

Swindon Borough Council

Health and Wellbeing Board

Wednesday, 25 May 2016

Committee Room 6, Civic Offices

At 2.00 p.m.

Contact Officers:

Vicki Yull (Committee Officer), 01793 463603, vyull@swindon.gov.uk
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AGENDA

- 1. Apologies for Absence**
- 2. Declarations of Interest**
Members are reminded that at the start of the meeting they should declare any known interests in any matter to be considered, and also during the meeting if it becomes apparent that they have an interest in the matters being discussed.
- 3. Public Question Time**
Please refer to the explanatory notes below.
- 4. Minutes** (Pages 3 - 10)
To receive the minutes of the meeting held on 9 March 2016.
- 5. NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan 2016-2021** (Pages 11 - 48)
- 6. Tackling childhood obesity in Swindon** (Pages 49 - 86)
- 7. Restorative Youth Services Plan 2016/2017** (Pages 87 - 108)
- 8. Dying Well Community Charter** (Pages 109 - 114)
- 9. Suicide Prevention** (Pages 115 - 158)
- 10. Mental Health Street Triage Update** (Pages 159 - 166)
- 11. Independent Domestic Violence Advisor Pilot Project - Update** (Pages 167 - 174)
- 12. Annual Report of the Education Strategy Board** (Pages 175 - 178)

13. **Health and Wellbeing Board Provider Forum** (Pages 179 - 182)
14. **Better Care Fund 2016** (Pages 183 - 370)
15. **Joint Commissioning Group - Minutes for Information and Comment**
(Pages 371 - 386)
16. **Health and Wellbeing Board Terms of Reference** (Pages 387 - 396)

Date of Despatch: 26 May 2016

Public Question Time - Swindon Borough Council remains committed to increasing its accountability to the public and to promoting active citizenship. 15 minutes will be allowed at the start of all Council meetings for questions to the Chair from the public about the work of the Committee (except for confidential matters, and matters relating to planning and licensing applications). We will give priority to those who submit questions in writing at least two days before the meeting. Questions must be relevant, clear, and concise. You may not use Public Question Time as an opportunity to make speeches or statements.

Questions in writing should be sent to the Committee Officer whose contact details appear on the agenda above, or to the Director of Law and Democratic Services. We will publish it, along with the answer, alongside the Minutes. The process associated with asking a public question is set out in the "Public Question Time at Council Meetings Protocol and Guidance" available from the Committee Officer named above or on the Council's Website at:

<http://ww5.swindon.gov.uk/moderngov/ecCatDisplay.aspx?sch=doc&cat=13338&path=0>.

Access Arrangements - The venue is wheelchair accessible and an infrared receiver hearing system is provided. If you have any special requirements to enable you to attend the meeting, or would like to receive any of the pages contained in this agenda in a larger print size, please contact the Committee Officer as soon as possible prior to the date of the meeting.

HEALTH AND WELLBEING BOARD

WEDNESDAY, 9 MARCH 2016

PRESENT:- Councillors David Renard (Chair), Brian Mattock, Fionuala Foley, Ray Ballman, Crouch (Vice-Chair), May and Angus Macpherson

Also in attendance were: John Gilbert (Chief Executive, Swindon Borough Council), Cherry Jones (Director of Public Health, Swindon Borough Council), Sue Wald (Interim Director of Adult Social Services, Swindon Borough Council), Tom Frost (Swindon Borough Council) and Mike Ash (Swindon Borough Council).

Apologies for absence were received from: Nicki Millin (NHS Swindon Clinical Commissioning Group) and Debra Elliott (NHS England).

44. Declarations of Interest

The Chair reminded members of the need to declare any known interests in any matter to be considered at the meeting. No declarations were made.

45. Public Question Time

At the invitation of the Chair, Ms Hayley Jackson submitted questions to the Board on behalf of a group of parents whose children are on the Autistic spectrum or who are awaiting diagnosis. The questions were regarding: what the Board will do to make sure these children's learning and medical needs are met and the diagnosis service developed to see children at the earliest point possible; how the Board will develop services that will address these issues; if the Board will consider using other professionals within Swindon to do diagnosis and enable these to be recognised as viable routes to services within the town; and if the commissioners will meet representatives of the parents to discuss this further.

The Chair thanked Ms Jackson for her submission and invited the NHS Swindon Clinical Commissioning Group (CCG) to respond.

Gill May, Executive Nurse at the CCG, confirmed that these issues have been identified as concerns. Terms of Reference have been drafted to undertake a full review of children's services and this area has been identified as the first priority area within that review. The Terms of Reference can be circulated upon request, and the CCG will welcome their input on how parents and children can be involved with the review.

The following matters were raised by Board members during discussion:

- The acceptable waiting time as identified within the CCG Constitution, and how to reduce waiting times whilst ensuring that assessments are still comprehensively done.
- Representations made by members of the public to the two Swindon MPs regarding waiting times, and the request from the MPs for a briefing with the CCG to help resolve concerns.

Resolved – That the minutes of the meeting held on 9 December 2015 be confirmed as a correct record.

Indices of Deprivation 2015

The Board considered a report providing a summary of the Indices of Deprivation 2015, focusing on data and results for the Swindon Health and Wellbeing Board area. Approval is required from the Board to make a suite of reports, data and analyses available on the Joint Strategic Needs Assessment (JSNA) website. Using this data, the Council and its Partners will also be able to understand communities better, target resources, plan and monitor services, and understand the relationship between deprivation, behaviour, service utilisation and outcomes.

Tom Frost, Senior Public Health Intelligence Analyst at Swindon Borough Council, introduced the report. It was noted that the pockets of severe deprivation across Swindon have not really changed over the last 15 years and that the results from the data produced by the Department for Communities and Local Government for 2015 showed that the focus in Swindon had been on the right areas, and also where there was more to do in the future.

Following the presentation of the report, Board members discussed the matters raised, including:

- Ways of making the information available to members of the public in a format that was easy to understand and interpret.
- The lessons learnt from interpreting changes over time, and identifying ways to address subsequent issues.
- Ways to utilise the data at locality level to generate interest and momentum by highlighting ward issues.
- Using the data to inform community discussions to help improve local areas.
- The level of detail currently available within the data, and future plans for analysis of the data to identify issues and problems.
- The potential for analysing specific gradients of deprivation in an area.

Resolved – (1) That the contents and main findings of the summary report attached at Appendix 1 to the report and the other associated reports and resources be noted.

(2) That the report and its findings as the preferred evidence base for measuring and understanding area deprivation in Swindon be adopted.

(3) That the reports, data and analyses through publication on the Joint Strategic Needs Assessment website be promoted.

(4) That the dissemination of ward 'packs' to staff and members working at a local level be approved.

Joint Strategic Needs Assessment Summary 2015-2016

The Board considered a report regarding its statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Swindon. The JSNA must describe the current and future health and wellbeing needs of the people of Swindon and is the principal work stream to inform the Health and Wellbeing Strategy. The Swindon

JSNA is an iterative process led by Swindon Borough Councils public health team and involving a wide range of stakeholders. The JSNA also informs decisions about how services are commissioned and designed.

Tom Frost, Public Health Senior Information Analyst at Swindon Borough Council, introduced the report and noted that the 2015/16 JSNA Summary, attached at Appendix 1 to the report, provides an overview of the current and future health and wellbeing needs of people in Swindon and provides an update to the 2014/15 JSNA Summary published in January 2015. It collates evidence and intelligence from previous JSNA topic reports, the Public Health Outcomes Framework, and a range of other local and national data sources. He confirmed that an additional page for equalities has been included, and that attempts have been made to ensure the data is more accessible for general readership.

Following the presentation of the report and the JSNA Summary in Appendix 1, Board members discussed the matters raised, including:

- The challenges identified as a result of the process such as addressing obesity amongst 11 year olds, or inequalities in the life expectancy of men from differing social backgrounds, and the need to focus resources on key areas.
- The work with MOSAIC data and Newton Europe, and the need to use targeted communication with different members of the public to help drive changes in their behaviours.

It was agreed that the App for the current Public Health England 'One You' campaign aimed at 40 – 60 year olds would be publicised in the Member's Bulletin.

Resolved – (1) That the Joint Strategic Needs Assessment Summary report for 2015-2016 attached as Appendix 1 to the report be noted.

(2) That its use in commissioning and strategy preparation, including the Health and Wellbeing Strategy, be endorsed.

49. Children and Young People - Best Start Joint Strategic Needs Assessment

The Board considered a report regarding the findings of the Children and Young People Best Start Joint Strategic Needs Assessment (JSNA) which looks at available local and national data to describe the current picture with regard to Children and Young People and early years (0 – 4 year olds) in Swindon. The JSNA is part of a suite of documents to understand the needs of children and young people in Swindon, and the Bulletin attached at Appendix 1 to the report provides a brief summary of the full JSNA which is a comprehensive and detailed analysis of all aspects of the first five years of a child's life and the influences on this.

Cherry Jones, Director of Public Health at Swindon Borough Council, introduced the report. The full JSNA document is around 300 pages and there are some data protection issues which may affect its ability to go into the public domain. Partner organisations can request access to the information if they would find it useful however. The Board noted that some service changes may be required to fulfil the population needs in Swindon because of the number of births. Focus groups have also been held with service users and providers which helped identify some high impact areas. The JSNA has also identified 19 specific recommendations under

these six early years high impact areas, as set out in the report. A multi-agency forum will be established and tasked with monitoring these.

Following the presentation of the report, Board members discussed the matters raised, including:

- The usefulness of the full 300 page JSNA as a resource for professionals to dip into.
- The Council recently recruiting to a Strategy and Development post, and how this post will be creating the scope for the early help strategy which is broader than just under five year olds.
- Historical service changes being used as a good baseline from which to identify progress.

Resolved – That the recommendations identified in the Children and Young People Best Start Joint Strategic Needs Assessment attached as Appendix 1 to the report be noted and agreed.

50. Swindon and Wiltshire Strategy to reduce Domestic Abuse 2015-2017

The Board considered a report regarding the 2015 – 2017 Swindon and Wiltshire Strategy to reduce Domestic Abuse, and how the Swindon and Wiltshire Community Safety Partnerships are committed to reducing the prevalence and impact of domestic abuse in local communities.

Mike Ash, Head of Housing and Community Safety at Swindon Borough Council, introduced the report. He noted that they are seeing a 45% return of people who have been in a multi-agency risk assessment conference before, and that five priorities have been identified within the Strategy to tackle domestic abuse. Ways of working with perpetrators are also being looked at.

Following the presentation of the report and the Strategy attached at Appendix 1 to the report, Board members discussed the matters raised, including:

- Going forward, tackling domestic abuse is a focus within the Chief Inspectors plans for the Police.
- The future funding of the Independent Domestic Violence Advisor who works in surgeries and at the hospital with victims of abuse. It was agreed that a report on this work will be presented to the May meeting of this Board.
- The difficulties of managing domestic abuse situations where reporting can sometimes make the issue worse.
- The pressures of demand on the service areas involved and the importance of partner organisations to work together and share information.
- The announcement by the Home Secretary regarding £18m of funding being available to help tackle domestic abuse.
- The rise in child to parent abuse, and the need to raise awareness amongst specialists to help identify possible cases of abuse.
- The importance of and benefits from utilising the learning points from previous incidents.
- The widening access to personal and sensitive information through electronic access to healthcare records and the potential for this to be abused.

Resolved – (1) That the 2015 – 2017 Swindon and Wiltshire Strategy to reduce Domestic Abuse be approved.

(2) That the NHS Swindon Clinical Commissioning Group be recommended to adopt this strategy which was adopted by Swindon Borough Council Cabinet on 9 December 2015.

51. Swindon Clinical Commissioning Group Operational Planning 2016/17 - 2020/21

The Board considered a report regarding Phase 1 of the NHS Swindon Clinical Commissioning Group (CCG) transformational agenda for 2016 – 2021 and the steps required to deliver the Five Year Forward View Vision.

Dr Peter Crouch, Clinical Chair at NHS Swindon CCG, introduced the report. He noted that the CCG is considering three elements as part of this phase:

- the review of the existing community services provider model in Swindon which is currently provided by SEQOL, considering the national and local context;
- a consideration of primary care at scale, and;
- the impact of new models on commissioning functions.

The Board noted that the CCG is testing new models at workshops it is currently holding, with a view to creating a new accountable care organisation. Proposals will then be consulted upon from April through to June. The CCG recognise that the current way of procuring will not be suitable in the future and will be looking at how community services are provided. He confirmed that the biggest changes will be within the originating organisation, such as only having one electronic record for patients, one contract for HR functions, changes to the way services are procured and delivered and other types of efficiencies.

The Board also noted that the footprints for the Sustainability and Transformation Plans have been decided nationally and that Swindon is now grouped with Bath and North East Somerset and Wiltshire. This will not be a merger, and any plans will have to be signed off by each of the three Health and Wellbeing Boards involved.

Following the presentation of the report, Board members discussed the matters raised, including:

- Gloucester being grouped with Worcester to better recognise patient flows.
- The appointment of the Chief Executive from the Royal United Hospital to lead on planning the footprint.
- The content of the letter received from the Chair of the Wiltshire Health and Wellbeing Board regarding opportunities for the three Boards to work more closely together.

Resolved – That the progress made to date on the development of the Operational Plan for 2016/17 and the Sustainability and Transformation Plan for 2016-2021 be noted.

52. Transforming Care Partnership Service Model Plan

The Board considered a report regarding the proposed plans for Swindon, working with Wiltshire to implement the changes required as stated within the Transforming Care programme. As part of the governance requirements prior to final submission to NHS England, the plan must be shared and signed off by the Health and Wellbeing Board.

Gill May, Executive Nurse at NHS Swindon Clinical Commissioning Group, introduced the report. She noted that Swindon is acknowledged as best practise on how to deal with these issues. The Board noted the 9 Core Principles set out in the National Service Model Plan upon which the delivery plan has been based, and it was confirmed that the plan had been presented to NHS England for initial comments.

Following the presentation of the report, Board members discussed the clarification required within the plan on the population figures of both Wiltshire and Swindon, which appear to be logged in different ways.

Resolved – (1) That the Swindon elements of the plan be noted.

(2) That an update on the implementation progress be submitted to the Board meeting in October 2016.

53. Better Care Fund

The Board considered a report regarding the detailed policy framework for the implementation of the Better Care Fund (BCF) in 2016/17 which has been published by the Department of Health and Department for Communities and Local Government. The Better Care Fund provides financial support for the closer integration of health and social care, and the Government requires that the BCF Plan 2016/17 is considered by this Board.

Sue Wald, Interim Director of Adult Social Services at Swindon Borough Council, introduced the report and noted that only one week had been given for a response to be produced. The main changes since the last submission have been set out in the report, and the Board noted that the detailed financial information had been submitted on 2 March. The Narrative Plan has to be submitted by 21 March 2016 and this will be circulated electronically to Board members prior to submission.

Following the presentation of the report, Board members discussed how advanced the BCF negotiations are of the authorities within the new proposed CCG grouping, and the potential impact this may have on working together.

Resolved – (1) That the Better Care Fund Financial Information 2016/17 as submitted on 2 March 2016 (attached at Appendix 1 to the report), and the draft Narrative Plan to be submitted by 21 March 2016, be endorsed.

(2) That the proposed capital expenditure to support the Better Care Fund be agreed.

54. Healthwatch Swindon Retender Update

The Board considered a report regarding the recent procurement for the Healthwatch Swindon contract. The Health and Social Care Act 2012 stated that

local Healthwatch providers be established from 1 April 2013. Local Healthwatch providers are independent bodies, able to employ their own staff and involve volunteers, to become the influential and effective voice of the public. They act as an independent consumer champion for both health and social care. The current contract with Parkwood expires on 31 March 2016 and from 1 April 2016 the new provider for Healthwatch Swindon will be The Care Forum.

Cherry Jones, Director of Public Health at Swindon Borough Council, introduced the report and noted that the Annual Report is still expected to be produced by Parkwood. The Care Forum has written to volunteers and have explained how they work differently at Director level, and how they will ask their volunteers to help direct the healthwatch agenda.

Following the presentation of the report, Board members discussed the opportunities for the different Healthwatch organisations to work together across boundaries.

Resolved – That the report and the appointment of The Care Forum as the Healthwatch Swindon provider from 1 April 2016 be noted.

55. Joint Commissioning Group - Minutes for information and comment

The Board noted the minutes of the Joint Commissioning Group meetings held on 1 December 2015 and 5 January 2016. The Group have been looking at delayed discharges, available capacity within the system, and dementia amongst other issues.

Resolved – That the minutes of the Joint Commissioning Group meetings held on 1 December 2015 and 5 January 2016 be noted.

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NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan 2016-2021

Health and Wellbeing Board

Date: 25 May 2016

Author:	Accountable Officer, Swindon Clinical Commissioning Group
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 The NHS in England is required to produce place-based Sustainability and Transformation Plans, driving the Five Year Forward View over the period October 2016 to March 2021, for submission to national bodies in June 2016. Clinical Commissioning Groups (CCG) were asked to form footprints for submission of place based plans. Swindon CCG are working with Bath and North East Somerset (BANES) and Wiltshire CCGs to develop a footprint plan.
- 1.2 This report provides an update for the Health and Wellbeing Board on the development of the plan across the footprint and the Swindon specific elements.
- 1.3 A further iteration of the plan will be shared with the Health and Wellbeing Board in July 2016.
- 1.4 The Chair of the Health and Wellbeing Board and the Interim Director of Adult Social Services have a seat on the Sustainability and Transformation Board, along with the CCG Accountable Officer and CCG Clinical Chair.

2. Recommendations

The Board is recommended to:

- 2.1 Note the update provided on the Sustainability and Transformation Plan for 2016-2021 as attached at Appendix 1 to the report, and discuss any areas where further clarification may be required.

3. Detail

- 3.1 Appendix 1 provides an overview of the national expectations, the BANES, Swindon and Wiltshire (BSW) draft submission, and the Swindon approach to developing a local service model.

Swindon elements of the plan

- 3.2 The approach the CCG has taken is to begin to develop a local strategy for the five year plan which will then support the discussion and development of the wider footprint plan. Appendix 1 provides an overview of progress to date.

Further information on the subject of this report can be obtained from Nicki Millin, 01793 683700.

NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan 2016-2021

Health and Wellbeing Board

Date: 25 May 2016

National Requirements

- 3.3 There was a requirement for the BSW footprint to submit an outline Sustainability and Transformation Plan (STP) by 11 April 2016. A copy of this submission is contained within Appendix 1. The submission outlined the key challenges in relation to Health and Wellbeing; Improving the care and quality of services, and Improving productivity and closing the financial gap.
- 3.4 Finalised STPs are to be submitted by 30 June 2016. NHS England and NHS Improvement will assess plans in July. They will consider:
 - 3.4.1 The quality of plans, particularly the scale of ambition and track record of progress already made in addressing each of the three gaps. The best plans will have a clear and powerful vision across health, quality and finance, owned by all local partners in the system. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new models of care; and trusts in special measures and finance. They will systematically borrow good practice from other geographies and adopt national frameworks.
 - 3.4.2 The reach and quality of the local process, including community and voluntary sector engagement.
 - 3.4.3 The strength, maturity and unity of local system leadership and partnerships, with clear governance structures to deliver them.
 - 3.4.4 How confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.
 - 3.4.5 The extent to which systems can already point to tangible, early progress.

4. Alternative Options

- 4.1 None.

5. Implications, Diversity Impact Assessment and Risk Management

- 5.1 All of the following assessments will be included in the Plan as it is developed:
 - 5.1.1 Patient Benefits
 - 5.1.2 Safety and Quality Impact
 - 5.1.3 Financial and Procurement Implications
 - 5.1.4 Legal and Human Rights Implications

Further information on the subject of this report can be obtained from Nicki Millin, 01793 683700.

NHS Swindon Clinical Commissioning Group Sustainability and Transformation Plan 2016-2021

Health and Wellbeing Board

Date: 25 May 2016

5.1.5 All other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.1.6 Equality & Diversity Impact Assessment

5.1.7 Risk Management

6. Consultees

6.1 Elements of the STP have been discussed in a number of different fora including CCG Governing Body, and STP workshops involving provider organisations from Swindon and Swindon Borough Council representation.

7. Background Papers

7.1 None.

8. Appendices

8.1 Appendix 1 - Sustainability and Transformation Plan 2016 -2021. Update for the Health and Wellbeing Board in May 2016

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Sustainability and Transformation Plan 2016-2021

Update for H&WBB May 2016

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BSW footprint

- The BANES, Swindon and Wiltshire (BSW) plan is being led by James Scott, Chief Executive of Royal United Hospital in Bath, a position he has held since 2007. James will oversee and coordinate a team drawn from the leaders of each of the health and social care organisations included in our STP 'footprint' area. During this time, James will continue with his responsibilities as CEO of the RUH.
- The BSW plan brings together our three hospitals (Royal United Hospital, Great Western Hospital and Salisbury Foundation Trust), the three Clinical Commissioning Groups; BANES, Swindon and Wiltshire Councils, South West Ambulance Service and Avon and Wiltshire Mental Health Partnership Trust. The providers of our community services – Wiltshire Health and Care, SEQOL and Sirona and the Wessex Local Medical Committee (representing GPs from across the BSW area) complete our organisational grouping.
- Working together to cover a combined population size of approximately one million people, the BSW grouping will bid for and receive a transformation fund from 2017/18 onwards, which will be used to pay for health and social care services for people living in our area.

Contents

- Outline of national guidance – slides 4 – 10
- BSW draft STP submission – slides 11 - 23
- Swindon process slides 24 - 34

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The background of the slide features a photograph of two individuals, likely healthcare professionals, in a meeting. One person, an older woman with glasses and a blue cardigan, is looking down at a document. The other person, a man with glasses and a white shirt, is looking at the same document. The image is overlaid with a semi-transparent blue geometric pattern.

Developing Sustainability and Transformation Plans

Preparing for 15 April and beyond

March 15 2016

STPs are an opportunity to develop a local route map to an improved, more sustainable, health and care system

44 STP footprints have been agreed

- Each will be convened by a local leader, backed by national bodies
- Footprints are not statutory boundaries – they are vehicles for collaboration
- Planning will still need take place at different levels - subsidiarity is a key principle

A good STP focuses on the big questions and early action

- Get going on some early actions rather than waiting for the plan to be complete
- As 'umbrella' plans, STPs can be a way of making sense of competing priorities
- Think about populations, not institutions or organisational form
- Spend time on identifying the practical opportunities and solutions, not endlessly debating the scale of the challenge

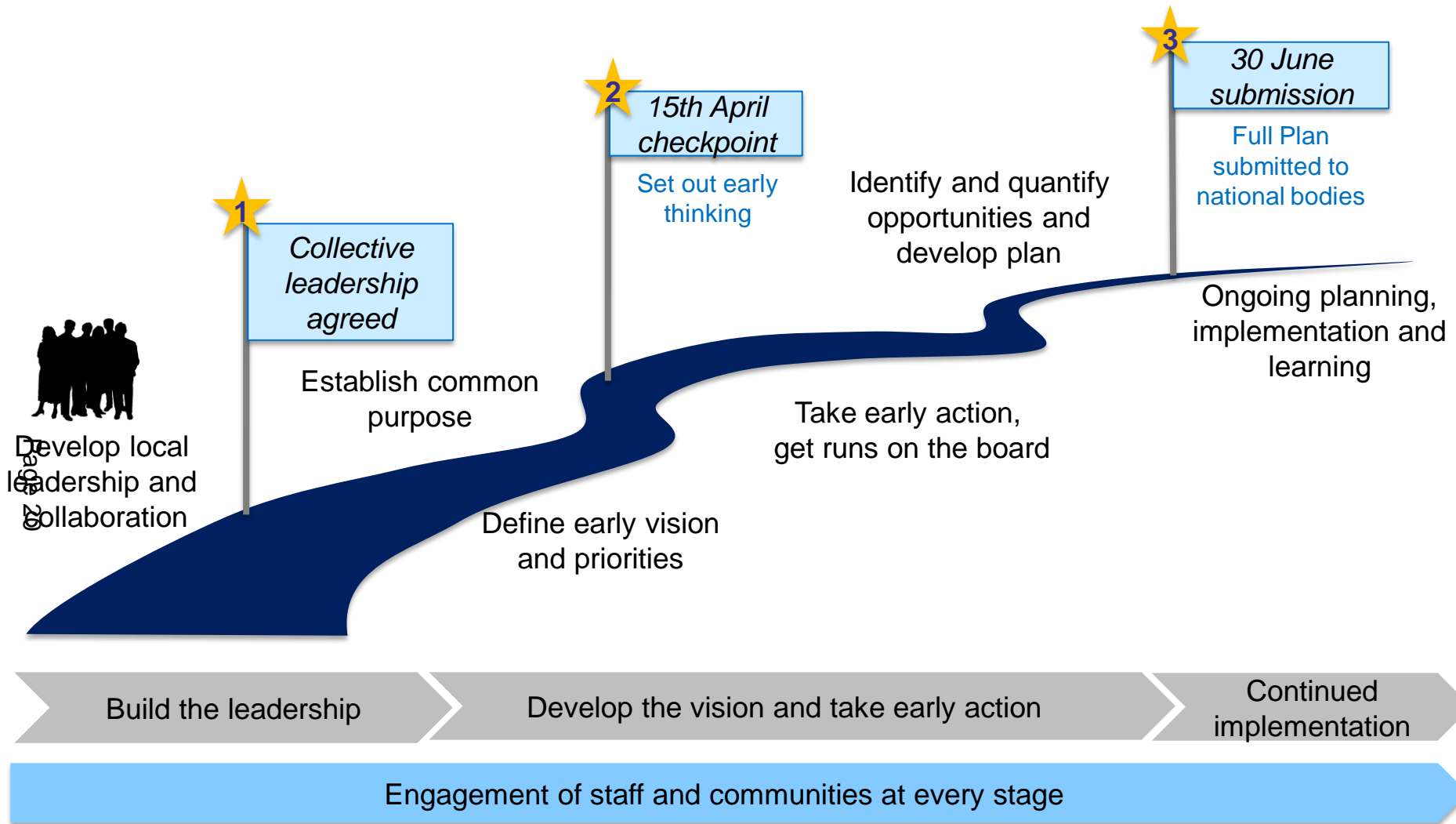
It won't be easy

- There will be technical challenges, e.g.
 - Cross-footprint flows and boundaries
 - Incentives that pull in different directions
- Non-technical challenges, e.g.
 - Building meaningful relationships
 - Freeing people to focus on the long-term
 - Moving quickly, whilst ensuring buy-in

This is an opportunity to build or strengthen relationships

- Across health, social care and local government – but also with patients, communities, staff and the voluntary sector
- STPs aren't all about writing the plan: building energy, relationships and collaborative leadership is even more important
- Trust and ownership is crucial for implementation

Overview of the process



The April 15th checkpoint: Summary

Each STP area is asked to make a submission by 15 April focusing on the following **two questions**:

- a. What leadership, decision-making processes and supporting resources you have put in place to make progress?
- b. What are the major areas of focus and big decisions you will need to make *as a system* to drive transformation?

