HEALTH AND WELLBEING BOARD

20 June 2016

Agenda item

Health and Wellbeing Board

Better Care Fund Update and Amendment

1. Summary

1.1 Details of the requirements for the BCF Plan 2016/17 Submission were set out in the report to the Health and Wellbeing Board of 29 February 2016. This report sets out the feedback via the assurance process, and the work underway leading to the final submission**.**

1.2 The financial envelope of the BCF is very similar to that in 2015/16 of circa £24m, however this report covers the urgent adjustment within the 2016/17 financial envelope, necessary to support the Walsall CCG de-commissioning of the over 75s GP Locally Commissioned service, designed to reduce emergency admissions within this age group.

1.3 The 2016/17 Better Care Fund Plan has greater clarity, than the 15/16 submission on the programme approach that will be adopted to achieve the objectives for integrated services and better outcomes set out in the plan and draws on lessons learned last year. The "place" shaping of care and support for the people of Walsall is important, as well as specialist cross boundary commissioning of services in the Black Country. This report sets out the alignment of the Better Care Fund Plan to the longer term strategic intentions of the "Sustainability Transformation Plan" (STP) for health and social care for Walsall within the Black Country. The STP should be developed for submission in June 2016.

2. Recommendations

2.1 To note progress with the development of the plan for the Better Care Fund;

2.2 To delegate authority for the Chair of the Health and Wellbeing Board to sign-off the Better Care Fund plan in time for the next submission date of 27th June 2016.

2.3 That the Health and Wellbeing Board endorses the Walsall CCG Governing Body decision to reduce investment in the GP Local Commissioned service, equivalent to £1.007 million in 2016-17. The level of investment within the Better Care Fund would still exceed the minimum levels stipulated within the national guidance.

2.4 That the Health and Wellbeing Board notes the joint strategic intentions to be developed for the submission in the five-year Sustainability & Transformation Plan.

3. Report detail

3.1 The Better Care Fund (BCF) 2016/17 Plan has successfully been through an assurance process in the West Midlands. The outcome based on this assessment is 'approved with support'.

Further work is underway to update the plan to provide further evidence to respond to the eleven (3 unmet and 8 partially met) outstanding Key Lines of Enquiry (KLOE) in time for the next submission on 27th June 2016.

3.2 The Walsall BCF financial envelope is largely the same as in 2015/16, with a range of services aimed at prevention of hospital and care home admissions within existing contracts. There is one adjustment to the schedule, which will alter the total fund in the BCF pooled budget, although the remaining level of investment will still exceed national minimum requirements. Walsall CCG Governing Body decision is the disinvestment in 2016/17 of £1.007 million in the LCS (Local Commissioned Services) for additional GP preventative assessments of people over 75 years.

The Local Commissioned Services (LCS) was a pilot scheme, started by the CGG in 2014/15, whereby GPs were paid an annual sum of £60 per additional assessment of individuals who were 75 years old with the aim of reducing unplanned admission to hospital in this group. The target population was 22,000. The scheme also required practices to deliver a target of 75% of patients over 75 to receive an additional review by the end of March 2016.

There was a detailed evaluation undertaken in the last year by the Commissioning Support Unit (independent of the CCG) of the outcomes of the scheme. The evaluation found that whilst most assessments had some benefit to those assessed, there was no evidence to support a reduction in emergency admissions for this cohort of patients. The CCG considered the evaluation of the scheme alongside an assessment of its wider strengths and weaknesses and on balance made the judgement that the scheme was unable to demonstrate value for money.

The Walsall outcomes for this scheme are similar to those evaluated nationally as reported in the BMJ 28.01.16 *"case management improves patient satisfaction, promotes high levels of professional satisfaction, and reduces carer strain. But its impact on reducing future emergency admissions has not been demonstrated..."*

The Governing Body decided to decommission the scheme during 2016-17 with no further payments to GP practices being made from July 2016 onwards.
Mitigation of any possible impact of withdrawing the LCS is the development and rollout of the multidisciplinary 'Locality Teams' who will work proactively assessing those, including over 75 year olds, at risk of admissions. Locality Teams will comprise of community nurses, social care staff, and others (including mental health) in coordination with GPs.

The localities pilot in Darlaston over the last year has proven to be positive in helping reduce admissions, and enhance joint working across disciplines including GPs. Therefore, following this sound evidence base there will be an

expansion of the multi-disciplinary approach (community healthcare, social care and mental health staff) to all of the borough over the next 2 months.

Locality Teams is one of the four key work-streams of the Better Care Fund Plan that will be delivered through the Walsall Together Programme Team governed by the Health Walsall Partnership Board. The other work streams are 'Resilient Communities', 'Intermediate Care' and 'Access'. All of the work-streams are aimed at keeping people well and independent at home for as long as possible and delivering alternatives to A&E or emergency admissions to hospital.

3.3 The four work streams were developed following a review of the BCF 14/15 & 15/16 work streams undertaken in the final quarter of 15/16.

The review highlighted that although there was some good progress in the 'Health' elements of Locality Teams, many services commissioned through the Better Care Fund, were still commissioned and delivered separately. Through the review, a clear aim emerged to drive forward opportunities for integration in order to reduce duplication and improve outcomes. Stakeholders identified the four priority areas listed previously, where it is felt that there are the greatest opportunities to improve efficiency, and outcomes through integration.

The review also highlighted that although ambitions and plans were relatively well formed, delivery against those plans had not progressed as much as was hoped. To address this, partners across commissioning and provider organisations are working through the Healthy Walsall Partnership Board to develop a well-managed programme to ensure all of the work streams and interdependencies are delivered effectively across boundaries in 2016/17.

3.4. There is a strategic commissioning and planning process underway to generate the five-year vision and plan for "Sustainability Transformation Plans" (STP) both in Walsall and across the Black Country by June 2016.

There is a commitment, which the Health Wellbeing Board is asked to endorse, to align as much of social care (adults and then children) funds together with NHS commissioning funds and to jointly commission services that meet joint priorities and statutory functions that prevent admissions to institutional care (hospitals, care homes) and promote independence, choice and early support.

This could include for example: the alignment of Council DFG grant funding with that funded through the BCF; the alignment of CCG Continuing Health Care (CHC) budgets with Adult Social Care commissioned care; the alignment of Adult Social Care Mental Health commissioning budgets with those in Mental Health by the CCG; the complimentary alignment of Public Health Commissioning to BCF and related objectives. This is in addition to the existing long standing pooled budget for Learning Disabilities of £30m/year which is continuing.

3.5 The five-year Sustainability Transformation Plan (STP) will incorporate the four 2016/17 priorities that promote integration of services outlined above, and other elements including: estate; workforce; digital/assisted technology; community assets/voluntary sector; and information/advice.

Specialist and acute health service plans being developed through Black Country STP will incorporate local “place” based plans such as those in Walsall.

The governance for the STP in Walsall will be through the Health and Wellbeing Board. The Joint Commissioning Committee (JCC) is reviewing its Terms of Reference to better support the wider agenda involved in the STP. It will need to consider how it will include the business, as appropriate, of children and public health commissioning, as well as adult health and social care.

4. Council priorities

The proposals and plans set out in his report support the Council’s priority to ensure vulnerable, disabled and ill people of Walsall receive the best health and social care.

5. Risk management

There is a risk to the short and long term sustainability of the Council and the CCG finances, if the joint approach to commissioning and promotion of preventative and reabling services is not developed through integrated services and aligned or pooled budgets. There are more opportunities for demand on health and social care to be better managed through an integrated approach than separately. The amendment, the mitigation and the longer term plans are all aimed at this goal.

6. Financial implications

The proposed amendment to the BCF reduces the total revenue BCF Pooled Budget from £21.7million to £20.7 million, which is still in excess of the national minimum CCG contribution of £19.3 million. The total BCF budget, inclusive of the Disabled Facilities Capital Grant (£2.9 million), has, as a consequence, reduced from £24.6 million to £23.6 million.

7. Staffing implications

There are a small number of staff that some GP practices have employed in relation to the over 75 LES. Separate consultations and resolutions to these staff implications have been followed up by the CCG following the decision at the Governing Body.

8. Equality implications

There was an uneven spread of assessments in some areas through the LCS. The multi-disciplinary approach through localities is designed to ensure all GP practices can refer to and take part in a locally based multidisciplinary network that will holistically and consistently assess older people in areas covering 50,000 people in each locality.

Background papers
BCF Final Submission

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Walsall Better Care Fund Plan 2016/17 – Final Submission 3rd May 2016

1) PLAN DETAILS

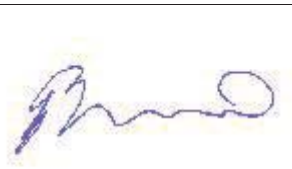
a) Summary of Plan

Local Authority	**Walsall Metropolitan Borough Council**
Clinical Commissioning Groups	**Walsall Clinical Commissioning Group (CCG)**
Boundary Differences	**The boundaries are within the Borough of Walsall.**
Date agreed at Health and Well-Being Board:	**3rd May 2016 (delegated to Chair of HWBB)**
Date submitted:	**3rd May 2016**
Total agreed value of pooled budget: 2016/17	**The revenue sum via the CCG will be £21,712,862.** **The Disabled Facilities Grant will be £2,895,213** **The total BCF will be £24,608,075**

b) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	**Walsall CCG**
By	 ***Salma Ali***
Position	**Accountable Officer, Walsall CCG**
Date	**3rd May 2016**

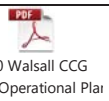
Signed on behalf of the Council	**Walsall Metropolitan Borough Council**

By	 ***Paula Furnival***
Position	**Executive Director of Adult Social Care**
Date	**3rd May 2016**

Signed on behalf of the Health and Wellbeing Board	**Walsall Health and Well Being Board**
By Chair of Health and Wellbeing Board	 ***Councillor Rose Martin***
Date	**3rd May 2016**

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Integration of Health and Social Care – Implementing the Better Care Fund	**Walsall Council Website - Reports to HWBB: 27 April 2015; 22 June 2015; 7 Sept 2015; 7 Dec 2015; 29 Feb 2016**
The Health and Well Being Strategy for Walsall 2013 to 2016	**Walsall Council Website** **Walsall CCG website**
Walsall Joint Strategic Needs Assessment refresh 2013	**Walsall Council Website** **Walsall CCG website**
Walsall CCG Strategic Operating Plan	 V3.0 Walsall CCG Draft Operational Plar
Walsall Council Budget Consultation	**Walsall Council Website**

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

(KLOE B1 i)

Our vision, as set out in our Health and Well Being Strategy and based upon our Joint Strategic Needs Assessment (see Walsall Council website) is to maintain and where possible improve the independence, health and well-being of the people of Walsall. In doing so we aim to reduce the prevalence of unnecessary admissions to hospital and to reduce the number of older people who are receiving on-going social care services, especially admissions to care homes.

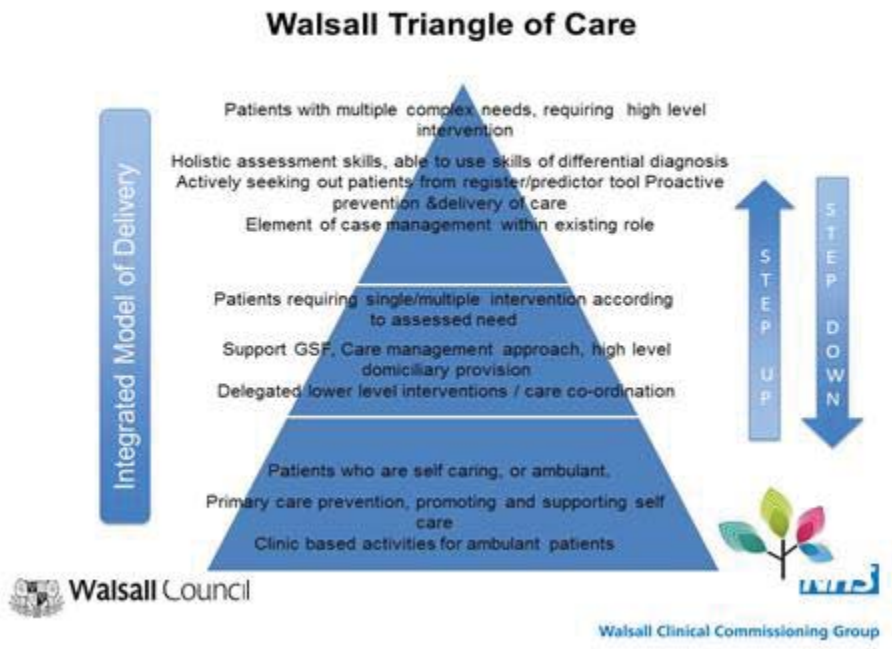
The three objectives of our vision are:

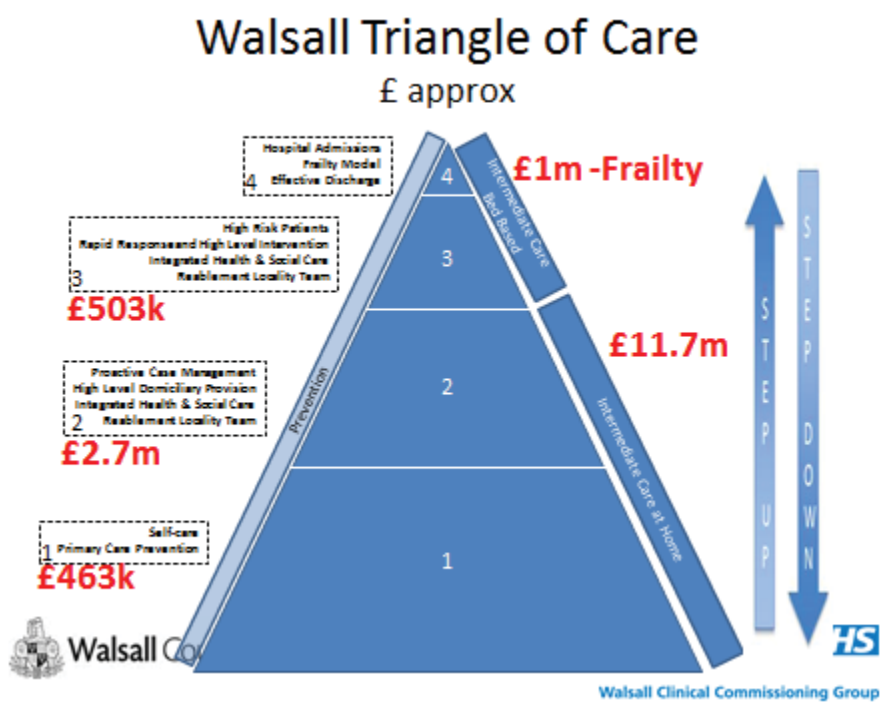
- Enable people to remain well and independent at home for as long as possible
- Avoid unplanned admissions to hospital – aiming for a reduction of at least 2%
- Swift return home following an episode of bedded care

Since 2014 we have enhanced our vision by recognising that our current system is overly reliant upon supporting discharge of patients from hospital in order to create capacity within the hospital to meet demand from emergency admissions. Our vision has been developed to show how we need to be more successful with our admission avoidance measures to reduce demand on the hospital system, and thus be able to switch some of the system capacity that is currently being used supporting hospital discharge to be used for increased admission avoidance, thus creating a 'virtuous cycle' of increasing support for care at home services that maintain independence.

The challenges we face require solutions where we focus on prevention of illness rather than treatment; where we care for patients and residents in the community more than we do within hospital settings; and where we focus on the correct level of care for the individual rather than placing patients in care settings that are of a higher dependency than their needs require. They also require us to make radical changes to how we apportion our funding and on what services we focus our scarce resources and on building community capacity and resilience to help people and communities help themselves. They require us to work even better together.

