GENERAL MEDICINE	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	29 Jul 15	30 Jul 15	1
A&E (A&E)	A&E	FOWLER JM (G8700212)	66	M	THE ROYAL WOLVERHAMPTON N: (RL4)	02 Jun 15 09:44	02 Jun 15 10:56	0
Outpatient (OPFUP)	101: UROLOGY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	25 Aug 14	25 Aug 14	0
Inpatient (NEL)	101: UROLOGY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	22 Aug 14	22 Aug 14	0
A&E (A&E)	A&E	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	21 Aug 14 22:21	22 Aug 14 00:44	0
Inpatient (EL)	101: UROLOGY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	12 Aug 14	16 Aug 14	4
Outpatient (OPFUP)	100: GENERAL SURGERY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	01 Aug 14	01 Aug 14	0
Outpatient (OPFUP)	101: UROLOGY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	02 Jul 14	02 Jul 14	0
A&E (A&E)	A&E	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	12 May 14 15:56	12 May 14 18:45	0
Inpatient (NEL)	101: UROLOGY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	12 May 14	12 May 14	0
Outpatient (OPFUP)	101: UROLOGY	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	11 Apr 14	11 Apr 14	0
A&E (A&E)	A&E	FOWLER JM (G8700212)	65	M	THE ROYAL WOLVERHAMPTON N: (RL4)	26 Mar 14 03:16	26 Mar 14 06:58	0
Outpatient (OPFUP)	101: UROLOGY	FOWLER JM (G8700212)	64	M	THE ROYAL WOLVERHAMPTON N: (RL4)	02 Mar 14	02 Mar 14	0
A&E (A&E)	A&E	FOWLER JM (G8700212)	64	M	THE ROYAL WOLVERHAMPTON N: (RL4)	01 Mar 14 14:06	01 Mar 14 17:50	0
A&E (A&E)	A&E	FOWLER JM (G8700212)	64	M	THE ROYAL WOLVERHAMPTON N: (RL4)	16 Feb 14 03:14	16 Feb 14 11:04	0

Done | Internet | Protected Mode: Off | 100%

Top 2% Unplanned Admissions

A list of the top 2% of unplanned admissions can be quickly produced and exported from Aristotle. This data can then be imported into practice patient administration systems.



<u>For booking WebEx, 1:1 or Classroom training sessions please contact:</u>

Linda Dobson	0121 612 1496	linda.dobson5@nhs.net
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Better Care Fund – Risk Stratification Summary Objectives:

Case for change

- Ageing population
- Increasingly complex comorbid health problems
- Increased demand on hospital services
- Increased used of nursing and residential home placements
- Economic position requiring financial efficiency enhancements

Programme Objectives

- A shift from hospital to community care, from residential care to home care, from service led to more personalised support for those who require it.
- Patients being managed more effectively in the community
- To develop and deliver Wolverhampton's transformational approach to fully integrated Community Neighbourhood Teams (CNTs).
- Through integrated working, it is felt that impact could be had on reducing avoidable attendances and emergency admissions in Wolverhampton.
- Plan for integration of primary care, social services, local authority and secondary care in line with BCF plans.
- To reduce unplanned admissions by focusing on Long Term Conditions
- Risk Stratification and Case Management via Multi-Disciplinary Teams (MDTs), in conjunction and close collaboration with Primary Care and GP practices
- Reduce Emergency admissions by monitoring patients with:
    - Long Term Conditions to improve management of their condition(s)
    - Frequent attendance at A&E or emergency admissions particularly where there is a 0 length of stay and with no procedures carried out
- Reduce Delayed Transfers of Care (DTOC's)
- Increased Dementia Diagnosis
- Reduce nursing and residential home placements
- A reduction in UCC, A&E and Walk in Centre attendances by monitoring patients:
    - likely to attend due to **Abdominal Pain, UTI, Falls and Chest Pain**
    - over 75 and high attenders

Out of Scope:

- 0-17s are out of scope of this workstream

Going Forwards

- There will be three Community Neighbourhood Teams, initially one based in each locality, eventually being co-lated utilising existing health or social care premises using a fully integrated single Operating Model
- Patients will be Risk Stratified to identify medium - high risk patients
- There will be the allocation of a care co-ordinator to patients on the caseload of a Community Neighbourhood Team.

The notion is that this knowledge will be carried forward into MDT's so that these patients can be correlated with "known" patients to determine whether they are in receipt of a care plan and if not, begin to develop one to lower the risk and case manage the patient in the community.

Background Headline Information

- Wolverhampton has a population of approximately 262,000. Approximately 31% of the Wolverhampton population are currently registered on a chronic condition register
- The Department of Health estimates that there will be a 30% increase in the number of people with three or more long term conditions between 2010 and 2020.
- The cost of Emergency Admissions with one or more Long Term Condition Diagnosis between Apr 14 & Mar 15 was £31,639,044
- The Department of Health estimates that the average cost of providing hospital and community health services for a person aged 85 and over is around three times greater than for a person aged 65 to 74.

There is an upward trend in emergency admissions for people aged over 65 as well as a higher than national average representation of this age group across the City. Without any intervention in the current pathway this group will present our greatest challenge in managing demand for hospital services. We also know that an admission to hospital for older people quickly reduces ability so that rehabilitation and reablement potential is diminished this in turn results in an increased risk of admission to permanent residential care and we know from public consultation that the majority of people would prefer to stay in their own homes whenever possible.

At present, multi-disciplinary teams are meeting monthly across the 3 localities to assess caseloads and discuss high risk patients within the community. We are aiming to enhance the effectiveness of these teams by bringing the teams together with GP practices to use the Risk Stratification tool and to discuss the most appropriate patients for proactive management.

Source Documents:
Better Care Fund – Redesign of Community Service Models and Pathways V0.1
Primary and Community Care Business Outline V0.9

BETTER CARE FUND
PROGRAMME BOARD

Date of Meeting: 21/04/2016

Subject: Performance & Finance Monitoring for the Better Care Fund
Period 11 (end of February) - Finance
February Update - Performance

Author: Helena Kucharczyk (Business Intelligence Manager - WCC)
Alison Shannon (Finance Lead – WCC)
Supporting data provided by Mark Taylor (Business Insight Lead – Midlands and Lancashire CSU)

Responsible Core Group: Finance and Information

Key Points:

- Period 11 (February) finance summary is reported.
- February data for Emergency Admissions & DTOCS is now available.
- The number of Emergency Admissions, as measured by MAR data, has increased in January and February compared with December
- DTOCS has improved significantly in January and February.

1.0 Purpose and Summary

1.1 The purpose of this report is to update the Board on the draft finance out-turn position following the period 11 (end of February) monitoring and the forecast cost pressures in line with the risk sharing agreement for each organisation.

1.2 It will also provide the Better Care Fund Programme Board with an update of current performance against the key Payment for Performance Indicator and relevant supporting indicators.

2.0 Background

2.1 The Finance and Information Core Group have lead responsibility for undertaking and implementing monitoring of the programme's financial position and activity and ensuring that the BCF Oversight Group and BCF Programme Board are apprised of the current situation and any potential issues.

2.2 This report focuses on the performance reporting element of the programme with a financial summary included.

3.0 Financial Implications

3.1 The financial monitoring as at period 11 (end of February) is showing a revenue cost pressure across the pooled fund of £4.6 million. The forecast cost pressure for each organisation is as follows:

CCG - £3.1 million
WCC - £1.5 million

3.2 This is broken down across the following workstreams:

Workstream	Budget £000	Forecast Out-turn £000	Variance £000	Risk Sharing £000	
				CCG	CWC
Community and Primary Care	21,019	22,191	1,172	856	316
Dementia	4,606	4,642	36	33	3
Mental Health	9,443	9,770	327	229	98
Intermediate Care	35,795	35,917	122	69	53
Sub Total	**70,863**	**72,520**	**1,657**	**1,187**	**470**
Capital Ring Fenced grant	2,085	2,085	-	-	-
Savings Targets					
Demographic Growth Target	2,000	-	2,000	1,320	680
Care Act Target	964	-	964	636	328
Cost Pressure	**2,964**		**2,964**	**1,956**	**1,008**
Overall Total Risk			**4,621**	**3,143**	**1,478**

3.3 Period 11 has seen a net increase in the cost pressures of £747,000 from the previous month.

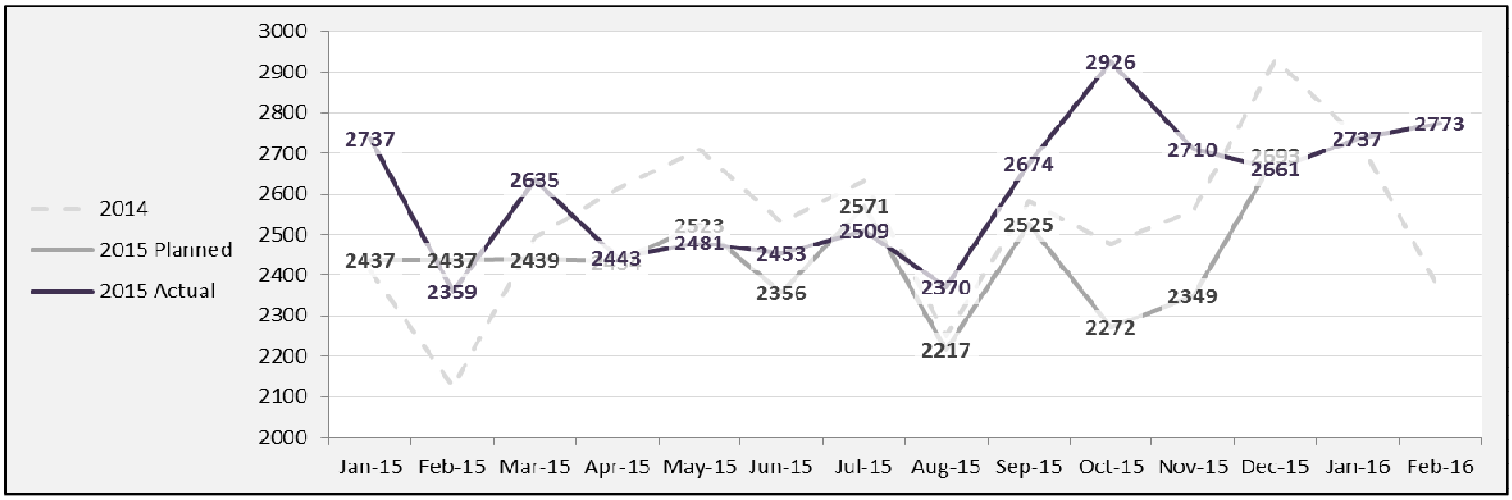
3.4 In addition to the pressures noted above, there is also the Payment for Performance (P4P) element of the pool to consider. The CCG is underwriting any non-achievement of P4P in 2015/16. The target has not met so far during the year. Whilst there is an opportunity to recoup the position over the rest of the year to mitigate the scale of the impact this is unlikely so late in the financial year; therefore P4P will not be achieved.

4.0 Current Performance - Emergency Admissions

4.1 December 2015 was the last month that plans were in place as part of BCF for emergency admissions. Emergency admissions are not a key measure for 2016/17, although it is likely to continue to be measured in some capacity, however, measurement will be undertaken using the SUS data rather than the MAR data.

Although plans did not extend to January and February, while the new measurements are being developed, performance for the latest 2 months is shown below and indicates that emergency admissions as measured by MAR continue to increase compared with the same period last year

Month on Month Performance	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
2014	2410	2124	2493	2614	2710	2531	2632	2251	2580	2478	2561	2930	2737	2359
2015 Planned	2437	2437	2439	2434	2523	2356	2571	2217	2525	2272	2349	2693	N/A	N/A
2015 Actual	**2737**	**2359**	**2635**	**2443**	**2481**	**2453**	**2509**	**2370**	**2674**	**2926**	**2710**	**2661**	**2737**	**2773**

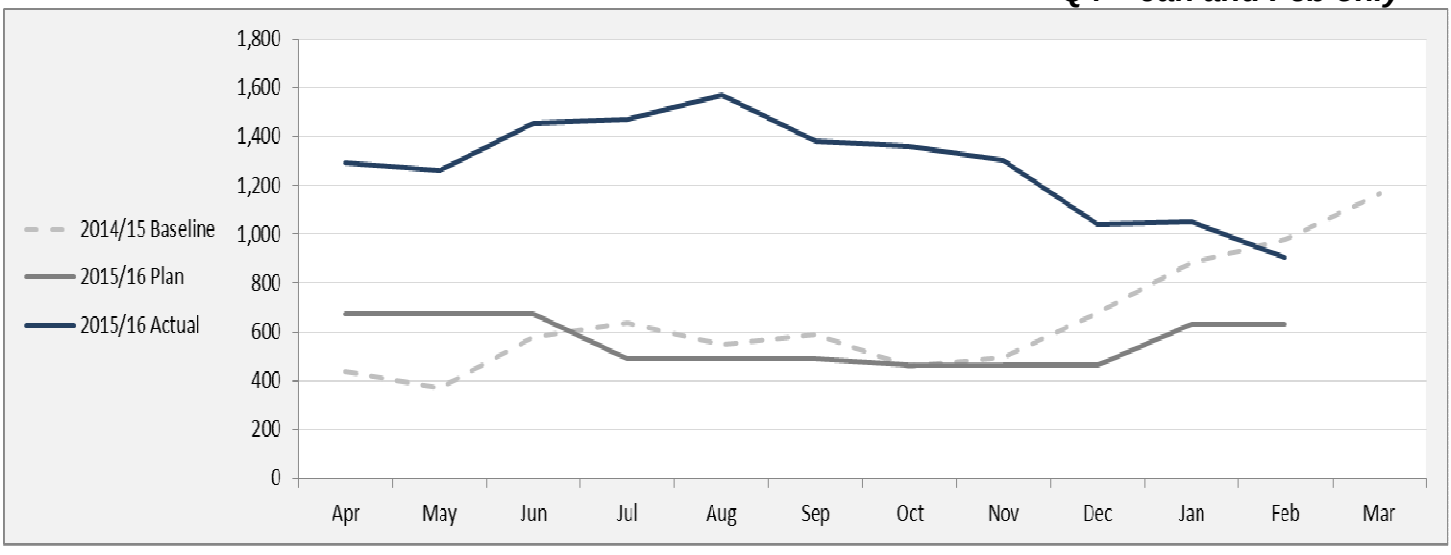


5.0 Delayed Transfers of Care (DTOCS)

5.1 February DTOCS data shows that the number of delayed days continues to decrease with delayed days in February being below the same period last year. This is the first time in over 12 months that performance has been better than the same period in the previous year.

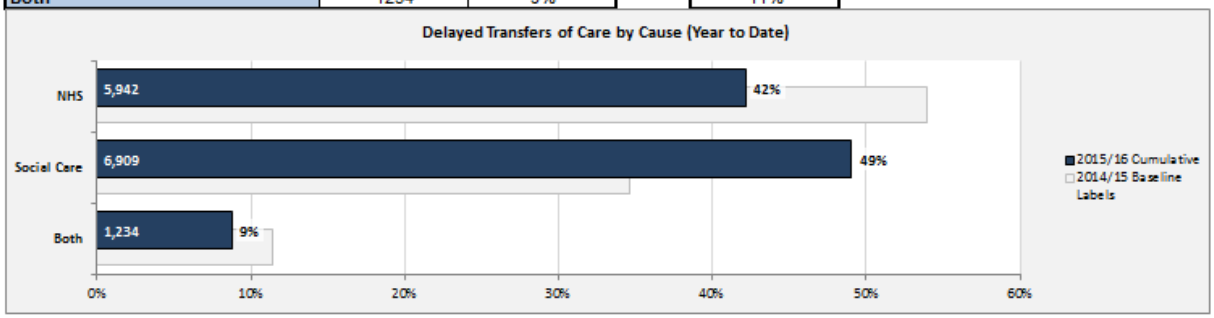
Metric	13/14 plans (revised)	Q1 (Apr 13 - Jun 13)		Q2 (Jul 13 - Sep 13)		Q3 (Oct 13 - Dec 13)		Q4 (Jan 14 - Mar 14)	
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	**1055**		**770**		**728**		**986**	
	Numerator	2054		1500		1418		1929	
	Denominator	194708		194708		194708		195605	
	14/15 plans (revised)	**Q1 (Apr 14 - Jun 14)**		**Q2 (Jul 14 - Sep 14)**		**Q3 (Oct 14 - Dec 14)**		**Q4 (Jan 15 - Mar 15)**	
		Plan	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
	Quarterly rate	**1044**	**709**	**761**	**906**	**718**	**833**	**976**	**1543**
	Numerator	2042	1386	1488	1773	1405	1630	1916	3029
	Denominator	195605		195605		195605		196274	
	15-16 plans (revised)	**Q1 (Apr 15 - Jun 15)**		**Q2 (Jul 15 - Sep 15)**		**Q3 (Oct 15 - Dec 15)**		**Q4 (Jan 16 - Mar 16)**	
		Plan	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**	**Plan**	**Actual**
	Quarterly rate	**1033**	**2041**	**750**	**2253**	**708**	**1887**	**966**	**993**
	Numerator	2027	4006	1473	4423	1390	3703	1901	1954
	Denominator	196274		196274		196274		196857	

Q4 = Jan and Feb only

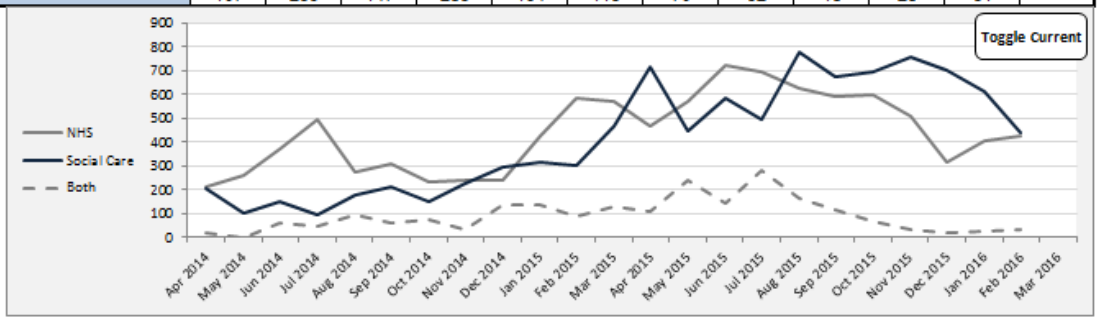


5.2 The proportion of delayed days that are the responsibility of Social Care has increased throughout the year, although in February the number of delayed days that are the responsibility of social care has fallen significantly compared to previous months and the number of delays that are the responsibility of NHS has increased:

Cause of DTOC (cumulative)	2015/16 Cumulative Number	2015/16 Cumulative Proportion	2014/15 Baseline Proportion
NHS	5,942	42%	54%
Social Care	6,909	49%	35%
Both	1234	9%	11%

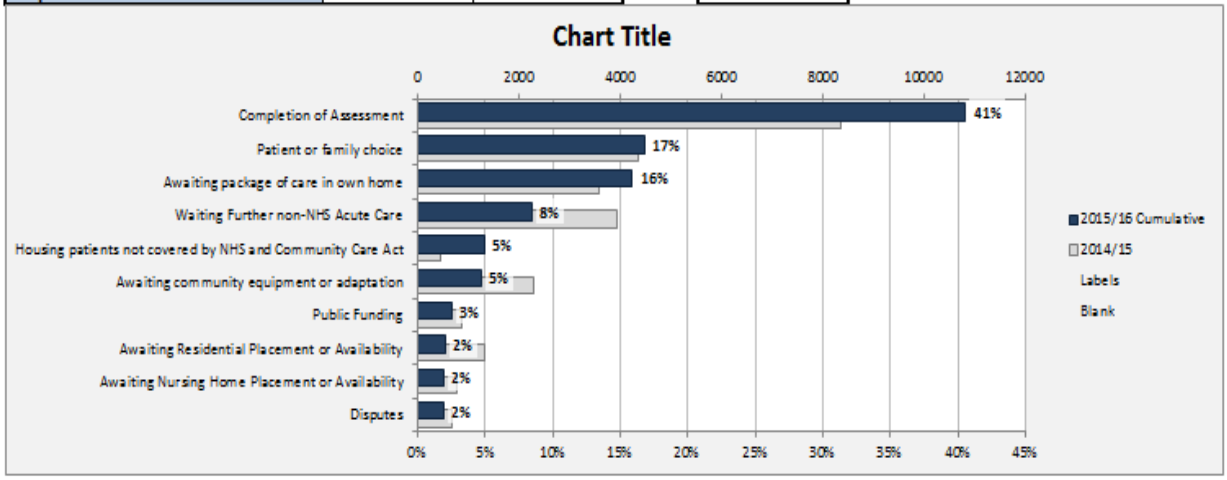


Cause of DTOC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	469	573	721	694	630	591	596	510	319	409	430	
Social Care	714	449	586	493	777	676	694	759	705	613	443	
Both	107	239	147	285	164	113	70	32	18	28	31	



5.3 The proportion of delays that are due to patients waiting for assessment continues to increase and almost one fifth of delays are due to patient or family choice.

Reason for DTOC	2015/16 Cumulative Number	2015/16 Cumulative Proportion	2014/15 Proportion
Completion of Assessment	5,715	41%	31%
Patient or family choice	2,365	17%	16%
Awaiting package of care in own	2,242	16%	13%
Waiting Further non-NHS Acute	1,187	8%	15%
Housing patients not covered by	707	5%	2%
Awaiting community equipment	669	5%	9%
Public Funding	363	3%	3%
Awaiting Residential Placement or	295	2%	5%
Awaiting Nursing Home	275	2%	3%
Disputes	267	2%	3%



6.0 Measures for 2016/17

The first submission for the 16/17 BCF plans included the first attempt at planning the metrics and performance for next year. There have been further revisions since last month's report and the current plans are shown below. Notably the "% of individualised management plans for patients in residential homes" has been replaced with "New supported living placements for people with mental health issues"

6.1 :

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17
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	644.8	638.0	638.0	581.9
	Numerator	273	273	273	252
	Denominator	42,338	42,787	42,787	43,307
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.5%	94.3%	79.3%	80.3%
	Numerator	330	330	340	490
	Denominator	410	350	429	610
New supported living placements for people with mental health issues	Metric Value				17 placements
	Numerator				
	Denominator				
Overall satisfaction of people who use services with their care and support	Metric Value	69.0%	70.0%		70.0%
	Numerator		235.0		235.0
	Denominator		340.0		340.0

		15-16 plans				15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				16-17 plans			
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	1032.7	750.5	708.2	965.7	2040.5	2253.5	1886.7	1590.0	1447.8	1104.9	800.1	1051.0
	Numerator	2,027	1,473	1,390	1,901	4,005	4,423	3703	3130	2850	2175	1575	2075
	Denominator	196,274	196,274	196,274	196,857	196,274	196,274	196,274	196,857	196,857	196,857	196,857	197,432

7.0 Reporting Framework Update and Next Steps

7.1 Work is now being undertaken to identify the targets against the key indicators for the 16/17 plan. Initial targets have been set; however, these will have to be refined further over the coming weeks to ensure that they are ambitious but realistic and achievable.

7.2 Following agreement of the indicators and targets the performance framework will be reviewed and strengthened to ensure that it is in a strong place for the start of the financial year.

7.3 The City of Wolverhampton Council has procured the PI Care and Health Trak system and is in the process of agreeing the content and delivery timescales. This will provide access to much more detailed information about health and social care needs across the City.

Theory of Change: Prevention & Well-being

FOR DISCUSSION/ CONSULTATION

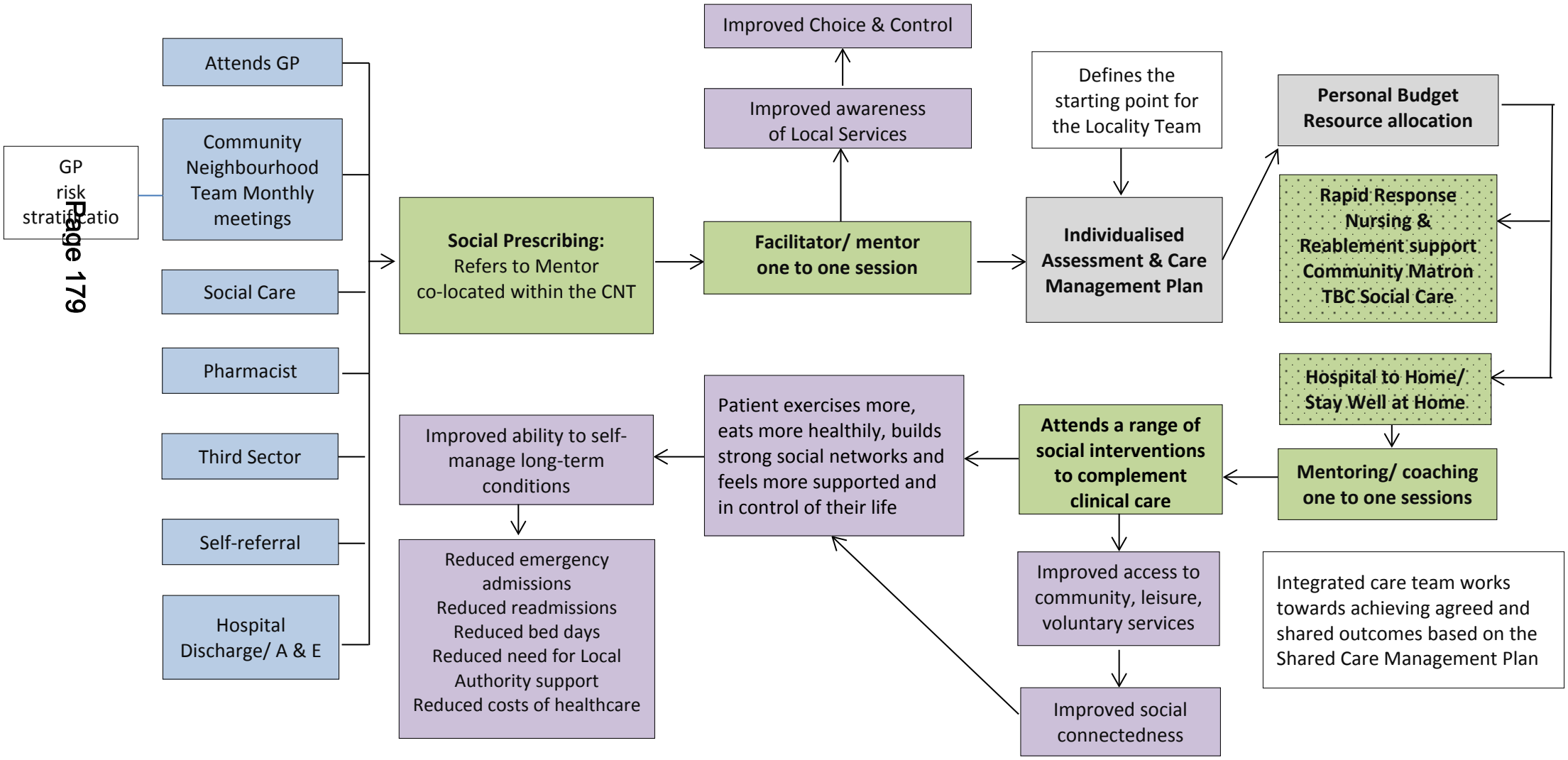
Cohort:
No Social Care Plan
At risk of (re/)admission
Living alone
Poverty (pension credit)

Key

	Outcomes
	New Interventions/
	Existing Interventions
	Outputs
	Referrals

Partnership approach

- Focus on patients' goals and outcomes, through care planning across an entire pathway and a system of referral and social prescription that incorporates nonmedical provision.
- Changing format to provide flexible, alternative structures according to what is most useful to the patient, not most convenient to the institution.
- Changing relationships to value patient experience and new professional and non-professional roles as sources of expertise



Integrated care team works towards achieving agreed and shared outcomes based on the Shared Care Management Plan

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Wolverhampton

Overarching Information Sharing Protocol

Version 1.9

Version 1.6

Document references

Version	Version 1.9 Draft for final virtual sign off by WISG members
Date	March 2015
Author	Raz Bassi – Information Governance Lead- Royal Wolverhampton NHS Trust Anna Zollino-Biscotti – Senior Information Governance Officer – Wolverhampton City council

Change History

Version	Date	Description of change
1.0	June 2011	Draft
1.1	August 2011	Amendments to section 14. 4.1 following feedback.
1.2	September 2011	Amendments following feedback.
1.3	October 2011	Amendments to section 7.1 & 13.1 following feedback
1.4	October 2011	Amendments following feedback.
1.5	October 2011	Amendments following review by Dilys Jones Associates. Amendments also made to 14.2.
1.6	November 2011	WCC Legal sign off
1.7	December 2014	Review At WISG - Raz Bassi to incorporate feedback
1.8	Jan 2015	Comments added, circulated again for review. Changes to tier two and three templates.
1.9	March 2015	Final amendments made. Document circulated for Final Virtual sign off

With Thanks to:

Wolverhampton City Council and its partners acknowledge the work that Kent & Medway undertook to produce this structure on which this document is based.

This high level document has been jointly further developed by public sector organisations in Wolverhampton, to facilitate the sharing of information amongst key organisations.

Table of Contents

1 Executive summary

- This document is an overarching information sharing protocol for inter-agency information sharing within Wolverhampton. It does not impose any new obligations, but reflects current regulations and legislation.

- This protocol sets out the agreed standards that staff in public, voluntary and independent partner organisations must adhere to. It is intended to complement any existing professional Codes of Practice that apply to any relevant professionals working within partner agencies.

2 Introduction

- It is recognised that effective information sharing is required in order to enable organisations to improve client services, protect the public and respond to statutory requirements. Organisations also recognise the importance of having clear guidelines to follow and ensuring that this information is shared in a secure and confidential manner and in accordance with the law, including the Common Law of Confidentiality, the Data Protection Act 1998, the Human Rights Act 1998 and other related legislation and guidance.This overarching Information Sharing protocol (and appendices) comprises of a set of rules that the organisations identified in section 10 agree to comply with when sharing any personal information with another partner agency. It sets out the standards that staff must follow when sharing personal data to ensure that legislation is not breached and that confidentiality is maintained.

- The sharing of anonymised or purely statistical information is outside of the remit of this protocol, as the majority of legislation and rules concern only the sharing of personal information. However, the Purpose Specific Information Sharing Agreement (PSISA) template created under this protocol can be used to form a basis for the sharing of anonymised or statistical information.

- Signatories to this overarching protocol must be the highest level official within the partner organisation (e.g. Wolverhampton Council's Chief Executive). This high level commitment is recognition that information sharing is a key strategic objective of the partnerships within Wolverhampton.

- This Overarching Information Protocol (Tier 1) is the highest level in the protocol structure and applies to all sharing of personal information. Please refer to Section 4 – Structure, for an outline of the protocol structure.

3 Purpose

3.1. Overarching Objectives

To provide a robust policy framework for the legal, secure and confidential sharing of personal information between partner agencies within Wolverhampton, in order to enable them to meet both their statutory obligations and the needs and expectations of the people who they serve.

3.2. Strategic Objectives

- To deliver integrated public sector services in line with government initiatives and requirements,
- To facilitate the management and planning of effective and efficient services; and
- To enable parties to this Protocol to review, account for and improve on what they do through shared working and information sharing.

3.3. General Objectives

- Clarifies the legal background on information sharing
- Outlines the principles that are needed to underpin the process
- Provides practical guidance on how to share information in a series of supporting procedures
- Provides a framework within which organisations can develop Information Sharing Agreements between specific services or information communities.
- Includes arrangements for reviewing the use of this Protocol and for responding to breaches of this Protocol, any Information Community Agreements or Purpose Specific Information Sharing Agreements (PSISA).

4 Structure

4.1. Protocol Tier Structure

Tier 1 – Wolverhampton Overarching Information Sharing Protocol.

This document is a high-level policy document common to all organisations delivering health, social and community services, across Wolverhampton. It describes a common set of **principles** and defines the general parameters within which the signatory organisations will share information with each other. This document establishes ownership and transparent agreement to the spirit of information sharing in the best interests of service users and their families and carers, and it commits those who sign it to sharing information lawfully, ethically and effectively at all levels of their organisation. This Tier One document provides the context for the underlying tiers in the model.

The Overarching Policy is to be signed by Chief Executives (or equivalent) and by their Caldicott Guardians (or Designated Officers).

Tier 2 – Information Community Agreements

These documents are high-level agreements common to organisations delivering health, social and community services. They satisfy the Tier Two level of the Three-Tier Model for Information Sharing and focuses on the collective **purposes** underlying the sharing of information within the 'Information Community'. Tier Two documents describe common contexts and shared objectives between agencies delivering services of a similar scope. They reference the relevant underpinning legislation and the associated duties and powers that enable legally justifiable exchanges of information within the same Information Community. They also provide context for a supporting set of individual information sharing agreements (Tier 3) that determine at a detailed level, how personal information can be shared amongst organisations with the same information community.

Information Community Agreements are to be signed by Service Directors or the equivalent functional leads.

Tier 3 – Purpose Specific Information Sharing Agreements (PSISA)

These documents are the lowest level or third element of the Three-Tier model. These documents are aimed at an organisation's "operational management/practitioner" level and will define the relevant **processes** which support the information sharing between two or more agencies for a specified purpose. These documents will detail:

- What information is to be shared
- Why it is being shared (for what specific purposes)
- Who it is being shared with (between which agencies)
- When it is being shared (the times, the frequency etc)

- How it is being shared (format)

Purpose Specific Information Sharing Agreements (PSISA) are to be signed by Heads of relevant services who have the devolved local and/or operational responsibility for delivery.

4.2. 3-Tier Model for Information Sharing Diagram

To view the proposed 3-tier model, please refer to **Appendix A- 3-Tier Information Sharing Structure.**

5 Formal Implementation, Monitoring and Review

5.1. Approval

This Protocol will be formally signed off by the Chief Executive (or equivalent) for each of the partner agencies.

5.2. Adoption

- Formal adoption will follow as soon as 2 or more partners have signed this document. Agencies who sign the document will make their own arrangements for the publication of it on their individual internal and external websites, and for the internal operational implementation of this overarching document.

- Following implementation, this Protocol will be reviewed after 6 months. Thereafter it will be reviewed every year or sooner as legislation and guidance dictates. The reviews will be undertaken by Wolverhampton City Council (local Information Governance Officers) in consultation with the Caldicott Guardians and Data Protection/Information Governance Officers of the Partner agencies.

- This document then forms the basis for information exchanges between those agencies who have signed up. All partner agencies wanting to share personal data under this information sharing framework must sign this agreement.

5.3. Monitoring & Review

- Each of the partner agencies will have in place processes to audit and provide assurance in respect of compliance with all aspects of this Protocol and individual Purpose Specific ISAs that they have signed up to.

- Breaches of this protocol and subsequent Information Community Agreements or Purpose Specific ISAs will be managed according to the Procedures set out in **Appendix E -Handling Breaches.**

6 Organisations Covered by this Protocol.

Section 10 contains a list of the organisations who have signed up to this Overarching Information Sharing Protocol.

7 Legal Requirements and professional Framework

7.1. Understanding the legal framework for information sharing

- The legal framework within which public sector data sharing takes place is complex and overlapping and there is no single source of law that regulates public sector information sharing.

- It is essential that practitioners sharing information are clearly aware of the legal framework within which they are operating.

- The purpose therefore of detailing the law within this protocol, is to highlight the legal framework that affects all types of personal information sharing, rather than to serve as a definitive legal reference point.

- This protocol has been developed in accordance with the ICO Data Sharing Code of Practice.
  http://www.ico.gov.uk/for_organisations/data_protection/topic_guides/data_sharing.aspx

7.2. How to approach questions around information sharing

- In order to approach questions around information sharing the protocol contains useful checklists and guidance notes (see appendices).

- **Appendix B - Legal Considerations** raises some of the questions in a more user-friendly way.

- In summary approaches to information sharing comes down to:

    - Establishing whether there is power to carry out the function to which the information sharing relates.

    - Checking whether there are express statutory restrictions on the data sharing activity proposed, or any restrictions which may be implied by the existence of statutory, common law or other provisions.

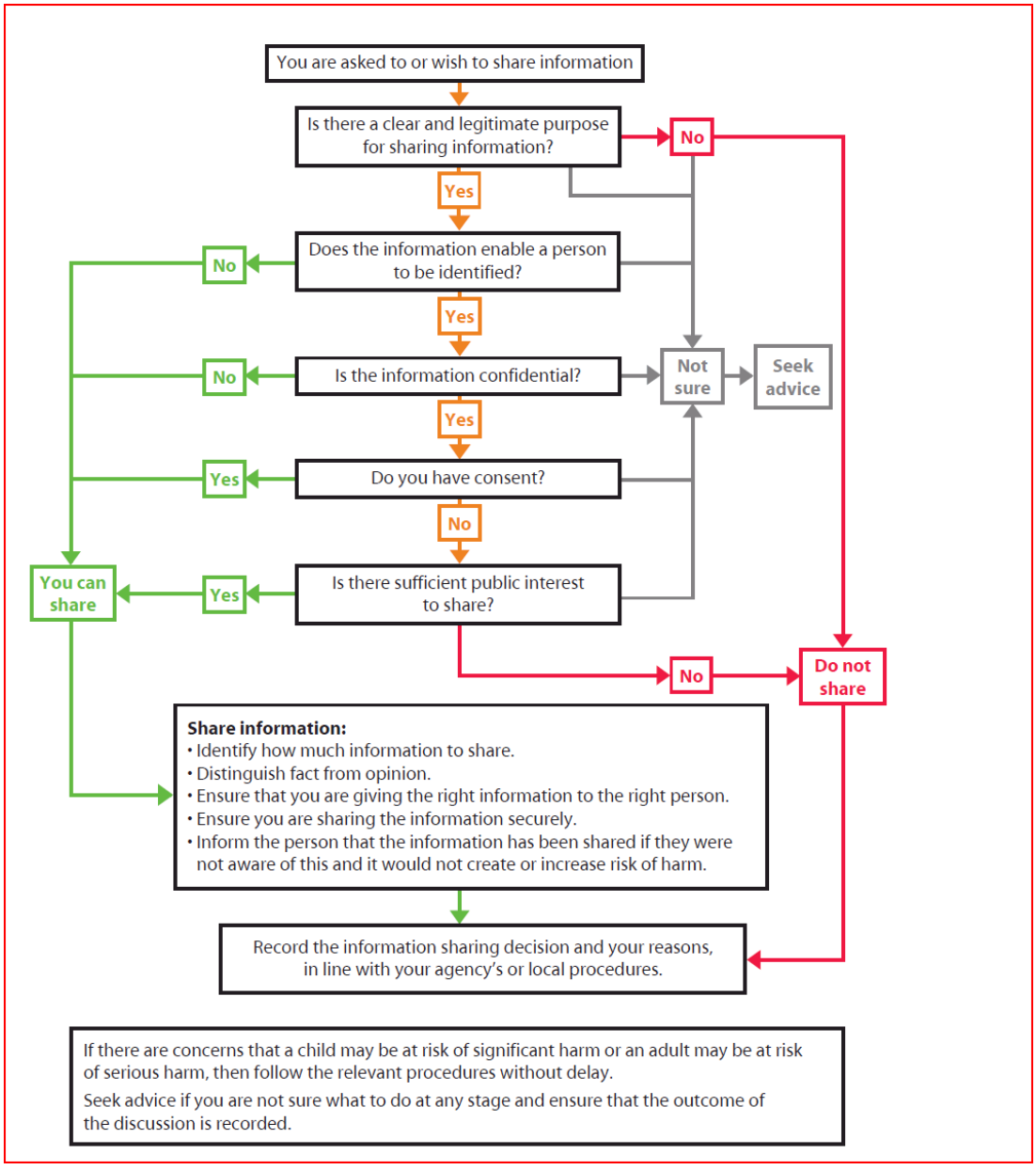
    - Deciding whether the sharing of the data would interfere with rights under Article 8 of the European Convention on Human Rights in a way which would be disproportionate to the achievement of a legitimate aim.

    - Decide whether the sharing of the data would breach any obligations of confidence.

    - Decide whether the data sharing could take place in accordance with the Data Protection Act 1998, with particular reference to the 8 Data Protection Principles.

- Following the Information Sharing Guidance for Managers and practitioners provided by HM Government; as detailed below in the Information Sharing Flowchart[1]:

Key questions for Information Sharing.



[1] Information Sharing : Guidance for Practitioners and managers (HM Government 2006)

7.3. Freedom of Information Act (FOIA) 2000 requests

A number of the partner organisations are “public authorities” for the purposes of the Freedom of Information Act 2000 (FOI). This means that they could receive requests for information relating to the information sharing activities under this protocol or resultant purpose specific Information Sharing Agreement (e.g. statistics on the amount of data sharing being undertaken or the general nature of the data sharing). The public authority that receives the FOI request must make the other public authority aware of the nature of the request and their intended response.

8 Duties and Requirements of Parties

8.1 General undertakings by each agency

- A number of safeguards are necessary in order to ensure a balance between maintaining confidentiality and sharing information appropriately.

- The sharing of information by organisations under this Protocol (and subsequent Information Community Agreements and Purpose Specific Information Sharing Agreement (PSISA) will be based on the following principles:

8.1.1 **Commitment to sharing information**

Partner organisations recognise that multi-agency working sometimes requires a commitment to sharing personal information about service users in compliance with guidance and legislation.

8.1.2 **Statutory duties**

- Partner organisations are fully committed to ensuring that they share information in accordance with their statutory duties including the requirements of the Data Protection Act 1998, the Human Rights Act 1998 and The Common Law Duty of Confidentiality (see 8.1.4 below).

- Partner organisations recognise the sensitivity of information about a person's racial or ethnic origin, political opinions, religious or other similar beliefs, trade union membership, physical and mental health, sexuality, the commission or alleged commission of any offence and any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings and will adhere to the requirements of Schedule 3 of the Data Protection Act 1998 in respect of such information.

8.1.3 **Caldicott requirements**

All organisations recognise the requirements that Caldicott imposes on NHS organisations and Social Services Departments. They will ensure that requests for information from these organisations are dealt with in a manner compatible with these requirements:

1. Justify the purpose(s)

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don't use personal confidential data unless it is absolutely necessary

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. Use the minimum necessary personal confidential data

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data — both clinical and non-clinical staff — are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. The duty to share information can be as important as the duty to protect patient confidentiality.

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

8.1.4 **Duty of confidentiality**

- Partner organisations recognise the importance of the legal duty of confidentiality, and will not disclose information to which this duty applies without the consent of the person concerned, unless there are lawful grounds and an overriding justification for so doing. In requesting release and disclosure of information from partner organisations, all staff will respect this responsibility.

- Agencies who are party to this Overarching Protocol will exercise caution when contemplating the disclosure of personal information relating to a deceased person. Although the Data Protection Act only applies to personal information of a living person, a duty of confidentiality may still apply after the person has died.

- All agencies who are party to this Protocol will have in place appropriate measures to investigate and deal with the inappropriate or unauthorised access to, or use of, personal information whether intentional or inadvertent.

- In the event of personal information that has been shared under this Overarching Protocol (and subsequent agreements) having or may have been compromised, whether accidental or intentional, the organisation making the discovery will without delay:
    - Inform the information provider (agency) of the details.
    - Take steps to investigate the cause.
    - If appropriate, take disciplinary action against the person(s) responsible.
    - Take appropriate steps to avoid a repetition.
    - Take appropriate steps where possible to mitigate any impact.

- On being notified that an individual's personal information has / have been compromised, the original provider will assess the potential implications for the individual whose information has been compromised and if necessary:
    - Notify the individual concerned,
    - Advise the individual of their rights,
    - Provide the individual with appropriate support.

- See **Appendix E - Handling Breaches** for more information.

8.1.5 **Consent**

- Where required, and unless legal exemptions are applicable, all agencies who are party to the Overarching Protocol will endeavour to seek informed consent from the individual concerned to share their personal information in accordance with an agreed Purpose Specific ISA.

- Consent will normally be obtained at the earliest opportunity and should be sufficient to cover the needs for a particular 'piece of work' or situation. It is essential to avoid the need to repeatedly seek consent over minor issues.

- In seeking consent to disclose personal information, the individual concerned will be made fully aware of the nature of the information that it may be necessary to share, who the information may be shared with, the purposes for which the information will be used and any other relevant details including their right to withhold or withdraw consent.

  For further guidance on consent, see **Appendix D - Consent: Guidance notes.**

8.1.6 **Sharing without consent**

- Organisations will put procedures in place to ensure that decisions to share personal information without consent have been fully considered and comply with the requirements of the relevant law. Such decisions will be appropriately recorded for audit purposes. All relevant staff will be provided with training in these procedures.

- For further guidance see **Appendix D Consent: Guidance notes.**

8.1.7 **"Need to know"**

Where it is necessary and permissible for information to be shared, this will be done on a "need-to-know" basis only. i.e. the minimum information, consistent with the purpose for sharing, will be given.

8.1.8 **Information kept confidential from the service user**

Where professionals request that information supplied by them be kept confidential from the service user, the outcome of this request and the reasons for taking the decision will be recorded. Such decisions will only be taken on lawful grounds.

8.1.9 **Specific purpose**

- Partners will not abuse information that is disclosed to them under the specific purpose(s) set out in the relevant Purpose Specific ISA. Information shared with a member of another organisation for a specific purpose will not be regarded by that organisation as intelligence for their general use.

- Agencies wishing to use information for any purpose other than that for which it was originally provided, or who wish to disclose that information to any person other than those authorised to receive that information, must attempt to:

    - Inform the organisation that provided the information of their intention to use that information for a different purpose, and

    - Obtain explicit consent from the individual(s) concerned before processing such information (unless this is not practical – e.g. crime prevention purposes).

- Agencies who wish to use information that has been provided to them under a Purpose Specific ISA for research or statistical purposes must ensure that policies and procedures are in place to guarantee that such personal information is anonymised and in line with ethical standards.

8.1.10 **Fact / opinion**

Agencies who are party to this Overarching Protocol will ensure that their staff, who are authorised to make disclosure of personal information, will clearly state whether the information that is being supplied is either fact or opinion, or a combination of the two.

8.1.11 **Use of anonymised information where possible**

Personal information will only be disclosed where the purpose for which it has been agreed to share clearly requires that this is essential and appropriate. For all other purposes, information about individual cases that is to be shared will be anonymised. See diagram below for proposed uses for identifiable and di-identified information.

Class of data according to ICO code	Status of data	Description*	Legal basis required for processing?	Need to inform Public?	Conditions for onward disclosure
Anonymised	De-identified data for publication	Personal confidential data which has been anonymised with a low residual risk of re-identification. This means third parties can only re-identify the persons with unreasonable effort.	Not applicable	Desirable	No conditions for disclosure. Data may be published.
	De-identified data for limited disclosure or limited access	Personal confidential data that has been anonymised but with a residual high risk of re-identification. This means that the data does not identify persons on its own, but there is a significant risk that third parties could re-identify the persons with reasonable effort. A defining characteristic is a data set containing a single identifier such as NHS number or postcode**.	Legal basis requires safeguards that maintain anonymity. This means: • a contract that prevents re-identification; and • assured data stewardship arrangements***. Linkage of this data from more than one organisation for any purpose other than direct care must only be done in the Health and Social Care Information Centre OR an accredited safe haven.	Recom-mended	Either as de-identified data for publication OR to an environment covered by the same contractual arrangements as the disclosing party and confirmed data stewardship arrangements.
Identifiable	Personal confidential data	Personal confidential data that has not been through anonymisation and that may or may not have been redacted. Examples include: • any data set with greater than one direct identifier** OR • pseudonymised data with access to key for reversibility OR • pseudonymised data and holding one or more of source data sets in identified form.	Legal basis for processing is required that meets the common law duty of confidentiality, Human Rights Act 1998 and Data Protection Act 1998. This means: • consent OR • statute OR • exceptionally on public interest grounds. Linkage of this data from more than one organisation for any purpose other than direct care must only be done in an accredited safe haven.	Required unless exempt	With consent for direct care OR under statute OR anonymised AND with appropriate contract or agreement***.

8.1.12 **Access to information**

- Individuals will be fully informed about the information that is recorded about them, who may see their information, for what purposes and their right to object to the relevant person within that organisation. Under the Data Protection Act they will normally be able to gain access to information held about them and to correct any factual errors that may have been made.

- If an agency has statutory grounds for restricting a person's access to information about themselves, they will normally be told that such information is held and the grounds on which it is has not been provided (unless this would prejudice an investigation or place an individual at risk).

- Information that has been provided by another agency under an agreed Purpose Specific Information Sharing Agreement (PSISA) may be disclosed to the individual without the need for obtaining the provider's consent to disclose, with the following exceptions when consent must be obtained prior to disclosure:

    - The provider has specifically stated that the information supplied must be kept confidential from the service user.
    - The information contains medical details.
    - The information is legally privileged.
    - The information is likely to prejudice the carrying out of social care duties.

- In the situation of two or more organisations having a joint (single) record on an individual, that individual may make their access to record request to any of the organisations. The organisation receiving the request will be responsible for processing the request for the whole record and not just the part that they may have contributed, subject to the conditions for disclosure mentioned above.

- Where an opinion about an individual is recorded and the individual feels the opinion is based on incorrect factual information, they will be given the opportunity to correct the factual error and record their disagreement with the recorded opinion.

8.1.13 **Complaints procedures**

- Partner Organisations shall put in place procedures to address complaints relating to the disclosure of information. Partners must also ensure that service users are provided with information about these Complaint procedures.

- In the event of a complaint relating to the disclosure or the use of an individual's personal information that has been supplied/obtained under an agreed Purpose Specific Information Sharing Agreement (PSISA), all agencies who are party to the Purpose Specific Information Sharing Agreement (PSISA) will provide co-operation and assistance in order to resolve the complaint.

8.1.14 **Ensuring minimum standards for all Purpose Specific Information Sharing Agreements**

- In order to maintain a consistent approach, all agencies who are party to this Protocol will ensure that any Purpose Specific Information Sharing Agreement (PSISA) will follow the framework set out in **Appendix F.**

- Where information sharing protocols exist between agencies prior to signing up to the Overarching Protocol, such protocols will remain valid. However, such protocols should be reviewed and if necessary brought into line with the Wolverhampton 3-Tier Information Sharing Structure at the earliest opportunity in order to maintain a consistent approach.

8.1.15 **Disciplinary action**

Partner organisations will ensure that contracts of employment and/or relevant policies and procedures include reference to the issue of disciplinary action should staff disclose personal information on a basis which cannot be justified as reasonable in the particular circumstances (taking into account the purpose of the disclosure and any relevant statutes).