A short template to fill in and submit to england.fiveyearview@nhs.net is provided in the annex.

Page 21 Different areas will be starting from different places

- Many areas will have already undertaken considerable amounts of work. Where this is the case, you should of course build on this work – we are not asking areas to redo what they've already done, although there may be gaps to fill.

The April 15th checkpoint: agreeing areas of focus for your STP

A full STP will need to be underpinned by

- an understanding of your current major local challenges against the '3 gaps' (health and wellbeing, care and quality, and finance and efficiency);
- how those challenges are expected to evolve over the next 5 years in a 'do nothing scenario';
- emerging hypotheses for what is driving the gaps and therefore the action needed.

National priorities and local challenges

- The STP process is intended above all to be a process for partners across a footprint to work together to identify, agree and address significant challenges. **It is not a checklist exercise.**
- In order to support this effort, and drawing on commitments from the mandate to NHS England and the shared planning guidance, on the following pages we have set out 10 key areas where we know we need to make progress across the health and care system.
- Reflecting on these 10 areas, for the April submission we would expect footprints to be identifying key local priorities for transformation through the remainder of the STP process.

10 big questions – what are your priorities? (1/2)

Given your local circumstances, where do you need to focus in order to allow you to deliver the priorities for the health and care system by 2020/21?

- page 23
- 1 How are you going to prevent ill health and moderate demand for healthcare?** Including:
 - A reduction in childhood obesity
 - Enrolling people at risk in the Diabetes Prevention Programme
 - Do more to tackle smoking, alcohol and physical inactivity
 - A reduction in avoidable admissions
 - 2 How are you engaging patients, communities and NHS staff?** Including:
 - A step-change in patient activation and self-care
 - Expansion of integrated personal health budgets and choice – particularly in maternity, end-of-life and elective care
 - Improve the health of NHS employees and reduce sickness rates
 - 3 How will you support, invest in and improve general practice?** Including:
 - Improve the resilience of general practice, retaining more GPs and recruiting additional primary care staff
 - Invest in primary care in line with national allocations and the forthcoming GP 'Roadmap' package
 - Support primary care redesign, workload management, improved access, more shared working across practices
 - 4 How will you implement new care models that address local challenges?** Including:
 - Integrated 111/out-of-hours services available everywhere with a single point of contact
 - A simplified UEC system with fewer, less confusing points of entry
 - New whole population models of care
 - Hospitals networks, groups or franchises to share expertise and reduce avoidable variations in cost and quality of care
 - health and social care integration with a reduction in delayed transfers of care
 - A reduction in emergency admission and inpatient bed-day rates
 - 5 How will you achieve and maintain performance against core standards?** Including:
 - A&E and ambulance waits; referral-to-treatment times

10 big questions – what are your priorities? (2/2)

Given your local circumstances, where do you need to focus in order to allow you to deliver the priorities for the health and care system by 2020/21?

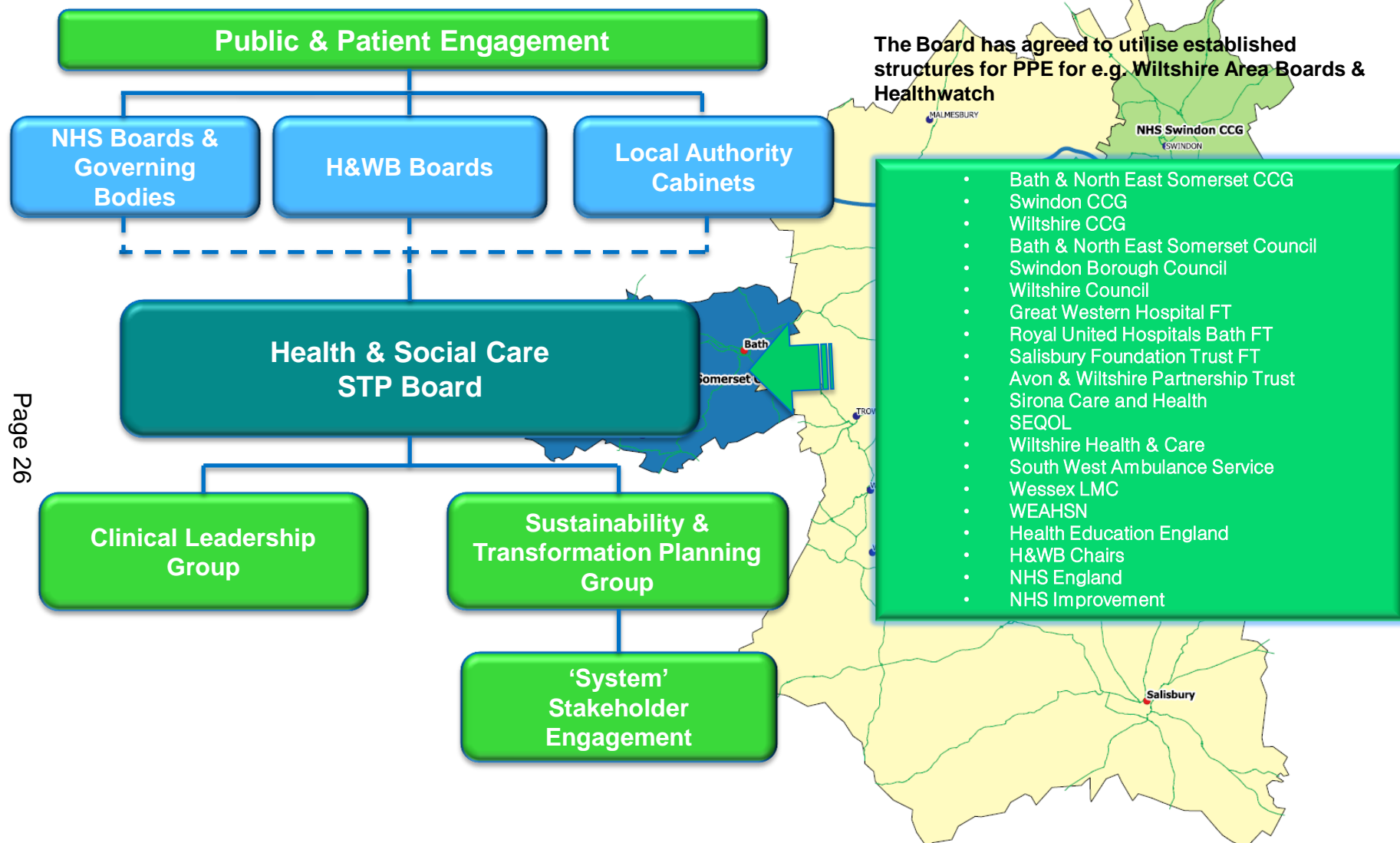
- 6 How will you achieve our 2020 ambitions on key clinical priorities?** Including:
- Achieve at least 75% one-year survival rate (all cancers) and diagnose 95% of cancer patients within 4 weeks
 - Implement two new mental health waiting time standards and close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole, and deliver your element of the national taskforces on mental health, cancer and maternity
 - Improving maternity services and reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries
 - Maintain a minimum of two-thirds diagnosis rate for people with dementia
- 7 How will you improve quality and safety?** Including:
- Full roll-out of the four priority seven day hospital services clinical standards for emergency patient admissions
 - Achieving a significant reduction in avoidable deaths
 - Ensuring most providers are rated outstanding or good– and none are in special measures
 - Improved antimicrobial prescribing and resistance rates
- How will you deploy technology to accelerate change?** Including:
- Full interoperability by 2020 and paper-free at the point of use
 - Every patient has access to digital health records that they can share with their families, carers and clinical teams
 - Offering all GP patients e-consultations and other digital services
- 9 How will you develop the workforce you need to deliver?** Including:
- Plans to reduce agency spend and develop, retrain and retain a workforce with the right skills and values
 - Integrated multidisciplinary teams to underpin new care models
 - New roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice
- 10 How will you achieve and maintain financial balance?** Including:
- A local financial sustainability plan
 - Credible plans for moderating activity growth by c.1% pa
 - Improved provider efficiency of at least 2% p.a. including through delivery of [Carter Review recommendations](#)

BANES, Swindon & Wiltshire draft STP submission

11 April 2016

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Leadership, governance & engagement



Programme Infrastructure

Central Leadership Team

Senior Responsible Officer
James Scott

Programme Director
David McClay

Programme Assistant
TBC

Commissioned Packages - TBC

**Wiltshire
CCG**

STP Planning
Lead
David Noyes

**Swindon
CCG**

STP Planning
Lead
Tess Green

**BaNES
CCG**

STP Planning
Lead
Julie-Anne Wales

Workstream Leads

Health & Wellbeing Workstream

Maggie Rae
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Care & Quality Workstream

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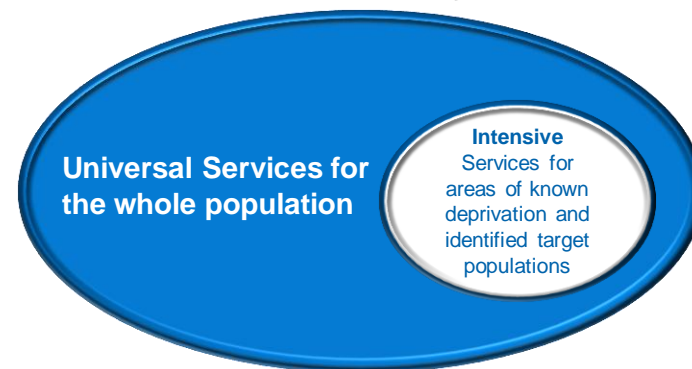
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Improving Health & Wellbeing (1/2)

Using Public Health intelligence the Health & Social Care STP Board has identified the current key priorities across the three commissioning localities on both prevention and narrowing the gap on Health Life Expectancy.

A key tenet of the plan will be the focus on providing focused, intensive services to those parts of our population that need them most.



Priority/Topic area	Swindon	BaNES	Wiltshire
Healthy Life Expectancy – narrowing the gap	<ul style="list-style-type: none"> Increasing the length of time and percentage of life spent in good health and reducing the inequality in life expectancy 	<ul style="list-style-type: none"> Focusing on groups with the worst outcomes (people experiencing deprivation, mental illness, disability) 	<ul style="list-style-type: none"> Increasing the length of time and percentage of life spent in good health is a key priority in closing the health and well-being gap
Prevention	<ul style="list-style-type: none"> Prevention of Long Term Conditions. Independent and active lives. 	<ul style="list-style-type: none"> Keeping prevention strong. Focusing on groups with the worst outcomes (people experiencing deprivation, mental illness, disability). Empowering people to look after their health 	<ul style="list-style-type: none"> Reducing early deaths from major causes of mortality; reducing child mortality; keeping people healthy, active and independent longer and improving people's quality of life.

Improving Health & Wellbeing (2/2)

Healthy Life Expectancy – Narrowing the gap

Life Expectancy and healthy life expectancy reflect the focus not only on how long we live, but also on how well we live, at all stages of our lives.

Increasing the length of time and percentage of life spent in good health is a key priority in closing the health and wellbeing gap.

Attention will be paid to the gap in healthy life expectancy between the most and least deprived areas, focusing targeted attention on areas of deprivation with poor health outcomes in addition to the provision of good quality universal services for all.

Prevention

A radical upgrade on prevention over the next five years will help to reduce early deaths from major causes of mortality; reduce child mortality; keep people healthy, active and independent longer and improve people's quality of life.

Intervening before the development of disease and disability through prevention is key to improving life expectancy and healthy life expectancy. Investment in improving the wider determinants of health will help achieve this.

Our belief is that patients and communities have a key role to play in achieving these outcomes and this will be set out within our June submission.

The following ten priorities have been identified by Public Health Intelligence teams and approved by the STP Board

H&WB 10 Priority Areas



Improving Care & Quality of Services (1/2)

Care & Quality Workstream

Lead nurses and senior quality representatives from across the footprint have identified the current major local challenges and have developed an emerging hypothesis on the causal factors.

Key themes are as follows:

- ✓ Ensuring the right number of people with the right skills are employed in the right place at the right time.
- ✓ Comprehensive redesign of urgent care services
- ✓ A need to maximise the value a patient / user derives from their own care and treatment.
- ✓ The need to make dramatic improvements in mental health services, and in particular in support for children, young people and their families.
- ✓ Strengthening primary care as an agent in reducing health inequalities.
- ✓ Comprehensive support for people with dementia, their carers, families and friends.
- ✓ Expand Personal Health budgets beyond CHC.
- ✓ Improve value through standardised pathways and systematic approach to quality improvement.

The following ten priorities have been identified by the Wiltshire Public Health Intelligence team and approved by the STP Board

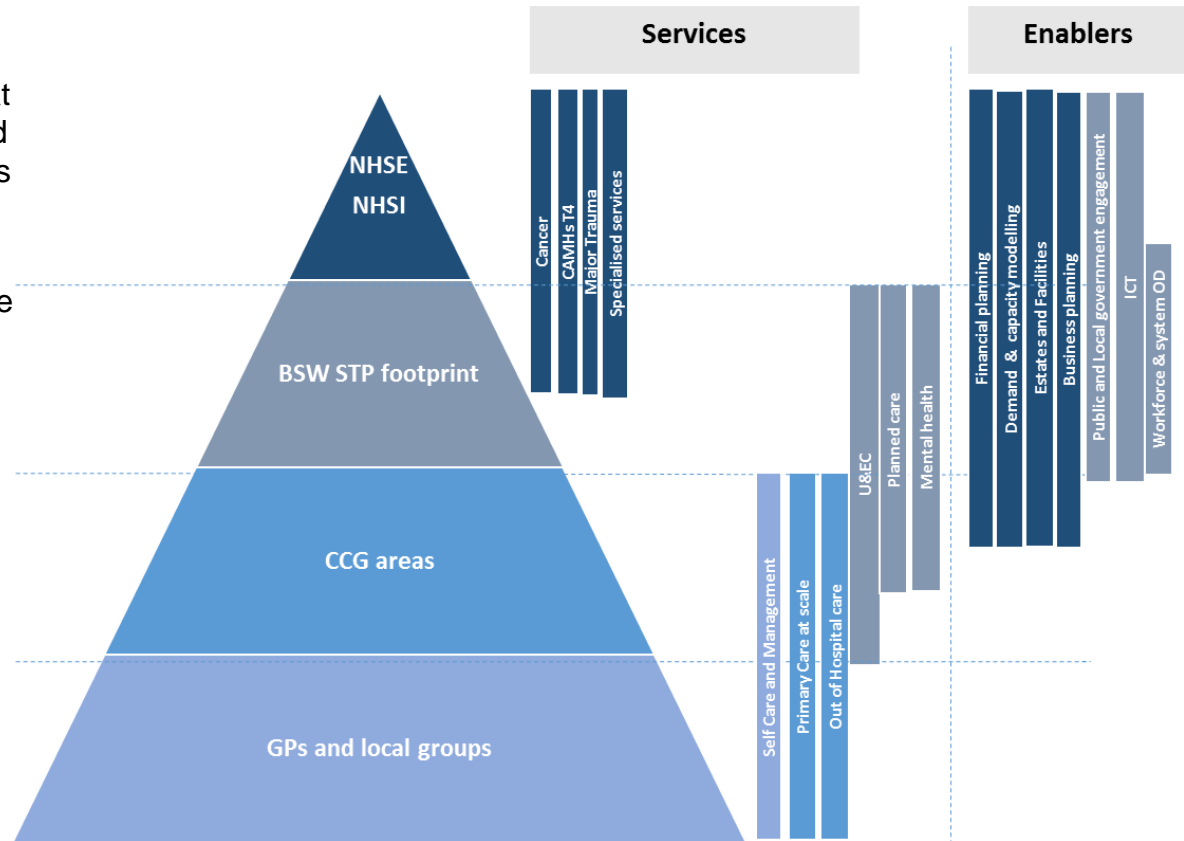
Care & Quality 10 Priority Areas



Improving Care & Quality of Services (2/2)

Intended approach

- This model looks to demonstrate that the national planning focus, STP and local priorities must be considered as a whole not as separate entities.
 - The approach is layered to reflect the importance of place based planning and delivery balanced with opportunities to improve health outcomes, quality, and economics more effectively at scale.
- The diagram is colour coded to indicate at which layer planning and delivery should be led from.



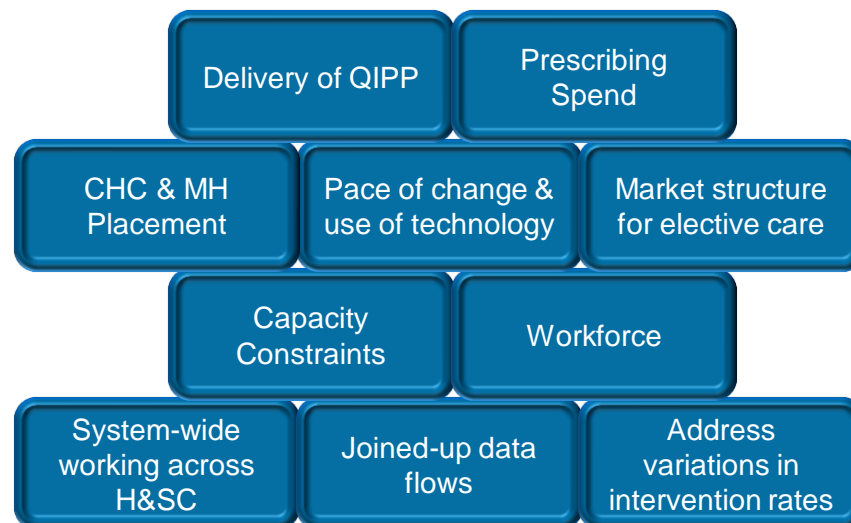
Improving Productivity & Closing the Financial Gap

Financial Challenge facing Commissioners, Providers and Local authorities annually over the next five years is over £100m. Note, that local authority figures have not been included for 2020/21 because they work on a four year financial settlement.

Cumulatively, the STP system is looking at an overall financial pressure of £490m.

The following ten priorities have been identified by the finance teams across the footprint:

Improving Productivity & Financial Performance 10 Priority Areas



	2016/17	2017/18	2018/19	2019/20	2020/21	TOTAL
	£m	£m	£m	£m	£m	£m
Commissioners	30.40	22.54	21.34	17.62	8.51	100.41
Providers	51.21	45.41	51.83	53.45	33.20	235.09
Local authorities	31.63	37.54	48.64	37.19	-	154.99
	113.23	105.49	121.81	108.26	41.71	490.49

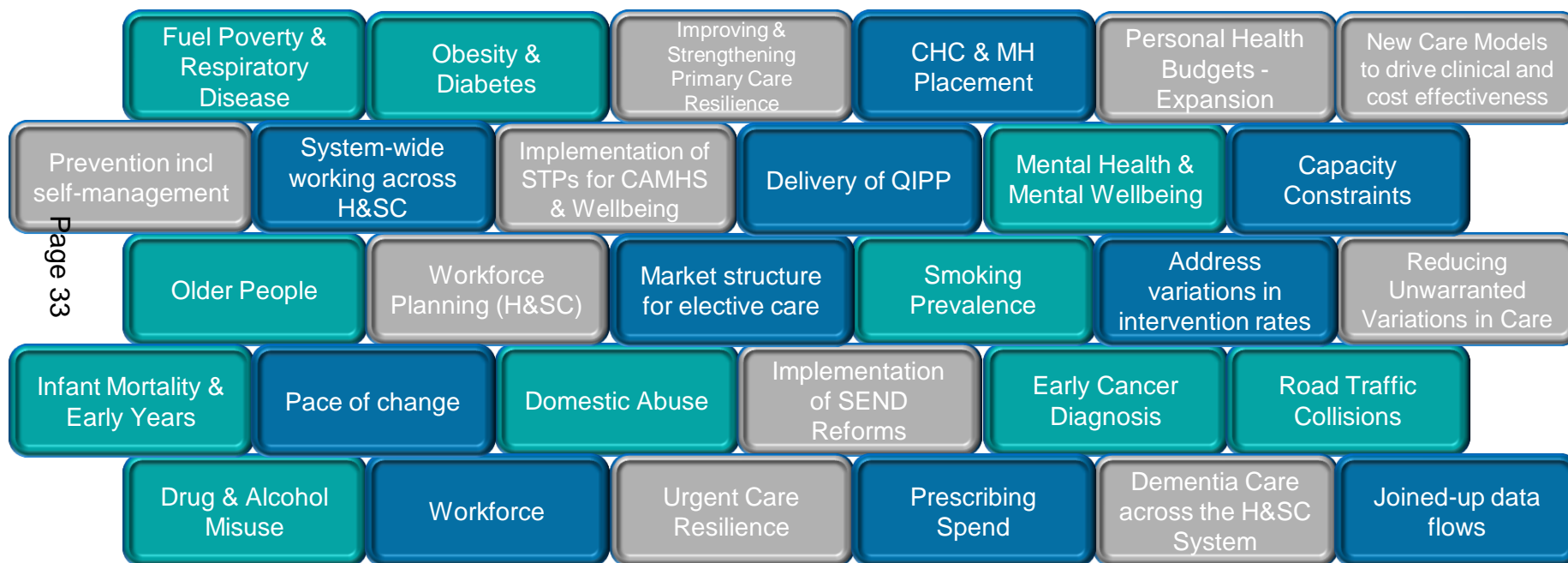
STP Financial Challenge Over 5 Years

490.49

Emerging Priorities – the long list

Having identified and collated the top 30 emerging priorities, key member of the STP Board undertook a prioritisation exercise that sought to identify the high impact areas that would drive system improvement. The group also sought to combine and align priorities where it was prudent to do so.

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Emerging Priorities – the short list

Obesity & Diabetes

Addressing childhood and adult obesity; promoting active and healthy lifestyles for the public and our workforce.

Workforce across the system

Workforce plans that address the strategic issues across organisational boundaries; reduction in agency; spread specialist skills across the system and address primary care challenges

Clinical & Cost effective new models of care

Redesigning models of care based on clinical and cost effectiveness (including Mental Health) as current models unaffordable; developing prevention agenda; reducing unwarranted variation; use of technology as fundamental enabler.

Capacity Constraints (inc capital)

Capacity & demand insight & real time monitoring; greater collaboration across the system in managing demand; developing comprehensive infrastructure plan.

Older People

Reducing isolation and focusing on aligning services focused at caring for older people; adding value – as defined by them; enhanced dementia care.

Urgent Care Resilience

Variations in patterns of admission for ambulatory care sensitive conditions; review quality and outcome measures used by SRGs

Social Care Capacity

Right-sizing social care capacity to enable users to be cared for in the most appropriate setting for their needs

Drug & Alcohol Misuse

Address underlying causes of drug and alcohol misuse; early support for users and integrated intensive support to those prone to admission.

Programme Priorities

Relationship building; cementing the infrastructure; goal alignment across the footprint; Developing a shared narrative on current and future state; Prioritising the priorities

10 Early Priorities for the Programme

1. Further liaison with Healthwatch and established engagement bodies to dovetail plans.
2. Detailed working with the AHSN to understand how we maximise their involvement in bringing innovative solutions to the patient safety challenges facing the footprint.
3. Engagement with statutory and non-statutory bodies to align and integrate agenda's, including assessing the offer of the Severn Urgent and Emergency Care Network (SUECN).
4. Undertaking / collating more detailed public health needs analysis to correctly identify sections / groups within our communities that require intensive input and high impact areas.
5. Mapping current interoperability plans / digital roadmaps to identify gaps and overlaps.
6. Defining optimal catchments for service planning and improvement – particularly for cancer pathways (building on the Cancer Alliance discussions).
7. Developing cohesion within the STP leadership team through facilitated sessions.
8. Establishing the overall programme infrastructure – including the working groups that will oversee our response to the 8 priorities, develop our communications strategy and formal approach to consultations.
9. Consideration of how we ensure STP agenda is woven into Board agenda's within the footprint to ensure strong governance links with STP Board.
10. Planning for clinical and stakeholder engagement events across May and June. Planning for wider community engagement event in June.