This is represented in the following diagrams:





b) What difference will this make to patient and service user outcomes?

(KLOE B1 iii)

The vision is one of ensuring more collaborative ways of working that reduce crises that result in hospital and care home admissions and improving outcomes for patients/service users.

The components of this improvement and the difference that will be made are as follows:

- A targeted integrated approach to those most at risk of admission to hospital/care homes to keep people well and independent at home for as long as possible.
- A responsive integrated approach to react to crisis in patients/services users physical/mental health/well-being to avoid hospital/care home admission wherever possible and facilitate timely discharge home for those who unfortunately are admitted.
- A far more coordinated and integrated pattern of care, across the NHS, Social Care Housing, the Independent and Voluntary sector, with reduced duplication and better placing of the patient/service user at the centre of care.
- A pattern of services that better meets population needs, by bringing teams together for more hours of the day and more days of the week.
- A systematic shift towards greater care in the community and in the home
- Reducing dependence upon paid support and enabling and maximising individual independence.
- Better supporting and enabling carers to continue with their vital role whilst establishing and maximising the use of peer support.
- An increased focus on prevention and early intervention, maximising the use of technology, family and community support networks and universal services that lead to a general improvement in population health and a reduction in health inequalities for our population

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

(KLOE B1 ii)

1. **Locality Teams** – Locality Teams will utilise tools such as Risk Stratification, drawn from a range of health and social care data sets to understand the individual needs of people most at risk of hospital/care home admissions and target the services which best enable them to stay at home. To support people identified through the risk stratification as 'at risk' to remain at home for as long as possible and reduce unnecessary admission to hospital/care homes we will create integrated locality teams comprising of Primary, Acute, Mental health, Secondary and Social Care in collaboration with Communities, Independent and Third Sector organisations and wider partners e.g. ambulance, housing, fire service. Teams will work to keep people well and independent in their own home by targeted prevention and early intervention.
2. **Integrated Intermediate Care –** Preventing people from being admitted to hospital/care home in a crisis and discharging people back to their own homes following an acute episode of care in a timely manner, requires a coherent and efficient joint intermediate care service. This will be made up of the current separate health and social care services. This service will have the skills of hospital discharge and social care reablement, linking with the wider multi-disciplinary locality teams
3. **Single Point of Access –** Multiple Points of access across Health and Social Care will be replaced with an integrated Single Point of Access. Through the Single Point of Access, there will be a menu of packages of services ranging from at the most intense, our specialist intermediate care beds in the Hollybank Unit,

through to at the least intense, community and voluntary sector support.

4. **Resilient Communities** – Develop communities that support people to remain well and independent for longer. This includes an increased focus on prevention and early intervention, maximising the use of housing, aids and adaptations, technology, family/community support networks, carers support services and universal services that lead to a general improvement in population health and well-being and a reduction in health inequalities for our population.

There is very little difference in the distribution of funding between the work-streams between 2015/16 and 2016/17 as shown in the table below which is a summary of the expenditure plan at Tab 4 of the Planning Template. **(KLOE A3 iv and v).** There are some minor adjustments for inflation and to take account of the changes in the funding of DFG's. **(KLOE A3 iii)**.

Scheme Name	Total 15-16	2016/17
Integration of Community Services	£2,202,900	£2,193,627
Transitional Care Pathways – non bed based	£5,830,788	£6,077,662
Transitional Care Pathways – bed based	£7,216,130	£6,799,271
Assistive Technology	£3,613,093	£4,882,306
Dementia Care	£220,000	£220,000
Mental Health	£519,000	£524,627
Support to Carers	£450,000	£450,000
Long Term Residential Care (Community and Residential)	£2,193,000	£2,252,192
Voluntary and Community Sector Impact on Hospital Flows	£146,840	£146,840
Contingency against over-performance of emergency admissions	£1,050,000	£1,061,550
TOTAL	£23,441,751	£24,608,075

Our overall aim for the Better Care Fund Plan in 2016/17 is to continue to work on the reconstituting of our plan around the revised work-streams as identified by the Healthy Walsall Partnership Board and to build on and consolidate progress to date.

We have a number of schemes and services that make up our whole system with a historical legacy of separate contracting arrangements that the current expenditure plan reflects. We will therefore explore the extent to which we can integrate the overall contracting and commissioning of all these services as an enabler to a higher level of integrated delivery and thus achieve more efficiencies.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area:

Balance of Care Analysis

Walsall's overall population is predicted to increase over the next 10 years by 4.5% from 269,500 in 2011 to 281,700 in 2021. In addition to this, Walsall's older population (those aged 65 and above) is also predicted to increase by 12.9%, with the number of people 85 years and older increasing from 5,467 in 2008 to 8,109 in 2021 (Source: Walsall JSNA Refresh 2013).

With Public Health colleagues we have updated our 'Balance of Care' analysis of Walsall's population over the age of 55 to identify levels of need at local ward level, map service provision at local ward level, and analyse for gaps and priority areas for service development. Data sources included a range of Health Data from the Health and Social Care Information Centre/NHS Digital; Social Care Service User data; and Insurance and Retail data and analysis was conducted using Mosaic Experian – a social marketing piece of software. **(KLOE B2 iv)** A summary of the high level results was:

- An ageing population in Walsall shows a projected need to ensure suitable provision is in place.
- Ethnicity figures demonstrate a more diverse population in the Borough which is set to increase with a skewer towards more elderly dependent people from BME groups with a particular support need.
- The data suggests an increase in those suffering with Physical, Learning Disability and Mental Health need in particular for females.
- Long-term projections show a greater proportion of people over 85 requiring some form of support (either care provided privately or by a local authority).
- There is a predicted increase in the number of people who are aged over 65 and are also carers providing unpaid care.

In our 2014 plan we also set out a high level analysis of long term conditions in the population and this has continued to be updated since, and has informed work on risk stratification. **(KLOE B2 ii)** This analysis is being used to guide the prioritisation of our work on integration of community services.

Urgent And Emergency Care Analysis

(KLOE B1 iii)
In broader terms we recognised that the urgent and emergency care system in Walsall was not working well for the people of the Borough or for the organisations responsible for health and social care services because:

- Too many patients were waiting too long for admission to hospital from A&E and the local NHS had not delivered the 95% 4 hour A&E waiting time standard since

July 2013.

- The hospital was running at occupancy levels that were too high to cope with peaks in admissions leading to too frequent use of areas such as Endoscopy for inpatients, moves between wards and discharges that were too rushed.
- The whole system was over-reliant on institutional care whether in hospital, short-term placements outside the hospital or longer-term placements.
- There was a growing problem affecting all organisations with increased demand for mental health support by older people with mental health difficulties.
- There were a large number of clinically stable patients (circa 100 out of 520 hospital beds) ready for discharge but unable to leave hospital quickly.

We were clear that we had a whole system problem that required a whole system solution involving all four partners.

Since then, our targets to reduce the rate of emergency admissions to hospital and the rate of permanent admissions to residential care have not been met. We have continued to experience the same difficulties and we have set out our latest response in the form of our most recent submission of the System Resilience Group Recovery Plan. This includes a diagnostic **(KLOE B2 i)** which identifies three key causes as follows:

Demand management:

- A continuing significant increase in emergency admissions to Walsall Manor Hospital (4.4% increase in 2015 compared to 2014, and an increase by 21% since 2012) see below:

	2012	2013	2014	2015
Walsall Healthcare NHS Trust	19,952	22,494	22,880	23,933
Royal Wolverhampton Hospitals NHS Trust	2,504	2,917	3,328	3,696
Other	3,483	3,404	3,778	3,849
Total	25,939	28,815	29,986	31,478

Annual Growth - Walsall Healthcare NHST	13%	2%	5%
Period growth - Walsall Healthcare NHST			20%

Annual Growth - All Hospitals	11%	4%	5%
Period growth - All Hospitals			21%

- Higher numbers of emergency ambulance conveyances; and
- Disorganised systems in the Emergency Department (finding from recent CQC Inspection of Walsall Manor Hospital).

Hospital flow:

- Inconsistent ward processes;
- Reduced focus over weekend;
- Inconsistent hospital discharge planning processes at ward level;

Supported Discharge:

- High numbers of ‘medically fit for discharge (MFFD)’ patients

- Discharge to Assess (DtA)' model too focussed on bed-based solutions
- Lack of alternative provision for complex patients
- 30% increase in permanent residential admissions between 2014/15 and 2015/16 has been mostly derived as a result of hospital discharge and mental health cases

We have continued to analyse demand and capacity flows across the system and we report a dashboard on a monthly basis to the System Resilience group **(KLOE B2 iv)**. The System Resilience Group Recovery Plan sets out ten high impact changes which are designed to bring our system **(KLOE B2 iii)** to achieving the constitutional targets for urgent care by June 2016. These are incorporated in to our Plan of Action (Section 4). They were derived following analysis of our system as set out in the 'High Impact Change Model for Managing Transfers of Care' issued by the Emergency Care Improvement programme (ECIP).

Learning from Local Work Programmes

The case for change for 16/17 is also informed by the learning from the work programmes that commenced in 14/15 & 15/16. The following progress has been made:

1. **Multi-disciplinary Locality Teams / Risk Stratification for Long Term Conditions**

What we said we'd do:
(KLOE B2 ii)
The objective was to implement a proactive coordinated integrated assessment and case management service. This supports bringing together health and social care workers who provide a rapid response assessment and subsequent on-going support to the most vulnerable older adult population in Walsall.

What we did:
In order to ensure the outcomes from the new investment were maximised, existing services and resources were re-modelled. This included realigning and investing in existing community services to enable delivery of an enhanced model of care which includes an assessment of risk of the frail elderly population and stratification of risk with a clear pathway of patient care delivered based on need.

The model of care includes an integrated "Wrap Around" approach to patient care through collaborative work between Primary and Secondary care and includes Frail Elderly Services within Accident and Emergency, a "Rapid Response" Service for patients who are sub acutely unwell, acute 'In-reach' to support expediting hospital discharge, medical outreach support and robust community nursing teams, attached to each of the 4 Primary Care Commissioning localities, with enhanced case management and transitional patient care. A dashboard of data showing levels of activity is shown below.

Community Health Services have been re-organised in to five locality teams that align with primary care across the Borough. Each team has implemented risk stratification for frequent flyers and those at high risk of admission since the summer 2014.

From September 2013 Community teams have been analysing data each month for patients who have been readmitted 4 or more times in the previous 12 months. This work

has been on-going until June 2015 when the sample was changed to patients who had been readmitted 2 or more times in the previous 3 months. The 4 or more admission work proved very useful and has helped to reduce avoidable readmissions for this cohort and also identified a population of patients whom despite community intervention require frequent acute intervention.

What we'll do next:
The plan is that Social care will now be integrated with community health locality teams by the end of March 2016 and work is underway to extend risk stratification to include social care issues. **(KLOE C6 iv)** There has been limited progress with integration of the community mental health teams for older people to date, but a business case for additional investment to further reduce emergency admissions is currently included in the CCG QIPP programme for 2016/17.

2. Rapid Response Service and Single Point of Access

What we said we'd do:
The objective was to develop a Rapid Response service and Single Point of Access to prevent patients being admitted into hospital if they become sub-acutely unwell and are safe to remain at home. The service is available for any adult (over the age of 18 years) if they are registered to a Walsall GP.

What we did:

The Rapid Response Team (RRT) was implemented from autumn 2014 with circa 130 referrals per month. The RRT have access to an extended range of professionals via Intermediate Care, and the Reablement Team which is led by Social Care.

The response by RRT is activated by a G.P, A&E or paramedic calling a single point of entry to alert the RRT that a patient requires immediate support. Alternatively, patients could be stepped up to the RRT from the Long Term Condition teams within the community.

The Rapid Response team have access to medical outreach support who will also visit patients within their own home environment to treat and stabilise patients who are sub acutely unwell. Medical Outreach is available weekdays to take referrals from GP's, Rapid Response Team and Community Matrons.

The rapid response team operates between the hours of 08:30-10:00pm over 7 days per week. The multi-disciplinary team consist of;

- 1wte general practitioner
- 4.8wte band 7 rapid response lead nurses
- 5.8wte band 6 clinical sister/charge nurses
- 2wte band 6 physiotherapists
- 2wte band 6 occupational therapists.

The Rapid Response team responds within a maximum 2-hour time frame to complete a comprehensive holistic assessment based on the principles of the comprehensive geriatric assessment, medication review and design of a sub-acute management plan.

The multi-disciplinary team review patients as required for a period of up 14 days as they improve to restore optimum independence and functional ability.

The Virtual Ward is an electronic data base, which is linked to Fusion and Lorenzo, of patients who are on the community nursing team's caseloads who are either at very high risk of hospital admission or have had an earlier than expected discharge or turnaround from Accident and Emergency.

The key aim of the Virtual ward is to care for acutely ill patients within the community to prevent avoidable hospital admissions and deliver care within patients own home environment. This may also facilitate a reduced length of stay in the acute hospital where appropriate care pathways are available outside of the hospital environment.

The ward serves as a communication hub ensuring the transition period from hospital/higher levels of care is safe and of high quality and patients are monitored and reviewed appropriately. It acts as a hospital at home where care is reviewed by multidisciplinary teams with discharge planning and optimising independence being an integral aspect of care.

Admission to the Virtual ward is determined by clinical/medical judgement and/or predictive modelling. Patients will remain under the care of the virtual ward for as long as their medical condition requires. It is anticipated this should be up to a period of 3 weeks however, it will be determined based on each individual patient's clinical needs. The number of patients supported each month is between 320 and 380 with a Length of Stay of up to 3 weeks. This means that over 5,000 people are supported each year on this pathway.

There is a single point of access for health services in each of the 5 Locality teams. All referrals for the related GP practices attached to each team are taken by an experienced clinician who will be able to direct the referral to the most appropriate service. There is a Borough wide single point of access available out of hours.

Activity across all of these schemes is captured each month in the form of a dashboard as shown below.

What we'll do next:

The Rapid Response/Virtual Ward and Single Point of Access work stream has successfully created an appropriate alternative to acute hospital care for those who an admission to hospital is unnecessary. The next phase of this work stream is to simplify the pattern of services to reduce complexity and fragmentation of 'Intermediate Care' services across both Health and Social Care to create a single pathway.

3. Frail Elderly Pathway / Service

What we said we'd do:

The objective was to develop a Frail Elderly Pathway in A&E to facilitate a timely turnaround of Frail Elderly Patients presenting at A&E who do not require an Acute hospital admission.

What we did:

Frail Elderly Pathway (FEP) nurses have been present in Accident and Emergency since March 2015 to arrange support at home for older people as a means of avoiding admission to hospital.

The success of this scheme has led to a further development whereby the FEP nurse team has been supplemented with additional capacity and skill mix to become a more comprehensive enhanced Frail Elderly Service (FES) spanning both acute and community. The enhanced FES provides MDT assessment/screening in ED including Consultant Geriatrician – a single model across hospital and community frail elderly pathways with rotational working of the staff – and availability of 8 beds in Ward 29 for 24 hour turnaround to prevent admission. T

The FES is linked to rapid response and the virtual ward. This enhanced service has been operational since 11th Janauary 2016. In the first week 88 patients were seen with 73 (83%) either being discharged to an appropriate community pathway same day or within 72 hours.

What we'll do next:

We will ensure that the Frail Elderly Pathway is aligned to future developments in Integrated Intermediate Care.

4. Support to Nursing Homes for Reducing Hospital Admission

What we said we'd do:
Develop a wrap around service to residents in Residential and Nursing homes to prevent unnecessary hospital admissions.

What we did:
The wrap around support to reduce admissions from Residential and Nursing homes was implemented from spring 2015.