8.1.16 **Recording information disclosed under these protocols**

Agencies who are party to the Overarching Protocol will:

- Ensure that all personal information that has been disclosed to them under an agreed Purpose Specific Information Sharing Agreement (PSISA) will be recorded accurately on that individual's manual or electronic record in accordance with their policies and procedures.

- Put in place procedures to record not only the details of the information, but who gave and who received that information.

8.1.17 **Storage, transfer and destruction of personal information**

Agencies who are party to the Overarching Protocol will put in place policies and procedures governing:

- The secure storage of all personal information retained within their manual and/or electronic systems.

- The secure transfer of personal information both internally and externally. Such policies and procedures must cover:

    - Internal and external postal arrangements.
    - Verbally, face-to-face and telephone.

- Facsimiles (safe haven).
- Electronic mail (secure network or encryption).
- Electronic network transfer.

- The access by their employees, and others, to personal information held within their manual and/or electronic systems and to ensure that access to such information is controlled and restricted to those who have a legitimate need to have access.
- The retention and destruction of records containing personal information retained within their manual and/or electronic systems.

8.1.18 **Ensuring that staff under this protocol comply with their obligations**

Agencies who are party to the Overarching Protocol will ensure:

- That all staff are aware of, and comply with, their responsibilities and obligations with regard to the confidentiality of personal information about people who are in contact with their agency.
- That all staff are aware of, and comply with, the commitment of the organisations/agency to only share information legally and within the terms of an agreed Information Community Agreement or Purpose Specific Information Sharing Agreement (PSISA).
- That all staff are aware of, and comply with the commitment that information will be shared on a need-to-know basis only.
- That staff will be made aware that disclosure of personal information which cannot be justified, whether recklessly or intentionally will be subject to disciplinary action.

8.1.19 **Ensuring staff are trained to enable them to share information legally.**

- All parties to the Overarching Protocol will ensure that employees who need to share personal information under an Information Community Agreement or Purpose Specific Information Sharing Agreement (PSISA) are given appropriate training by their agency to enable them to share information legally, comply with any professional codes of practice and comply with any local policies and procedures.
- Staff who are not directly involved with sharing personal information should not be excluded from such training as it is possible that they may come across such information during the course of their duties. It may therefore be appropriate that such employees receive awareness training.

8.1.20 **Ensuring organisations signed up to this protocol can provide relevant assurances for data handling**

All organisations must have at least one of the following in place:

- ISO/IEC 27001:2005 an information security management
- Cyber essentials as per national guidance

  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395716/10_steps_ten_critical_areas.pdf
- Minimum toolkit level 2 on the Information Governance Toolkit

9 Agreement

9.1 Purposes for which information will be shared

9.1.1 **Overview**

- Information will only be disclosed where the relevant agreed purpose for sharing clearly requires this. However, each agency must have regard to its legal power in deciding whether they can share information for that particular purpose. The following range of purposes are agreed as justifiable for the transfer of personal information between the Partner Agencies as defined within the remit of this protocol:

    - Provision of appropriate care services
    - Assuring and improving the quality of care and treatment;
    - Improving the health of people in the local community
    - Monitoring, reporting and protecting public health;
    - Protecting children, young people and adults
    - Prevention of crime or disorder and the promotion of community safety
    - Supporting communities (geographical or otherwise)
    - Supporting people in need
    - Investigating complaints or potential legal claims
    - Compliance with court orders
    - Managing and planning services
    - Commissioning and contracting services
    - Developing inter-agency strategies
    - Performance management and audit
    - Research
    - Other statutory requirements

Please note that the above list provides an example of justifiable purposes for sharing information, however, the Data Protection Act 1998, Common Law Duty of Confidentiality and rights to privacy under the Human Rights Act 1998, still need to be considered.

9.1.2 **Relevant information**

Consideration must be given to the extent of any personal information that is proposed to be disclosed, taking into account the circumstances of the proposed disclosure. It may not be necessary to disclose all information held regarding a service user and only such information as is relevant for the purpose for which it is disclosed should be passed under the sharing arrangement to the recipient(s).

9.2 Agreement

9.2.1 **Indemnity**

- Disclosure of personal information without consent must be justifiable on statutory grounds, or meet the criterion for claiming an exemption under the Data Protection Act. Without such justification, both the agency and the member of staff expose themselves to the risk of prosecution and liability to a compensation order under the Data Protection Act or damages for a breach of the Human Rights Act.

- Where a disclosing agency provides information to a requesting agency both parties shall assume that both the request and the disclosure are compliant with the requirements of the Data Protection Act 1998.

- If subsequently it is found that either the request for, or the disclosure of, information is in contravention of the requirements of the Data Protection Act 1998, the agency who originally breached the requirements of the Data Protection Act 1998, either in requesting or disclosing information, shall indemnify the other agency against any liability, cost or expense thereby reasonably incurred. However, this indemnity shall not apply:

    - Where the agency originally found to be in breach of the Data Protection Act 1998 did not know and, acting reasonably had no reason to know, that it had acted in breach of the Data Protection Act 1998 either in requesting or disclosing information

    - Unless either agency notifies the other agency as soon as reasonably practical of any action, claim or demand against itself to which it considers this indemnity may apply, permits the other agency to deal with the action, claim or demand by settlement or otherwise, and renders all reasonable assistance in doing so.

9.2.2 **The undersigned parties agree to:**

- Promote good practice in the sharing of personal information by ensuring compliance with the principles, purposes and processes of this Protocol.

- Take necessary action to identify and mitigate any breaches of the Protocol and to have established policies and practices for dealing with complaints about the sharing of information.

- Ensure that no restrictions are placed on sharing personal information other than those that are specified in this Protocol.

- Ensure that clients are informed of their rights in respect of personal information, including right of access and the complaints procedure.

- Develop systems of implementation, dissemination, guidance, training and monitoring to ensure that the Protocol is known, understood and followed by all professionals who need to share personal information.

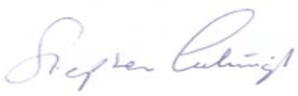
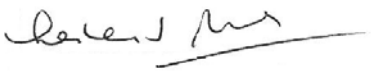
- Establish processes to review the use of the Protocol, in order to ensure that practice is in accordance with the requirements of the Protocol, and to take corrective action as needed.

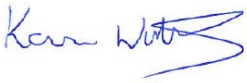
- Develop information processing systems that ensure collected data is complete, accurate, kept up-to-date and relevant.

- Ensure that collected data is stored and transmitted securely.

10 Signatories

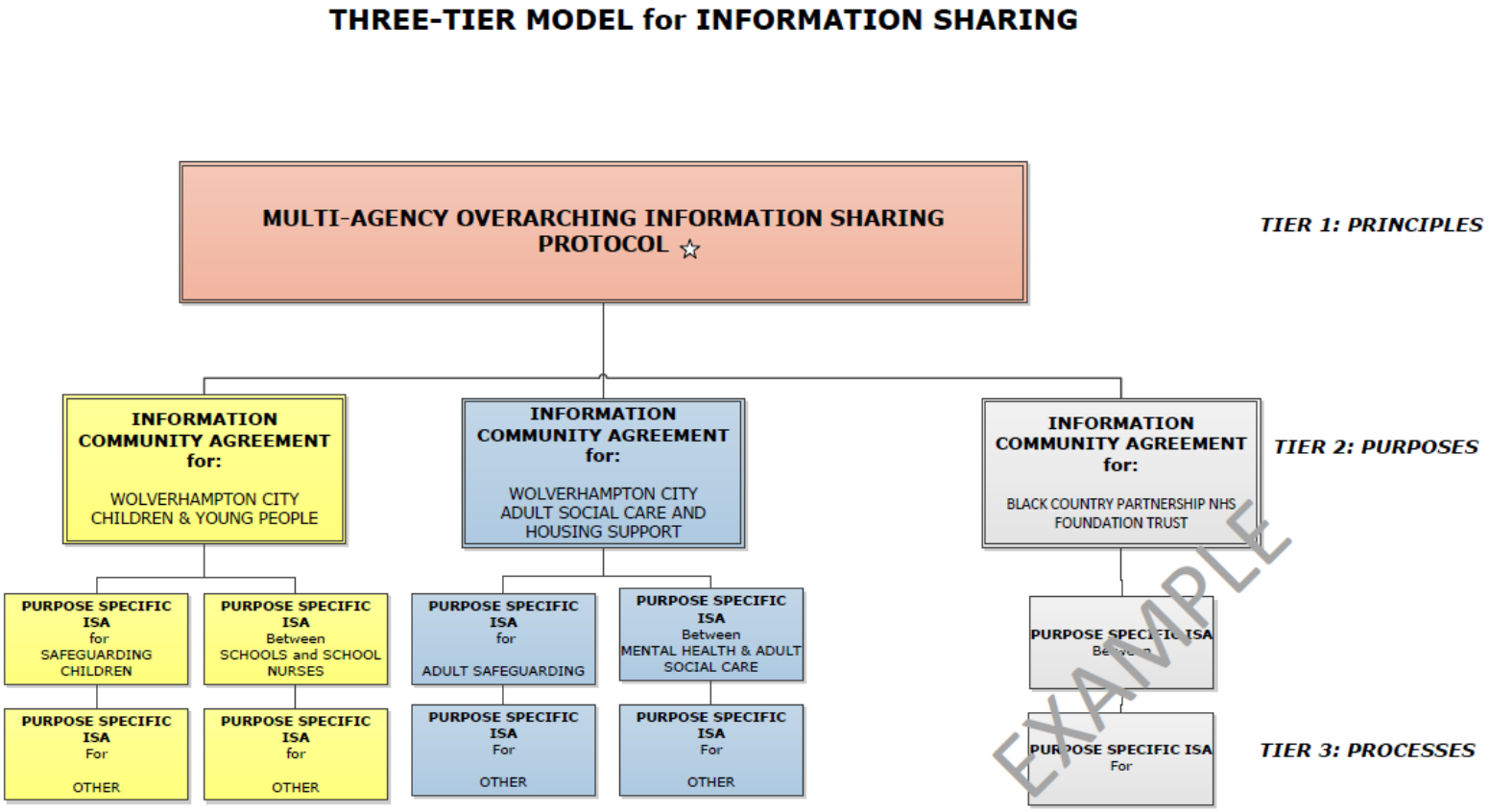
This protocol will be signed by chief officers of the respective agency organisations on behalf of their organisations:

Organisation	Name of Signatory	Designation/Role	Date Signed
Wolverhampton City Council	Simon Warren 	Chief Executive	17th November 2011
Staffordshire and West Midlands Probation Trust	Neil Appleby 	Head of Probation Services Wolverhampton	16th November 2011
Black Country Partnership NHS Foundation Trust	Paul Stefanoski 	Deputy Chief Executive, Director of Resources	17th November 2011
Black Country Primary Care Trust Cluster	Stephen Cartwright 	Medical Director Primary Care Trust Black Country Cluster	21st November 2011
The Royal Wolverhampton Hospital NHS Trust	David Loughten CBE 	Chief Executive	5th December 2011
West Midlands Police	Neil Evans 	Chief Superintendent LPU Commander Wolverhampton	17th November 2011
Wolverhampton Homes	Lesley Roberts 	Chief Executive	5th March 2012

Bushbury Hill Estate Management Board	Karen Williams 	Chief Officer	28th March 2012
North Midlands (Neighbourhoods) Midland Heart Wolverhampton Office	Joanne Kelsall 	Operations Manager Midland Heart	25th April 2012
Bromford Housing Group's	Phillipa Jones 	Executive Director and Company Secretary	9th May 2012
Nehemiah Housing Group	Llewellyn Graham 	Chief Executive	18th May 2012
Sanctuary Housing Association	Craig Moule 	Company Secretary	1st June 2012

10.1 Signed copies of this document shall be retained by Wolverhampton Council's Data Protection/IG Officers.

11 APPENDIX A – 3-Tier Information Sharing Structure



☆ Main agencies represented in multi-agency approach include Wolverhampton City Council, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust, West Midlands Police, Probation Services, Schools, Wolverhampton Homes, & Wolverhampton Voluntary Sector Council, Wolverhampton CCG.

12 Appendix B - Legal Considerations

12.1 Purpose

This is meant as a guide to assist in determining how to establish the legal basis for data sharing:

12.1.1 **Vires issues**

- Is the existing information that is to be shared subject to any statutory prohibitions whether express or implied?
- Even if there are no relevant statutory restrictions, do the bodies sharing the data have the vires to do so? This will involve careful consideration of the extent of express statutory, implied statutory and common law powers (see **Appendix C – Relevant legislation** for further detail on statutory powers).
- If there is no existing legal power for the proposed data collection and sharing, then, can the individual's consent to the disclosure be obtained?

12.1.2 **Human Rights Act issues**

- Is Article 8 of the European Convention on Human Rights (ECHR) engaged i.e. will the proposed data collection and sharing interfere with the right to respect for private and family life, home and correspondence? If the data collection and sharing is to take place with the consent of the data subjects involved, Article 8 will not be engaged.

- If article 8 of the ECHR is engaged, is therefore the interference:

    - in accordance with the law
    - in pursuit of a legitimate aim;
    - a proportionate response to the problem
    - necessary in a democratic society?

12.1.3 **Common law duty of confidence issues**

- Is the information confidential:

    - Does it have the necessary quality of confidence?;
    - Was the information in question communicated in circumstances giving rise to an obligation of confidence?;
    - Has there been unauthorised use of that material?

- Consider also whether the information has been obtained subject to statutory obligations of confidence. If the data collection and sharing is to take place with the consent of the data subjects involved, the information will not be confidential.

- If the information is confidential is there an overriding public interest that justifies its disclosure? The law on this aspect overlaps with that relating to Article 8 of the ECHR.

12.1.4 **Data Protection Act issues**

Please refer to **Appendix C – Relevant Legislation** when reading the following points:

- Does the DPA apply i.e. is the information personal data held on computer or as part of a "relevant filing system" or an "accessible record"?
- If the DPA applies, can the requirement of fairness in the First Data Protection Principle be satisfied?
- Can one of the conditions in DPA Schedule 2 be satisfied?
    - Paragraph 5 relating to public functions are of particular relevance to public sector data sharing;
    - Paragraph 6, relating to the balance between the interests of the data subject and the legitimate interests of the body that share and/or that receives the data.
- If the data are sensitive personal data can one of the conditions in Schedule 3 also be satisfied?
    - Paragraph, 7 which is in similar terms to paragraph 5 of Schedule 2, may be applicable.
- Can the requirement of compatibility that is in the Second Data Protection Principle be complied with?
- Do any of the exemptions that are set out in the Data Protection Act apply?

Seek advice from your organisation's Data Protection Officer/Legal Advisor if unsure.

13 APPENDIX C - Relevant Legislation

13.1 List (non exhaustive) of legislation and other guidance that is of relevance to information sharing:

- The Data Protection Act 1998
- The Freedom of Information Act 2000
- The Human Rights Act 1998
- The Mental Health Act 1983
- The Children Act 1989 (sections 17, 27, 47 and Schedule 2)
- The Children Act 2004 (sections 10, 11 and 12)
- The Care Act 2014
- The NHS & Community Care Act 1990
- The Access to Health Records Act 1990
- The Carers (Recognition & Service) Act 1995
- The Crime & Disorder Act 1998
- The Health Act 1999 (section 31)
- The Health and Social Care Act 2001 (Section 60)
- The Local Government Act 2000 (section 2)
- The Local Government Act 1972 (section 111)
- The Education Act 1996 (sections 10 and 13), The Education Act 2002 (section 175)
- The Learning and Skills Act 2000 (sections 114 and 115)
- The Crime and Disorder Act 1998 (section 115)
- The NHS confidentiality code of practice
- The Civil Contingencies Act (2004) Part 1 and supporting regulations.
- The Access to Health Records Act 1990
- The Mental Capacity Act 2005
- The Equalities Act 2010

Some of the legislation is defined in greater detail below. For further advice on this legislation and other relevant professional guidance contact your organisations designated officer.

13.2 Introduction

- Legislation, under which most public sector agencies operate, defines the role, responsibility and power of the agency to enable it to carry out a particular function.

- In many instances legislation tends to use broad or vague statements when it comes to the matter of sharing personal information, for example: the agency is required 'to communicate, or will co-operate with' without actually specifying exactly how this may be done. This is because legislation that specifically deals with use of personal information (collection; use; storage; destruction; protection etc.) already exists namely, the Data Protection Act 1998.

- The Data Protection Act 1998, in most cases, is the key to the use of personal information and links into most other legislation. The Act sets out to govern the collection, use, storage, destruction and protection of a living person's identifiable information (Personal Data). In general, recorded information held by public authorities about identifiable living individuals will be covered by the Data Protection Act 1998. It is important to take account of whether the information is held in paper records or in automated form (such as on computer or on a CCTV system): some of the provisions of the Data Protection Act 1998 do not apply to certain paper records held by public authorities. Broadly speaking, the eight data protection principles set out in Schedule 1 to the Data Protection Act 1998, and discussed further below, will apply to paper records held in a "relevant filing system" or an "accessible record", but not to other paper records.

- The Data Protection Act 1998 does not set out to prevent the sharing of personal information. To the contrary, providing that the necessary conditions of the Act can be met, sharing is perfectly legal. It is important to share information, when appropriate to do so, as to withhold it. Each information sharing episode needs to be assessed on it's own merits.

13.2.1 **Administrative Law**

- The principles of administrative law regulate the activities of public bodies; these principles are mainly enforced by way of claims for judicial review in the courts. The courts do not generally review the merits of public law decisions but consider the legality, rationality or procedural propriety of decisions made by public bodies. The rules relating to illegality are most relevant to data sharing: a public body may not act in excess of its powers. If it does act in excess of its powers, then the act is said to be ultra vires. Acts within a public body's powers are said to be intra vires. Under the Human Rights Act 1998, an act of a public authority may be unlawful on the basis that it is contrary to the ECHR. Where questions involving the Convention are involved, the Court will need to consider the merits of the decision more closely than would be the case where the traditional administrative law principles are involved.

- Local authorities derive their powers entirely from statute and cannot act outside those limited statutory powers. Most of these statutory powers relate to specific local authority functions. In addition to these specific powers, section 111 of the Local Government Act 1972 provides that local authorities are empowered to do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any of their functions. Section 2 of the Local Government Act 2000 confers a wide (but not unlimited) power on local authorities to promote the well-being of their area.

- There is no general statutory power to disclose data, and there is no general power to obtain, hold or process data. As a result, it is necessary to consider the legislation that relates to the policy or service that the data sharing supports. From this, it will be possible to determine whether there are express powers to share data, or whether these can be implied. Express powers to share data are relatively rare and tend to be confined to specific activities and be exercisable only by named bodies. Implied powers will be more commonly invoked. Alternatively it may be possible to rely on section 111 of the 1972 Act or section 2 of the 2000 Act as a basis for data sharing.

- The starting point in relation to implied powers or in relation to section 111 of the 1972 Act must be the power to carry out the fundamental activity to which data sharing is ancillary. If there is no power to carry out that fundamental activity then there can be no basis for implying a power to share data or for relying on section 111 of the 1972 Act.

- A statutory power must be exercised for the purpose for which it is created. If it is not, the exercise of the power will be ultra vires.

13.2.2 **Administrative powers**

- Express statutory powers: Express statutory powers can be permissive or mandatory.

    - Express permissive statutory powers (or gateways) to share data include section 115 of the Crime and Disorder Act 1998 (which allows persons to share information with relevant authorities where disclosure is necessary or expedient for the purposes of the Act) and regulation 27 of the Road Vehicles (Registration and Licensing) Regulations 2002 (which, among other things, permits the Secretary of State to make particulars in the vehicle registration register available for use by a local authority for any purpose connected with the investigation of an offence or of a decriminalised parking contravention). Examples of mandatory statutory gateways include: section 17 of the Criminal Appeal Act 1995, which makes it obligatory for a public body to provide information, when requested, to the Criminal Cases Review Commission in connection with the exercise of its functions; and section 6 of the Audit Commission Act 1998, which imposes a legal obligation on the Council to provide relevant information to the Audit Commission.

- Local authorities are only able to do what is expressly or by implication authorised by statute. The following statutory powers are relevant, in addition to the specific powers mentioned above:

    - Section 111 of the Local Government Act 1972, which provides that a local authority has power to do anything, which is calculated to facilitate, or is conducive or incidental to, the discharge of any statutory functions.

    - Section 2 of the Local Government Act 2000, which provides that a local authority has power to do anything likely to achieve the promotion or improvement of the economic, social or environmental well-being of the area.

13.2.3 **Data Protection Act 1998**

- The key principles of the Data Protection Act are:

    1. Personal Data must be processed (e.g. collected, held, disclosed) fairly and lawfully and that processing must satisfy one of the conditions in schedule 2 of the Act. The processing of sensitive data is further protected in that processing must also satisfy at least one of the conditions in schedule 3 of the Act.

2. Personal Data shall be obtained and processed for only one or more specific and lawful purpose(s).

3. Personal Data shall be adequate, relevant and not excessive in relation to the specified purpose(s).

4. Personal Data shall be accurate and kept up to date.

5. Personal Data shall not be held for longer than is necessary.

6. Processing of Personal Data must be in accordance with the rights of the individual.

7. Appropriate technical and organisational measures should protect Personal Data.

8. Personal data should not be transferred outside the European Union unless adequate protection is provided by the recipient.

With few exceptions the Data protection Act 1998 requires anyone processing personal information to notify (register) with the Information Commissioner.

- The registration details include the type of information held, the purpose of use and who the information may be disclosed to. It is therefore essential that anyone considering sharing personal information establishes that their registration covers who they may disclose information to, or what information they may collect (when receiving shared information). If their registration does not cover these matters adequately, amendments must be registered with the Information Commissioner.

- The first and second principles of the Data Protection Act are crucial when considering information sharing. In essence, these require that personal information should be obtained and processed fairly and lawfully and that personal information should only be used for a purpose(s) compatible with the original purpose.

- Schedules 2 and 3 of the Act set out conditions that must be met before personal information can be processed fairly and lawfully – For personal information to be processed lawfully, one of the conditions in Schedule 2 must be met. For sensitive personal information, one of the conditions in Schedule 3 must also be met.

- Sensitive information, as defined by the Act, includes information concerning a person's physical or mental health; sexual life; ethnicity or racial origin; political opinion; trade union membership; criminal record or details of alleged offences etc.

- In order for there to be no misunderstanding, on anyone's part, it is always advisable for the 'collector' of the information to ensure that the person is made fully aware of why the information is needed, what will be done with it, who will have access to it, their rights and if appropriate seek to inform consent of the individual concerned before sharing that information. This will usually be done via the use of Privacy Notices.

- There are circumstances where information can be shared even if informed consent has not been given. These include the following:

- Section 29 of the Act permits disclosure for the purposes of prevention or detection of crime, or apprehension or prosecution of offenders, and where those purposes would be likely to be prejudiced by non-disclosure.

- Disclosure is also permitted where information has to be made public, or where disclosure is required by law.

- For the purposes of the common law duty of confidentiality, if there is no informed consent, this is the point where the need for confidentiality would have to be balanced against countervailing public interests – again preventing crime is accepted as one of those interests. See the more detailed discussion of confidentiality, below.

- For the purposes of the Human Rights Act 1998, Article 8 – Right to respect for private and family life, would need to be considered. See the more detailed discussion of Article 8, below.

- The Data Protection Act gives individuals various rights in respect of their own personal data held by others, namely the right to:

    - Access to their own information (subject access request).

    - Take action to rectify, block, erase or destroy inaccurate data.

    - Prevent processing likely to cause unwarranted substantial damage or distress.

    - Prevent processing for the purposes of direct marketing.

    - To be informed about automated decision taking processes.

    - Take action for compensation if the individual suffers damage.

    - Apply to the Information Commissioner or the court to have their rights under the Act enforced.

- Section 7 of the Act, gives an individual the right to access the information held about themselves, irrespective of when the information was recorded or how it is stored (manual or electronic).

- Disclosure of information held on an individual's record that identifies or has been provided by a third party is subject to certain restrictions (e.g. section 7(4) and the exemption provided by section 30 of the DPA).

- The Act provides the holder of the information a limited number of exemptions to decline/refuse access to an individual's record which are set out under Part IV of the Act.

- The Data Protection Act 1998 does not apply to personal information relating to the deceased person.

  The Data Protection Act 1998 supersedes the Access to Health Records Act 1990 apart from section 3.1.(f) which continues to provide a right of access to the health

records of deceased person made by their personal representatives and others having a claim on the deceased's estate.

In all other circumstances, disclosure of records relating to the deceased person should satisfy common law duty of confidence.

It is also worth noting that third party information that is held within a record of a deceased person is still covered by the Data Protection Act 1998, where the third party is still alive.

- **Schedule 2** of the Data Protection Act 1998 specifies conditions relevant for the processing of any personal data, namely:

    1. The data subject has given his/her consent to the processing, or

    2. The processing is necessary for the performance of a contract to which the data subject is a party, or for the taking of steps at the request of the data subject with a view to entering into a contract, or

    3. The processing is necessary for compliance with any legal obligation to which the data controller is subject, other than an obligation imposed by contract, or

    4. The processing is necessary to protect the vital interests of the data subject.

    5. The processing is necessary-for the administration of justice for the exercise of any functions conferred on any person by or under any enactment for the exercise of any functions of the Crown, a Minister of the Crown or a government department for the exercise of any other functions of a public nature exercised in the public interest by any person, or

    6. The processing is necessary for the purpose of legitimate interests pursued by the data controller or by the third party or parties to whom the data are disclosed, except where the processing is unwarranted in any particular case by reason of prejudice to the rights and freedoms or legitimate interests of the data subject. The Secretary of State may by order specify particular circumstances in which this condition is, or is not, to be taken to be satisfied.

- **Schedule 3** of the Data Protection Act 1998 specifies additional conditions relevant for the processing of sensitive personal data. In addition to meeting a condition set out in schedule 2, at least one other condition must be met in schedule 3, namely:

    1. The data subject who the sensitive information is about has given his/her explicit consent, or

    2. The processing is necessary to comply with employment law, or

    3. The processing is necessary to protect the vital interests of the:

        a. the individual, (where consent cannot be given or reasonably obtained), or

        b. another person, (where the individual's consent has unreasonably been withheld), or

4. In the course of legitimate activities of specified non-profit organisations, and does not involve disclosing personal data to a third party unless the individual has consented. Extra limitations apply to this condition, or

5. The individual has deliberately made the information public, or

6. Processing is necessary in relation to legal proceedings; for obtaining legal advice; or otherwise for establishing, exercising or defending legal rights, or

7. Processing is necessary for administering justice, or for exercising statutory or government functions, or

8. Processing is necessary for medical purposes, and is undertaken by a health professional or someone who is subject to an equal duty of confidentiality, or

9. To monitor equality of opportunity, and is carried out with appropriate safeguards for the rights of the individual.

Further conditions relating to the processing of sensitive personal information are detailed in Data Protection (Processing of Sensitive Personal Data) Order 2000.

13.2.4 **Human Rights Act 1998 and European Convention on Human Rights**

- The Human Rights Act 1998(the HRA) gives effect to the principal rights guaranteed by the European Convention on Human Rights (the Convention). In general, it is unlawful under the HRA for a public authority to act inconsistently with any of the Convention rights.

- Article 8.1. of the European Convention on Human Rights (given effect via the Human Rights Act 1998), provides that "everyone has the right to respect for his private and family life, his home and his correspondence."

- This is however, a qualified right i.e. there are specified grounds upon which it may be legitimate for authorities to infringe or limit those rights.

- Article 8.2 of the European Convention on Human Rights provides "there shall be no interference by a public authority with the exercise of this right except as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety, or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others."

- In the event of a claim arising from the Act that an organisation has acted in a way which is incompatible with the Convention rights, a key factor will be whether the organisation can show, in relation to its decision(s) to have taken a particular course of action:

    - that it has taken these rights into account;

    - that it considered whether any breach might result, directly or indirectly, from the action, or lack of action;

- if there was the possibility of a breach, whether the particular rights which might be breached were absolute rights or qualified rights;
    - (if qualified rights) whether the organisation has proceeded in the way mentioned below. “Evidence of the undertaking of a 'proportionality test', weighing the balance of the individual rights to respect for their privacy, versus other statutory responsibilities e.g. protection of others from harm, will be a significant factor for an organisation needing to account for its actions in response to claims arising from the Act”.

13.2.5 **Crime and Disorder Act 1998**

- The Crime and Disorder Act 1998 introduces measures to reduce crime and disorder, including the introduction of local crime partnerships around local authority boundaries to formulate and implement strategies for reducing crime and disorder in the local area.

- Section 115 of the Act provides a power (not a statutory duty) to exchange information between partners where disclosure is necessary to support the local Community Safety Strategy or other provisions in the Crime and Disorder Act. This power does not over ride other legal obligations such as compliance with the Data Protection Act (1998), the Human Rights Act (1998) or the common law duty of confidentiality.

- Section 115 of the Act provides that any person has the power to lawfully disclose information to the police, local authorities, probation service, fire brigades or health authorities (or persons acting on their behalf) where they do not otherwise have the power, but only where it is necessary and expedient, for the purposes of the Act.

- Whilst all agencies have the power to disclose, section 115 does not impose a requirement on them to exchange information, and responsibility for the disclosure remains with the agency that holds the information. It should be noted, however, that this does not exempt the provider from the requirements of the second Data Protection principle.

13.2.6 **Common Law Duty of Confidentiality**

- All staff working in both the public and private sectors should be aware that they are subject to a Common Law Duty of Confidentiality, and must abide by this.

- A duty of confidence arises when one person (the “confidant”) is provided with information by another (the “confider”) in the expectation that the information will only be used or disclosed in accordance with the wishes of the confider. If there is a breach of confidence, the confider or any other party affected (for instance a person whose details were included in the information provided) may have the right to take action through the courts.

- Whilst it is not entirely clear under law whether or not a common law duty of confidence extends to the deceased, the Department of Health and relevant professional bodies accept that there is an ethical duty to respect the confidentiality of the dead.

13.2.7 **Exemptions to the duty of confidentiality**

- The duty of confidence is not absolute and the courts have recognised three broad circumstances under which confidential information may be disclosed. These are as follows:

    - Disclosures with consent. If the person to whom the obligation of confidentiality is owed (whether an individual or an organisation) consents to the disclosure this will not lead to an actionable breach of confidence.

    - Disclosures which are required or allowed by law. “Law” in this context includes statute, rules of law, court orders etc.

    - Disclosures where there is an overriding public interest (e.g. to protect others from harm).

    - The courts have generally taken the view that the grounds for breaching confidentiality must be strong ones.

    - The duty of confidence only applies to person identifiable information and not to aggregated data derived from such information or to information that has otherwise been effectively anonymised i.e. it is not possible for anyone to link the information to a specific individual.

    - Unless there is a sufficiently robust public interest justification for using identifiable information that has been provided in confidence then the consent of the individual concerned should be gained before disclosure of their information. Schedules 2 and 3 of the Data Protection Act 1998 apply whether or not the information was provided in confidence.

13.2.8 **Caldicott Principles**

- Although not a statutory requirement, NHS and Social Care organisations are committed to the Caldicott principles which encapsulate the above mentioned statutes when considering whether confidential information should be shared. These are:

1. Justify the purpose(s)

Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

2. Don’t use personal confidential data unless it is absolutely necessary

Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. Use the minimum necessary personal confidential data

Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

4. Access to personal confidential data should be on a strict need-to-know basis

Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

5. Everyone with access to personal confidential data should be aware of their responsibilities

Action should be taken to ensure that those handling personal confidential data — both clinical and non-clinical staff — are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. Comply with the law

Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

7. The duty to share information can be as important as the duty to protect patient confidentiality.

Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

13.2.9 **Access to Health Records Act 1990**

Within the governance structures and processes of healthcare organisations, Practitioners have been given professional accountability to protect specific 1st and 3rd party statements. This may include clinical assessments, diagnostics and results as well as sections of sensitive care plans and progress notes.

13.2.10 **The Children Act 2004**

- The Children Act 2004 created the legislative framework for developing more effective and accessible services focused around the needs of children, young people and families by ensuring co-operation, clearer accountability and safeguarding of children. The key event, which led to these proposals for fundamental change, was the death of Victoria Climbie. This demonstrated that there were major flaws within the systems and structures for safeguarding and ensuring the welfare of children and young people.

Main provisions of the Act:

- o A duty on agencies to co-operate to improve the well being of children and young people
- o A duty to safeguard and promote the welfare of children
- o A power to set up a new database with information about children

- Summary of the Children Act 2004

The following is a brief account of the key parts of the Act that specifically relate to the Change for Children programme in England.

Children's Services in England – Part 2

1. Section 10 establishes a duty on Local Authorities to make arrangements to promote co-operation between agencies in order to improve children's well-being, defined by reference to the five outcomes and a duty on key partners to take part in those arrangements. It also provides a new power to allow pooling of resources in support of these arrangements.
2. Section 11 creates a duty for the key agencies who work with children to put in place arrangements to make sure that they take account of the need to safeguard and promote the welfare of children when doing their jobs.
3. Section 12 allows further secondary legislation and statutory guidance to be made with respect to setting up indexes that contain basic information about children and young people to help professionals in working together to provide early support to children, young people and their families. Case details are specifically ruled out of inclusion in the indexes.

13.2.11 **Civil Contingency Act 2004 – Part 1**

This deals with information sharing between responder bodies, as identified in the Act, as a distinct duty under the Act and as a means of achieving other duties under the Act, and is summarised below:

- o Information sharing is a crucial element of civil protection work, underpinning all forms of co-operation.
- o The initial presumption is that information should be shared, but that some information should be controlled if its release would be counter productive or damaging in some other way.
- o There are various types of information. Information may be suitable for some audiences, but not for others. Also, the circulation of information can be limited to certain classes of organisation or individual.
- o In most instances, information will pass freely between responders, as part of a more general process of dialogue and co-operation.

- However, a formal system exists to request information in circumstances where that is necessary.
- Information may also be accessible from open sources, and responders should endeavour to use this route as well.
- Not all information can be shared. Responders may claim exceptions in certain circumstances (and, as a result, not supply information as requested).
- Exceptions relate to sensitive information only. Where the exceptions apply, a responder must not disclose the information. (Readers of this document are advised to read Chapter 3 of the Guidance Notes to the Civil Contingency Act 2004)

14 APPENDIX D - Consent: Guidance notes

14.1 Consent

14.1.1 Consent issues can be complex and a lack of clarity can sometimes mean the information can be incorrectly shared. Consent can be “explicit” or implicit”. Obtaining explicit consent for information sharing is best practice therefore; it is recommended that where possible the consent sought should be explicit, obtained at the start of any involvement and appropriately recorded.

14.1.2 In order to facilitate the sharing of personal information (without specific statutory grounds) careful consideration should be given to obtaining explicit consent whenever possible, regardless of the person’s age.

14.1.3 For consent to be valid it must be:

- Fully informed – the individual is aware of what information will be shared, with whom and for what purpose.
- Specific – a general consent to share information with “partner organisations” would not be valid. Specific means that individuals are aware of what particular information we will share, who with and for what purpose.
- A positive indication by the data subject – the provision of opt outs on forms would therefore not obtain the consent of an individual.
- Freely given – the individual is not acting under duress from any party.

14.1.4 The person giving the consent must also have the capacity to understand what they are consenting to.

14.1.5 Consent may be given verbally or in writing. In order to avoid any confusion or misunderstanding at a later date, verbal consent should be witnessed and the details of the witness recorded.

14.1.6 To give valid informed consent, the person needs to understand why their information needs to be shared, what type of information may be involved and who that information may be shared with.

14.1.7 The person should also be advised of their rights with regard to their information, namely:

- The right to withhold their consent.
- The right to place restrictions on the use of their information.
- The right to withdraw their consent at any time.
- The right to have access to their records.

14.1.8 As well as discussing consent with the person, it is seen as good practice that the person should also be given such information in another required format e.g. different language, Braille.

14.1.9 In general, once a person has given consent, that consent may remain valid for an indefinite duration unless the person subsequently withdraws that consent.

14.1.10 If a person makes a voluntary and informed decision to refuse consent for their personal information to be shared, this decision must be respected unless there are sound legal grounds for disclosing without consent (see 13.9 below).

14.1.11 A person, having given their consent, is entitled at any time to subsequently withdraw that consent. Like refusal, their wishes must be respected unless there are sound legal grounds for not doing so.

14.1.12 If a person refuses or withdraws consent, the consequences should be explained to them, but care must be exercised not to place the person under any undue pressure.

14.1.13 In the Purpose Specific Information Sharing Agreement (PSISA), detail must be provided on when and how often individuals are reminded of the fair processing notice (and in effect given the chance to withdraw the consent that they have previously provided).

14.1.14 New consent will be required where there are to be significant changes to:

- the personal data that will be shared,
- the purposes for which it will be shared, or
- the partners involved in the sharing (I.e. the proposed data sharing is not covered by the original fair processing notice which states which agencies information will be shared with).

14.2 Capacity to consent

14.2.1 For a person to have capacity to consent, he/she must be able to comprehend and retain the information material to the decision and must be able to weigh this information in the decision making process.

All people aged 16 and over, are presumed in law, to have capacity to give or withhold their consent to sharing of confidential information unless, there is evidence to the contrary. Having mental capacity means that a person is able to make their own decisions. The Mental Capacity Act says that a person is unable to make a particular decision if they cannot do one or more of the following four things:

- Understand the information given to them
- Retain that information long enough to be able to make the decision
- Weigh up the information available to make the decision

- Communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

The Mental Capacity Act 2005 Code of Practice provides information on points to consider when assessing a person's capacity to make a decision and should be referred to for more detailed guidance.

http://www3.imperial.ac.uk/pls/portallive/docs/1/51771696.PDF

14.3 Young Persons

14.3.1 Section 8 of the Family Law Reform Act entitles young people aged 16 or 17, having capacity, to give informed consent.

14.3.2 The courts have held that young people (below the age of 16) who have sufficient understanding and intelligence to enable them to understand fully what is involved will also have capacity to consent.

14.3.3 It should be seen as good practice to involve the parent(s) of the young person in the consent process, unless this is against the wishes of the young person.

14.4 Parental Responsibility

14.4.1 The Children Act 1989 sets out persons who may have parental responsibility, these include:

- The child's parents if married to each other at the time of conception or birth;
- In the case of children born after 1 December 2003, where the father's details are registered on the birth certificate the father will also have parental responsibility.
- The child's mother, but not the father if they were not so married and not named on the child's birth certificate (as above), unless the father has acquired parental responsibility via a court order or a parental responsibility agreement or the couple subsequently marry;
- The child's legally appointed guardian;
- A person in whose favour the court has made a residence order in respect of the child;
- A local authority designated in a care order in respect of the child:
- A local authority or other authorised person who holds an emergency protection order in respect of the child. (Note: Foster parents or guardians do not automatically have parental responsibility)

14.5 Whilst, under current law, no-one can provide consent on behalf of an adult in order to satisfy the Common law requirement, it is generally accepted by the courts that decisions

about treatment, the provision of care, and the disclosure of information, should be made by those responsible for providing care and that they should be in the best interests of the individual concerned.

14.6 Obtaining Consent

14.6.1 For consent to be valid a number of criteria must be satisfied (see 13.1.3 above). In order for consent to be obtained lawfully it is essential that all persons who may be expected to obtain consent for the sharing of personal information receive appropriate training and that under normal circumstances only those employees who have received training and been approved by management should seek consent.

14.7 Disclosure of Personal Information

14.7.1 The passing of personal information without either statutory power or the consent of the person concerned, places both the agency and the individual member of staff at risk of litigation.

14.7.2 It is therefore essential that all agencies who are party to the Overarching Protocol have in place policies and procedures governing who may disclose personal information and that such policies/procedures are communicated to all of their employees.

14.8 Disclosure with consent

14.8.1 Only staff who have been authorised to do so should disclose personal information about an individual service user.

14.8.2 Prior to disclosing personal information about an individual, the authorised member of staff should check the individual's file/record in order to ascertain:

- that consent to disclose has been given, and
- the consent is applicable for the current situation, and
- any restrictions that have been applied.

14.8.3 On the first instance of disclosure with respect to the particular situation, the person making the disclosure should notify the recipient if consent has been given for the disclosure and any specific limitations the individual has placed on their consent.

14.8.4 Disclosure of personal information will be strictly on a need to know basis and in accordance with any Information Community Agreement and/or Purpose Specific Information Sharing Agreement (PSISA).

14.8.5 All information disclosed should be accurate and factual. Where opinion is given, this should be made clear to the recipient.

14.8.6 On disclosing personal information to another agency, a record of that disclosure should be made on the individual's file/record, this should include:

- When the disclosure was made
- Who made the disclosure
- Who the disclosure was made to
- How the disclosure was made
- What was disclosed

14.8.7 The recipient of information should record:

- The details of the information received
- Who provided it
- Any restrictions placed on the information that has been given

14.9 Disclosure without consent

14.9.1 Disclosure of personal information without consent must be justifiable on statutory grounds, or a meet the criterion for claiming an exemption under the Data Protection Act. Without such justification, both the agency and the member of staff expose themselves to the risk of prosecution and liability to a compensation order under the Data Protection Act or damages for a breach of the Human Rights Act.

14.9.2 There are exceptional circumstances in which a service user's right may be overridden, for example:

- Where there is evidence or reasonable cause to believe that a child, young person or adult is suffering or risk of suffering, significant harm, or
- if there is evidence of serious public harm or risk of harm to others, or
- if there is evidence of a serious health risk to an individual, or

- o if the non-disclosure would significantly prejudice the prevention, detection or prosecution of a crime.
- o if instructed to do so by a court

14.9.3 All agencies should designate a person who has the knowledge and authority to take responsibility for making decisions on disclosure without consent. This person should hold sufficient seniority within the agency with influence on policies and procedures. Within the heath and social care agencies it expected that this person will be the Caldicott Guardian.

14.9.4 If information is disclosed without consent, then full details will be recorded about the information disclosed, the reasons why the decision to disclose was taken, the person who authorised the disclosure and the person(s) to whom it was disclosed.

14.9.5 A record of the disclosure will be made in the service user's case file and the service user must be informed if they have the capacity to understand, or if they do not have the capacity then any person acting on their behalf must be informed. If information is disclosed without consent, there may be some exceptional circumstances (particularly in the context of police investigations or child protection work) where it may not be appropriate to inform the service user of the disclosure of information. This situation could arise where the safety of a child (or possibly sometimes of an adult) would be jeopardized by informing the service user of such disclosure. In many such situations it will not be a case of never informing the service user, but rather delaying informing them until further enquiries have been made. Any decision not to inform, or to delay informing, should be recorded on the service user's case file, clearly stating the reasons for the decision, and the person making that decision.

14.9.6 In deciding whether or not disclosure of information given in confidence is justified it is necessary to weigh the harm that would result from breach of confidence against the harm that might result if you fail to disclose the information.

14.9.7 All agencies who are party to this Overarching Protocol should set in place policies and procedures that deal specifically with the sharing of information under emergency situations e.g. major disaster.

14.9.8 If disclosure is made without consent, the person making the disclosure must:

- o Advise the recipient accordingly.
- o Record the full details of the disclosure that has been made, including the reason why the decision to disclose was taken (statute or exemption);
- o Who made the disclosure and to who it was disclosed to.

14.9.9 The recipient of information that has been disclosed without consent should record:

- o The details of the information received.

- Who provided it.
- Any restrictions placed on the information that has been given e.g. 'not to be disclosed to the service user'.
- That the information was provided without consent, and the reason(s) why (if known).

14.10 Recording Consent

14.10.1 All agencies should have in place a means by which an individual, or their guardian/representative, can record their explicit consent to personal information being disclosed and any limitations, if any, they wish to place on that disclosure.

14.10.2 The consent form should indicate the following:

- Details of the agency and person obtaining consent.
- Details to identify the person whose personal details may/will be shared.
- The purpose for the sharing of the personal information.
- The organisation(s)/agency(ies) with whom the personal information may/will be shared.
- The type of personal information that will be shared.
- Details of any sensitive information that will be shared.
- Any time limit on the use of the consent.
- Any limits on disclosure of personal information, as specified by the individual.
- Details of the supporting information given to the individual.
- Details of the person (guardian/representative) giving consent if appropriate.

14.10.3 The individual or their guardian/representative, having signed the consent, should be given a copy for their retention.

14.10.4 The consent form should be securely retained on the individual's file/record and that relevant information is recorded on any electronic systems used in order to ensure that other members of staff are made aware of the consent and any limitations.

15 APPENDIX E - Handling Breaches

The process for reporting breaches of this Protocol (Tier 1), any Information Community Agreement (Tier 2) and other Purpose Specific Information Sharing Agreement (PSISA) (Tier 3) is outlined below.

15.1 All breaches are to be logged, investigated, and the outcome noted. The logs will be examined as part of the review process.

15.1.1 The following types of incidents will be logged:

- Refusal to disclose information
- Conditions being placed on disclosure
- Delays in responding to requests
- Disclosure of information to members of staff who do not have a legitimate reason for access
- Non-delivery of agreed reports
- Inappropriate or inadequate use of procedures e.g. insufficient information provided
- Disregard for procedures
- The use of data/information for purposes other than those agreed in the protocol
- Inadequate security arrangements.

15.2 Breaches noted by members of staff:

15.2.1 A member of staff working on behalf of any organisation party to this protocol who becomes aware that the procedures and agreements set out in the protocol (or subsequent agreements) are not being adhered to, whether within their own or a partner organisation, should first raise the issue with the line manager responsible for the day-to-day management of the protocol.

15.2.2 The manager should record the issue and check whether the concern is justified. If the manager concludes that the protocol is being breached, he or she should first try to resolve it informally. If the matter can be resolved in this way, the outcome should be noted and forwarded to the designated person for that Information Community Agreement or Purpose Specific Information Sharing Agreement (PSISA) who should file the details in a 'breaches log'.

15.3 Breaches alleged by a member of the public:

15.3.1 Any complaint received by, or on behalf of, a member of the public concerning allegations of inappropriate disclosure of information will be dealt with in the normal way by the internal complaints procedures of the organisation who received

the complaint: Any disciplinary action will be an internal matter for the organisation concerned.

15.3.2 In order to monitor adherence to and use of the protocol, procedures should be established within each organisation by which complaints relating to the inappropriate disclosure of information is passed by the officer designated to deal with breaches of the Purpose Specific Information Sharing Agreement (PSISA). The designated officer should report any complaints of this nature to the equivalent officer in each agency.

15.3.3 All alleged breaches of the protocol, whether proven or not, should be analysed as part of the formal review of this protocol and subsequent Information Community Agreements or Purpose Specific Information Sharing Agreement (PSISA)s.

15.3.4 The ICO has produced guidance on data security breach management. In the event of a data breach occurring, each will be managed on a case by case basis, in accordance with this guidance. This guidance will also be followed where a decision is required regarding notification of the data breach to the ICO.

16 APPENDIX F – Template Tier Two – Information Community agreement

To follow – April 2015

17 APPENDIX G - Purpose Specific Information Sharing Agreement (PSISA): Template

Note:

THIS TEMPLATE IS IN DRAFT FORMAT AND ILLUSTRATES THE TYPE OF INFORMATION THAT NEEDS TO BE CONSIDERED WITHIN A TIER 3 DOCUMENT. AT THIS DRAFT STAGE, TITLES AND LAYOUT MAY BE SUBJECT TO CHANGE.

PURPOSE SPECIFIC INFORMATION SHARING AGREEMENT (PSISA)

The Agreement

TITLE:

Document History

This document has been distributed to:

Version	Date	Author	Released to	Comments/Changes made

Links to other Information Community Agreements or Purpose Specific Information Sharing Agreement (PSISA)s:

Agreement Title	Date & Version	Lead Agency	Contact details

Template

Please refer to the accompanying guidance notes when completing this form.

1 What category of data under the Data Protection Act is being shared?	**YES/NO**
Data to be shared is classified as Personal Data	
Data to be shared is classified as Sensitive personal Data	
Data to be shared will be anonymised	
Data to be shared will be psuedonymised	

2 Who will I be sharing information about?

3 For what purpose is the information being shared?	
Is the information being shared for Primary Purposes	YES/NO
Is the information being shared for secondary purposes	YES/NO

4 What information will be shared?			
(A) Description of data/information:	**(B) Field:**	**(C) Extracted from which system/Derived from:**	**(D) Agency Name:**

(E) Frequency of data sharing	One off: Y/N	Routine: Y/N
(F) Other relevant information:		

5 Who might I be sharing with?		
Agency & Lead Contact details:	**Provider**	**Recipient**

6 Can I legally share this information?	
(A)Legislation	**(B) Duties**
(C) Data Protection Act 1998	Under **Schedule 2** of the DPA, either of the following conditions can be met: 1. Under **Schedule 3**, the following conditions can be met: 1. It is also important to ensure that other Data Protection principles are complied with, for example the information being shared is relevant to the purposes of this agreement and is not excessive; information being shared is accurate and up to date; information is kept for no longer than necessary; information shared is kept secure.

7 Do I need to obtain consent?	
(A) Are you relying an on implied statutory power to share?	Y/N
(B) Are you relying on consent?	Y/N

8 What am I telling Service Users about this information sharing & how are they notified?	
(A) Is the information being shared for a different purpose other than that set out in each agency's fair processing notice on how we use information?	**Yes** – go to A1 **No** – go to B
(A1) Provide the link to each Agency's privacy notice	
(B) How will individuals be notified of the data sharing under this agreement?	

9 How and when might I share information?			
(A) Role/ person sending/receiving data	(B) Organisation	(c) Method of Secure Transfer	(D) Frequency of Transfer

10 How will shared information be recorded and held?			
(A) Organisation	(B) Location/Technical arrangements	(C) Duration	(D)Destruction

11 Who else can access this information?

12 Handling Breaches	
(A) Name and contact details of person who is to be informed of breach	
Agency	Name and contact details
(B) Timescales	

13 Other measures or considerations

14 Review of this agreement	
Name/Role of Reviewers:	
Date of Initial Review	
Date of Consequent Reviews:	

Annex 1

Purpose Specific Information Sharing Agreement (PSISA)

In respect of

(Insert Title)

DECLARATION OF ACCEPTANCE & PARTICIPATION

Signed by, for and on behalf of: Page 1 of

Organisation	
Name	
Position	
Contact Details: Phone: Email:	
Signature:	
Date:	

Name of agency contact for sharing information under this Purpose Specific Information Sharing Agreement (PSISA)	
Position	
Contact Details: Phone: Email:	
DPA Registration Number & Date of Renewal:	

Each agency who signs up to this agreement is to complete this form. Please print off as required.