Emerging thinking – national and regional support

National barriers:

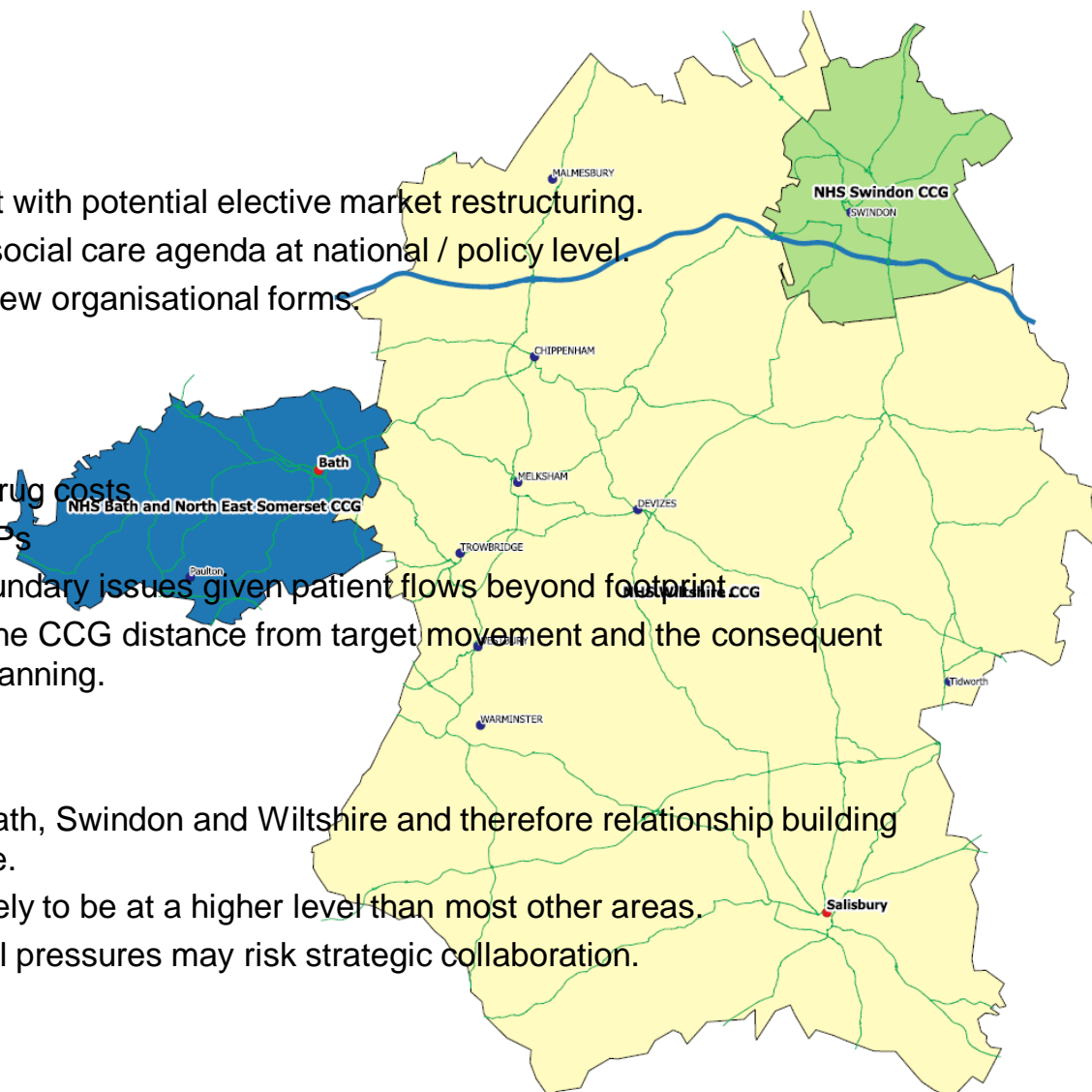
- Choice and procurement conflict with potential elective market restructuring.
- Closer alignment of health and social care agenda at national / policy level.
- Barriers to the development of new organisational forms.

Regional/National support:

- Spread of STP best practice.
- National progress on reducing drug costs
- Early clarity on future role of STPs
- Support / guidance on cross-boundary issues given patient flows beyond footprint
- The pace of change applied to the CCG distance from target movement and the consequent impact on short term financial planning.

Risks:

- STP is a new footprint across Bath, Swindon and Wiltshire and therefore relationship building and goal alignment will take time.
- June submission is therefore likely to be at a higher level than most other areas.
- Current operational and financial pressures may risk strategic collaboration.



Swindon Sustainability and Transformation Plan

Two workshops have been held to begin to develop a model of care for Swindon. The outputs from this are in the following slides.

Adopting a whole system view for transformation

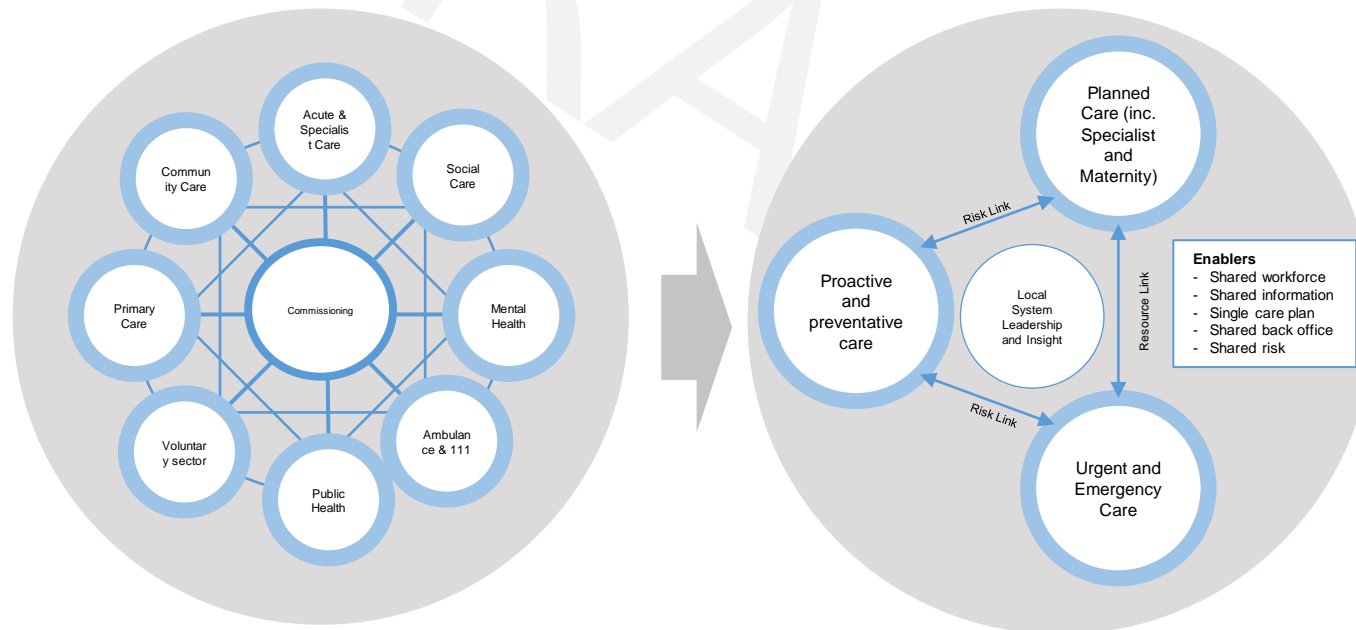
Traditionally the NHS has been organised around organisations delivering separate parts of a patient's pathway. Each organisation had control over part of the patient but not the whole. This system has been characterised by fragmentation and competing incentives. Swindon aims to adopt a whole system model that focuses on value. This will require us to develop a different model that is both coherent, integrated and focuses on population health and system value.

The diagram below summarises a shift in care that views population health and care needs through three lenses;

- Proactive and preventative – supporting patients to stay well and to manage their condition
- Urgent and emergency – incorporating the full range of urgent and emergency care it provides services when people need them most
- Planned care – (1) an optimised planned care services providing effective and efficient elective care and, (2) people being able to access services in a planned way through early interventions to prevent longer-term issues

There remains a need to provide local system leadership, insight and co-ordination. However, this will also need to change in order to delivery the local transformation required.

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Five 'big shifts' were identified during the workshop

Focus on system value

System value can be defined as delivering improved patient outcomes and quality at a lower cost. There should be a single view of value across the system that cuts across organisational boundaries and reflects the true cost of provision. This includes sharing resources across organisations (such as a shared back office) and developing a system view of financial sustainability.

A population based approach to health and care services

Services should be organised around patients with similar needs. Budgets and payments should reflect this to enable the system to deliver greater value. Organisations, and care professionals, will have joint accountability for patient outcomes and are focused on prevention where possible. Lessons should also be drawn from the healthy towns model.¹

Care management supported by effective risk stratification

Risk stratification will be used to identify patients based on needs. Services will be tailored to each group. Those groups requiring greater support will be proactively managed. This would take place within neighbourhoods and enabled by separation of functions in primary care.

Integrated delivery supported by information and data

Patients – particularly those with complex needs – should be known across all parts of the system. In this model *no patient is unknown* to a provider. The ambition should be to move to an integrated workforce capable of supporting the different needs of patients who are working from a single, shared, care plan. This will reduce duplication, enable scarce resources to be directed appropriately and promote the shared ownership of patients. Achieving this will require a single source of information and enhanced means of communication across the system.

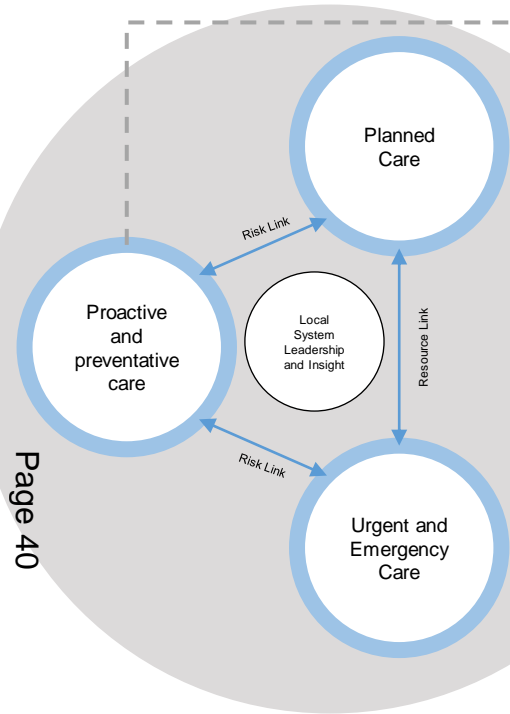
Simplify points of contact across the system

A joined up model of care will support patients to access the right part of the system when they need it. The aim will be to simplify the points of contact for the population, and support those who need it to navigate the system. This will be supported through the development of a single workforce across all settings of care.

1. <https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns>

Proactive and preventative care

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Proactive and preventative care focuses on keeping people well and providing ongoing support to those patients and service users who need it. Delivery is characterised by integrated teams that bring together different professionals involved in a person's care. This includes both health, social and other forms of care. This type of care will focus on reducing demand and pressure on more expensive parts of the system – namely the number of people going to A&E and/or hospital. If patients experience an emergency or need a planned procedure, the co-ordination of their care will continue through improved management and dialogue. It combines primary prevention (e.g. public health initiatives) and secondary prevention (e.g. case management for high-risk patients).

Key features:

- **Patient segmentation:** Patient cohorts will be segmented into coherent groups with similar needs. This will enable the appropriate provision of services to meet the needs of those groups. This will be supported by improvements in digital and informatics capabilities.
- **Management of complex patients:** Patients with complex needs will be proactively managed within primary care. This function will co-ordinate a patient's care and act as a single point of contact regardless of where the patient is in the pathway. This will be achieved by separating routine primary care – those patients who have a health need but are otherwise healthy – and those patients who need extra management and support.
- **Drawing on a range of community assets to support patients with different needs:** Ability of health and care professionals to draw on a range of community based assets and resources to help people live healthy lives. This will be supported by a comprehensive director of services and stronger local communities that can be self supporting.
- **Underpinned by self-management:** Across all contact points, patients will be encouraged and supported to manage their condition. This will be a key focus for those professionals proactively managing complex patients.
- **Multi-disciplinary teams focused on delivering services around the patient:** Further integrate teams to support the full range of patients needs both before and after a hospital admission. This will include the integration of social care.
- **Prevention initiatives will underpin delivery:** Primary prevention initiatives focusing on issues such as child obesity and the wider determinants of health will be delivered across Swindon. Local providers will understand these services and proactively recommend these to different patient groups.

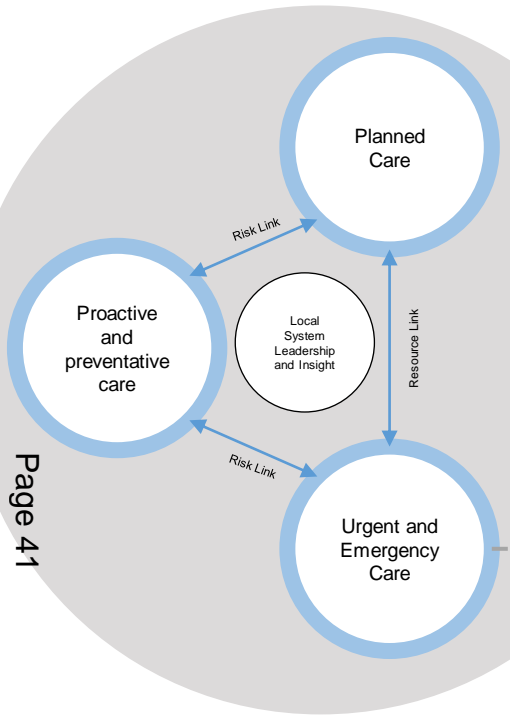
Enablers:

- Primary care operating at scale to provide sufficient workforce and capacity to meet additional needs
- Enhanced out of hospital estates centred around primary care / out of hospital hubs / campuses
- Risk stratification and segmentation tools
- Digital and shared workforce
- Integrated social care

Further areas/ questions for consideration:

- Plan for primary care at scale and estate to support separation of functions
- Population segmentation methodology
- Contracting and performance
- Investment in IT and risk stratification
- Practical integration of social care

Urgent and Emergency Care



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Further areas/ questions for consideration:

- Plan for primary care at scale and OOH estates plan
- How to integrate U&EC services particularly those services across boundaries
- Development of the hospital 'front door'

Urgent and Emergency Care (U&EC) is a fundamental component of the NH. However, its use should be seen as a failure of the local health system to keep patients well. While proactive and preventative care aims to reduce demand for these services, patients will continue to experience crises. Therefore, patients should have access to the appropriate support when they need it. The high-cost of these services means that duplication should be avoided. Access should be simple and reflect the national direction for U&EC facilities and the move towards integrated delivery.¹ Overall, we should expect to see peoples reliance on this part of the system reduce over time.

Key features:

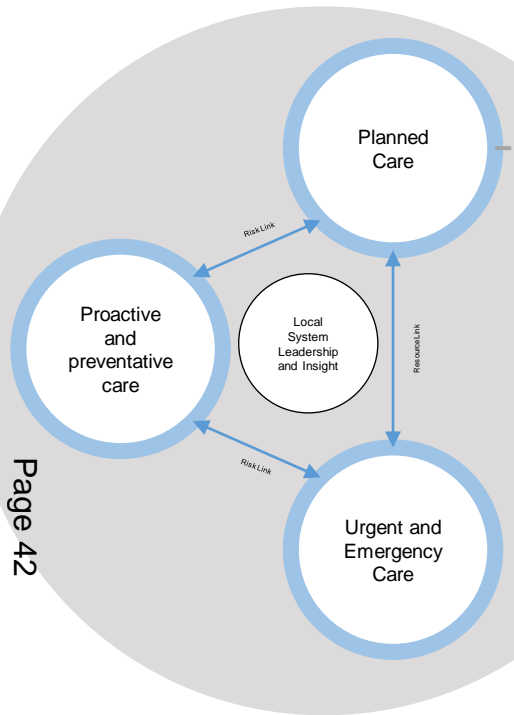
- **Coordinated U&EC provision:** Integrated and joined up Urgency and Emergency system bringing together existing resources under a common governance. This includes Pharmacy.
- **Simplified access:** Patients should be given clear messages about how to access care in a crisis. At the same time access points across the system should be clear. In this context Using A&E physical locations as a legitimate way to access a range of services is viewed as a positive way to use existing assets and streamline provision – although patients will need to be effectively 'streamed' at the front door.
- **Improved access in primary care:** Patients will have increased access to appointments in primary care. Patients in each neighbourhood will have access to extended hours throughout the week facilitating on-the-day appointments. Where appropriate, these will be located in hubs/campuses across Swindon including the hospital. This will help to move decision-making nearer the patient and break down barriers between organisations.
- **Integrated IT and communication:** IT should be integrated across settings enabling instant access to information on patients – particularly those with complex conditions. This will enable each setting to identify complex patients and enable effective communication between teams.
- **Access to specialist opinion, advice and support:** In order to prevent unnecessary admissions or A&E attendances, some health and care professionals will need access to specialist advice and opinion. This should be supported by integrated health records and care plans – particularly for higher risk patients.
- **Identifying which U&EC services should be provided at scale:** Some urgent and emergency care should be delivered at scale across CCG boundaries. This could include Ambulance services and 111. Where this is the case these services will need to be integrated into the local U&EC network.
- **Supported by efficient flow through the system:** A focus of the system will be to ensure patients move through the system as efficiently as possible. This will result in more time spent out of hospital.

Enablers:

- Primary care operating at scale to provide enhanced access
- Passport of training (e.g. I am an advanced nurse and can practice here and everywhere)
- Communication and education

1. <https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>
<http://www.nhs.uk/NHSEngland/keogh-review/Pages/published-reports.aspx>

Planned Care



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Further areas/ questions for consideration:

- Development of a single workforce
- Opportunities for delivering lower costs services (workforce, estate?)
- What, if any, planned care services should be delivered at scale beyond Swindon?
- How to improve productivity (across whole system)

Planned Care will be delivered as effectively and efficiently as possible, underpinned by effective co-ordination across the system. Patients will be supported in the most appropriate setting with high-levels of patient satisfaction and only interact with the 'system' for as long as is clinically required. At the same time patients will be supported to access their care in a planned way through earlier intervention where appropriate

Features:

- **Adopting an effective client management system:** This will co-ordinate patients' care across the system and along the planned care pathway.
- **Shared understanding of thresholds across the system:** Mechanisms need to be in place to push back on inappropriate referrals and increase understanding of referrals – this will include education, advice and training rather than referral management centres.
- **A focus on outcome:** Using aids such as a patient decision tool, health and care professionals will work with patients to consider the most effective and appropriate intervention to help them achieve their preferred outcome.
- **Planned and co-ordinated discharge:** Care should be provided seamlessly via end-to-end integration of care from the point of referral through discharge and recovery.
- **'In-reach' supported by a single workforce:** When patients find themselves in hospital, workforces from across the system should be able to access them. This will be supported by the concept of an '*NHS Swindon workforce*'.
- **Early intervention:** Patients will be supported to access planned care earlier in the pathway where it will help them achieve their preferred outcome and reduce longer term consequences of their condition
- **Shifting unplanned to planned care:** Patients and service users should be supported to access the system in a planned way through earlier intervention and improved management of conditions.
- **Prioritising resources:** Develop a shared understanding of resources, services and initiatives across the system. This will inform decision-making about what to prioritise for patient groups.

Enablers:

- Dialogue between settings of care to manage referrals
- Review thresholds for some services
- Effective care plans
- Patient decision tools focused on outcomes

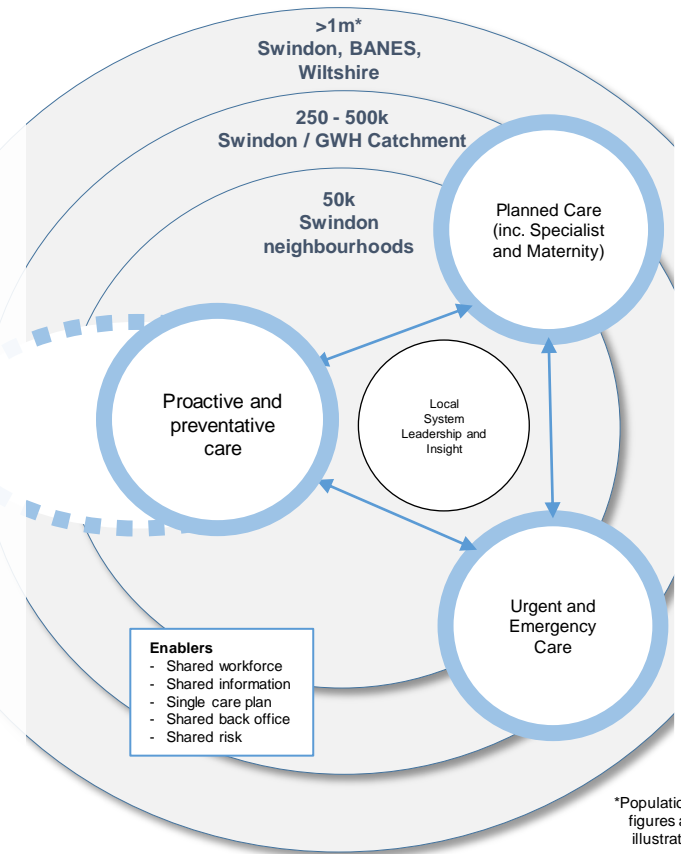
Services will be aligned to different geographies

A place-based model suggests that care needs to be organised around different geographies and population groupings. This reflects the need to deliver local, joined up care for different patient groups as well as the need to manage some services across a wider geography due to scarcity of resources, workforce or demand. This page considers the different levels of provision that may be required within Swindon and across neighbouring geographies.

- Tier 1: circa 50,000 population:** The majority of health and care provision will be organised around populations of around 50,000. This will support a patient-centric model and enable care management and co-ordination for complex patients. Evidence¹ suggests that this size of population enables services to be delivered at some scale whilst enabling a personalised patient experience. At the same time, this scale enables alternative payment models to be used if required². Some U&EC care will take place at these levels including access to pharmacy and WICs or UCCs. While care is delivered within neighbourhoods there should be standardisation across system (tier 2) in terms of segmentation, access and links to broader services.

Tier 2: circa 250,000 - 500,000 populations: At a scale of circa 500,000 the majority of planned care and U&EC services will become viable although some service may still operate as a hub and spoke model with neighbouring hospitals. While services are delivered at this scale they should be fully integrated with other areas of provision.

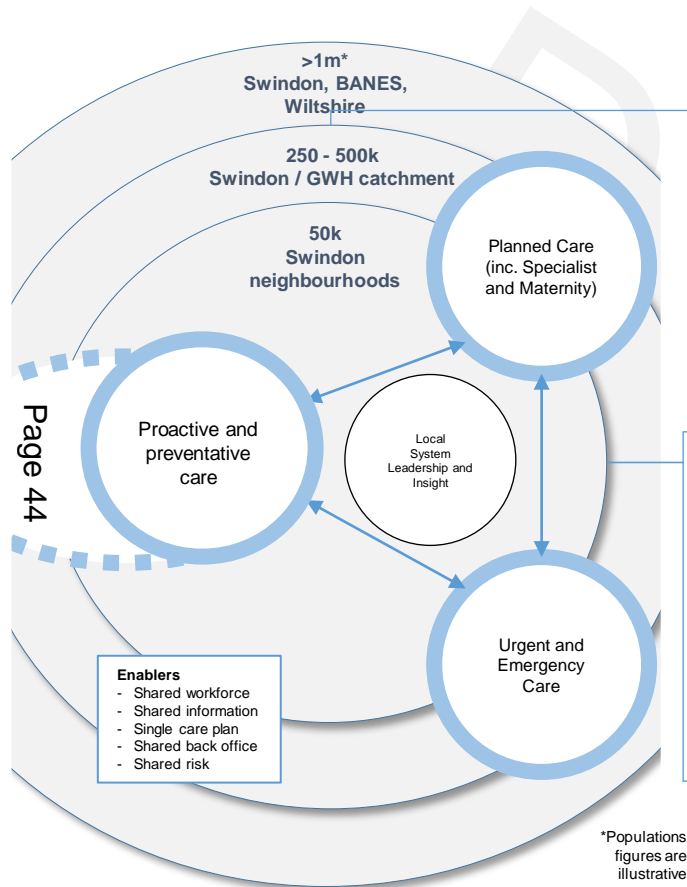
- Tier 3: Over 1m population:** Some services, as is currently the case, will need to be delivered on a much wider scale. This would include tertiary services where complexity and volume require such a scale. It may also include specialist/acute Mental Health services and Ambulance Services. In addition, some preventative/public health services will take place across the wider geography.
- System leadership and delivery architecture:** Systems will need to develop a single delivery architecture that operates across these tiers. A single delivery architecture will enable organisations to fully utilise the assets, tailor services for different populations and enable feedback loops between settings of care. There are a number of mechanisms to achieve this; for example, Alliances and Accountable Care organisations.