1wte Band 6 Nursing Home Case Manager has been recruited to identify and undertake comprehensive holistic assessment of residents who are at high risk of hospital admission, develop a personalised care management plan and provide care co-ordination for an identified caseload. This role covers the 11 Independent Nursing Homes across Walsall. There are also 5wte Band 6 Case Managers who undertake the same activity in the c80 Residential homes across the borough of Walsall.

Whilst the community nursing teams do visit the residential homes for care delivery, the case managers for the residential homes will also deliver nursing activity and provide enhanced case management for the most complex patients in residential care who are at risk of hospital admission.

The case manager visits each nursing/residential home on a regular basis to:
1) Increase the number of early intervention/emergency passports in place.
2) Reduce the number of inappropriate 999 West Midlands Ambulance calls.
3) Reduce the number of patients being admitted into hospital inappropriately.
4) Improve access for Nursing Home staff to educate and training, in-order to enhance the quality and consistency of care that has been provided for patients and reduce

avoidable patient harms.
5) Provide clinical assessment and deliver nursing care.

The CCG has commissioned a separate contractual arrangement for GP cover to nursing homes whereby there is the equivalent of twice weekly 'ward rounds' to review each resident on a pro-active basis.

The Emergency Care Passport (ECP) is a shared care plan between the resident, West Midland Ambulance Service (WMAS), primary and secondary care. Should WMAS attend to a resident with an active ECP who is not acutely unwell and does not require hospital attendance or admission but requires further support in the home to prevent admission then WMAS will contact the rapid response via the single point of access. This has been fully implemented across all five locality teams.

What we'll do next:
We will continue to review and refine the service model to ensure continuous improvement.

5. Early Supported Discharge

What we said we'd do:

Commission a number of 'Discharge to Assess' beds for patients who need supported discharge but are unsafe to return to their own home

What we did:

40 Discharge to Assess beds were commissioned across 5 nursing homes from November 2014 with a social care support team.

By November 2015, the average LoS was circa 40 days which equates to 400 to 500 patients per year.

What we'll do next:

The contract for the Home from Hospital service has been fully utilised to date in 2015/16. One of the SRG Recovery Plan actions is to transfer half of this resource to a model of discharge to assess at home by reducing the number of beds commissioned from nursing homes from 40 to 20 and increasing the capacity of domiciliary care by 700 hours per week.

The Social Care Reablement Service is supporting between 75 and 90 people at any one time with intensive rehabilitation at home following hospital discharge. The average length of reablement episode per patient is 30 days. This equates to between 700 to 800 patients per year supported at home. This provides a baseline against which an additional investment of 700 hours from switching resource from the Discharge to Assess beds in nursing homes can be measured.

The re-procurement exercise to renew the framework contract (joint between Council and CCG) for the full range of domiciliary care services -including for support of hospital discharge – is continuing with a current contract award at end of March 2016, and

mobilisation from June 2016.

6. Ambulatory Care in the Emergency Department of the Hospital

What we said we'd do:
Develop ambulatory care pathways to reduce the demand for in-patient services.

What we did:
The Ambulatory Care Pathway went live in January 2015 and performance has varied since then. January and February saw consistent number around the 50 per week mark. A GP pilot was introduced in March 2015 where numbers initially went up to 55 – 60 per week and then dropped in April to the high 30's to 40's. This trend continued into May, with numbers in June around the 25/30 mark. The Consultant led service was re-established in July, where an immediate increase in numbers to the 50's was seen. Numbers since then have varied between 14 and 53 dependant on the acuity of patients presenting in ED.

What we'll do next:
Consultant Connect service will be implemented during Spring 2016 where GPs will have a designated telephone number to communicate with a Consultant before referral or admission to hospital. We will continue to review and refine the service model to ensure continuous improvement.

7. Delayed Transfers of Care

What we said we'd do:
Review the reasons for Delayed Transfers of Care and introduce a programme to reduce the number of people whose discharge from hospital is delayed.

What we did:
There has been a major effort to reduce the number and lengths of stay of patients on the Clinically Stable List from an average of around 80 patients to nearer 50.

The action to date has been based upon a set of actions that the Emergency Care Improvement Programme (ECIP) refers to as the SAFER Bundle (e.g. early discharge planning; ward and board rounds; discharge by lunchtime; trusted assessors, patient choice policy, etc). This practice has been extended to include the Clinically Stable numbers in the SWIFT Discharge Ward.

This has increased the need for social care reablement capacity and 300 extra hours have been mobilised from November 2015. DToC cases are a subset of the patients on the Clinically Stable List and so the plan for the Clinically Stable List represents the plan for DToC's

What we'll do next:
Continuing with the implementation of the EPIC SAFER Bundle and with additional capacity for social care reablement are included in the ten SRG high impact changes.

We will also undertake to understand the reasons for delays outside of the acute hospital setting and develop an action plan to address.

8. Aids/Adaptations and Assistive Technology (including Telehealth)

What we said we'd do:
Improve the Aids/Adaptations and Assistive Technology offer and increase the uptake of this.

What we did:

Telehealth was included in the Assistive Technology work-stream of the 2014 submission, together with telecare, community equipment and Disabled Facilities Grants (DFG's). Walsall provides a Telehealth monitoring and triage service, and at the time of the previous submission there were 166 service users who had been identified as having a long-term condition such as chronic heart failure or COPD. Reviews of cases during 2015 to ensure that the service was still needed by each service user reduced the number to 130 and this is the current level. We will continue to ensure that we are taking an evidence based approach to implementation of telehealth schemes.

There has been increased take-up of telecare and increased footfall in the Independent Living Centre since 2014. The Integrated Community Equipment Service (ICES) has maintained its high performance of delivery and recycling, and has faced additional demand for specialised nursing beds and mattresses. A full-time nurse was appointed to review over 800 cases of people with specialised beds and mattresses and provide a quality assurance function over prescribing practice and this reduced take-up to enable the service to remain within budget.

(KLOE C1 vi)
To supplement the award of £1,632,000 Better Care Funding (BCF) allocation for DFG's in 2015/16, the council allocated a further £750,000 for 2015/16 with a further sum of £340,000 for expenditure on carry-forward commitments from 2014/15. At average costs of £6,640 per DFG this allowed 422 households to be assisted in 2015/16. This level of funding is being continued in 2016/17.

Whilst applicants for statutory DFG's have up to 12 months to undertake their adaptations from grant approval, the vast majority are completed well within 4 months. Demand for DFG's is rising and without additional investment there will either be a need to increase thresholds for eligibility, or to introduce waiting lists. During 2015 the council met with housing partners and Registered Social Landlords (RSL's) to update them on the levels of demand (and future demand) for assistance. The meetings confirmed agreement to:

a) continued support by RSLs to minor works – 100% funded by RSL up to cost of £1,500;

b) funding for works up to £3,000 where the RSL funds the first £1,500;

c) DFGs for works that cost over £3,000

d) A new detailed guidebook for residents seeking adaptations (all costs)

e) New detailed leaflet for social sector tenants when their works are completed advising them of their and their landlords obligations.

f) Undertake more research on the mental wellbeing of DFG applicants.

The above actions have meant that through combined working we are able to help more people faster and at a lower initial capital cost to the council. New tenders have been sought for lifts and domestic ceiling track hoists to replace the current framework that ends in the summer. This new framework will again be open for all partners in the west midlands to join to secure lower unit costs for key adaptations.

Since last autumn the Housing Standards service has following the above consultation been undertaking research using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWEBS) of residents who have applied for DFGs, the WEMWEBS is being administered pre and post adaptation and results so far indicate: 73% have low mental wellbeing with 27% having medium (0% have high). The arithmetic mean results indicate a low well being for the 67 who have responded.

What we'll do next:
Review the Aids/Adaptations and Assistive Technology offer and pathways as part of a wider Prevention/Early Intervention offer.

9. Support for People with Dementia at Home (KLOE C6 iv)

What we said we'd do:
Improve the diagnosis rate for Dementia and increase the support offered to people with Dementia by increasing the number of Dementia Support Workers.

What we did:

At the end of March 2015, Walsall had achieved the national ambition for a diagnosis rate of 67% and achieved 68%. From April 1st 2015, NHS England introduced a new methodology for calculating prevalence to take into account the positive effects of healthy lifestyle interventions. However, Walsall's prevalence of dementia actually increased by 3% when five of its neighbouring CCGs from the same Local Area Team have their prevalence reduced between 12 and 24%. This was not reported by NHS England until mid-October 2015. The CCG challenged this data in October and despite several follow-up requests, has still not received a satisfactory explanation form NHS England.

Walsall's dementia diagnosis rate for December 2015 was 65.8%. This reduction was due to the increase in prevalence, deaths from the dementia registers and Memory Assessment Service performance. Since April 1st 2015, 130 people have been diagnosed with dementia and 106 have been removed from the registers due to death or moving out of area.

The Memory Assessment Service had a 25% reduction in staff which was not reported to the CCG and resulted in a waiting list of 152 people. The CCG issued a Contract Performance Notice and the Memory Assessment Service is due to be back on track by April 2016.

Commissioners have met with all four GP localities and encouraged them to use the tools provided to increase the diagnosis rate and specialist dementia support workers work with care homes to improve dementia care, end of life care with a view to reducing acute hospital admissions. Hospital dementia support workers continue to support care

improvements in the acute hospital and the dementia cafés support carers to reduce the strain of caring which can often lead to acute admissions.

The number of Dementia Support Workers (DSW's) has increased since the original 2014 submission with DSW's working within the hospital as well as community, and we have increased the number of dementia café's.

Care home support and end of life (DSWs) became operational in May/June of 2015. Their role is to audit the quality and understanding of dementia care for every Walsall care home (residential and nursing) using Care Fit for VIPs and then support the home with their individual action plan to improve the quality of care for people with dementia.

The DSWs have received specialist training in end of life care in association with St Giles Hospice who provide one of the DSWs.

What we'll do next:
We will continue to increase the diagnosis rate for Dementia and continue to develop the role of the Dementia Support Workers. Imminently, the DSWs are planning to introduce the Abbey Pain Scale and Namaste Care Programme (end of life dementia programme) to Walsall care homes.

10. BCF Planning

During the period 2014 to 2016 we have been working with our providers under the auspice of the Healthy Walsall Partnership Board to review our plans in the eight original work streams around the three primary headings of Demand Management (Staying well at home); Hospital Flow (Rapid Emergency Assessment and Treatment); and Supported Discharge (Getting Home Quickly and Safely).

We are in the process of reconstituting our plan from being centred on the eight work-streams that featured in the 2014 BCF submission to aligning with these four primary work-streams

Our overall aim for the Better Care Fund Plan in 2016/17 is to continue to work on the reconstituting of our work-streams around the four primary work-streams as identified by the Healthy Walsall Partnership Board and to build on and consolidate progress to date.

We will strengthen our programme management approach of the work streams that contribute to the overall plan and review our assumptions of impact of the work streams to ensure that the work streams will deliver the improvements across the Health & Social Care economy that we require.

We have a number of schemes and services that make up our whole system with a historical legacy of separate contracting arrangements. We will therefore explore the extent to which we can integrate the overall contracting and commissioning of all these services as an enabler to a higher level of integrated delivery and thus achieve more efficiencies

Whilst this plan focuses primarily on the 8 work streams, there are other important cross-cutting themes, such as data integration, which need to be integrated into the plan. These areas serve as 'enablers' for the work streams rather than schemes in their own

right, and so we will ensure that these are mapped clearly into the overall programme and that the same programme management approach is applied.

Our plan for achieving this is shown in the next section.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

(KLOE B1 iv) (KLOE B3 iv)
A timeline is included in section 4c. The priority actions for 2016/17 are as follows:

1. Continue to develop our implementation plan through the Healthy Walsall Partnership Board for the Better Care Fund and ensure alignment with the SRG Recovery Plan, the CCG Operational Plan in the context of the Walsall Health and Well Being Strategy (2016/17). The SRG High Level Actions that should align with the BCF Plan are as below.

SRG High Level Actions

Demand Management

- **Action 1**: Increase ambulance diversion via direct access for paramedics to patient GP at point of incident and enhanced access to Rapid Response Service.
- **Action 2:** Support care homes to prevent necessity for residents being conveyed to hospital unnecessarily.
- **Action 3:** Conduct therapy assessments in ED or within 24 hours of admission aligned with therapy support for discharge to assess at home.
- **Action 4:** Complete implementation of Frail Elderly Service (with social care and mental health input).
- **Action 5:** Improve processes within the ED including improved ED pathways between UCC, ED and AMU.

Hospital Flow

- **Action 6:** Complete Implementation of the 'SAFER' bundle consistently across all wards (**S**enior review, **A**ll patients have an expected date of discharge, **F**low early from assessment units, **E**arlier discharge, **R**eview long length of stay patients).
- **Action 7:** Increase number of weekend discharges.

Discharge

- **Action 8:** Implement individual case management of patients on MFFD longer than 14 days, aligned to DTOC guidance.
- **Action 9:** Enhance flow management in Swift Ward.
- **Action 10.** Revise Discharge to Assess pathway by reducing DtA beds in nursing homes (from 40 to 20) and transferring funds to create a home-based DtA model with social care reablement and specialist support, particularly for those with dementia.

2. Continue the development of multi-disciplinary teams at locality level comprising community health, primary care, social care, mental health and therapy workers based upon the locality structure of community health services; using a common approach to risk stratification and supporting frequent flyers and those most at risk of admission to hospital or care home with long term conditions. Expected outcomes: Reduced admissions to acute hospital settings, better outcomes for citizens, reduced cost of meeting better outcomes.

3. Implement a redesign of community mental health services to provide crisis response and recovery services 7 days a week linked to the development of the Integrated Intermediate Care (as below) and Locality Teams (as above). To ensure parity of esteem the 4 work streams fully incorporate Mental Health services within them and the Mental Health Trust is fully committed to working with the Integration Programme Board to develop new models of integrated delivery. (KLOE C6 iv) Expected outcomes: Reduced admissions to acute hospital settings, more timely discharge from acute hospital settings, better outcomes for citizens, reduced cost of meeting better outcomes.

4. Review and re-commission the current range of separate intermediate care services to become more integrated i.e. combines current/legacy specifications for social care reablement (bed and non-bed based); community health rapid response service; community health intermediate care service; CCG purchased intermediate care (i.e. spot purchased and Richmond Hall) and Mental Health Crisis Response with an explicit aim to utilise more of this capacity to support people at home – often in 'urgent' circumstances, and thus reduce hospital and care home admissions; (Complete in time for April 2017) Expected outcomes: Reduced admissions to acute hospital settings, more timely discharge from acute hospital settings, better outcomes for citizens, reduced cost of meeting better outcomes.

5. Develop a combined specification for a single point of access/referral to the full range of Health and Care services bringing together current access points in WHT, DWMHT and Walsall Council (again drawing together existing separate specifications). (Complete in time for implementation to take place from April 2017); Expected outcomes: Reduced admissions to acute hospital settings, better experience for users, reduced duplication & risk, reduced cost of delivery.

6. Develop a 'Local Digital Roadmap' IT solution to support real time access for front line workers in the MDT to access the critical parts of patient held records in primary care, community health, hospital, social care and mental health that enables them to provide/arrange effective support. This will also need to create an opportunity to track and monitor the movement of patients through the system and the outcomes in terms of the extent to which individuals are supported in their own homes, or are admitted, readmitted to hospital or to care home placements, etc. (Complete in time for implementation to take place from April 2017); Expected outcomes: Supports integrated delivery, reduces duplication, better patient experience.

7. Develop a single integrated approach to 'Resilient Communities' which broadens

and seeks alignment across prevention and early intervention interventions currently commissioned across health, social care, public health and housing. This includes Carers support, Aids/Adaptations and Assistive Technology, Housing, Community/Family Support Networks and Universal Services. This will include work with Walsall Strategic Housing Partnership to mitigate the impact of rising demand for DFG's and ensure that the provision of DFG's is tailored to those most in need, this to be delivered in partnership with the Registered Social Landlords in the Borough. (Complete in time for implementation to take place from April 2017); Expected outcomes: Reduced admissions to acute hospital settings, more timely discharge from acute hospital settings, better experience for citizens, better outcomes for citizens, reduced cost of meeting better outcomes.