Annex 2

Purpose Specific Information Sharing Agreement (PSISA)

(Insert Purpose Specific Information Sharing Agreement (PSISA) Title)

Master List of Signatory Organisations & their Designated Person's

Page 1 of

Agency	Designated Person & Position	Contact Details (telephone & Email Address)	Date when agency signed up to this PSISA

Please insert, complete and print additional sheets as required.

Purpose Specific Information Sharing Agreement (PSISA) – Guidance Notes

General

See Wolverhampton Overarching Information Sharing Protocol – **Section 4 - Structure** for an overall description of the Information Sharing three tier approach and the different elements.

In order to share appropriate information between partners there must be a lawful, defined and justifiable purpose(s) which supports the effective delivery of a policy or service that respects people's expectations about the privacy and confidentiality of their personal information but also considers the consequences of a failure to act. This in turn must be supported by robust business processes.

The questions in this document are designed to 'walk' Managers/Practitioners/Designated Person's and other specialist support (e.g. Legal, Technical, Data Protection, etc) through a process that should help fulfil this objective.

Scope

- This Purpose Specific Information Sharing Agreement (PSISA) is the third element of the information sharing framework. It is aimed at an organisations "operational management/practitioner" level and it will define the relevant business processes which support information sharing between two or more agencies for a specified purpose.

- Those Managers/Practitioners/Designated Persons negotiating this Purpose Specific Information Sharing Agreement (PSISA) will have to complete Sections 2 to 14 inclusive.

- This Purpose Specific Information Sharing Agreement (PSISA) is supplementary to Wolverhampton Overarching Information Protocol (Tier 1), which must be consulted when drawing up this agreement, along with any Information Community Agreements that are in place and relevant to this Purpose Specific Information Sharing Agreement (PSISA).

- Partner organisations may belong to a variety of differing Purpose Specific Information Sharing Agreement (PSISA)s and Information Community Agreements.

  Partners may use the information disclosed to them under a Purpose Specific Information Sharing Agreement (PSISA) only for the specified purpose(s) set out in that Purpose Specific Information Sharing Agreement (PSISA) document. They may not regard shared information as intelligence for the general use of their organisation unless they have defined and agreed this purpose within the Purpose Specific Information Sharing Agreement (PSISA) and have informed their respective service users of this use.

- Wherever this Purpose Specific Information Sharing Agreement (PSISA) impacts, or has a dependency, on another Purpose Specific Information Sharing Agreement (PSISA) then details of these must be entered into the Table at Section 2 of this document.

Parties to this Purpose Specific Information Sharing Agreement (PSISA)

- The parties to the Purpose Specific Information Sharing Agreement (PSISA) are those that have signed the Declaration of Acceptance and Participation (DAP) at the end of this document (See this Document Annex 1). This list, along with the details of each organisation's 'Designated Person(s)' as shown on the 'DAP' and at Annex 2, will be updated and reissued on a regular basis.

- Any party to this Purpose Specific Information Sharing Agreement (PSISA) who is not already a party to Overarching Protocol, agrees to comply with the terms of the Overarching Protocol insofar as it is relevant to the information sharing under this Purpose Specific Information Sharing Agreement (PSISA).

- By signing this document all of the parties agree to accept and implement this Purpose Specific Information Sharing Agreement (PSISA) and to adopt the statements and procedures contained within it.

- Any purported breaches of, or other complaints about, this agreement will be dealt with in accordance with the processes described at Appendix E - Handling Breaches of the Overarching Protocol.

User Guide

1 What category of data under the Data Protection Act is being shared?

Please select the category of data being shared.

- Personal Data – information that would identify a living individual such as name, date of birth, address etc.
- Sensitive Personal Data – personal data which consists of the following information:
    - The racial or ethnic origin of an individual
    - Political opinions
    - Religious beliefs or beliefs of a similar nature
    - Membership of a trade union
    - Physical or mental condition of an individual
    - Sexual life of an individual
    - The commission or alleged commission of an offence or
    - Any proceedings for any other offence committed or alleged to have been committed by the individual, the disposal of such proceedings or the sentence of any court in such proceedings.
- Anonymised Data – data which has had identifiers removed so that an individual cannot be identified.
- Pseudonymised Data – data which has had identifiers removed and replaced with a pseudonym.

The data being shared under this agreement is likely to be either personal or personal sensitive data, unless the information to be passed is entirely anonymised or statistical. Where if it is anonymised or statistical, you should give careful consideration to the possibility that an individual could nevertheless be identified from it – e.g. if it provides statistics on the ethnicity of crime victims in a limited geographical area it might inadvertently identify someone from an uncommon ethnic group in that locale. Pseudonymised information may be a consideration in these circumstances.

2 Who will I be sharing information about?

Please detail the types of service users whose information is being shared.

3 For what purpose is the information being shared?

Provide detail on the specific purpose for which personal information will be shared and the benefit that is to be achieved by sharing the information.

Please indicate whether the information sharing is for PRIMARY or SECONDARY PURPOSES.

Primary Purposes – this is information that is being shared for direct healthcare and medical purposes. This would directly contribute to the treatment, diagnosis or the care of the individual. This also includes relevant supporting administrative processes and audit/assurance of the quality of healthcare service provided.

Secondary Purposes – this is information being shared for non-direct healthcare and medical purposes - such as service improvement, performance management, reporting or commissioning.

4 What information will be shared?

(A) List the items of information to be disclosed - for example Name, DOB, Address, Postcode,
(B) List the data field name/criteria each item will be derived from.
(C) List the system(s) from which each data field/record is extracted from/derived from
(D) List the Agency from where the information is being sent from.
(E) Detail the frequency of when the information is being sent. Is the information being shared as a one-off data sharing initiative - if so detail when the information is being sent. Is the information being shared on a routine basis – if so detail the frequency. If on the other hand you propose an agreement to make a series of individual disclosures in response to specific requests – sharing offender details at case conferences for instance -it may be necessary to be more general.
(F) Are there any data quality issues, such as the accuracy, validity, timeliness and relevance of the data, if there are, then these should be considered here.

5 Who might I be sharing with?

Identify the relevant agencies/ organisations/practitioners and whether they are a provider or recipient of personal information or both.

6 Can I legally share this information?

Does your organisation have the vires (power) to share? Which particular legislative function is the data sharing taking place?

(A) List the legislation/statutory duty that the information can be shared under.
(B) List the relevant section and statutory duties that enable the sharing to take place.
(C) Under the Data Protection Act 1998, what conditions in schedule 2 and/or schedule 3 of the Act can be met? If personal data is being shared then only 1 condition from schedule 2 needs to be met. Where sensitive personal information is being shared – then 1 condition from both schedule 2 and 3 need to be met.

Conditions for processing personal data under the DPA 1998.	
Schedule 2 - Personal Data	***Schedule 3- sensitive personal data***
The individual who the personal data is about has consented to the processing.	The individual whom the sensitive personal data is about has given explicit consent to the processing.
For the performance of a contract to which the 'individual' is a party, or the individual has	The processing is necessary so that you can comply with employment law.

asked for something to be done so they can enter into a contract	
The processing is necessary because of a legal obligation that applies to the agency (except an obligation imposed by contract)	The processing is necessary to protect the vital interests of: - the individual (in a case where the individual's consent cannot be given or reasonably obtained), or - another person (in a case where the individual's consent has been unreasonably withheld).
The processing is necessary in order to protect the vital interests of the data subject. This applies in cases of life or death, such as where an individual's medical history is disclosed to A&E treating the data subject following a serious road accident.	The processing is carried out by a not-for-profit organisation and does not involve disclosing personal data to a third party, unless the individual consents. Extra limitations apply to this condition.
The processing is necessary for exercising statutory, governmental, or other public function	The individual has deliberately made the information public
The processing is in accordance with "legitimate interests" condition	The processing is necessary in relation to legal proceedings; for obtaining legal advice; or otherwise for establishing, exercising or defending legal rights.
	The processing is necessary for administering justice, or for exercising statutory or governmental functions.
	The processing is necessary for medical purposes, and is undertaken by a health professional or by someone who is subject to an equivalent duty of confidentiality
	The processing is necessary for monitoring equality of opportunity, and is carried out with appropriate safeguards for the rights of individuals.

See Appendix B and C of the Wolverhampton Overarching Information Sharing Protocol for further guidance.

7 Do I need to obtain consent?

(A) Are you relying on an expressed or implied statutory power to sharing? Refer to section 6 - is there a statutory power or legal duty that enables you to share information without consent? What conditions for processing are being met for the data you are sharing?
(B) Are you normally going to rely on consent? If so describe how consent will be obtained, recorded and how long it will be valid for.

If consent is normally required to share information for this purpose; provide detail on any specific circumstances where this consent is not required.

Advice on consent is available from Appendix D in the Wolverhampton Overarching information sharing protocol

8 What am I telling Service Users about this information sharing & how are they being notified?

(A) Identify whether the sharing of information under this agreement is covered by each relevant agency's "fair processing notice"/Privacy Notice (See Appendix D – 13.1.6 and 13.1.7 of the Wolverhampton Overarching Information Sharing Protocol).
(B) If the sharing of data is not covered under this agreement complete section B and describe how you are informing individuals of the data sharing under this agreement.

Also outline how and when this notification is provided to individuals. If applicable, outline the circumstances where the Service User will not be told about the information sharing. If the consent is due to last for a lengthy period of time, detail at what points/how often an individual will be reminded of the fair processing information and given a subsequent chance to "opt out" having previously given consent.

9 How and when might I share information?

(A) Detail the role/name of persons sending or receiving data
(B) Detail the name of the organisation sending or receiving the information
(C) Detail the method of transfer – e.g. secure email, Secure FTP etc.
(D) Detail the frequency of the transfer

10 How will shared information be recorded and held?

(A) Name of organisation
(B) How/Where will the information be stored by the receiving partner? Describe the physical and technical security arrangements each agency has in place?
(C) Detail how long the information is being kept for. Do any operational retention periods apply? Can it be securely deleted once processed or do you need to keep if for a certain period of time after the transfer? The nature of the information to be shared will have a bearing on how long it should be held. Refer to your organisations record retention schedule for further guidance or discuss with the organisation(s) that is going to be providing the information.
(D) Personal information must be securely disposed of in line with the requirement under the 7th Data Protection Principle. Describe how each agency will ensure that the personal data is

securely removed from their systems and any printed copies securely destroyed at the end of the work for which it was intended, or on termination of the contract. For example - In complying with this clause, electronic copies of the personal data shall be securely destroyed by either physical destruction of the storage media or secure deletion using appropriate electronic shredding software that meets HM Government standards. Any hard copy will be destroyed by cross-cut shredding and secure re-cycling of the resulting paper waste.

11 Who else can access this information?

Access should be limited to a need to know basis, specify if any internal or external parties have access to the information. For internal staff specify any vetting arrangements in place.

12 Handling Breaches

(A) Detail the specific point of contact details for reporting any data breaches or near misses under this agreement. Where possible detail a 2nd point of contact for Business Continuity purposes.
(B) Detail the agreed timeframes that data breaches are to be reported. As soon as possible or no longer than 24 hours after the incident was identified.

Refer to Appendix E – Handling Breaches of the Wolverhampton Overarching Information Sharing Agreement for further information around handling breaches.

13 Other measures or considerations

Add in any other measures and considerations that you may need to document within this agreement. **Example text could be**:

- Information provided by the partner will be held securely, will not be transferred to a third party, and will be used only by appropriate staff for the purposes identified.
- Electronic copies of information will only ever be held on encrypted devices or servers, will not be e-mailed outside the receiving organisation, and if transferred onto portable devices (which must be encrypted), will be disposed of securely and permanently.
- The partner organisation will not keep the personal data on any laptop or other removable drive or device unless that device is protected by being fully encrypted, and the use of the device or laptop is necessary for the provision of the services under this agreement. Where this is necessary, the partner organisation will keep an audit trail of which laptops/drives/devices the personal data are held on.
- Paper copies of information, and printouts of electronic information, will be held securely, transferred either by safe haven fax or couriered in sealed containers and shredded upon disposal.
- Personal identifiable data will only be provided where there is a need to have that level of detail, and it is within the scope of consent on use of information given by the individual.

- The partner organisation shall employ appropriate operational and technological processes and procedures to keep the Personal Data safe from unauthorised use or access, loss, destruction, theft or disclosure. The organisational, operational and technological processes and procedures adopted are required to comply with either the NHS Information Governance Toolkit to level 2, or the requirements of ISO/IEC 27001:2005 (ISO/IEC 17799:2005) as appropriate to the services being provided.
- The partner organisation shall ensure that only such of its employees who may be required by it to assist it in meeting its obligations under the Agreement shall have access to the Personal Data.
- The partner organisation shall ensure that all employees used by it to provide the services as defined in the Agreement have undergone training in the law of data protection, their duty of confidentiality under contract, and in the care and handling of Personal Data;
- The partner organisation agrees to assist the Data Owner promptly with all subject information requests which may be received from the data subjects of the Personal Data;
- The partner organisation shall not use the Personal Data for any purposes other than those formally agreed with the Data Owner.
- The partner organisation shall not disclose the Personal Data to a third party in any circumstances other than at the specific written approval of the Data Owner.
- The partner organisation is NOT permitted to sub-contract any of the processing, nor transfer the personal data to any third party, without explicit written agreement from the Data Owner.
- The partner organisation will NOT transfer the Personal Data to any other country without explicit written agreement from the Data Owner.
- The partner organisation will ensure that the personal data is securely removed from their systems and any printed copies securely destroyed at the end of the work for which it was intended, or on termination of the contract. In complying with this clause, electronic copies of the personal data shall be securely destroyed by either physical destruction of the storage media or secure deletion using appropriate electronic shredding software that meets HM Government standards. Any hard copy will be destroyed by cross-cut shredding and secure re-cycling of the resulting paper waste.
- The partner organisation will indemnify the Data Owner against any costs, expense, including legal expenses, damages, loss, liabilities, demands, claims, actions or proceedings which the Data owner may incur as a result of any breach of this Agreement by the partner organisation.
- This protocol is an integral part of any data sharing Agreement between the signatories to the protocol and shall be governed by and interpreted in accordance with the laws of the United Kingdom.

14 Review of this agreement

When will this agreement be reviewed to assess its validity in future? (it is recommended that each agreement is review every 12 months). Who will undertake the review?

Insert text here

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Privacy Notice:The Better Care Wolverhampton Programme aims to deliver and improve seamless care for patients and service users. To enable us to do this, some information will be shared between City of Wolverhampton Council, Wolverhampton Clinical Commissioning Group, Royal Wolverhampton Hospitals NHS Trust and Black Country Partnership Foundation NHS Trust. If you do not wish your information to be shared please contact WOLCCG.bettercarefund@nhs.net .

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Community Neighbourhood Team MDT Review

Please Selec Locality: North East

Patient Name:					to correctly identify patient
NHS Number:					to correctly identify patient
Primary Diagnosis:					to identify patients/service users needs
Interventions from any MDT reviews in last 12 months:					To identitify if the patients is known to the team
Is there a Health Care and Management Plan in place? If so, provide brieft details:					
Is there a Social Care and Support Plan in place? If so, provide brieft details:					
Aristotle Risk Stratification Score:		**Date**			
Name of Key Worker:					to enable the team to know who has manages the patient
Contact Details of Key Worker:					
Medical History Summary (Last 12 Months):					To enable the team to determine appropraite interventions for patients
Social circumstances:					to enable t he team to understand wider social issues that may impact on the patient/service user condition/progress
Date of first MDT Review:					to identify when the patient was first referred into the CNT. This will help to qaunitfy impact of intervention
Reason for referral to MDT:					
Source of referral to MDT:					

Health History

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Number of Attendances at A&E in last 12 months:					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Reason for Attendances:					
Date of Attendance:					
Time of Attendance:					
Number of Attendances at A&E in last 12 months that resulted in admission:					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Number of Admissions to RWT in last 12 months:					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Reason for Admission:					
Admissions to other facilities in last 12 months e.g. West Park, Intermediate Care, Nursing Home, Rapid Response, Resource Centres, Respite etc.:					to identify if recurring adamissions are for the same/similar conditions or are different. To establish the effectiveness of interventions
Reason for Admission:					
Provide Details of which other facilities accessed:					
Number of GP attendances					**To identify the current state**
Number of GP home visits					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Reason for Home Visit:					
Number of Walk in centre attendances					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Reason for Attendances:					
Number of WMAS call outs					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Reason for call out:					
Number of OOH Call out's					**To identify the current state and to monitor if the interventions masde by the team are effective i.e. reduction in attendances**
Reason for call out:					to identify if recurring attendances are for the same/similar conditions or are different. To establish the effectiveness of interventions

Social Care History

Vulnerable Adults Notification (include Police and WMAS):					To inform health and social care teams in terms of direct patient care - protecting vulnerable adults
Number of Callouts from Carelink:					
Does the Person Live Alone:					
Who is the main carer/ significant other:					
Does the person have capacity:		**Date of Capacity Assessment:**			
Current interventions from MDT:					to enable relevant members of the team to know what interventions are currently being undertaken with patient

Voluntary Sector interventions:		to enable relevant members of team to have a view of any additional interventions by voluntary sector (or lack of) in order to manage the patient effectivelv

MDT Summary and Outcomes

Patient Name:		
Aristotle Risk Stratification Score:		
MDT Review Record:		
Date of review:	27/10/2015	to enable the team to know
Date Discharged from MDT Caseload		
MDT Lead for review:		to inform the team who led the
MDT members present:		to inform the team who was involved in the review
Key issues for patient:		any issues that the patient would like the team to be aware of (consent to be sought during discussion with the patient

Actions from this MDT review:

Start Date	Action	Who	When	Status

to ensure a clear record of actions to ensure that the patient is being managed effectively and in a timely manner
to enable to team to understand what the desired outcomes for the patient/service user are

MDT Actions Lead:		
Measurable outcomes for patient **e.g. decreased/attendances admissions:**	e.g. Outcomes such as redirecting to appropriate care, reducing interventions, linking to BCF outcomes. The BCF Outcomes include: Reduction in Admissions Reduction in Rapid Response Call outs Reduction in Risk Strat Score Case Conference Carried out with GP Referral to CICT Joint Assessment undertaken	
Future review dates:		to inform the team of the next scheduled review/ to avoid duplication of appointments

Case Studies, Admission Avoidance, Rapid Response Team

Case Study 1

- 96 year old lady, referred by her GP.
- He had treated this lady with oral antibiotic with no improvement and had been bedbound for over a week. Her daughter was out of the country on holiday and the lady refused to go into hospital.
- One of the Specialist Nurse Practitioners from the Rapid Response Team completed a full health assessment.
- Diagnosed as an unresolved Chest Infection.
- The dose of Antibiotics was increased, CICT nurse working within rapid response were contacted and visits were made on a daily basis to encourage mobility, independence, ensure medication was given and also ensure adequate dietary intake.
- The outcome of this was the lady was able to stay safely within her own home, a hospital admission was avoided.
- Discharged from Rapid Response Service.

Case study 2

- 81 year old male. Referred by the GP, currently being treated with anti biotics for a confirmed UTI. Known Parkinson's disease.
- Specialist Nurse Practitioner triaged the referral and forwarded to therapy services within Rapid Response Service. Visit made within the 2 hour window.
- The Gentleman was found to have reduced mobility and required immediate support with personal care. Urgent equipment was provided including a rollator frame, wheeled commode and pressure relieving cushion. The CICT within rapid response responded the same day providing lunchtime and enablement calls.
- Outcome was hospital admission was avoided
- Referred onto other services to improve mobility, social services for assessment, GP and Parkinson nurse.

Case Study 3

- 81 year old lady recently discharged from local hospital with cellulitis and bilateral leg ulcers. The lady had long standing mental health problem, this affected her ability to engage with staff. Once home she was unable to mobilise a her daughter was unable to cope with her needs.
- Occupational therapist and Physiotherapist visited her home within 1 hour of referral. The lady was chair bound. Therapist assisted to stand and transfer to commode. Immediate provision of a rotunda patient turner enabled the daughter and HARP team to assist with personal care. The following day provision of a hospital bed and pressure relieving mattress avoided pressure damage and immobility.
- Referrals were made to the community CICT for ongoing rehabilitation to improve independence, GP for medical review, district nurses for leg ulcers and social service help and support for her daughter.
- Outcome was that hospital readmission was avoided.

Case Study 4

- 88 year old lady. Had a fall at home the previous week, seen by paramedics nil acute to note. Referred by GP for assessment by Specialist nurse practitioner as the lady is still experiencing pain on her right side, also had has remained upstairs since the fall.
- Assessed by Specialist nurse practitioner from rapid response. On examination wrist and hand joints were slightly red , inflamed and warm to touch. Diagnosed inflation of Arthritis. Also noted was this lady appeared very nervous and anxious on standing.
- Specialist nurse practitioner prescribed some ibuprofen for inflammation and pain, Therapist within rapid response were contacted for re enablement for loss of confidence post fall.
- Therapists worked intensively with this lady who now goes down stairs and has returned to her pre fall mobility.
- Full mobility returned, pressure sore development avoided and the lady has remained within her own home

Case Study 5

- 81 year old lady referred by her GP for unresolved cellulitis following 3 courses of oral anti biotics, previously admitted to local hospital for Intra venous antibiotics (2 week admissions).
- Assessed by Specialist Nurse Practitioner, confirmed unresolved cellulitis, candidate for Hospital at home for commencement of IV anti biotics within the ladies home. During the assessment the lady mentioned her 83 year old husband also had cellulitis to his legs, he had just completed his 2nd course of oral anti biotics and also was unresolved.
- The couple were referred to Hospital at Home for IV Ertapenem. Rapid Response nurse prescribed all of the required components to initiate treatment.
- Education provided by Rapid response nurse, regarding hygiene and leg/foot care.
- Both patients legs improved. Lengthy hospital admission avoided in both cases.
- Very positive feedback given by both parties.

Patient Feedback

“ We received all of the help we had hoped for when the new service was mentioned . We cannot stress how valuable the help and support that was given by the rapid response team. We were able to receive treatment at home and remain out of hospital”.

Patient Feedback

"The service and attention has been brilliant.

I felt really well cared for throughout the visits.

Thank you very much"

Patient Feedback

“ On every occasion rapid response have been to the care home it has been a pleasure. They are very professional and make the service users feel at ease on every visit. They are all very polite and thoughtful”.

Patient feedback

“Rapid response have been very helpful and I could not have received better care or attention anywhere. I thank you”.

Thank You

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Wolverhampton Transfer of Care Project

Final Report

Version 1.3 DRAFT

18th February 2016

Version control

Date	Details	Action
26/01/16	Version 0.1 created	PwC lead
16/02/16	Versions 0.2 to 1.0 created	PwC lead
16/02/16	Version 1.0 submitted for review by S Marshall and A Ivko	
18/02/16	Version 1.1 reviewed by Project Delivery Group	
19/2/16	Version 1.3 circulated to Project Board	

Contents

Section 1 – Executive summary

1

1.1 Context and background

Introduction

The Rapid Review of Delayed Transfer of Care (DTOC) in August 2015 identified that an unexpected turnover of social care staff in the hospital based Integrated Health and Social Care (IH&SC) Team was the principle factor for a three fold increase in the number of delayed discharges between November 2014 and July 2015. The lack of a standardised approach to managing discharges and an absence of timely management information were the underlying causes that allowed the situation to escalate without intervention.

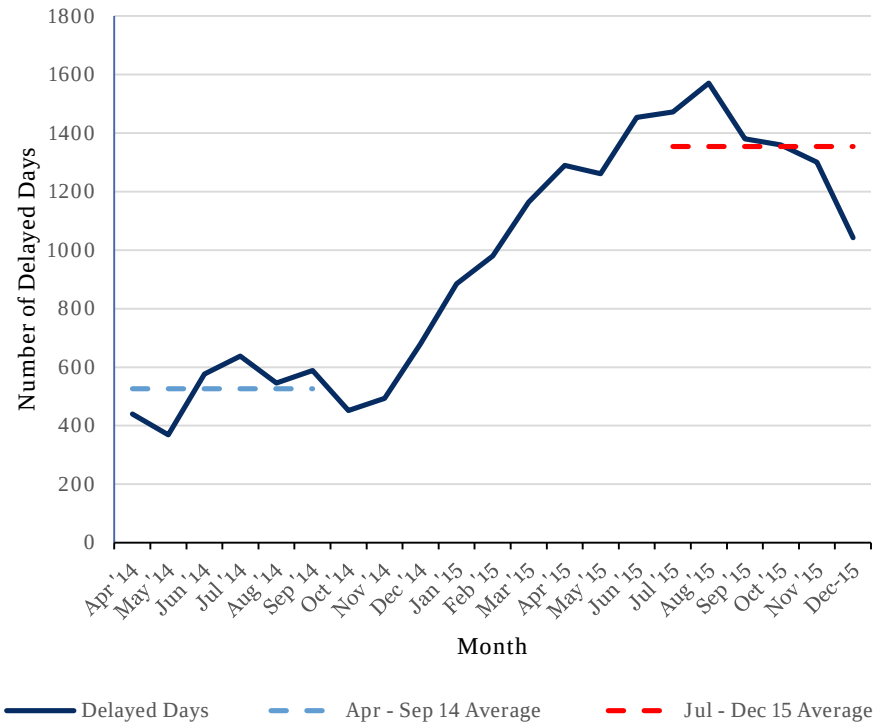
Figure 1 opposite shows the number of reported delayed days in Wolverhampton between April 2014 and December 2015. A 33.6% reduction in reported delays between August and December 2015 is in part attributable to increases in both the number and the stability of hospital based social workers. The efforts of partners from across the system to improve the situation should be commended. It should be recognised, however, that eight of the twenty three social workers are either agency staff or the result of non recurrent funding and there is some residual risk posed by this resourcing option. This report recommends maintaining current hospital based social worker staffing levels.

Working with ward based teams and gathering data from over 251 admissions the Project Team have identified two factors that contribute to discharge performance. These factors have a detrimental effect on patient experience, quality and system resilience. These are:

Significant variation in the approach to discharge plans.

A disjointed model of intermediate care that is not optimised to meet demand.

Fig 1. Number of Reported Delayed Days Apr 2014 – Dec 2015



1.2 Significant variation in the approach to discharge plans

Significant Variation

The project team have witnessed significant variation in the approach taken to discharge planning. Specific issues that impact on the quality of discharge planning are:

There is no recognised means of recording and sharing a patient's individual discharge plan.

There is confusion amongst ward staff regarding the range of services that are available in the community and the most efficient means of referral.

Ward and directorate leadership teams typically focus on managing flow in a short timeframe, routinely focussing on the next 24/36 hours. There is little evidence of collective reflection to improve processes and performance.

The cumulative impact of this variation is an inability to forecast both flow from the acute setting and demand for sub acute services.

Discharge Planning Tools

The diverse needs of patients and the wide range of clinical and emotive issues that impact on discharge planning preclude the development of a one size fits all discharge process. The Project Team have worked with ward based MDTs in four focus areas to drive incremental improvements. The four focus areas are common to any ward or department, and are listed opposite.

1. ***Clear purpose, roles and responsibilities*** – having a shared vision for the purpose of the huddle and also on individual roles and responsibilities.
2. ***Maximised engagement*** – balancing the need to maintain an operational ward whilst ensuring huddle participants are fully engaged in a quality conversation.
3. ***A structured patient centred conversation*** – reviewing the needs of each patient in a structured fashion promotes engagement and increases efficiency.
4. ***Discharge planning*** – creating a simplified question set that enable MDTs to assess the needs of the most complex patients.

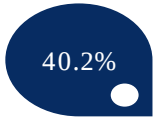
Impact of Standardised Discharge Planning

Using snapshot data gathered from both in scope and control wards on 26 Jan and 11 Feb '16 the Project Team have been able to identify the following impacts of a more engaged approach to MDT Discharge Planning:

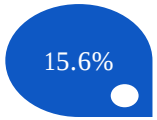
- ***10.7%*** reduction in the average length of stay on the in scope wards between 26th Jan and 10th Feb '16.
- ***14.5%*** difference in average length of stay between the in scope and control wards on 10th Feb '16.
- ***17%*** increase in the use of detailed discharge plans that included a planned MFFD date and Predicted Date of Transfer on the in scope wards between 26th Jan and 10th Feb '16.

1.3 A disjointed model of intermediate care

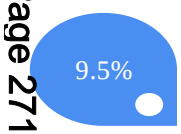
This project has identified three key categories of patient that account for 65.4% of all delays observed on in scope during the period of data collection (11 Jan – 10 Feb '16), these are:



Of all delays observed on in scope wards are experienced by medically fit Out of Area (OoA) patients, i.e. those who are registered with a non Wolverhampton GP.



Of all delays observed on in scope wards are experienced by Wolverhampton patients with social care needs; these delays are incurred during assessment for and commissioning of social care packages.

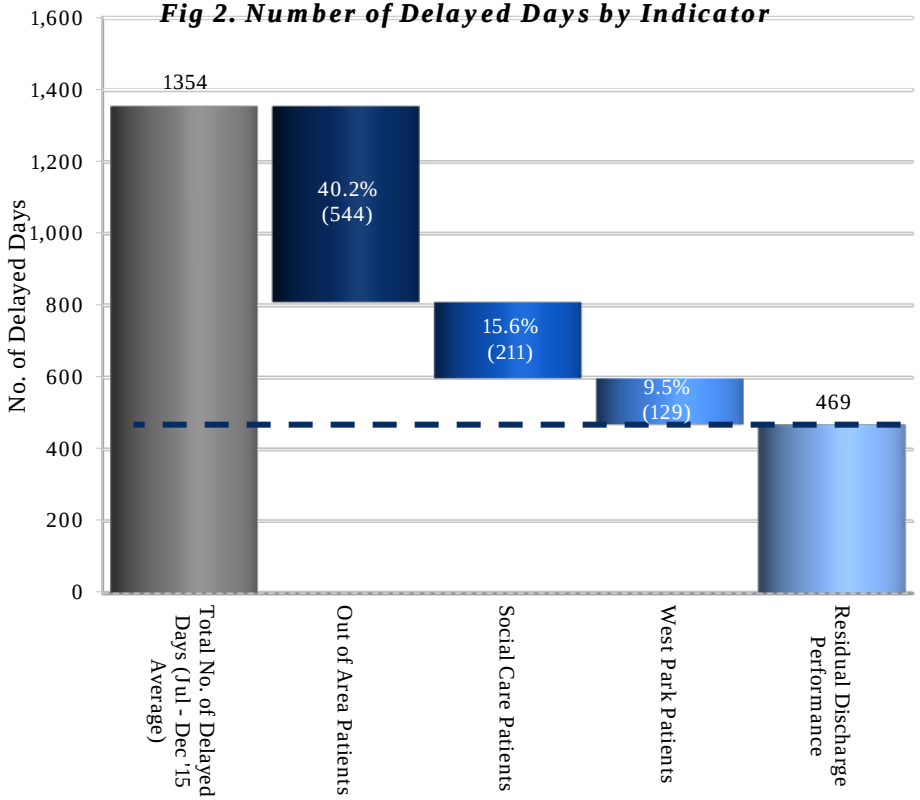


Of all delays observed on in scope wards are experienced by patients waiting for bedded rehabilitation at West Park.

If the trends observed on in scope wards are representative of all wards it would indicate that 884 bed days are being lost to these three categories of patient, as shown in Figure 2. This figure has been derived using the average number of reported DTOC days between Jul and Dec '16 as a baseline.

Developing an integrated model of intermediate care that prevents admission and expedites discharge is a key recommendation of this report. A fully integrated intermediate care model could reduce the levels of reported delays to levels witnesses~~s~~d in the summer of 2014.

Fig 2. Number of Delayed Days by Indicator



1.4 Headline recommendations

Headline Recommendations

This report makes two headline recommendations.

1. Standardise discharge planning processes to identify the most appropriate next care setting for patients and create a consistent view of demand for out of hospital services.

2. Integrate intermediate care services to ensure an appropriate balance of care settings that expedites the discharge of acute patients. Doing so will reduce system costs and reduce the level of hospital based risks experienced by patients.

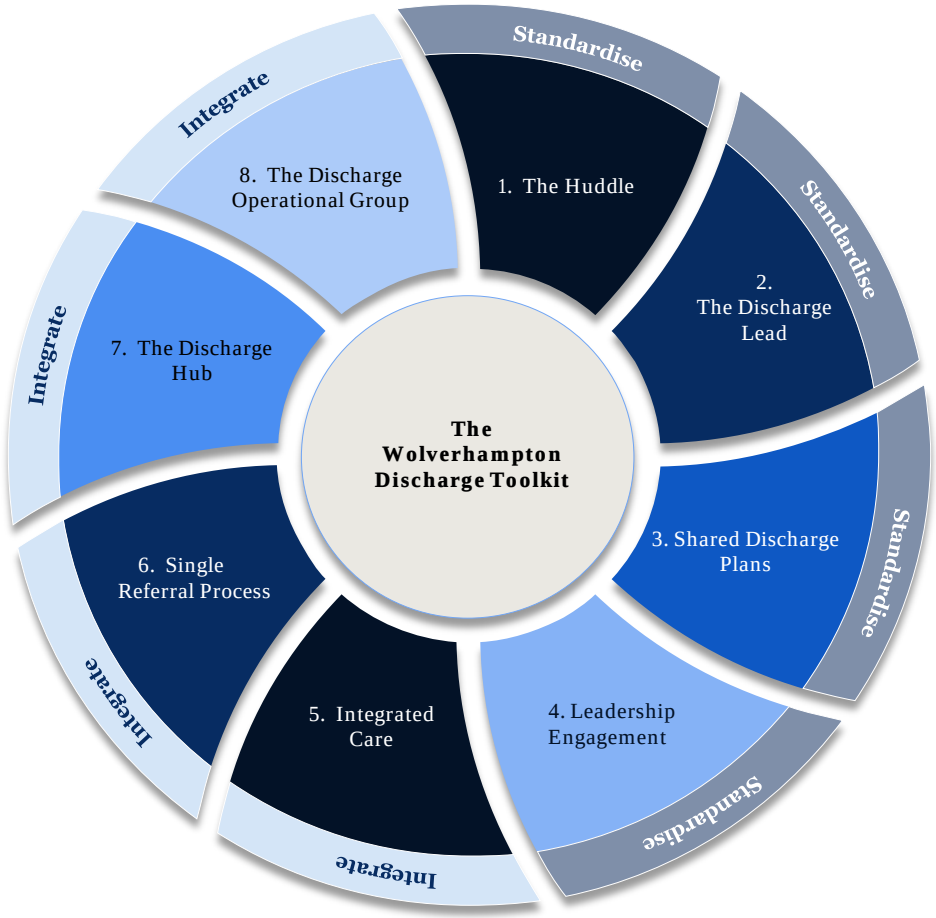
The Wolverhampton Discharge Toolkit

The Project Delivery Group have identified eight interventions that will achieve the headline recommendations of this report. Collectively we are referring to this as the ***Wolverhampton Discharge Toolkit***.

Successful implementation of the Discharge Toolkit will be dependant on:

- Adopting a system perspective of cost and benefit.
- A programme managed approach.
- Continued review of demand, supply and resources.

Fig 3. The Wolverhampton Discharge Toolkit

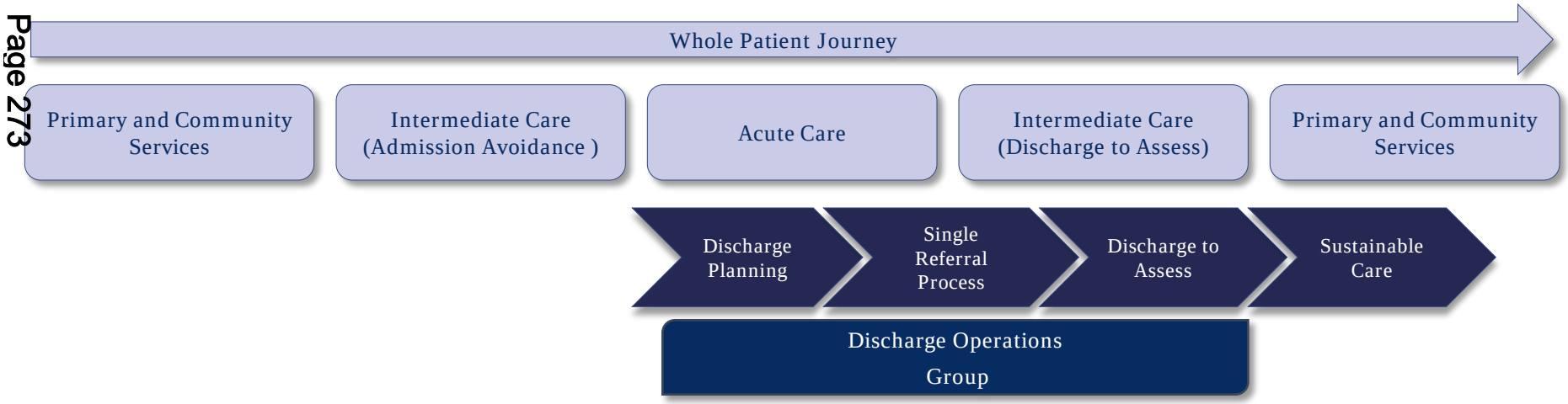


1.5 Relationship with a wider model of care

This report has made specific recommendations targeted at improving the flow of patients between acute and intermediate care settings. It recommends transforming a new model of integrated intermediate model of care in which patients are discharged at the point of being declared medically fit. Assessment for ongoing, long term care needs should happen either at home or in an intermediate care setting.

The interaction between acute, ward based care processes and the wider model of community provision demands a system level response. We recommend a programme managed approach to implementing standardised discharge planning that will increase flow from acute wards and improve the understanding of demand. Commissioning a more integrated model of intermediate care that is optimised to meet demand will sustain increased flow through the system.

Creating a Discharge Operational Group to maintain balance between demand for and supply of intermediate care will provide oversight and a system wide point of escalation beneath the System Resilience Group. This group should have a strong mandate to improve performance and make in year operational changes. In this role it could be considered as the steering group to lead implementation of the Wolverhampton Discharge Toolkit.



Section 2 – Project overview

2

2.1 Project overview

MDT Discharge Planning

During implementation the Project Team have worked closely with in scope wards to identify areas of best practice and develop the transfer of care planning process. This has focussed on improving the value and output of MDT ward huddles ensuring that they function as the primary forum for discharge planning. Staff engagement has been focussed on coaching and mentoring rather than intervention.

Improving the level of engagement between member of the MDT has enabled a higher quality transfer of care conversation. Improving moves the MDT from a simple information exchange to a level where discharge plans are created, goals established and planned dates of discharge agreed. Creating this has enabled staff to prioritise their work and to enhance their interaction with patient and family.

Ward	w/c 11 Jan	w/c 18 Jan	w/c 25 Jan	w/c 1 Feb	w/c 8 Feb
C15 and C17	Ergonomics and Engagement	Structured Conversations	Performance	Discharge Planning	Continued
A8 and C24		Ergonomics and Engagement	Structured Conversations	Performance	Discharge Planning
A5			Huddle Analysis	Review Discharge Procedure	Structured Conversations

Management Information

In addition to improving MDT discharge planning, the team have collected data on all patients admitted to the in scope wards between 11 January and 10 February '16. The data collected has included the key dates established during the patient journey, information on the patient's background and the outcome of their transfer of care, providing statistical grounding to the identified causes of delayed transfers.

2.2 Data analysis of discharge planning

Introduction to the Data Collection Activity

Data from 251 admissions to in scope wards was collected using a two-step approach:

Attendance of the daily ward huddles to obtain information on new admissions and the discharge planning of existing patients.

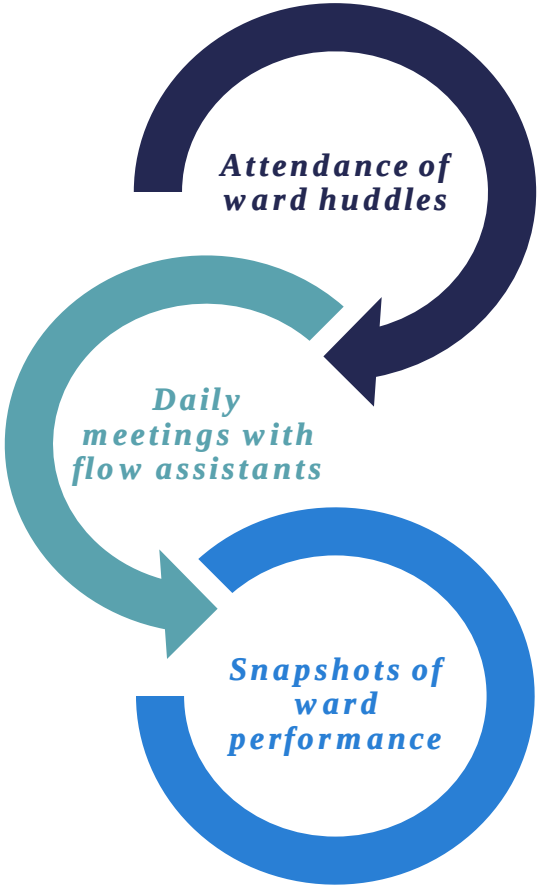
Daily meetings with flow assistants to validate the information captured at the ward huddles and obtain any missing data on patients' backgrounds and transfer of care journeys.

Of the 251 patients entering the wards during this timeframe 61.4% (n=154) have been discharged or no longer require hospital care, with 38.6% (n=97) remaining in RWT care. The data presented here is a composite of both these patient groups.

It should be noted that this data is bespoke and is not a subset of the data reported monthly by RWT to the NHS. It is therefore possible that there will be a discrepancy between this data and the publically available data for RWT in Feb '16.

In addition, the information on in scope patients has been supplemented by snapshots of the discharge planning activity for all patients (irrespective of admission date) present on the intervention wards on 26 Jan and 10 Feb '16. This provides an insight into performance at two points during the project and allows comparison between in scope and control group wards.

Fig 4. Method for Data Collection



2.3 Identifying the causes of delay

The Frequency of Delayed Transfers of Care

251 patients were admitted to the in scope wards during the period 11 Jan to 10 Feb '16, 26.3% of these patients experienced a delay. This cohort of patients typically experienced a delay of more than five days leading to an overall length of stay of eleven days.

Highlighting the Leading Factors Influencing Performance

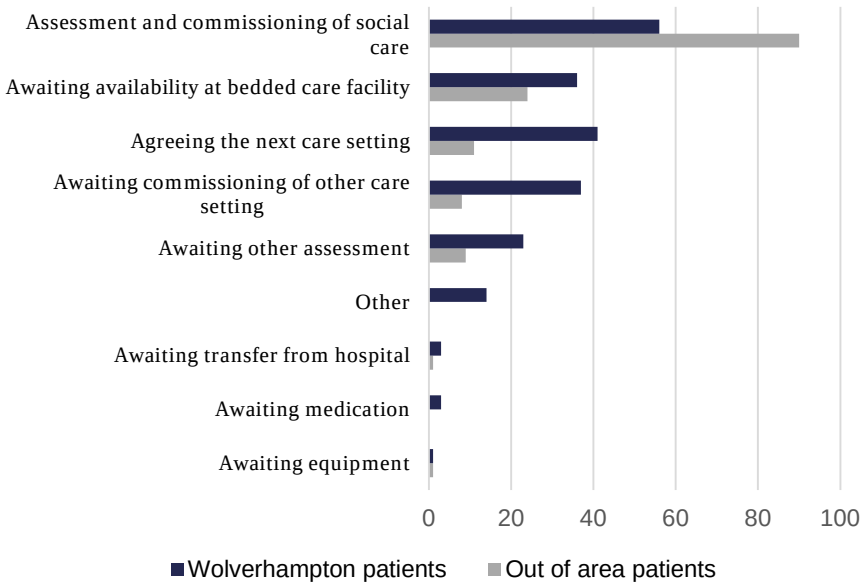
The data gathered on patients admitted to the intervention wards during the implementation phase suggests the following:

- 65.4% of all delayed days are attributable to three categories of patients:
  - Patients who reside in local authorities other than Wolverhampton but who have been admitted to RWT's care (40.2%).
  - Wolverhampton patients requiring social worker allocation, assessment and packages of care (15.6%).
  - Patients waiting for transfer to West Park (9.5%).
- 14.3% of all patients have been, or are due to be, discharged to an intermediate care setting.

Analysis

The high proportion of delayed bed days (65.4%) that can be attributed to medically fit patients and the relatively low use (14.3%) of intermediate care settings collectively indicates (3rd person singular - refers to proportion) that the provision of intermediate care services is not aligned with demand. The relatively low use of these settings points towards a lack of understanding of the services that are available and difficulty in accessing the services.

Fig 5. The Number of Delayed Days by Cause of Delay



2.4 Patient category: Out of Area patients

Data Insight

- Out of Area (OoA) patients account for 40.2% of delayed days (n=144) but just 30.7% of the total number of admissions (n=77).
- The average delay per delayed patient for Out of Area admissions is 6.5 days – 34.6% higher than the average delay for Wolverhampton patients.
- 86% of Out of Area patients are discharged to sustainable settings.

Observations

Ward-based staff have consistently highlighted the complexity surrounding the discharging of Out of Area patients owing to:

- A perceived divide between health and social care funding that prevents Wolverhampton funding residential care placements for OoA patients.
- A lack of appropriate intermediate care settings to manage these patients in Wolverhampton.
- The absence of a clear process for escalating complex cases.

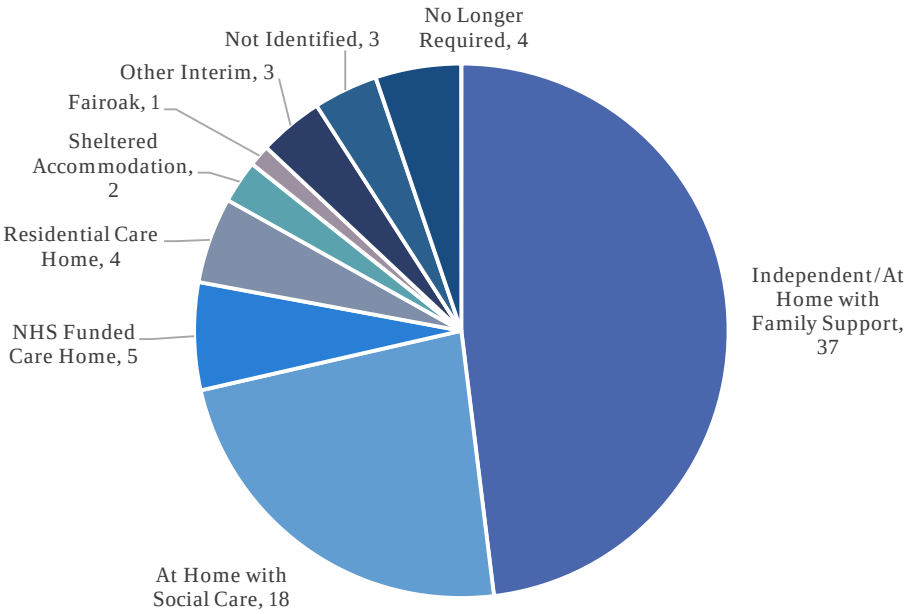
Recommendation

Diverting 75% of these **patients** to a ~~mid tier~~ intermediate residential care settings could release 318 bed days back to the system each month and potentially save £1.43m annually*. **Please remember that Provider cost ≠ Commissioner Cost so this holds true for only one side of the equation, unless the concomitant capacity is removed form a provider setting**

Providing a means of identifying and then escalating complex, Out of Area patients to a level at which the discharge can be planned across local authority boundaries.

*The indicative business case for these benefits is included as Appendix 3.

Fig 6. Next Care Settings for Out of Area Patients



2.5 Patient category: Wolverhampton patients requiring social care input

Data Insight

15.6% of delays observed on in scope wards were attributable to patients who were medically fit and awaiting completion of a social care assessment and commissioning of a new package of care.

The majority of these delayed days relate to patients waiting for completion of assessment processes.

Observations

Working with ward based staff and members of the Integrated Health and Social Care Team indicate that the following are drivers of delay:

Lack of a credible intermediate care setting in which medically fit patients can be assessed for social care needs.

The time taken to complete a social care assessment has increased significantly since the introduction of the Care Act 2015 which requires more complex assessment reporting.

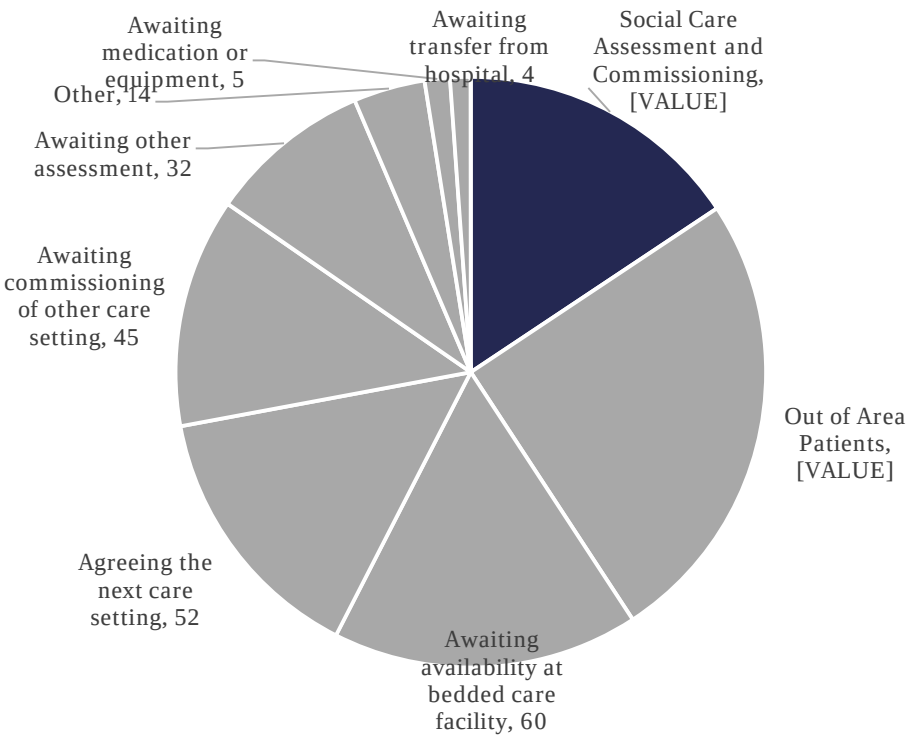
Recommendation

Creating a capability to assess for long term social care needs at home or in a residential setting will reduce delays and the minimise the patients' exposure to hospital based risks.