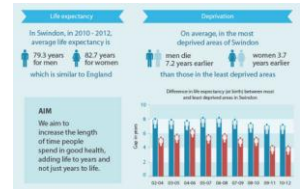
1. For example Patient Centred Medical Homes in the USA

2. <https://www.gov.uk/government/publications/supporting-innovation-in-the-nhs-with-local-payment-arrangements>

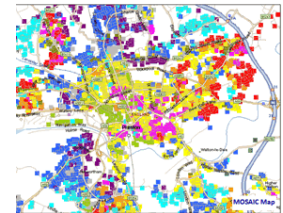
Population needs will be mapped at different levels within Swindon



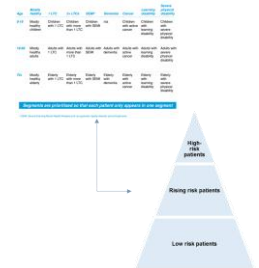
Population health and wellbeing: There is a developed understanding of health and wellbeing needs across the population. Factors include clinical and care needs, demographic and behavioural. This will draw on existing material just as the JSNA (<http://www.swindonjsna.co.uk/>). and reflect the wider planning footprint as required. An understanding of service usage and patient flow across Swindon and the wider footprint will also support planning.



Neighbourhoods informed by demographic analysis: Using Mosaic analysis it is possible to identify a number of distinct neighbourhoods around which care can be organised. At a system level care can be prioritised based on need and flexed to respond to changes in over time. Within these neighbourhoods people will have different needs, behaviours and wants. This can be used to inform the allocation of resources based on need.

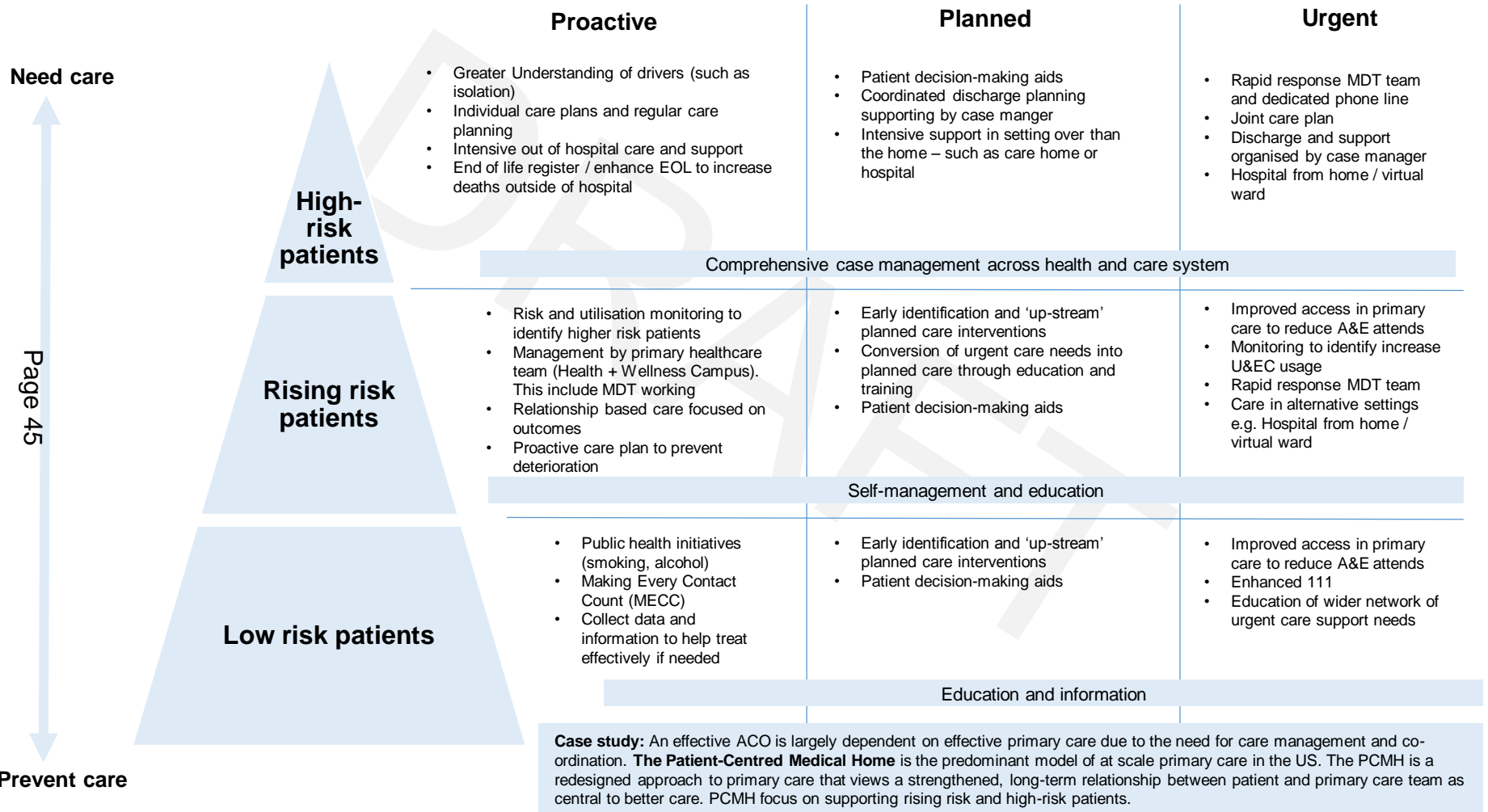


Patient segmentation to identify high risk/cost people: A consistent approach to population/risk segmentation will be developed across Swindon and used by all parts of the system/network. Patients will be risk



Neighbourhoods will be responsible to planning care for these individuals based on need. Segmentation looks at the drivers of need as well as current/recent usage

Attendees at the workshop considered the different needs for each group



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Key features of enabling programmes

Workforce

- **Develop a single workforce:** Establish as single workforce across organisations. In the immediate term this may be 'virtual' but overtime may become more integrated.
- **A system workforce plan:** Collectively identify new roles across the system as well as training needs of the existing workforce to deliver the new models of care.
- **Increase access and communication:** Establish a culture of shared access and communication across the system. This will enable in-reach into acute settings and support in the community

IM&T

- **Shared analytics:** Develop a shared approach to management information and reporting. This includes the development of shared definitions and data gathering
- **Single view of population:** Develop a single view of the population that is shared across organisations to enable effective management of risk
- **Interoperable IM&T:** Develop an interoperable system that enables each part of the system to access real-time information

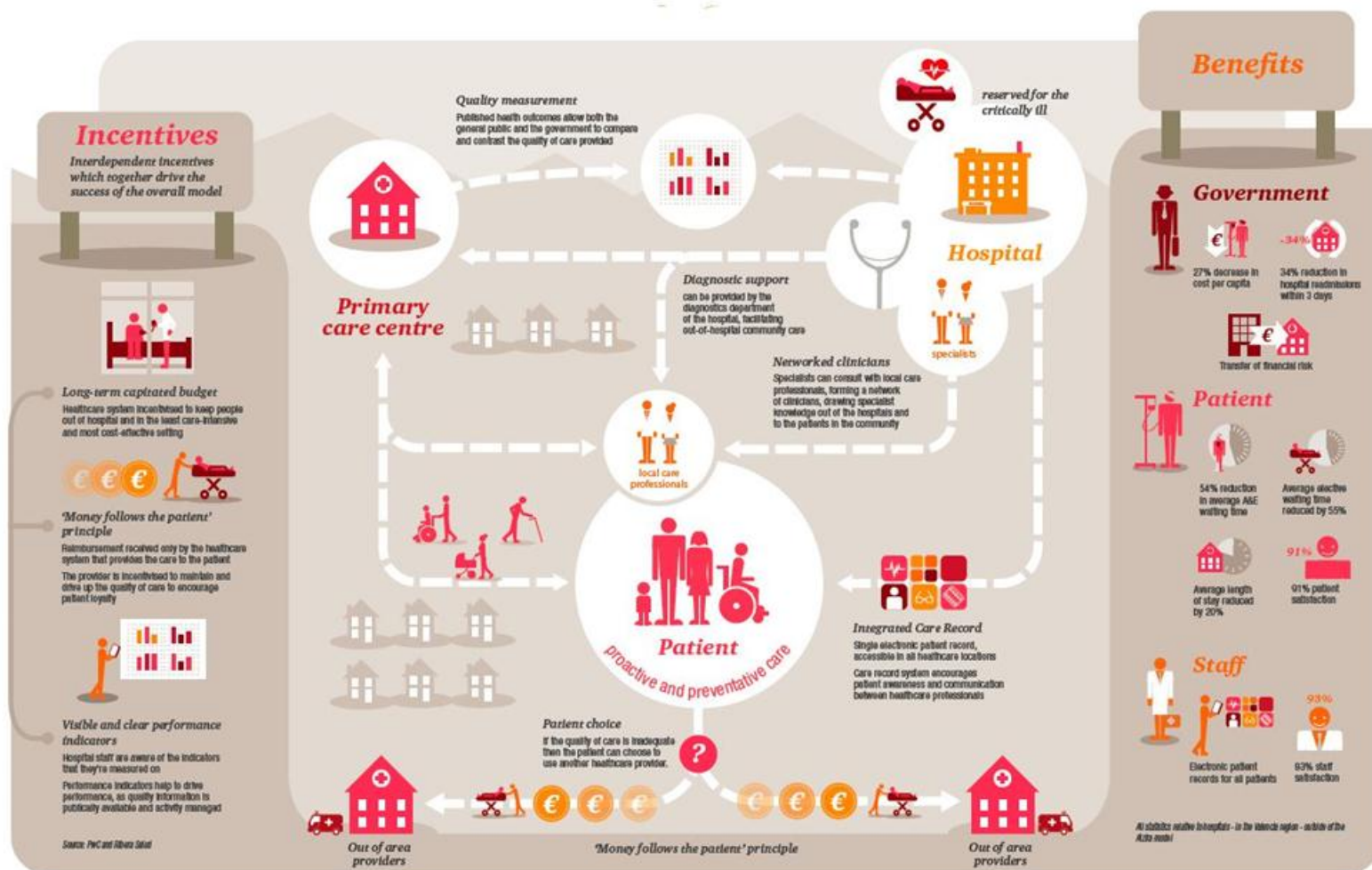
Estates (note – not discussed at workshop)

- **Shared understanding of capital investment:** Take a place-based view on capital investment decisions so that they optimise the existing health and care estate
- **Understand the current estate:** Understand the existing estate across the health and public service economy to inform decision-making. Development of health campus model across a number of acute and primary care sites.
- **Adopt a flexible approach to estates:** Consider how to use estate flexibly to optimise overheads and provide the right care across Swindon, recognising the need to optimise the use of the estate on the GWH site to ensure use of PFI financed facility is maximised.

Finance and commissioning

- **Align incentives to promote prevention:** Develop ways to change incentives in the system through alternative payment and reward mechanisms. This should flow through organisations and workforce
- **Joint financial planning:** To agree priority investments that benefit the system. This would form the basis of a place-based budget reflecting the need to demonstrate system financial balance.
- **Understand system baseline:** Collectively establish and agree the system baseline. Identify fixed and variable costs in the system

The aim should be to develop a coherent model focused on outcomes and value



Next steps for Swindon

A number of actions need to take place in the short-term to build on the principles and vision set out above.

Planning

- Develop a 5-year road map to accountable care organisation and new models of care
- Develop appropriate working groups to develop STP in key areas
- Establish joint team to focus on the work of the system

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Model of care

- Further define the model of care – in particular an outline model for ‘health campus’ and primary care at scale that includes a description of the enablers required to support it

Tackling childhood obesity in Swindon

Health and Wellbeing Board

Date: 25 May 2016

Author:	Public Health Programme Manager, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 This report explores the causes and consequences of childhood obesity and provides a local picture of the prevalence of childhood obesity in Swindon.
- 1.2 In Swindon over 20% (2 in 10) children in reception class at school (aged 4 – 5 years old) are overweight or obese (approx. 580 children). In year 6 at school (aged 10 – 11 years old) over 34% (3 in 10) are overweight or obese (approx. 830 children).
- 1.3 Childhood obesity is a major challenge to health and wellbeing and is associated with an increased risk of premature mortality in adults, as well as poor health and development in children. Childhood obesity also impacts on mental wellbeing, including increasing the risk of low self-esteem, anxiety, depression, bullying and poor educational attainment.
- 1.4 The World Health Organisation regards childhood obesity as one of the most serious global public health challenges for the 21st century with obesity having a substantial impact on the health and wellbeing of children, both now and in the future. This is acknowledged as a long term challenge requiring a whole system approach.
- 1.5 The Chief Medical Officer's 2015 report highlighted concerns around the normalising of being overweight, that in children aged 11-18 years almost a third of the added sugar in their average diet comes from soft drinks and that according to estimates, almost two thirds of adults and one third of children under 18 are overweight or obese. Her report also highlighted that, in one study, 77 percent of parents of overweight children did not recognise that their child was overweight.
- 1.6 The Swindon Health and Wellbeing Strategy Outcome One is that 'Every child and young person in Swindon has a healthy start in life' with reducing childhood obesity levels an indicator of success.
- 1.7 Reducing excess weight in children is one of Swindon Borough Council's pledges and a priority for Swindon CCG. NHS England and Public Health England (PHE) have both identified reducing childhood obesity as a key priority area.

Further information on the subject of this report can be obtained from Fiona Dickens, 01793 444680, fdickens@swindon.gov.uk or Penny Marno, pmarno@swindon.gov.uk

Tackling childhood obesity in Swindon

Health and Wellbeing Board

Date: 25 May 2016

2. Recommendations

The Board is recommended to:

- 2.1 Consider the content of this report and local action to tackle childhood obesity.
- 2.2 Ensure every department/organisation commits to creating and supporting increasingly healthier environments to make healthy choices easy choices.
- 2.3 Support the development of the refresh of the current healthy weight strategy and action plan (attached at Appendix 1 and 2 to this report) to increase its focus on tackling childhood obesity.

3. Detail

- 3.1 The table below shows the overweight and obesity prevalence rates and trend for children in Swindon (Source: National Child Measurement Programme (NCMP)).

Reception			
Year	Overweight	Obese	Overweight & Obese
2008-09	13.6%	9.5%	23.1%
2009-10	11.3%	9.4%	20.7%
2010-11	14.2%	8.6%	22.8%
2011-12	14.0%	9.9%	23.9%
2012-13	13.1%	10.2%	23.3%
2013-14	14.7%	9.5%	24.2%
2014-15	11.3%	9.2%	20.5%

Year 6			
Year	Overweight	Obese	Overweight & Obese
2008-09	14.4%	16.5%	30.9%
2009-10	16.1%	16.7%	32.8%
2010-11	13.9%	17.3%	31.2%
2011-12	16.7%	19.2%	35.9%
2012-13	13.4%	19.5%	32.9%
2013-14	15.5%	17.5%	33.0%
2014-15	14.8%	19.6%	34.4%

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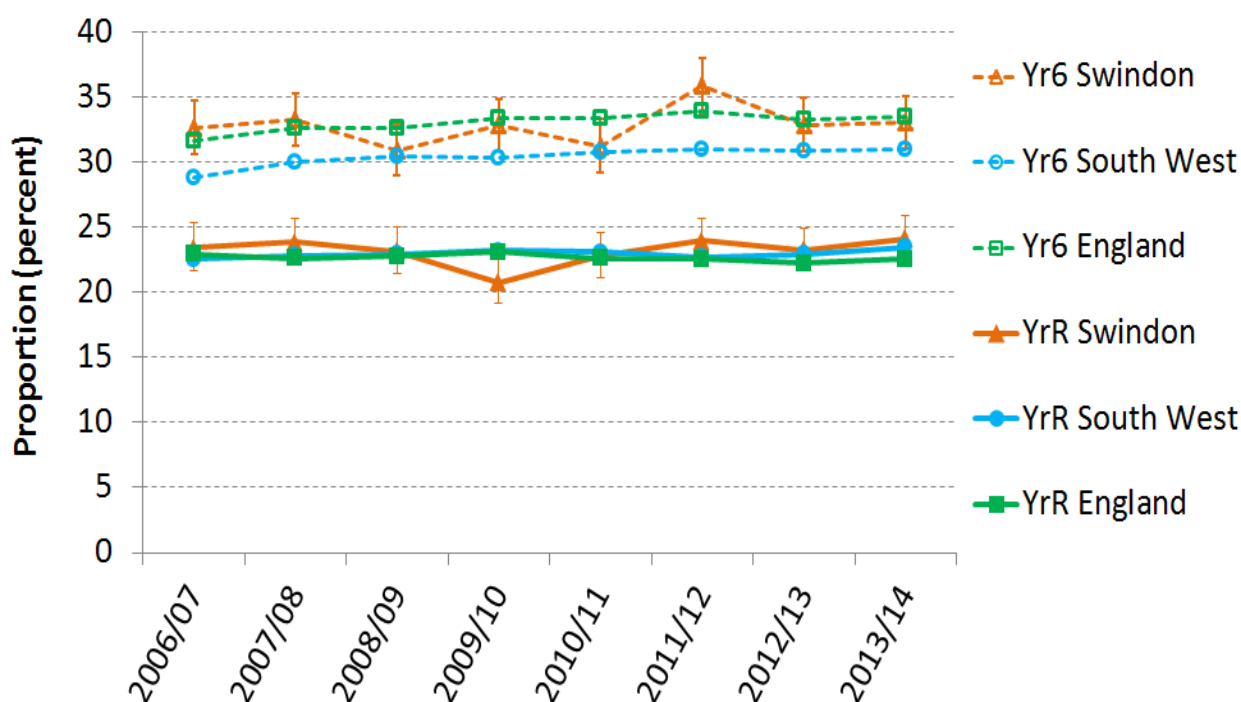
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- 3.2 The prevalence of excess weight in Swindon in 2014/15 was 20.7% in Reception year and 34.6% in Year 6. In 2014/15 the proportion of Swindon pupils with excess weight in Reception year fell from higher than England and the South West in 2013/14 to lower than England in 2014/15 and significantly lower than the South West. The trend in excess weight in Swindon is essentially flat for Reception year (down an average of 0.12% each year), similar to England, where it is down 0.1% per year. In Year 6, the trend in excess weight in Swindon is a 0.24% increase on average each year compared to 0.18% in England. The prevalence of children with excess weight in Year 6 has been consistently higher in Swindon than the South West region (not always statistically significant) and in 2014/15 was also higher than England.

Trend in the proportion of children with excess weight, age 4-5 and 10-11 years (2006/07 - 2013/14)



Source: <http://fingertips.phe.org.uk/national-child-measurement-programme>

- 3.3 Evidence shows that at a basic level, obesity is caused by an intake of calories in excess of calories expended. However, obesity is a complex problem with a range of influences and determinants which makes it difficult for people to adapt their behaviour to make changes to their diet and lifestyle. There is no single effective solution. A complex interplay of factors drives this imbalance of calorie intake and calorie expenditure including individual physiology, food consumption, food environment, societal influences, individual psychology, the environment in which pupils live and individual physical activity.

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- 3.4 Childhood obesity presents a major challenge to health and wellbeing and is associated with an increased risk of premature mortality in adults, as well as poor health and development in children. Obesity in children is associated with an increased risk of type 2 diabetes, asthma, obstructive sleep apnoea, musculoskeletal problems and cardio vascular disease.
- 3.5 Childhood obesity also impacts on mental wellbeing, including increasing the risk of low self-esteem, anxiety, depression, bullying and poor educational attainment.
- 3.6 High levels of obesity are associated with high levels of deprivation. Opportunities to make healthy choices and achieve a healthy weight can be particularly limited in more deprived areas due to factors including income poverty, restricted availability to access to healthy food and fewer options for children to be physically active.
- 3.7 In Swindon, analysis of NCMP data shows that the trend is for obesity levels to be higher in areas of deprivation. The percentage of obese children in the Reception Year and year 6 varied according to the level of deprivation of the location of the school, from:
 - 3.7.1 7.8% in the least deprived wards to 10.4% in the most deprived wards, in reception year (although this difference did not quite reach statistical significance.)
 - 3.7.2 from 16.9% in the least deprived wards to 19.8% in the most deprived wards in Year 6 (although this difference did not quite reach statistical significance.)
- 3.8 These social gradients have also been observed at a national level in England as a whole.
- 3.9 Self-reported physical activity in children aged 2 to 15 years from the Health Survey for England 2012 (most recent data) show a higher proportion of boys than girls aged 5-15 years (21 per cent and 16 per cent respectively) were classified as meeting current guidelines for children and young people of at least one hour of moderately intensive physical activity per day.
- 3.10 Among both sexes, the proportion meeting guidelines was lower in older children. The proportion of boys meeting guidelines decreased from 24 per cent in those aged 5-7 years to 14 per cent aged 13-15 years. Among girls the decrease was from 23 per cent to 8 per cent respectively. There are no local data on physical activity in children.
- 3.11 The National Institute for Health and Clinical Excellence (NICE) produced public health guidance aimed at preventing and managing childhood obesity and preventing excess weight gain. These guidance cover a range of settings and

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approaches at a population level to prevent children and young people aged under 18 years from becoming overweight or obese (NICE, 2015). These include:

3.11.1 **Local authorities** should work with local partners, such as industry and voluntary organisations, to create and manage more safe spaces for incidental and planned physical activity, addressing as a priority any concerns about safety, crime and inclusion, by:

- providing facilities and schemes such as cycling and walking routes, cycle parking, area maps and safe play areas
- making streets cleaner and safer, through measures such as traffic calming, congestion charging, pedestrian crossings, cycle routes, lighting and walking schemes
- ensuring buildings and spaces are designed to encourage people to be more physically active (for example, through positioning and signing of stairs, entrances and walkways)
- considering particular people who require tailored information and support, especially inactive, vulnerable groups.

3.11.2 **Early years settings:** Nurseries and other childcare facilities should:

- minimise sedentary activities during play time, and provide regular opportunities for enjoyable active play and structured physical activity sessions
- Implement Department for Education and Skills, Food Standards Agency and Caroline Walker Trust guidance on food procurement and healthy catering.

3.11.3 **Schools** Head teachers and chairs of governors, in collaboration with parents and pupils, should:

- assess the whole school environment and ensure that the ethos of all school policies helps children and young people to maintain a healthy weight, eat a healthy diet and be physically active, in line with existing standards and guidance.
- This includes policies relating to building layout and recreational spaces, catering (including vending machines) and the food and drink children bring into school, the taught curriculum (including PE), school travel plans and provision for cycling, and policies relating to the National Healthy Schools Programme and extended schools.

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3.11.4 **Workplaces** should provide opportunities for staff to eat a healthy diet and be physically active, through:

- active and continuous promotion of healthy choices in restaurants, hospitality, vending machines and shops for staff and clients, in line with existing Food Standards Agency guidance.
- working practices and policies, such as active travel policies for staff and visitors.
- a supportive physical environment, such as improvements to stairwells and providing showers and secure cycle parking.
- recreational opportunities, such as supporting out-of-hours social activities, lunchtime walks and use of local leisure facilities.

3.11.5 **Children and young people, and their parents or carers:**

- encouraged to develop physical activity and dietary habits that will help them maintain a healthy weight and prevent excess weight gain.
- encourage people to monitor their own weight and associated behaviours.
- using vending machines in local authority and NHS venues can buy healthy food and drink options.
- can see details of nutritional information on menus at local authority and NHS venues.
- see healthy food and drink choices displayed prominently in local authority and NHS venues.
- have access to a publicly available up-to-date list of local lifestyle weight management programmes.
- Children and young people identified as being overweight or obese, and their parents or carers as appropriate, are given information about local lifestyle weight management programmes.
- Family members or carers of children and young people are invited to attend lifestyle weight management programmes, regardless of their weight.
- Reducing sedentary behaviour (there is an identified need for evidence based guidance on interventions to reduce sedentary behaviour in children and young people).

3.12 The Government is leading a number of initiatives which have both direct and indirect links to tackling childhood obesity that are implemented locally and include:

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- **The Change4Life social marketing campaign:** providing information to support families and individuals to make simple changes to their diet and activity levels
 - **The Public Health Responsibility Deal:** working with the food and drink industry to agree actions that support people to make healthier choices
 - **The National Child Measurement Programme:** to inform local planning and commissioning
 - **The Healthy Child Programme:** the main delivery mechanism for obesity prevention in early years and provides greater emphasis on nutrition, breastfeeding and physical activity
 - **Early Years Foundation Stage framework:** statutory requirements for all early years providers to ensure children in their care are provided with healthy, balanced and nutritious food
 - **Standards for School Food:** Standards stipulating nutrients required for all school food including breakfast, lunch, vending machines and tuck shops
 - **Healthy Start:** Vitamin and food voucher distribution initiative for pregnant women and women with children up to 5 years
- 3.13 Tackling obesity requires a whole system approach across a wide range of issues and partnerships; from planning roads, to promoting cycling and walking and maximising the use of open spaces; to working with local businesses to provide healthy menu options, and developing workplace initiatives that support staff to improve their health and increase activity levels.
- 3.14 This whole system approach needs strong leadership support, with councillors and senior officers representing both planning and public health visibly championing this agenda and helping to create the right conditions for collaborative working across teams and organisational boundaries
- 3.15 Swindon has a Healthy Weight Strategy adopted by both SBC Cabinet and the CCG which aims to reduce obesity by creating
- 3.15.1 An environment that encourages people to live active and healthy lives.
 - 3.15.2 An ethos of taking responsibility for the health of yourself and your family with support when needed.
 - 3.15.3 Communities where a healthy lifestyle is seen as desirable and the norm.
 - 3.15.4 An understanding of what works effectively at individual, community and population level.
- 3.16 Locally using levers, such as policies, to create environments that support both children and adults to maintain healthy weight including:
-

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- 3.16.1 National Planning Policy Framework. Examples include: joint working on new developments such as the New Eastern Villages development, limiting development of hot food takeaways in certain areas, conducting health impact assessments on large planning developments, joint training for both public health and planning to ensure integrated policy work.
- 3.16.2 Transport policy. Examples include reducing carbon emissions, 20 MPH zones, Local Sustainable Transport Fund to improve cycle ways and active modes of transport, development of a Cycling Strategy, setting up of the Playing Out programme.
- 3.16.3 Protection of green spaces e.g. protect land for food growing from inappropriate development, including allotments and particularly the best and most versatile agricultural land, protect parks and open spaces from development, improve the aesthetics of green space, alongside appropriate safety and crime prevention initiatives to encourage people to use their local green space, promote and encourage the use of existing green spaces.