8. Bring forward recommendations to the Health and Well Being Board to transfer funding and services between work-streams to support this process as appropriate. (June 2016)

9. Strengthen our programme management approach of the work streams that contribute to the overall plan and review our assumptions of impact of the work streams to ensure that the work streams will deliver the improvements across the Health & Social Care economy that we require. The work to develop the work streams and the Integration Programme Board includes strategic housing leads (KLOE C1vi). (June 2016) Expected outcomes: Expedite development and delivery of integration.

10. Extensive work force planning was completed in the development and implementation of the phase 1 work stream (Locality Teams). As the 16/17 work streams develop, we aim to bring a greater and more effective level of integrated working amongst this range of services leading to a point of maximum possible integration as soon as is practical and no later than 2019/20.

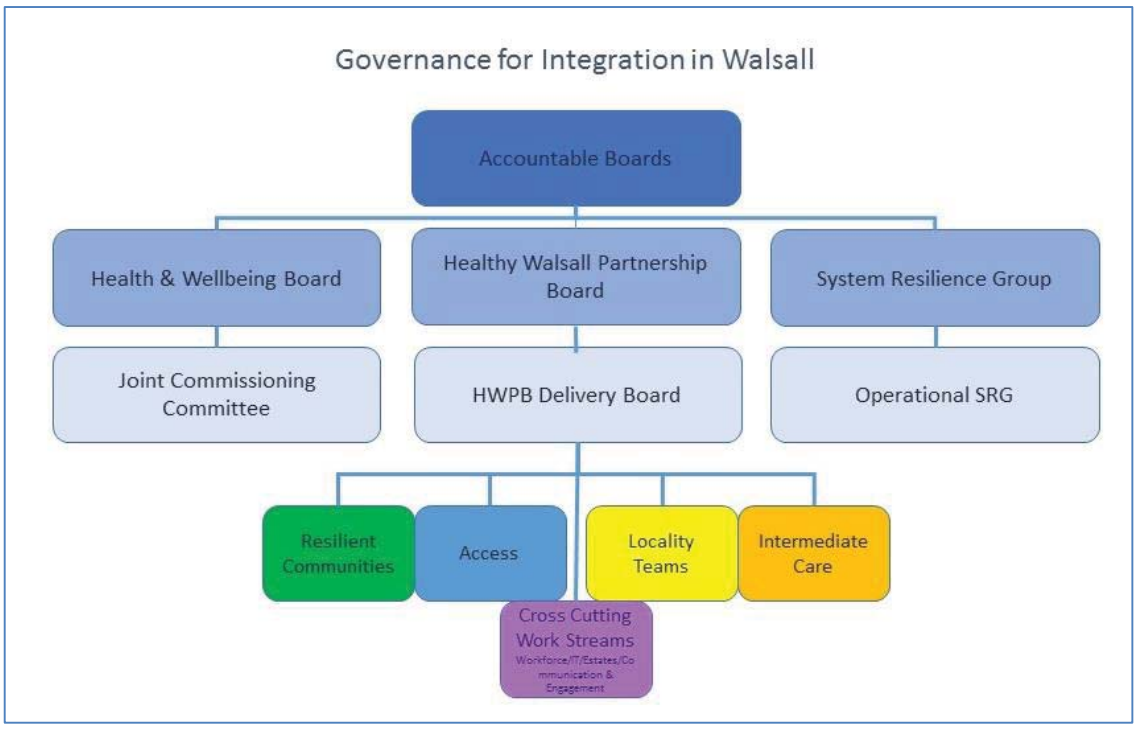
    We have agreed some general principles to guide our workforce planning and development and to ensure that work force development runs in parallel to the work stream development, a 'workforce' work stream has been developed which is expected to report to the Integration Programme Board (KLOE C1iv, KLOE B1ii).

b) Please articulate the overarching governance arrangements for integrated care locally

(KLOE B3 i)
Since the original submission in 2014, the Vulnerable Adults Executive Board (est. 2009) has been renamed the Joint Commissioning Committee (JCC) with a revised Terms of Reference that incorporates the role of the Partnership Board for the BCF Pooled Fund. The JCC reports directly to the Health and Well Being Board, and decisions of the Health and Well Being Board are ratified by the Governing Body of the CCG and Walsall Council Cabinet. **(KLOE C6 ii)**
Alongside the Health and Wellbeing Board there is a Healthy Walsall Partnership Board where commissioners and providers sit together to work in partnership. This Board provides the means for high level engagement with providers in developing the plan for the BCF, this includes representatives of the recently formed GP Federations (Palmaris

Healthcare Ltd and Walsall Alliance Ltd). **(KLOE C1iii)**

WHT and DWMHT Boards **(KLOE C6 iv)** also have a governance oversight role in



respect of their directly provided services. The governance arrangements are illustrated in the diagram below:**(KLOE B3 ii)**

c) Please provide details of the management and oversight of the delivery of the Better Care Fund plan, including management of any remedial actions should plans go off track

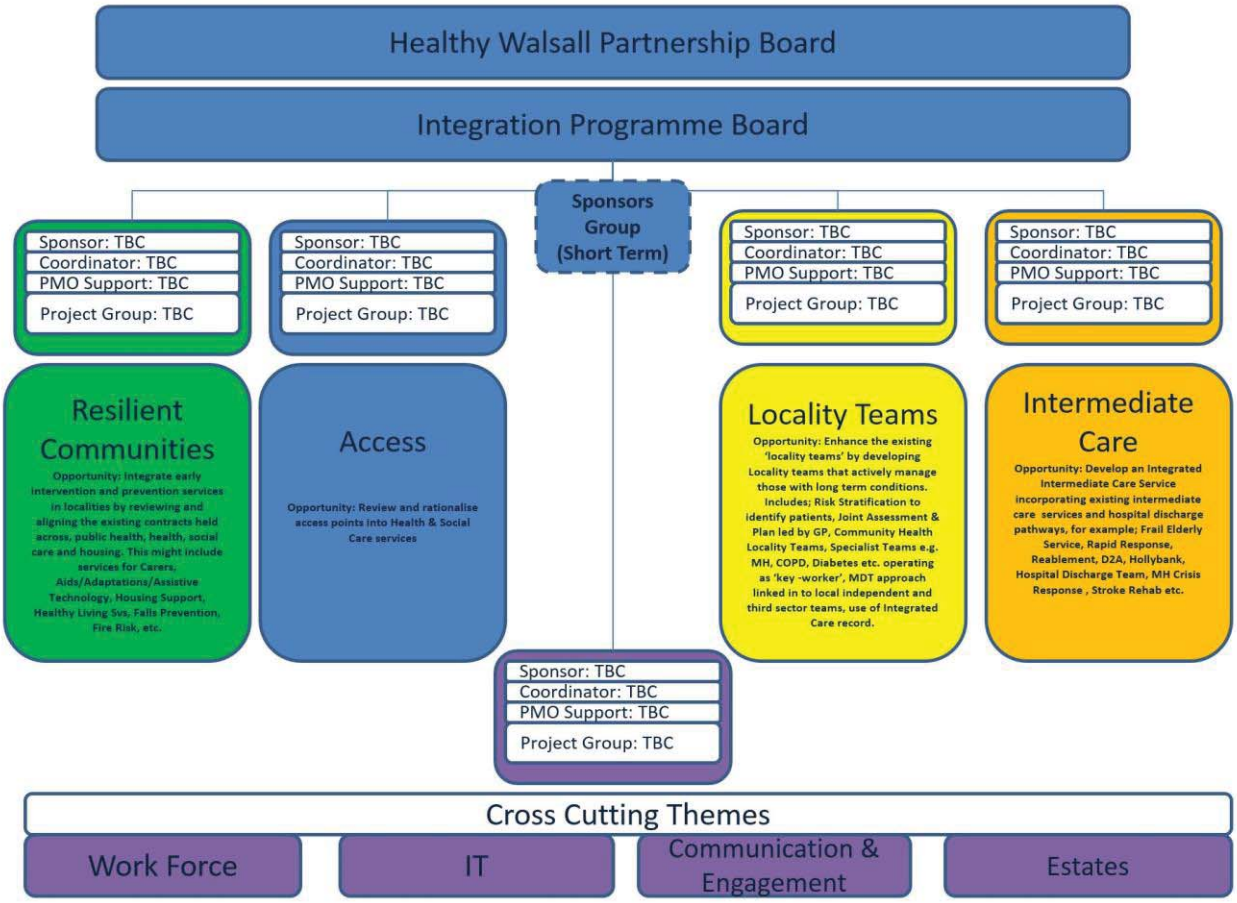
(KLOE B3 ii)(KLOE B3 iii) (KLOE C1 ii)
During 2015/16, the Healthy Walsall Partnership Board identified three specific delivery work-streams around the three primary headings of Demand Management (Staying well at home); Hospital Flow (Rapid Emergency Assessment and Treatment); and Supported Discharge (Getting Home Quickly and Safely).

Two workshops were held in April 2016 to discuss the priorities and future direction of the Healthy Walsall Partnership Board (HWPB). Both events had exceptional attendance from System Leaders across all partners in the Health & Social Care Economy in Walsall including Health & Social Care Providers, GP's, and Health, Social Care and Public Health Commissioners.

At the workshops, the HWPB considered the existing work streams that have worked to deliver the progress to date on the Better Care Fund Plan and agreed the 'Big Ticket' work streams for 2016/17. The HWPB also agreed the need to develop a more robust programme management structure to improve oversight and the pace of delivery of the big ticket work streams.

This Board provides the means for high level engagement with all providers in developing the plan for the BCF (KLOE C1iii)

The 4 ‘Big Ticket’ work streams and programme management structure agreed are detailed below.

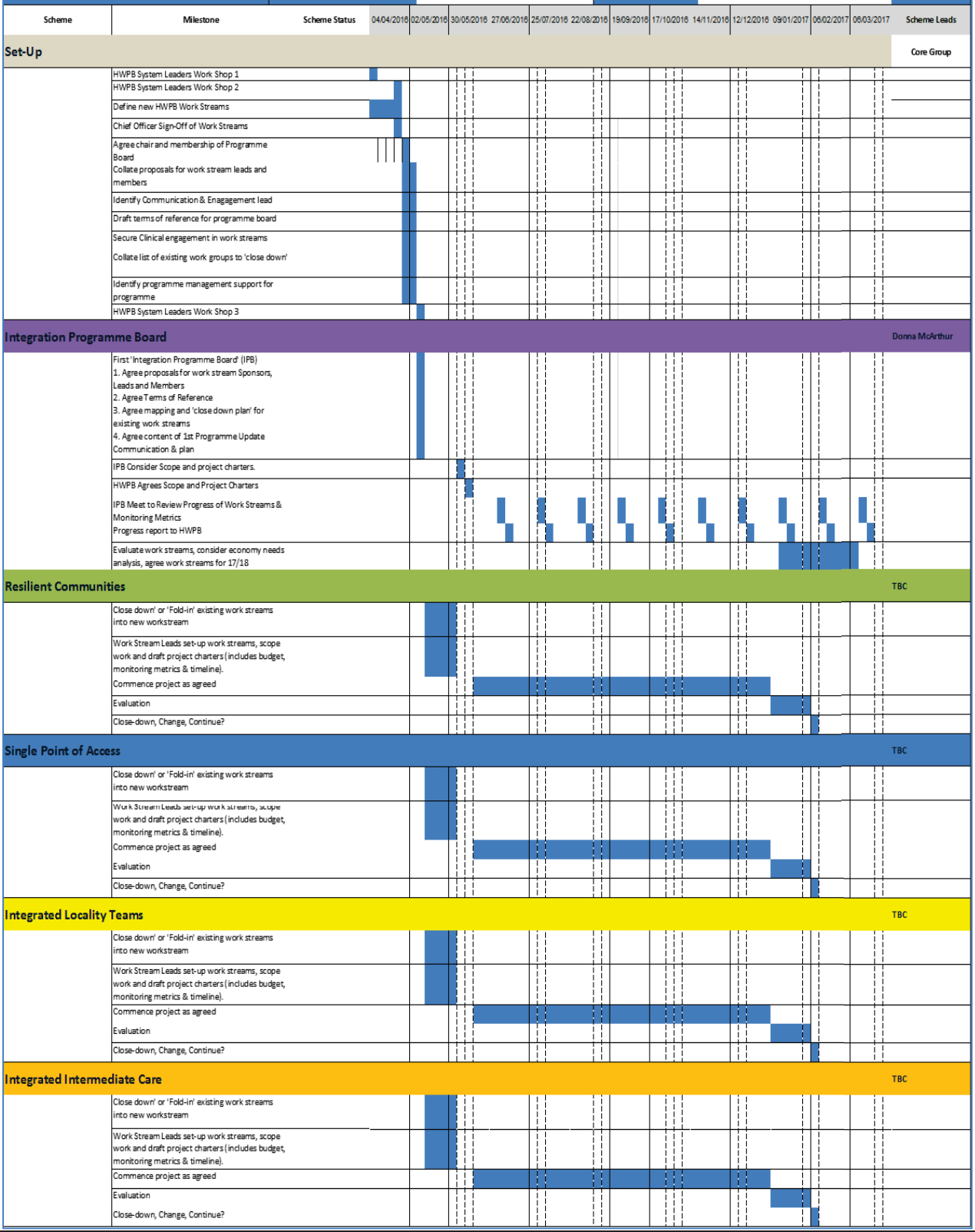


The membership of the Integration Programme Board includes:

- Director of Primary Care & Integration (CCG)
- Director of Commissioning, Performance and Transformation (CCG)
- Head of Integrated Commissioning (Adult Social Care)
- Consultant Public Health Medicine/Associate Director Public Health (Public Health)
- Director of Strategy and Transformation (Walsall Healthcare Trust)
- Director of People & Corporate Development (Dudley & Walsall MH Partnership Trust)
- Clinical Executive (CCG)
- Senior Housing Strategy Officer
- Chief Executive of Walsall Voluntary Action
- Patient Representative
- Communication & Engagement Lead
- Programme Manager

The HWPB transition plan is detailed below (KLOE B3iv).

	Date	04/04/2016	Group Name	Health Walsall Partnership Board	
	Originator	K. Allward	Version	v1.1	



5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**

(KLOE B3v)(KLOE B5 iii)

ID No.	Risk	Possible Outcome	Consequence	Likelihood	Rating	Mitigation	Owner	Residual risk score
1	Failure to reduce Emergency Admissions	Emergency Admissions continue current trends	Major	Likely	16	BCF Projects : SRG Recovery Plan; Integrated Intermediate Care; Frail Elderly Service;	SRG	9
2	Financial risk of failure to reduce Emergency Admissions	Financial risk to CCG under PbR/Tariff	Major	Likely	16	CCG Budget and BCF sum for contingency	CCG	12
3	Unable to implement 7 day working	Services not available 7 days per week	Major	Likely	16	Redesign of services through work streams with expectation of 7 day delivery where required	HWPB	9
4	Walsall Council unable to achieve budget savings due to rising demand for adult social care	Walsall Council would have to make adjustment to budgets impacting on other services.	Moderate	Likely	12	Ongoing monitoring and increased measures to reduce demand	WCC	9

5	Destabilisation of health care providers	NHS Providers would need to adjust financial plans and capacity	Moderate	Likely	12	Full engagement in BCF by provider units with early sharing of commissioning plans to identify risks and mitigations.	HWPB	9
6	Unable to achieve API data sharing	Unable to share patient data at front line	Moderate	Likely	12	Identify and pilot technical solution and then embed	HWPB	6
7	Workforce development unable to deliver integrated job roles	Unable to optimise MDT working	Moderate	Likely	12	Workforce Development plans	HWPB	6
8	Unable to achieve cultural/behavioural change that is required	Unable to achieve improved outcomes following change	Moderate	Likely	12	Workforce Development plans. Clear sign-up from Chief Officers and Communication engagement throughout organisation.	HWPB	9
9	Unable to improve outcomes from MDT working	Continuing duplication between agencies	Moderate	Low	9	Co-locate service providers and agree single muti-disciplinary approach	HWPB	6
10	Quality of NH/RH Home Care fails to meet agreed Walsall Council/CCG Standards	Increase in suspensions and restrictions	Moderate	Low	9	Joint quality improvement programme between CCG & LA	CQC Walsall Quality Board	6

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

(KLOE B5i)(KLOE B5ii)(KLOE C7i)(KLOE C7ii)

The sum of £1,050,000 was allocated in 2015/16 on a non-recurring basis as a contingency for not achieving a reduction in emergency admissions or for over-spend on Council budget.