Transferring 75% of delays attributable to social care to a mid tier residential care setting could release up to 123 bed days each month and create system savings of £0.56m annually*.

Achieving these benefits is likely to require a shift in staffing needs with a greater emphasis on community based social workers.

Fig 7. The Number of Delayed Days by Cause of Delay



*The indicative business case for these benefits is included as Appendix 4.

2.6 Patient category: Patients waiting for transfer to West Park

Data Insight

15.9% (n=34) of all delayed days observed on the in scope wards were experienced by Wolverhampton patients waiting for rehabilitation beds at West Park. These patients account for just 5.2% (n=9) of the patient cohort.

The average delay for patients awaiting transfer to West Park is 6.8 days compared to 4.9 for in scope patients who are resident in Wolverhampton.

The average length of stay is 35.9% longer for patients awaiting discharge to West Park than it is for in scope patients who are resident in Wolverhampton.

Observations

Engagement with therapy staff and stakeholders indicates that Length of Stay at West Park (32 days*[1]) exceeds target and that poor flow through West Park is preventing the discharge from acute wards.

The majority of West Park patients are discharged home with no further rehabilitation or reablement support.

Average length of stay is 14.2% over the target level.

Reducing Length of Stay at West Park by 2 days* will release sufficient capacity to improve flow, see detail in the benefits case in Appendix 5.

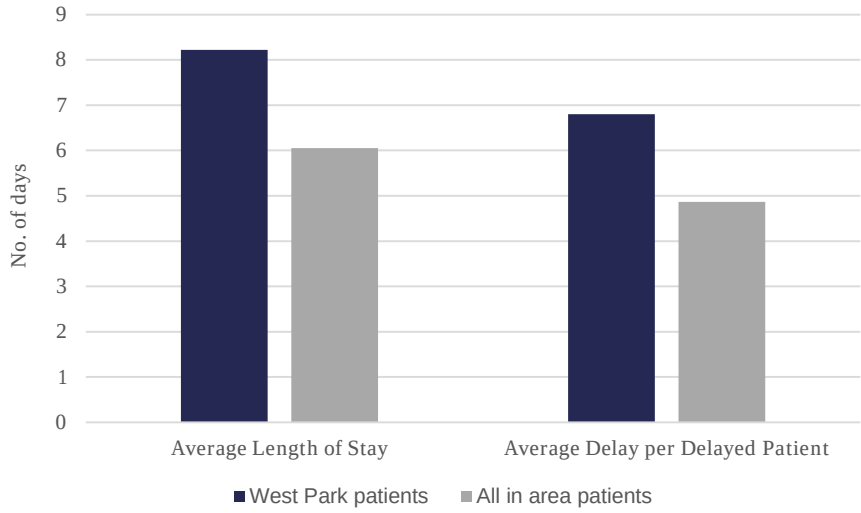
Recommendation

A more integrated model of intermediate care should provide increased options for bedded rehabilitation. It should also improve the use of intermediate care for West Park patients.

Improving flow through West Park will increase demand in the community, the costs of this increase have not been modelled as part of this report.

*[1] Source West Midlands Quality Review Service – July 2015

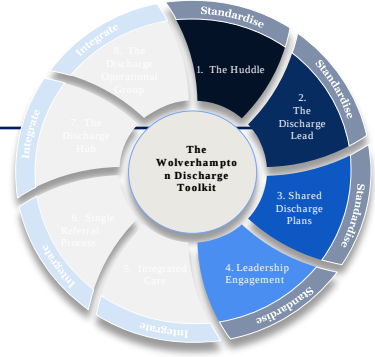
Fig 8. Length of Stay in West Park and Average Delay for West Park Patients



Section 3 – Recommendation 1: A standardised approach to discharge planning

3

3.1 Introduction to discharge planning



Significant Variation

The project team have witnessed significant variation in the approaches taken to discharge planning among the in scope wards, while also identifying shortfalls that are consistently found across the group.

- There is no recognised means of recording and sharing a patient's individual discharge plan.

There is confusion amongst ward staff regarding the range of services that are available in the community and the most efficient means of referral.

Engagement from Directorate Leadership Teams focusses on expediting individual cases and not on wider performance.

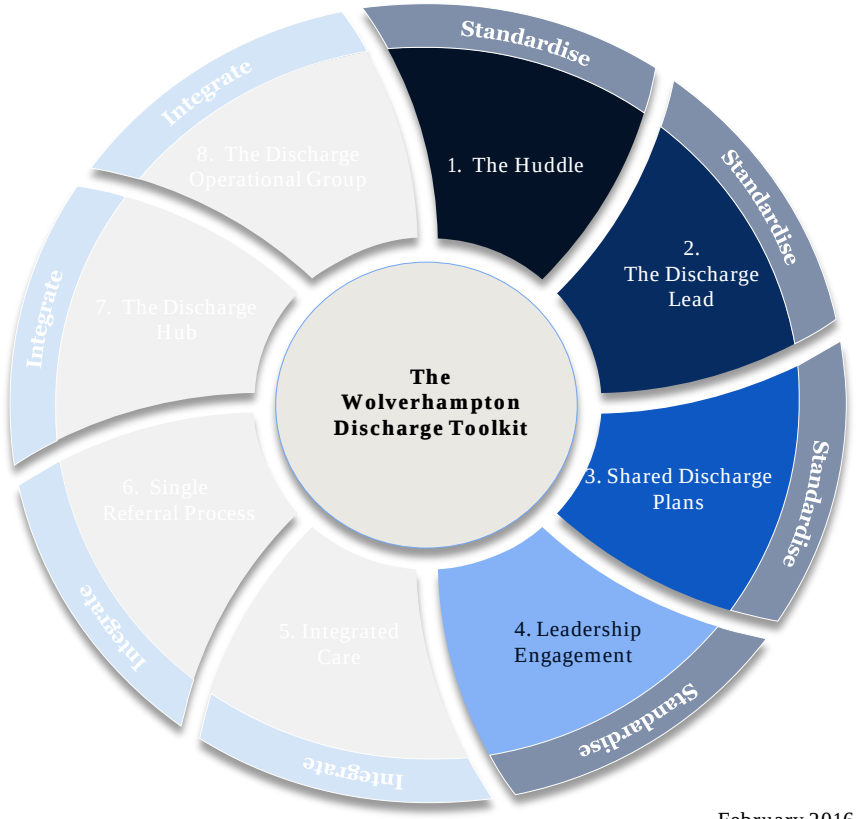
Discharge Planning Interventions

This report recognises that discharge planning may be expedited differently across the wards in line with the varying discharge needs of patients.

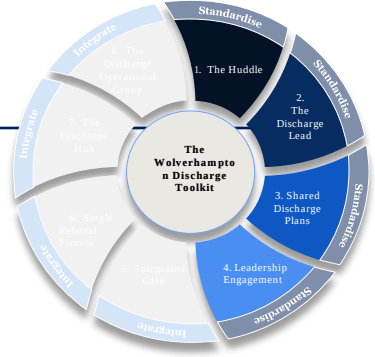
However, it is recommended that the introduction of the following four interventions across all wards will help to significantly reduce the frequency of delays:

1. The MDT Huddle as the principle forum for discharge planning.
2. Appointing a Discharge Lead for each patient.
3. Sharing discharge plans to inform the management of flow.
4. An engaged Directorate Leadership team to sustain performance.

Fig 9. The Wolverhampton Discharge Toolkit



3.2 Benefits of standardised discharge planning



Introduction

The Project Team have worked with ward based MDTs in four focus areas to drive incremental improvements in huddle performance. The four focus areas for the huddle are:

1. ***Clear purpose, roles and responsibilities*** – having a shared vision for the purpose of the Huddle and also on individual roles and responsibilities.
2. ***Maximised engagement*** – balancing the need to maintain an operational ward whilst ensuring a huddle participants are fully engaged in a quality conversation.
3. ***A structured patient centred conversation*** – reviewing the needs of each patient in a structured fashion promotes engagement and increases efficiency.
4. ***Discharge planning*** – creating a simplified question set that enable MDTs to assess the needs of the most complex patient.

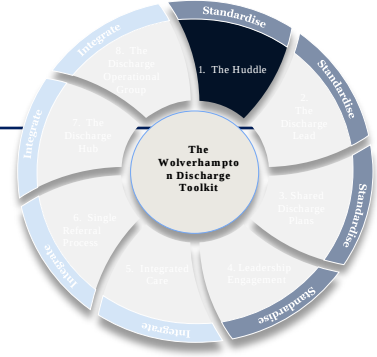
Impact

Where ward teams have engaged with the process we can identify the following benefits:

- ***10.7%*** reduction in the average length of stay on in scope wards between 26th Jan and 10th Feb '16.
- ***14.5%*** difference in average length of stay between in scope and control wards on 10th Feb '16.
- **16%** increase in the use of Planned Dates of Discharge on the in scope wards between 26th Jan and 10th Feb '16.
- ***17%*** increase in the use of detailed discharge plans on in scope wards.

The following four slides identify the tools used to drive huddle performance in each of the four focus areas.

Image 1



3.3 Intervention 1 – The Huddle; Focus area 1 – Clear purpose, roles and responsibilities

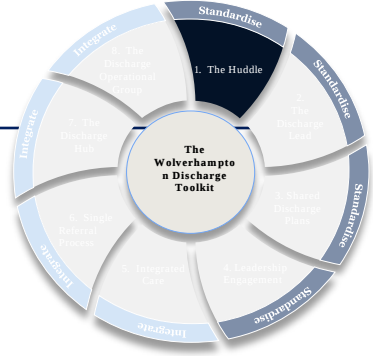
Role of the Huddle

Huddles provide the single point of reference, ideally at the start of each day, when key multi agency staff come together to review the clinical and discharge needs of each patient. Each huddle allows individual members of the MDT to prioritise their work for the day in line with agreed patient needs. Collectively a sequence of huddles provides the opportunity for staff to share updates and expedite a patients treatment and transfer of care.

Roles and Responsibilities

The table below lists the recommended attendees for ward huddles and their associated responsibilities.

Appointment	Huddle Roles
Consultant	Chairs the huddles and is accountable for the safe transfer of patients. The consultant is the final decision maker regarding the decision to transfer a patient from the care of RWT.
Band 7 Nursing Lead	Facilitates the huddle and ensures that the required information is available at the start of each huddle. Ensures that patient information gathered through daily nursing contact with the individual is available. Responsible for ensuring that the action log is completed.
Flow Assistant	Specialist discharge advisor providing support to clinical and therapy colleagues. Advises and updates the MDT on progress of individual discharge plans.
Social Care	Advises the huddle on the suitability of patients for social care services and on the progress of current social care assessments.
Physio/ OT	Advises the huddle on the progress of physio and OT assessments.



3.4 Intervention 1 – The Huddle; Focus area 2 – Maximised engagement

Optimal huddle location

Wards have adopted different approaches to the huddle settings. The majority of wards assume that the nursing station is the optimum position to hold the huddle, as shown in image 2. Wards have, however, trialled alternative settings which has significantly improved the levels of engagement between members of the MDT. Image 3 shows an information centred approach and image 1 (page 19) shows a huddle taking place away from the ward in an effort to optimise MDT engagement through minimising exposure to potential disruptions.

Senior Sisters must make an active decision to review and consider the location of their huddle. The location of the huddle must balance four factors:

Quality of conversation – much of the discharge conversation is confidential and should happen beyond the ear shot of patients and relatives.

Access to information – handover notes, the Safe Hands screen and patient notes are all regularly required during huddles.

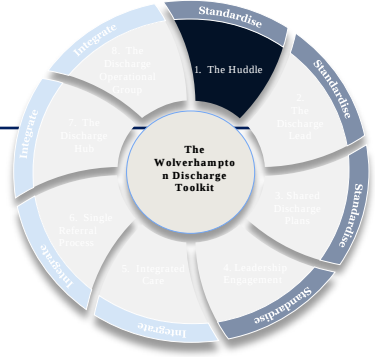
Minimise disruption – MDTs should aim to minimise disruption to and from routine ward business such as meals and portering.

Ability to respond – whilst there are significant benefits to be gained from moving the huddle into a ward office / training room Senior Sisters may decide that staffing levels will negate the ward teams ability to respond to urgent patient needs.

Image 2

Image 3

3.5 Intervention 1 – The Huddle;
Focus area 3 – Structured patient conversations

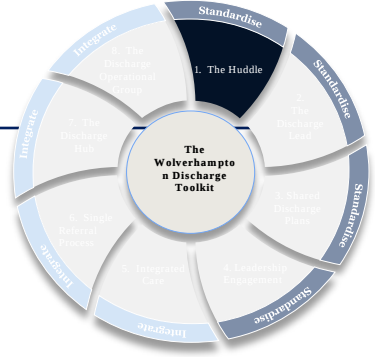


Observations during implementation indicate that a lack of a structured approach to the huddle impacted the quality of discharge planning. Viewing the huddle as a series of patient reviews has helped huddle teams to capture key dates and actions. Adopting a structured patient conversation ensures information flows in a logical, consistent fashion and each member of the MDT can maximise their contribution.

The table below outlines our recommended approach to structured patient conversations.

Component	*Example discussion points*	*Value*
1. Patient Introduction	• Patient name and age • Patient background • Previous care setting • Out of Area status	The huddle facilitator gives a clear introduction to each patient giving all huddle attendees the chance to familiarise themselves with the patient's circumstances.
2. Medical care	• Medical background • Current treatments • Clinical assessments • **Ends with expected MFFD**	This allows staff concerned with the patient's medical status to provide and receive updates on treatments and medical requirements. Establishing an **expected MFFD** date is the key outcome of this part of the structured patient conversation.
3. Discharge planning	• Planned next care setting • Assessments • **Ends with Planned Date of Discharge**	Agreeing the likely next care setting and confirming the actions required to access that next care setting offer help to inform the **Planned Date of Discharge** for that patient. A recommended approach to this part of the conversation is on page 23.
4. Key Actions	• Confirm next steps and actions • Agree Discharge Lead • Update Safe Hands	The facilitator recaps the key actions agreed for the patient, allocating these to an appropriate. The MDT agree the most appropriate Discharge Lead and Safe Hands is updated.

3.6 Intervention 1 – The Huddle;
Focus area 4 – Discharge planning question set

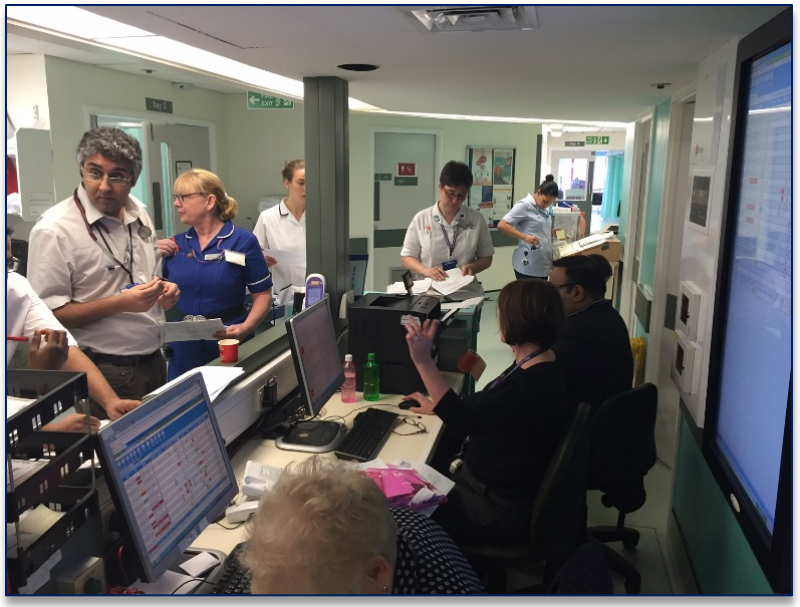


Discharge planning for the majority of patients is a straightforward and efficient process. For the most complex patients at greatest risk of being delayed this is often not the case. The ***Discharge Planning Question Set*** on the following page provides a standardised framework for agreeing a patient's likely post discharge needs. It should be used by MDTs in situations where there is a lack of clarity or the MDT has come to an impasse regarding the future care needs of a patient. Most importantly the outcome should be recorded as the Discharge Plan on the Safe Hands system.

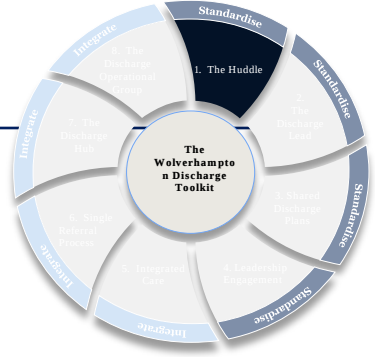
The agreed discharge plan must be made available for all members of the MDT and should be used to manage patient expectations regarding likely eligibility for services.

The Discharge Planning Question Set comprises eight questions. Each question is supported by consideration and action prompts which are outlined on the following page.

Following the questions in sequence will enable an MDT to discount those care options for which the patient is unlikely to be eligible. In doing so the MDT will naturally arrive at the most appropriate next care setting.

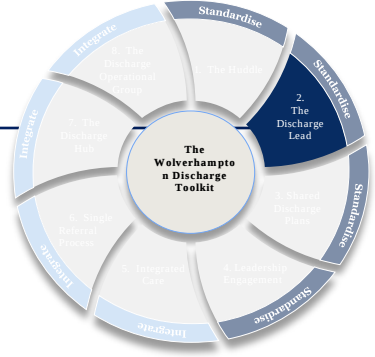


3.6 Intervention 1 – The Huddle;
Focus area 4 – Discharge planning question set



	Question	Consideration	Action	Remarks
1.	Are there any indicators of a high risk of delay or a complex discharge?	Out of Area? West Park? Requirement for full social care assessment? Complex family situation? Housing related issues?	Appoint appropriate Discharge Lead. Consider escalation.	
2.	Can this patient be assessed for their ongoing care requirements at home?		Referral to D2A hub.	
3.	Is the patient already in receipt of nursing or social care support?	Is the demand for this likely to change?	Review likely MFFD date with current care provider.	
4.	Is the patient likely to have ongoing complex health needs?	CHC eligibility.	Complete CHC Checksheet.	If patient triggers for CHC, D2A referral for nursing care.
5.	Is the patient likely to require rehabilitation support post discharge?	D2A rehabilitation pathway.	Physio becomes Discharge Lead	
6.	Is the patient likely to require social care assessment and services once discharged?	If expected date of MFFD is longer than 72hrs consider use of IH&SC Team.	Refer to D2A social care pathway.	
7.	Can the MDT agree likely eligibility for services?			Update Safe Hands
8.	Does the patient have capacity to make decisions regarding their future care needs?	If Yes then patient preference discussed regarding eligible services only.	If no family / carer takes on the role of reviewing eligible care options.	Capacity and preference to be captured on Ward Handover.

3.7 Intervention 2 – The Discharge Lead



Observations

Discharge planning is a complex, often emotionally charged issue. The complexity derives from the wide range of factors that can impact on a single patients' discharge and the changing personal views of the patient and family members. Analysis of the data gathered by the Project Team indicates that there are three key categories of patients that are at greatest risk of delay. From a total of 358 observed delayed days on in scope wards:

•40.2% of all delayed days were attributable to Out of Area (OoA) patients.

•15.6% of all delayed days were attributable to patients waiting for the allocation, assessment and commissioning of a package of care.

•9.4% of all delayed days were attributable to patients waiting for bedded rehabilitation at West Park.

Recommendation

Identifying a member of the ward based MDT to act as Discharge Lead for the patient will minimise complexity.

Using risk triggers to escalate a patient as a complex discharge will increase efficiency of ward based teams.

- The Discharge Lead is not an established post, it is a role that any member of the MDT can perform. It is likely to change during a patients acute care journey.
- When selecting the Discharge Lead the MDT must consider the following three factors:

1. Needs of the patient.
2. Most likely next care setting.
3. Relationship with key discharge enablers.

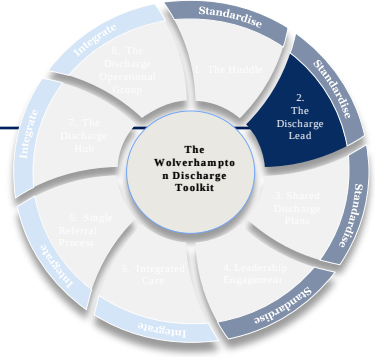
NICE Guidance Dec '15

The role of the discharge coordinator

1.5.1 Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital - or community based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence.

1.5.2 Ensure that the discharge coordinator is a central point of contact for health and social care practitioners, the person and their family during discharge planning. The discharge coordinator should be involved in all decisions about discharge planning.

3.8 Intervention 2 – The Discharge Lead: Relationship between discharge complexity and the Discharge Lead



Discharge Complexity

Balancing both objective data analysis and subjective observations creates a view of the risk triggers that indicate a patients susceptibility to delay. Patients displaying one or more of these risk triggers should be escalated early in their acute pathway to both the appropriate Division and the Integrated Health and Social Care Team.

Escalating these patients early in the acute pathway allows the Trust to understand the level of delay risk currently in the system. Initially patients should be escalated "for information" only. Once ward based processes (e.g. discharge planning, section 2 / 5 actions, CHC checksheet etc.) have been completed ward based MDT should consider escalating "for action". Complex patients should be escalated "for action" where ward based teams believe that there is a lack of action by the receiving local authority.

Type of Discharge	Description	Potential Discharge Lead
Simple	• Patient discharged to the care of their GP in their own home, sheltered accommodation or the home of a relative. • The patient does not require a publically funded package of health or social care.	Band 7 Ward Staff
Transfer of Care	• Wolverhampton patients who are transferred either to a discharge to assess care setting or return to a sustainable care setting which is publically funded. • Out of Area patients for which there is a clearly identified assessment / package of care in place.	Flow Assistant Physiotherapist Social Worker

Complex	• Patients that typically exhibit one or more of the following risk triggers:
	  • Out of Area patients requiring social care assessment.
	  • Complex family circumstances such as a partner with on going health or social care needs.
	  • Homeless patients or those in privately rented housing.
		Integrated Health and Social Care Team

3.9 Intervention 3 – Shared discharge plans

Observations

Observations from working with ward based staff indicates that there is no consistent means of recording and sharing a patient's discharge plan. Images 4, 5 and 6 demonstrate different paper based tools currently being used. These ward specific, paper based solutions act as a barrier to effective flow management and prevent the collection of detailed discharge data.

Recommendation

All patients should have a discharge plan recorded on the Safe Hands system. The minimum information set to be included on the Safe Hands is included as Appendix 1. This discharge plan should be reviewed at four key points during a 24 hour cycle:

Morning shift change.

During the MDT ward huddle.

At the end of the daily ward round.

During evening shift change.

Benefits

Capturing discharge plans will enable the following benefits:

Increased visibility of discharge plans across all members of the MDT.

Ability to assess discharge performance at a ward, specialty or divisional level.

Increased ability to forecast demand for out of hospital care services accurately.

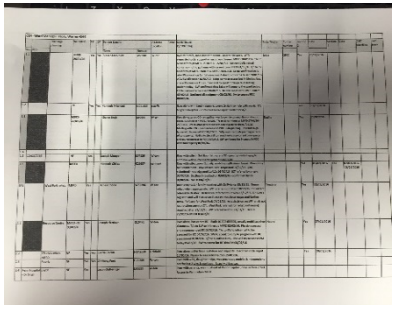


Image 4

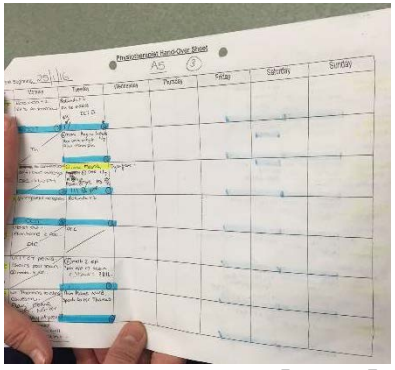


Image 5

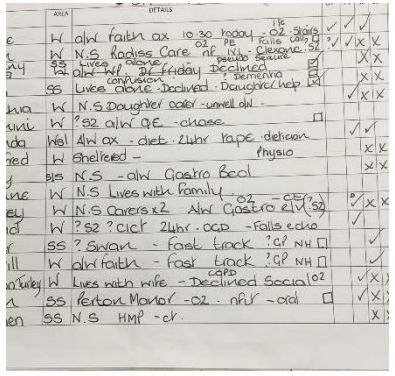


Image 6

3.10 Intervention 4 – Leadership engagement

Observations

A significant amount of leadership time is exhausted in pursuing discharge performance and maintaining flow in the very short term. The efforts of Directorate Managers, Matrons and Clinical Directors are undermined by an absence of management information and the lack of a consistent methodology with which ward teams can engage.

Recommendations

This report recommends that Directorate Management Teams become the focus for driving discharge performance. Performance should be assessed utilising three methodologies:

Huddle effectiveness. Leadership teams should visit daily ward huddles and assess their effectiveness using the checksheet included as Appendix 2. The huddle score should be reviewed with the facilitator to identify immediate quick fixes or solutions for individual patients.

Weekly Discharge Reviews. Holding a weekly discharge review with the MDT will allow the ward team to collectively reflect on recent discharge performance and identify collective areas for reward and improvement. This meeting should be collaborative in nature and encourage team working; it requires careful facilitation and should focus on goals as opposed to blame.

Monthly Discharge Performance Meetings. On a monthly basis directorate teams should review discharge performance across multiple wards using the data available from Safe Hands. This meeting should identify trends and operational issues where intervention across multiple wards will drive benefits. It may identify issues for escalation to the Discharge Operational Group (see intervention eight, page 35)

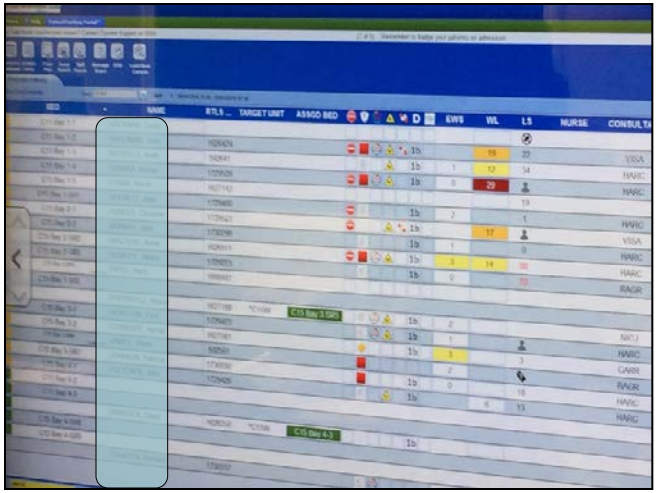


Image 7

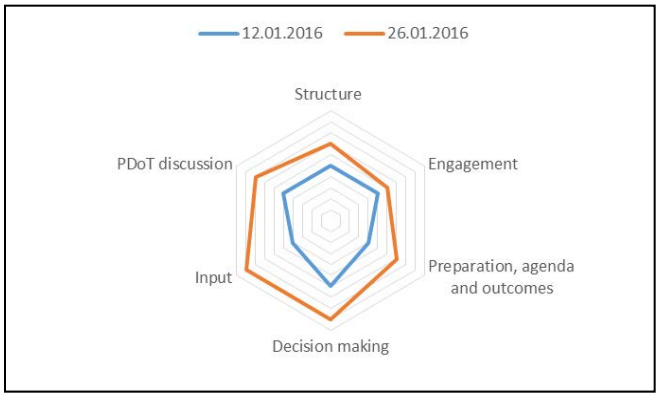
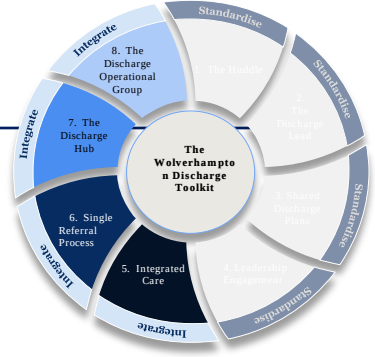


Image 8

Section 4 – Recommendation 2 – An integrated model of intermediate care

4

1.3 An integrated model of intermediate care



This project has identified three key categories of patient that account 65.4% of all delays observed on in scope during the period of data collection (11 Jan – 10 Feb '16), these are:

40.2%

Of [illegible]s observed on in scope wards are experienced by medically fit [illegible](OoA) patients, i.e. those who are registered with a non [illegible]pton GP.

15.6%

Of [illegible]ays observed on in scope wards are experienced by [illegible]pton patients with social care needs; these delays are incurred [illegible]ssment for and commissioning of social care packages.

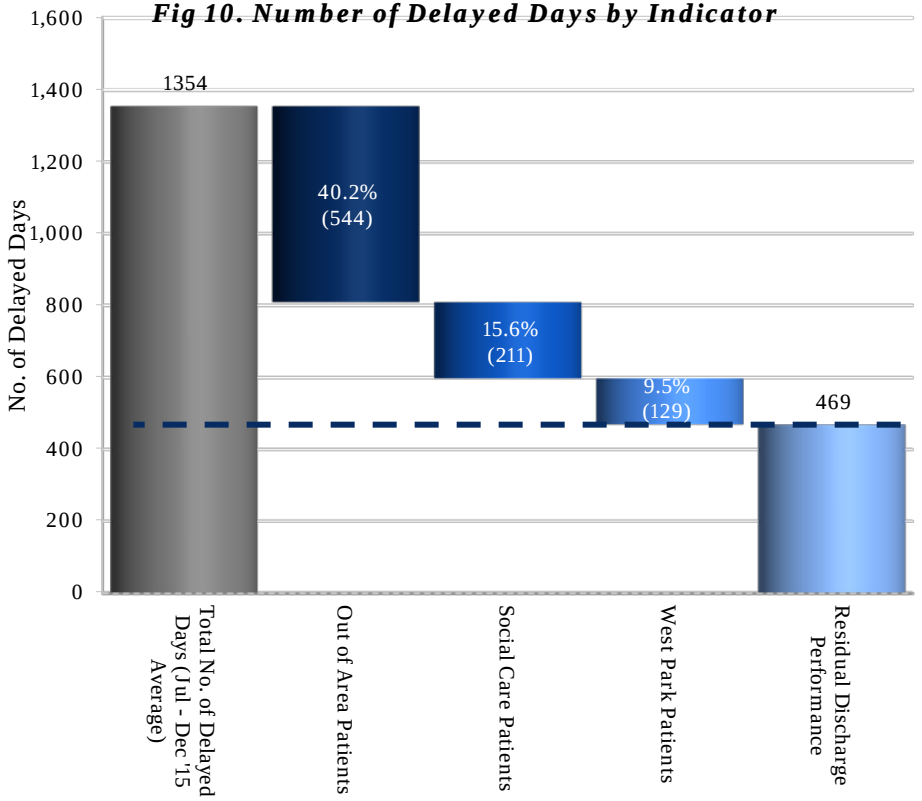
9.5%

Of [illegible]ays observed on in scope wards are experienced by patients [illegible]edded rehabilitation at West Park.

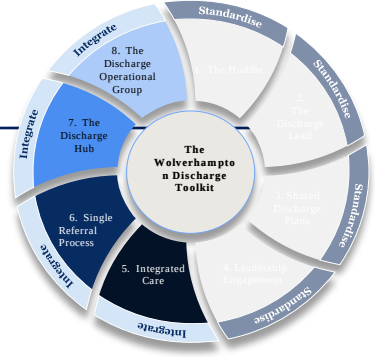
If [illegible] observed on in scope wards are representative of all wards it would indicate that 884 bed days are being lost to these three categories of patient, as shown in Figure 10. This figure has been derived using the average number of reported DTOC days between Jul and Dec '16 as a baseline.

Developing an integrated model of intermediate care that prevents admission and expedites discharge is a key recommendation of this report. A fully integrated intermediate care model could reduce the levels of reported delays to levels witnesses in the summer of 2014.

Fig 10. Number of Delayed Days by Indicator

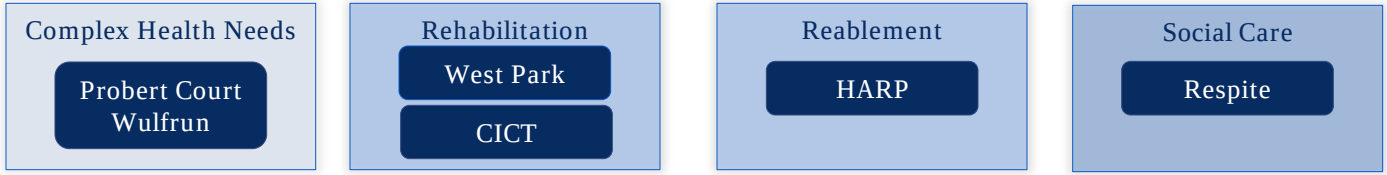


4.2 The current model of provision



Current Provision of Intermediate Care

The current model of intermediate services has been developed according to organisational funding. In this model very narrow access criteria and multiple referral processes create complexity for ward based staff. During periods of high demand narrow access criteria can effectively create a barrier to flow as patients are only eligible for a single service.



Future Model

This report recommends the implementation of an integrated model of intermediate care services in which patients are discharged at the point of being declared medically fit and then are assessed for ongoing, long term care needs either at home or in an intermediate care setting. Each care setting should have integrated access criteria in order to provide flexibility and resilience to respond to fluctuating demands. The proposed model has four component parts:

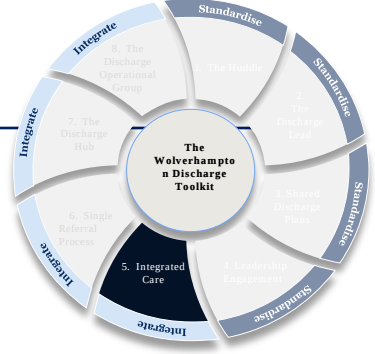
An integrated model of Discharge to Assess (D2A) services.

A Single Referral Process through which staff can access intermediate care.

A D2A hub that manages the referral process; triages patient needs and manages resource.

A Discharge Operations Group (D.O.G) which is a system wide group that has operational oversight of system flow from acute wards and optimises performance of the single referral process, the D2A hub and intermediate care providers.

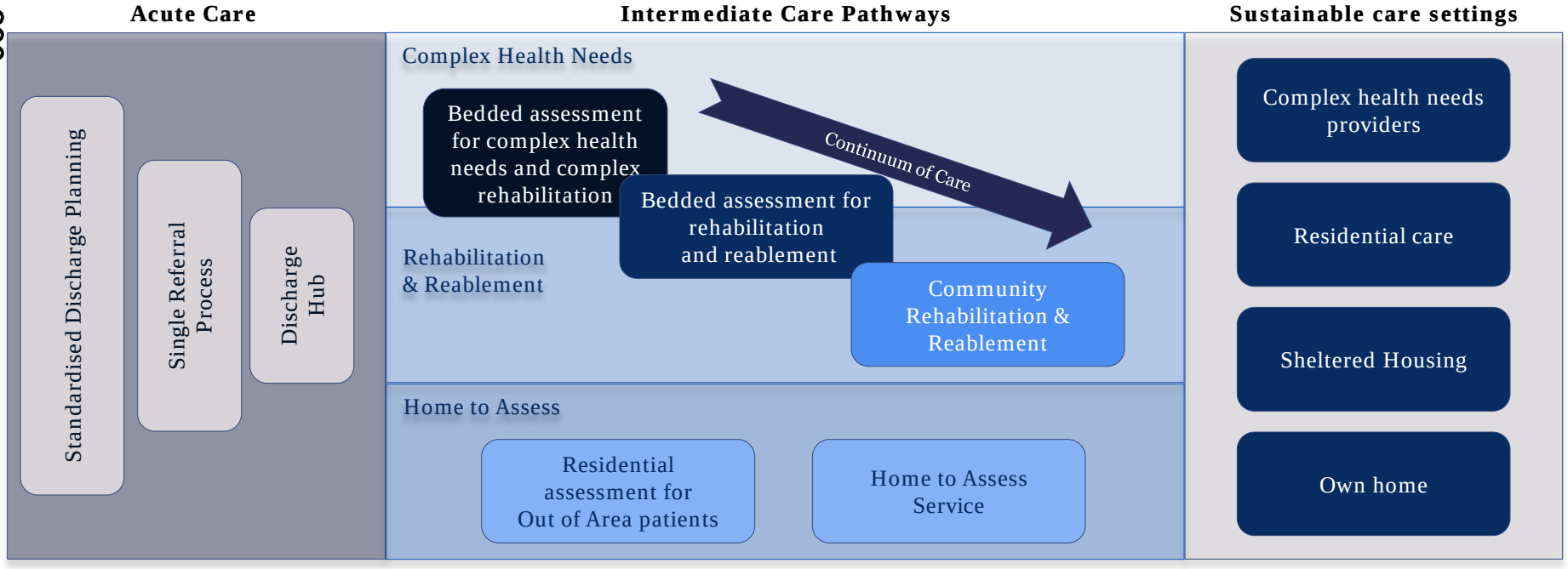
4.3 Intervention 5 – Discharge to Assess



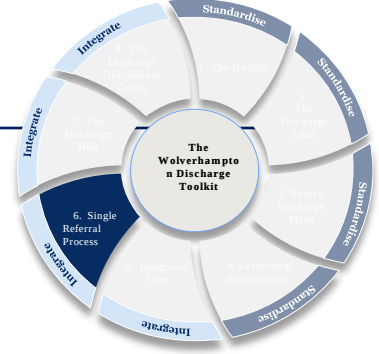
Integrated Intermediate Care

Moving towards a more integrated Discharge to Assess (D2A) model will allow the Wolverhampton care economy to manage the return of patients to a sustainable care setting in a graduated fashion. At each stage of a patient journey the care provider should promote and prepare the patient for the maximum level of independence appropriate to their needs. Integrating providers along a continuum of care requires a integrated access criteria that create flexibility to expedite discharge and also resilience to manage the service during times of increased demand.

The D2A model of care should be commissioned and managed as a single service that includes the ability to assess patients for social care needs in their own home and the ability to manage Out of Area patients in the community whilst awaiting assessment and repatriation.



4.4 Intervention 6 – Single Referral Process



Observations

The disjointed nature of a model of provision that includes multiple referral processes creates complexity for ward staff. Significant amounts of staff time is wasted following up referrals in an attempt to understand progress and potential dates of transfer. This has a significant impact on patient quality as staff cannot manage patient expectations and patients remain exposed to hospital based risks.

Recommendation

The Wolverhampton Care Economy should adopt a Single Referral Process to facilitate the efficient transfer of patients from the acute setting to the D2A model described in Intervention 5. Doing so will provide insight into system level flow and allow health and social care partners to monitor changing trends in demand. The Single Referral Process will need to be coordinated centrally through a D2A hub which is outlined in Intervention 7 of this report.

The key characteristics of a Single Referral Process are:

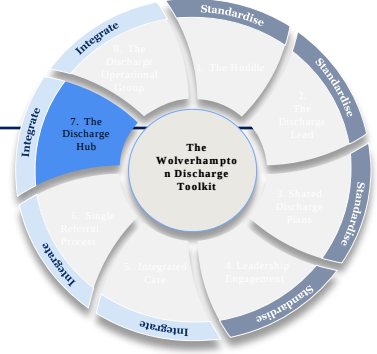
Electronic system with access available to staff across acute and community services.

Includes the ability for health and social care professionals to assess progress of a referral.

Includes a feedback loop to ensure staff and patients remain informed of likely transfer dates.

Includes a reporting function providing indicators of pressure in the system.

4.5 Intervention 7 – D2A Hub



Observations

The segregated model of sub acute services in Wolverhampton results in the inefficient allocation of patients to interim care settings. The lack of a developed understanding of the range of discharge to assess options among staff results in the referral of patients to inappropriate follow-on settings. The absence of a centralised coordination function means that patients are often allocated by chance rather than based on an assessment of their level of acuity or suitability for treatment.

Recommendation

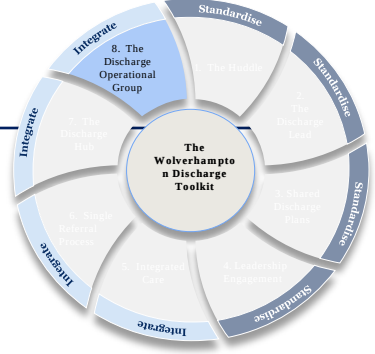
The Wolverhampton Care Economy should establish a discharge hub to coordinate the Single Referral Process and manage the network of D2A care providers. The D2A Hub will be responsible for quality assuring referrals and triaging patient needs, identifying the most appropriate discharge to assess care setting and prioritising allocations based on a consistent criteria.

The D2A Hub will be the fulcrum around which the D2A model operates. Its position at the centre of the model will deliver a real time understanding of service availability and operational pressures, providing the insight required make informed service improvement recommendations to the Discharge Operational Group.

Role of the Discharge Hub
Manage the Single Referral Process: • Quality assure referrals. • Triage referral to most appropriate D2A care setting. • Prioritise and manage D2A waiting lists. **Manage the network of providers:** • Monitor availability and demand for D2A resources. • Communicate availability to acute wards and services. • Identify performance trends and recommend service improvements to the Discharge Operational Group.

Discharge Hub Resource Pools
Managerial resource: • D2A Service managers. • Service quality and improvement managers. **Clinical / nursing and therapy resource:** • Clinical support for triage / prioritisation. • Nursing support for quality assurance. **Administrative** • Management process & communications. • Data capture and reporting capability.

4.6 Intervention 8 – Discharge Operational Group



Observations

Ensuring the efficient flow of patients through a health and social care economy is a complex challenge and one that must be addressed at the system level. The key requirement is a multi disciplinary group that can maintain the balance of supply and demand with a mandate to drive service improvement.

Recommendation

A Discharge Operational Group (D.O.G.) should be introduced to manage system flow from acute care settings and the provision of D2A care settings. Acting on behalf of WCCG, WCC and RWT this group should be empowered to mange in year resources and funding on behalf of partners.

Effectively actins as a system level MDT the D.O.G should meet monthly to review discharge performance and flow. Management information available from electronic discharge plans and the D2A Hub will provide the D.O.G. with a detailed view of system flow and performance of the D2A model. This will enable the group to make informed decisions on the design and implementation of improvement measures required to ensure the appropriate availability of services. A suggested attendance list and agenda for the Discharge Operational Group are shown below.

Attendance
Deputy COO RWT – Medical Division
Head of Individual Care– WCCG
Service Manager Older People WCC
Divisional Medical Directors
Group Manager – Therapy Services
Integrated Health and Social Care Team Manager
Out of Area Local Authority Social Care Service Managers
D2A Service Managers

Agenda
1. Introduction
2. Performance update
3. Factors impacting on performance
4. Service improvement
5. Summary of actions
6. Points for escalation
7. Operational communications
8. Next meeting

Section 5 – Benefits and roadmap

5

5.1 Benefits summary

Benefits Summary

Outlined below are the potential benefits from both headline recommendations. These benefits should not be viewed as cumulative as some of the benefits of standardised planning will also be realised through a more integrated D2A model.

The individual benefits summary for each of these recommendations are included as Appendices 3 – 6. Note that these benefits do not take into account any additional system costs incurred through the commissioning of a Discharge Hub or a additional resource. The detailed assumptions for the benefit summaries is included as Appendix 7.

Recommendation 1 – Standardised Discharge Planning

Wards who engaged most directly with the support provided by the Project Team experienced a length of stay reduction of 1.2 days between 26 Jan and 10 Feb 16.

If this performance could be sustained across all wards in the Medical Division it could release:

312 o the system, equivalent to 1o beds.

£1.27m ts annually.

Recommendation 2 – Integrated D2A Model

If 75% of delays associated with Out of Area Patients, Social Care and West Park were diverted to more appropriate care settings the following benefits could be achieved:

537 bed days released back to the system, equivalent to 17 beds or a small ward.

£2.38m of system savings*.

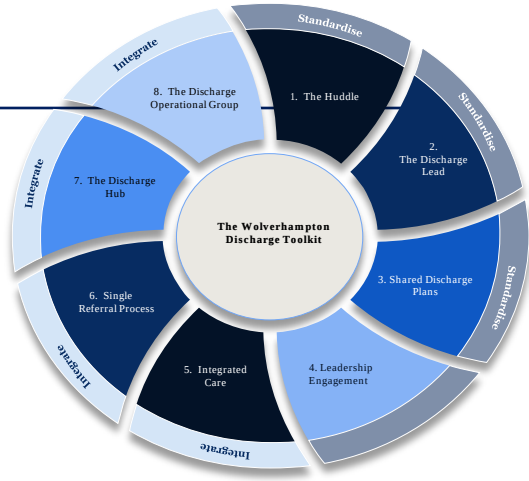
Release of capacity and system savings

318 £1.43m Acute bed days released and reduced hotelling costs as a result of managing delayed out of area patients in a residential setting.

123 £0.56m Acute bed days released and reduced hotelling costs as a result of assessing patients and commissioning social care packages from an intermediate care setting.

96 £0.39m Acute bed days released and reduced hotelling costs as a result of improving flow through West Park.

5.2 Approach to transformation



Approach

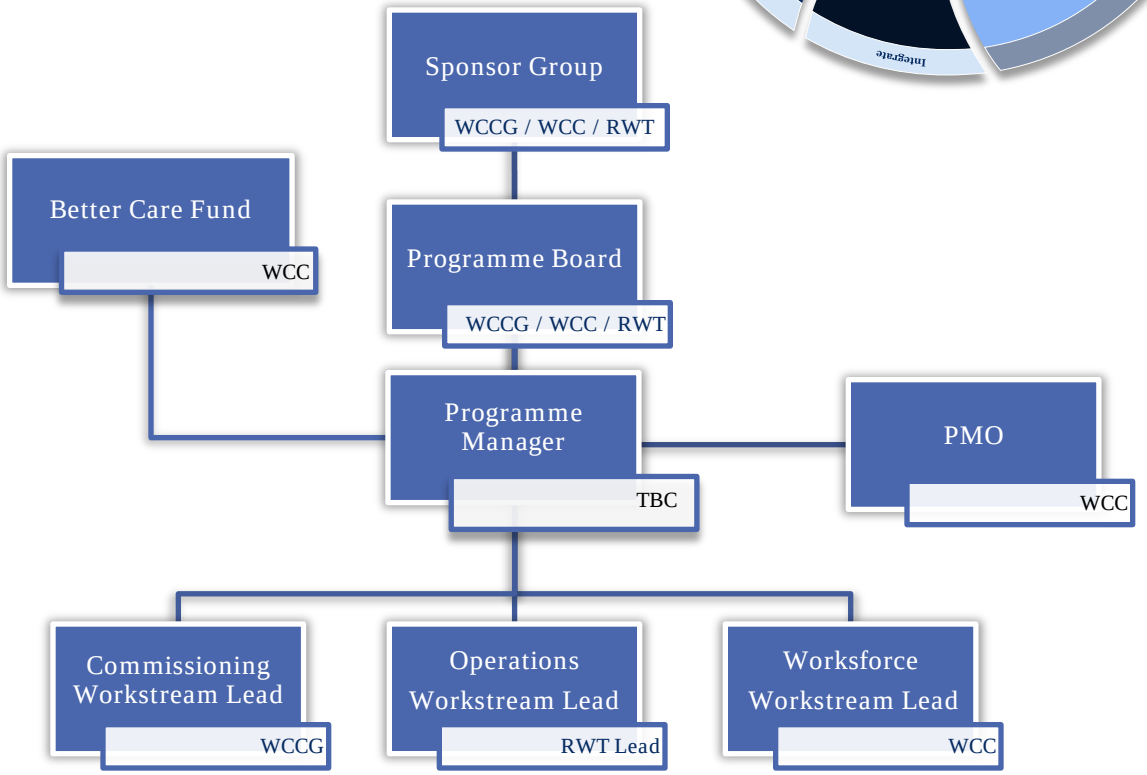
Implementing the Wolverhampton Discharge Toolkit through a system wide programme in which partners design and develop solutions collaboratively will maximise benefits and de risk service delivery.

We recommend forming a multi disciplinary programme team to harness the value of existing knowledge and skills in Wolverhampton.

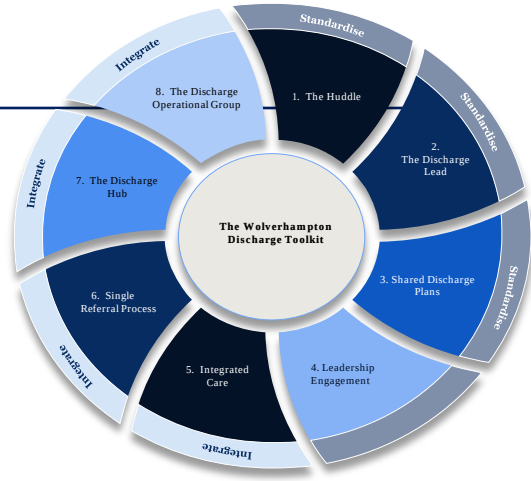
The role of Programme Manager / PMO

We recommend an engaged delivery Programme Manager and PMO team that enable and support work stream leads. Adopting this approach brings valuable extra capacity to workstreams whilst retaining more traditional PMO roles such as stakeholder engagement, benefits, risk and dependency management and communications.