3.17 Local programmes include;

- 3.17.1 Healthy Schools Programme – 47 out of 75 Swindon schools and colleges (63%) are actively engaged in the programme. They have either achieved the healthy school status for another 3 years or they are in the process of completing it.
- 3.17.2 Community cookery classes – this academic year there have been 3 targeted courses on basic cookery and healthy eating:
- Penhill Children's Centre - 8 learners (3 with a learning disability), consisting of young mums and a granddad looking to improve the diet of the whole family.
 - Women's Refuge (Women's Aid). The 3 learners involved are all vulnerable mums with children.
 - Maryfield Supported Housing- 3 young people who have mental health issues or learning difficulties who want to improve their health.
- 3.17.3 Physical activity programmes include health walks, disability sports (takes children 14+ with a disability), tri active programme (young people are involved as part of a family). Primary schools also receive PE and sports premium funding from the Government to encourage and promote physical activity to pupils - for 2015/16 this

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is £8,000 and an additional payment of £5 per pupil except for schools with 16 pupils or less who receive £500 per pupil.

3.17.4 Breastfeeding and the Breastmates peer support programme.

3.17.5 Alive 'n' kicking – healthy lifestyle and weight management programme aimed at children 5-16 years and their families.

3.17.6 Work with children and families on healthy lifestyle by health professionals such as Health Visitors and School Nurses. This includes brief intervention as well as more in-depth support.

3.17.7 Communication and media activity – Change4Life, programme which is aimed at children and their families.

3.17.8 Swindon Borough Council continues to liaise with other providers of leisure and sport such as GLL and the Swindon Sports forum to maximise opportunities to promote an active lifestyle.

3.18 Barriers to making healthy lifestyle changes include the following:

3.18.1 Not recognising that your child is carrying excess weight. Parents do not see their child as having a problem as they are similar to many other children.

3.18.2 Most parents feel that being happy is the most important thing for their child and see restricting their child's intake of chocolate and sweets as difficult.

3.18.3 Busy lifestyle, which restricts time to cook and shop for healthy foods and to be active.

3.18.4 Lack of money to go swimming or to a gym on a regular basis or buy healthy foods.

3.18.5 Fear of letting children play outside independently, due to level of traffic and 'stranger danger'.

3.18.6 Not seeing a healthy lifestyle as a normal and enjoyable thing to do.

3.19 Efforts to tackle childhood obesity are ongoing as outlined above and will continue to focus on a whole systems approach. Other areas for consideration include;

3.19.1 A review of the current healthy weight strategy with a more explicit focus on childhood obesity

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3.19.2 Development of the 'Make Every Contact Count' initiative with front line staff confident in having conversations with people about adopting a more healthy lifestyle

3.19.3 Continue to promote adult healthy weight

3.19.4 Adopt a more innovative approach to a whole systems model of tackling this issue, including across the local authority and its various departments, services and partner organisations, e.g.:

- Transport
- Planning and environment
- Leisure and culture
- Parks and green spaces
- Education and learning
- Health and social care
- Housing
- Workplaces

(see Appendix 3 for more details of how each area can contribute)

4. Alternative Options

4.1 Not to support the Healthy Weight Strategy for Swindon.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 There are no direct financial or procurement implications arising from the delivery of the current strategy. Planned work as outlined in the action plan is covered by existing budgets. The current public health grant allocation funding which covers both child and adults weight management programmes, NCMP, physical activity programmes, healthy schools and other initiatives as outlined in the strategy is £330,500.

Legal and Human Rights Implications

5.2 Legal and Human rights have been taken fully into account in compiling this report. It is considered that the recommendations within this report are compatible with Convention Rights.

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All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 There are implications for improving health and wellbeing, as a result of implementing the strategy through reduced levels of obesity, increased levels of physical activity, healthy eating and nutritional quality of people's diet.
- 5.4 There are positive implications for sustainability through increased uptake of active modes of travel (linking with the Local Transport Plans).
- 5.5 There should be no significant staffing or other implications arising from this report.

Links to One Swindon, Strategic Objectives, Plans and Policies

- 5.6 This links directly to the One Swindon priorities of 'Everyone is enjoying sports, leisure and cultural opportunities and, 'living independently, protected from harm, leading healthy lives and making a positive contribution.
- 5.7 It also will help deliver the corporate priorities of 'Together, find new ways to reduce vulnerability and improve health for all' and 'Work with people and families to help them fulfil their potential'. The latter is particularly pertinent as obesity can lead to bullying, social isolation and further health problems and supporting people to achieve and maintain a healthy weight can significantly improve quality of life.

Diversity Impact Assessment

- 5.8 The strategy includes a diversity impact assessment. No adverse or significant issues were found.

Risk Management

- 5.9 No specific risks have been identified at this stage for this report, however not addressing issues around the potential increase in levels of obesity is likely to have a negative impact on health outcome.

6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 - Healthy Weight Strategy 2013-2015

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8.2 Appendix 2 - Summary of Action plan

8.3 Appendix 3 - Whole systems approach to tackling obesity

Swindon's Healthy Weight Strategy 2013 - 2015



December 2013

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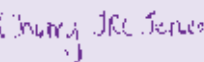
Forward

Obesity is a major public health problem which costs the NHS in Swindon £31million a year, increases costs to social services and has a negative impact on the local economy. It is caused by an energy imbalance between what we eat and what we do. Overweight and obesity affects children and adults; in Swindon one in ten 4-5 year olds and one in five 10-11 year olds are obese. Being overweight or obese can affect people’s ability to make the most of their lives. It also increases the risk of illnesses such as stroke, heart disease, type 2 diabetes and dementia.

Learning about healthy eating is important from a young age to enable children to make the healthy choice the first choice when growing up. This strategy includes actions to both prevent people becoming overweight and to support people who need extra help in making healthy food choices and managing their weight. Working with partners who can contribute skills, knowledge and influence is key to achieving our strategy, together with talking to local people about what encourages them or makes it difficult to be a healthy weight. It is a ‘healthy weight’ rather than an ‘obesity’ strategy to capture what we are aiming to achieve in Swindon and recognises that weight can be an issue for anyone.

Achieving a healthy weight depends on factors in every part of life: the environment we live in, our workplace, school, social life and the people around us. In Swindon we want to build on the good work to date and the legacy of the Olympics to create an environment where people have the opportunity and are supported to be a healthy weight. We also know that these influences are not the same for everyone – the strategy is also about reducing inequalities and ensuring people living in particular parts of Swindon are not more likely to become ill than in other areas. Eating well and being physically active go hand in hand so this strategy should be read together with the Active Swindon Strategy which is about getting more people in Swindon active.

We are committed to making Swindon a great place to live, work and play. Obesity levels in Swindon are not increasing but nor are they going down. We need to work together to make eating healthily and being active a reality for everyone.



Cherry Jones
Acting Director of Public Health
Swindon Borough Council



Brian Mattock
Deputy Leader of the Council
Cabinet Member for Health
and Adult Social Care

Swindon Borough Council

1. Executive summary

The vision

A Swindon where everyone achieves and maintains a healthy weight

The Aim


To encourage people in Swindon to reduce obesity and maintain a healthy weight by creating:

- an environment that encourages people to live active and healthy lives
- an ethos of taking responsibility for the health of yourself and your family with support when needed
- communities where a healthy lifestyle is seen as desirable and the norm
- an understanding of what works most effectively at an individual, community and population level by including effective evaluation and learning from others.

Being overweight is caused by an energy imbalance between what we eat and how much we move about. Healthy eating and physical activity go hand in hand to achieve a healthy weight. An integral part of achieving the vision is delivery of the Active Swindon Strategy.

Objectives

There are 4 key objectives:

1. To deliver a range of evidence based policies and programmes across different settings that reflect the needs of people at different points in the life course to:
 - develop a less obesogenic environment
 - prevent obesity
 - manage obesity
- 

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graph LR; Children --> Teenagers; Teenagers --> Young Adults; Young Adults --> Adults; Adults --> Older People;
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2. To tackle the inequalities in health outcomes in relation to obesity by targeting services appropriately
 3. To monitor progress related to targets as part of an on-going action plan to ensure activity and investment is effective and meeting local need

Key targets

- Reducing obesity at age 11 years to the same level or less than the average for England (Source: National Child Measurement Programme (NCMP) data)
- Increasing the number of people physically active to 25% by 2015 (Source: Active Peoples’ Survey.)
- Reducing inactivity in line with national targets (Source: Active People’s Survey.)

2. Introduction

Ensuring local people are encouraged to develop and maintain a healthy weight is a key part of the role of public health. Obesity is a major problem in today’s society and predicted to become worse if nothing is done. It is linked to a range of health problems particularly in later life which reduce life expectancy and reduce quality of life.

This strategy sets out a vision and rationale for co-ordinated multi- agency action to achieve a healthy weight in Swindon, identifying where integration of other strategies is necessary. Moving forward the focus will be on encouraging people in Swindon to achieve a healthy lifestyle recognising the interaction between what we eat, how active we are, whether we smoke and drink. Services will be co-ordinated to promote and signpost other initiatives to support people more holistically.

This healthy weight strategy sets a clear picture of the consequences of obesity and the current known prevalence, establishing it as a major public health issue.

- The guiding principles of the strategy are to ensure that:
- Recommended actions are based on reliable up-to-date evidence, national guidelines and targets, and address health inequalities.
 - Monitoring and evaluation is an integral part of all work.
 - A multi-sectorial approach is used (involving the Local Authority, NHS, other public sector, voluntary sector and private business in partnership) in developing and implementing the action plans.
 - The wider community are involved in development and implementation of the strategy, to ensure ownership.
 - Local communities are empowered to make positive choices regarding physical activity and healthy eating, and address the barriers to weight loss and maintaining a healthy weight.
 - It reflects the Swindon’s Joint Health and Wellbeing Strategy, One Swindon vision and Corporate Objectives.
 - Links to other local strategies, policies and targets which underpin the healthy weight strategy, are recognised e.g. Swindon Borough Council’s transport strategy, Local Plan and Development Management Policies.

- Awareness of the risks associated with obesity and the benefits of weight loss are raised, in order to create a culture of change e.g. increased risk of heart disease, stroke and type 2 diabetes.
- Needs are addressed, identifying and acknowledging cultural, religious and gender issues and those individuals at increased risk of obesity e.g. people in lower socio-economic groups, particularly women.
- Training and education is developed for all front line staff so they provide consistent advice reflecting local and national best practice and are able to signpost across services.

Much of the focus in terms of developing and maintaining a healthy weight tends to be on tackling obesity. However for around 2% of adults gaining weight is important as they are underweight according to the Health Survey for England. This strategy recognises the importance of underweight as a public health issue but does not address it explicitly. There are other strategies and care pathways which specifically focus on issues around being underweight.

Defining healthy weight and overweight

Weight is often classified using the Body Mass Index (BMI), which calculates the amount of excess body fat in relation to a person’s height^{1, 2}. For adults, underweight is defined as a BMI of less than 18.5; overweight is defined as a BMI of over 25; and obesity is defined by a BMI over 30 (see table 1).

Table 1: Classification of underweight, overweight and obesity in adults

BMI (kg/m2)	CLASSIFICATION
Less than 18.5	Underweight
18.5 to 24.9	Healthy weight
25 to 29.9	Overweight
30 to 34.9	Obesity I
35 to 39.9	Obesity II
40 or more	Obesity III

BMI does not take into account factors such as size of body frame, proportion of lean body mass, gender and age and is not a direct measure of underweight, overweight or obesity. However it is a fairly reliable indicator of body fatness for most people and is an inexpensive and easy-to-perform method of screening for weight categories that may lead to health problems. Although it does not measure body fat directly it has been shown to correlate well to direct measures of body fat. If there is doubt about a person’s health risk, additional assessments such as waist circumference, skinfold thickness, diet and physical activity can be carried out.

Presently there is debate about the definition of childhood obesity and the best way to measure it in England. For clinical practice the Royal College of Paediatrics and Child Health growth charts are recommended, which include BMI, for children aged 2-18 years (2012). For public health programmes, such as the NCMP and the Health Survey for England, the British 1990 growth reference (UK90) charts are used. Assessing the BMI of children is more complicated than for adults because a child’s BMI changes as they mature. Growth patterns differ between boys and girls so both the age and sex of a child needs to be taken into account when estimating BMI. Because the relationship between a child’s BMI and the level of fatness changes over time, fixed thresholds such as those used for adults should not be applied to children as they would provide misleading findings. For these reasons a special measure called a growth reference must be used.

Underweight

The focus of this strategy is tackling obesity as this is a major complex health issue. However around 2% of adults are underweight according to the Health Survey for England. Although proportions are small, there has been an increase in adults identified as underweight, particularly for men increasing from 1.2% in 2007 to 2.2% in 2009.

For children, NCMP data shows that the proportion of underweight children in England in reception year was 0.9% for the 2012/13 school year. Underweight has reduced in reception years from 1.3% in 2006/07. In Year 6, the proportion of underweight children (1.3%) in 2012/13 was also lower than in 2006/07 (1.5%). A

recent study by researchers at University College London (Institute of Child Health) found that 1.5 in every 200,000 British children under 10 have anorexia nervosa.

Older People are particularly vulnerable to malnutrition and becoming underweight. A Call to Action from the Conference of the European Nutrition for Health Alliance in 2005 included research which found that malnutrition amongst older adults in the community could be as high as 40%. Nationally the Care Quality Commission have carried out inspections to look at whether the dignity of older people is respected and if their nutritional and hydration needs are met in inspections of care homes (both nursing and residential), mental health trusts and acute trusts. Locally the Great Western Hospital have malnutrition and respect as a priority as a result of these inspections- staff are trained to use MUST, a nutrition screening tool for all patients, and there is a care pathway of action to take if there is a risk of malnutrition. There has also been training on malnutrition with GPs and care home staff by the community dietitians.

Children who are underweight in Swindon are identified through a number of routes. One is from NCMP measures. School nurses follow up children found to be underweight, unless they are known to be already being seen for medical reasons. Another route for identification of underweight is when visiting a GP with medical problems.

Underweight is considered to be a possible sign of neglect in children. There is on-going discussion about whether severe child obesity is also a sign of neglect. Section 11 of the Children Act 2004 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children. Child protection training is mandatory for all staff employed by partners in this strategy to ensure that there is awareness of the child protection issues around the issue of weight in children.

Causes of obesity

The fundamental cause of obesity is an imbalance between energy intake and expenditure, which is brought about by consuming more calories than are expended in daily life. It has been argued that obesity is a predictable response to an increasing sedentary environment with, in general, a wide availability of food³.

The relationship between energy intake and expenditure may be influenced by genetic, social, cultural, psychological, environmental and economic factors. It is likely that obesity is the result of a combination of factors including³:

- Lifestyles becoming increasingly sedentary.
The number of hours spent watching television has increased and a more automated lifestyle (increased use of domestic appliances and the motor car, and more sedentary occupations) has reduced the amount of physical activity incorporated into daily life ^{4,5}.
- Alcohol is associated with increased risk of obesity as many people are not aware of the calories in alcoholic drinks and alcohol consumption can be linked to an increase in food intake .
- Children in particular are becoming less active with only 21% of boys and 16% of girls aged 2-15 years in England in 2012 meeting the Chief Medical Officer’s recommendation of a minimum of 60 minutes of at least moderate intensity physical activity each day^{6,44}. For girls this varied by age from 35% at aged 2 to 12% at aged 14.
- The UK diet has been changing significantly since the 1950s in terms of both the types and amount of food consumed. There is an increased availability of energy dense convenience foods and an increase in food eaten outside the home.
- The high energy density of many convenience foods (a typical fast food meal contains more than one and a half times as many calories as an average traditional British meal) means that people often unconsciously consume more calories than the body needs. Studies show that there is a tendency to overeat on high fat diets, a phenomenon called ‘high-fat hyperphagia’ or passive over-consumption of fat³. Consuming high sugar foods and drinks has been shown to have a similar effect. Another factor is that portion size is increasing. Evidence from several research studies shows that when faced with larger portions, people eat more³.

There are a number of factors that seem to predispose an individual to obesity and certain groups are known to be more at risk of obesity than others.

- Obesity is more common in some minority ethnic groups and less common in others⁷. Women of black African, black Caribbean and Pakistani origin have marked higher obesity prevalence rates than those in the general population. Chinese women have significantly lower obesity prevalence rates. Men from minority ethnic groups have markedly lower obesity prevalence rates than those in the general population, with the exception of black Caribbean and Irish men where there was a higher incidence. These differences may be the consequence of genetic, cultural or socio-economic factors or more likely, some combination of all three⁸.
- Obesity prevalence is greatest among those of low socio-economic status. The Health Survey for England shows that in 2011, the prevalence of obesity increased with increasing levels of deprivation for both men and women. 22% of men and 19% of women in the least deprived quintile were obese, rising to 25% and 30% respectively in the most deprived quintile. However, the pattern was reversed for the prevalence of overweight, which was highest among both men and women living in the least deprived areas⁹.
- There is little detailed evidence on whether people who are lesbian, gay, bisexual or transgender are more likely to be overweight or obese. However some studies show a higher prevalence of obesity amongst lesbians than heterosexual women¹⁰. Theories as to why this is include the impact of stress and different exercise patterns although this has not been widely researched.
- There is conflicting evidence connected to diet related to intake in low income groups. Studies in the USA have shown that those who live in low income neighbourhoods have less access to reasonably priced healthy food than in more affluent areas³. This poor diet may lead to obesity. However a low income diet and nutrition survey published in England by the Food Standards Agency in 2007 did not find any direct link between dietary patterns and incomes, food access or cooking skills¹¹.

- There is some national evidence¹² that the prevalence of obesity is increased amongst people who have a disability or limiting long term illness (LLTI), particularly with the four most prevalent disabling conditions in the UK: arthritis, back pain, mental health disorders and learning disabilities. This is thought to be due to reduced mobility, the effects of medication, and difficulties in accessing exercise opportunities. People with a learning disability are more likely to be underweight or obese than the general population¹³, with an increased risk at a younger age and with some types of learning disability such as Downs Syndrome. People who suffer from both obesity and common mental health disorders may also face particular risks to health and well-being, as it is likely that the conditions may perpetuate each other⁴¹

- Analysis of NCMP data for Swindon showed that the prevalence of obesity was higher in schools located in the most deprived areas compared to those located in the least deprived areas. This is also reflected nationally¹⁴.

Consequences of obesity

Obesity is an important risk factor for known chronic medical conditions and premature death in adults. In addition to the physical consequences of obesity the psychological and social consequences of obesity are immense.⁴ There is good evidence of an association between childhood obesity, chronic medical conditions and psychological consequences¹⁵ (Table 2).

Table 2: Physical, Psychological and Social Consequences of Obesity^{4,15}

CONSEQUENCES	ADULTS	CHILDREN
PHYSICAL	Non-insulin dependent diabetes mellitus Raised blood cholesterol Coronary heart disease	Type 2 diabetes mellitus Raised blood cholesterol Adverse changes in left ventricular mass Increased blood pressure
	Stroke High blood pressure Osteoarthritis Gall bladder diseases Ovarian cancer, breast cancer and cancer of the colon Infertility Increased anaesthetic risk Respiratory disease and sleep apnoea Pregnancy complications Surgical complications Increase premature mortality Avoidance of physical activity	Development of asthma and worsening of pre-existing asthma Abnormalities of foot structure Persistence into adulthood and predisposition to the medical problems of adulthood Early puberty onset Avoidance of physical activity
PSYCHOLOGICAL	Depression Guilt, anger, frustration and low self esteem Eating disorders	Low self esteem, and depression Disordered eating, bulimia, negative self image
SOCIAL	Stigma Breakdown in relationships Potential for altered health behaviours Discrimination Isolation Employment difficulties Days lost from work Lack of participation in sport	Poor school performance Bullying Can lead to poor school attendance Lack of participation in sport

Obesity significantly increases the risk of death at any age¹⁶ however the risk of death is influenced by the individual level of physical activity. Physically fit obese individuals have lower mortality risks than otherwise unfit obese individuals¹⁷. For young adults the risk of mortality for someone with a BMI of 30 is 50% higher than that of someone with a BMI in the normal range (20-25). For those with a BMI greater than 35 this risk is doubled⁵.

Based on international literature it is estimated that women who are obese are 12.7 times more likely to develop type 2 diabetes and 1.3 times more likely to experience a stroke than non-obese women. Obese men, whilst having the same increased risk for stroke as women, are 5.2 times more likely to develop type 2 diabetes⁴ (Table 3).

Table 3: Estimated increased risk for the obese of developing associated diseases⁴ compared to people of a 'healthy weight'

DISEASE	RELATIVE RISK* FOR WOMEN	RELATIVE RISK FOR MEN
Type 2 diabetes mellitus	12.7	5.2
Hypertension	4.2	2.6
Myocardial infarction	3.2	1.5
Cancer of the colon	2.7	3.0
Angina	1.8	1.8
Gall bladder diseases	1.8	1.8
Ovarian cancer	1.7	-
Osteoarthritis	1.4	1.9
Stroke	1.3	1.3

*relative risk is used to compare risk in 2 different groups of people

In Swindon according to Quality Outcome Framework data 2011/12 recorded by GPs, there are over 10,302 people with diabetes (4.7% of patients registered) and over 29,866 people with hypertension (13.5% of patients registered).



In addition to these risks, obesity increases clinical risks e.g.

- Obesity in pregnancy is associated with an increased risk of a number of serious adverse outcomes, including miscarriage, pre-eclampsia, postpartum haemorrhage, wound infections, stillbirth, maternal and neonatal death⁴¹.
- Obesity increases risks of complications following surgery⁴².

Economic cost of obesity

A 2010 report ‘the Economic Burden of obesity’ by the National Obesity Observatory drew together literature highlighting:

- in 2007 direct costs of obesity to the NHS were £4.2 billion
- obesity accounted for between 0.7% and 2.8% of a country’s total healthcare expenditure, raising to 9.1% for overweight and obese
- in 2008 in England the average spending by a Hospital Trust on specialist equipment (e.g. larger beds, chairs, hoists) was £60,000
- obese individuals are estimated to have medical costs 30% higher than normal weight peers.

Further work is required to calculate the costs of obesity to Local Authorities e.g. to social services, the impact on the local economy and educational achievement.