The same amount (slightly increased to £1,061,550) remains as a contingency for continued increased emergency admissions (EA) in 2016/17. This sum allows for an increase of 712 emergency admissions against the original 2014 baseline (i.e. at £1,490 per EA) and any further increase in emergency admissions will be met from funding that

currently sits outside of the BCF. This funding will be held in the BCF and released in tranches to Walsall Healthcare Trust to fund additional expenditure directly related to any increase in emergency admissions. The Non Elective Admissions (NEA) activity value has been updated following the third 2016/17 Shared NHS Planning submission. Walsall's Plan target is now 32,417 NEA in 2016/17. These are Secondary Users Service, not Monthly Activity Return data as reported in 2015/16.

The Plan figure represents the gross NEA admissions figure before the application of QIPP Programmes agreed with Providers following the conclusion of 2016/17 contract negotiations. The CCG and the Council will continue to work collectively to refine and improve the agreed monitoring methodology

This forms the basis of the risk sharing agreement between the CCG and the Council. If the level of emergency admissions does level off, or start to decrease, then consideration can be given to investing this sum in out-of-hospital services to provide further support for reducing the rate of emergency admissions.

BCF Risk Sharing Arrangements
(KLOE C7iii)(KLOE C7iv)(KLOE C7v)
Our risk sharing arrangements are built upon our Section 75 agreement for the BCF which includes specific clauses around over and under spends of budgets.

The System Resilience Group receives a dashboard of weekly data used to closely monitor the performance of the system. The SRG Recovery Plan sets out the actions currently underway to achieve the A&E 4 Hour wait target on a sustainable basis from the end of June 2016.

Each of the 10 high impact actions have a specified individual lead and timescale for implementation. A monthly meeting of the SRG Operational Group oversees implementation of the plan reporting to a weekly meeting of the Chief Officers.

(KLOE B5 iv)
Financial performance of programmes in the Better Care Fund will be managed in line with financial regulations of each agency and this can be summarised as follows:

- Programme Directors will be accountable and held responsible for ensuring that their programme expenditure remains within the budget provision. Any change to required resources will have to be agreed by the Joint Commissioning Committee in line with the agreed Governance Arrangements;
- Program Leads will need to consider the full year effect of the commitments that they are making to ensure that the allocated budgets are not exceeded in future years;
- The program leads will be responsible for the budgets that have a number of pre-commitments. It will be essential that the Programme Leads gain assurance on any pre-commitments and to work with colleagues to ensure that the Better Care Programme resources are used effectively and efficiently;
- Program Leads will need to ensure that all of the commitments are supported by formalised contractual arrangements. These arrangements will include clear service specifications, financial commitments, contractual activity and key performance indicators (KPIs);
- All future commitments will need to be supported by a service specification and a

contract with clear financial values, activity targets and KPI's;

- For 2016/17 the resources will be held as a pooled budget under the governance of the Joint Commissioning Committee reporting to the Health and Wellbeing Board.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

(KLOE C6 iii)
The Better Care Fund Plan for 2016/17 aligns to and references the System Resilience Group Recovery Plan and is submitted as part of the CCG operational Plan. The plan is integrated across the health and social care economy with action elements across all agencies. **(KLOE C6 v)**

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

(KLOE C6 iii)
Our close working relationship between Walsall Council, the Clinical Commissioning Group, Walsall Healthcare Trust and DWMHPT, means that we have developed our plans for the Better Care Plan and the CCG 5 year strategic/2 year operational plans at the same time with a high degree of coherence. **(KLOE C6 v)** The Health and Wellbeing Board has recognised the importance of a coherent programme of change across the operational plans for the CCG and the BCF as a means of implementing the overarching Health and Well-being Strategy. Joint governance and performance reporting arrangements are in place to ensure this degree of coherence continues.

The Health and Well Being Strategy is strongly aligned to the Sustainable Communities Strategy within Walsall Council, which itself is a partnership document.

This Plan forms part of Walsall's 5-year Strategic Operating Plan being developed by Walsall Clinical Commissioning Group, and is in line with Walsall Council's Medium Term Financial Planning (MTFP) process.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

(KLOE C6 iii)
The CCG will take delegated responsibility for commissioning of primary medical services from April 2016 on the basis that it will contribute to the 5 year strategy priorities of:

- Improving male life expectancy and reducing the gap in mortality between the most deprived and the least deprived 10% of the population.

- Bringing care out of hospital closer to home through developing new models of primary care.

In particular the CCG wishes to explore the following areas:

- opportunities for co-commissioning specific priority pathways for long term conditions such as diabetes; Initially, this will take the form of review and transformation of the diabetes care pathway, tackling health inequalities in the deprived areas of Walsall. The CCG would like to explore designing enhanced services that build upon the instructions within the Directed Enhanced Services (National). Full delegation under co-commissioning arrangements will support this work and allow consideration to be given to the development of new contracts and new models of care that are innovative and deliver improved health outcomes and improved patient experience

- The CCG aims to strengthen current working relationships with NHS England and NHS Property Services so that primary care premises in Walsall are able to deliver high quality care in a safe environment.

7) NATIONAL CONDITIONS

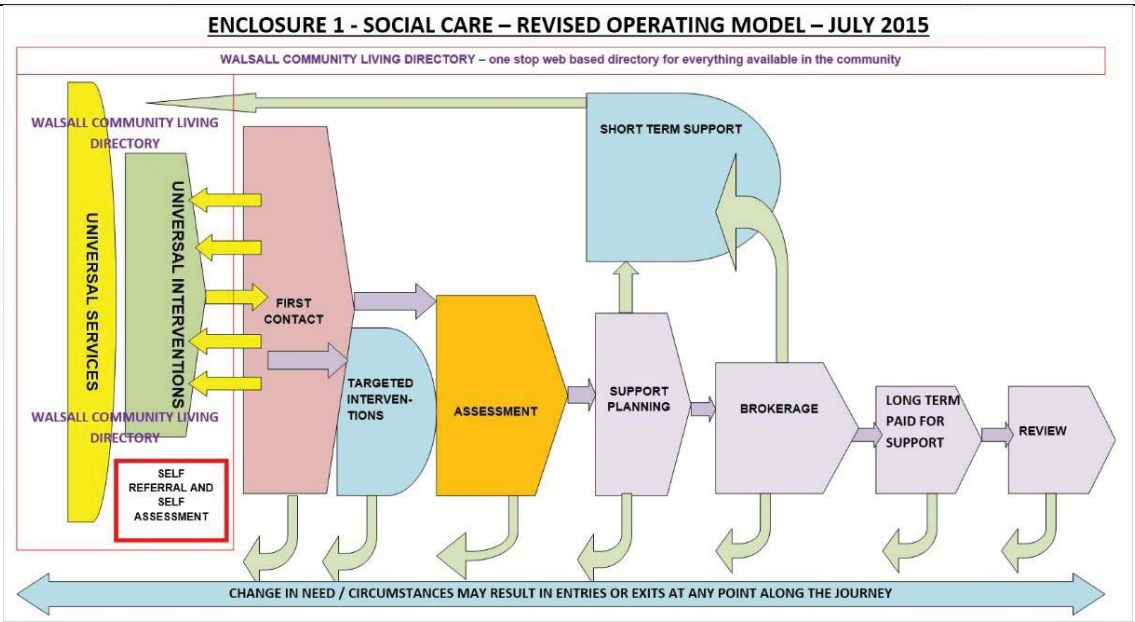
Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

(KLOE C2 v)
Our definition of protecting adult social care services relates to the extent to which we are able to sustain high quality social care services in line with rising demand and implementation of the Care Act (e.g. Increase support to Carers, Social Care Funding Reform, and prevention) whilst maintaining a balanced budget.

Delivery of our two primary objectives (improvement to multi-disciplinary local community services to support people at home; and integration of intermediate care services) will support the delivery of the Adult Social Care Operating Model, as illustrated below.



The model maintains investment in a range of prevention services including telehealthcare; community equipment; intermediate care and reablement; extra care schemes; neighbourhood support; information, advice and advocacy; dementia support; bereavement support; end of life care services; assessment and care management; and so on. This is in line with the requirements of the Care Act which are included in the scope of the BCF.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

(KLOE C2 i) (KLOE C2 vi) (KLOE C2 vii)(KLOE C2 viii)

During 2016/17 £11,956 million of Council Adult Social Care expenditure will have been transferred to the Council from the CCG via the BCF. This is a slight increase on the sum in 2015/16 and represents nearly 50% of the total BCF pooled fund. (Funding for DFG's is not included in this calculation because it is transferred to the Council as a grant directly from the Department of Health). This funding is invested across the sectors as follows:

£5.880 million	Council Services
£4.323 million	Private Sector
£1.486 million	Walsall Healthcare Trust
£0.267 million	Voluntary and Community Sector

(KLOE C2 ii)

This sum is significantly higher than the sum required to be allocated to social care from the mandated BCF minimum allocation.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

(KLOE C2 viiii)
The sum identified for protection of social care services is increased from £2.953m in 15/16 to £3.703m in 16/17. This is made up as follows:

£2.193 million	Short term care home placements
£ 760 million	Social care staff to support development of the locality teams model and the reablement pathway
£ 750 million	Switch of capital to revenue within sum allocated to DFG's to support Adult social care funding pressures

(KLOE C2 iii)
Walsall' share of the £130 million identified as support for implementation of the Care Act has been included in the local plan for the BCF. The ready reckoner calculates this as a total of £823,000 and we have agreed a sum of £840,000 which is made up as follows:

£400k	Additional social work posts
£ 73k	Independent Living Centre
£ 47k	Walsall Disability Forum
£ 39k	Information and Advice from Age UK
£220k	Dementia Support Workers
£ 61k	Home from Hospital support to carers

iv) Please specify the level of resource that will be dedicated to carer-specific support

(KLOE C2 iv)
The sum of £450,000 that was originally allocated to Walsall from the Carers Grant has remained within our BCF pooled fund and there is an investment programme for supporting informal carers.

v) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The Council's overall budget for adult care was developed with consideration of the Better Care Plan and underpinned by joint working with health partners. Walsall Healthcare Trust is reporting continuing financial pressures arising from increasing emergency admissions and Walsall Council has experienced a higher than planned rate of permanent admissions in to care homes and the £1,062 million in the BCF is unlikely to be sufficient to meet both of these issues. It is therefore likely that both Walsall Council and Walsall Council will face ongoing financial pressures during 2016/17.

The financial position of the Council for 2016/17 is for net growth to adult social care due to additional corporate support to address over-spends arising from increased demand for services, particularly a higher than planned rate of permanent admission to residential care, a significant number of which were to meet the needs of patients leaving hospital care and to support the uplift to care fees required in line with National Living Wage implementation.

The Adult Social Care Net budget for 2015/16 was £57.888m. For 2016/17 there are approved savings of £5.574m. There is then ongoing investment to cover existing pressures of £9.024m, and a further £4m investment to cover additional costs from rising

fee levels resulting from reprocurement of contracts with care homes and domiciliary dare agencies (including for Living Wage), plus a further one-off investment of £0.665m to support the implementation of savings. The outcome is a net cash limit for 2016/17 of £66.003m.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

(KLOE C3 i)(KLOE C3 ii)(KLOE C3 iii) (KLOE C3 iv)
Current seven day services include social care reablement and social work services, and has been incorporated in to the redesign of the Community Health Services which is now complete and aligned to primary care. Two Urgent Care Services are open seven days a week. There is also seven day access to primary care and rapid response intermediate care services to prevent hospital admissions and supported discharges. CCG commissioners have developed a business case to extend community mental health teams for older people to seven days.

A multi-disciplinary team to support week-end discharges has been in place since September 2014. This team holds 2 Consultant led MDTs at 08:30 and 13:00 to review and discuss a list of patients that will be able to be discharged following their intervention. A Weekend Discharge Co-Ordinator (from the Discharge Co-Ordinators Team) liaises with wards and fellow Discharge Co-Ordinators to compile the list of patients ready for the weekend. Therapy and Pharmacy services are incorporated in the arrangements, together with a focus on transport availability.

Standards 1 to 5 of the clinical standards forum for 7 day working were prioritised for joint review in the summer 2015 between the CCG and Walsall Healthcare Trust and a summary of the conclusions was as follows:

- Standard 1 Patient Experience: Patient involvement is evidenced in the Net Promoter Scores (NPS). Real-time feedback is not available and the trust has a performance display that includes partial evidence of what is required by the standard. The CQC Inspection conducted in September 2015 found that “Patients reported being involved in their care across the majority of services, with more work required in maternity services and the emergency department because with increased activity there was a decline in patient involvement”. Further work to assure that differences between weekday and weekend are understood is underway.

- Standard 2 Time to First Consultant Review: This is referred locally as the Early Senior Review and is operational from 8.00am to 22.00pm M to F and 8.00am to 14.00pm Sat/Sun. This mirrors the consultant on site presence within A&E. Our plan for coverage 24 hours 7 days is to establish the Early Senior Review Model with middle grades within the limited space available to have a dedicated area. There are no current plans to extend consultant cover within A&E.

- Standard 3 Multi-disciplinary Team Review: a multi-disciplinary team ward and board round processes are embedded at ward level, particularly in the MAU and medical

wards, with social care input included. These take place on Saturdays, but currently not on Sundays.

- Standard 4 Shift Handovers: An electronic handover process is in existence. Handovers take place twice per day, and utilise the electronic spreadsheet and data from clinical systems. Further work is needed to standardise across 7 days per week.

- Standard 5 Diagnostics: 7 day diagnostics are available for the majority of diagnostic services.

Ongoing review of progress against the 7 day working standards is built in to the contractual arrangements with WHT. The Trust has completed the self-assessment tool on the 7 Day Standards website, and further progress will be added in to the self-assessment following a further review during March 2016. This review will include progress with Standard 9.

Transformed, integrated services developed through the work streams will work to an expectation that appropriate access over 7 days is essential (KLOE C3i, C3ii & C3iii, and C3iv).