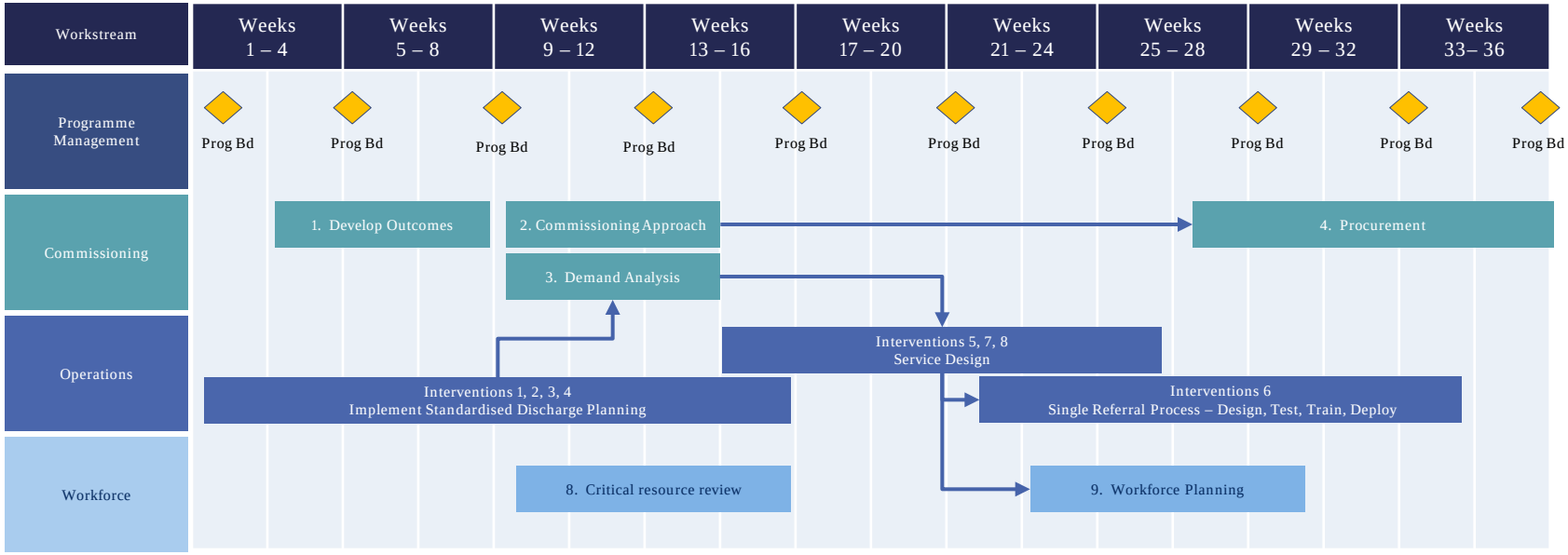
Most significantly we recommend a specific Workforce workstream to review the workforce needs of the staffing needs of a new intermediate care model and develop actionable plans that balance the needs of both acute and intermediate care settings. This will be most relevant to social workers, flow assistants, physiotherapist, occupational health and community nursing professionals.



Roadmap



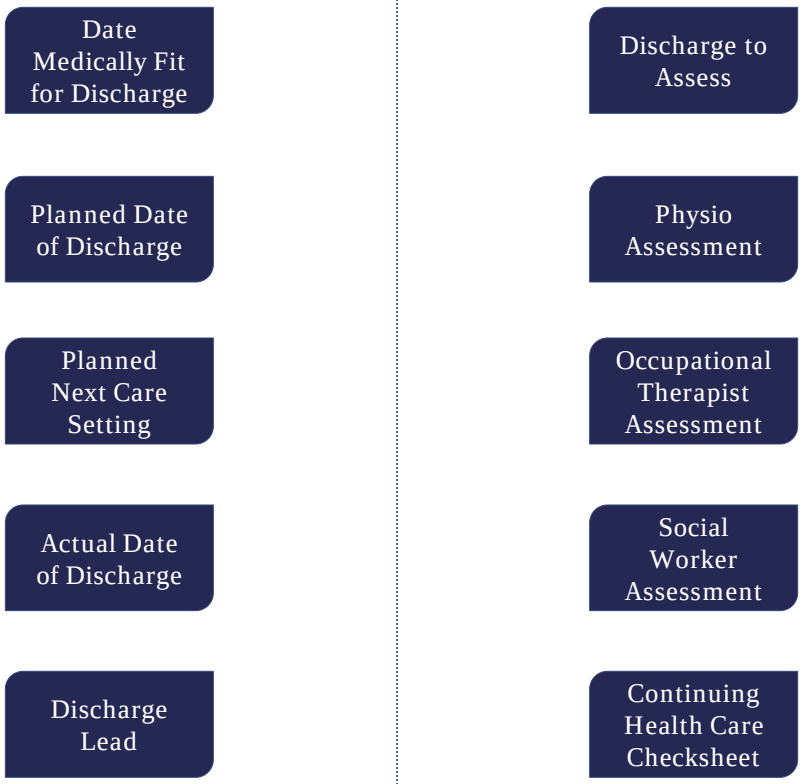
The roadmap below outlines a proposed solution to delivering the benefits from a both recommendations within a FY 16/17. Engaging both public and private sector providers in the co design of a model of intermediate care will significantly reduce commissioning and delivery risk in the long term. We envisage that a new model of intermediate care could be commissioned and delivering benefits within FY 16/17.



Section 5 – Appendices

Appendix 1 – Shared discharge plans: Safe Hands data fields

Outlined below are the minimum information fields required to effectively develop a Safe Hands discharge planning function. It should be noted that use of Safe Hands is inconsistent across RWT and a significant culture shift will be required to realise the potential benefits



Appendix 2 – Engaged leadership: Huddle checksheet

Ward		Meeting Date:		Completed By:		/10
Meeting Logistics	**1.**	Did the huddle start on time?				☐
	2.	Did the huddle finish on time – within 30minutes.				☐
	3.	Did the meeting use the Structured Patient Conversation?				☐
	4.	Did the required attendees turn up on time and stay for the whole meeting?				☐
	5.	Were all attendees engaged for the full duration of the huddle?				☐
Meeting Preparation	**6.**	Did the facilitator come prepared to the meeting, focussed on the agenda and the required outcomes to be achieved during the huddle?				☐
	7.	Did huddle attendees know and provide the information required from them to contribute towards decision-making in the huddle?				☐
Meeting Content	**8.**	Did the huddle take the form of a proactive decision-making huddle? (as opposed to a passive information-receiving huddle)				☐
	9.	Was there input from each individual?				☐
	10.	Was Safe Hands updated during the huddle?				☐
	11.	Did the huddle actively discuss MFFD and PDD for each patient?				☐
	12.	Did the huddle consider discharge to assess pathways and options for early transfer?				☐
	13.	Did the huddle review performance and consider ways of improving transfer of care performance?				☐
	14.	Was the meeting fast paced with high energy?				☐
Meeting score:		**0-60**	**61-110**	**111-140**		

Appendix 3 – Benefits summary : Reducing OoA delays by 75%

Using data gathered during the Rapid Review and this project we have modelled the potential release of acute capacity and the potential system savings that could be enabled by a 75% reduction in the number of Out of Area delays. These savings could be enabled by increased use of residential care whilst a patient awaits assessment and repatriation.

318 Number of bed days that could be released, equivalent to closing 10 beds

£1.43m System savings generated by use of residential rather than acute care beds

Acute Care Costs

Factor	Impact
78% of delayed days baseline attributable to medical patients	1056 delayed days
40.2% of all delays are attributable to OoA patients on medical wards	425 delayed days
Acute care hotelling costs per night	£340
Monthly acute care costs	£144,500
Annual acute care costs	**£1.734,000**

Residential Care Costs

Factor	Impact
78% of delayed days baseline attributable to medical patients	1056 delayed days
40.2% of all delays are attributable to OoA patients on medical wards	425 delayed days
75% of delayed days diverted to a residential care setting	318 delayed days
An average delay of 6.5 days equates to	49 patients
Monthly cost of 49 patients in mid level residential care at £512 per week	£25,088
Annual cost of 49 patients in mid level residential care at £512 per week	**£301,056**

***Assumptions**

Average number of delayed days between Jul and Dec '15 = 1354, (source NHS public reporting).

78% of all delayed patients are medical patients (source Rapid Review of DTOC).

An integrated D2A model of care reduced the impact of OoA patients by 75%

An average Out of Area delay of 6.5 days (Transfer of Care Project data collection).

Full cost of mid tier residential care home met by WCC, equates to is £432 plus £80 top up fee = £512 per patient per week.

Appendix 4 – Benefits summary : Reducing social care delays by 75%

Using data gathered during the Rapid Review and this project we have modelled the potential release of acute capacity and the potential system savings that could be enabled by a 75% reduction in the number of social care delays.

It should be noted that these benefits are based on the use of a mid tier residential care setting. Further benefits could be realised if patients could be assessed at home.

123 Number of bed days that could be released, equivalent to closing 3 beds

£0.56m Number of bed days that could be released, equivalent to closing 3 beds

Acute Care Costs

Factor	Impact
78% of delayed days baseline attributable to medical patients	1056 delayed days
15.6% of all delays are attributable to patients waiting for allocation of a social worker, assessment and commissioning of social care.	164 delayed days
Acute care hotelling costs per night	£340
Monthly acute care costs	£55,760
Annual acute care costs	**£669,120**

Residential Care Costs

Factor	Impact
78% of delayed days baseline attributable to medical patients	1056 delayed days
15.6% of all delays are attributable to OoA patients on medical wards	164 delayed days
75% of delayed days diverted to a residential care setting	123 delayed days
Number of beds required to manage case load	17
Monthly cost of 17 patients in mid level residential care at £512 per week	£8,704
Annual cost of 17 patients in mid level residential care at £512 per week	**£104,448**

***Assumptions**

1. Average number of delayed days between Jul and Dec '15 = 1354, (source NHS public reporting).
2. Assessment and commissioning in a residential care setting reduces delays attributable to social care by 75%
3. Patients are transferred to a residential care setting for a maximum one week.

Appendix 5 – Benefits summary : Reducing West Park delays by 75%

Using data gathered during the Rapid Review and this project we have modelled the potential release of acute capacity that could be enabled by a 75% reduction in the number of delays associated with West Park hospital.

Increasing flow from West Park could be achieved through increased use of community based rehabilitation and reablement.

96 Number of bed days that could be released, equivalent to closing 3 beds

£0.39m Annual hotelling cost of 96 acute bed days per month

West Park Flow

Factor	Impact
Delayed days baseline	1354
9.5% of delays are attributable to West Park	129
75% of 129 delayed days saved by D2A	96
West Park case load per month	45 patients
LoS reduction required to accommodate acute demand (delayed days / number of patients)	**2.1 days**

***Assumptions**

1. Average number of delayed days between Jul and Dec '15 = 1354, (source NHS public reporting).
2. An integrated D2A model of care reduced the impact of West Park patients by 75%
3. Number of bed days available per month at West Park = 48 x 30 = 1488.
4. Average Length of Stay at West Park = 32 days (West Midlands Quality Review Service Jul '15).
5. Patient flow per month through West Park = 46 (total number bed days available (1488) / average length of stay (32))

Appendix 6 – Benefits summary : Standardised discharge planning

Using data gathered during the Rapid Review and this project we have modelled the potential release of acute capacity that could be enabled by a the roll out of standardised discharge planning across all Medical Division wards.

Improving the quality of discharge planning could lead to a reduction in average length of stay of 1.2 days; creating 10 beds of additional capacity in New Cross.

312 Number of bed days that could be released, equivalent to closing 10 beds

£1.27m Annual hotelling cost of 312 acute bed days per month

Medical Division Bed Reductions

Factor	Impact
Medical Division Bed Base across 12 wards	290
Number of patients – (bed days available (2760) / average Los (10.6))	260
Reduction in LoS observed between 26 Jan and 11 Feb '16	1.2 days
Potential reduction in bed days (patients (260) x reduction (1.2))	312
Reductions in bed base (reduction / 30)	10
Monthly hotelling cost of reduced beds (312 x £340)	£106,080
Annual hotelling costs of reduced beds	**£1.27m**

Appendix 7 – Benefits summary: Assumptions

The following assumptions have been used during the calculations of costs and benefits;

The average number of delayed transfers of care is 1354 per month. This figure is derived from the average number of delays reported by the NHS for Royal Wolverhampton Trust between Jul and Dec 2015. These figures include patients in West Park.

78% of reported DTOC patients are medical or care of the elderly patients. These figures were provided by RWT to the Rapid Review project.

The hotelling cost for a single patient on a medical ward is £340. This figure was provided to the Rapid Review Project in Aug '15.

The total cost of a residential care bed is £512. This cost comprises a cost of £412 normally payable by the local authority and an £80 supplement normally payable by the family. This figure has been provided by the Integrated Health and Social Care Team.

In the case of Out of Area patients it is assumed that the Wolverhampton care economy will be responsible for all costs (i.e. £512) associated with the assessing Out of Area patients in a residential care setting.

Bed capacity has been calculated using the formula = Total number of bed days / 30.

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Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: Guidance

Overview

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Timetable

The submission and assurance process will follow the following timetable:

• NHS Planning Guidance for 2016-17 released – 22 December 2015
• BCF Allocations published following release of CCG allocations – 09 February 2016
• Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
• BCF Planning Return template, released – 24 February 2016
• First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:
o BCF planning return template
All submissions will need to be sent to DCO teams and copied to the National Team (england.bettercaresupport@nhs.net)
• First stage assurance of planning return template and initial feedback to local areas - 02 to 16 March 2016
• Second version of the BCF Planning Return template, released (with updated NEA plans) – 9th March
• Second submission following assurance and feedback by 2pm on 21 March 2016, to consist of:
o High level narrative plan
o Updated BCF planning return template
• Second stage assurance of full plans and feedback to local areas - 21 March to 13 April 2016
• BCF plans finalised and signed off by Health and Wellbeing Boards and submitted by 2pm on 03 May 2016
This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

Introduction

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

Data needs inputting in the cell
Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

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

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.
The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B7) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

All data that has been pre-populated in the yellow cells has been taken from submission 2 templates submitted by Health and Well-Being Boards, where a submission 2 template was not received the submission 1 data has been used instead."

On the cover sheet please **enter the following information:**
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

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 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

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.

On this tab please **enter the following information:**
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.
- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.
- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. 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, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

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 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is 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 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**
- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.
- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.
- Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure.
- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.
- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

5b. HWB Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the “Technical Definitions” and the “Supplementary Technical Definitions” at the foot of the following webpage:

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

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C 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, or any other relevant information.

CCG - HWB Mapping

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.

Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B7) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

Complete Template

1. Cover

	Cell Reference	Complete?	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
Sheet Completed:			Yes

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	E37	☐	Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance.	F37	☐	Yes
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	F47	☐	Yes
Sheet Completed:			Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	☐	Yes
Gross Contribution: £000's	C16 : C25	☐	Yes
Comments (if required)	E16 : E25	☐	N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42	☐	Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54	☐	Yes
Gross Contribution: £000's	C45 : C54	☐	Yes
Comments (if required)	E45 : E54	☐	N/A
Funding Sources Narrative	B61	☐	N/A
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	C70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	C71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73	☐	Yes
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments	D70	☐	Yes
2. 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	D71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	D72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73	☐	Yes
Sheet Completed:			Yes

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B266	☐	Yes
Scheme Type (see table below for descriptions)	C17 : C266	☐	Yes
Please specify if 'Scheme Type' is 'other'	D17 : D266	☐	Yes
Area of Spend	E17 : E266	☐	Yes
Please specify if 'Area of Spend' is 'other'	F17 : F266	☐	Yes
Commissioner	G17 : G266	☐	Yes
If Joint % NHS	H17 : H266	☐	Yes
If Joint % LA	I17 : I266	☐	Yes
Provider	J17 : J266	☐	Yes
Source of Funding	K17 : K266	☐	Yes
2016/17 (£000's)	L17 : L266	☐	Yes
New or Existing Scheme	M17 : M266	☐	Yes
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N266	☐	Yes
Sheet Completed:			Yes

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	☐	Yes
5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	☐	Yes
5.1 - Cost of NEA	E54	☐	Yes
5.1 - Comments (if required)	F54	☐	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	☐	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	☐	Yes
5.2 - Comments (if required)	I68	☐	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	☐	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	☐	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	☐	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	☐	Yes
5.3 - Comments (if required)	I81	☐	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	☐	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	☐	Yes
5.4 - Comments (if required)	Q93	☐	N/A
5.5 - Local Performance Metric	C105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	☐	Yes
5.5 - Comments (if required)	G105	☐	N/A
5.6 - Local defined patient experience metric	C117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	☐	Yes
5.6 - Comments (if required)	G117	☐	N/A
Sheet Completed:			Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	☐	Yes
2) Maintain provision of social care services (not spending)	C15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	C16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	☐	Yes
5) 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	C18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	☐	Yes
1) Plans to be jointly agreed, Comments	D14	☐	Yes
2) Maintain provision of social care services (not spending), Comments	D15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments	D16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	☐	Yes
5) 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, Comments	D18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	☐	Yes
Sheet Completed:			Yes

Template for BCF submission 3: due on 03 May 2016

Submission 3 Template Changes - Updates from Submission 2 template

Change	Tabs Impacted	
Data from the Newcastle and Gateshead late submission Q2 templates included.	All tabs	
Footnotes to describe how the expenditure plan summary figures have been calculated.	2. Summary and confirmations	
The NEA activity values have been updated following the third '16/17 Shared NHS Planning' submission. Please review the impact and amend the additional quarterly reduction value, if required.	5. HWB Metrics	5b. HWB Metrics Tool
Updated SUS 15/16 Actual and FOT figures (mapped from CCG data) provided as support to the third '16/17 Shared NHS Planning' submission.	5b. HWB Metrics Tool	
Locally reported actual Q3 15/16 NEA data is now included.	5b. HWB Metrics Tool	
Residential Admissions Planned 15/16 rate has been amended for 6 HWBs to show the rate as calculated by using the numerator and denominator shown in the table.	5. HWB Metrics	5b. HWB Metrics Tool

Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

All data that has been pre-populated in the yellow cells has been taken from submission 2 templates submitted by Health and Well-Being Boards, where a submission 2 template was not received the submission 1 data has been used instead."

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. 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 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

It presents a summary of the first BCF submission and a mapped summary of the NEA activity plans received in the second iteration of the "CCG NHS Shared Planning Process".

Health and Well Being Board	**Wolverhampton**
completed by:	Andrea Smith
E-Mail:	andrea.smith21@nhs.net
Contact Number:	01902 441775
Who has signed off the report on behalf of the Health and Well Being Board:	Steven Marshall

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'

	No. of questions answered
1. Cover	5
2. Summary and confirmations	3
3. HWB Funding Sources	13
4. HWB Expenditure Plan	13
5. HWB Metrics	34
6. National Conditions	16

Template for BCF submission 3: due on 03 May 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Wolverhampton

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£17,697,541
Total Minimum CCG Contribution	£17,862,219
Total Additional CCG Contribution	£22,117,000
Total BCF pooled budget for 2016-17	**£57,676,760**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes
2. 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
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes

4. HWB Expenditure Plan

Summary of BCF Expenditure (*)

	Expenditure
Acute	£0
Mental Health	£11,300,452
Community Health	£17,597,104
Continuing Care	£0
Primary Care	£0
Social Care	£28,779,311
Other	£0
Total	**£57,676,867**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£6,418,000	There is a variance due to additional contribution by Local Authroity for social care activities

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool (**)

	Expenditure
Mental Health	£0
Community Health	£2,814,683
Continuing Care	£0
Primary Care	£0
Social Care	£3,594,080
Other	£0
Total	**£6,408,763**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£5,075,936
Total value of NHS commissioned out of hospital services spend from minimum pool	£6,408,763
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£1,332,827**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	8,018	8,038	8,051	7,798	31,904
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	8,018	8,038	8,051	7,798	31,904
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
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	581.9

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	80.3%

5.4 Delayed Transfers of Care

		Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	1447.8	1104.9	800.1	1051.0

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
New supported living placements for people with mental health issues	17.0

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
Overall satisfaction of people who use services with their care and support	0.7

6. National Conditions

National Conditions For The Better Care Fund 2016-17	Please Select (Yes, No or No - plan in place)
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development
4) Better data sharing between health and social care, based on the NHS number	Yes
5) 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	No - in development
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	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 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

Template for BCF submission 3: due on 03 May 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:
Wolverhampton

Data Submission Period:
2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

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.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Wolverhampton	£17,697,541	N/a
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£17,697,541**	

CCG Minimum Contribution	Gross Contribution
NHS Wolverhampton CCG	£17,862,219
Total Minimum CCG Contribution	**£17,862,219**

Are any additional CCG Contributions being made? If yes please detail below;	Yes

Additional CCG Contribution	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
NHS Wolverhampton CCG	£22,117,000	n/a
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**£22,117,000**	

Total BCF pooled budget for 2016-17	**£57,676,760**

Funding Contributions Narrative

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	Select a response to the questions in column B	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes	
2. 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	
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	Yes	
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Wolverhampton

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. 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, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E: if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

						Expenditure							
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Social Care		Joint	56.0%	44.0%	Local Authority	Local Authority Social Services	£2,864,421	Existing	£8,039,998
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Community Health		Joint	56.0%	44.0%	NHS Acute Provider	Additional CCG Contribution	£950,000	Existing	£1,130,000
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Community Health		Joint	56.0%	44.0%	Charity/Voluntary Sector	Additional CCG Contribution	£879,658	Existing	£3,431,100
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Community Health		Joint	56.0%	44.0%	Private Sector	Additional CCG Contribution	£7,196,000	Existing	£7,138,000
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Community Health		Joint	56.0%	44.0%	NHS Community Provider	Additional CCG Contribution	£3,545,227	Existing	£10,984,000
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Community Health		Joint	56.0%	44.0%	NHS Community Provider	CCG Minimum Contribution	£5,026,219	Existing	£5,326,100
Mental Health Care Pathway	Integrated care teams		Mental Health		Joint	60.0%	40.0%	NHS Mental Health Provider	Additional CCG Contribution	£3,818,156	Existing	£2,967,500
Mental Health Care Pathway	Integrated care teams		Mental Health		Joint	60.0%	40.0%	Private Sector	Additional CCG Contribution	£2,178,480	Existing	£935,000
Mental Health Care Pathway	Integrated care teams		Mental Health		Joint	60.0%	40.0%	Local Authority	Local Authority Social Services	£0	Existing	£0
Mental Health Care Pathway	Integrated care teams		Mental Health		Joint	60.0%	40.0%	Charity/Voluntary Sector	Local Authority Social Services	£66,150	Existing	£137,320
Mental Health Care Pathway	Integrated care teams		Mental Health		Joint	60.0%	40.0%	Private Sector	Local Authority Social Services	£2,652,080	Existing	£2,683,588
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Social Care		Joint	56.0%	44.0%	Private Sector	Local Authority Social Services	£15,772,981	Existing	£13,059,270
Adult Community Care - Development of Community Neighborhood tea	Integrated care teams		Social Care		Joint	56.0%	44.0%	Local Authority	CCG Minimum Contribution	£6,418,000	Existing	£6,304,000
Dementia Hub	Personalised support/ care at home		Mental Health		Joint	88.0%	12.0%	NHS Mental Health Provider	Additional CCG Contribution	£2,585,586	New	
Dementia Hub	Personalised support/ care at home		Social Care		Joint	88.0%	12.0%	Local Authority	Local Authority Social Services	£246,150	New	
Dementia Hub	Personalised support/ care at home		Social Care		Joint	88.0%	12.0%	Charity/Voluntary Sector	Local Authority Social Services	£73,759	New	
Care Act	Other	Implementation of care	Social Care		Local Authority			Local Authority	Additional CCG Contribution	£964,000	Existing	£964,000
Disabled Facilities Grant	Personalised support/ care at home		Social Care		Local Authority			Local Authority	Local Authority Social Services	£2,440,000	Existing	£1,319,000

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Wolverhampton

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. 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, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E: if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Wolverhampton

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. 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, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E: if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Wolverhampton

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. 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, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Template for BCF submission 3: due on 03 May 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board:
Wolverhampton

Data Submission Period:
2016/17

5. HWB Metrics

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 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is 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 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

			Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
Contributing CCGs	% CCG registered population that has resident population in Wolverhampton	% Wolverhampton resident population that is in CCG registered population	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Dudley CCG	1.4%	1.7%	9,976	142	10,223	146	10,362	148	10,385	148	40,946	585
NHS Sandwell and West Birmingham CCG	0.1%	0.3%	15,364	19	15,800	19	15,593	19	15,941	19	62,698	76
NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%	5,708	98	5,947	102	5,873	100	5,817	100	23,345	399
NHS Walsall CCG	3.9%	4.0%	7,643	299	7,953	311	8,260	323	8,035	314	31,891	1,247
NHS Wolverhampton CCG	93.7%	92.7%	7,960	7,460	7,960	7,460	7,960	7,460	7,700	7,217	31,580	29,598
Totals		**100%**	**46,651**	**8,018**	**47,883**	**8,038**	**48,048**	**8,051**	**47,878**	**7,798**	**190,460**	**31,904**

Are you planning on any additional quarterly reductions?	No											
If yes, please complete HWB Quarterly Additional Reduction Figures												
HWB Quarterly Additional Reduction Figure												
HWB NEA Plan (after reduction)												
HWB Quarterly Plan Reduction %												

Are you putting in place a local risk sharing agreement on NEA?	No	
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£5,075,936	
Cost of NEA as used during 15/16 ****	£1,490	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.
Cost of NEA for 16/17 ****		At this point we assume last years figure plus growth 1.1%

Additional NEA reduction delivered through the BCF							
HWB Plan Reduction %							

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 12th April 2016.

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
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	644.3	638.0	638.0	581.9	Based on an approach to assisted technology roll out we expect to see a corresponding reduciton in residential admissions
	Numerator	273	273	273	252	
	Denominator	42,375	42,787	42,787	43,307	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data. Planned 15/16 rate has been amended for 6 HWBs to show the rate as calculated by using the numerator and denominator shown in the table.

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

	Actual 14/15*****	Planned 15/16	Forecast 15/16	Planned 16/17	Comments

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.6%	94.3%	79.3%	80.3%	N/A
	Numerator	330	330	340	490	
	Denominator	410	350	429	610	

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

5.4 Delayed Transfers of Care

- Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	1032.7	750.5	708.2	965.7	2040.5	2253.5	1886.7	1590.0	1447.8	1104.9	800.1	1051.0	Please add comments, if required
	Numerator	2,027	1,473	1,390	1,901	4,005	4,423	3,703	3,130	2,850	2,175	1,575	2,075	
	Denominator	196,274	196,274	196,274	196,857	196,274	196,274	196,274	196,857	196,857	196,857	196,857	197,432	

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
New supported living placements for people with mental health issues	Metric Value	0.0	17.0	This is a new metric for 2016/17 therefore there is no comparison data for 2015/16.
	Numerator	0.0	0.0	
	Denominator	0.0	0.0	

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Overall satisfaction of people who use services with their care and support	Metric Value	0.7	0.7	this is an annual measure, and we are already in the upper quartile. Satisfaction has increased over the last few years. The satisfaction survey is currenlty being undertaken. Once we have the results of this we will review the target for 2016/17 accordingly
	Numerator	235.0	235.0	
	Denominator	340.0	340.0	

Template for BCF submission 3: due on 03 May 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Wolverhampton

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

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

5.1 HWB NEA Activity

Wolverhampton Data Source Used - 15/16	MAR				
	Q1	Q2	Q3	Q4	Total
Wolverhampton 14/15 Baseline (outturn)	7,855	7,463	7,969	7,731	31,018
Wolverhampton 15/16 Plan	7,313	7,313	7,314	7,460	29,400
Wolverhampton 15/16 Actual	7,377	7,553	8,297		23,227

14/15 baseline and plan data has been taken from the "Better Care Fund Revised Non-Elective targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection" returned by HWB's in July 2015. The Q1 15/16 actual performance has been taken from the "Q1 Better Care Fund data collection" returned by HWB's in August 2015. The Q2 actual performance 15/16 and the Q4 15/16 plan figure have been taken from the "Q2 Better Care Fund data collection" returned by HWB's in November 2015. The Q3 15/16 actual performance has been taken from the "Q3 Better Care Fund data collection" returned by HWB's in February 2016. Actual Q4 data is not available at the point of this template being released.

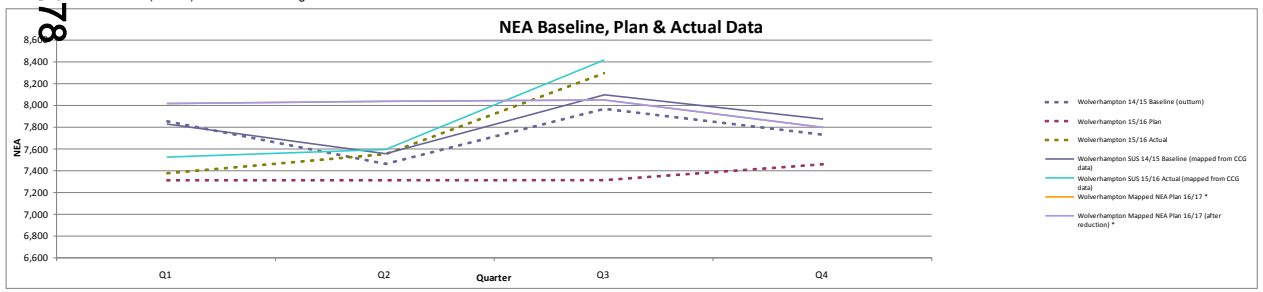
Wolverhampton SUS 14/15 Baseline (mapped from CCG data)	**7,829**	**7,557**	**8,098**	**7,875**	**31,359**
Wolverhampton SUS 15/16 Actual (mapped from CCG data)	7,526	7,596	8,418		23,540
Wolverhampton SUS 15/16 FOT (mapped from CCG data)					31,507

SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures were mapped from the baseline data supplied to assist the CCGs with the 16/17 shared planning round.

Over the last year the monitoring of non-elective admission (NEA) activity has shifted away from the use of the Monthly Activity Return (MAR) towards the use of Secondary Users Service data (SUS). This has been reflected in the latest planning round where NHS England, Monitor and TDA have worked with CCGs and providers to create a consistent methodology to enable the creation of consistent NEA plans. The SUS CCG mapped data included here has been derived using this methodology. More details on the methodology used to define NEA can be found in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Wolverhampton Mapped NEA Plan 16/17 *	**8,018**	**8,038**	**8,051**	**7,798**	**31,904**
Wolverhampton Mapped NEA Plan 16/17 (after reduction) *	**8,018**	**8,038**	**8,051**	**7,798**	**31,904**

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



Template for BCF submission 3: due on 03 May 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Wolverhampton

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

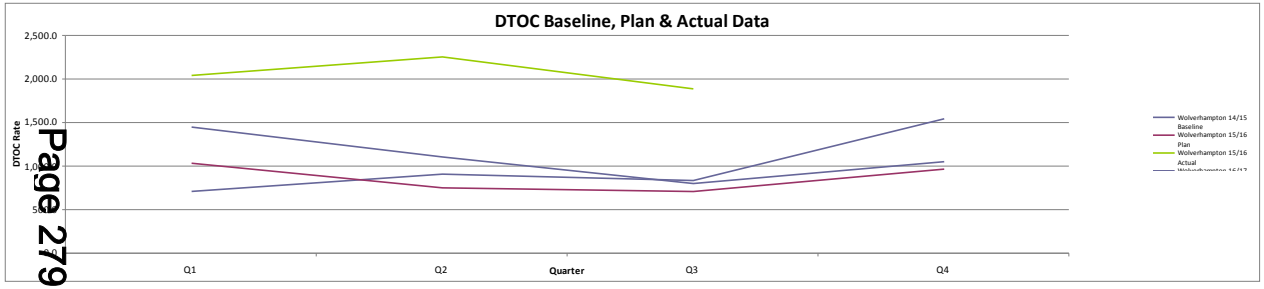
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4
Wolverhampton 14/15 Baseline	709.6	907.7	834.5	1,543.3
Wolverhampton 15/16 Plan	1,032.7	750.5	708.2	965.7
Wolverhampton 15/16 Actual	2,040.5	2,253.5	1,886.7	

Delayed Transfers Of Care numerator data for baseline and actual performance has been sourced from the monthly DTOC return found here http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/. Actual Q4 data is not available at the point of this template being released.

Wolverhampton 16/17 Plans	**1,447.8**	**1,104.9**	**800.1**	**1,051.0**



Template for BCF submission 3: due on 03 May 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Wolverhampton

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C 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, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	Yes	
2) Maintain provision of social care services (not spending)	Yes	
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development	The Better Care fund programme is working alongisde the 7 day services Project to ensure alignment. Wolverhampton has been chosen (by NHSE) as an early adoptor site for 7 day services.
4) Better data sharing between health and social care, based on the NHS number	Yes	
5) 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	No - in development	The development of community Neighbourhood Teams is working to ensure a joint approach to assessments and joint health and social care teams meet on a regular basis to undertake care planning. The development is not yet at a stage where and accountable professional is identified
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	

CCG to Health and Well-Being Board Mapping

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	89.7%	88.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.2%	0.4%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.1%	2.9%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.9%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	0.8%	0.5%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
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	08H	NHS Islington CCG	0.1%	0.0%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.4%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.3%
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	94.0%	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%	0.7%
E09000004	Bexley	07N	NHS Bexley CCG	93.6%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.5%	1.6%
E09000004	Bexley	08A	NHS Greenwich CCG	7.7%	8.9%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	92.0%	57.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.9%	20.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	2.9%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.1%	18.6%
E08000025	Birmingham	05P	NHS Solihull CCG	15.0%	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	87.0%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.6%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.3%	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	45.7%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.8%
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%	2.2%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.8%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.7%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	21.5%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.8%	58.4%
E08000032	Bradford	02T	NHS Calderdale CCG	0.1%	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	0.1%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.0%	2.1%
E09000005	Brent	07P	NHS Brent CCG	89.6%	87.2%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.7%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.6%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.2%	0.1%
E09000005	Brent	08E	NHS Harrow CCG	5.7%	3.9%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.4%	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%	0.2%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.7%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.8%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.9%	95.3%
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	0.0%	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	91.2%	35.0%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.1%	59.9%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.5%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.2%	0.6%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.8%
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	94.3%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.1%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01M	NHS North Manchester CCG	2.0%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.8%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.6%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.4%	0.4%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.8%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.9%	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	0.1%	0.2%
E09000007	Camden	07P	NHS Brent CCG	1.5%	2.2%
E09000007	Camden	07R	NHS Camden CCG	84.6%	88.4%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	6.0%	5.1%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.4%	3.2%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.1%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.1%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.2%	0.5%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.4%	2.0%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.3%	50.6%
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%	45.3%
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	2.0%	1.3%
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	96.8%	69.4%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.2%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	0.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.9%	74.1%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.1%
E09000001	City of London	08Q	NHS Southwark CCG	0.0%	0.1%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.8%
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	97.4%	53.0%
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%	45.7%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.0%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.5%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.6%	93.7%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.7%	2.6%
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	0.4%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Lancashire North CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.3%
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	50.1%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.1%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.2%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.2%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	1.9%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.3%	36.0%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.2%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.0%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.1%	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	70.0%	80.5%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.7%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.4%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.2%	0.5%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%

E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.3%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.1%
E10000009	Dorset	11J	NHS Dorset CCG	52.7%	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	0.2%	0.5%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.9%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.6%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000009	Ealing	07W	NHS Ealing CCG	86.7%	90.8%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.7%	2.9%
E09000009	Ealing	08E	NHS Harrow CCG	0.3%	0.2%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.6%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	5.0%	3.7%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.2%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.4%	8.0%
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	6.4%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.5%
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%	29.7%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.9%	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%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.5%	90.7%
E09000010	Enfield	08D	NHS Haringey CCG	7.8%	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%	18.3%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.4%	11.7%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.8%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.2%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.4%
E10000012	Essex	06T	NHS North East Essex CCG	98.7%	22.4%
E10000012	Essex	08N	NHS Redbridge CCG	3.2%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.3%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	39.6%	98.0%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.7%
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	5.2%	4.3%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.6%	89.9%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.1%	4.5%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.6%	94.6%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.1%	3.4%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.7%
E06000006	Halton	01J	NHS Knowsley CCG	0.1%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	0.9%
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	0.0%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.3%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.9%	88.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.8%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.6%	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%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.4%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.5%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.7%	0.0%

E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.0%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.5%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.6%
E09000014	Haringey	07R	NHS Camden CCG	0.5%	0.5%
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	87.7%	91.6%
E09000014	Haringey	08H	NHS Islington CCG	2.3%	1.9%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.7%	5.0%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	90.0%	84.3%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.4%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.7%	1.9%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.1%	0.4%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.6%	99.6%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	4.0%	3.3%
E09000016	Havering	08F	NHS Havering CCG	92.0%	95.9%
E09000016	Havering	08M	NHS Newham CCG	0.0%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.5%	0.6%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.1%
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	96.8%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.3%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.9%
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	0.7%	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	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	90.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%
E09000018	Hounslow	07W	NHS Ealing CCG	5.8%	8.0%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.0%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.3%	3.6%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.4%	4.9%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.4%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.2%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.7%
E09000019	Islington	08H	NHS Islington CCG	89.8%	89.0%
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	4.1%	5.1%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	0.9%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	64.1%	93.2%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.1%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.8%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	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%	13.0%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.3%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.5%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.6%	98.5%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.8%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.0%	1.2%
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%	0.5%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.8%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.6%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.8%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	99.0%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.1%	0.9%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.9%	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%	2.9%

E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	86.8%	92.7%
E09000022	Lambeth	08R	NHS Merton CCG	1.2%	0.7%
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	13.0%	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	98.9%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.4%	11.9%
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 Lancashire North CCG	99.8%	12.8%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.0%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.1%	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%	24.3%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.5%	31.9%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	42.7%
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	1.5%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.5%	2.2%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.2%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.6%	2.6%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.3%	40.1%
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	5.7%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.6%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.7%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.3%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.2%	2.0%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.2%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	92.1%	92.5%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.7%	3.7%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.1%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.4%
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	90.6%	19.5%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.2%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.8%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.3%	96.2%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.2%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	00W	NHS Central Manchester CCG	93.7%	36.9%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01M	NHS North Manchester CCG	85.1%	30.3%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01N	NHS South Manchester CCG	93.9%	28.2%
E08000003	Manchester	01W	NHS Stockport CCG	1.5%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.3%	1.8%
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%	0.8%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	0.9%	1.4%
E09000024	Merton	08R	NHS Merton CCG	87.7%	81.5%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.5%	10.5%
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	52.0%	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%	1.4%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.0%	95.0%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.2%
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	0.1%	0.0%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.9%	97.9%
E09000025	Newham	08N	NHS Redbridge CCG	0.2%	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	47.5%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.1%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.8%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.7%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.8%	25.3%
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%	98.7%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.1%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.1%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.4%
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	1.7%	1.6%
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	93.1%	96.4%
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	1.3%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.7%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.3%
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	32.6%	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%	9.6%
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%	85.0%
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	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	94.8%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.1%
E06000018	Nottingham	04M	NHS Nottingham West CCG	5.7%	1.6%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.1%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.5%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.7%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.8%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.1%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.1%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.5%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.4%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	89.3%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.5%	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	1.4%	1.3%
E08000004	Oldham	01M	NHS North Manchester CCG	2.6%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.7%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.2%	1.8%
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	0.7%	0.3%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.6%	96.1%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.2%	3.9%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.3%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.2%	36.6%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.9%	60.1%

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	0.9%	0.8%
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	47.7%	99.0%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	5.0%	7.1%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	92.2%	90.3%
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%	0.5%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.6%
E08000005	Rochdale	01M	NHS North Manchester CCG	1.8%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.8%	0.9%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	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	0.7%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.6%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	12.0%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	00W	NHS Central Manchester CCG	0.3%	0.3%
E08000006	Salford	01M	NHS North Manchester CCG	2.1%	1.7%
E08000006	Salford	01G	NHS Salford CCG	93.9%	95.1%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.1%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.2%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	2.8%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.8%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.3%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.6%	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%	5.2%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.9%
E08000014	Sefton	01V	NHS Southport and Formby CCG	97.0%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	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	0.5%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.5%	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	2.4%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.2%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.7%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.2%	6.7%
E06000039	Slough	10T	NHS Slough CCG	96.6%	92.9%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	2.0%	6.8%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.3%	0.3%
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	05P	NHS Solihull CCG	83.8%	91.7%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.5%
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%	0.4%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	4.7%	8.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.0%	89.4%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.1%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.3%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.5%	99.6%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.4%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.6%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	07R	NHS Camden CCG	0.5%	0.4%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.0%	1.3%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.6%
E09000028	Southwark	08L	NHS Lewisham CCG	1.9%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.5%	88.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.0%	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%	96.5%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.6%	1.1%
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	91.9%	14.5%
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	1.1%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	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%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.8%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	00W	NHS Central Manchester CCG	0.7%	0.6%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	01N	NHS South Manchester CCG	2.9%	1.7%
E08000007	Stockport	01W	NHS Stockport CCG	95.2%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.3%	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	66.8%	98.7%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.3%	0.5%
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	52.5%	16.5%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.3%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.2%	0.4%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.0%	29.6%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.7%	0.7%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.3%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.2%
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%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.6%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.5%	0.1%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.2%	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	99.5%	29.6%
E10000030	Surrey	08P	NHS Richmond CCG	0.5%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.9%
E10000030	Surrey	10C	NHS Surrey Heath CCG	99.0%	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	7.7%	1.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.3%	3.2%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.2%	6.5%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	86.0%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.1%	0.2%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.3%	98.4%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.6%	1.4%
E08000008	Tameside	00W	NHS Central Manchester CCG	0.5%	0.5%
E08000008	Tameside	01M	NHS North Manchester CCG	6.4%	5.5%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.6%	2.1%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	3.0%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.0%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.2%
E06000034	Thurrock	08F	NHS Havering CCG	0.1%	0.2%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.3%
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	0.3%	0.2%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.8%	0.8%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.7%
E08000009	Trafford	00W	NHS Central Manchester CCG	4.7%	4.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	01N	NHS South Manchester CCG	3.2%	2.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.3%	93.2%

E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	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	94.6%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.7%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.4%	90.7%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.3%	1.2%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.1%	1.5%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.8%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	2.7%	2.9%
E09000032	Wandsworth	08R	NHS Merton CCG	3.0%	1.8%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.8%	93.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.5%	0.3%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.1%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.6%	21.4%
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	96.1%	45.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.8%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.1%	66.2%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.7%	23.7%
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	9.1%	7.6%
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	95.6%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.2%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.5%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	2.9%	3.1%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	81.6%	71.1%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.5%	23.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.1%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	1.1%	0.8%
E08000010	Wigan	01X	NHS St Helens CCG	3.9%	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	0.7%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.5%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.6%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.9%	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	1.0%	0.5%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.1%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	97.0%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.9%
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%	0.2%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.5%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.9%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.2%	1.2%
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%	2.7%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.1%	0.0%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.5%
E06000041	Wokingham	10W	NHS South Reading CCG	11.1%	9.0%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.9%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.7%
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	3.9%	4.0%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.7%	92.7%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.5%	0.6%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.6%	1.1%
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%	48.8%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.5%	18.8%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.4%	99.9%

Produced by NHS England using data from National Health Applications and Infrastructure Services (NHAIS) as supplied by Health and Social Care Information Centre (HSCIC)

CITY OF WOLVERHAMPTON COUNCIL

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton Health and Care Economy

BCF Narrative Plan – May 3rd 2016

Black Country Partnership NHS Foundation Trust

The Royal Wolverhampton NHS Trust

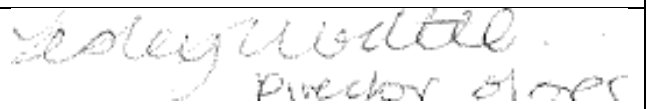
Section	KLOE Reference	Supporting Document (s)
Compliance		
a) Summary of Plan	1.i 1.ii 1.iii 1.iv	

LA	CWC
CCGs	Wolverhampton CCG
Boundary Differences	None
Date submitted – Draft 1	3rd May 2016
Minimum required value of pooled budget 2016/17	£17.9 million
Total agreed value of pooled budget 2016/17	£57.7 million

b) Authorisation and sign off

Signed on behalf of the CCG	Wolverhampton CCG 
By	**Dr Helen Hibbs**
Position	**Chief Officer**
Date	**03/05/16**

Signed on behalf of the Council	CWC 
By	**Linda Sanders**
Position	**Strategic Director**
Date	03/05/16
Signed on behalf of the HWB	Wolverhampton HWB 
By Chair of HWB	Councillor Sandra Samuels Chair
Date	03/05/16
Signed on behalf of RWT	
By	David Loughton CBE

	Chief Executive		
Date	03/05/16		
Signed on behalf of Black Country Partnership Foundation Trust			
By	Lesley Writtle		
Date	03/05/16		
A. Confirmation of funding contributions			
Overview of funding contributions 2016/17 The revenue value of the pooled fund to be managed via the Section 75 agreement is £57.7 million and consists of £32.6 million (60%) of Clinical Commissioning Group (CCG) funded services alongside, £21.7 million council funded services (40%). The council contribution includes £6.4 million representing the NHS transfer to social care (Section 256 funding). The pooled budget also includes a capital grant (Disabled Facility Grant) amounting to £2.4 million which is managed by the council. This is in line with the governance arrangements detailed in Appendix 1. Care Act funding of £0.96 million is also included. **Changes from 2015/16 funding levels** The Better Care Fund (BCF) Programme board have discussed and agreed a number of principles in relation to the BCF Programme for 2016/17. In terms of the funding, all parties have agreed that the pooled budget should contain only those services that could be jointly influenced and improved in terms of service efficiency and the individual's pathway experience. This principle formed the basis of a thorough review of all services in order to determine what should be included in 2016/17 pooled budget. Consequently, a number of "specialist" services such as Neurology were not carried forward. This has enabled a 2016/17 approach that focusses on those areas where joint working is able to have the greatest influence.		A.3.iii A.3.iv A.3.v	Appendix 1

Other areas such as Physiotherapy and Independent Living services are currently undergoing transformation but could be brought back into the pooled fund a later point when this work has been completed. In 2015/16 the value of the pooled fund was £70.7 million revenue; of which £22.8 million related to council funded services and £47.9 million related to CCG funded services. The 2015/16 fund also included £2.1 million capital grant. The 2015/16 year on year difference is £16 million, however the 2016/17 figure remains substantially above the minimum requirement for a pooled fund. There has been no impact on the services excluded from the 2016/17 overall fund because from a commissioning and redesign perspective it was never possible for the partnership to jointly influence their operational activity. For those services that are included in the 2016/17 pooled fund there will be joint health and social care focus on pathway design and associated operational activity to deliver improved outcomes through partnership working. The anticipated impacts on the 2016/17 BCF pool funded services will broadly be in the following areas across all work streams: • Re-structure/redeployment/re-location of existing resources (staffing and/or infrastructure) • Changes to staff working hours to cover 5/7 working and extended daily operational cover periods e.g. 08.00 to 20.00 hours. • Changes to the skills mix within existing and 'new' service teams and subsequent workforce development and training requirements. • Changes to working practices across the spectrum e.g. managerial and front-line that include routine cross fertilisation of ideas, information sharing and best practice.		
B. Overview		
<u>The local vision for health and social care services:</u> In common with the rest of England, Wolverhampton's health and social care economy is experiencing unprecedented demand growth for services with limited resources to meet those demands. Despite progress in recent years, the resultant pressures are being reflected across the hospitals, GP surgeries, community healthcare teams and social services on a daily basis. As the population grows and people live longer, the challenge to balance available resources and local needs will continue to grow. Wolverhampton's starting point for responding to this challenge is to not regard it as simply a financial issue or view pressures in one part of its public services as being resolvable in isolation from others. The vision for the next 5 years is therefore nothing less than a fundamental transformation of the quality and experience of care, across all elements of commissioning and provision on behalf of Wolverhampton's population.	B.1.i B.1.ii B.1.iii B.1.iv	Appendix 2 Appendix 3 Appendix 4 Appendix 5 Appendix 6 Appendix 7 Appendix 8 Appendix 9 Appendix 10

Five Year Forward View

In line with the five year forward view Wolverhampton CCG's Primary Care Strategy describes a number of emerging new models of care in Wolverhampton. There are three GP practices exploring vertical integration with the acute and community provider Royal Wolverhampton Trust (RWT). A further eight practices (Primary Care Home) are developing a Multi-speciality Community Providers (MCP) approach.

From a person's perspective the Primary Care Home model describes that practices will offer *"multi-speciality working through our 'Home', creating a 'one organisation' approach to delivering bespoke population health to the registered lists of all 26 constituent GPs – whilst ensuring we retain personalised care for individuals, and continue to identify at risk patient groups."*

Clearly the BCF programme will need to work closely with these models to ensure that care across the city is aligned. It is the responsibility of current commissioners to ensure our services are developed and implemented in a way that makes them the preferred services for the new emerging organisations.

Within the programme we will;

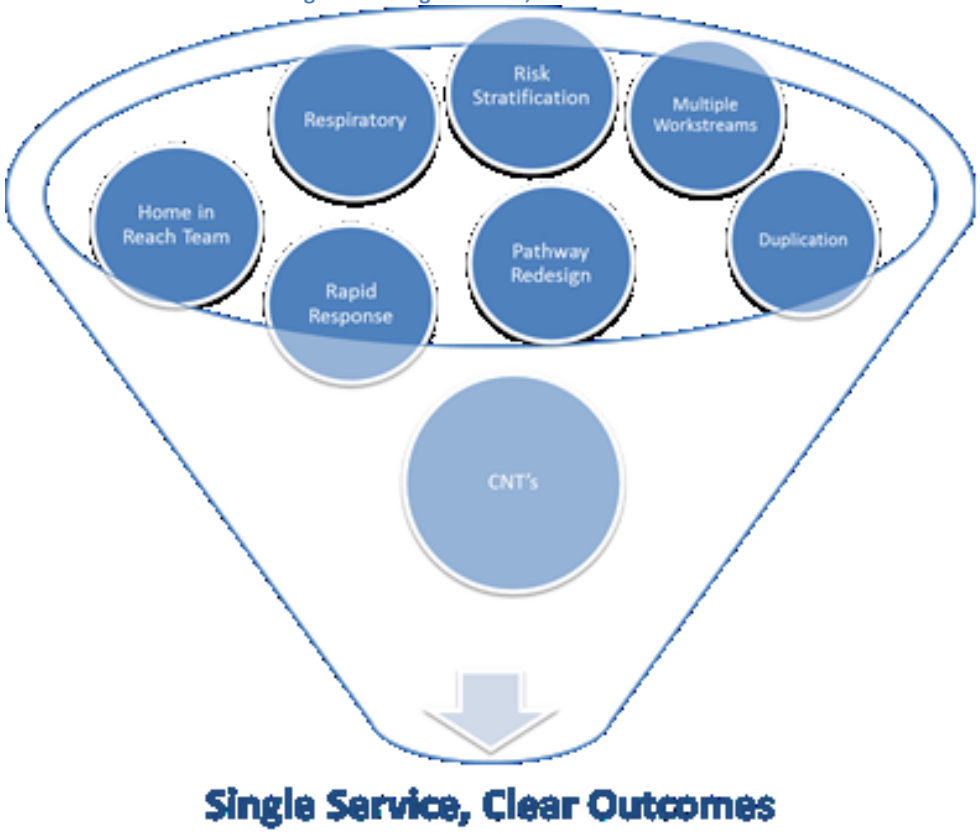
- Deliver holistic, person-centred care (Figure 1) based on a population, place based approach. This ensures parity of esteem across physical, mental health and social care service.
- Increase the diagnosis and management of people with Dementia within a primary and community setting. Please refer to the (Appendix 2).
- Deliver a range of services to support care closer to home, promote confidence to enable people to manage their own care (this includes educating patients and carers of how to manage crisis situations) thus enabling a reduction in A&E attendances and emergency admissions.
- Actively promote a shared care approach with Primary Care professionals, supporting Primary Care in the identification and case management of people identified at high/medium risk.
- Be wrapped around Primary Care based in our three localities to enable the delivery of a more localised approach to care closer to home.