3. Where are we now?
National context

Policy framework

In 2008 the Department of Health published the national strategy ‘Healthy Weight, Healthy Lives’ followed by:

- Guidance for local areas⁷
- A toolkit for developing local strategies⁸
- Commissioning weight management services for children and young people⁹

In 2011 the Department of Health published ‘Healthy Lives, Healthy People: a call to action on obesity in England which:

- Focused on a whole population approach to reducing obesity which covers all life stages
- Included plans to measure adults as well as child obesity to encourage a more outcomes based approach

This included two national ambitions:

- A sustained downward trend in the level of excess weight in children by 2020
- A downward trend in the level of excess weight averaged across all adults by 2020

It also outlines a role for local government including:

- Promoting active travel
- Ensuring widest possible access to opportunities to be physically active
- Making the most of the potential for the planning system to create a healthier built environment
- Working with local businesses and partners to increase access to healthy and affordable food choices
- Linking activities on healthy weight to initiatives relating to the environment and sustainability
- Making the most of key opportunities to engage with communities and promote behaviour change

This is underpinned by the role of the Health and Wellbeing Boards which have a statutory responsibility to develop and implement a Health and Wellbeing Strategy by bringing together key partners and understanding the needs of the local area. NICE

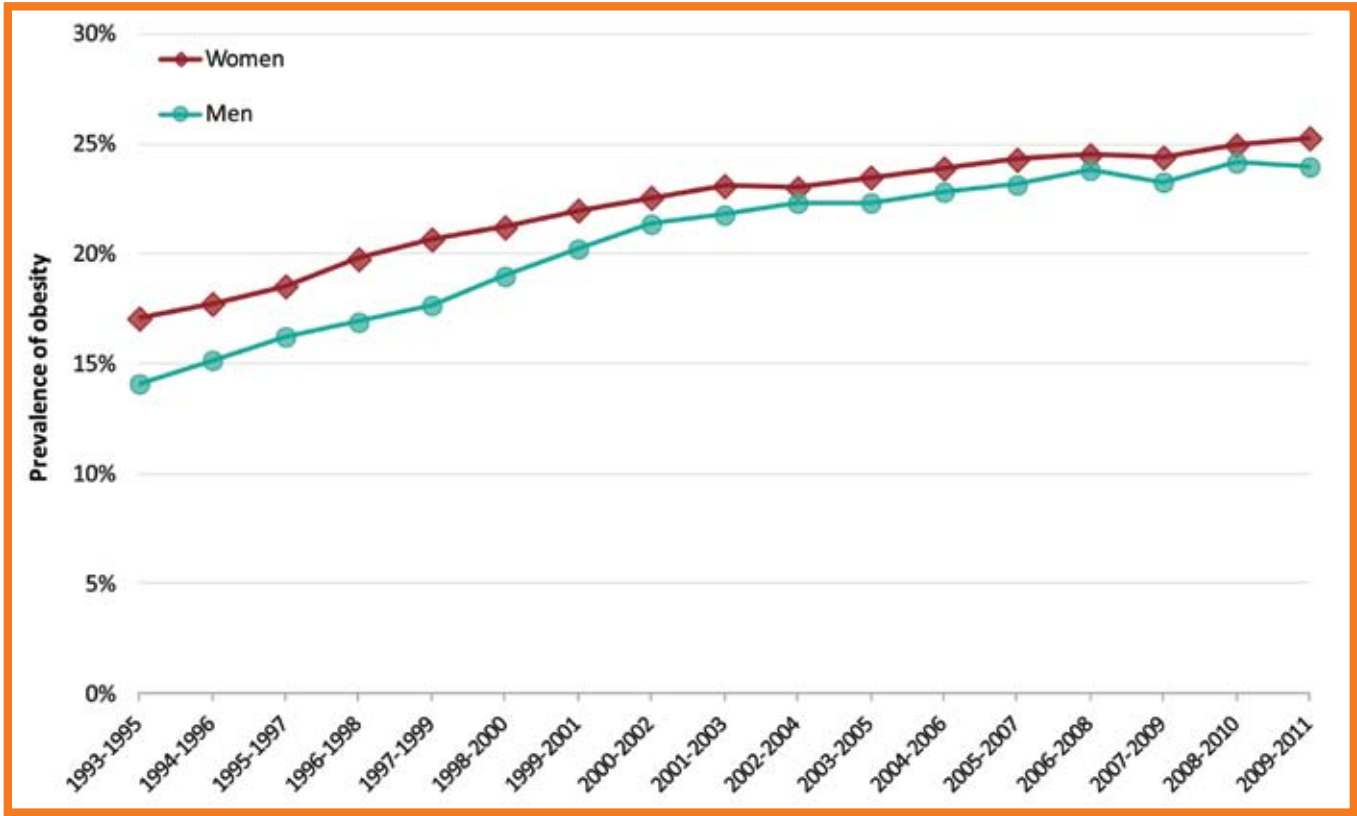
Guidance published in November 2012 included an expectation that Directors of Public Health would secure high level commitment as part of the Health and Wellbeing Strategy to long-term integrated action on obesity.

“Directors of Public Health would secure high level commitment as part of the Health and Wellbeing Strategy”

Prevalence of obesity

Adult obesity in the UK has more than doubled over the last 25 years; 24% of men and 26% of women were obese in 2011²¹ (most recent figures) whereas 8% of men and 12% of women were obese in 1986/87²². Chart 1 shows the trend since 1993 (however it does not include the 1986/87 figure as it was a separate survey although done using the same methods). Obesity is also an increasing problem in children. Between 1995 and 2010 the proportion of obese children (aged 2-15 years) increased from 10.9% to 16.6% in boys and from 12.0% to 15.9% % in girls. Whilst the proportion of children who are obese has increased notably over the last 15 years, the prevalence of overweight children aged 2 to 15 has remained fairly constant²³.

Chart 1: Prevalence of obesity amongst adults²⁴: (Health Survey for England 1993-2011 BMI >=30kg/m2 (3 year average))



National interventions

There are a number of government strategies and programmes that will impact achievement and maintenance of a healthy weight.

✓ **Change4life²⁵** was launched in 2009 in England and is a government backed, phased campaign aiming to prevent obesity. The initial phase was a social marketing campaign targeting young families to ‘Eat Well, Move More and Live Longer’. It is now extended to include all adults and children and provides a range of resources to encourage healthy living. Evaluation²⁶ of the first year found that families were making changes to their children’s diet or activity levels but further work was required to assess whether this led to reductions in obesity. Campaigns in 2012 included promoting quick and healthy meals on a budget and Games4Life building on the interest from the Olympics. Campaigns for 2013 included ‘Get Going this Summer’ promoting physical activity for adults and children and ‘Back to School’ to encourage and support parents to make a positive change to their family’s routine

- ✓ **Every Child Matters** (2003) was an approach to the wellbeing of children and young people from birth to age 19 years²⁷ The aim was for every child, whatever their background or their circumstances, to have the support they need to be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing.
- ✓ **Healthy Lives, Healthy People: A call to action on obesity** (2011) is the national strategy for improving public health in England, in response to future challenges including obesity. It includes:
 - Local government taking new responsibilities for public health (including obesity and nutrition initiatives), supported by Public Health England
 - A stronger focus on outcomes
 - A commitment to reduce health inequalities

- ✓ **The Healthy Start Scheme**, which replaced the Welfare Food Scheme²⁸. It allows eligible pregnant women, mothers and young children to get free vitamins and free weekly vouchers to exchange for milk, fresh fruit, vegetables and infant formula. From April 2013, it will be the responsibility of the new commissioning bodies (NHS England, Clinical Commissioning Groups, and where Local Authorities provide child health clinics) to arrange the provision of Healthy Start vitamins.
- ✓ **Sure Start** is a government programme to deliver the best start in life for every child focussing on disadvantaged areas²⁹. Information and guidance on breastfeeding and nutrition are offered on the programme which is delivered via the Sure Start Children’s Centres.
- ✓ **The Healthy Schools Programme** is delivered at local level. It was originally a national programme focusing on food and physical activity. Implementation and monitoring is on a ‘schools led’ basis.
- ✓ In 2011 the⁴ Chief Medical Officers in the UK launched **new physical activity guidelines³⁰**:
 - Under-fives
180 minutes – (three hours) – each day, once a child is able to walk.
Children and young people (5-18 year olds)
60 minutes and up to several hours every day of moderate to vigorous intensity physical activity.
 - Adults (19-64 years old) and older people (65+)
150 minutes – (two and half hours) – each week of moderate to vigorous intensity physical activity (and adults should aim to do some physical activity every day).
- ✓ **School meals-** Compulsory nutrient based standards and food based standards were introduced in September 2008 in primary schools and in September 2009 in secondary schools. Food based standards for ‘food other than lunch’ (e.g. tuck shops and vending machines) were introduced in September 2007. Together these standards cover all food and drink sold or served in schools³¹ to ensure that children have a healthy balanced diet. This means there must be high-quality meat, poultry or oily fish, at least 2 portions of fruit and vegetables with every meal and bread, other cereals and potatoes³². Academy schools are exempt from the standards although some

do choose to follow them. The school food plan was launched in 2013⁴⁵. This is a plan of action to improve the quality and take up of school food. From September 2014 every child in state funded schools will receive a free school lunch.

- ✓ **5ADAY Programme³³**-Current recommendations are that everyone should eat at least 5 portions of a variety of fruit and vegetables each day, to reduce the risk of death from chronic diseases such as heart disease, stroke, and cancer by up to 20%³⁴. The National School Fruit and Vegetable Scheme is part of the 5ADAY programme to increase fruit and vegetable consumption, offering every child age 4 to 6 years old at a fully state funded infant, primary or special school a free piece of fruit or vegetable on every school day.
- ✓ **Healthy Eating Advice** The Government has a set of Eight Guidelines for a Healthy Diet³⁵. It aims to help people to understand and enjoy healthy eating. The guidelines are supported by the Eatwell plate, a pictorial food guide showing the proportion and types of food that are needed to make up a healthy balanced diet.
- ✓ **Choosing Better Oral Health:** an oral health plan for England (2005) highlighted that the majority of the English population consumes more sugar than the recommended 60g per day³⁶. There are particular concerns over the high level of the consumption of soft drinks, confectionery and biscuits among pre-school children, adolescents and older people as well as people living in areas of material and social deprivation. Some of the foods we associate with a modern diet such as fruit, fruit teas, wine and soft drinks contain acids that can lead to acid erosion of the teeth. This is defined as loss of tooth substance caused by the direct action of chemicals on the tooth surface. It is particularly vulnerable to erosion by soft drinks including carbonated and fruit based ones, and may affect up to 25% of children with deciduous teeth. General advice is to keep food and drink that contains sugar to no more than four times in a day.
- ✓ In 2009 **Delivering Better Oral Health: a toolkit for prevention** set out the evidence base and clear guidance on healthy eating advice, toothbrushing, fluoride and the importance of regularly attending the dentist. A new version is expected in 2014.

✓ **The Local Transport Plan**³⁷ is a statutory requirement for every local authority with a responsibility for transport. It must set out the transport objectives that the Council wants to achieve over the next five years, and the types of schemes, which the Council would like to implement. These schemes include measures to encourage walking, cycling and public transport use.

Local context

Overview of Swindon

Swindon is a new and growing town with a higher proportion of the population of working age than in England as a whole. Swindon’s population is forecast to rise by about 5% by 2015 and about 15% by 2022 from around 201,000 in 2010 to 232,000 in 2022³⁸.

Broadly speaking, the main shift will be to a more ‘middle-aged’ and older population. It is estimated that the number of people aged 65+ years will increase by 34.0%, and the number of people aged 85+ by 59% by 2022.

2011 Census data for Swindon shows 84.6% of its people were white British, 6.4% Asian / Asian British and 1.4% Black/African/Caribbean/Black British, 0.9% Irish, 0.1% are from traveller communities and 4.2% other white which includes Eastern European.

Implication of population changes for supporting increasing physical activity and eating a healthy diet are important as people’s expectations and requirements change as they age. The take up of different activities can also reflect cultural strengths and barriers to participation e.g. swimming has very low uptake by Asian women.

There are extremes of poverty and wealth in the borough, and deprivation can have an impact on reducing participation rates for physical activity or affecting type of diet eaten. Of the 119 Super Output Areas’ in the

Swindon Unitary Authority area in 2010:

- 18 are among the most deprived 20% nationally overall,
- 1 is within the most deprived 5% nationally
- 28 are among the most deprived 20% nationally for education, skills and training,

Within life expectancy figures there are major variations with those in the lowest quintile for social deprivation in Swindon having a life expectancy of more than 5 years less than those from the highest quintile (75.7 years in Parks compared with 82.6 years in Covingham-Nythe). The Slope Index of Inequality data for 2006-08 shows that life expectancy is 8.8 years lower for men and 5.8 years lower for women in the most deprived areas of Swindon than in the least deprived areas.

Health inequalities in Swindon are focused in a small number of localities. These localities are also poor performers in relation to other ward indicators such as economic indicators and have poor educational attainment.

The impact of local demographic characteristics and changes will mean that there will be:

- increased demand for services to prevent and treat obesity due to a growing population and an increase in obesity over time in both adults and children
- a need for targeting services to tackle obesity in the most deprived communities, where obesity prevalence is highest in the population and people have less choices to improve their health.
- development of services to meet the needs of communities and groups where obesity prevalence is particularly high such as learning disability groups, certain BME communities and deprived communities.



Prevalence of obesity

Measuring adult obesity on a population basis is very costly for local areas, therefore it is not carried out at present. Adult obesity prevalence data from synthetic estimates by the Department of Health and Association of Public Health Observatories (with interpretation by the South West Public Health Observatory²⁰) predict that Swindon’s prevalence of adult obesity is higher than the England average (27% compared to 24.2%). One of the Quality Outcome Framework (QOF) indicators for GPs is that each practice can produce a register of patients aged 16 and over with a BMI of

greater than or equal to 30 in the previous 15 months: across Swindon in 2011/12 20,389 people were on the register, 9.2% of the total practice population. This underestimates adult obesity as obesity is not systematically measured in GP practices in all patients when they visit as it is not necessarily relevant to their care.

The 2011/12 NCMP results in table 4 show that in Swindon the prevalence of obesity in 4 to 5 year olds is 9.9% and in 10 to 11 year olds is 19.2%.

Table 4: % of children identified as obese by NCMP³⁹

Year	Reception Year (aged 4-5)		Year 6 (aged 10-11)	
	Swindon	England	Swindon	England
2005/06	11.0%	10.0%	19.1%	17.3%
2006/07	9.8%	9.9%	17.4%	17.5%
2007/08	9.1%	9.6%	19.1%	18.3%
2008/09	9.5%	9.6%	16.5%	18.3%
2009/10	9.4%	9.8%	16.7%	18.7%
2010/11	8.6%	9.4%	17.3%	19.0%
2011/12	9.9%	9.5%	19.2%	19.2%

Chart 2 shows the trend in obesity over time for Reception Year children. The confidence intervals on the columns take account of the fact that the data is

from a sample of children each year and because they overlap year on year for Swindon this indicates there is no significant change year to year.

Chart 2: % of children identified as obese by NCMP³⁹

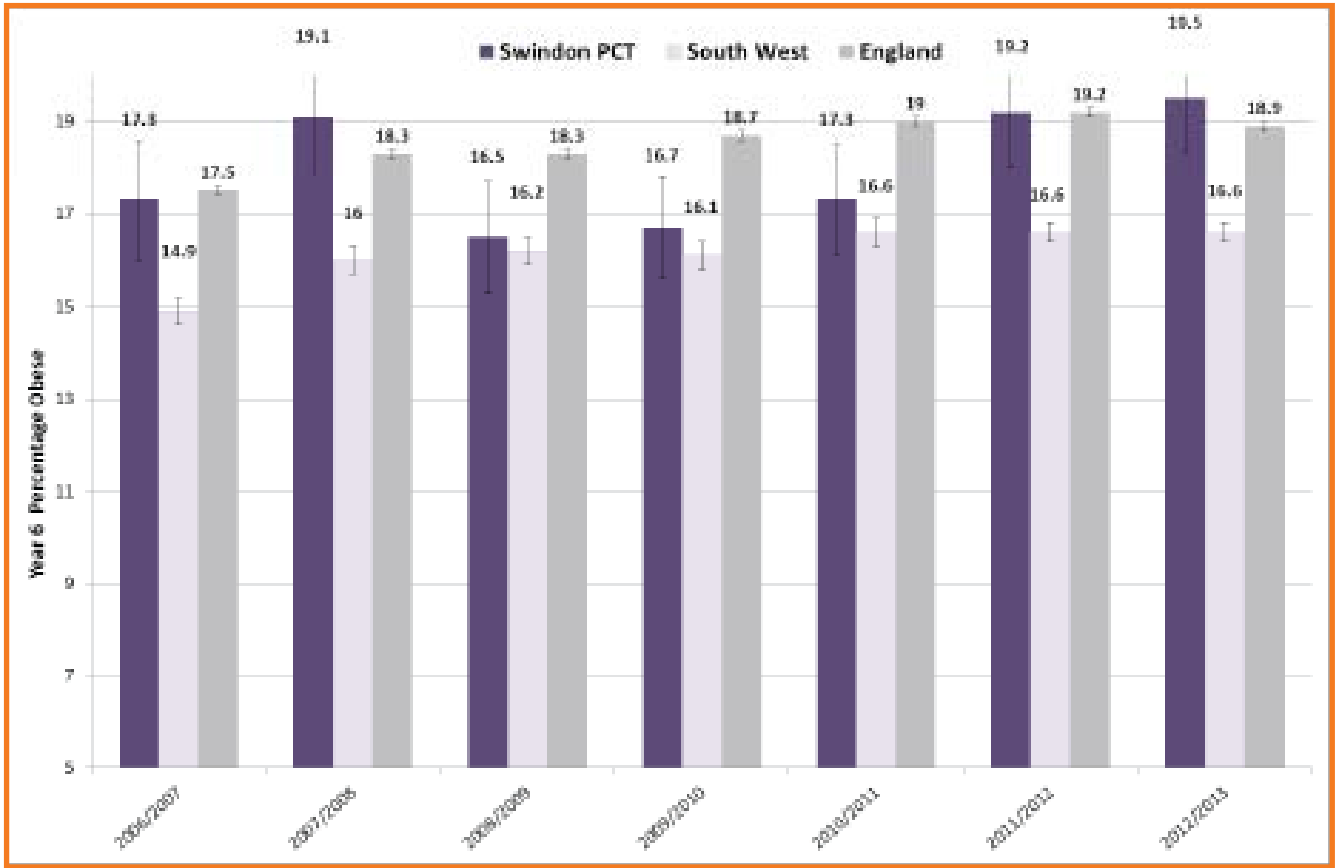


Chart 3 compares Swindon to its nearest neighbours based on a range of social and environmental factors. These are a more accurate comparison than say other

areas in the south west which may be socially or demographically very different to Swindon.

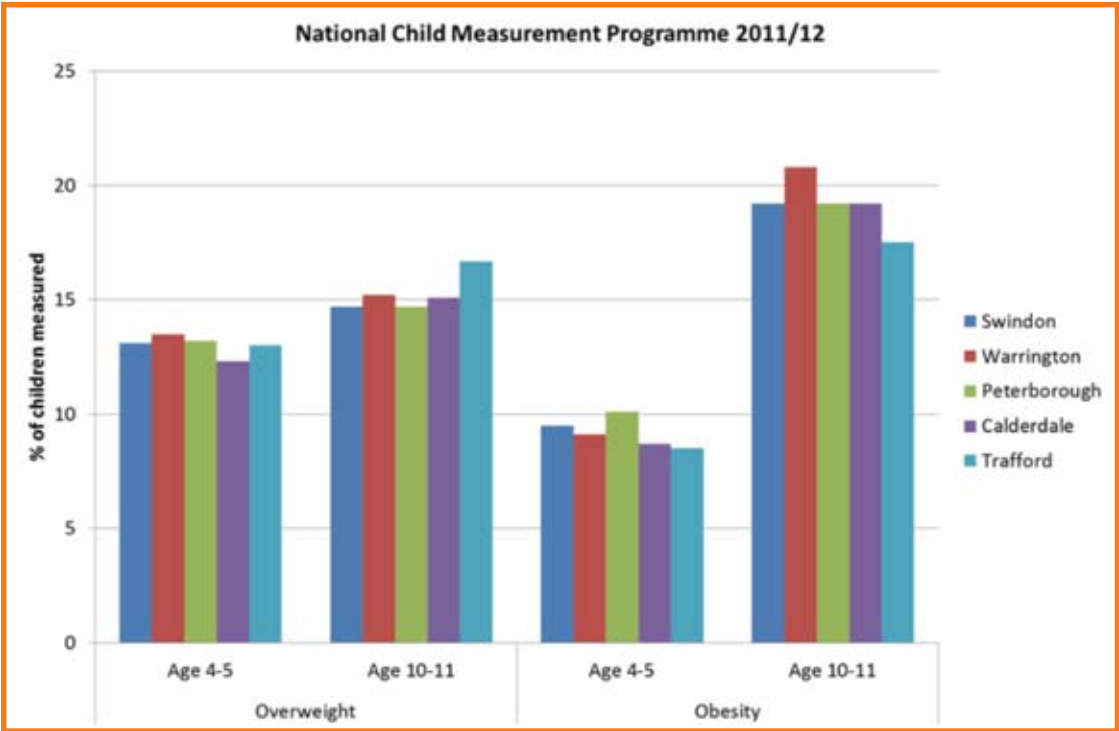


Chart 3: NCMP recorded levels of childhood overweight and obesity for Swindon and comparator areas

The national dental survey⁴⁰ measures the proportion of children with teeth which are missing, decayed or filled. For Swindon in 2008/9, 28.1% of 12 year old children had some sort of decay experience (with one or more obviously decayed, missing (due to decay) and/or filled teeth). For 5 year olds (latest survey is 2007/08) this was 30.6%. Both are based on a sample of children.

Local interventions

In Swindon interventions include both local implementation of national interventions and local activity specific to the needs of the borough. Table 5 highlights the national interventions we are implementing and Table 6 the breadth of local interventions by age groups and setting.

Table 5: Local activity on National Initiatives

	Local activity
Change4Life	Implemented locally
Every Child Matters	Informs both health and local authority strategies
Healthy Lives Healthy People: a call to action on obesity	Informs overall development of Healthy Weight Strategy
Healthy Start / Sure Start	As well as services provided by health visitors, Swindon also has a Healthy Steps programme which is a healthy lifestyle and cookery course for the parents of 0-5 year olds. The Baby Friendly Initiative is also implemented locally.
Healthy Schools Programme	Implemented locally. Schools can also bid for funding from Public Health to support 'Healthy Weight' projects. 12 schools received funding in 2012/13 and there were 20 applications in 2013/14.
School Meals	Schools are encouraged to follow national criteria i.e. food and nutrient based standards for school meals and 'food other than lunch' standards, through the Swindon Healthy School programme. The national Food for Life Partnership programme is also promoted through the Swindon Healthy Schools programme- (www.foodforlife.org.uk/)
5ADAY Programme	All children aged 4-6 are given a piece of fruit every day.
Choosing Better Oral Health	Work has included the Happy Little Teeth Award scheme for children and nurseries and working with dentists to ensure consistent messages Classroom based lessons are also offered to all key stage 2 and 3 children in every school in Swindon.
Local plan	Public health worked with the local transport department to influence and inform the development of the Local Transport Plan
Physical activity in schools	All implemented locally: Change4Life clubs, Sustran's Bike It programme, Local Schools Sport partnership, Sportivate programme and School games.

Table 6: Local Interventions by setting

Setting	Children and Teenagers	Adults and Older People
Early Years	Breastfeeding Initiative Healthy Steps - healthy lifestyle and cookery course Happy Little Teeth Award scheme for playgroups and nurseries Children’s centres programmes Health Visitors work on weaning and healthy lifestyle	
Schools	School Fruit and Vegetable Scheme Healthy Schools Programme School meals and school food - national food and nutrition standards NCMP Food for Life Partnership in schools Sportivate – Sport England Project Active travel to school initiatives	
Community	Child & Family Weight Management Programme Working together with dental health colleagues to ensure consistent messages on public health promotion Dental staff also work with children centres, health visitors and nursery nurses in baby clinics and post natal groups. Swindon Youth Forum – creation of healthy eating DVD	Change 4 Life Physical Activity Programmes Dietbusters- adult weight management Ability sports Community Dietitian Clinics Exercise on referral schemes (Steps to Health) Walking for Health/Walk Swindon Triactive programme - walking, cycling and swimming for inactive people Healthy Eating Basic Cookery Courses Exercise group for COPD Patients Swindon running groups Development of an Obesity Pathway for Adults with a Learning Disability
Workplace		Swindon Mindful Employers scheme Great Western Hospital Travel Policy to encourage walking to work
Environment		Active Travel Promotion walking and cycling as part of built environment development in the Swindon Core Strategy Implementation of the Local Sustainable Transport Fund bid to promote cycling and walking
Hospital	Underweight care pathway Obesity care pathway	Obesity care pathway Maternal obesity pathway Underweight care pathway Intense specialist weight management programme Pre and post bariatric surgery support service Access to bariatric surgery at Bristol, Cornwall, Plymouth, Gloucestershire , Bournemouth & Christchurch or Taunton

4. Where do we want to be?

A life course approach

Healthy Lives, Healthy People: A Call to Action on obesity in England (2011) advocates a lifecourse approach to tackling obesity. As table 7 illustrates there are different challenges to achieving a healthy weight depending on age and the stage of life people are at. There is also increasing understanding that poor nutrition at an early age can have long term consequences for health including increasing the risk of obesity and chronic disease.

Table 7: Challenges for achieving a healthy weight by lifecourse stage

Children	Teenagers	Young adults	Adults	Older People
Early years support - breastfeeding - maternal care - postnatal depression School support - preventing obesity - identifying underweight - working with parents, particularly obese parents	Concern over image: - opportunities for healthy eating - barrier to physical activity - power of peers - power of media	Maintaining a healthy and active lifestyle: - when leaving home - at university - financial constraints Personal responsibility	Role as parents / carers Healthy eating Risk of chronic diseases Work-life balance Pregnancy Cooking Skills Personal responsibility	Maintaining good nutrition Issues around weight loss Encouraging active lifestyle Co-morbidities and long term conditions Personal responsibility

The Healthy Weight strategy for Swindon will complement and add to those population interventions developed by the Department of Health such as Change4Life, as well as implementing national initiatives locally where appropriate. As well as targeting different stages of life, activity for Swindon will also:

- be targeted via a range of different settings
- ensure that all levels of need are met via pathways to care
- focus on prevention as well as diagnosis and treatment
- reflect the whole community including those with physical or learning disabilities
- link to other strategies to ensure working stronger together applies to achieving healthy weight in Swindon

Priorities for action

The Health and Wellbeing strategy for Swindon has five outcomes:

- Every child and young person in Swindon has a healthy start in life
- Adults and older people in Swindon are living healthier and more independent lives
- Improved health outcomes for disadvantaged and vulnerable communities
- Improved mental health, wellbeing and resilience for all
- Creation of sustainable environments in which communities can flourish

These address some of the key points across the life course and also prioritise addressing health inequalities. The objectives to address healthy weight in Swindon link and contribute to these outcomes.