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

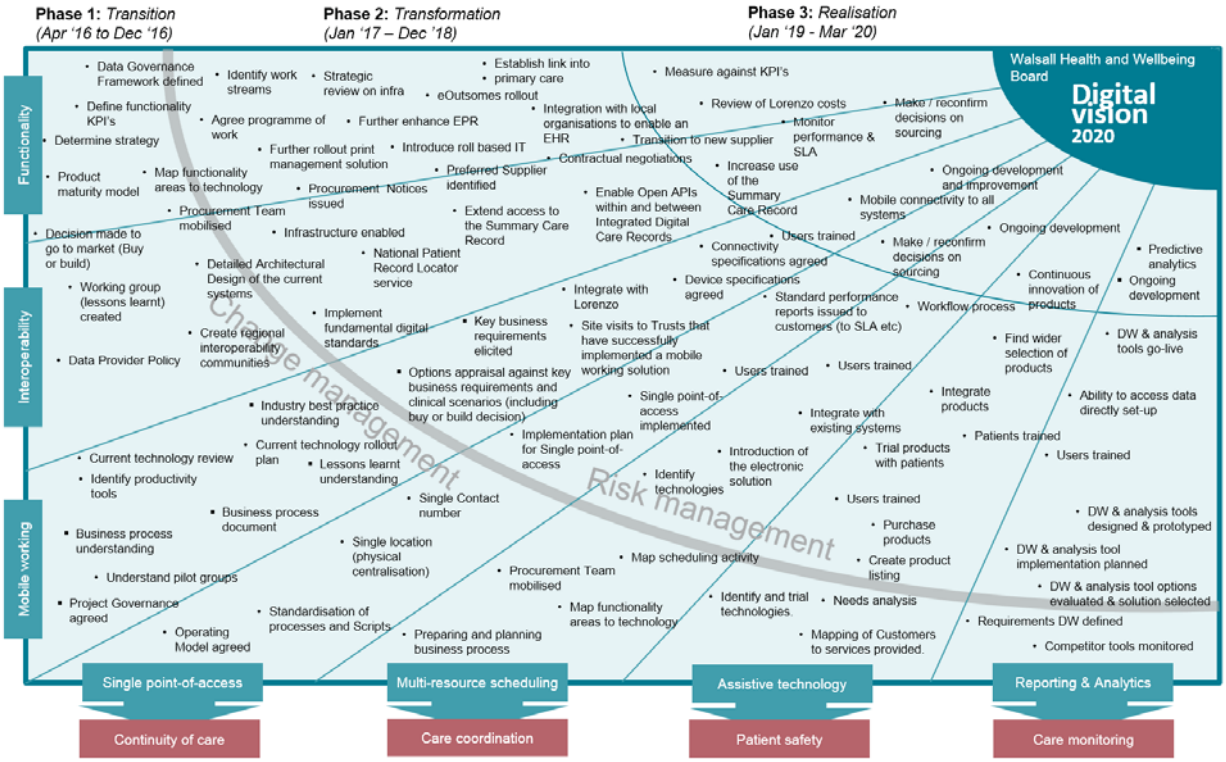
(KLOE C4 ii)
The use of the NHS number in all social care records has been in place starting from 1st April 2014. The NHS number has been the primary identifier since April 2015.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

(KLOE C4 i)(KLOE C4 iii)
The Walsall Health and Social Care 'System' Digital Roadmap emphasises the key themes of partnership working across Health and providers, creating new relationships with patients and co-creating new models of care to meet the challenges of increasing demand within resource constraints.

The Digital Roadmap below seeks to establish a more responsive system that allows Commissioners to design and implement enhanced service delivery models for our local population. This is underpinned by a significant increase in the use of technology to enable seamless information flows across the patient journey, help patients engage with their care plan, streamline communication and planning across health and service providers.

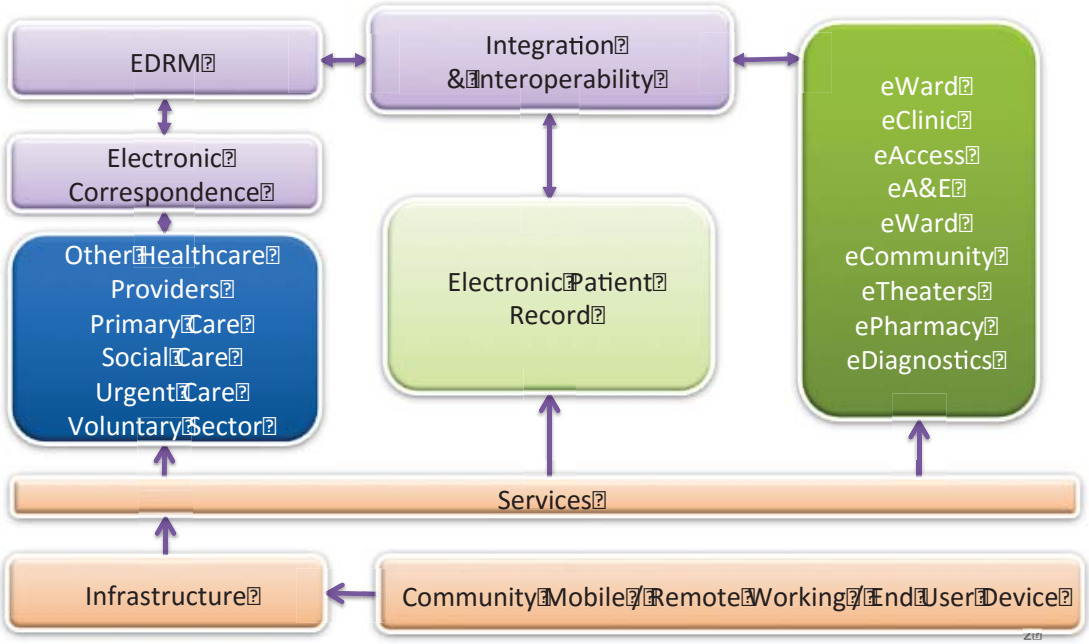
The following critical success factors will be implemented through the roadmap, as illustrated below:



Critical Success Factors

1. Mobile working: Improve productivity through continuous access to functionally rich clinical systems coupled with user-friendly productivity tools to reduce travel time and effort on non-clinical activities to enable more time to be spent with patients.
2. Interoperability (with data sharing): Platform to integrate with multiple IT clinical systems e.g. Fusion Clinical Portal, EMIS, Lorenzo, eChemo etc and provide connected/disconnected capability to enable continuous 'access' to patient data/functionality for mobile workers. The NHS number will be used as the primary identifier in all settings when sharing information.
3. Operational reporting: Accurate and time activity reporting with financial reporting across different health needs
4. Business analytics: Determine the cause of ill health and the development of total cost data for individual patients across multiple health and care settings

The application architecture underpinning the Digital Roadmap is shown below:



(KLOE C4 vi)

The Digital Roadmap will make available these critical success factors across the Walsall System and be the technical foundation for service integration, streamline processes and enhanced patient care through access to rich patient data from across systems and decision support to increase the focus on the patient needs. In addition, it will enable the Walsall system to become agile to design and implement new models of care.

(KLOE C4 v)

WHT Primary Care and Social Services enjoy more mature IT systems compared to the secondary care landscape. In particular, EMIS Web, deployed across all GPs, has rich functionality that has already enabled patient's to better engage with their health, for example:

1. Patients to have online access to their GP records contributing to a 'paperless' NHS (relevant for GP Practices only)
2. Patients should have access to an easy-to-use electronic prescription service (relevant for GP Practices only)
3. Patients should have access to online services, including extending online access to medical records and the availability of online appointments (relevant for GP Practices only)

The Walsall System IT services are working with partners and clinical leads to design and implement the enterprise architecture in line with current and future business requirements. Walsall is receiving support from the BCF National Support Team in the form of KPMG consultants who are assisting with further conceptualisation of the roadmap (i.e. to incorporate assistive technology, and single point of access). The agreed outcome of this worm will be An enhanced digital roadmap which will illustrate the following high level requirements:

- Functionality
- Interoperability
- Mobile working

- Multi-resource scheduling
- Reporting / analytics
- Single point of access
- Assistive technology

The Walsall Digital Road Map 2016-20 that has been created, supported by KPMG, has been widely accepted across the Health & Social Care Economy and robust implementation plans will be developed in the IT Work Stream reporting to the Integration Programme Board. We recognise that culture and behaviour change is a risk to delivery and as such has been entered on the risk register, this will be mitigated by ensuring that Chief Officers are fully signed up and work to remove barriers to change and that staff are engaged in the development & implementation.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

(KLOE C4 iv)
Where integrated systems are currently used e.g. Mental Health, appropriate IG controls are currently in place.

We are committed to ensuring that the appropriate IG Controls will be in place in the implementation of the Walsall Digital Roadmap. These will cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and requirements set out in Caldicott 2.

We have a data sharing agreement in place between Walsall GP Practices and Walsall CCG and this is being extended to include Walsall Healthcare Trust to support this.

A consultation, communication and engagement plan will be developed as part of the overall implementation plan to ensure that local citizens and staff are fully engaged and informed about the implications of this (KLOE C4v).

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

(KLOE C5 i)
Based on Walsall's GP population as at June 2015 there are 5,495 Patients (2% of 274,754) who are in our Risk Stratification cohort. Across the five integrated Localities in Walsall i.e. North, South, East, West and Trans. Of the 5,495 patients identified, some 3,830 local residents have been identified as in need of preventative care, which is 70%.

This has been accomplished through community nursing redesign, integrating community matrons with district nursing teams and including the recruitment of 7wte Clinical Case Manager Transition Nurses this has enhanced integrated work with the Primary Care Teams, hospital wards, social care and many other key stakeholders.

Through using risk stratification processes supporting identification of patients in GP Practice population who are older, frail and vulnerable with long term conditions and co-

morbidities.

To enhance the risk stratification model, work has progressed identifying patients who have had 4 or more admissions during previous 12 months To the Manor Hospital. This information has been used to provide “Wrap Around” services to support patients in their own home with a view to avoiding unplanned hospital attendance / admission. The team proactively manage this group of patients “the Virtual Ward” stepping up to the Matron, (who has advanced skills in disease management), when the patient is deemed unstable, or reviewing these patients on a more frequent basis to stop them going into crisis.

The clinical case manager role also includes providing an enhanced visiting / assessment regime throughout the period of transition. This period is defined as 30 days following a period of hospitalisation, or transfer of care from rapid response or intermediate care services. As discussed above, the recruitment of additional clinicians has supported work analysing and implementing case management for patients who have multiple long term conditions and have been identified as having frequent hospital admissions into the Manor hospital.

To validate outcomes for this admission avoidance activity we have rag rated patients who were/are known frequent admission patients. Rag rated Green if they have had no further admissions since community teams have been involved, Amber if just one more admission and Red if despite intervention they continue to be readmitted.

Figure 1 below illustrates the outcomes of this work commencing September 2013

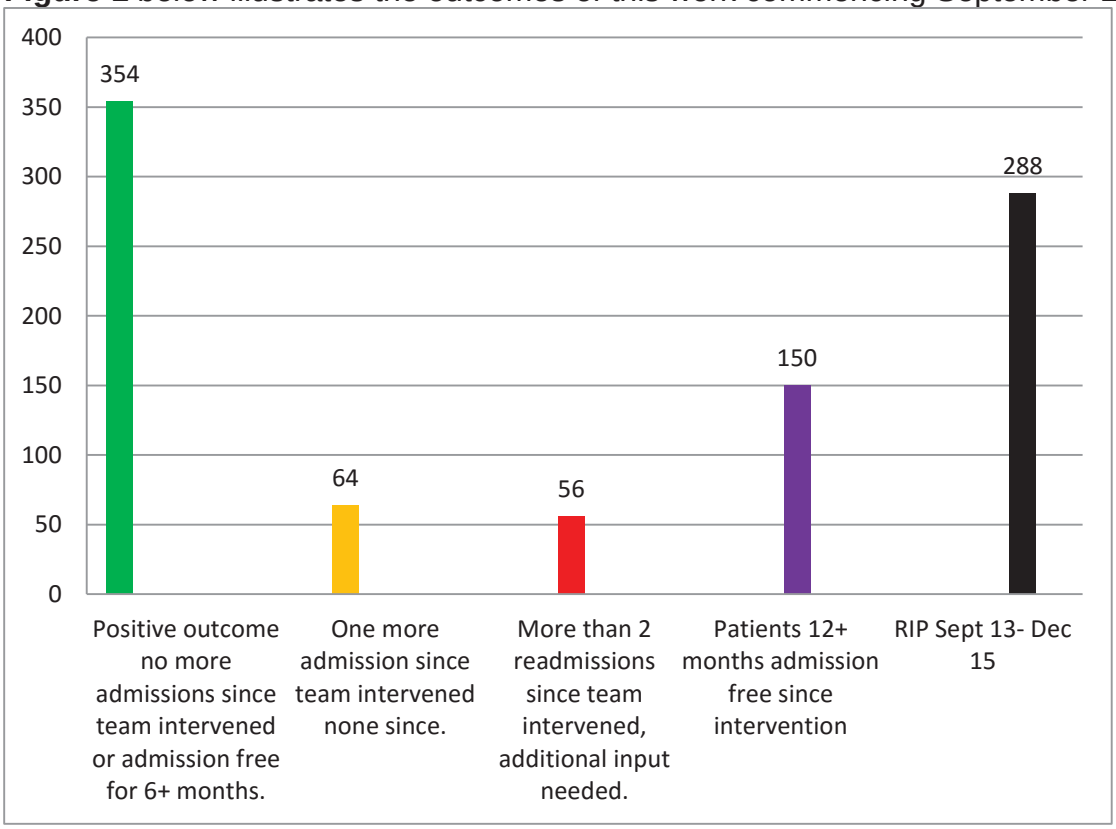


Fig 1 High user analysis – frequent hospital admission patients – following case management

In October 2014 WHT recruited to an admission avoidance administrative role who

continues to lead on the work described above and enhances this work further by focussing on patients whom have been readmitted within 30 days of discharge and frequent re-attendees into A&E.

Investment has also been utilised to recruit to a small team of Occupational Therapist and Physiotherapist who work with the community teams to provide assessment and interventions to keep patients safe in their homes and maximise their independence. The therapists are supported by therapy assistants who provide low-level equipment assessment and carry out therapy care plans under the care of the qualified therapists. This team are heavily involved with patients whom are deemed to be frequent hospital admission patients and are beginning to produce evidence of how their intervention is not only supporting reducing readmissions but reducing risk of falls.

(KLOE C5 ii)
The number of Dementia Support Workers (DSW's) has been increased since the original 2014 submission with DSW's working within the hospital as well as community, and an increase in the number of dementia café's. Care home support and end of life (DSWs) became operational in May/June of 2015. Their role is to audit the quality and understanding of dementia care for every Walsall care home (residential and nursing) using Care Fit for VIPs and then support the home with their individual action plan to improve the quality of care for people with dementia.

We have implemented a Local Enhanced Service (LES) for GP case management of people aged over 75 years old which is different from and complements the Direct Enhanced Service (DES) that has been implemented at national level. The DES requires GP's to proactively case manage a minimum of 2% of the practice's adult population (aged 18 and older), identified as being at the highest risk of avoidable admission.

Our LES is for GP's to review 50% of all patients over the age of 75 years old by April 2015 including elements that are not included in the national DES as follows:

- The need for medication reviews
- Dementia screening using 6-cit
- Checking that immunisations are up to date
- Health and social care assessment
- Long Term Conditions assessment

The requirement to review 50% of all patients over 75 years old is well beyond the requirement of the national scheme. This is undertaken in partnership with community matrons (CM) and undertaken in formal meetings with GP Practices and CM. Each patient is risk assessed and a care plan with a named key coordinator is generated. The DES was originally for practices to look at the top 100 patients but this has now been extended. We are currently examining the impact of this scheme during 2015/16 and we will make adjustments to generate a greater impact during 2016/17 depending upon the outcome of this monitoring.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The community nurse team provide case management care for frail elderly patients and proactively manage this group of patients in the "the Virtual Ward", stepping up to the Matron, (who has advanced skills in disease management) when the patient is deemed unstable, or reviewing these patients on a more frequent basis to stop them going into crisis.

All the most vulnerable patients who are on the community nursing caseloads are linked to an alert in Fusion (an electronic information sharing software available to GPs, community and acute health care services) which informs the community teams if patients are admitted to or attend A&E. The key coordinator liaises with the discharge co-ordinator to arrange the appropriate aftercare / treatment. This works in conjunction with the existing jointly provided Frail Elderly Pathway which identifies those patients in A&E and turns them around in the department, where appropriate, to a safe and effective discharge.