- Be multi-disciplinary across health and social care in three localities. To ensure equity of access and efficient use of wider community resources.

Figure 1 – Person-centred Care Model

In 2015/16 the BCF Programme piloted two rapid response services (Community Care and Mental Health Street Triage) each of which relied on MDT working by staff from one or more of the nursing, social care, therapy, ambulance and police disciplines. Building on these successes, plans for 2016/17 include the realisation of joint health and social care Community Neighbourhood Teams (CNT's); effective joint working around Urgent Mental Health Care and the embedding of national and international best-practice into all services. The Wolverhampton BCF Programme is now recognised as central to the development of person-centred, co-ordinated care closer to home. To ensure Wolverhampton's shift to more proactive ways of working, 2015/16 also saw the introduction of a scheme to bring Community Matrons, Social Workers and GP's together to assess a list of risk stratified patients in order to identify those most at risk of hospital admission (Figure 2).		

Figure 2 – Single Service, Clear Outcomes



This targeted work will continue in 2016/17 with the development of joint care plans which promote reablement and independence for those identified and mechanisms that ensure they are managed within their usual place of residence.

Wolverhampton recognises that change on this scale will mean consistently providing people with the right care, in the right place, at the right time; care that is planned and tailored to individual capabilities and needs; care that is delivered in partnership, to the highest possible standards.

This will involve putting customers at the heart of everything health and social care related, not simply because it is what people tell us they want, because it is morally the right thing to do, or even because it is the most efficient way of doing

things (although experience demonstrates all of these statements are true) but because this is the only way to ensure a sustainable, healthy future for the communities in Wolverhampton This document captures not just Wolverhampton's vision and commitment, but the practical steps being taken in order: • to transform the quality of care for customers, carers and families; • empower and support people to maintain their independence; • lead full lives as active participants in their community; • shift resources to where they will make the biggest positive difference. Wolverhampton's partner organisations believe that the BCF is a fundamental part of this journey and they understand that change on this scale will not happen without significant and joined-up investment. Building on progress to date we recognise that working together across traditional public sector boundaries to keep people well and support their recovery after periods of illness can improve individual quality of life whilst also reducing demands upon local services. However, the desire to go beyond what is currently being done underpins all the BCF planning activity. Analysis of lessons learned in 2015/16 prompted a wider consideration of what services it might be possible to influence in the coming year. This has resulted in the agreement of a slightly reduced pooled budget amount for 2016/17 with a view to building on this incrementally across the coming years. Wolverhampton's proposal is to pool a large proportion of its future health and social care funding, (in excess of the minimum mandated by the BCF) to create new forms of joined-up support and care within communities, in and around people's homes, across both urgent and planned care, that will transform outcomes and transform lives. This will help drive reductions in emergency admissions to hospital, the demand for nursing and residential home care, with benefits for customers, the local authorities and the CCGs alike. Working together in better ways to put health and social care systems on a steady footing, translating improved outcomes for customers into long-term, sustainable support for our communities as a whole is fundamental to Wolverhampton's approach. There is current and planned 2016/17 investment to work with customers, communities and providers of health and care services. Such investments will develop partner understanding, organisations, shared infrastructure, and the way in which partner services operate to ensure real progress towards the shared vision for health and social care services in 2019/20, with associated improvements in the quality and experience of care today.		

The document sets out the joint commissioning intentions, local operating and service planning with the shared 5 year vision for Wolverhampton. Underpinning all of the plans is a focus on systems that support and remove barriers to integrated care through **:**

- Prevention and proactive support through care planning and co-production
- Caring for people in the most appropriate setting, starting at home
- Supporting independence through understanding individual capabilities and needs
- Tackling social isolation, with a "whole-person" approaches to wellbeing
- Using technology to develop networked, personalised health and care services
- Eliminating gaps, duplication and disconnects between our health and care services

Wolverhampton's vision for the future will require whole system change e.g. how work is commissioned from providers to how providers interact with people and with each other. Wolverhampton is committed to effecting behavioural and attitudinal change in all areas by working together in partnership as a joint health and social care economy, with a central role for the voluntary, community sectors, and not least its citizens.

This document sets out the joint commissioning intentions and areas for development. It explains how local authorities and CCGs, working with customers and communities, will mobilise resources to target areas of need and deliver improved outcomes in 2016/17 and beyond. It captures why this is needed, what the expected outcomes are on both an individual and locality-wide basis and the current best estimates of the specific investments required to make this happen.

In doing so Wolverhampton's plan is to go far beyond using BCF funding to back-fill existing social care budgets, preferring instead to work jointly to reduce long-term dependency across the health and social care systems, promote independence and drive improvement in overall health and wellbeing for local people.

The volume of emergency activity in hospitals will be reduced as will planned care activity in hospitals. This will be achieved through the strengthening of alternative community-based services. A managed admissions and discharge process, fully integrated into local specialist provision and the CNT's, will result in a minimisation of delays in transfers of care, reduced pressures in A&Es and wards, and ensure that after episodes of ill health, people are helped to regain their independence as quickly as possible.

Wolverhampton recognises that there is no such thing as integrated care without the inclusion of mental health services. This in mind, the plans are designed to ensure that the work of community mental health teams is:-

- Integrated with community health services and social care teams;
- Organised around groups of practices;
- Enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

By improving ways of working with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

BCF will continue to be used to:

- Help people self-manage and provide peer support working in partnership with voluntary, community and long-term conditions groups.
- Invest in developing personalised health and care budgets working with patients and service users and frontline professionals to empower people to make informed decisions around their care.
- Implement routine patient satisfaction surveying to enable the capture and tracking of the experience of care.
- Invest in reablement reducing hospital admissions and nursing and residential care costs.
- Reduce delayed discharges, through investment in neuro-rehabilitation services and strengthen 7 day social care provision in hospitals.
- Integrate NHS and social care systems around the NHS Number to ensure frontline professionals, and ultimately all patients and service users, have access to all of the records and information they need.
- Undertake a full review of the use of technology to support primary and secondary prevention, enable self-management, improve customer access and service experience, and release professional resources to focus on those customers in greatest need.

Developing a new model of joined-up care will require a physical and cultural shift; new ways of working and new ways of thinking. At the moment, Wolverhampton's health and social care system takes a reactive approach to managing the care of people in crisis; this often leads to a hospital admission and a journey in to long term care. This needs to change so that people have a positive and joined-up experience of care and local NHS resources are used properly at a time when every penny needs to count. The CCG Strategic Plan sets out its intent to put the health and care economy on a sustainable footing, through developing community-based services and addressing the default of receiving care in acute settings. This is also in the context of City of Wolverhampton Council (CWC) needing to save in excess of £120 million over 5 years. To address this, both organisations will be working in partnership, with a CCG focus on increasing capacity in primary care and council focus on strengthening the community reablement offer.

The BCF programme aims to reduce the number of people treated in hospital who could be treated more effectively in, or closer to their own homes. It also aims to reduce the number of people attending hospital at the point of crisis by focusing on how to prevent the crisis happening. Wolverhampton wants to encourage people to take control and lead

healthier lives. The assets of local communities will also play a big role in helping people to access different types of support closer to where they live. The mapping of community assets to ensure they can become part of how we plan care with people has begun and will continue throughout 2016/17

A lot has been learned from a number of local initiatives throughout 2015/16. Using this and other sources of knowledge, Wolverhampton will work to build community capacity and resilience that enables people to access care closer to where they live.

Our Vision for Health and Social Care Services 2019/20

Wolverhampton's vision for health and social care services for its community is underpinned by:

- The jointly agreed and developed Health and Wellbeing Strategy. (Appendix 3)
- Effective engagement with the local community and listening to what they have told us (Appendix 4)
- The CCG 5 year strategic plan (Appendix 5)
- The Council's Corporate Plan and Vision 20:20 Statement (Appendix 6)
- The evidence base regarding the future needs of the population of Wolverhampton through the JSNA (Appendix 7)

The Wolverhampton Health and Wellbeing Strategy, outlines the jointly agreed vision as,

"***ensuring good health and a longer life for all in Wolverhampton"***

Moving forward into 2019/20 the vision for services in Wolverhampton is the provision of sustainable, seamless, person-centred support delivered as close to home as possible, that maximises opportunities for independence to be retained.

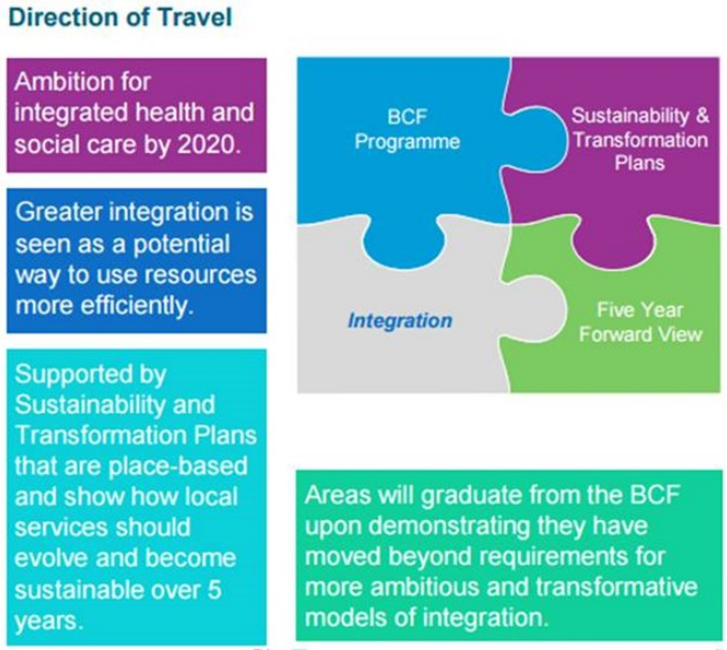
Wolverhampton stakeholders, through a number of engagement exercises and events, have identified that in order to deliver the vision for health and social care services across Wolverhampton, partners must be committed to the strategic approach.

As an example Mental Health public and patient engagement events were held in 2015 which clearly identified that the local population wanted services delivered closer to home. Further engagement events are planned for 2016. A number of stakeholder / partner / public events are planned for May 2016. These will be used to update people on the progress of the programme to date and to help inform the detail of development going forward. (Appendix 8 and Appendix 9)

Building on Wolverhampton stakeholders appetite and engagement to commit to the development of ***One Ambition, Working as One, for Every One*** BCF partners are re-focusing and relocating innovative, high standard, quality services able to provide community facing support and interventions that support the 'home as hub' as a way to realise this ambition. This means that in 2019/20 health, social care, and voluntary services will operate in seamless pathways which deliver; ✓ A reduced reliance on hospital facing services ✓ Increased and redesigned capacity in primary and community care which improves flexibility, accessibility and responsiveness through integrated, demonstrably high quality services. ✓ Receiving the right care, in the right place, at the right time. ✓ A demonstrable improvement in the health outcomes for those people in Wolverhampton who currently have relatively poor outcomes. ✓ A redeployment of resources which are directed to helping people to stay healthy for as long as possible. ✓ Integrated pathways which prioritise people receiving the right care, and that promote self-support and ownership. ✓ Design that is person-centred and which pays specific attention to those people who are older with complex health and care needs, those with life limiting conditions, and the very young. ✓ Demonstrable quality and services delivered to the right standards; they will be safe and reliable, and the people of Wolverhampton will have confidence in them. ✓ Where a professional is needed, this will be the most appropriate one to coordinate the needs of the individual. ✓ Outcomes which are commissioned at the heart of person-centred care. In December 2015 NHS also published the guidance "Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21" Which in summary mandates: • A five year Sustainability and Transformation Plan ("STP"), place-based and driving the Five Year Forward View; and a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP • Place based planning - planning by individual institutions will increasingly be supplemented with planning by place for local populations, and the agreement of transformation footprints' and the programming of clear deliverables across the STP		

From this guidance (Figure 3) it is clear that the future policy direction for health and social care is to arrive by 2020 in a fully integrated framework and as part of the BCF programme for 2016/17 the programme has introduced a new integration work stream which will be the vehicle to design and plan how the integrated model across health and social care will work by 2020.

Figure 3 – Direction of Travel (Extract from Social Care Institute for Excellence BCF Presentation)



Supporting our Vision

The Health and Wellbeing Board (HWB) has defined its commitment to developing integrated and collaborative approaches across partners which will support the achievement of this ambition for the people of Wolverhampton.
The programme has identified some shared key principles which will support it in delivering the shared vision, and they are;

- ✓ Making knowledge-led decisions – utilising, understanding and interpreting information in all its forms, including data, research and evidence, experience and expertise, and setting it within our local context.

- ✓ Encouraging and embracing innovative approaches – delivering the ambitions of the strategy through being dynamic, forward-thinking and within a culture of innovation.

- ✓ Focusing on outcomes – retaining a clear focus on delivering outcomes and demonstrating change and;

- ✓ Delivering demonstrable value – remaining bound to the commitment to ensure that the services Wolverhampton delivers or commissions offer the greatest possible value in terms of quality, cost and outcome. For every initiative implemented, the aim is to demonstrate the expected return in terms of the investment made.

Alongside these principles the BCF programme has utilised 5 strategic priorities identified by the HWB as a core support to delivering the vision, they are;

- ✓ **Wider Determinants of Health –** In demonstrating the impact of the wider determinants of health it is understood that 60% of what determines good **or** poor health comes from potentially modifiable circumstances of an individual's life – either directly related to the social and economic circumstances or related to behavioural patterns that will have been developed based on life experiences. Therefore the HWB will prioritise taking action on improving the wider social determinants of health in order to deliver impact on the health of Wolverhampton residents and positively impact on reducing health inequalities.

- ✓ **Dementia (early diagnosis)** – In Wolverhampton there are over 3000 people living with dementia and a forecast increase of 44% over the next 20 years. Taking action to ensure that dementia is diagnosed earlier, the right support is available, and that an integrated care pathway is delivered from raising education and awareness through to supporting the delivery of effective and compassionate end of life care is essential to delivering person-centred care.

- ✓ **Mental Health (Diagnosis and Early Intervention)** – Focusing on parity of esteem, delivering integration and seamlessness, supporting the approach to ensure the people of Wolverhampton can live well with mental health needs is a strategic priority for Wolverhampton. Developing a focus on the entire care pathway for those experiencing mental health needs, including mental health promotion and prevention, intervening early when people experience mental health needs, and establishing longer term, high impact changes are priorities.

- ✓ **Urgent Care** – Urgent and emergency care demand management and ensuring that people receive the right care in the right place has been prioritised locally due to the pressure that the entire system is under. It is acknowledged that in order to impact upon the urgent care system, there must be development of integrated community, primary and neighbourhood facing services to ensure that people can access the right care and

support in the right place at the right time. The strategic priority is to develop integrated community and primary care pathways that allow people to receive support in, or as close to their home as possible, developing community resilience and a new approach to self-care and support

- ✓ **Integration and collaboration** – By ensuring effective support that puts people and their families first, the traditional boundaries between health, social care and the voluntary sector in the delivery of services and interventions to the people of Wolverhampton, will be lessened. This will be driven forward through a culture of continuous development, innovation, collaboration and improvement and integration of health and social care working in wider community partnerships.

In Wolverhampton the appetite for transformational change and integration is strong. There is a clear recognition that to move from traditional, fixed models of delivery to ones which are flexible and responsive, focused on early intervention and integration, the synergies and opportunities available across the health and social care commissioning and provider communities must be maximised.

Delivering Improved Outcomes

By utilising the BCF programme, Wolverhampton CCG and CWC, in collaboration and partnership with their 2 main NHS providers, and other stakeholders, have been working together over the last 18 months to define and develop the plans for Wolverhampton which deliver transformational change at both a provision and commissioning level.

Our vision for the impact on individual outcomes over the lifecycle of the programme is;

- ✓ People will spend less time in hospital
- ✓ People will live longer healthier lives
- ✓ The home will be considered the hub for the delivery of all services
- ✓ Less people will move into residential and nursing home care
- ✓ People will be more in control of the care and support they receive through the implementation of personal budgets
- ✓ An individual's experience of receiving health and care services will be different. One person will co-design the care plan, with the person, there will only be one care plan and care will be coordinated by a single professional on behalf of the health and social care CNT's
- ✓ Customers will have self-care and self-management plans which focusing on maximising the potential for good quality independence

Demonstrating The Outcomes to Patients and Service Users

Achievement of identified outcomes will be achieved through the development of a programme sensitive monthly dashboard. As can be seen in the example below there will be a high level summary showing overall performance against yearly targets and scheme by scheme performance by monthly targets. Each scheme will have monthly targets set for the full length of the BCF according to the overall scheme's contribution to the overall targets (and scheme's component commencement dates).

Should monthly targets not be hit or exceed expectation, this will be quickly identified with the corresponding impact to the overall target quantified so an appropriate intervention can be suitably developed and directed at a detailed scheme level.

Using the BCF as a mechanism, collaborative working will enhance the delivery of schemes and effectiveness on service users ensuring services are wrapped around the person.

Each workstream within the programme has its own toolkit which includes a critical path and detailed implementation plan along with issues and risks. (An example of this can be found in Appendix 10)

To ensure we can demonstrate an improvement in outcomes for our local population, we are moving towards an outcomes based approach to commissioning health and social care services.

The phased implementation of the new CNT's will include the delivery patient focused outcomes. Following a period of baselining, the delivery of these outcomes will be collectively monitored through the established governance structure.

These patient focused outcomes fall into 6 domains:

1. Patient experience
2. Patient choice
3. Treatment
4. Carers
5. Care planning
6. Information & education

Following a successful pilot, the Rapid Response nursing service will be fully implemented using a phased approach.

The new specification will draw together the rapid response nursing service with the home in reach team ensuring. This service will also include the delivery of patient focused outcomes covering the 6 domains detailed above.

The progress of schemes will be monitored through our dashboard below;

Figure 4 – Extract of BCF Dashboard

Better Care Fund Scheme Performance Summary Jan-16 << update this to current data month

All BCF Schemes together

ACTIVITY

All schemes	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Full year
Contract Plan pre BCF reduction adjustment	700	723	723	723	723	700	723	700	723	711	653	711	8513
Planned BCF reduction	-8	-8	-8	-73	-117	-117	-119	-119	-119	-119	-119	-119	-1048
1516 Actuals	570	540	534	506	487	611	694	649	621	639	11	0	
Variance (plan vs Actual)	-130	-183	-189	-217	-236	-89	-29	-51	-102	-72			-1298 << YTD
Variance (planned reduction vs Realised reduction)	-121	-175	-181	-144	-119	29	90	69	17	47			-488

Delivery Model

The vision began in 2015/16 and will continue through to 2019/20 into the delivery of sustainable and seamless health and care services, closer to people's homes which will be enhanced by;

- An integrated approach to asset based community development, and building community capacity to improve health and reduce social isolation around the person
- A material shift from care and support being delivered on an episodic basis to support and interventions being wrapped around the individual to maximise the potential for independence

- Fully integrated mental health, dementia, community health and social care neighbourhood teams and urgent care pathways that support person-centred care and provide community facing alternatives to admission
- Effective coordination of care (irrespective of levels of complexity) held by the most appropriate person
- Improved approaches to accelerated discharge planning and post discharge from hospital support which is delivered and coordinated on an integrated basis in the community
- Consistent and responsive community access and effective support in a crisis
- Clear, agreed health and social care defined outcomes
- Innovative approaches to the co-design and commissioning of services

It is anticipated that in order to deliver the outcomes expected for the people of Wolverhampton, service transformation and integration development across the next 5 years will significantly change the way in which services are structured and delivered.

Developing an integrated approach to asset based community development, and building community capacity to improve health and reduce social isolation around the person

By 2019/20 Wolverhampton will have facilitated a three locality structure. The locality approach will support a move away from more traditional methods of delivery, to utilising the whole system to promote and maintain emotional, physical and social wellbeing. A profile will be developed of community facing support which harnesses existing voluntary and community services. Augmenting these to support the whole person in a non-statutory, community, and person-centred way will be a priority. This will be achieved by realising the benefits of a reduction in hospital facing services and transforming the traditional organisational approach to service delivery.

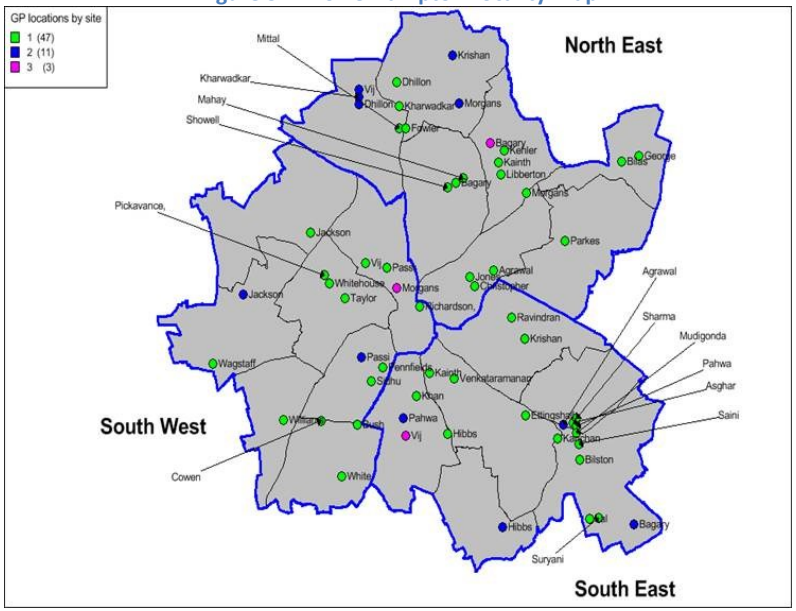
A material shift from care and support being delivered on an episodic basis to support and interventions being wrapped around the individual to maximise the potential for independence

The BCF schemes will support the delivery of effective care coordination which is consistent irrespective of complexity. At the heart of these service delivery changes are integrated neighbourhood teams that have the scope and range of skills to support an individual irrespective of changing needs. This will allow a more consistent wraparound approach, particularly in the support of people who have multiple complex comorbidities.

Fully integrated mental health, dementia, community health and social care neighbourhood teams and urgent care pathways that support person-centred care and provide community facing alternatives to admission.

In redesigning the way primary and community care services are structured by 2019/20, there will be a major shift in the landscape of care across Wolverhampton. Services in Wolverhampton will be structured around 3 core localities, and wrapped around a cluster of GP practices (Figure 5).

Figure 5 – Wolverhampton Locality Map



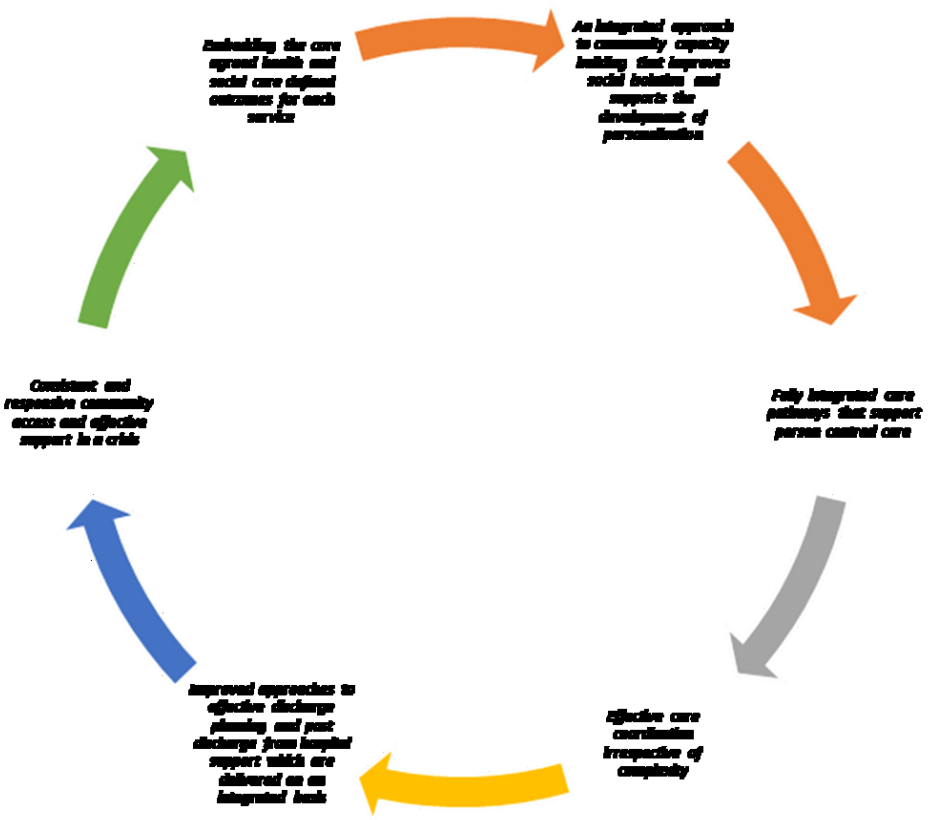
This will enable more effective primary care engagement and integration in the way services are delivered. Access to services will be improved via a broader range of the 24 hour services extended across 7 days. Health and social care will be jointly delivered with effective care coordination and co-production of care plans with customers which will be at the heart of our delivery model. A rapid responses function will be an integral part of all care pathways.

Effective coordination of care irrespective of levels of complexity held by the most appropriate person

Everyone in Wolverhampton with one or more complex condition will have their care coordinated by the most appropriate professional. The effectiveness of care coordination will be delivered through the adoption of a partnership approach to

care planning with customers, an emphasis on reducing dependency and increasing self-help and resilience development, supporting care as close to the home, or in the home wherever possible. In dementia services this means that by 2019/20, anyone with a diagnosis of dementia will have an advanced plan and have the opportunity to consider advance decisions. **Improved approaches to accelerated discharge planning and post discharge from hospital support which is delivered and coordinated on an integrated basis in the community** The integrated CNT's will include an accelerated discharge function which means that where need has been identified, anyone being discharged from hospital will have access to 5 days of intensive follow up support across health and social care services delivered into their own home. **Consistent and responsive community access and effective support in a crisis** All customers with a care coordinator will have a developed and shared, crisis contingency plan. A pathway will be in place (via the urgent care centre) for access to intensive home treatment as a way to avoid unnecessary hospital admissions, build confidence in community facing accessibility and services, and enhance resilience and a self-guided approach. Intensive home treatment will be available to all, based upon assessed need, and the function will be delivered for up to 5 days. **Clear, agreed health and social care defined outcomes** Services will be commissioned and performance assessed on an outcomes basis in 2019/20. Pathways will be designed and specifications developed which reflect the anticipated outcomes of health and social care commissioners and the people of Wolverhampton. To drive effective delivery of outcomes integrated service delivery on a more enhanced basis through our commissioning approaches will be encouraged. **Innovative approaches to the co-design and commissioning of services** In 2019/20, there will be an embedded approach of whole system engagement in design where providers confidently bring forward ideas for change and innovation. There will be an established, multi-agency, design innovation network, where commissioners and providers can collaborate to deliver innovation ideas which meet the identified needs of the population of Wolverhampton (Figure 6).		

Figure 6 - Wolverhampton BCF Integration Continuum



Incrementally, the pooled commissioning budget for integrated services will have increased by building on successes and applying them to other areas.

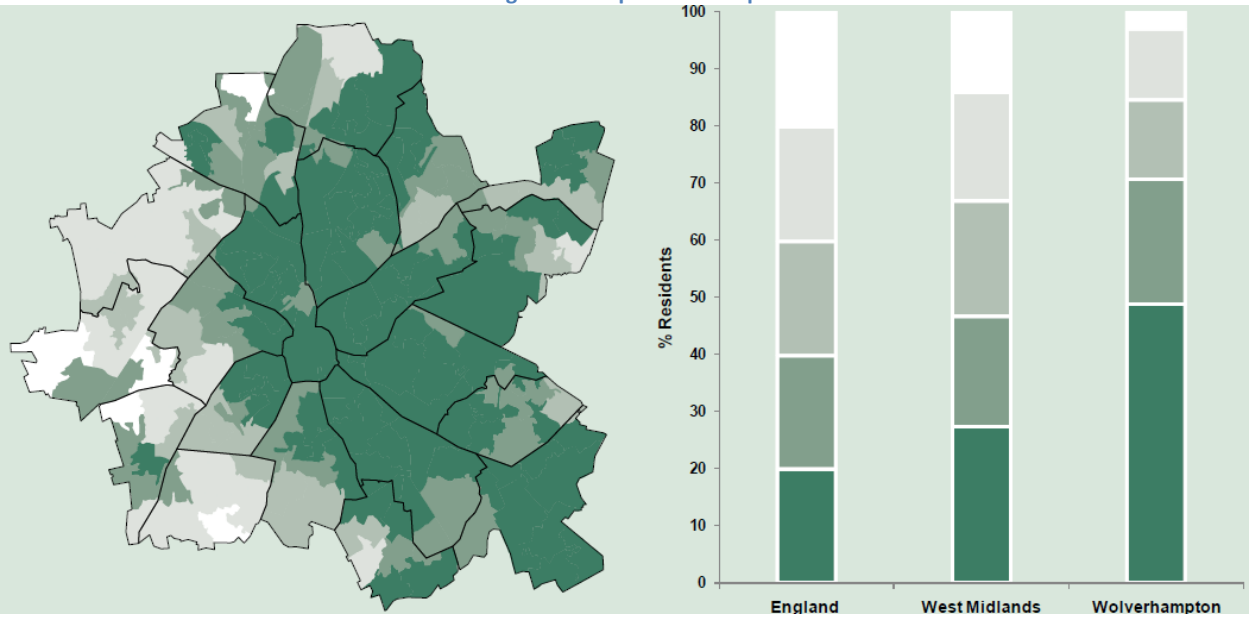
A range of payment and benefit systems will be utilised for different types of care, depending on the aspirations of different services and populations, and the strategic value in mixing payment models will have been reviewed

As a result of the BCF, it's work streams and projects - the next five years will see:

Landscape Change	Demonstrated Through
People in Wolverhampton receive wrap around services that are seamless.	Through the delivery of integrated, multi-disciplinary neighbourhood teams across three localities. An increase in the number of people with identified care coordinators, a care plan, and contingency plan
Less people living, permanently, in Nursing & Residential care with more people receiving services in their own homes	An uplift in the number of services, and support offered across 7 days and 24 hrs. within the community
Those that remain in Nursing & Residential Care will have a named GP (1 GP per Home unless patients choose otherwise), with agreed care plans for their Long Term Conditions and services designed to wrap around them, including access to Specialist Services historically provided in a hospital setting	Number of patients who are resident in a nursing or residential home with a named GP – 100% Clear transition of activity form hospital to the community
A planned reduction in the number of acute medical beds, equivalent to 2 medical wards	Benefits realised through a reduction in Delayed Transfers of Care (DTOC) and non-elective admissions
A shift of workforce numbers from acute settings into community services	Demonstrable activity shifts from hospital to community Access to more services across 24 hrs., and 7 days per week in communities Increase in self-management and asset based community services being delivered in each neighbourhood
People living with Long Term Conditions managing their own conditions – with the appropriate support, taking control through personalised health and social care budgets and enjoying a better quality of life	The number of active personal budgets
People with mental health problems identified early - in the primary care setting - and early intervention commenced	Increase in dementia diagnosis Increase in self-help and early intervention services for mental health

An evidence base supporting the case for change; Too often, care is fragmented by boundaries between services and teams when it should be co-ordinated around the needs of customers. Delivering integrated, or joined-up, care for people with complex needs is a priority for everyone working in health and social care in Wolverhampton. Positive steps have been made to begin to shape the framework to deliver this in 2015/16. **The Economic Picture Locally** The Wolverhampton economy as a whole is financially challenged. A flat health care income with significant reductions in central funding settlements has contributed to a QIPP delivery programme in the CCG's current 5 year plan of £52 million. Equally, the savings target for CWC is currently in excess of £100 million. The entire health and social care community in Wolverhampton understands that in order to gain the most value from its joint investment, the BCF is the opportunity, particularly around community based services to pool its resources. For the CCG, this means enacting its strategic intentions to transfer appropriate elements of care from a hospital setting into the community as well as reviewing and transforming existing community based services to deliver the most significant demonstrable quality and value. Figure 7 below shows the deprivation level comparator between Wolverhampton, the West Midlands region and England, the darker the green the more deprived, which shows Wolverhampton as a city area experiencing more than 2 x the level of most significant deprivation than the national average, and proportionately much lower areas of prosperity.	B.2.i B.2.ii B.2.iii B.2.iv	Appendix 11 Appendix 12 Appendix 7

Figure 7 – Deprivation Map



The CCG have employed an Aristotle Community Facilitator whose sole purpose is to work with GP Practices, Community Matrons and District Nurses to undertake a programme of work around Risk Stratification.

The facilitator is engaging with all GP practices and has already met and trained a large number of practice staff.

The purpose of the meeting is to review high and medium risk patients using new functionality in the latest Aristotle Risk Stratification software (Appendix 11). The output of the meeting is to identify patients with long term conditions who can go on the CNT's caseload. These patients are then assessed at the Multi-Disciplinary Team (MDT) meetings.

The purpose of the MDT meeting is to establish the CNT's to manage patients more effectively in the community. A care plan for these patients is jointly developed in order to manage the patients more effectively in the community with an integrated care approach to reduce emergency admissions.

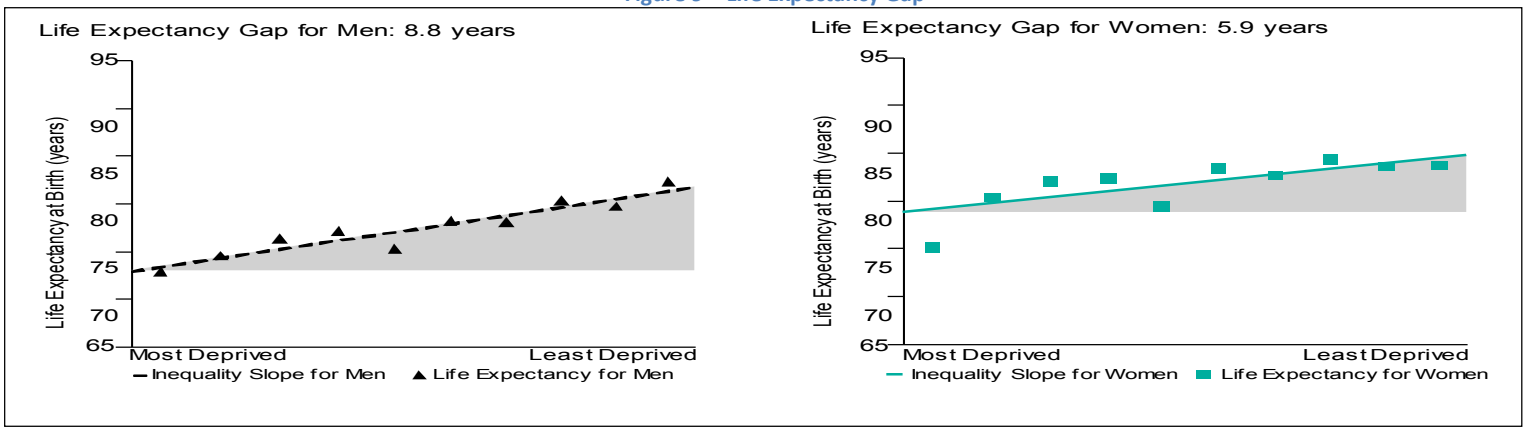
The long term objective is for the CNT's MDT meeting to integrate primary care, social services, Local Authority (LA) and secondary care in line with the BCF programme (Appendix 12).

The consequence of this early intervention in patient care will result in efficiencies associated with attendance and admissions at our acute and community provider and will ultimately improve patient experience and quality through proactive case management. Wolverhampton GP's have adopted a shared care approach to the case management of people with one or more long term condition utilising a risk stratification tool. The process to date has identified a total of 129 patients that would benefit from the case management approach delivered by our Community Matrons. The process includes an MDT within Primary Care to identify and agree the most clinically appropriate approach to delivering pro-active care to this patient cohort to support them within their own home if required. The MDT also identifies patients that would benefit from a more proactive approach to care delivered by their practice nurse or community based specialist nurse. **The Demand Picture Locally** As they grow older, the longer people remain healthy, the less growth in demand for healthcare services there will be. The pressure of an aging population is not in itself the key factor but rather how healthy people are, in particular whether they have a life limiting illness and/or long term medical condition as they grow old, in most cases these are typically driven by lifestyle factors e.g. smoking, obesity and alcohol consumption. Evidence suggests that Wolverhampton can't assume a reduced demand or growth in demand for health care services in our aging population, moreover it is more likely that there will be an increased demand as people live longer with increased complexity. Doing nothing is not an option. The evidence suggests that Wolverhampton, in line with its demographic profile, benchmarks very poorly against a number of significant health factors, and the wider determinants of health, alongside a growth rate for the over 85s (although a lower than England average trend for overall growth). Please see Figures 8 and 9 below;		

Figure 8 – Public Health Spine Chart

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	115575	48.8	19.9	89.2		0.0
	2 Proportion of children in poverty	17360	30.8	20.9	57.0		5.7
	3 Statutory homelessness	339	3.42	1.86	8.28		0.08
	4 GCSE achieved (5A*-C inc. Eng & Maths)	1527	51.8	55.3	38.0		78.6
	5 Violent crime	4355	18.3	15.8	35.9		4.6
	6 Long term unemployment	2590	17.0	6.2	19.6		1.0
Children's and young people's health	7 Smoking in pregnancy	626	20.5	14.0	31.4		4.5
	8 Breast feeding initiation	1968	64.6	73.6	39.9		95.2
	9 Physically active children	20662	60.6	55.1	26.7		80.3
	10 Obese children (Year 6)	657	24.7	18.7	28.6		10.7
	11 Children's tooth decay (at age 12)	n/a	0.7	0.7	1.6		0.2
	12 Teenage pregnancy (under 18)	263	56.3	40.2	69.4		14.6
Adults' health and lifestyle	13 Adults smoking	n/a	20.8	21.2	34.7		11.1
	14 Increasing and higher risk drinking	n/a	14.0	23.6	39.4		11.5
	15 Healthy eating adults	n/a	22.5	28.7	19.3		47.8
	16 Physically active adults	n/a	9.1	11.5	5.8		19.5
	17 Obese adults	n/a	27.5	24.2	30.7		13.9
Disease and poor health	18 Incidence of malignant melanoma	13	5.3	13.1	27.2		3.1
	19 Hospital stays for self-harm	312	135.7	198.3	497.5		48.0
	20 Hospital stays for alcohol related harm	4819	1757	1743	3114		849
	21 Drug misuse	2514	16.3	9.4	23.8		1.8
	22 People diagnosed with diabetes	13886	6.87	5.40	7.87		3.28
	23 New cases of tuberculosis	72	30	15	120		0
	24 Hip fracture in 65s and over	278	491.6	457.6	631.3		310.9
Life expectancy and causes of death	25 Excess winter deaths	153	19.7	18.1	32.1		5.4
	26 Life expectancy - male	n/a	76.3	78.3	73.7		84.4
	27 Life expectancy - female	n/a	81.0	82.3	79.1		89.0
	28 Infant deaths	22	6.46	4.71	10.63		0.68
	29 Smoking related deaths	425	240.8	216.0	361.5		131.9
	30 Early deaths: heart disease & stroke	213	85.2	70.5	122.1		37.9
	31 Early deaths: cancer	303	123.3	112.1	159.1		76.1
	32 Road injuries and deaths	81	33.9	48.1	155.2		13.7

Figure 9 – Life Expectancy Gap



The Joint Strategic Needs Assessment (JSNA) (Appendix 7) for Wolverhampton shows people in the city are living longer than ever before, however, the gap between life expectancy in the city and the national figure is not closing.

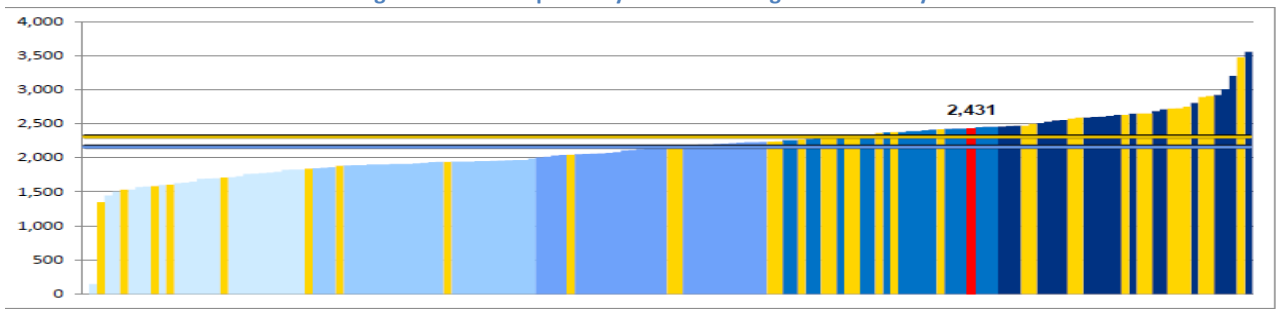
Nevertheless, both males and females in Wolverhampton experienced lower overall life expectancy in 2010/12; 77.4 years for males and 81.7 years for females. This is almost two years less than the national average for both males and females. Additionally a male in Wolverhampton can expect to live just over 58 years free of any disability which is almost three years less than the national average. Women can expect to live almost 61 years free of any disability which is two years less than the national average.

Cardiovascular Disease (CVD) remains the single greatest cause of lost life years in Wolverhampton and although this is improving, mortality from CVD remains considerably higher than the national average.

The conclusion is that at present, not only do Wolverhampton residents live shorter lives but they also spend more of their lives experiencing ill health and disability.

This is demonstrated in Figure 10, with yellow bars denoting authorities in the same Office for National Statistics (ONS) range as Wolverhampton. Wolverhampton is identified by the red marker.

Figure 10 – Life Expectancy vs. Years Living with Disability



Wolverhampton's population demographic has been modeled utilising the Monitor developed Care Spend Estimate Tool, and a local data analysis.

The figures outlined in the table below have been reviewed and we are utilising them to enhance our understanding of the Wolverhampton health and care profile.

Estimated Wolverhampton population breakdown based local data									
	Mostly healthy	1 LTC	Multiple LTCs	SEMI	Dementia	Cancer	Learning Disability	Physical Disability	Grand Total
Child	48,616	2,411	13	8	-	34	-	108	51,190
16-69	121,308	33,630	16,380	2,200	142	2,897	968	1,791	179,316
70+	5,234	6,169	14,070	361	1,725	3,257	45	413	31,274
Grand Total	175,158	42,210	30,463	2,569	1,867	6,188	1,013	2,312	261,780

Highlighted areas of demand identified through this tool suggest that significant proportion of the Wolverhampton population – 16.1% - have a long term condition, with 11.6% having more than one long term condition; in total 27.7%, with 79% of those people with a single long term condition being within the 16-69 age range, and 53% of those with more than on long term condition are represented in this age range. Whilst this sits within the national average range, the growth expectations regarding the over 85 population suggest that Wolverhampton will experience a potential increase in the numbers of older adults with comorbid health problems of a complex nature, and with challenging social care needs.

The assumption from this data and the current data analysis regarding emergency admission activity is that there is a need to plan for an increasingly health challenged aging population with complexity and co morbid conditions. Alongside this is an absolute need to adopt an early intervention, self-care management and prevention approach to support this population over the next 5 years positively to live well and with general good health.

In partnership with Wolverhampton Public Health team a deeper understanding of the impact of demographic change and health status on hospital utilisation has been developed. This has particularly focussed on the concept of 'disability-free life expectancy' and the analysis demonstrates that small changes in the health of the general population, linked to their overall life expectancy, will have a significant impact on the demand for local healthcare services.

The Challenge Picture Locally

- Population projections to 2018 suggest an increase in Wolverhampton's resident population. This growth rate is however below the national, regional and Black Country averages. Wolverhampton will experience projected increase in the 85+ age range in Wolverhampton above the national average.

- The Black Minority Ethnic (BME) population is over represented in relation to emergency hospital admissions. 32% of Wolverhampton's residents are classified as being from BME backgrounds; the largest is Asian at 18.8%, followed by black and mixed race at 6.9% and 5.1% respectively. This diversity is higher than the national distribution where 14.3% of the population is classified from a BME community. In addition, Wolverhampton has an increasing growth population from Eastern Europe.

- A high percentage of emergency admissions are identified with Mixed, Asian and Other BME backgrounds. This suggests that some patients are not accessing or receiving the care most suited to managing their condition, and are therefore further disadvantaged.

- Wolverhampton is the 21st most deprived LA in the country, with 51.1% of its population falling amongst the most deprived 20% nationally. Deprivation is disproportionate across the city and is expected to worsen by 2018 due

to the current levels of austerity. As demonstrated in the wider determinants of health, those deprived are more likely to have lower life expectancies and earlier disease manifestations.

- Both males and females in Wolverhampton experienced lower overall life expectancy in 2010/12; 77.4 years for males and 81.7 years for females. This is almost two years less than the national average for both males and females. In addition, a male in Wolverhampton can expect to live just over 58 years free of any disability which is almost three years less that the national average. Women can expect to live almost 61 years free of any disability which is two years less than the national average.

- There are also considerable inequalities in the experience of life expectancy and healthy life expectancy (disability-free) across Wolverhampton. Local analysis shows that there is a gap of approximately seven years for males and four years for females between those who are least and most deprived in Wolverhampton. This gap has remained fairly consistent over time.

- Wolverhampton's current performance with respect to lifestyle indicators such as obesity, physically inactivity, smoking prevalence and alcohol related admissions is significantly higher compared to regional and national average. Wolverhampton also has a statistically significant lower offer and uptake of the NHS Health Check programme compared to the national average.

The Sub-National Population Projections show that Wolverhampton's population is changing. According to the sub national population projections, this growth is set to continue. The projections estimate Wolverhampton's population in 2037 as 273,300 with growth being most rapid in the child and older populations. The estimates show:

- The number of children (aged 0 to 15 years) in Wolverhampton is projected to increase from 50,000 in 2012 to 54,300 in 2037. This is a net gain of about 4,300 (8.6% growth).
- The number of people aged 16 to 64 years in Wolverhampton is projected to fall slightly from 159,600 in 2012 to 159,200 in 2037. This is a net loss of about 400 (0.3% decline). During this period the state pension age will rise, increasing the size of the working-age population.
- The number of people aged 65 years or older in Wolverhampton is projected to grow from 41,400 in 2012 to 59,900 in 2037: a gain of 18.500 (44.7% growth). The number aged 85 years or older is shown to grow by 6,200 (106.9% growth), from 5,800 in 2012 to 12,000 in 2037.

People in Wolverhampton are living longer than ever before and the gap between life expectancy in the city and the national figure is closing. We know that socio-economic factors affect life expectancy. In Wolverhampton and similarly disadvantaged communities, the determinants of health such as skills, jobs and housing, are well below the national average. There are six conditions which account for over half of the difference in life expectancy that exists between

Wolverhampton and England. These are heart disease, stroke, infant mortality, lung cancer, suicide and alcohol. This is seen disproportionally in the most disadvantaged communities. Deaths due to alcohol and those occurring in infancy are the major reasons why life expectancy has not improved.

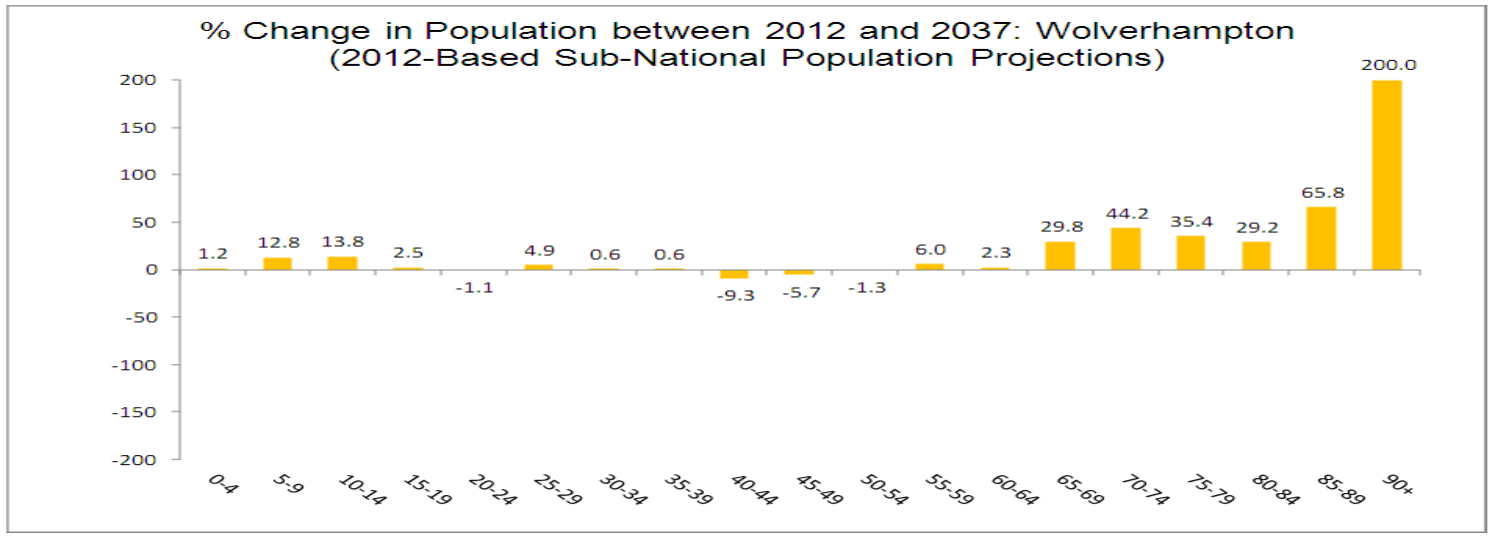
2012-Based Sub-National Population Projections (SNPP), released in May 2014, estimate the city's population will be 273,300 by 2037, an 8.9% rise from their baseline 2012 figure of 251,000.