Healthy Weight Objectives for 2013-2015 are:

- To deliver a range of evidence based policies and programmes across different settings that reflect the needs of people at different points in the life course to
 - develop a less obesogenic environment
 - prevent obesity
 - manage obesity



- There will be links to other strategies such as Active Swindon, Children and Young People’s Early Support Strategy, Swindon’s Joint Health and Wellbeing Strategy and One Swindon
- To tackle the inequalities in health outcomes in relation to obesity by targeting services appropriately
- To monitor progress related to targets as part of an on-going action plan to ensure activity and investment is effective and meeting local need

The Healthy Weight Strategy is closely linked to the Active Swindon Strategy which has the following aims:

- increase the physical activity levels in adults and young people
- create an environment that promotes physical activity as part of everyday life
- empower people to be more physically active
- increase the capacity to deliver physical activity and sport

National Targets

Within the Public Health Outcomes Framework (2012) there are indicators explicitly related to:

1. Overweight and obesity:

- Excess weight in 4-5 year olds and 10-11 year olds
- Excess weight in adults

For children these are based on NCMP data and show Swindon as similar to the England average for 4-5 year olds (23.3% compared to 23.3%), and (32.9% compared to 33.3% for the 2012/13 school year). For adults this is measured at a local level through the Active People Survey. This is published 6 monthly. These will be measured annually.

2. Physical activity:

- proportion of physically active and inactive adults. This is measured by the Active People Survey which is published at 6 monthly intervals.
- utilisation of outdoor space for exercise / health reasons. This is measured via the Natural England: Monitor of Engagement with the Natural Environment (MENE) survey which asks people whether they have taken a visit to the natural environment for health or exercise over the previous seven days.

Local Targets

- Reducing obesity at age 11 years to the same level or less than the average for England (Source: NCMP data)
- Increasing the number of people physically active to 25% by 2015 (Source: Active Peoples’ Survey)

The healthy weight strategy will also contribute to targets resulting from the Health and Wellbeing Strategy.

5. How will we get there?

Working in partnership

Tackling obesity and promoting healthy weight depends on action to address many different areas as health depends on physical, social and environmental factors. Therefore the obesity strategy will link to the range of local strategic documents which all contribute to preventing and reducing obesity and promoting healthy lifestyles:

- Active Swindon Strategy and Implementation Plan
- Swindon Breastfeeding Strategy and implementation plan
- Children and Young People’s Early Support Strategy
- Swindon Core Local Plan
- Local Transport Plan
- Green Infrastructure Strategy
- Local NHS strategies on Cancer, Coronary Heart Disease, Diabetes
- Safer and Smarter Journeys to School Strategy
- Swindon Borough Councils Initiatives on Building Community Capacity and Corporate Responsibility
- Development Management Policies and the Local Plan 2026

Promoting healthy weight will also be a key part of workplace health initiatives and healthy lifestyle courses.

This strategy will be implemented through the healthy weight action plan. This outlines a framework for action that demonstrates a range of preventive and management interventions for obesity across a range of settings (community, workplaces, early years settings, local authority, and health), based upon evidence for effective interventions presented in the above strategy. The Healthy Weight Implementation group oversees the implementation of the healthy weight action plan.

The action plan is separate as it is a working document-available from Fiona Dickens, Public Health Programme Manager at Swindon Borough Council (Contact details: fdickens@swindon.gov.uk 01793 444680)

Engaging with communities

In order to tackle obesity effectively, we need to engage with our local communities in all areas related to Healthy

Weight, including developing strategies, commissioning and service provision, particularly those at higher risk of obesity. There are a number of opportunities for engagement. These include at local events and festivals, using local volunteers and champions for health programmes (e.g. walk to health volunteers and health champions) and other local networks.

It is also recognised that schools have a potential role in both promoting physical activity and influencing healthy food choices. The action plan includes linking to our local Healthy Schools Programme and looking for opportunities to work collaboratively with schools in Swindon: evidence suggests that a whole school approach may be most effective in reducing childhood obesity. This could include healthy school lunches, healthy choices in vending machines, safe walking to school routes, and encouraging sport and activity for all abilities. There is also opportunity to work with the Planning Department to look at the public health impact of licensing applications for food outlets nearby to schools.

Monitoring and evaluation

Evaluation is vital for understanding what works and why, and also for ensuring that funding is spent in the most cost-effective way. Evaluating interventions to tackle obesity can be challenging as short term success is not always sustained long term and following up people over time is difficult. Any commissioned initiatives are required to include evaluation as part of delivery.

Communication and awareness training

Communication is important in a number of ways:

- To explain why a healthy weight matters
- To engage with the local community
- To provide consistent messages to local people about what is important for achieving and maintaining a healthy weight
- To link lifestyle services so people are aware of what is available in Swindon to keep active, stop smoking, improve their mental health as well as specifically about weight management
- To celebrate success.
- To raise awareness

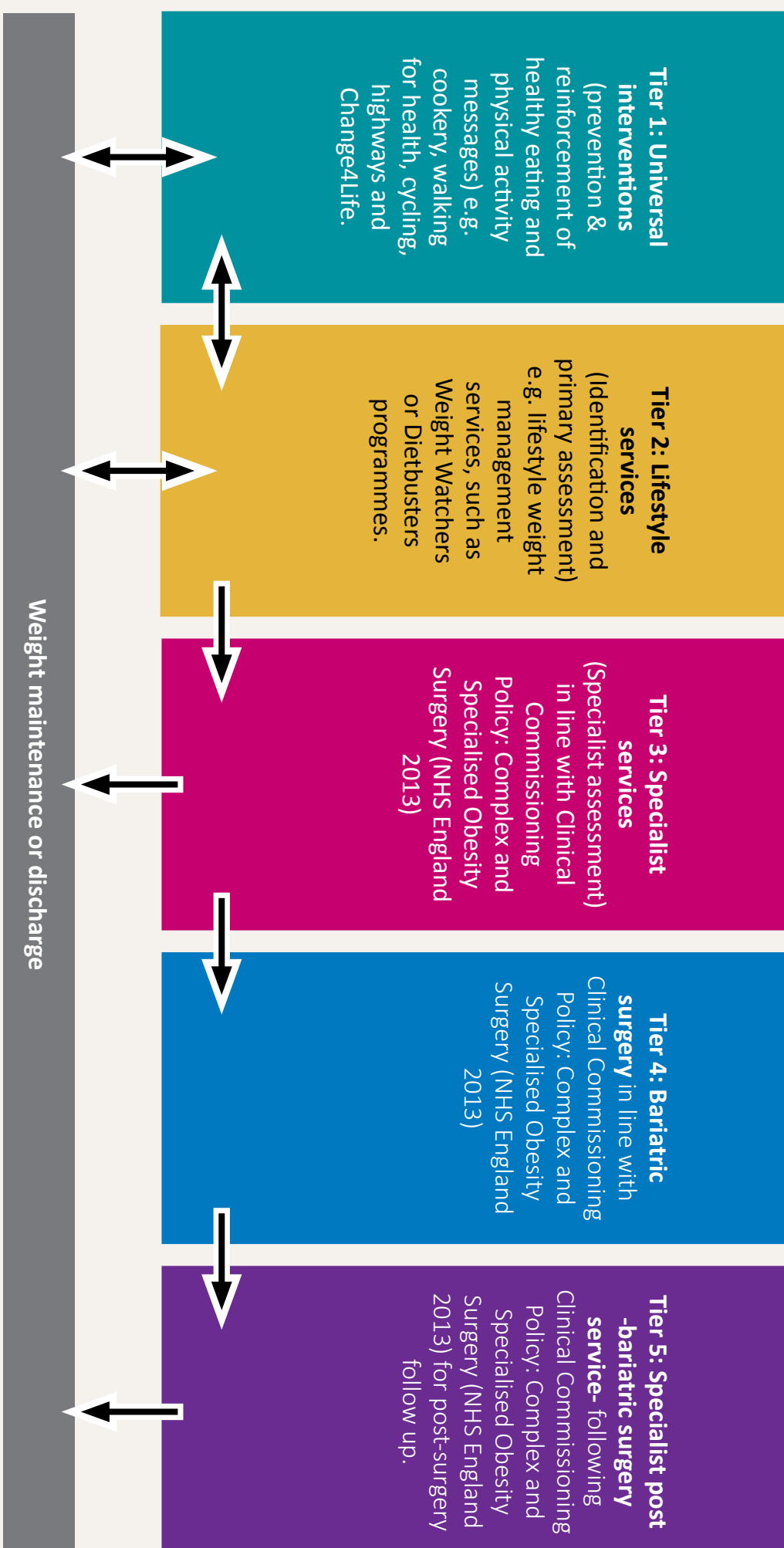
The action plan will include a communications strategy which incorporates these aspects.

Appendix 2: Progress against Healthy Weight strategy 2009-2011

Objective	Milestones	Progress
To establish a baseline of obesity levels in children and monitor progress related to targets	Information routinely uploaded to NCMP and quarterly performance reports produced.	All met
To deliver evidenced based programmes in a range of settings to prevent obesity with a focus on early years, breastfeeding support, training and embedding prevention in the work of health professionals	Milestones include raising awareness around obesity prevention for professionals and a range of projects and initiatives including delivery via Children's Centres, school based activity, active travel for schools, a breastfeeding action plan, and engagement with Swindon Youth Forum	<ul style="list-style-type: none"> Breastfeeding- aiming to increase breastfeeding prevalence at 6-8 weeks through full Baby Friendly Initiative accreditation in the Great Western Hospital NHS Foundation Trust and Swindon Community. Great Western Hospital: Stage 2 Assessment, achieved May 2012. Now working towards stage 3 (final stage) - takes up to 1 year. Swindon Community: Stage 1 assessment passed March 2012. Now working towards stage 2 which takes up to one year. Development and implementation of an early years healthy lifestyle programme, called Healthy Steps, which is being implemented in Children's centres Implementation of school based programmes, including the: <ul style="list-style-type: none"> NCMP Swindon Healthy Schools programme, which has supported programmes to reduce obesity, including implementation of the Food for Life Partnership programme support with implementation of national school meals standards support to develop active travel policies and programmes Swindon Youth Forum- reducing obesity is one of 5 priorities of the forum. A cookery DVD is currently being produced by the forum, to support home cooking of healthy food. The forum has supported work on improving school meals in the last 2 years. Walking for Health programme- currently 13 free weekly walks in Swindon for adults to support an increase in physical activity. Ability sports- a range of activities for adults with physical and learning disabilities Active travel (promoting and encouraging people to cycle and walk) is promoted and encouraged through the development of the Local Transport Plan (LTP3).

Appendix 1: Adult Healthy Weight Care pathway- Managing adult obesity in primary and secondary care in Swindon (adults aged over 18 years)

Identification of obesity in primary or secondary care



Objective	Milestones	Progress
		<ul style="list-style-type: none">• Built environment - promoting and encouraging walking and cycling are key considerations in the Swindon Core Strategy and Supplementary Planning Documents.• Local Sustainable Transport Fund (LSTF) -The LSTF project is focussed on partnering the economic (business) sector to target employees who currently drive to work in the town centre. The target is reducing the need to travel, providing personalised travel planning advice and identified missing infrastructure, associated with walking and cycling.• Raising awareness/ training- Specific training on effective interventions to prevent obesity, including brief intervention, at an individual and group level have been available free to primary care health professionals and other community staff annually for the last 3 years.• Promotion- use of the Change4Life brand and sub-brands to promote local health programmes, linking to national Change4life programme



Objective	Milestones	Progress
To deliver evidenced based programmes in a range of settings to manage obesity with a focus on continuing expansion of services	This covers tier 1, 2 and 3 services for obesity treatment plus maternal obesity programmes and exercise referrals. Many of the measures are delivered via contracts with providers.	<ul style="list-style-type: none">• Tier 1 (community based initiatives):<ul style="list-style-type: none">• Child and Family weight management group service• Adult weight management group service- including Dietbusters, Weight Watchers and the Friday Fit club (for adults with a mild learning disability).• Avon and Wiltshire Mental Health Partnership NHS Trust offer a free weight management course for people who need extra support in putting lifestyle changes into practice.• Individuals who do not wish to attend a group can be referred to a Dietitian and in some GP practices, the practice nurse or nursing assistant offer weight management advice.• Exercise on referral programme- for adults who are obese and would like support in developing an appropriate exercise programme. This programme is for patients at any stage of the obesity care pathway• Tier 2 (intensive, specialist weight management service in community and hospital settings)<ul style="list-style-type: none">• Adult programmes, consisting of a mixture of group and individual support, provided in community and hospital settings.• Maternity obesity clinic-based at the Great Western hospital.• Tier 3 (Specialist pre-bariatric surgery service- assesses a patient’s suitability for surgery and manages their expectations of surgery.)• Tier 4 (bariatric surgery)• Tier 5 (specialist post-bariatric surgery service)

Appendix 3: Consultation feedback

A draft strategy was developed, followed by an extensive consultation process. This included a stakeholder group, public consultation, Swindon Youth Forum, Children’s Trust Board, and distribution of the draft strategy to interested organisations and individuals. Their comments which were gratefully received have informed both the final version of the strategy and the development of annual action plans. The following provides a summary of the feedback.

27th March 2013 Stakeholder Consultation

Overarching themes

- Better coordination between action to promote healthy eating and action to promote physical activity – one should be an opportunity for the other but currently much more siloed.
- Need to address healthy lifestyle in a much more holistic way – move towards commissioning lifestyle service
- There needs to be clear consistent messaging across all lifestyle related services – communication strategy
- Could include healthy options in vending machines as one of the criteria for reviewing healthy school status
- should include more on motivation and psychological support – what really makes people change behaviour
- systems approach – recognise role of environment and community as well as individual
- don’t commission things that can’t be evaluated – need to understand which interventions are making a difference and which are not

Themes from discussion

- Understanding that the primary purpose of some activities is not about losing weight and yet they are missed opportunities for giving broader healthy lifestyle messages e.g. many people do healthy walks for the social benefits and then meet for cake and coffee which could be an opportunity to promote healthy eating.
- Need a much more holistic approach to healthy lifestyle
- e.g. healthy choices / eating as part of smoking cessation service and vice versa. E.g. recognition that teenagers often see smoking as a way to manage weight and need support / information to avoid replacing one unhealthy behaviour with another.

- All staff should have basic training in all lifestyle services.
- Scope for reviewing vending machines and including healthy options both in leisure centres and schools.
- Employers should also set an example with vending machine choices – mixture of options but also information about comparisons e.g. mars is more calorific than a kitkat, or a list of 100 calorie snacks. Public sector could lead the way with this. Focus on choice not ban.
- Strategy should focus more clearly on what is working well and what is most effective in terms of intervention use intelligence to really understand what people like and which interventions make them change their behaviour – recognition evaluation can be a challenge and NCMP data doesn’t allow identification of which intervention might be affecting trends.
- Need greater clarity on structure of different levels of intervention and how to access them – how do people know what is available?
- Strategy should include more on motivation and psychological support e.g. LIFT, programmes for 50+ which includes physical activity could expand to look at healthy eating, falls prevention etc. Age well course has run previously.
- Need to look at how vulnerable groups access services (or not) – what are the barriers e.g. attitude of staff in leisure centres – if people try once and fail they don’t go back again. Brief intervention training may be useful (evidence of effectiveness?)
- Need to get information outside leisure centres and into the community e.g. children’s centres who can target vulnerable people but recognise some people do not access anywhere. Opportunity in terms of role of health ambassadors – extending role to work across healthy lifestyle and providing training rather than signposting.

- Need to focus on perception of normal = healthy
- Promoting ideas of taking responsibility for self and children – can’t ‘do’ things to the community but can facilitate the creation of peer groups to support people in the community
- In tackling obesity – recognise the role of place and community – not just individual. Greater focus on systems and hence the role of planning, environmental health etc. Recognition that the environment may be working against people having a healthy weight – vision needs to capture this wider community aspect.

One thing to make a difference

- Joining up issues – lifestyle approach
- Normalising healthy behaviour e.g. positive marketing – 85% of young people don’t drink ‘I want to be in that group’. Could apply to messages on smoking, fizzy drinks, healthy eating – would need partners for an ongoing campaign.
- Need all organisations to sign up to vision
- Build Health Impact Assessment into planning decisions – scope to develop Bristol model where public health review planning applications – encourage use of S106s to promote healthy lifestyles
- Opportunities to work with retailers
- Programme of activity needs to be aspirational / normalising a healthy lifestyle by capturing people’s imagination and making it exciting. Event to celebrate success / achievements.
- Need to develop a communications strategy – with clear and consistent message.
- Stop commissioning things we can’t evaluate – define what the difference is for each intervention commissioned – how effective is what we pay for

16th April 2013 Community Consultation Event

Overarching themes

Complete integration of the role of healthy eating and exercise
Physical activity is both organised and self-generated – people understand the benefits of walking
Motivation for a healthy lifestyle is to avoid illness and look good
Key barriers are time , lack of information and depression or lack of motivation
For people who are obese being supported / mentored

/ encouraged and being given good information to inform choices was felt to be most important
Suggestions for improvements in Swindon covered every type of setting (e.g. home, school, GPs, work, social life) recognising the holistic approach needed
Priorities included making the consequences of obesity clearer, limiting temptation, and supporting people to make the healthy choice the easy one.

What do I do that’s healthy?

Watching portions
Walking, cycling, eating fruit and veg, cutting fat off meat, grilling instead or frying, reducing oil, herbal teas, lots of water
Walking, cycling, swimming, fitness classes, gym
Run, cycle, walk, swim, pilates, eat fruit & veg
2 health walks per week
Zumba, tai chi, barn dances, U3A walk 3-5 miles, always played sport
Painting
Looking after grandchildren
Do not sit in front of television
Eat healthily – no meat (veggie) eats fish
Plain food (no butter etc) – 3 meals
Not smoking
Joined walking group
Learnt to swim
Go walking, cut down portions, eat more vegetables
Lunch clubs, exercise class x3 a week

What encourages me to eat well and do exercise?

Joint problems
Maintaining weight and looking good
Getting around the house
Health risks
Social interaction
Feeling better
Cheaper / free activities
Feeling healthier
Awareness e.g. classes
Eating – stay slim
Cancer – ill health
Brought up with good lifestyle attitudes
Keep mid-age weight down – plus age related health conditions
Mental wellbeing
Seeing positive results from making healthy changes
Clothes fit

Feel fitter which encourages perseverance - difficult as there's lots of temptation

What makes it difficult to eat well and do exercise?

Being on your own not bothering with cooking
Depression
Fear of the unknown
Dark evenings
SAD
Lack of information on food products
Confusing information
Cost e.g. healthy food
Time – fast food, exercise
Finances
Time
Lack of organisation
Lot of salt / sugar in food
Lack of cooking skills, lack of budget skills
Lack of understanding about content in foods
Time, label reading – when you're out for the day it's harder
Healthy food can be cheaper than fast food (most people think healthy=expensive)

What would help people who are obese?

Food diary
Encouragement from other people, friends, family
Education, mentoring
Health awareness
Awareness of portion size
Time of eating
Making it not acceptable
Encouraging people to move more
More awareness – alcohol, sugars etc
More hard hitting information – TV adverts etc.
Dangers highlighted re: obesity
Keep food diary – that should open their eyes
Eat breakfast
Encourage restaurants to show / calculate calories per meal / item
How to approach obese people?
Information re: not dieting but lifestyle changes
Changing their diet, walking, exercise, leisure cheaper
More activities available – motivation of others

How could things be improved to encourage eating more healthily in Swindon?

Affordable fruit and veg
Education in schools
Cookery
School cookery lessons
Attracting new mothers
Doctors surgery
Work-based policies e.g. vending machines, rules re: food
Parental guidance – role models
Restaurants – food labelling
More food offers on fruit / veg in supermarkets
More education in schools – compulsory
Parents should teach children cooking and budgeting
More meetings to encourage people in Swindon to discuss health issues
More awareness of what's available
Spreading the word
More local advertising
Less distractions – tv, video and cinema that encourages being sedentary
Healthier ready meals – but still a long way to go
More awareness about consequences of not eating healthy
Health needs to start from a young age – more education around health in schools
More encouragement to promote a healthy balanced diet
Parents need to be more involved

How can professionals help? What can local people do?

Professional chefs – more recipes that are healthy – currently use lots of salt and sugar
Role for doctors, nurses, midwives, health visitors
Domestic science classes
Issue more information, more joined up advice
Nutritionists, dietitians attached to doctors surgeries
Information / awareness – harder impact as in smoking
Professionals more accessible – advice / information
People into communities – health promotions e.g. health ambassadors, information on walks / exercise
GP's able to give advice and should do so – should be more proactive and not re-active
Health professionals should set example
Proper breaks at work – activity @ work place
More promotion around these meetings
Continuing to have consultation meetings
As locals – volunteer to speak to others – talking to others about health – raising awareness
Recognise professionals can't always be around

Priorities: what one thing:

... do people think is most important for helping people in Swindon achieve a healthy weight
... do people think is most important for health and wellbeing in Swindon?

Happiness
Fear of disability
Prioritisation, budget management
Education, education, education – children, young mums, everybody
Doctor surgeries should refer more and include nutritionist / dietitians and advisors or health ambassadors
Being able to walk / cycle safely
Choice e.g. able to eat healthy / information
Encouraging businesses that promote healthy choices e.g. juice bar
Awareness of what's available and dangers of being obese
Everything in moderation
Alcohol consumption should be reduced
Keep open spaces – so people can go freely. Green spaces.
Serious messages at school that kids can relay back to parents
Gardening / growing own veg
Remove sweets from near tills
Remove multi-buys
Encourage smaller businesses e.g. green grocers / fishmongers
Need to tackle alcohol issues
Real hard-hitting adverts on TV etc.
More visual aids to produce impact leading to change
Education at younger age
People to listen and change their attitudes and lifestyle
Be more active – get encouragement from a young age and at school
More opportunities to learn how to cook healthy
More opportunities to be active in a safe environment that is cost effective
More leaflets available / posters at doctor's surgeries
More social groups e.g. walks to feel safe
Needs to come from within – people need to take responsibility

One Point Summary Per Group

Portion control important
Education most important – schools / young mums / pensioners
Education – hard hitting adverts / danger of obesity
More promotion at doctor's surgeries
Encouraging businesses who promote healthy choices e.g. juice bar in old town

Youth Participation Consultation April 2013

Overarching themes

- Being healthy is seen as physical activity more than food choices.
- Motivation for being healthy comes from looking good and being more confident
- Barriers are around information, skills and consistent messages and more should be done around education and a whole family focus.

What do you do that's healthy?

Football
Running
Walking
Eat healthily
Yoga
Cricket
Golf
Dancing
Cycling
Performing arts
Ice Skating
Swimming
Gym

What encourages you to eat well and do exercise?

Want to be healthy
My family, we all eat healthily
So I don't get overweight and out of breath
Look like celebrities
Makes me feel better than eating McDonalds
Thought of my future
Makes me feel good
Local places to do sports
Makes me feel more confident
Fun to do exercise with friends, keeps me motivated
Like looking and feeling good
Easy to get to sports centres
Cheap cost of activities
Self esteem
Stuff to do in my area

What makes it difficult to eat well and do exercise?

- Cost of food, and exercise
- Chocolate
- TV / Xbox / PlayStation
- Healthy food doesn't taste as nice as junk food
- How to make healthy food
- Sticking to a routine
- McDonalds
- Advertising
- Mum cooks food, don't have a choice
- Friends don't bother
- Laziness
- Easier to be unhealthy than healthy

What can local people do to encourage their family and community to be more active and eat a healthy diet?

- Start a running club
- Exercise club for people who don't normally exercise
- Cooking lessons for healthy food
- Promote healthy activities more
- Learn from early age about being healthy
- Lessons in schools about dangers of getting fat and unhealthy
- Educate them
- Health festival where you can try nice healthy food and do different sports
- Cooking competition with prizes
- Get kids to show mums and dads how to cook good food
- Healthy shopping booklet with recipes
- Watch the Swindon Youth Forum Healthy eating DVD!!

**Swindon Children's Trust
Boards feedback**

There was praise for the Swindon context.

Name of strategy should be healthy weight strategy not obesity strategy as this is the outcome we are trying to achieve, and was a more positive message than calling it an obesity strategy.

Re. the definition of BMI: 'BMI does not take into account factors such as size of body frame, proportion of lean body mass, gender and age and is not a direct measure of underweight, overweight or obesity. Therefore these need to be considered when interpreting BMI'. Need to explain more about why we use BMI if we say it has limitations e.g. have several of the children who are told they are overweight by the NCMP just got a big frame?

This strategy should focus on obesity, not related areas such as eating disorders and underweight. It should define what is included and what is not, saying that associated issues are not part of this scope and are covered elsewhere in clinical care pathways and/ or strategies.

'What works' to reduce obesity and can we do more of it?

Email feedback

Discussion on the definitions of childhood obesity

Not sure whether you note the increased clinical risk associated with obesity, across all specialties e.g. a woman's choice of childbirth delivery will be impacted by a clinical assessment of the attendant risks (inc. those associated with obesity), assume we have recovery data that show longer timescales associated with weight.

Have you captured a strong enough message about the mental health dimension?

**Appendix 4: Diversity Impact
Assessment**

**Swindon Borough Council Diversity Impact
Assessment**

1 What's it about?

Refer to equality duties

What is the proposal? What outcomes/benefits are you hoping to achieve?

The Healthy Weight Strategy sets out the rationale, vision and objectives for people in Swindon, to improve their health, by identifying effective strategies and interventions to prevent obesity and help people in Swindon to achieve and maintain a healthy weight. It covers the period 2013-15, and incorporates national and local targets to reduce childhood obesity from the current baseline.