This scheme is undergoing continual review and improvement and further update on this will be available for the final draft submission of the plan.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

Our approach to risk stratification (as described above) has identified 3,830 local residents who are in need of ongoing preventative case management (which is 70% of those identified as at risk). Out of these 3,830 residents, 81% have been offered a Care Plan.
(KLOE C5 iii)(KLOE C5 iv)
We are aiming to increase this figure in 2016/17. A social care worker will have joined each of the community health locality teams by June 2016 following work to cross reference social care case management systems with community health case management and this will result in more effective joint assessment and case management.

All the most vulnerable patients who are on the community nursing caseloads are linked to an alert in Fusion (an electronic information sharing software available to GPs, community and acute health care services) which informs the community teams if patients are admitted to or attend A&E. The key coordinator liaises with the discharge co-ordinator to arrange the appropriate aftercare / treatment. This works in conjunction with the existing jointly provided Frail Elderly Pathway which identifies those patients in A&E and turns them around in the department, where appropriate, to a safe and effective discharge.

New National Condition Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care.

NB: Draft guidance states: Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund. This should be achieved by funding NHS commissioned out of- hospital services which may include a wide range of services including social care, as part of their agreed BCF plan (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16); or Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as

part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services; This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

(KLOE C7 i to iv)(See also Contingency Planning and Risk Sharing above)
Our plan for the BCF in Walsall has from the outset included a majority of investment in out-of-hospital services. Only £1,050,000 of the total of £23,977,000 in 2015/16 was allocated for acute hospital service as part of the financial recovery of Walsall Healthcare Trust following a continuing rise in emergency admissions. This represented only 4.4% of the total of the pooled fund.

The sum of £1,050,000 was allocated in 2015/16 on a non-recurring basis and so the same amount (slightly increased to £1,061,550) remains as a contingency for continued increased emergency admissions in 2016/17. This forms the basis of the risk sharing agreement between the CCG and the Council. If the level of emergency admissions does level off, or start to decrease, then consideration can be given to investing this sum in out-of-hospital services to provide further support for reducing the rate of emergency admissions.

New National Condition Agreement on a local target for Delayed Transfers of Care (DTOC) and to develop a joint local action plan

NB: draft guidance states: Each local area is to develop a local action plan for managing DTOC, including a locally agreed target. All local areas need to establish their own local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the nationally reported metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue. The plan should also demonstrate engagement with the independent and voluntary sector providers and show consideration to how all available capacity can be effectively utilised to support safe and effective discharge.

(KLOE C8 i to viii)
The focus of our work in Walsall has been to manage the total of clinically stable patients (i.e. medically fit for discharge) rather than just the smaller sub set of these that meet the criteria for a DToC. There is, therefore, agreement to not using the DToC fines mechanism and sharing the risks associated with DToC's. **(C8 v)** As part of the SRG Recovery Plan (see section 3 above) **(C8 vi)(C8 vii)** there is an action to reduce the number and lengths of stay of clinically stable patients in the hospital and this represents our joint plan for reducing the level of DToC's. **(C8 i)** This is based upon a comprehensive data analysis and diagnostic that was a requirement of the SRG Recovery Plan submission. **(C8 iii)** The SRG Recovery Plan trajectory **(C8 ii)** is featured as part of the CCG Operational Plan **(C8 iv)** and Walsall Healthcare Trust Recovery Plan following the outcome of the recent CQC Inspection.

Provider engagement to address DTOC's has been sought through the SRG and Healthy Walsall Partnership Board and all plans were jointly signed off between Commissioners and Providers.

During August and September 2015, joint work was undertaken to review and rebalance the reporting of Delayed Transfers of Care to ensure that the reporting systems were in line with the revised national guidance issued in July 2015 **(C8 viii)**. The outcome has

been a significant increase in the level of days reported from October 2015 onwards. We have therefore agreed quarterly targets for DToC's which are in line with the rebalanced figures as reported from Q3 onwards. These figures include DToC's reported from other hospitals, and a significant proportion of these are from Wolverhampton New Cross Hospital which runs a specialised rehabilitation hospital at West Park near the border with Walsall. Walsall Council is planning to provide designated social care support to West Park to reduce the level of DToC's from this hospital.

As a result of this work we are confident that the level of days being reported is now in line with the national guidance **(C8 viii)**. However, within this higher level of reporting, there is a comparatively high percentage of days attributed to social care compared to national and regional averages, and so further work is underway to ensure that this element of the reporting is correct and signed off each week by the Local Authority.

During the last three months both the number and lengths of stay of patients on the Clinically Stable list have reduced (from a previous level of circa weekly average of 80 to 100 to a current circa weekly average of between 50 and 70) and this will have had a similar level of knock-on impact to DToC's. This has happened during the same period as the change in reporting methodology and so we have set a target for 2016/17 (see planning template) which is to maintain our level of DToC's at the national average during 2016/17 **(KLOE C8 ii).**

Our plans to further reduce the level of DTOC follows the guidance of best practice issued by ECIP.

8) METRICS

What targets have been set against the BCF metrics and what was the rationale and data diagnostic for these targets?

Non Elective/Emergency admissions all ages: **(KLOE E1 i)(KLOE E1 ii)**

As described above there has been a close monitoring of the level of emergency admissions, as described in section 3 above. There has been a continuing significant increase in emergency admissions to Walsall Manor Hospital (4.4% increase in 2015 compared to 2014, and an increase by 21% since 2012) see below:

	2012	2013	2014	2015
Walsall Healthcare NHS Trust	19,952	22,494	22,880	23,933
Royal Wolverhampton Hospitals NHS Trust	2,504	2,917	3,328	3,696
Other	3,483	3,404	3,778	3,849
Total	25,939	28,815	29,986	31,478

Annual Growth - Walsall Healthcare NHST	13%	2%	5%
Period growth - Walsall Healthcare NHST			20%

Annual Growth - All Hospitals	11%	4%	5%
Period growth - All Hospitals			21%

The 2016/17 target will be based upon the BCF planning technical guidance which states

that the metric target "will initially be established by mapping agreed CCG level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in first draft CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach".

Although the work of the BCF to date has resulted in a positive impact on NEL's, the overall level is still increasing and so the pressure is sustained. Analysis has been undertaken to identify the reasons for admission and the work streams for 16-17 have been agreed as these appear to be the most likely interventions required to prevent acute hospital admissions. (KLOE E2iii)

Permanent Residential Placements for Adults age 65 years and over:
(KLOE E2 ii)(KLOE E2 iii)

The 2015/16 out-turn was 272 compared to a target of 232. Whilst there is a concerted effort to reduce permanent placements, the absence of suitable alternatives for those with dementia continues to place a pressure on this measure. Therefore, the target for 2016/17 has been set against the increased level of admissions in 2015/16 compared to 2014/15 at 302.

Reablement for Adults age 65 years and over: **(KLOE E3 ii)(KLOE E3 iii)**

The work of the BCF to date has seen a positive impact on this indicator. 16-17 plans will extend the scope and coordination of reablement pathways and therefore we are anticipating further improvement.

The target for 2015/16 was 80% to be at home 91 days after discharge, and this was achieved at the end of 2015/16, and so a target of 81% has been set for 2016/17.

9) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

(KLOE C6 ii)
In 2014 we set out a public engagement and communications plan and taking learning from the 'Hot-House' programme developed by Coventry and North Warwick's CCG regrettably, we have made limited progress with implementing this plan to date.

As part of the Integration Programme Board we have created a Communication and Engagement work stream that will be expected to develop a robust Communication & Engagement Plan which must include meaningful engagement and co-production with the public and report progress against this to the Board. To ensure additional oversight of this, a patient/citizen representative and the Chief Executive of Walsall Voluntary Action Group will sit on the Integration Programme Board and Health watch will be invited to sit on the overarching Healthy Walsall Partnership Board (KLOE C6ii).

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

(KLOE C6i)
Walsall CCG has incorporated the aims of the Better Care Fund in the commissioning intentions for the two main local NHS provider trusts (Walsall Healthcare NHS Trust (WHT), and Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT)).

All providers, Walsall CCG and Walsall Council have developed a shared view of the future shape of services, the impact of this Better Care Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made.

Our two main NHS providers have each signed up in their own right to our BCF Plan and are integral to the development of our plan via the Healthy Walsall Partnership Board.

ii) Primary care providers

(KLOE C6 i)
During the period since the original plan submission in 2014, we have seen the development of two GP led Federations (Palmaris Healthcare Ltd and Walsall Alliance Ltd) which will take responsibility for delivery of primary care services in Walsall. Both Federations are represented on the Healthy Walsall Partnership Board, and this has created an opportunity for meaningful engagement over the plan for the BCF.

iii) Social care and providers from the voluntary and community sector

(KLOE C1ii)(KLOE C6 i)(KLOE C8 ix)

Walsall Council and Walsall CCG are currently in the process of a joint re-procurement exercise to update framework contracts for care homes, and for domiciliary care providers. The specifications for the new frameworks incorporate the aims of the BCF for example:

- the care homes framework has specific lots for intermediate care, discharge to assess, and step downs in nursing homes with specific requirements to reduce conveyances to hospital based on wrap around support to care homes from community matrons and GP medical cover;

- the domiciliary care framework reconstitutes the market so that there is a small number of providers in each of six zones across the Borough and this will enable the Council to align capacity in the market with the fluctuations in demand coming through the hospital system.

Voluntary and Community sector organisations provide a range of services in Walsall and the funding for some of this is included in the Better Care Fund, for instance Home from Hospital schemes and Dementia Support services. These services will continue to receive funding from the BCF during 2016/17.

During 2015/16 there has been a major review of the support to the Voluntary and Community Sector (VCS) in Walsall by Walsall Council. This has concluded that there is a need to take a more strategic approach to local commissioning of the VCS providing greater accountability and clarity on how Council monies are directed to support third sector activity, and to appropriately resource a lead organisation that will be able to exponentially increase funding into the sector. Walsall CCG has historically invested some funding for partnership working with the Council to support the sector, and will continue to make an investment as a partner in this review.

The aim will be to support the sector to develop to the point where it is more able to contribute a higher level of partnership working to achieve the aims of the BCF Plan, by for instance supporting more frail elderly people to remain at home with prevention type services such as home visiting. As a first step in this journey, the CEO of Walsall Voluntary Action Group has been invited to join the Integration Programme Board & Healthy Walsall Partnership Board.

There has been comprehensive engagement with the social care market as part of the procurement process which has included our local plans for the BCF. Walsall Council has also published Market Position Statements as advice and information on commissioning intentions for providers

There has been limited involvement to date of the local RSL's with the development of the plan for the BCF. However, there is strong partnership work underway on development of well-being services which is strongly aligned to the plan, and this will be incorporated more specifically as part of the Resilient Communities work-stream under the HWPB (KLOE C1vi)

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets.

The implications for providers of the 16/17 Better Care Fund plan are unclear, however WHT and DWMHPT are committed alongside the CCG and Walsall Council to greater integration of hospital and community services to deliver care closer to home.

The main providers are fully committed to the Healthy Walsall Partnership Board where oversight of the Better Care Fund transformation work streams takes place. The providers have engaged fully in the debate around new models of care and are fully committed to the 4 'big ticket' work streams that have been agreed.

As service redesign delivers more integration of community services between community health, mental health, primary care and social care, our long-term plans include assumptions about a reduction in acute hospital activity for the population of Walsall. These assumptions will be developed further in the next stage of our detailed planning for service change from 2016/17 onwards.

(KLOE B5 iii) (KLOE C1 v)
At this stage, however, WHT and DWMHPT have asked the Walsall CCG and Walsall Council to recognise the risks for local providers related to this scheme in particular:

- the detail of the operational changes required to deliver our agreed objectives are currently in development;

- further joint work is needed to clarify the future capacity and workforce requirements across the system **(KLOE C1 iv)**

- some of the resources being committed to the Better Care Fund are already supporting services within the combined acute and community provider portfolio that are the subject of a major joint integration programme which is at an early stage;

- we are in the process of developing a shared model for the overall impact on WHT or DWMHT in sufficient detail to confirm that risks can be mitigated.

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

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:
  - 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:
  - High level narrative plan
  - 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**

Introduction

populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cell

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.

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

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

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

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

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

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 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.

4. HWB Expenditure plan

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

- 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 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

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
- 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
- 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
- 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
- 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

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:

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

CCG - HWB Mapping

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and

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 lcoal 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	**Walsall**
completed by:	Kerrie Allward
E-Mail:	kerrie.allward@walsall.gov.uk
Contact Number:	01922 654713
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Rose Martin

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:

Walsall

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	£2,895,213
Total Minimum CCG Contribution	£19,327,355
Total Additional CCG Contribution	£2,385,507
Total BCF pooled budget for 2016-17	**£24,608,075**

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	£524,627
Community Health	£8,821,433
Continuing Care	£0
Primary Care	£1,386,608
Social Care	£12,507,857
Other	£1,367,550
Total	**£24,608,075**

Please confirm the amount allocated for the protection of adult social care	
Expenditure	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
£3,703,000	This figure includes £760k that was originally winter pressure funding and £2.193m for Local Authority savings in prior years and £750k for 16/17 for Adult Social Care. The remainder of the expenditure is for existing services previously funded through section 256/ section 75

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool (**)

	Expenditure
Mental Health	£461,000
Community Health	£5,850,840
Continuing Care	£0
Primary Care	£44,000
Social Care	£0
Other	£1,074,685
Total	**£7,430,525**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£5,492,286
Total value of NHS commissioned out of hospital services spend from minimum pool	£7,430,525
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£1,061,550
Balance (+/-)	**£2,999,789**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	7,803	8,096	8,379	8,172	32,450
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	7,803	8,096	8,379	8,172	32,450
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	599.1

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 %	82.0%

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	827.4	803.7	851.0	846.8

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
Dementia Diagnosis	67.0

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
% of service users who are surveyed express satisfaction at the quality of the integrated services	92

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	Yes
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	Yes
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:

Walsall

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
Walsall	£2,145,213	Capital DFG element only
Walsall	£750,000	Capital ICES element (from DFG allocation)
<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	**£2,895,213**	

CCG Minimum Contribution	Gross Contribution
NHS Walsall CCG	£19,327,355
Total Minimum CCG Contribution	**£19,327,355**

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 Walsall CCG	£2,385,507	
<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	**£2,385,507**	

Total BCF pooled budget for 2016-17	**£24,608,075**

Funding Contributions Narrative
£1.342m for GP LCS payment has been moved from Community Health in 2015/16 to Primary Care in 2016/17 £1.061m for contingency has been moved from Acute in 2015/16 to Other in 2016/17 with the agreement that this funding will be released in tranches to WHT to fund additional expenditure related directly to increases in NEA rates; any reduction in NEA rates will enable this funding to be utilised to provide other services (to be agreed by Health and Wellbeing Board) to support further/ ongoing reductions in NEA rates.