The balance of the population will change: an increase in the number of children, but fewer working-age people, and more older people

Slightly increasing birth rates, and inflow of migration greater than outflow, are important aspects of population growth, but decreasing mortality rates and longer life expectancies point to a steadily aging population overall.

Figure 11 below shows population change by 5-year age band, detailing which groups are projected to rise and fall over the 25-year period;

Figure 11 – Demographic Forecast



59,900 residents aged 65+ by 2037, and 44.7% increase in the size of that group between 2012 and 2037. As a consequence, there will be 12,000 residents classified as being in the 'oldest old' according to the ONS (aged 85+), a group that often requires specialist healthcare

Any specialist healthcare provision attached to gender (e.g. male / female only wards, prostate clinics…) will be influenced by shifting demographics. Housing provision will also need to adapt to the possible demand for older couples / lone person accommodation. Men are living longer than before, possibly increasing the number of older couples. The aging population, however, may also be likely to provide support to one another, lessening need for intervention in some cases. The JSNA process has informed the development of the Wolverhampton Joint Health and Wellbeing Strategy, produced by the HWB, and the BCF Programme planning. The outcomes for the strategy are aimed at increasing life expectancy, improving quality of life and reducing child poverty by tackling: the wider determinants of health; alcohol and drugs; dementia (early diagnosis); mental health (diagnosis and early intervention; and Urgent Care (improving and simplifying). **<u>Service Delivery In Wolverhampton Today</u>** From local stakeholder consultation events, the BCF Programme Board, and work stream workshops, services have been mapped and identified across each work stream. This has been done to identify the way in which services both contribute towards effective delivery currently, but also how they contribute towards disjointed, confusing pathways that drive the residents of Wolverhampton towards overuse of the emergency and urgent care systems. Currently, the RWT provides both acute hospital and community services for Wolverhampton. No current services in the community operate within a fully integrated system. Social care provision currently resides outside of integrated pathways. The BCF programme consists of 5 worksteams, the visions of which are described below. **Adult Community Care** To provide a truly integrated, person-centred community based adult care service to the local population. Supporting people to remain as independent as possible by managing their condition confidently through access to a professional, skilled community based workforce when necessary. This will reduce the demand on other services (e.g emergency care portals, GP out of hour's services and walk-in centres) during times of crisis. Given the importance of supporting people who are both frail and elderly the programme will also be developing a clear frail elderly pathway, there are a large number of overlaps with the work scheduled in Adult Community Care and as such the frail elderly pathway will be delivered in conjunction with the Adult Community Care work stream.		

Mental Health

To improve the experience of people of all ages in Wolverhampton through the delivery of parity of esteem. This will include quality, sustainable, compassionate, seamless and effective mental health treatment. Prevention, early intervention, support and care including work with the crisis home treatment teams will be delivered in line with the City's existing Mental Health Strategy and Crisis Concordat agreements.

Dementia

As part of the Wolverhampton Joint Dementia Strategy 2015-17 and the BCF Dementia work stream the development of a city wide Dementia Hub is the aspiration of the BCF programme. A city wide Dementia hub would be a community resource that offers support and guidance to people affected by dementia, their families, friends and carers. A range of resources, tailored to the needs of local communities should be on offer in the hub. It is envisaged that there would also be spaces for spiritual and cultural celebrations, sensory zones providing stimulation and cultural heritage areas to preserve people's sense of identity with a digital information centre and a community café for everyone to use. The dementia hub should be a dementia friendly environment that offers support and guidance to people affected by dementia to help them live well and longer at home.

In the meantime an options appraisal will be developed to determine what is achievable this year within existing resources. The hubs may be smaller, more localised hubs utilising shared community space within existing premises.

The workstream which includes representatives from voluntary sector; will also review existing dementia specific day services, education and awareness training and the health and social care pathway. The aim is to promote greater independence and choice for people with dementia, increasing their self-esteem and encouraging people to maintain good social and personal relationships.

Integration

This work stream has two main elements. The first is to deliver elements of the programme which enable the other work streams to progress such as IT, HR, information Governance and Estates.

The second element of this work steam is to begin the planning process of an integrated health and social care system as described in (name guidance). This will involve looking at options and working with CCG and LA colleagues to determine the most appropriate integration model for Wolverhampton.

Children and Adolescent Mental Health Services (CAMHS) (in shadow form) With regard to inclusion in the 2016/17 BCF plan, CAMHS will only be a 'shadow' work stream for governance purposes with all the budgets remaining with their respective organisations. This has been agreed as the Transformation work is already underway in its own right, however, the need to involve the adult mental health services in the re-design particularly around outcomes from 'tri-partite funded' placements and 'transition' activity has been recognised by its inclusion in the overall BCF Programme. The Wolverhampton CAMHS Transformation project has two remits, delivery of the 'Future in Mind' guidance and Transformation of the existing CAMHS pathway. Future in Mind is a focussed approach towards access and delivery of health services. There are currently 7 health specific task and finish groups looking at a variety of traditional CAMHS services (e.g. IAPT; Peri-natal care etc.) Transformation of the CAMHS pathway is a focussed approach to re-designing the CAMHS pathway to strengthen lower tier CCG & LA services. There are 5 H&SC task and finish groups engaged in this re-design work (e.g. early intervention; Headstart etc.). Headstart is a Big Lottery funded LA initiative aimed at strengthening resilience in younger children (aged 10-14) Within each work stream are a number of identified projects. Development of a reablement pathway including therapy led beds, domiciliary reablement and community intermediate care team is underway at the time of this submission. The table below describes the projects and the proposed aims and objectives.		

Work Stream	Project	Aims and Objectives	Measurable Outcomes	National Conditions
Adult Community Care	The continuing development of three locality based Integrated Health and Social Care Community Neighbourhood Teams, wrapped around Primary Care and supported by specialist teams and Voluntary Sector.	Working with partners to develop a Wolverhampton City strategy to deliver the vision of the BCF Adult Community Care work stream. To ensure that our planning of services takes account of the opportunities to provide truly integrated care to our local population by wrapping services around our patients to deliver person centred, holistic care. To ensure that we are commissioning services based on evidence of need including the complexity of conditions our population is presenting with. To continue to build good working relationships with our providers, co producing services based on the holistic needs of the population working towards commissioning for outcomes. Providing both a proactive and rapid response	Reduction of Emergency Admissions Reduction of A&E attendances Reducing Delayed Transfers of Care Improve Patient Experience Bette	Jointly agreed plans Supporting 7 day services Better Data Sharing Joint Approach to assessments and care planning Agreement on the consequential impact of changes on the providers Investing in out of hospital services Supporting plans for reducing Delayed Transfers of Care.
	The Development of a Wound Care Pathway	To provide a seamless 7 day service for patients who will receive treatment at the right time, in the right place by an appropriate health professional.	New Wound care pathway Improved patient experience Efficiencies in reducing variance	Jointly agreed plans Supporting 7 day services Better data sharing Agreement on the consequential impact of changes on the providers Investing in and out of hospital services

Work Stream	Project	Aims and Objectives	Measurable Outcomes	National Conditions
Dementia	The Development of a Dementia hub for Wolverhampton	The aim is to promote greater independence and choice for people with dementia, increasing their self-esteem and encouraging people to maintain good social and personal relationships. Amongst other things the hub would host an Integrated Dementia team, a Dementia Café, the Education and Awareness programme and the Dementia Pathfinders.	A detailed specification for the Dementia hub and the services it will provide. A detailed building specification for the Dementia Hub Comprehensive Business case developed.	Jointly Agreed Plans Supporting 7 day services Investing in out of hospital services Agreement on the consequential impact of changes on providers

Work Stream	Project	Aims and Objectives	Measurable Outcomes	National Conditions		
Mental Health	Street Triage	The MH Rapid Response Triage car is a dedicated 'blue light' ambulance vehicle deployed under guidance of Police / AMBO Control rooms. It delivers a 7 day multi-agency response (Police, Ambulance and CPN) to appropriate 999 and 111 calls across the Black Country population of 1.2 million. ● Planning is underway to further develop the service through the inclusion of AMHP expertise ● Expanded as per 15/16 service re-design and in 16/17 to include focus on dementia.	Options appraisal for inclusion of AMHP into rapid response car developed	• Jointly agreed plans • Support of 7 day services • Better data sharing • Investing in out of hospital services		
	Hospital Discharge Pilot	Hospital Discharge Pilot (to include re-focus in 16/17 on Penn and RWT delays. ● Dedicated social care mental health support to urgent care pathway to increase numbers of AMHPs and provide dedicated support to Penn Hospital to reduce delayed discharges and facilitate mental health in-patient flow within RWT and BCPFT.	● Achievement of 7 day access to urgent health and social care services	• Jointly agreed plans • Support of 7 day services • Better data sharing • Supporting plans for reducing DTOC		
	Mental Health Liaison Psychiatry	Service (expanded as per 15/16 service re-design and in 16/17 to include re-focus on dementia).	● Achievement of 7 day access to urgent health and social care services	• Jointly agreed plans • Support of 7 day services • Better data sharing		
	Reablement and 1st Avenue	This will involve the implementation of a re-designed recovery and outreach service that includes:- ● Provision of a 2 bed crisis unit. ● Integrated reablement /outreach recovery pathway ● An assertive outreach service	● Operational 2 bed crisis unit in the community ● Operational social care assertive outreach service	• Jointly agreed plans • Support of 7 day services		

		Community Recovery Service – provides Assertive Outreach Approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and / or relapse and re-admission, delivered from a range of bio – medico – psycho social interventions, fully utilising NICE Guidance.		
	Resettlement	This will involve a two tier approach that will include: • The timely identification of individual needs through health and social care assessment and case review activity • The development and implementation of additional supported living (50 units over a 3 year period) • The development and implementation of a single floating support service	• Operational access to 26 additional supported living units • Integrated reablement / outreach recovery pathway	• Jointly agreed plans • Support of 7 day services • Better data sharing • Supporting plans for reducing DTOC
	Prevention	This will involve the recommissioning via a tender process of a single joint prevention service across health and social care	• Commissioned single joint prevention service	• Jointly agreed plans • Investing in out of hospital services
	Urgent care Pathway	Delivers Wolverhampton Crisis Concordat for Adults of all ages, with a focus on compassionate and pro-active and responsive services and interventions, including starter schemes initiated in 2015/16 described above and also including Single Point of Access and Crisis Resolution and Home Treatment fully utilising NICE Guidance.	• Re-design, develop implementation of interoperational implementation plan across AMHS and Dementia. • Achievement of 7 day access to urgent health and social care services	• Jointly agreed plans • Support of 7 day services • Better data sharing • Investing in out of hospital services
	Community Recovery Service	Provides Assertive Outreach Approach for people with moderate to severe mental health difficulties to provide early diagnosis and commencement of treatment pathway to ensure and maintain recovery and prevent episodes of crisis and / or relapse and re-admission, delivered from a range of bio – medico – psycho social interventions, fully utilising NICE Guidance.	• Re-design, develop implementation of interoperational implementation plan across AMHS and Dementia.	• Jointly agreed plans • Support of 7 day services • Better data sharing • Supporting plans for reducing DTOC • Investing in out of hospital services

Work Stream	Project	Aims and Objectives	Measurable Outcomes	National Conditions
CAMHS	Transformation of CAMHS services	This work stream is to be included in the Programme for 2016/17 in "shadow form". It will utilise the Governance and joint working approach of the programme to deliver a review and transformational change of CAMHS services across Wolverhampton. The Programme manager leading on this piece of work is a joint appointment between the CCG and Local Authority.	An assessment and review of current CAMHS services A Transition plan of redesign of CAMHS services	Jointly Agreed Plans

Work Stream	Project	Aims and Objectives	Measurable Outcomes	National Conditions
Integration	Estates	To identify estates requirements for the Programme as a whole and for individual projects. For example to support the co-location of Community Neighbourhood teams, the move of outpatient clinics from an Acute setting to the Community, the development of a dementia hub and of developing dementia services in the community. To work with Estates colleagues to scope appropriate premises and to work towards the move to integrated health and social care teams.	Estates specifications produced Premises identified	Jointly agreed plans Supporting 7 day services Ensure and joint approach to assessments and care planning. Agreement on the consequential impact of changes on the providers Investing in out of hospital services Supporting plans for reducing Delayed Transfers of Care.
	IT	To implement the Fibonacci system to enable health and social care staff to share information on a role based access view only basis. To continue the exploration of open APIs for the economy with a long term view of developing integrated health and social care systems.		Jointly agreed plans Better Data Sharing Joint Approach to assessments and care planning Supporting plans for reducing Delayed Transfers of Care.
	IG	To ensure that pathways, process and systems have robust and appropriate information sharing agreements at all stages and comply with Caldicott 2.		Jointly agreed plans Better Data Sharing Joint Approach to assessments and care planning Supporting plans for reducing Delayed Transfers of Care.
	HR	To ensure that in the move toward integration and the changes in patient and service user pathways that change management processes are undertaken appropriately and fairly and all relevant policies and legislation is adhered to.		Jointly agreed plans Supporting 7 day services Joint Approach to assessments and care planning Agreement on the consequential impact of changes on the providers Investing in out of hospital services

	Integrated Health and Social Care	To develop a plan for Integration in line with national guidance by March 2017 this clearly outlines the health and social care economies' plan for Integration by 2020.	Jointly agreed plans Supporting 7 day services Better Data Sharing Joint Approach to assessments and care planning Agreement on the consequential impact of changes on the providers Investing in out of hospital services Supporting plans for reducing Delayed Transfers of Care.		

The Evidence Base

Integration is the key to delivering demonstrable improvements in quality, value and outcomes for the people of Wolverhampton. There are a significant number of emerging case studies and papers which support the case for integrating services.

The case for developing integrated, person-centred services and the benefits to be derived from this is clearly articulated in the Kings Funds 'Making Best Use of the BCF" and "Making Our Health and Care Systems Fit for an Aging Population", the 9 components of which have been absorbed into Wolverhampton's planning.

Evidence suggests implementing integrated care has shown that integration can support older people to maintain their independence longer. This prevents emergency admissions, reduces length of stay in intermediate care and as a result reduces demand on full social care, all core areas of focus in Wolverhampton.

There is a strong emerging evidence base for the BCF plans and Wolverhampton is confident that by building on current and previous experiences, it can embed and deliver sustainable, resilient and responsive integrated services that are person-centred. A recent example of this is the delivery of integrated discharge planning services, and the mutual benefits derived from them.

Articulating what is meant by integration is equally important in supporting the case for change. Wolverhampton has undertaken significant consultation, local evidence review and engagement prior to selecting the 5 work stream programmes that it proposes to take forward in 2016/17.

Workshops have been held across the health and social care economy with stakeholders across all areas, professions, providers and communities. There have been public events for people and their carer's to talk about their experience of local community as well as through GP locality events with our primary care providers.

Themes have emerged that have become golden threads in the description of the need to deliver integrated, person-centred services , in short Wolverhampton' services;-

- Must be more explicit and coordinated across health and social care in the targeting of resources, thereby removing the traditional boundaries in existence
- Must be sustainable, resilient and able to deliver better outcomes, quality and value through behavioural and organisational change.
- Must strengthen the way community and primary care facing services are constructed and delivered in order to reduce the growing pressures on the local emergency and urgent care systems
- Must maximise the value of return on investment through activity shifts from hospital to community facing services as a means of successfully realising benefits
- Must 'upstream' the focus toward asset based local community developments for a redesigned model of integrated delivery of community facing services
- Must encourage through design, living well, self-care and self-management

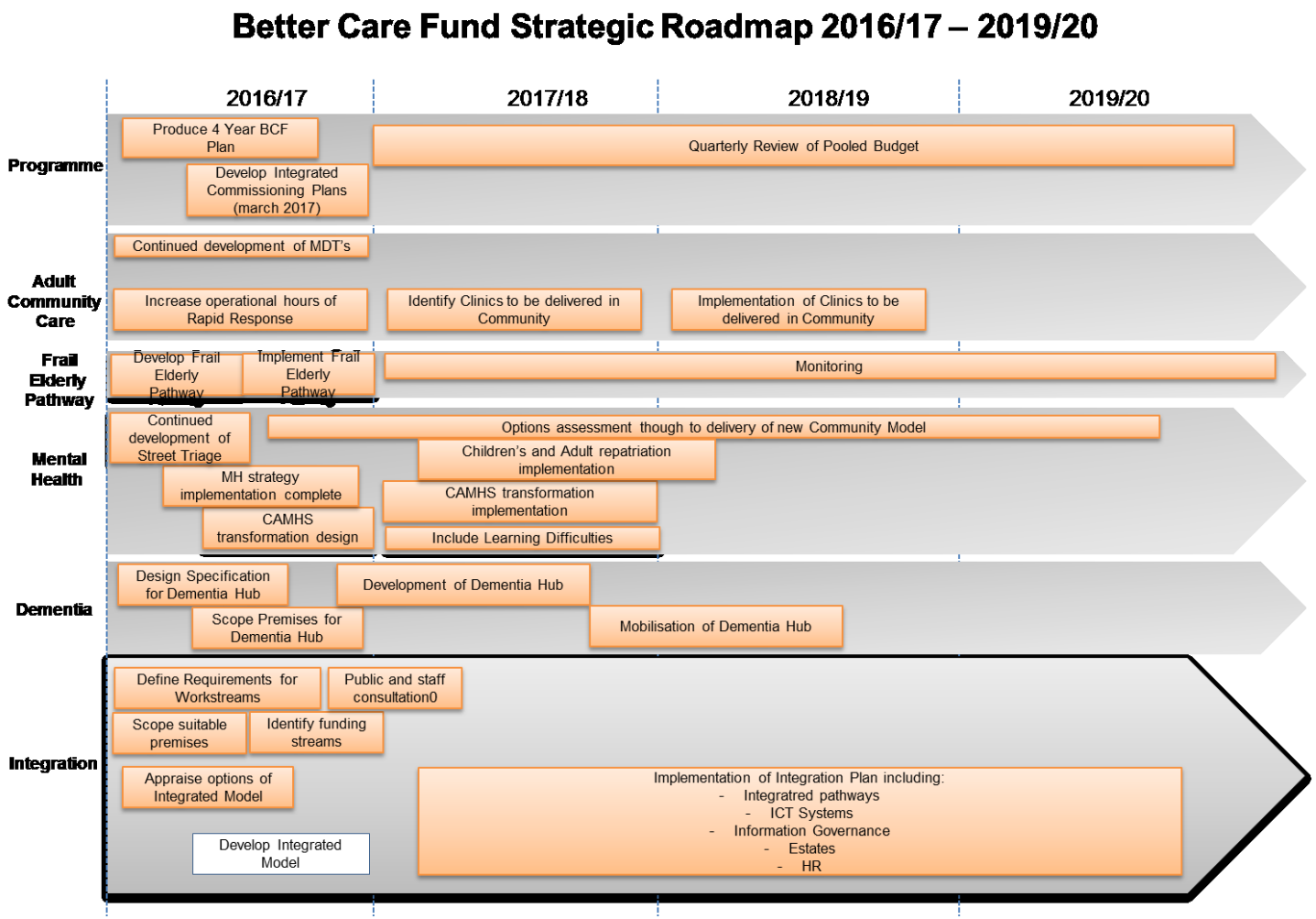
The outcome of this process has been the identification of core work streams whose focus will be on transformational service redesign. In doing so Wolverhampton has laid down the marker for its level of ambition and commitment to deriving maximum benefit from the BCF Programme.

The core work streams are outlined in the table below, alongside the national and local evidence base for their inclusion in the programme;

Workstream Programme	Evidence Base
Adult Community Care	The Kings Fund: Making Our Health and Care Systems Fit for and Aging Population NHS England: The House of Care LGA Integrated Care Value Toolkit The Kings Fund: Making Best Use of the BCF Case Study: CICT input to nursing homes
Mental Health	No Health Without Mental Health Case Study: Sandwell Nurse Led Psychiatric Liaison
Dementia	JCPMH:Practical Mental health Commissioning - Dementia LGA Integrated Care Value Toolkit Dementia Map

CAMHS	Future in Mind: Children and Young People's Mental Wellbeing (Department of Health/NHS England) Transforming Care Plan (The Black Country) Wolverhampton CCG CAMHS Transformation Plan		
A coordinated and integrated plan of action for delivering that change; **<u>Overarching Governance Arrangements</u>** Wolverhampton's BCF is overseen by the HWB, with commissioning oversight provided by the Integrated Commissioning and Partnership Board.		B.3.i B.3.ii B.3.iii B.3.iv B.3.v	

Figure 12 – BCF Roadmap

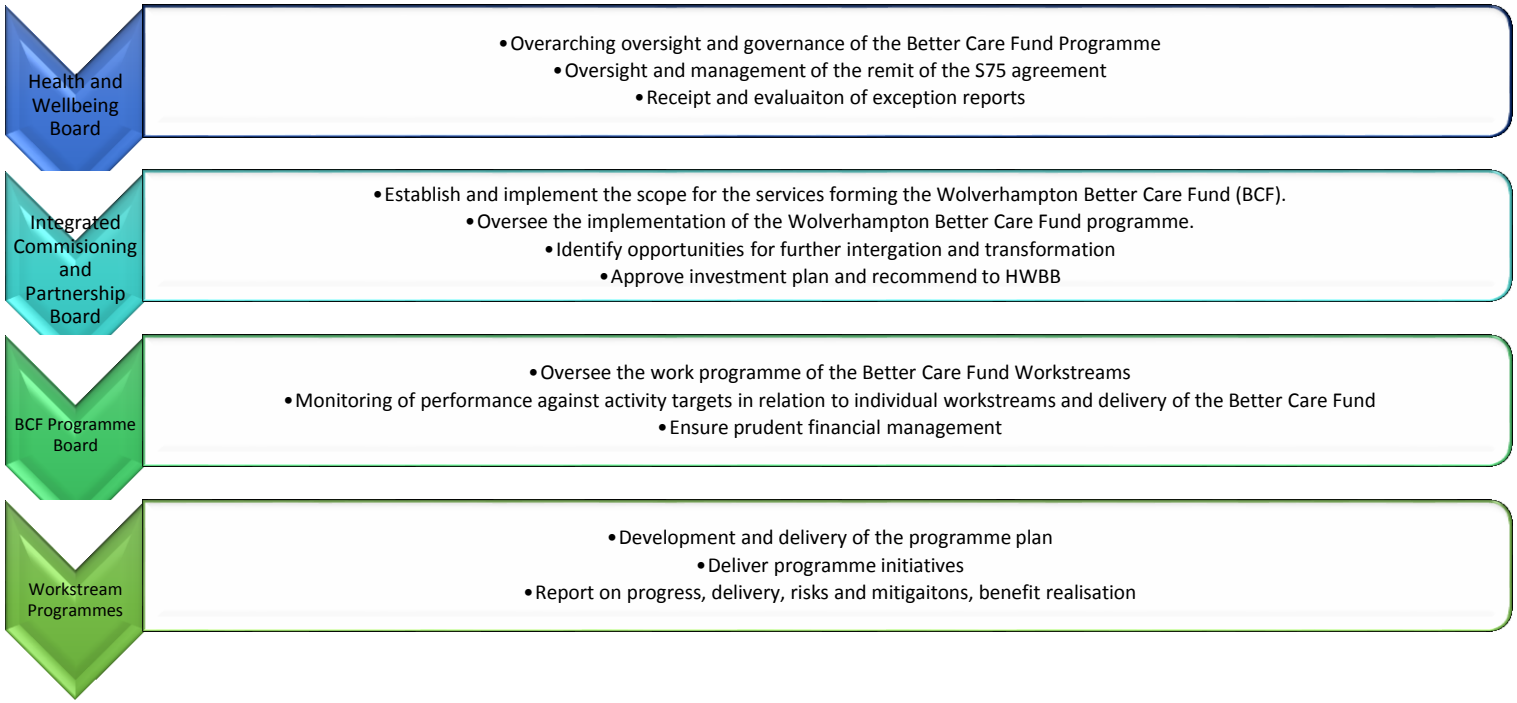


The programme of work as demonstrated above in Figure 12 is managed through the BCF Programme Board which is co-chaired by the Chief Executive Officer at the Wolverhampton CCG and the Strategic Director (People Directorate) for CWC.

The programme is underpinned by a refreshed (effective 01.04.2016) formal Section 75 agreement between CWC and Wolverhampton CCG. Membership of the HWB will be reviewed in order to reflect the requirements of the Section 75 agreement and the robustness of approach it will need to take. The governance arrangements for the BCF are as streamlined as possible, bearing in mind the scale of the financial commitment involved and the scope of the overall project. Day to day operational management and oversight of the fund will be the responsibility of the Integrated Commissioning and Partnership Board (ICPB). Members of ICPB have delegated responsibility from both partner organisations to hold the Senior Responsible Owners to account and make necessary decisions from a planning and performance management perspective. The Integrated Commissioning and Partnership Board is co-chaired by the Chief Executive Officer (Wolverhampton CCG) and the Strategic Director People (CWC.) Membership of ICPB includes Healthwatch, CWCs leadership team, and Accountable Officer, Director of Transformation (Wolverhampton CCG), and other core leads including Programme, finance and public health The ICPB has been established with powers to be within the existing limits set by both organisations schemes of delegation, particularly from a financial and procurement perspective. Beyond these limits, decision making will remain within the responsible bodies in the individual organisations (Cabinet and the CCG's Governing Body), to whom the members of the Integrated Commissioning and Partnership Board will be accountable for the operation of the fund. Beyond this, the HWB will continue to oversee both organisations for the performance of the fund against the objectives set out in the BCF plan and the Health and Wellbeing strategy. **Wolverhampton's Governance Flow** **<u>Management and Oversight</u>** Wolverhampton CCG and CWC have co-terminus boundaries, and as such, have an element of already established oversight and management arrangements. Nevertheless, in relation to the BCF Programme, and in order to support the wide transformation agenda and current joint commissioning arrangements across the City, the 2 commissioning organisations have recognised the need to establish a clear and explicit governance framework which adds value to the existing partnership mechanisms. At the heart of the arrangements is the HWB, which, as mandated by the BCF Framework, has overarching accountability and oversight of the BCF Plan. Both CWC's Cabinet, and Wolverhampton CCG, have issued initial delegated authority to the Board for this oversight on behalf of the 2 organisations, with the HWB now being enhanced by additional elected membership.		

Figure 13 below demonstrates the governance flow for the delivery of our BCF programme and its on-going development.

Figure 13 – Governance Flow



Section 75

Underpinning the management and oversight of the BCF Programme is the development of a Section 75 agreement. Wolverhampton currently has established joint commissioning arrangements in relation to mental health, learning disability, and all age disability.

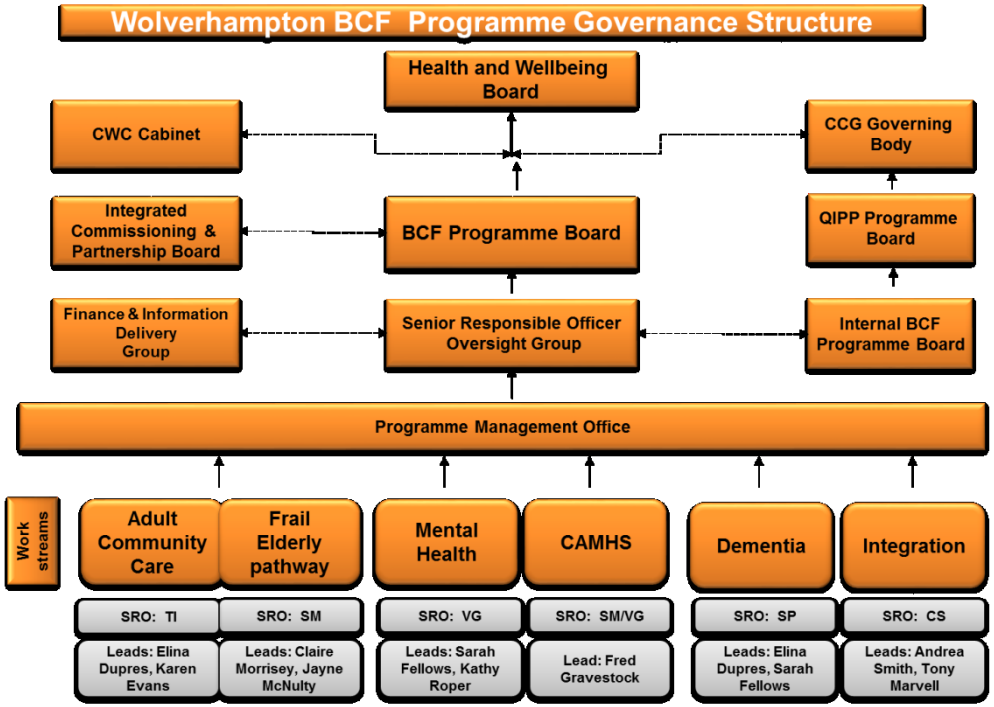
The Specific Section 75 agreement for BCF will cover

- the complexity of the role of the HWB in relation to Section 75 oversight (i.e.: the requirement for a change to Council constitution, and the Boards broader remit)

- risk sharing
- specific inclusion requirements

These governance arrangements will ensure that there is sufficient authority to take appropriate decisions and scrutiny of those decisions and the operation of the arrangements generally. The Governance arrangements have been developed over the last 12 months, and clearly articulate the reporting requirements. They will be set out in full in Schedule 2 of the Section 75 agreement. Existing contracts between the CCG and providers and the Council and their respective providers will not be affected by the continuation of a single host for the pooled fund (Figure 14).

Figure 14 – Governance Structure



Pooled fund management

Each individual work stream where there is a pooled fund has designated pooled fund management from both a health and social care perspective (commissioner). This role is undertaken by existing commissioners within each of the statutory partners, with the following duties and responsibilities:

- The day to day operation and management of the pooled fund;
- Ensuring that all expenditure from the pooled fund is in accordance with the provisions of the Section 75 agreement and the relevant scheme specification;
- Maintaining an overview of all joint financial issues affecting the Council and the CCG in relation to the services and the pooled fund;
- Ensuring that full and proper records for accounting purposes are kept in respect of the pooled fund;
- Reporting to the Integrated Commissioning and Partnership Board (ICPB) as required (this would be through Executive work stream lead);
- Ensuring action is taken to manage any projected under or overspends relating to the pooled fund in accordance with the Section 75 agreement;
- In conjunction with the overall pooled fund manager preparing and submitting to the HWB/Integrated Commissioning and Partnership Board quarterly reports (or more frequent reports if required) and an annual return about the income and expenditure from the pooled fund together with such other information as may be required by the HWB to monitor the effectiveness of the BCF and to enable the CCG and the Council to complete their own financial accounts and returns;
- In conjunction with the overall pooled fund manager, preparing and submitting performance reports to the HWB on a quarterly basis.

Metrics and Performance Tools

Wolverhampton's health and social care community acknowledges the need to respond to the scale and pace of the BCF Programme with a governance and management oversight infrastructure that is robust and has clear lines of accountability. Supporting the roles of the management and oversight infrastructure is a portfolio of metrics in a developing dashboard. This will provide 'at a glance' oversight of work stream delivery against programme objectives, risks, mitigations and benefits realisation on a programme wide basis

These are outlined in the table below:

Management Oversight Tool	Reporting To	When
Workstream Dashboard – Metric Impact	BCF Programme Board	Monthly
Programme Plan Report	Programme Office	B- Monthly
Benefit Realisation Delivery report	Programme managers Senior Responsible Owners	Bi Monthly
Aggregated Performance Dashboard – Risk and Mitigations Exception Reports NAD (Notice, Action Decision) Reports	BCF Programme Board HWB Senior Responsible Owners	Monthly Bi Monthly
Engagement and Communication Report	Integrated Commissioning and Partnership Board	Monthly

The stakeholders will continue to operate a unified programme approach which pre-empts and mitigates any potential risks to delivery, is well governed and collaborative.

An agreed approach to financial risk sharing and contingency:

B.5.i
B.5.ii
B.5.iii
B.5.iv

Appendix 13

<u>Risks, Risk Share Arrangements and Management of Risk</u>

Alleviation of risk for providers relies heavily on understanding the commissioning intentions of the commissioning bodies. The 2016/17 Wolverhampton commissioning intentions for both the council and the CCG were published and launched via stakeholder events during 2015/16.

As outlined earlier in this section (see Risk Sharing) a comprehensive risk review has been undertaken across the 2016/17 programme. As part of this process risks that could impact NHS service providers and any financial risks for both the NHS and local government were given particular scrutiny.

In each case where a risk was identified, thought was given to potential mitigations that would alleviate, assist or resolve the risk should it develop into an issue for any given provider. For the two NHS Trusts, much of this work has

been addressed via contract negotiations, Commissioning for Quality and Innovation Payments Framework (CQUINS) and negotiated solutions using internal processes.

Current examples of the success of this approach are the restructured resources within both RWT and BCPFT that are now delivering as part of their 2016/17 'contract', the community focussed services of Rapid Response and the Mental Health Street Triage Car. Both these initiatives were pilots in 2015/16 and required the diversion of resources away from an acute focus towards a community one.

Meantime the council continues to directly liaise on a routine basis with its providers via established review monitoring processes, meetings and events.

The most important risks identified by the programme risk review are summarised below:-

	CCG Risk %	Council Risk %
Adults Community Services	56	44
Dementia	89	11
Mental Health	68	32
Ring Fenced Capital Grant	0	100
Demographic Growth	60	40
Care Act Monies	60	40

The 2016/17 pooled fund agreement was achieved through a transparent process of sharing detailed projections, outturn information, and data and looking carefully at those areas of the whole Health and Social Care system that when pooled could create "cause and effect". This approach allowed both Wolverhampton CCG and the CWC to develop a shared incentive for overall agreement.

As referred to earlier in the document the pooled fund for Wolverhampton during 2016/17 will be £57.7 million. This is broken down across the following work streams:

Work streams	CCG Funded services (£000)	Council Funded services (£000)	Total Services (£000)
Adult Community Services	24,015,104	18,637,402	42,652,506
Dementia	2,585,586	319,909	2,905,495
Mental Health	5,996,636	2,718,230	8,714,866
Total Contribution to Pooled Fund	**32,597,326**	**21,675,541**	**54,272,867**
(Ring Fenced) Capital Grants)		2,440,000	2,440,000
Care Act Funding	964,000		964,000
Total			**57,676,760**

Risk Share – Underperformance

The proposed revenue value of the pooled fund to be managed via the Section 75 agreement is £57.7 million and consists of £32.6 million (60%) of CCG funded services alongside, £21.7 million council funded services (40%). The council contribution includes £6.4 million representing the NHS transfer to social care (Section 256 funding). The pooled budget also includes a capital grant amounting to £2.4 million which is managed by the council.

The council's contribution to the pool is abated in order to retain funds for the burden of demographic growth and the costs associated with the implementation of the Care Bill.

This has the effect of creating a cost pressure within the pool and this risk is shared across each work stream according to its size. Each work stream is responsible for delivering efficiencies to meet this cost pressure and failure to do so will be dealt with in line with the arrangements for overspends below.

Risk Share – Overspend

The host organisation (CWC) will produce monthly financial reports and share these with the other party. The first reconciliation to recoup any overspend shall take place at quarter two (month six), and quarter three (month nine). Month 11 reporting will incorporate year end estimates on the pool fund.

The Integrated Commissioning and Partnership Board shall consider what action to take in respect of any actual or potential overspends. The Board will take into consideration all relevant factors including, where appropriate the BCF Plan and any agreed outcomes and any other budgetary constraints and agree appropriate action in relation to overspends which may include the following:

- Whether there is any action that can be taken in order to contain expenditure;
- Whether there are any underspends that can be vired from any other fund maintained under this Agreement;
- How any overspend shall be apportioned between the partners, such apportionment to be determined on the basis of the individual partner's contribution to the individual work stream as detailed in the table above.

Non-financial Risks

The major areas of non-financial risk sharing specifically within the BCF largely relate to performance against targets, information governance and equalities. Each of these key areas were identified at the very start of the BCF journey.

Performance against targets

The programme is well structured and managed. Work streams meet on a face-to-face basis fortnightly and management of activity and progress is documented and shared via the maintenance of comprehensive project management toolkits (critical paths, implementation plans, action, risk, issue and escalation logs) supplemented by highlight reports to programme board.

Performance is measured against targets through routine collections of data by each organisation's Business Intelligence team and reported to the programme board monthly (Appendix 13). This allows for early identification of issues which enables proactive management at appropriate levels of the governance arrangements. Indeed, it was this programme mechanism that has successfully resolved what could have been significant delays to progress during the

BCF's first year of operation. For example the report gave early insight to both the increase of DTOC and the increase in emergency admissions in certain conditions.

Mitigation was put in place for both of these areas with the collaborative work being undertaken on DTOC and the design and implementation of the Rapid Response team to provide management to patients with exacerbation of those conditions where emergency admissions were increasing.

Information Governance and Equalities

An overarching Information Sharing Agreement has been created to support the shared care approach we are working towards here in Wolverhampton. An agreement has been reached for two of the four partners to install, gain access and utilise a software platform that allows frontline workers to comprehensively 'view' client data across all available systems for identified purposes.

Given that this is a 'view only' solution that does not allow any changes to already stored data, this is a real step forward in the professional health and social care world. Because existing information and data cannot be compromised, the four BCF partners have each agreed a 25% financial cost and associated risk share arrangement.

This ability for professionals to instantly access a person's health and social care information irrespective of their employing organisation will profoundly affect the timeliness of treatment and support available to those people in need, reducing the risk of duplication and gaps in service

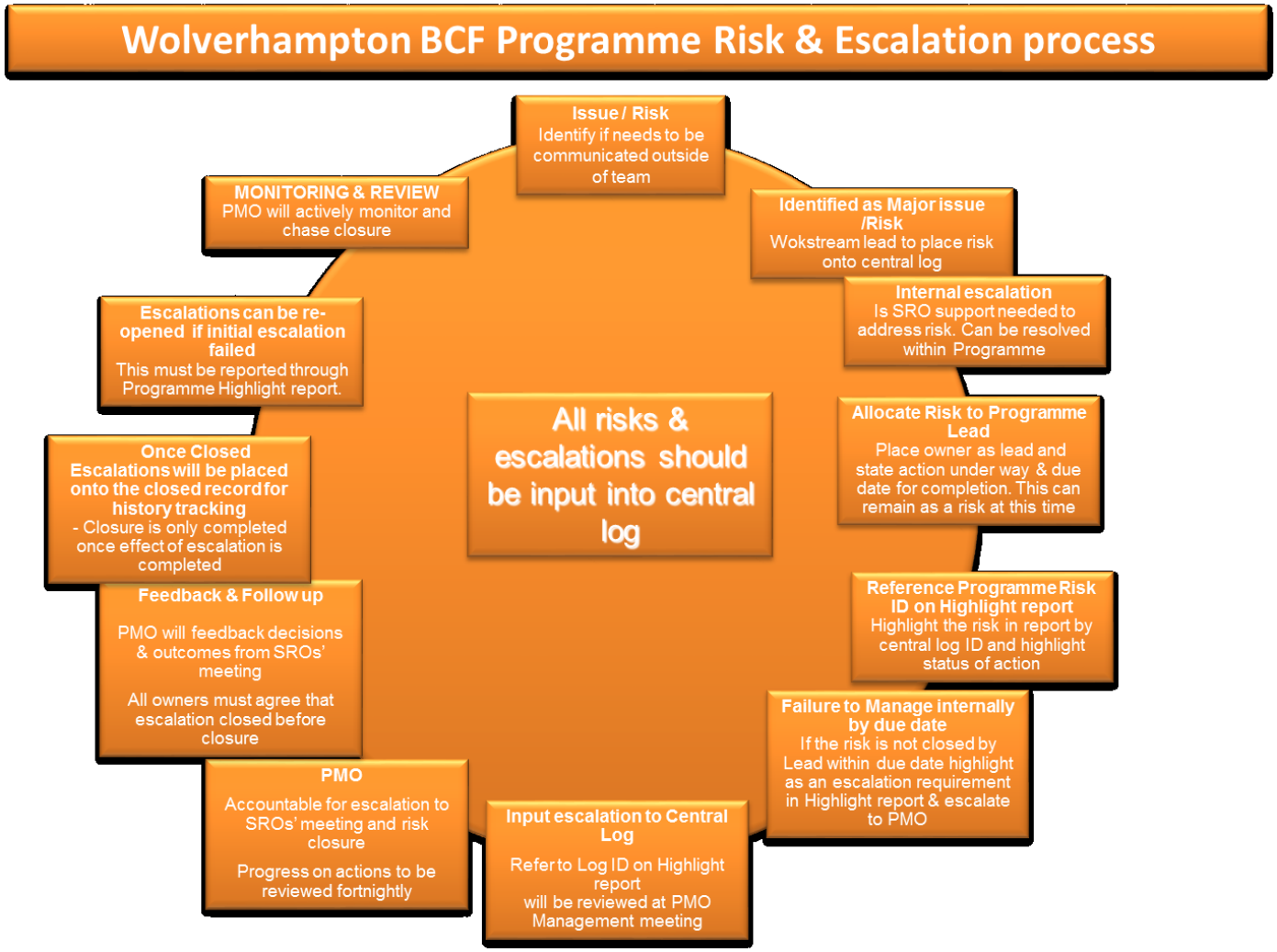
With regard to equalities, impact assessments are continually reviewed and refreshed as required.

Other non-financial risk sharing agreements sit largely across the BCF organisational partners as service level agreements rather within the Programme itself. These service level agreements relate to a variety of processes and practices across the health and social care economy the key ones relating to timeframes for:

- Hospital discharge
- Service response
- Service quality

Please also see Figure 15 below which illustrates how risks are managed across the BCF programme's governance structure;

Figure 15 – Risk and Escalation Process



A review has been undertaken across the 2016/17 programme looking specifically at risks that could impact on NHS service providers and any financial risks for both the NHS and local government. From this review the programme has identified the most important risks, which are summarised below:-

	ID No.	Risk	Possible Outcome	Consequence (Initial)	Likelihood (initial)	Rating (initial)	Mitigation	Owner	Residual risk score		
System Risks	1	Failure to reduce Avoidable Emergency Admissions	Avoidable Emergency Admissions continue current trends	Possible	Major	12	Modelling of benefits value of schemes. BCF Projects : Primary and Community Care Redesign Programme, GP Residential Care Liaison, Eclipse Scheme, MH Urgent Care Pathway, MH Reablement Pathway, Single Intermediate Care Service, 7 Day Therapy Services, Training for Care Home Staff, 1 GP per Care Home, In-reach Specialist Services, Single Commissioning Nursing Home and Residential Home (NH/RH) Arrangements, Dementia Hub	BCF Programme Board	9		

	2	Financial risk of failure to reduce Avoidable Emergency Admissions	Financial risk to CCG under PbR/Tariff	Possible	Mode rate	9	Risk sharing	BCF Programme Board	9		
	3	Financial regime of the LA in light of the reduction in budget & spend	Savings identified have been embedded into the redesign programmes. Failure to deliver could threaten the financial viability of the BCF.	Possible	Mode rate	9	Joint working has accelerated. Pooled budget identified and agreed. Section 75 agreement. Close monitoring through finance and information core group. BCF work programme includes conservative modelling.	CWC/CCG	6		
	5	Destabilisation of health care providers	Commissioning of services to deliver financial viability of BCF may require radical changes to services and potentially	Possible	Major	12	Full engagement in BCF by provider units with early sharing of commissioning plans to identify risks and mitigations. Ongoing impact modelling and solution development	BCF Programme Board	6		

			have a detrimental impact on provider income streams.								
Project Risks	6	Failure to identify & secure appropriate premises	Services remain fragmented & savings not realised	Possible	Mode rate	9	Co-locate services in existing premises, through new Integration work stream	CWC/CCG	6		
	7	Unable to optimise professional accountability and professional approaches within a multi-disciplinary approach	Duplication of assessments & care plans	Possible	Mode rate	9	Co-locate service providers and agree single multi-disciplinary approach	BCF Programme Board	6		
	8	Unable to reach agreement on aligning systems & processes	Duplication of assessments & care plans	Possible	Mode rate	9	Co-locate service providers and agree single multi-disciplinary approach	BCF Programme Board	6		
	9	Delay in securing pre-placement contract agreement		Possible	Mode rate	9	Ongoing dialogue with Wolverhampton Branch of the West	BCF Programme Board	4		

							Midland Care Association				
	10	Failure to secure a pre-placement contract agreement	Costs of individual placements do not reduce	Possible	Mode rate	9	Negotiations with Wolverhampton Branch of the West Midlands Care Association	BCF Programme Board	4		
	11	Quality of NH/RH Home Care fails to meet agreed CWC/CCG Standards	Contract with provider cancelled	Unlikely	Major	8	Residential & Nursing Home providers are statutory regulated services and a set of quality standards have been agreed by providers	BCF Programme Board	4		
	12	Care Homes will not attend training	Avoidable Emergency Admissions continue current trends	Possible	Major	12	Liaise with care homes (and encourage attendance) via the Wolverhampton branch of the West Midlands Care Association, LA Mental Health Forum. Quality Nurse Advisors to liaise with individual homes	BCF Programme Board	4		
	13	Care Homes with identified quality	Avoidable Emergency Admissions continue	Possible	Major	12	Quality Nurse Advisors to work closely with individual homes.	BCF Programme Board	4		

		issues will not attend	current trends								
	14	Lack of funding for training events	Training cannot be organised/run	Possible	Moderate	9	Funding identified as part of CCG Reablement budget	BCF Programme Board	4		
	15	Lack of resources to support Care Home Training Project	Training cannot be organised/run	Possible	Moderate	9	Work prioritised as part of the CCG Development & Delivery Group	BCF Programme Board	4		
	16	Training Project - Competing priorities for project resource	Training cannot be organised/run	Possible	Moderate	9	Identify early and report to CCG Development & Delivery Group for decision	BCF Programme Board	4		
	17	Care Homes do not support In-reach Service Project	In-reach service cannot enter home	Possible	Major	12	Liaise with care homes via Wolverhampton branch of the West Midlands Care Association and LA Mental Health Forum	BCF Programme Board	4		
	18	GPs do not support In-reach Service Project	Avoidable Emergency Admissions continue	Possible	Moderate	9	GPs invited to Care Homes Workshop where models & plans discussed	BCF Programme Board	4		

			current trends								
	19	Financial implications of community service in-reach will not be able to be met	Project cannot be implemented	Possible	Mode rate	9	Procurement options considered	BCF Programme Board	4		
	20	Data not available for monitoring impact of In-reach Service Project	Evaluation not possible	Possible	Mode rate	9	Agree with Commissioning Support Unit (CSU) Information Department data required and where collected prior to go-live	BCF Programme Board	2		
	21	In-reach Services Project - Competing priorities for project resource	Project cannot be implemented	Possible	Mode rate	9	Consider procurement options	BCF Programme Board	4		

Finance	22	£3m budget pressure: The current financial model for 2015/16 has a variance between sources and application of funds of around £3m.	Demographic changes will not be funded	Possible	Major	12	Effective performance management through Finance and Information group. Provider commitment to redesign programmes Section 75 agreement	BCF Programme Board	9		
	23	£1.5m performance fund: Failure to stem growth and achieve a reduction in non-elective.	Growth will mean that the CCG will not be releasing the performance fund to the pooled budget and a cost pressure will arise at max £1.5m	Possible	Major	12	Starter schemes go live on targeted areas Effective monitoring and a change model that is responsive to demonstrable effectiveness or lack of impact.	BCF Programme Board	8		
	24	Underperformance of embedded QIPP and LA efficiency schemes:	QIPP and efficiency schemes are locked into the redesign	Possible	Catastrophic	15	Programme plan Governance and management infrastructure	BCF Programme Board	10		

			programmes, with provider support, in order to utilise the maximum opportunity for transformation, and ensure alignment and synergy.				Performance monitoring Whole system approach				
	25	Emergency activity increase	Ability of the pool to mitigate a surge in emergency admission activity as well as delivering anticipated 3.5% reduction	Possible	Catastrophic	15	Programme plan Governance and management infrastructure Performance monitoring Whole system approach Effective performance management through Finance and Information group and contracts		10		

C. National Conditions		
Plans to be jointly agreed Wolverhampton local health & social care economy is wholly committed to improving the health and wellbeing of its people. The principle of co-production is fully supported by the BCF partner organisations and is embedded in the overall governance structure of the programme. To this end the partners agreed a set of principles about what the content of the pooled fund should support and how. E.g.:- • Co-production • Better Health Outcomes • Improved Well- Being • Promoting Independence • Identifying and utilising inter-dependencies between organisations • Moving intervention downstream • Targeted interventions by integrated teams • Working with Voluntary Sector • Care Closer to home **Current Position** Unfortunately, the 2016/17 BCF submission deadlines were incompatible with the pre-arranged decision making body meetings in the key partner organisations. To mitigate against this a paper requesting 'delegated authority sign off' was presented to the Health and Well Being Board in February 2016 and this delegation was agreed. Arrangements for formal acceptance and agreement of the BCF plan and content of the pooled budget were as follows:- • CCG Governing Body April 2016. • Council's Cabinet meeting 23rd March 2016. • Health and Well Being Board 27th April 2016. • Delegated Authority (Cllr Samuels, Chair of Health and Well Being Board) for sign off prior to submission.	C.1.i C.1.ii C.1.iii C.1.iv C.1.v C.1.vi	Appendix 14

Engagement Process Wolverhampton registered GPs have been involved in the development of this programme at various levels across all areas of work. Throughout 2015/16 the BCF programme has maintained routine links to the monthly GP locality specific meetings and will continue to do so in the future. Routine, regular, focused BCF meetings with the chair of the H&WB Board, other key elected members of the local council and the CCG Governing Body (made up of member elected GPs from each of the localities) have taken place throughout the duration of the programme and each body continues to approve and sign off planning at each stage of the implementation process. In the period prior to each submission phase, the development of the BCF plan (co-produced with work stream leads) is discussed at extensively with the Senior Responsible Officers and the BCF Programme Board each month. Executive representation from Health and Social Care providers (RWT, BCPFT and CWC) are full members of this BCF Programme Board. In addition, the Programme is supported by work stream groups (led by commissioning leads) who are pro-active in the planning and development of transformation plans. These work stream groups include operational managers from across Wolverhampton's health and social care commissioner/provider services. This co-production of transformation planning and implementation from strategic to operational ensures that all partners are cognisant of what the re-designed service will look like in the future and as a result, what the predicted impacts of changes to service delivery will be. This approach is supported within health by discussions within the contract negotiation process which details the activity that will be impacted at HRG level and within social care through the established review monitoring and negotiation processes. In terms of wider stakeholders, Wolverhampton has always and continues to engage with stakeholders. Design phase events included over 120 frontline Health and Social Care local professionals, patients, users, carers, voluntary sector organisations and community groups. Stakeholder events planned for early May (6th, 9th and 10th) will focus on feedback about the journey so far (what differences have the redesigned services made and what else might still be needed?). With regard to impacts for the voluntary sector, work is underway to fully engage with Wolverhampton Voluntary Sector Council (WVSC) at an operational level (see Social Impact Bond Overview comments below) whilst maintaining their involvement at the strategic level as members of the BCF Integrated Commission Board.		