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:
Walsall

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 schem 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)
A - LCS payment to GP's per head of OP aged 75+	Personalised support/ care at home		Primary Care		CCG			Private Sector	Additional CCG Contribution	£1,342,608	Existing	£1,358,000
A - Community Nursing In reach team	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£136,485	Existing	£135,000
A - Single point of access	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£222,420	Existing	£220,000
A - Frail Elderly Pathway OOH's A&E	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£77,847	Existing	£77,000
A - Enhanced case management approach in nursing and residential care	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£319,476	Existing	£316,000
A - Evening and Night Service	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	Additional CCG Contribution	£72,791	Existing	£72,000
A - Co-ordination of Personal Health Budgets	Personalised support/ care at home		Community Health		CCG			Private Sector	CCG Minimum Contribution	£21,840	Existing	£24,900
A - Co-ordination of Personal Health Budgets	Personalised support/ care at home		Community Health		CCG			Private Sector	Additional CCG Contribution	£160	Existing	£0
B - Development of Intermediate Care service including additional OT and	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£3,600,937	Existing	£3,426,788
B - Intermediate Care Services and Community Health Service within ser	Reablement services		Community Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£503,000	Existing	£503,000
B - Intermediate Care Services and Community Health Service within ser	Reablement services		Community Health		NHS England			NHS Community Provider	Additional CCG Contribution	£5,533	Existing	£0
B - Intermediate Care Services and Community Health Service within ser	Personalised support/ care at home		Community Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£655,000	Existing	£655,000
B - Intermediate Care Services and Community Health Service within ser	Personalised support/ care at home		Community Health		NHS England			NHS Community Provider	Additional CCG Contribution	£7,205	Existing	£0
B - Stroke Non bed based Home Care	Personalised support/ care at home		Community Health		Local Authority			Local Authority	CCG Minimum Contribution	£80,000	Existing	£80,000
B - The stroke association	Personalised support/ care at home		Community Health		NHS England			Charity/Voluntary Sector	CCG Minimum Contribution	£52,000	Existing	£53,000
B - The stroke association	Personalised support/ care at home		Community Health		NHS England			Charity/Voluntary Sector	Additional CCG Contribution	£572	Existing	£0
B - Walsall Cardiac Rehabilitation Trust	Personalised support/ care at home		Community Health		NHS England			Charity/Voluntary Sector	CCG Minimum Contribution	£330,000	Existing	£333,000
B - Walsall Cardiac Rehabilitation Trust	Personalised support/ care at home		Community Health		NHS England			Charity/Voluntary Sector	Additional CCG Contribution	£3,630	Existing	£0
B - Frail Elderly pathway	Personalised support/ care at home		Community Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£435,000	Existing	£380,000
B - Frail Elderly pathway	Personalised support/ care at home		Community Health		NHS England			NHS Community Provider	Additional CCG Contribution	£4,785	Existing	£0
B - Protecting Social Services - care act element additional staffing	Integrated care teams		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£400,000	Existing	£400,000
C - Bed Based Reablement (Hollybank)	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£1,310,262	Existing	£1,436,183
C - Integrated Discharge Team	Integrated care teams		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£176,253	Existing	£389,947
C - Walsall Healthcare Trust (Incl. Swift Unit)	Intermediate care services		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	£1,560,290	Existing	£1,560,290
C - Social Workers to support clients	Intermediate care services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£239,710	Existing	£239,710
C - Frail Elderly Pathway Additional Community Investment	Personalised support/ care at home		Community Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£600,000	Existing	£600,000
C - Frail Elderly Pathway Additional Community Investment	Personalised support/ care at home		Community Health		NHS England			NHS Community Provider	Additional CCG Contribution	£6,600	Existing	£0
C - End of life divisionary beds	Intermediate care services		Community Health		NHS England			Private Sector	CCG Minimum Contribution	£168,000	Existing	£200,000
C - End of life divisionary beds	Intermediate care services		Community Health		NHS England			Private Sector	Additional CCG Contribution	£1,848	Existing	£0
C - Spot Purchase of Intermediate Care Residential Services directly fund	Intermediate care services		Community Health		NHS England			Private Sector	CCG Minimum Contribution	£252,000	Existing	£328,000
C - Spot Purchase of Intermediate Care Residential Services directly fund	Intermediate care services		Community Health		NHS England			Private Sector	Additional CCG Contribution	£2,772	Existing	£0
C - ICT Beds at Richmond Hall Nursing Home	Intermediate care services		Community Health		NHS England			Private Sector	CCG Minimum Contribution	£382,000	Existing	£391,000
C - ICT Beds at Richmond Hall Nursing Home	Intermediate care services		Community Health		NHS England			Private Sector	Additional CCG Contribution	£4,202	Existing	£0
C - Blakenall Doctors Phoenix (Medical Cover to ICT Beds)	Intermediate care services		Primary Care		NHS England			Private Sector	CCG Minimum Contribution	£24,000	Existing	£22,000
C - Intermediate Care LES	Intermediate care services		Primary Care		NHS England			Private sector	CCG Minimum Contribution	£20,000	Existing	£20,000
C - Intermediate Care Services and Community Health Service within ser	Intermediate care services		Community Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£2,029,000	Existing	£2,029,000
C - Intermediate Care Services and Community Health Service within ser	Intermediate care services		Community Health		NHS England			NHS Community Provider	Additional CCG Contribution	£22,334	Existing	£0
D - Integrated Community Equipment Store - Council element	Assistive Technologies		Community Health		Local Authority			NHS Community Provider	CCG Minimum Contribution	£877,538	Existing	£877,538
D - Integrated Community Equipment Store - Council element	Assistive Technologies		Community Health		Local Authority			NHS Community Provider	Additional CCG Contribution	£462	Existing	£0
D - Community Equipment Service (CCG allocation)	Assistive Technologies		Community Health		Local Authority			NHS Community Provider	CCG Minimum Contribution	£608,000	Existing	£608,000
D - Independent Living Centre (CCG allocation)	Assistive Technologies		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£73,000	Existing	£73,000
D - Disabled Facilities Capital Grant	Assistive Technologies		Social Care		Local Authority			Local Authority	Local Authority Social Services	£2,145,213	Existing	£1,631,555
D - Integrated Community Equipment Store (ICES)	Assistive Technologies		Social Care		Local Authority			Local Authority	Local Authority Social Services	£750,000	Existing	£0
D - Integrated Equipment Service	Assistive Technologies		Community Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£423,000	Existing	£423,000
D - Integrated Equipment Service	Assistive Technologies		Community Health		NHS England			NHS Community Provider	Additional CCG Contribution	£5,093	Existing	£0
E - Dementia support workers (based in Manor Hospital), Dementia advis	Personalised support/ care at home		Other	Voluntary Sector	Local Authority			Vol sector	CCG Minimum Contribution	£220,000	Existing	£220,000
F - Psychiatric Liaison Team (Adults)	Personalised support/ care at home		Mental Health		NHS England			NHS Mental Health Provider	CCG Minimum Contribution	£153,000	Existing	£156,456
F - Psychiatric Liaison Team (Adults)	Personalised support/ care at home		Mental Health		NHS England			NHS Mental Health Provider	Additional CCG Contribution	£2,612	Existing	£0
F - Psychiatric Liaison Team (Adults) extended hours	Personalised support/ care at home		Mental Health		NHS England			NHS Mental Health Provider	Additional CCG Contribution	£57,627	Existing	£59,376
F - Psychiatric Liaison Team (OP)	Personalised support/ care at home		Mental Health		NHS England			NHS Community Provider	CCG Minimum Contribution	£308,000	Existing	£303,168
F - Psychiatric Liaison Team (OP)	Personalised support/ care at home		Mental Health		NHS England			NHS Community Provider	Additional CCG Contribution	£3,388	Existing	£0
G - Support to Carers	Support to carers		Community Health		Local Authority			Private Sector	CCG Minimum Contribution	£450,000	Existing	£450,000
H - Short term Care Home Placements 2014/15 budget saving and comm	Personalised support/ care at home		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	£2,193,000	Existing	£2,193,000
H - Short term Care Home Placements 2014/15 budget saving and comm	Personalised support/ care at home		Social Care		Local Authority			Private Sector	Additional CCG Contribution	£59,192	Existing	£0
I - Support for Older People and Disabled People via Third Sector	Personalised support/ care at home		Other	Voluntary Sector	CCG			Charity/Voluntary Sector	CCG Minimum Contribution	£38,860	Existing	£39,000
I - Support for Older People and Disabled People via Third Sector	Personalised support/ care at home		Other	Voluntary Sector	CCG			Charity/Voluntary Sector	Additional CCG Contribution	£140	Existing	£0
I - Walsall Disability Forum	Personalised support/ care at home		Other	Voluntary Sector	Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£47,000	Existing	£47,000
I - Home from Hospital Services required in the reablement pathway for p	Personalised support/ care at home		Community Health		Local Authority			Private Sector	CCG Minimum Contribution	£60,840	Existing	£60,840
J - Potential risk of unachieved reduction in admissions	Other	Contingency	Other	Contingency	CCG			CCG	CCG Minimum Contribution	£1,035,825	Existing	£1,050,000
J - Potential risk of unachieved reduction in admissions	Other	Contingency	Other	Contingency	CCG			CCG	Additional CCG Contribution	£25,725	Existing	£0

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:

Walsall

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:

Walsall

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:

Walsall

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 schem 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:
Walsall

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)

Contributing CCGs	% CCG registered population that has resident population in Walsall	% Walsall resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
			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 Birmingham Crosscity CCG	1.8%	4.7%	21,459	377	21,459	377	21,459	377	21,454	377	85,831	1,508
NHS Cannock Chase CCG	0.7%	0.3%	3,193	23	3,136	23	3,445	25	3,333	24	13,107	94
NHS Sandwell and West Birmingham CCG	1.6%	3.1%	15,364	238	15,800	245	15,593	242	15,941	247	62,698	972
NHS Walsall CCG	92.4%	90.7%	7,643	7,061	7,953	7,347	8,260	7,631	8,035	7,423	31,891	29,463
NHS Wolverhampton CCG	1.3%	1.2%	7,960	104	7,960	104	7,960	104	7,700	101	31,580	414
Totals		**100%**	**55,619**	**7,803**	**56,308**	**8,096**	**56,717**	**8,379**	**56,463**	**8,172**	**225,107**	**32,450**

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?	Yes
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£5,492,286

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 ****	£1,490	

Additional NEA reduction delivered through the BCF	£0						£0
HWB Plan Reduction %	0.00%						

* 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	480.0	469.2	608.7	599.1	The target for 2016/17 is based on forecast outturn for 2015/16. There were 226 permanent admissions of older people to residential and nursing care homes as at 31 December 2015.
	Numerator	234	232	301	300	
	Denominator	48,755	49,449	49,449	50,075	

*****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 %	77.2%	80.0%	81.3%	82.0%	The target for 2016/17 is based on forecast outturn for 2015/16. 81% of older people were still at home 91 days after discharge from hospital into reablement/rehabilitation services, as at 31 December 2015.
	Numerator	250	359	1,210	1,230	
	Denominator	325	449	1,489	1,500	

*****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	461.4	343.1	462.9	319.6	711.9	759.9	872.0	867.6	827.4	803.7	851.0	846.8	The measurement of this metric changed during 2015/16 and therefore the only reliable data we have is from October to December 2015. Our Plan for 2016/17 shows a slight improvement against this actual data from 2015/16.
	Numerator	971	722	974	676	1,498	1,599	1,835	1,835	1,750	1,700	1,800	1,800	
	Denominator	210,431	210,431	210,431	211,510	210,431	210,431	210,431	211,510	211,510	211,510	211,510	212,560	

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
Dementia Diagnosis	Metric Value	70.0	67.0	Changes to the prevalence calculation methodology resulted in a 3% prevalence increase and so a reduction in overall performance levels against an increased level of actual activity. Since 1st April 2015, 130 new diagnoses have been recorded, with 106 people removed from GP Dementia Registers due to moving out of the area or death. We have therefore set the target for 2016/17 at 67%.
	Numerator	2,451.0	2,105.0	
	Denominator	3,502.0	3,141.0	

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
% of service users who are surveyed express satisfaction at the quality of the integrated services	Metric Value	90.0	92.0	Our Better Care Fund Service User Satisfaction Survey for integrated services covers Hollybank Residential Care Home, the Community Intermediate Care team and Discharge to Assessment team. We have set up an electronic recording spreadsheet which captures the names and addresses of Service Users and compiles six domains of satisfaction with their integrated services. From the completed responses received so far, over 90% have been satisfactory. We have therefore set our target for 2016/17 at 92%.
	Numerator	1,350.0	1,380.0	
	Denominator	1,500.0	1,500.0	

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:

Walsall

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

Walsall Data Source Used - 15/16	MAR				
	Q1	Q2	Q3	Q4	Total
Walsall 14/15 Baseline (outturn)	7,177	7,415	7,781	7,503	29,876
Walsall 15/16 Plan	7,059	7,268	7,192	7,503	29,022
Walsall 15/16 Actual	7,574	7,539	8,297		23,410

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.

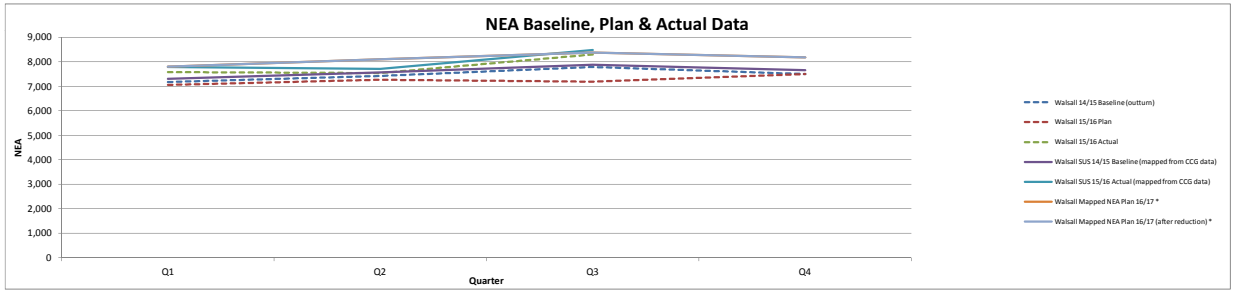
Walsall SUS 14/15 Baseline (mapped from CCG data)	**7,297**	**7,562**	**7,877**	**7,650**	**30,386**
Walsall SUS 15/16 Actual (mapped from CCG data)	7,781	7,702	8,485		23,968
Walsall SUS 15/16 FOT (mapped from CCG data)					32,142

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/

Walsall Mapped NEA Plan 16/17 *	**7,803**	**8,096**	**8,379**	**8,172**	**32,450**
Walsall Mapped NEA Plan 16/17 (after reduction) *	**7,803**	**8,096**	**8,379**	**8,172**	**32,450**

*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:

Walsall

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:

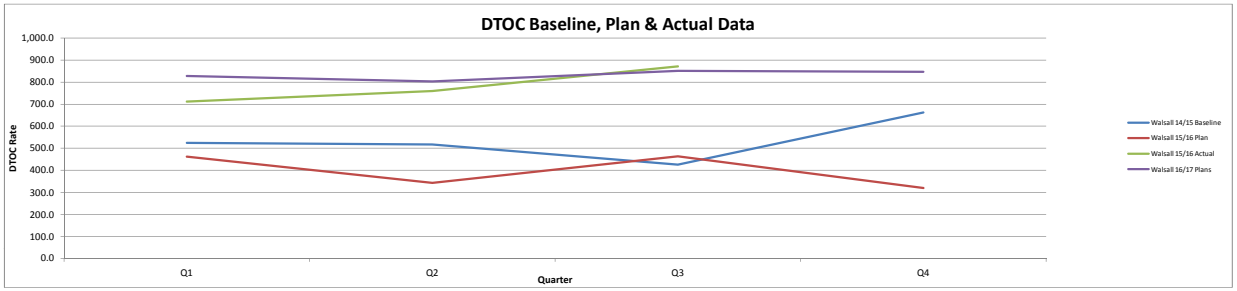
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4
Walsall 14/15 Baseline	524.8	517.7	425.1	662.0
Walsall 15/16 Plan	461.4	343.1	462.9	319.6
Walsall 15/16 Actual	711.9	759.9	872.0	

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.

Walsall 16/17 Plans	**827.4**	**803.7**	**851.0**	**846.8**



Template for BCF submission 3: due on 03 May 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Walsall

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	Yes	
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	Yes	
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%