Big Lottery Fund – Social Impact Bond Overview (Appendix 14)

More recently the CCG, with support from Wolverhampton Voluntary Sector Council (WVSC), succeeded in gaining a grant from the Big Lottery Commissioning Better Outcomes Fund to develop a Business Case for a Social Impact Bond to finance Voluntary and Community Sector (VCS) preventative well-being interventions for older people. The CCG's overall aim is to reduce ambulance call outs, emergency hospital admissions, and delayed discharges for older people by involving local community and voluntary groups in the maintenance of their overall well-being.

The CCG has commissioned a Business Case and appraisal of the options. A project plan has been developed and delivery involves needs assessment, evaluation, identifying evidence-based interventions, designing the model, engaging with social investors, and cost benefit analysis. BCF Partners are engaged in supporting this work so that the best possible strategic, economic, commercial, financial and management case can be developed to inform the Big Lottery decision-making processes. The work needs to be completed by the end of May 2016.

Disabled Facilities Grant (DFG)

DFG is again included in the Pooled Fund. Currently there is a partner led Health and Social Care review of the DFG underway. Discussions are on-going between BCF programme Senior Responsible Officers and Housing Authority representatives to determine how the Grant can mutually support the work of the BCF Programme in improving outcomes across health and social care. As part of the routine programme, work stream and stakeholder planning, where appropriate the inclusion of housing specialist representatives is always considered.

Future Capacity and Workforce Modelling

During 2015/16, programme activity to develop workforce modelling and subsequently implement service re-structure began in earnest across the BCF work streams.

By taking a demand analysis approach with partners across identified service areas it has been possible to successfully determine the level of resource required to cater to the future forecast demand. Examples of work already undertaken using this approach are;

The Adult Community Care Work stream *(formerly Primary and Community Care and Intermediate Care and Reablement Care work streams)*

This work stream undertook a capacity modelling exercise across community health and social care providers. Analysis of the demand across the City suggested a split of services into 3 localities to mirror the GP Locality and Council parliamentary boundary structures (North East, South East and South West).

CNT's

Comprising health and social care frontline staff these teams now work with integrated assessments and planning tools and meet on a monthly basis in the form of MDTs (MDT's).

The information gathered from this work stream activity is now being used to inform the estates element of the Integration work stream to move towards co-location and true integrated working across the three localities in Wolverhampton.

Rapid Response Pilot

A team of health community matrons and advanced nurse practitioners now work collaboratively with social care to operate a community rapid response service to people in their own homes (including nursing homes). This team focuses on exacerbations of existing conditions and is currently in "phase one - Monday – Friday" service however a transition plan is to increase the pilot to an established 7 day, 8.00am – 8.00pm service).

The pilot was the result of a demand analysis undertaken with the clinical providers to determine the level of resource required to cater to the forecast demand. This approach will be adopted when commissioning new services across health and social care working collaboratively to streamline pathways and consequentially, resource them.

The Mental Health Work Stream

Liaison Psychiatry Service

A team of highly skilled mental health practitioners able to respond appropriately to people with urgent mental health needs has been developed and is now based within the Urgent Care Centre of another non mental-health acute and community trust (RWT). Plans to co-locate social care Advanced Mental Health Practitioners (AMHP's) and support workers with this service are due to be implemented by September 2016. To date this has greatly enhanced collaborative working between the hospital's A&E, the mental health trust and social care and as a consequence has resulted in significant impacts in the following areas:-

- Better experiences for people with mental health needs presenting to A&E
- Timely 'professional to professional' contacts

- Timely and appropriate treatment for people in need
- Reduced potential to 'breach' A&E response timelines
- Improved use of highly skilled and costly resources.
- Mental Health Specific Street Triage Car.

The triage car is a dedicated 'blue light' ambulance vehicle deployed under guidance of control rooms to deliver a multi-agency response (Police, Ambulance and Community Psychiatric Nurse) to appropriate 999 and 111 calls.

At present the car covers the Black Country population of 1.2 million and operates daily between 10:00 – 02:00/03:00 including Bank Holidays and in its first year has achieved significant impacts in the following areas:-

- Fewer patients detained under section 136 (down 80%)
- Fewer patients attending A&E
- More patients being taken to an appropriate mental health service or left with advice/follow up by Mental Health Services
- Reduced time on scene by West Midland's Ambulance Service
- Reduced Police time dealing with mental health issues

Implications for Local Providers

In terms of the implications for local providers being set out clearly for HWB; there have been regular routine discussions with the chair, co-chair and the trust executives about development of community services across the health and social care system throughout the planning process.

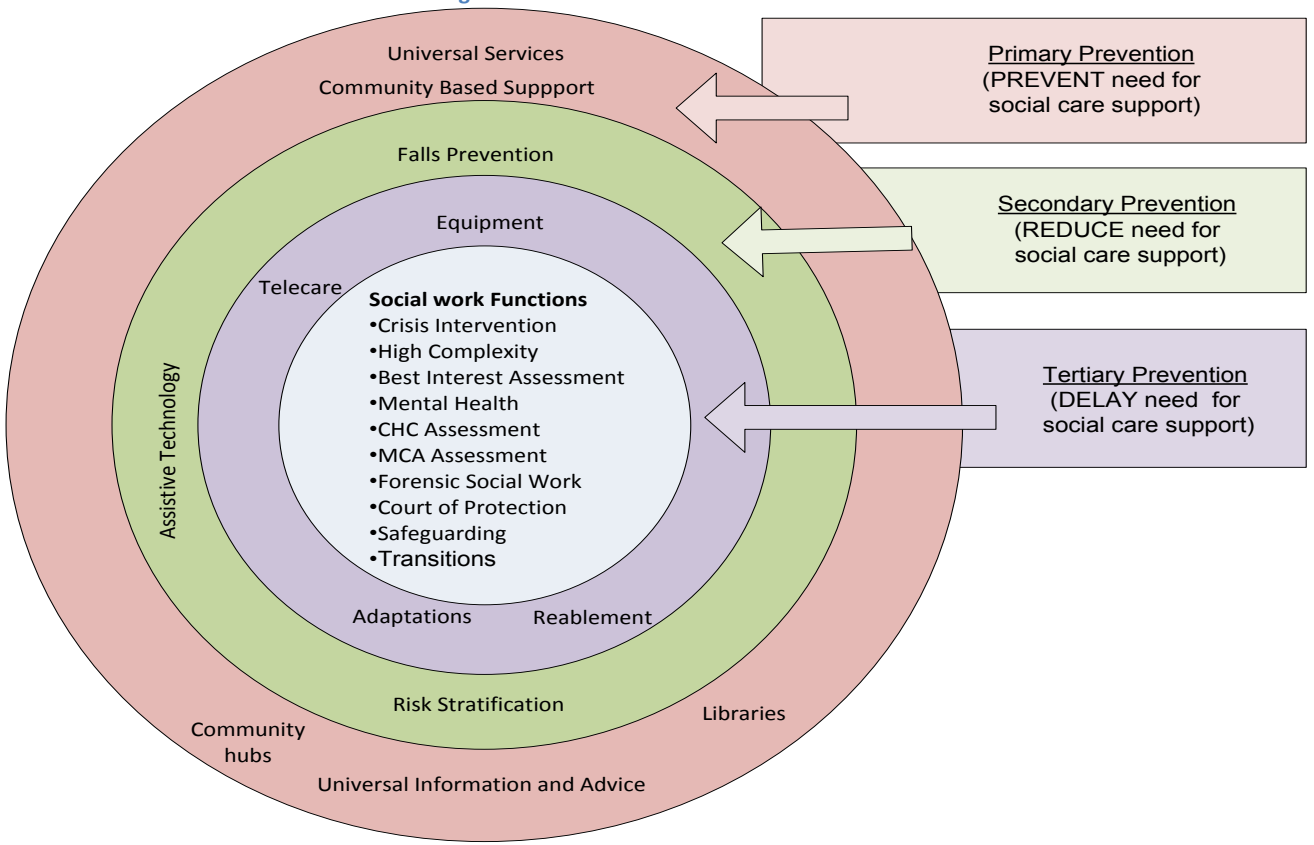
The implications of the 'shift' from hospital based treatment and care to care and treatment in a person's home (or much closer to it) for existing providers are broadly around their ability to develop flexibility within their workforce and working practices. This is greatly aided by the requirement for providers to develop 7 day, extended service hours across all provision which in Wolverhampton has resulted in a willingness of all parties to collectively engage in collaborative 'future proof' community service planning.

In the examples referred to already (see future capacity and workforce modeling examples) the use of existing supported and shared resources to deliver services that meet people's needs more imaginatively and cost effectively is gaining recognition across the city. It is the programme's intention to significantly build on these solid provider/commissioner foundations throughout 2016/17.

The inclusion of 'experts by experience' in each work stream is also being progressed as part of 2016/17 planning. Three targeted interactive stakeholder workshop events have been arranged for May 2016 (Adult Community Care, Mental Health and Dementia). Each of these events will have patient representative, carer, provider and voluntary sector representation. The role of Wolverhampton's Healthwatch and Voluntary Sector Council in facilitating local engagement forums for small businesses and 3rd sector providers is also a key element of the BCF programme's overall approach to stakeholder engagement and participation. Examples of such facilitated local community engagement forums are:- • Healthwatch • CCG Patient Engagement Groups / locality sessions: various. • BCF Mental Health patient, carer and service user targeted event • Alzheimer's Society Café discussion group • Dementia Action Alliance • Age UK • Over 50's Forum Wolverhampton is confident that its BCF vision for the delivery of care within Wolverhampton has a fundamental community and neighbourhood focus which will offer measurable benefits to the population of Wolverhampton. In short, as outlined in our approach to customers and their carer's, Wolverhampton has an active and robust engagement process which is underpinned by the primary shared vision of; One Ambition, Working as One, For Everyone.		
Maintain provision of social care services: Local adult social care services will continue to be supported within the plans for 2016/17. The financial value to protect adult social care is £6.4.in 2016/7 compared to £6.1 million in 2015/16. The development of integrated health and social care pathways and teams, including adult social care continues to be a priority within the programme, ensuring that there is no detrimental effect on the local health and social care system.	C.2.v C.2.vi C.2.vii C.2.viii C.2.viii	

Protecting Social Care: Alignment of each organisation's commissioning intentions highlighted in the JSNA and the key outcomes deliverable across health and social care will ensure that the key services requiring protection will be provided. This will also contribute to the integration agenda that will transform the way in which services in Wolverhampton are delivered. The Wolverhampton approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care whereby funding is transferred to local authorities via the NHS Commissioning Board to support Adult Social Care, utilising the Section 256 mechanism of the 2006 NHS Act. In Wolverhampton this funding is being used to support adult social care services, and to enable joint transformation across health and social care. Collectively BCF partners are re-shaping services to deliver the social care efficiencies required nationally whilst at the same time delivering improved outcomes that truly put people at the centre of services. The success factors are: - • Improvements in patient experience • Increase in use of direct payments to promote service user choice and facilitate discharges • Reduction in admissions to long-term care • Reduction in safeguarding referrals • Reduction in DTOC • Reduction in avoidable admissions • Reduction in emergency admissions to dementia services • Reduction in the use of services in a crisis The following protection of social care model (Figure 16), adopted across the BCF work streams, recognises that protection of social care is a key BCF objective;		

Figure 16 – Protection of Social Care Model



Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate: **<u>Community Intermediate Care</u>** The programme already has a number of services that support service delivery on a 7 day basis. The Community Intermediate Care Team (CICT), Home Access Reablement Programme (HARP), Therapy Access Team services are available 7 days a week from 8.00am until 8.00pm. The Council's therapy led resource beds in the community and the	C.3.i C.3.ii C.3.iii C.3.iv	

nurse led rapid response beds at West Park Hospital can be accessed 7 days a week. These services all support the existing acute and emergency services and the developing community teams. For the future plans are in place to develop a phased approach to the delivery of a city wide 7 day community rapid response service (currently in the pilot phase on a 5 day basis) and co-location of social care AMHPS in the Urgent Care Centre across weekends and bank holiday periods. As development of the programme progresses and in conjunction with provider colleagues, all new integrated services will have a phased approach to 7 day service delivery where appropriate in order to prevent avoidable admissions and support timely discharge. **Early Adopter** Wolverhampton is working with NHS England to be an early adopter of 7 day services and the BCF partners are working collaboratively to develop an implementation plan for delivery. A project group has been set up by RWT, which includes representation from: Wolverhampton CCG, CWC and BCPFT to collaboratively implement the plan. The programme will also explore how 7 day services can be supported by other organisations such as Primary Care and Voluntary Sector.		
Better data sharing between health and social care, based on the NHS number: **Use of NHS Number** Better data sharing is a key component of the vision for BCF in Wolverhampton and work continues to make progress in this area using the NHS number as the unique identifier across all work streams and services. The NHS services are already achieving the standards required for the use of the NHS number. The CWC's ICT infrastructure has been upgraded to meet the information governance requirements required by the NHS to enable the regular and routine transmission of NHS numbers from the NHS "spine". Information governance agreements have been produced and signed to enable the City council to establish this fully compliant technical connection (N3). Children, adults and carers who have had a referral or assessment (including safeguarding concerns) in the past 18 months or have received a service at some point in the past 2.5 years, total some 31,560. At the time of this submission the council have been able to match 23,092 people records across to the Social Care "CareFirst" system. The balance of records 8,468 are currently undergoing data cleansing.	C.4.i C.4.ii C.4.iii C.4.iv C.4.v C.4.vi	Appendix 15 Appendix 16

There is therefore a 74% match at the time of this submission. A plan for data cleansing is in place which will improve the matching of NHS numbers held in the CareFirst system to a level in excess of 90% within 3 Months.

The work around NHS numbers is working in tandem with the implementation of Fibonacci to support the integrated health and social care teams as referenced later in this section.

Work stream leads work closely with organisational Information Governance leads to ensure that there are robust policies and procedures in place to support the appropriate sharing of data within the local BCF programme.

Information Governance

This is largely related to individual work streams but also occurs on a programme wide basis. A BCF Information Governance (IG) group is in place to discuss issues and develop the appropriate governance. This group reports to the BCF Programme Board via the Finance and Information delivery group. IG leads continue to challenge processes and pathways to ensure that robust data sharing protocols are in place.

There is an overarching information sharing agreement across the Wolverhampton partners which addresses the sharing of data for both primary and secondary use (Appendix 15). New pathways / integrated teams are developed with the support of IG teams to ensure that the information sharing is in line with Caldicott principles and with national and local policy.

The Better Care website provides a Privacy Notice to people explaining what and how their information is used and what to do if they not want to have their information shared in this way (Appendix 16). Communications have been sent out to all health and social care customers in Wolverhampton allowing them to opt-out of the joint care records as well as notices being placed on all public facing websites at the CCG, LA, RWT and BCPFT.

Interoperable Systems

GP Clinical system suppliers are all working towards Open Application Interfaces (Open API) and the CCG deploy these products under GPSOC or they are purchased at a local level. The relevant security controls are approved at a national level and the solutions use N3 secure network. The CCG also use Graphnet Care Centric which acts as an interface between both primary care and secondary care systems to provide a unified record. The solution is hosted at RWT (RWT) and is secured under their security and IG protocols. Network communications occur over N3. The CCG are also pursuing the development of Graphnet to include social care and Mental Health Trusts.

Primary Data System – Fibonacci

As mentioned above, partners within the BCF programme in Wolverhampton have procured a system called Fibonacci to support the integrated health and social care teams. The system will enable the teams to access individually relevant (view only) data from each organisation. The NHS number will be used as the 'unique' identifier for data sharing within this system.

This is particularly important to the MDTs who hold a joint caseload as it will enable them to view the most up-to-date information about the people in their care and any interventions relevant to that individual. Data sources have been identified and agreed and other than the installation of hardware at RWT the system is ready to go live.

An overview of the intended outcomes and aims include:

- The provision of a shared record which will enable the implementation of the lead professional role for each patient.
- Patient care will be delivered in a more coordinated way across health and social care so that patients do not 'fall through the gaps' during transition across different service sectors.
- Patients will have a contact name for periods of crisis.
- The lead professional will instill confidence in patients to self-manage their condition where clinically appropriate, following delivery of education of the patient (and their carer if required) in their condition and what to expect as the condition progresses.
- The lead professional will promote the co-production of an individual, person-centered care plan that details specific outcomes and goals to help the patient live an optimal life.
- This will enable the management of individual cases to be more effective as different services will have access to information that they previously didn't have.
- This will reduce duplication and improve efficiency within the integrated teams
- The system will be accessed using Role Based Access controls and the IG leads have been involved in the planning of this work stream.

When this this system is successfully adopted by the CNT's, there is scope to roll out to additional service areas such as mental health and primary care.

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: Work is being undertaken by the emerging CNT's to identify a caseload for proactive case management. The proportion of the local population who receive case management and a named care coordinator will be the most vulnerable and this group will be identified via a risk stratification tool. This is being done by two methods:- 1) A consolidated view of current health and social care caseload within each of the 3 localities to identify a cohort of patients that would benefit from a joint approach of care planning. This is undertaken during regular MDT meetings where health professionals and social care staff meet to agree a joint approach to assessments and care planning. 2) Community matrons working with individual GP practices to identify a cohort of patients, based on risk stratification that would also benefit from a joint care planning approach from the integrated health and social care teams. People identified are either managed directly by the team of community matrons or referred into the MDT for a collaborative management plan to be developed. As the CNT's develop further and become more mature this approach will be embedded in their ways of working. This will be further be enhanced when the teams become co-located. The teams will develop an approach whereby each person is allocated a named accountable professional dependent upon their primary need. The CNT's are currently meeting on a monthly basis to discuss their caseload and a joint approach to care planning. The outcome of these meetings are recorded and updated accordingly. This is the first phase of development and our plans describe how these teams will be enhanced in the future. The ultimate vision for these teams is that they will be fully functional community based MDTs wrapped around a small group of GP practices. They will provide an integrated approach to both proactive and reactive management of patients within the community. Currently the teams consist of community matrons, advanced nurse practitioners and social work staff. This will develop to include specialist nursing teams, community mental health teams and voluntary sector. Work is underway with estates colleagues to identify available and suitable premises in each of the 3 localities and also to identify capital funding to enable this to happen. The opportunity to align to existing bids for new build premises within Primary Care is being explored as part of the longer term estate planning solution.	C.5.i C.5.ii C.5.iii C.5.iv	Appendix 17

Dementia Equally, in order to ensure its priority as an area of significant development across health and social care, Dementia is a dedicated work stream within the BCF programme structure. Work in this area will involve the development of the care coordinator role, review of day services and design of a dedicated hub. The target proportion of the population reviewed in the initial risk stratification meetings (detailed above) has been the top 0.5% based on the Kings Fund & BUPA Health Dialog model used in Aristotle. This is defined as the highest risk group in Aristotle followed by Disease Management (Top 0.5-5% of the population). The full Risk Stratification outcomes are recorded on the sheets that Community Matrons have been filling in (Appendix 17) and inputting into a Risk Stratification database. The first extraction will be carried out in May. Further information and continued monitoring will be provided via our Provider Patient Administration System (PAS) and will be monitored by the Persons named care co-ordinator – the GP.		
Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans: As described, agreement has been made with regard to the impact of changes which has resulted in a target reduction of emergency admissions supported by investment into community services. Please see section E.1/E.2 for further detail. Public and service user engagement has been through a variety of forums including consultation and stakeholder events to discuss planning and the impact of changes. Political engagement is ensured through adherence to LA democratic services; a process which requires elected members to have sight of all proposals affecting public services. BCF plans will mainly impact the provider trusts due to the move of services from an acute to a community setting. As referenced throughout this document provider colleagues are fully engaged at all levels of the programme. This potential shift in activity has been modeled in conjunction with the clinical community teams delivering the services. This modeling has been done to Health Resource Group (HRG) level with regard to a reduction in A&E attendance and in emergency admissions. The work stream leads have worked closely with the service delivery teams to ensure that the HRGs within the plan are indeed those that the teams feel can from a clinical perspective be safely delivered in the community. This should provide a realistic view of what can be influenced by the integrated teams.	C.6.i C.6.ii C.6.iii C.6.iv C.6.v	

Provider colleagues are involved at both strategic and operational workstream level in the development in the BCF programme planning. This ensures that our joint plans align with individual organisational and Black Country wide plans, for example work is underway to jointly agree the sustainability transformation plan which is required by June 2016. This is demonstrated in Figure 17 below;

Figure 17 – Organisational Alignment

As demonstrated within the programme's work stream structure mental health is a dedicated work stream led by mental health specialists. Parity of esteem is therefore maintained.

The development of our community services wrapped around GP practices reflects the vision within the CCG operational plan "*We will proactively work with practices to ensure they deliver high quality services with equity for all patients, including developing integrated community based support through the BCF*." Equally with regard to Mental Health and

Dementia "We will work with our provider to implement revised service models for Urgent and Planned Care, CAMHS, Early Intervention and Prevention (EIP), Improving Access to Psychological Therapies (IAPT) and Dementia Care with strong delivery against measurable outcomes". The CCG operational plan also states that "We will measure the efficacy of 24/7 services and connectivity and responsiveness of care pathways to ensure compassion and strong performance against clinical outcomes". These aims will be addressed by the Mental Health and Dementia work streams within the Better Care Programme but will also be incorporated into the development of CNT's ensuring a holistic view of both physical and mental health. Wolverhampton's provider partners have been involved in the development of the plans through the programme work streams. Each work stream has a lead from CCG, Council, RWT and BCPFT. Implementation plans and critical path documents are developed using this joint planning approach ensuring that they are both effective and ambitious whilst at the same time being achievable.		
<u>Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care:</u> The projects within the BCF programme all support the movement of activity from acute to community, primary, social care, voluntary and general preventative services. The development of the Dementia Hub and the work being undertaken in conjunction with the Big Lottery grant around post-discharge support and preventative services. Another example is the work between GP's and community nursing teams to risk stratify patients who are then case managed by the integrated health and social care teams. A risk stratification tool is being used which enables a collection analysis of data to support the risk stratification process. In 2015/16, whilst specific schemes aligned to the BCF programme proved successful, emergency admissions overall did not reduce in line with our 3.5% target. As a consequence of this we did not receive our P4P payment to fund any additional out of hospital services. We continue however to work with partners to redesign pathways with the ambition to move activity from secondary care to out of hospital services. We are currently negotiating with our providers the level of reduction of non-elective admissions. In line with the underlying principles of the BCF Programme the local area is committed to funding out of hospital commissioned services. This is demonstrated in the planning return expenditure plan. More detailed examples of these services are:-	C.7.i C.7.ii C.7.iii C.7.iv C.7.v C.7.vi	Appendix 18

The CCG has negotiated with Providers a shift in funding streams from the funding of emergency admissions to the increased funding in community services. This has been possible as the demonstration of the impact of the schemes during 2015/16 has instilled confidence in the future delivery of impact going forward into 2016/17. The BCF programme achieved a reduction of 1455 (April 2015 – February 2016) emergency admissions attributed to its schemes. This is clearly shown in the BCF dashboard extract (Figure 4). It is acknowledged that the development of community teams (health and Social care) is in its infancy and the program has an agreed transition plan to move from 5 to 7 day services giving opportunity for further impact to be realised. The programme is enhancing relationships with voluntary sector providers to support out of hospital services. Through a Grant Policy Framework a number of contracts have been awarded to voluntary sector organisations to support the teams in their delivery of support to the people of Wolverhampton. These schemes include a telephone befriending service with the aim of reducing social isolation, an advice and education programme for patients with long term conditions, a support network for patients at end of life and support for people with visual and hearing impairments. Two Step up beds have been commissioned and are ring fenced for use by the BCF teams. These beds will increase the opportunity for avoiding emergency admission and retaining people in the community in a safe environment. The Street Triage/Mental Health crisis car is an example of collaborative working between organisations to provide care out of hospital. The programme also commissions P3 a voluntary sector organisation that supports patients with mental health issues that are homeless so that when they hit emergency services help is given to identify suitable accommodation for the individual not in a hospital setting. The local area has opted to invest in out of hospital services up front rather than developing a risk sharing agreement as part of contingency planning in the event of excess activity. Monthly monitoring of activity is undertaken with detailed discussions undertaken at the BCF Programme Board enabling mitigation against increased activity to be taken at an early stage and by all organisations involved. This was demonstrated during 2015/16 when an increase in emergency admissions for a number of conditions including Urinary Tract Infection (UTI) and Respiratory was experienced, This prompted the implementation of the community Rapid Response team to manage patients with exacerbation of these conditions within the community. This service went live in January and has had both quantitative and qualitative results. (Appendix 18)		

Agreement on local action plan to reduce DTOC (DTOC): **<u>Current Position</u>** In common with many other areas Wolverhampton has had a significant issue with Delayed Transfer of Care. In Q2 there were 2253 DTOC against a plan of 750 and in Q3 we reported 1887 against a plan of 708. In response to the situation a report was commissioned which resulted in the adoption of a tripartite local action plan (between the CCG, Council and RWT) to reduce the DTOC across the city. (Appendix 19) Taking into account national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly DTOC Situation Reports Definition and Guidance, the local action plan has enabled the redesign of services and processes around DTOC. There has already been an improvement in DTOC delivery which has been evidenced over the last three months with a reduction in DTOC from over 1300 delayed days plus throughout most of 2015 to just over 1000 in December and January and under 1000 in February. The DTOC target relating to the BCF Programme is reflected within the CCG Operational Plan, as operationally achievable across the partnership and within the timeframes outlined, and we have made assumptions that we will continue to implement new ways of working which will see delayed transfers fall steadily throughout the year until they reach similar levels to 2013/14 and 2014/15 in September / quarter 3. Numbers will then follow the 2013/14 figures around winter pressures rather than the Q3 / Q4 increase that began in 14/15. Working with ward based teams and gathering data from over 251 admissions the project team involved identified two factors that contributed to discharge performance. These factors have a detrimental effect on customer experience, quality and system resilience. These are: • Significant variation in the approach to discharge plans. • A disjointed model of intermediate care that is not optimised to meet demand. The programme identified two key recommendations:- 1. ***Standardise discharge planning*** processes to identify the most appropriate next care setting for people and create a consistent view of demand for out of hospital services. 2. ***Integrate intermediate care services*** to ensure an appropriate balance of care settings that expedites the discharge of people from hospital wards. Doing so will reduce system costs and reduce the level of hospital based risks experienced by people.	C.8.i C.8.ii C.8.iii C.8.iv C.8.v C.8.vi C.8.vii C.8.viii C.8.ix	Appendix 19

The target agreed by LA and CCG regarding DTOC's for 2016/17 is 8675.

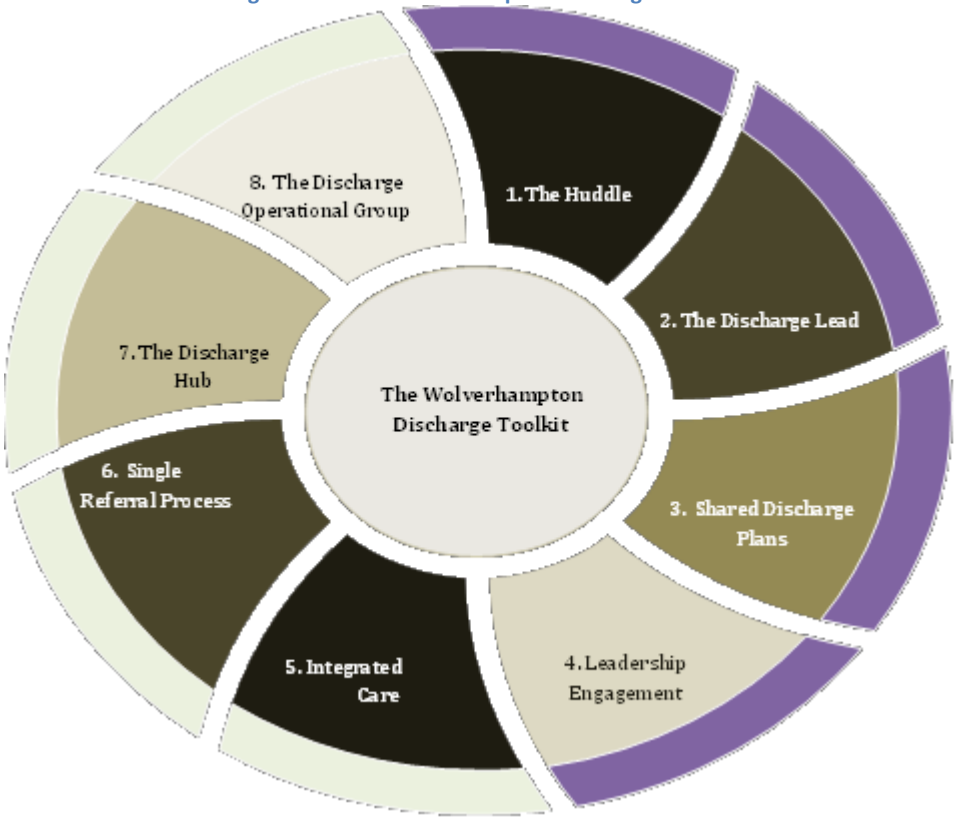
The Wolverhampton Discharge Toolkit (Figure 18)

The Project Delivery Group have identified eight interventions that will achieve the headline recommendations of this report. Collectively this is referred to as the '***Wolverhampton Discharge Toolkit***'.

Successful implementation of the Discharge Toolkit will be dependent on:

- Adopting a system perspective of cost and benefit.
- A programme managed approach. Continued review of demand, supply and resources.

Figure 18 – The Wolverhampton Discharge Toolkit



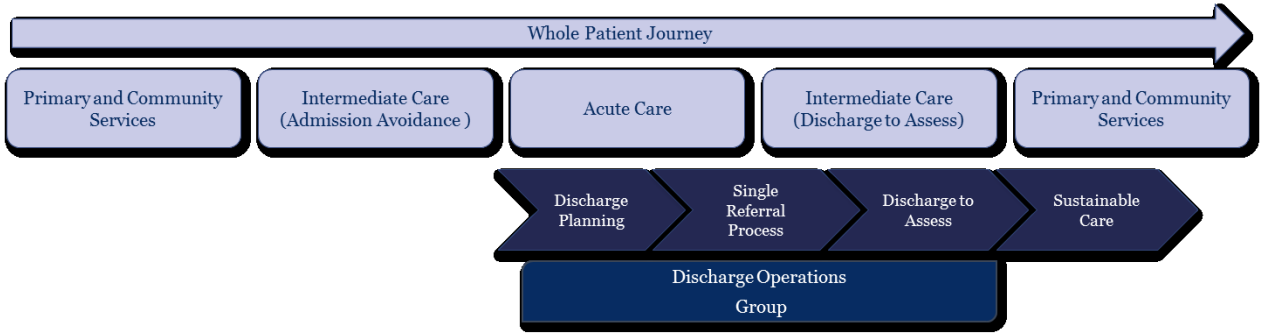
Whilst the programme of work commissioned to look at issues with DTOC is stand-alone from the BCF programme, the Adult Community workstream will be aligning itself to ensure that it supports the improvements that need to be made and to review the reduction in DTOC in line with the plan.

The report (Appendix 19) recommends "This report has made specific recommendations targeted at improving the flow of patients between acute and intermediate care settings. It recommends transforming a new model of integrated intermediate model of care in which patients are discharged at the point of being declared medically fit. Assessment for ongoing, long term care needs should happen either at home or in an intermediate care setting."

The interaction between acute, ward based care processes and the wider model of community provision demands a system level response. We recommend a programme managed approach to implementing standardised discharge planning (Figure 19) that will increase flow from acute wards and improve the understanding of demand. Commissioning a more integrated model of intermediate care that is optimised to meet demand will sustain increased flow through the system.

Creating a Discharge Operational Group to maintain balance between demand for and supply of intermediate care will provide oversight and a system wide point of escalation beneath the System Resilience Group. This group should have a strong mandate to improve performance and make in year operational changes. In this role it could be considered as the steering group to lead implementation of the Wolverhampton Discharge Toolkit."

Figure 19 – Standardised Discharge Planning



D. Scheme level spending plan		
Please refer to BCF Planning Return.	D.1.i D.1.ii D.1.iii D.1.iv	
E. National Metrics		
Non-elective admissions (General and Acute): The non-elective admissions (NEL) target reduction for 2016/17 was originally proposed to be 1850. During contract discussions with our provider colleagues this target has now been set and agreed at 1356. This is an increase on the 2015/16 target of 1061 NEL reductions across all areas. However this is not felt to be an overly ambitious target as all partners have been involved in discussions and have agreed that this is deliverable.	E.1.i E.1.ii E.1.iii	

This reduction represents an agreed financial value position achieved via the CCG's contract negotiation processes with the relevant provider trust.

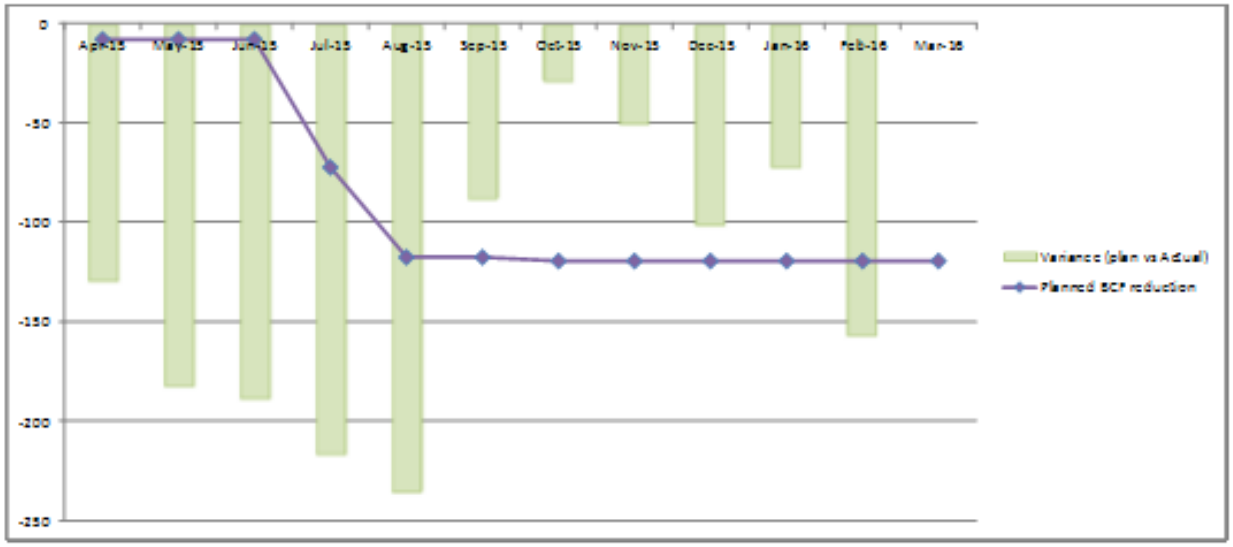
As previously described a data dashboard was designed and monitored throughout the financial year to track progress against associated activity and spend (Figure 20).

Figure 20 – Wolverhampton Data Dashboard

All BCF Schemes together	

ACTIVITY

All schemes	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Full year
Contract Plan pre BCF reduction adjustment	700	723	723	723	723	700	723	700	723	711	653	711	8513
Planned BCF reduction	-8	-8	-8	-73	-117	-117	-119	-119	-119	-119	-119	-119	-1043
1516 Actuals	570	540	534	506	487	611	694	649	621	638	496	1	
Variance (plan vs Actual)	-130	-183	-189	-217	-236	-89	-29	-51	-102	-72	-157		-1455
Variance (planned reduction vs Realised reduction)	-121	-175	-181	-144	-119	29	90	69	17	47	-38		-525



The dashboard demonstrates overall how the Programme overachieved – the granular detail behind the dashboard shows a scheme by scheme breakdown on which schemes did not deliver against plan and which could be carried forward. A full review of these was undertaken as part of that process before determining what our NEL target should be for 2016/17. The Programme exceeded this target and actually reduced admissions against the targeted conditions by approximately 1455 for the year. It is with this confidence that the Programme feels that through the schemes that have delivered at the tail end of 2015/16 that we feel that our target that has been perceived as ambitious for 2016/17, is realistic. The target has been quantified through analysis of the performance of our Rapid Response Pilot over 3 months as well as other schemes around Urgent Care Mental Health.

A collaborative exercise was undertaken with Operational Provider colleagues and Clinicians to undertake an assessment on which areas they felt would continue to see a reduction in activity as the Rapid Response Service expands its scope to Nursing and Residential Homes and patient's own homes throughout 2016/17 and eventual 7 day working in the 3rd and 4th quarters.

A transition plan was developed with our provider and the associated business case that details the scheme has been approved through contract negotiations in March 2016 and will be implemented in line with the detailed transition plan throughout 2016/17.

Admissions to residential and care homes;

'Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population' - Planned 2016/17 Targets are:

	Actual 14/15	Planned 2015/16	Forecast 2015/16	Planned 2016/17
Annual rate	644.8	638.0	638.0	581.9
Numerator	273	273	273	252
Denominator	42,338	42,787	42,787	43,307

Admissions to residential and care homes;

Service redesign to promote independence and strengthen access to treatment and support in the community is well underway as is work to support the development of mechanisms to track it.

E.2.i
E.2.ii
E.2.iii

Wolverhampton's performance in the national indicator for admissions of older people to permanent residential and nursing care in 2014/15 placed us in the top quartile among comparator authorities and upper mid-quartile regionally. Performance at the same levels have been maintained throughout 2015/16 (based on in year and provisional data) demonstrating that older people within the City are being helped to remain independent. Targets for 2016/17 have been based on a half way achievement of an ambition to reach national top quartile performance by the end of 2017/18. With plans in place to increase and extend the reablement offer within Wolverhampton, roll out a wide reaching and comprehensive assistive technology offer and the further development of preventative interventions and the community offer, the CWC is confident that more people can be helped to remain independent and in their own homes, thereby reducing the number of people admitted to residential or nursing care throughout the year. In addition, reductions in the number of emergency admissions and DTOC, will reduce the dependency that can arise from such situations and subsequent decline in ability which can lead to permanent admissions to care. Please note that the target is based on a provisional 2015/16 out-turn and may be revised following validation of the final result. The CWC is in the process of procuring the Care and Health Trak system and is currently working to agree the content and delivery timescales. This will provide access to much more detailed information about health and social care needs across the City.		
<u>Effectiveness of reablement;</u> The target for the Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services has been set for 2016/17 at around the same rate that is expected for 2015/16 and which was achieved in 2014/15. This is a two-part indicator, and although Wolverhampton's performance for this first part which deals with effectiveness was in the lower-mid quartiles nationally and among comparators and the upper-mid quartile regionally in 2014/15, performance in the second part of the indicator which deals with the proportion of people discharged from hospital who were offered reablement was in the top quartile across all comparator groups at 6.1% - almost double comparator averages. The plans set out within this BCF submission to further increase the reablement offer to the citizens of Wolverhampton both within the community and on discharge from hospital further. Increasing the offer of reablement through a more widely encompassing selection and identification criteria for people who would benefit from the offer, often leads to a decline in overall reported effectiveness due a lessening of the 'cherry picking' effect that more stringent selection criteria can produce. It is therefore believed that a maintenance of current performance against an increased reablement offer is realistic while providing a degree of ambition.	E.3.i E.3.ii E.3.iii	

The following metric has been selected:-

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

		Actual 14/15*****	Planned 2015/16	Forecast 2015/16	Planned 2016/17
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	80.6%	94.3%	79.3%	80.3%
	Numerator	330	330	340	490
	Denominator	410	350	429	610

E.4.i
E.4.ii
E.4.iii

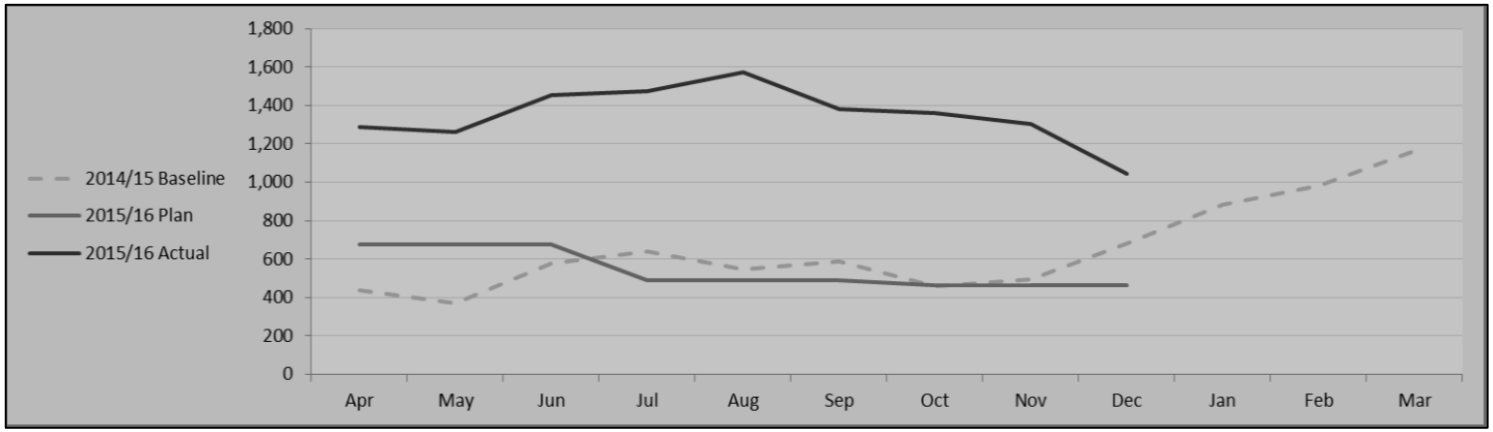
DTOC;

		2015/16 plans				2015/16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				2016/17 plans			
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
DTOC (delayed	Quarterly rate	1032.7	750.5	708.2	965.7	2040.5	2253.5	1886.7	1590.	1524	1270	1016	1013

days) from hospital per 100,000 population (aged 18+).	Numerator	2027	1,473	1,390	1,901	4,005	4,423	3,703	3,130	3,000	2,500	2,000	2,000
	Denominator	196,274	196,274	**196,274**	**196,274**	**196,274**	**196,274**	**196,274**	**196,857**	**196,857**	**196,857**	**196,857**	**196,857**

December DTOC data shows that the number of delayed days was significantly lower in December but remains significantly above plan (Figure 21).

Figure 21 – Wolverhampton DTOC Dashboard (Part A)



The proportion of delayed days that are the responsibility of Social Care is increasing although in recent months the proportion that is the responsibility of both is decreasing (Figure 22 and 23);

Figure 22 – Wolverhampton DTOC Dashboard (Part B)

Cause of DTOC (cumulative)	2015/16 Cumulative		2014/15 Baseline
	Number	Proportion	Proportion
NHS	5,103	42%	54%
Social Care	5,853	48%	35%
Both	1175	10%	11%

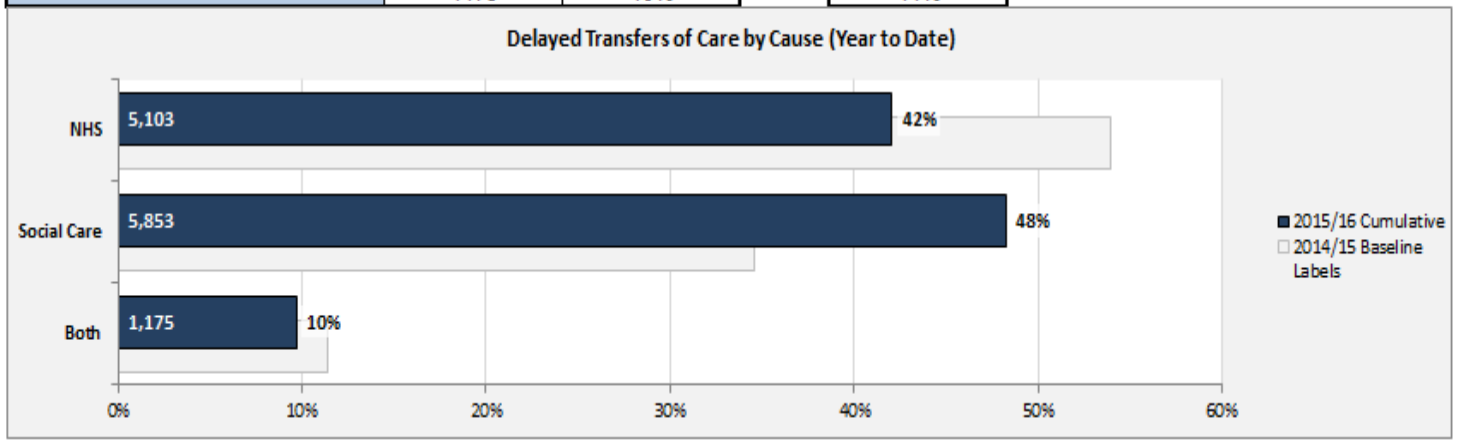
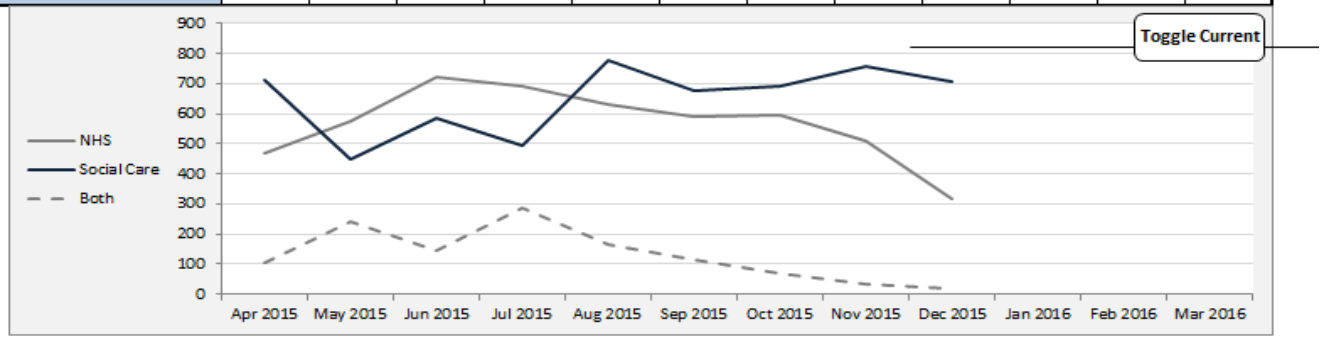


Figure 22 – Wolverhampton DTOC Dashboard (Part C)

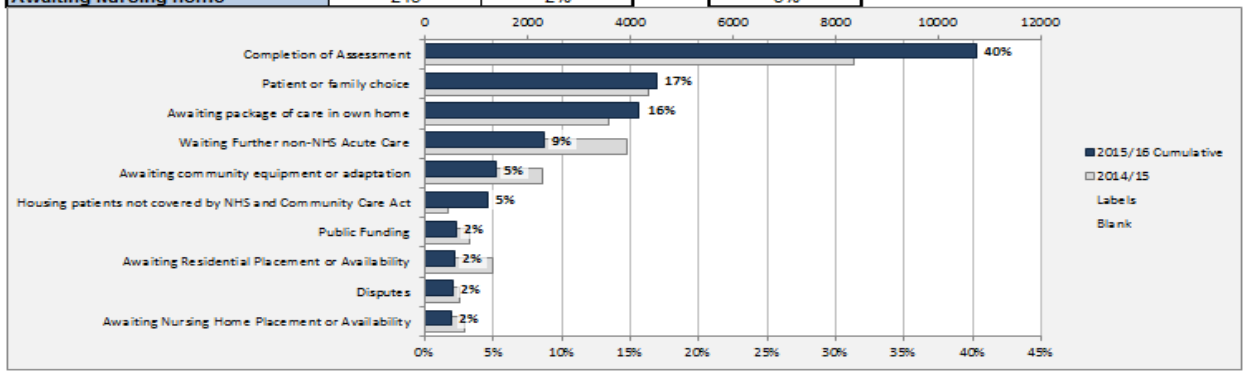
Cause of DTOC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	469	573	721	694	630	591	596	510	319			
Social Care	714	449	586	493	777	676	694	759	705			
Both	107	239	147	285	164	113	70	32	18			



The proportion of delays that are due to patients waiting for assessment continues to increase and almost one fifth of delays are due to patient or family choice (Figure 24).

Figure 23 – Wolverhampton DTOC Dashboard (Part D)

Reason for DTOC	2015/16 Cumulative Number	2015/16 Cumulative Proportion	2014/15 Proportion
Completion of Assessment	4,884	40%	31%
Patient or family choice	2,054	17%	16%
Awaiting package of care in own	1,899	16%	13%
Waiting Further non-NHS Acute	1,059	9%	15%
Awaiting community equipment	635	5%	9%
Housing patients not covered by	560	5%	2%
Public Funding	283	2%	3%
Awaiting Residential Placement or	268	2%	5%
Disputes	246	2%	3%
Awaiting Nursing Home	243	2%	3%



Locally Defined Patient Metric

The following metric has been selected:-

"New supported living placements for people with mental health issues"

As part of the Mental Health BCF scheme a transformational shift is underway across Wolverhampton's Mental Health system whereby services are being redesigned to promote independence and strengthen access to treatment and support in the community.

The local metric reflects plans to reduce the number of residential admissions for people with Mental Health issues, and the plan for 2016/17 is set at 17 new placements into supported living.

(For additional detail on DTOC's please see section C.8 of the document.) **<u>Patient Experience Indicator</u>** This is an annual measure, and Wolverhampton's performance in 2014/15 in the top quartile across all comparators. Despite continuing pressures on services, requirements to identify efficiencies and subsequent service redesigns and changes to existing offers, satisfaction among users of social care has increased consistently over the past 4 years. The adult social care user survey for 2015/16 is currently being undertaken with no reason to think that 2014/15 satisfaction levels will not at least be maintained. To this end the target for 2016/17 has been set at the same rate, although may need to be reviewed following verification of the 2015/16 result.		