The aim is to encourage people in Swindon to reduce obesity and maintain a healthy weight creating:

- an environment that encourages people to live active and healthy lives
- an ethos of taking responsibility for the health of yourself and your family with support when needed
- communities where a healthy lifestyle is seen as desirable and the norm
- an understanding of what works most effectively at an individual, community and population level by including effective evaluation and learning from others

The strategy will impact on all of the equality duties.

Who's it for?

The strategy covers and is relevant for all the community as its focus is not only on people who are obese or overweight but also on encouraging everyone to maintain a healthy weight.

How will this proposal meet the equality duties?

1. Eliminate discrimination, harassment and victimisation

National surveys indicate that people who are overweight or obese are often victims of discrimination or bullying. Action to support people to achieve / maintain a healthy weight will help people feel more confident and supported. The range of projects and initiatives commissioned and proposed are targeted in different settings such as at school or in the community,

and for different groups of people. There is also tiered support so those with the greatest need get the most intervention. For children some initiatives are about healthy eating and being active rather than weight management to reduce stigma, whilst others provide a safe supportive environment for children and their families to learn about ways to reduce obesity.

2. Advance equality of opportunity

Underpinning the strategy is the opportunity for everyone to maximise the likelihood of achieving a healthy life and reducing the risk of illness. By providing additional support and information for people who may be overweight, this promotes equality of opportunity to health. The strategy also explicitly recognises the increased risk of obesity and subsequent ill-health in different communities such as some BME communities and amongst people with learning disabilities.

3. Foster good relations

As a healthy weight strategy rather than an obesity strategy it is about drawing together communities to achieve their health potential. This is particularly demonstrated via initiatives such as healthy walks which bring together people to walk, motivate and socialise with each other.

What are the barriers to meeting this potential?

More could be done to meet the understand the cultural needs and barriers for people from different ethnic groups and to reflect religious and cultural diversity: this could be achieved by working with people from different communities to lead groups and support each other and the consultation process for the strategy looked at this.

Perceptions around obesity are also heavily influenced by the media and national initiatives and so the strategy recognises the need for a strong and consistent communications strategy in Swindon.

2 Who’s using it?

Refer to equality groups

What data/evidence do you have about who is or could be affected (e.g. equality monitoring, customer feedback, current service use, national/regional/local trends)?

The strategy is evidence based and draws on national and international research about the prevalence of obesity and interventions that are effective. It includes data on national, regional and local trends. Pages 10-11 in the strategy considers how obesity may vary within and between different groups including the BME community, socio-economic status and income, the LGBT communities and people with disabilities. There is no information that obesity varies on the basis of religion. For some disabilities obesity may be both a cause and a consequence; it can also be considered an illness itself requiring medical intervention¹⁰³. The development of actions plans and service specification will also recognise that there are groups such as those with sensory loss or physical impairment that whilst there is no evidence of increased obesity in these groups, access to services may be more difficult. Services that are currently commissioned collect data on who is using them and this is regularly reviewed to ensure they are accessible to the whole community. Service specifications include requirements for assessing diversity impacts and equality of access. One challenge is measuring adult obesity as the only source is by survey and this is known to include biases. Information on obesity in different equality groups is only from cohort studies if available.

How can you involve your customers in developing the proposal?

The development of the strategy included a public consultation. This actively encouraged a broad outreach response including people from different BME communities in Swindon, health ambassadors and people who use those services, people who currently attend health walks, the Swindon Youth Forum and contacts via the link nurse at Carfax Medical Centre. The consultation event was advertised by word of mouth and via social media. Whilst there was not a formal equality analysis of consultation respondents, many groups did contribute. People who currently use projects to support their

weight management are asked to evaluate the service and this is used for future service delivery. One of the recognised challenges is understanding how effective interventions are at having long-term impact on maintaining a healthy weight as most outcome measures are short term. This is an issue nationally as well as locally.

Who is missing? Do you need to fill any gaps in your data? (pause DIA if necessary)

The strategy development was informed by a detailed literature review and the latest available data. For some protected characteristics (these include ethnicity, religion, sexual orientation, learning disability) there is little evidence specifically for Swindon although the strategy draws on national research where available.

3 Impact

Refer to dimensions of equality and equality groups
Show consideration of: age, disability, sex, transgender, marriage/civil partnership, maternity/pregnancy, race, religion/belief, sexual orientation and if appropriate: financial economic status, homelessness, political view

Using the information in parts 1 & 2:

a) Does the proposal create an adverse impact which may affect some groups or individuals? Is it clear what this is? How can this be mitigated or justified?

The strategy recognises the important of a lifecourse approach to supporting people achieve and maintain a healthy weight from early years and the benefits of

breastfeeding to older age. It also focusses on specific times in the life course where obesity is an increased risk factor for ill health and /or is a good opportunity for obesity prevention, such as during pregnancy. Exercise on referral and weight management services such as Dietbusters are available to all adults but may be more aimed at those of working age. The introduction of two elder health ambassadors and initiatives on healthy ageing may mitigate this. Obesity is a sensitive topic and children and adults can feel very stigmatised: a mixture of school wide initiatives such as the Healthy Schools Initiative together with more targeted projects can help this. There is ongoing work with specific BME communities in Swindon to identify and address barriers to services: an example of this is work around diabetes with the Goan community.

There is little evidence for LGBT communities specifically around obesity but a recognition that they may face additional barriers to services which need to be

- acknowledged and addressed when services are being commissioned. Impact on dimensions of equality:
- Longevity – positive impact as proposals should result in an increased number of people having a healthier lifestyle
 - Physical security – neutral impact only as a result of increased health and mobility resulting of reduced levels of obesity
 - Health – positive impact as strategy makes clear case for health impact of being overweight or obese
 - Education – positive impact as many initiatives resulting from strategy include educational approaches of learning about healthy eating and lifestyle choice
 - Standard of living – neutral impact
 - Productive and valued activities - positive impact as being obese can be a barrier to full engagement in activities and community life
 - Individual, family and social life – positive impact as some initiatives resulting from strategy are targeted at families working together to learn about healthy eating and improving their lifestyle
 - Participation, influence and voice – neutral impact
 - Identify, expression and self-respect – positive impact as strategy promotes a tiered approach to intervention, allowing people who are a healthy weight, overweight or obese to access an appropriate service to manage their weight and improve confidence and wellbeing.
 - Legal security – neutral impact

What can be done to change this impact?
See above

b) Does the proposal create benefit for a particular group? Is it clear what this is? Can you maximise the benefits for other groups?
The Healthy Weight Strategy is applicable for the whole community and outlines a Swindon wide approach. Services are a mixture of universal and targeted provision: Targeted provision includes walking groups for women only, weight management services in known areas of higher deprivation, adjustments in physical activity and weight management programmes to be accessible and appropriate for people with physical activities and physical activity and healthy eating groups for people with learning disabilities.

Does further consultation need to be done? How will assumptions made in this assessment be tested?
Approval of the strategy will be via the Health and Wellbeing Board which is a public meeting. The communications strategy will identify ways for people

to be consulted on an on-going basis and informed of progress. There is also a healthy weight implementation team so any suggestions / comments from service users will be discussed and actioned at that group. The assumptions in the strategy will be tested via on-going feedback and input from service users who access commissioned projects. There is an expectation that providers will demonstrate awareness of equality and diversity and that staff delivering services will feel confident to implement inclusive practice and challenge where necessary.

4 So what?
Link to business planning process

What changes have you made in the course of this DIA?
Doing the DIA has widened the protected characteristics considered by the strategy, and encouraged a broader consideration of how the strategy can reflect the different barriers that arising from different needs.

What will you do now and what will be included in future planning?
We will include equality and diversity requirements within our commissioning specifications and require providers to demonstrate how services reach different groups in the community. The women only walking group is an example of responding to an identified need in the community where some BME communities feel more comfortable in a single sex activity. Over the next year we will also look at service provision for LLTI.

When will this be reviewed?
The 3 year strategy is supported by an action plan which is reviewed annually in March. The next review will be March 2014.

How will success be measured?
Targets have been set as to the success of the strategy as outlined in chapter 4. Where available data will also be gathered on these broken down by protective characteristics.

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Summary of Action Plan

Purpose To improve the health of the people of Swindon by identifying effective strategies and interventions to prevent obesity and help overweight and obese people to lose weight.

The action plan sets out details for local action to tackle obesity, based on national guidance and evidence base. It needs to be read in conjunction with Swindon's Healthy Weight Strategy, which sets the context and gives local targets as well as evidence of effectiveness of programmes.

Objective 1- to establish a baseline of obesity levels in children and monitor progress related to targets throughout 2013-14

1. Establish and track local obesity prevalence rates through regular recording of BMI in Swindon children through NCMP
2. Monitor and report on progress against child obesity and breastfeeding targets
3. Track progress of obesity related target

Objective 2- To deliver evidenced based programmes in a range of settings to prevent obesity, with a focus on early years, breastfeeding support, training and embedding prevention in the work of health professionals

1. Provide a range of health walks suitable for different clients groups
2. Swindon Borough Council to support behaviour change at community events, while promoting the Change4Life brand
3. Provide Healthy Steps programme in Children Centres. It is a preventive programme for families with children aged 0-5 years that incorporates healthy eating, physical activity and parenting advice as well as a practical 'cooking on a budget' workshop
4. Continue Walk4Life 5 minute walk zone scheme with schools
5. Investigate and develop scooter training scheme for primary schools
6. Continue to support Sustrans Bike It project
7. Continue to develop and review school travel plans that promote walking or cycling to school
8. Develop Y6/7 transition programme to promote active independent travel
9. Increase breastfeeding prevalence at 6-8 weeks through implementation of breastfeeding action plan
10. Continue implementation of Active Swindon Partnership (ASP) strategy and implementation plan- which addresses change to the structural environment, provision of a range of activities and campaigns to motivate and support people to be more physically active

11. Continued implementation of a local walking programme, particularly targeting areas of deprivation
12. Pilot an evaluation of MEND programme by school nurses- who weigh MEND children in schools

Objective 3- To deliver evidenced based programmes in a range of settings to manage obesity with a focus this year on continuing expansion of current services

1. Adult non-specialist/ tier 1 adult obesity treatment service achieves its outcome targets to reduce adult obesity-service provided by SBC Health Improvement, Physical Activity and Inclusion Services
2. Child and family weight management service achieves its aim to reduce obesity in children and their families (provided by SBC IHealth Improvement, Physical Activity and Inclusion services)
3. Plot MEND Champions scheme- where MEND Graduates help to promote MEND at events or with their friends and family
4. Continue work on maternal obesity – developing appropriate services for pregnant women
5. Steps to Health, exercise on referral scheme achieves its aim to increase physical activity- provided by SBC Health Improvement, Physical Activity and Inclusion services
6. Tier 2 obesity service (intensive and specialist service) provided by the Great Western Hospital NHS Foundation Trust (GWHFT) dietetic service achieves the aims set out in the service specification
7. Tier 3 obesity service achieves its contracts aims to, assess patients for surgery and prepare patients for surgery (provided by a multi-disciplinary team at GWHFT)
8. Post-bariatric surgery clinic at GWHFT achieves its contract aims

Whole systems approach to tackling obesity

Local authorities are ideally placed to develop co-ordinated action to tackle obesity across its various departments, services and partner organisations. The following table considers the potential role of different local authority departments and their contribution to this agenda.

Department or service area	Opportunity to tackle obesity
Transport	<p>Support, develop and encourage active travel and in doing so also reduce carbon dioxide emissions and improve road safety.</p> <p>Implement lower speed limits in residential streets.</p> <p>Speeds above 20 mph discourage active travel and deter parents from allowing children to play on their streets.</p>
Planning and environment	<p>Map access to green infrastructure to help understand whether all communities can use green space near their home and ensure such green spaces offer safe environments.</p> <p>Increase access to, and opportunities for physical activity and healthy food, for example provision of and access to green open space and opportunities for play and food growing.</p> <p>Ensure that health and wellbeing are prioritised and integrated throughout the planning system.</p> <p>Encourage the provision of healthier and more sustainable catering. There is a toolkit for serving foods to adults, which aims to provide practical information for caterers and procurement managers to improve the nutritional content of food provided while reducing the negative environmental impact of catering services. The toolkit also includes useful information for organisations aiming to meet Government buying standards for food and catering services.</p> <p>Limit the easy accessibility of unhealthy food choices, for example by working with existing hot food takeaways and sandwich shops to reformulate their menus to reduce the sugar, salt and fat content of food and to provide healthier options. Consider controlling the proliferation of hot food takeaways in specific areas, such as near schools.</p> <p>Protect land for food growing from inappropriate development, particularly the best and most versatile agricultural land.</p> <p>Conduct health impact assessments to ensure that all parties think about proposed developments from a health perspective, specifically the impact on levels of physical activity and healthy food choices.</p> <p>Provide training and support to elected members and senior officers in order to secure strong leadership and</p>

	commitment to health at all levels and in all policies.
Leisure and culture	<p>Encourage through appropriate commissioning access to and facilities for structured leisure programmes.</p> <p>Improve the access to and facilities for structured leisure programmes such as 'Back to Sport' run through sports development, or other exercise and physical activity schemes.</p> <p>Improve availability of unstructured opportunities for physical activity, such as access to parks and open spaces and safe play areas for children and young people.</p> <p>Ensure all opportunities are accessible to people with limited mobility, including those who are obese.</p> <p>Promote the value and benefits (health and otherwise) of an active lifestyle.</p>
Parks and green spaces	<p>Promote the green infrastructure strategy with a wide range of partners including health.</p> <p>Work together to improve the provision of high quality, local, accessible and safe green space in line with recommendations by organisations including The Design Council CABI.</p> <p>Make an assessment of the value local green infrastructure. There are an increasing number of tools available that aim to value green infrastructure. Many of these focus on specific services provided by the green infrastructure and estimate the economic value of these services.</p> <p>Improve the aesthetics of green space, alongside appropriate safety and crime prevention initiatives to encourage people to use their local green space.</p> <p>Promote and encourage the use of existing green spaces.</p>
Education and learning	<p>Encourage use of the school food plan. This plan contains a series of actions, each of which is the responsibility of a named person or organisation, outlining what needs to happen to transform what children eat at school, and how they learn about food.</p> <p>Encourage and support local Healthy Schools Programmes using Healthy Schools resources and toolkits.</p> <p>Encourage participation in the Eat Better, Do Better programme.</p> <p>Support initiatives in schools and communities to improve children's wellbeing and self esteem through physical activity and healthy eating.</p> <p>Ensure that there is full participation in the National Child Measurement Programme so that trends in child weight can be reliably monitored.</p>

Health and social care	<p>Work with partners to embed physical activity and healthy eating support within existing social care pathways.</p> <p>Work with partners to provide a wide range of appropriate physical activity and healthy eating opportunities across a range of settings.</p> <p>Provide necessary adaptations and carer support for severely obese people to help improve their quality of life and avert the need for emergency service intervention (as a result of falls, for example).</p>
Housing	<p>Work with social landlords to implement the practical action plan led by CAGE (now referred to as the Design Council) and the National Housing Federation that sets out ten priorities for change to provide more opportunities for people of all ages to be more active and enjoy the space outside their homes.</p> <p>Provide essential housing adaptations and support in the homes of severely disabled people.</p> <p>Work with other departments to ensure that obese people in social housing or in adapted homes have the opportunity to be physically active through home or community based physical activity programmes.</p> <p>Improve availability of unstructured opportunities for physical activity, such as access to parks and open spaces and safe play areas.</p>
Workplaces	<p>Encourage the provision of healthier and more sustainable catering. There is a toolkit for serving foods to adults, which aims to provide practical information for caterers and procurement managers to improve the nutritional content of food provided while reducing the negative environmental impact of catering services. The toolkit also includes useful information for organisations aiming to meet Government buying standards for food and catering services.</p> <p>Encourage local workplaces and businesses to sign up to the Responsibility Deal and put into place effective actions to support employees and customers to make healthier choices, for example, introduce policies to prevent, support and manage obesity. This could include ensuring the availability of healthy food choices and the provision and promotion of physical activity physical activity, for example, by introducing walking meetings or non-working lunch times. The effectiveness of such policies is dependent on the support and ongoing commitment of senior members of staff.</p> <p>Provide ongoing training and awareness raising to combat prejudice and discrimination against obese people in the workplace.</p>

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Restorative Youth Services Plan 2016/17

Health and Wellbeing Board

Date: 25 May 2016

Author:	Service Manager, Restorative Youth Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	Not Applicable

1. Purpose and Reasons

- 1.1 To note and approve the Restorative Youth Services (RYS) Plan for 2016/17, attached at Appendix 1 to this report.
- 1.2 The Youth Offending Team (YOT) in Swindon is required to produce a Plan which reflects on previous performance, and addresses priorities and business risks for the year ahead. This Plan incorporates two other services: the confidential youth counselling service On Trak, and the youth alcohol & drug misuse service U-Turn.
- 1.3 It is an expectation that the Plan is approved by the Youth Offending Team Management Board and the Local Authority, prior to submission (of the Plan) to the Youth Justice Board.
- 1.4 The Plan incorporates strategies for meeting Government and local targets for reducing first time offending, re-offending, remand, custodial rates, and substance misuse. The Plan also includes strategies for the timely and effective delivery of confidential youth counselling services.

2. Recommendations

The Board is recommended to:

- 2.1 Note and approve the Restorative Youth Services Plan for 2016/17, attached at Appendix 1 to the report.

3. Detail

- 3.1 The Local Authority (Chief Executive) with responsibility for Children's Services is required to ensure that the range of Youth Justice Services outlined in section 38 (4) of the Crime and Disorder Act 1998 are delivered through the Youth Offending Team.
- 3.2 The Restorative Youth Services Plan 2016/17 was approved by the Youth Offending Team Management Board on the 21 April 2016.
- 3.3 The confidential youth counselling service On Trak, and the youth alcohol & drug misuse service U-Turn are also under the direct management of the YOT's Service Manager and have their plans incorporated into the Restorative Youth

Further information on the subject of this report can be obtained from Matt Bywater, 01793 463890, mbywater@swindon.gov.uk.

Restorative Youth Services Plan 2016/17

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Services Plan 2016-17. This plan acknowledges national and local priorities relating to offending, substance misuse and counselling, and describes strategy, performance, partnerships, finance, as well as the challenges and opportunities which now govern future priorities.

- 3.4 Developments in 2015/16 associated with the Youth Offending Team included a low rate of custody, due in part to the success of working closely with the Courts to show that risk and rehabilitation, for even the most troubled young people, are manageable and effective in the local community. Re-offending rates experienced a spike in 2014 as a result of a more complex cohort of offenders which was explored further in the HMIP Inspection of the Youth Offending Team in March 2015. This resulted in the production of a full report and a local post inspection Action Plan which incorporated more effective scrutiny by the YOT Board, as well as subtle but important changes in operational practice. Performance monitoring is now centred on a more sophisticated analysis of re-offending data using a specialised tool kit. Other key factors (influencing progress with the objectives set out in the 2016/17 Plan) include: more focused work on internal auditing of case work and levels of risk and vulnerability ratings by case managers; the implementation of a programme around communication to improve the confidence and self-esteem of young people; intervention by a speech and language specialist; and a national overhaul and update of the ASSET assessment tool which requires the training of multi-agency staff in anticipation of new systems and processes designed to assess the risks and causes of offending behaviour (due for implementation in May 2016).
- 3.5 The Plan for 2016/17 also incorporates strategies to educate young people about the harm caused through the misuse of alcohol and drugs. To support this, U-Turn continues to operate through the traded services initiative to help schools raise awareness about the impact of drugs (including legal highs) on the teenage brain, but is also having impact through the introduction of short educational films (including the successful 'Jack's Story') which is available to young people via new forms of social media.
- 3.6 Incorporated within the Plan are those challenges facing the confidential youth counselling service On Trak. These include managing a high rate of referrals, mostly from GPs, which have resulted in waiting times for some young people in need of counselling. More streamlined and responsive processes are being put into practice (including a closer working relationship with Targeted mental health services) to help address the demand for counselling by young people and ensure that those most in need are prioritised for treatment.
- 3.7 All three RYS services are governed by developments taking place in the national context, of which the most significant is the wide-ranging review of youth justice services announced in October 2015 by the Rt. Hon Michael Gove being conducted by Mr Charlie Taylor, Chief Executive of the National College for Teaching and Leadership. The scope of this review suggests that the outcome
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could have significance for all YOTs in terms of future operating models, as well as funding, and statutory responsibilities under any new legislation. The Association of YOT Managers (which represents two thirds of all YOT Managers) has made several representations, including concerns about current threats to services' budgets from the Ministry of Justice. The Taylor review is due for publication in the summer of 2016. The YOT is also the recipient of a separate review conducted by the National Probation Service (NPS) which has just announced changes associated with funding and, the role of seconded Probation staff, as well as a reconfiguration of the level of management representing the NPS on YOT Boards. As a consequence of this review, funding from the NPS to Swindon YOT has been reduced from £19,067 to £5,000 per annum from 1 April 2016, as well as the withdrawal of the seconded Probation Services Officer, resulting in a reduction in the compliment of seconded officers from two to one. The 16/17 budget has been set taking account of this reduction in funding and has been achieved on the back of two internal staffing reviews which led to the removal from the establishment of one managerial post and one (part-time) support worker post at a total saving of £60,000 p.a. Finally, RYS continues to be influenced by local changes associated with 'Stronger Together', of which the move to Clarence House to co-locate with other teams from Children's Services in late 2014 was a key component.

- 3.8 The Plan for 2016/17 has also had to anticipate significant reductions in funding from the Youth Justice Board and key funding partners. The staff savings referred to above were a necessary response to the total reduction in central government funding (via the Youth Justice Board) which since 2012/13 has now reached over 36.7%, representing a cash reduction of £119,633. Further action has also been taken to produce a balanced budget in 2016/17, including further reductions in non-staffing costs, and the use of the YOT's remaining reserves.
- 3.9 In spite of the financial pressures and other uncertainties the YOT continues to have the full confidence of the YOT Management Board. The Youth Offending Team also has a close working relationship with other YOTs in the South West and is encouraged by the Youth Justice Board's local partnership adviser to compare outcomes in order to promote best practice and ensure that resources are deployed where they can be most effective. The Team also has a reputation for innovation in practice, acknowledged by Her Majesty's Inspectors, which includes the development of a new web site aimed at young people due for launch in late Summer 2016, as well as the continuing take up - by Primary schools - of the award winning Young Volunteers scheme, now operating across seven schools in Swindon. The Plans for 2016/17 also take account of the continuing influence and positive impact on service delivery and reputation which comes from a community of volunteers (of which there are over 40). In March 2016 six volunteers, each with over 10 years continuous service were cited for the 2016 Pride of Swindon Award, with names included on a plaque unveiled on the 5th April in the central library. RYS is also aiming to secure renewal of the

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prestigious Investors in Volunteers award, designed to ensure that RYS processes and policies are at the highest possible standard to recruit, manage and develop volunteers for 2016 and beyond, helping ensure that young people in Swindon receive the best start in life.

4. Alternative Options

4.1 None.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1. The YOT is financed through a mix of funding from the Youth Justice Board, Local Authority (Children's Services), Wiltshire Police and Crime Commissioner, and partner organisations. The total Youth Justice grant for 2016/17 amounts to £224,950 which includes funding set aside to help meet demands associated with Unpaid Work and Attendance Centre orders from Court. Partnership cash funding amounts to £369,194 of which £267,500 comes from Children's Services. The following agencies also provide cash contributions: £76,994 from the Police and Crime Commissioner; £5,000 from the National Probation Service; and £19,700 from the Clinical Commissioning Group, in addition to staffing resources (based on secondments) as listed at section 6 of the Plan (staffing).
- 5.2 In March 2016 RYS made a successful bid to the Wiltshire Community foundation for funding of £129,400 to deliver a programme of specialist interventions for families where adolescent to parent/ carer violence is prevalent. The programme will run for two years and will include the training of staff across Children's Services.
- 5.3 The substance misuse service U-Turn is funded from four sources; Local Authority based Public Health (£75,000); Youth Justice grant funding transferred from YOT income to U Turn (£13,000); and Children's Services core funding (£33,600), in addition to £3,600 from Health, and £300 (net) from traded services with Schools, making a total budget of £125,500.
- 5.4 The youth counselling service On Trak is funded by the Local Authority (£61,300, and the CCG (£64,000) making a total budget of £125,300.
- 5.5 The Budget for 2016/17 is to be presented in April 2016 for the approval of the YOT Management Board, and includes proposals to meet the challenges previously mentioned.

Legal and Human Rights Implications

- 5.6 The Plan conforms to all SBC protocols and policies concerning the Legal and Human Rights of Swindon residents.

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Restorative Youth Services Plan 2016/17

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- 5.7 The Plan also builds in interventions on behalf of young people designed to promote opportunities for constructive use of their leisure time and as a result, a reduction in anti – social behaviour or crime.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.8 Restorative Youth Services are uniquely placed to straddle the criminal justice and care environments, resulting in strong links with the overarching strategic themes encompassed within key partner agencies including the Police and Crime Commissioner (Wiltshire and Swindon).

Diversity Impact Assessment

- 5.9 The work of the YOT, substance misuse service U-Turn, and the youth counselling service On Trak, are embedded in the Restorative Youth Services Plan 2016-17 which includes the Diversity Impact Assessment.

Risk Management

- 5.10 Plans include activities or protocols and procedures designed to address known or anticipated risks, including those associated with the potential for public sector funding reductions, as well as safeguarding of staff and young people.

6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 - The Restorative Youth Services Plan 2016/17

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APPENDIX 1

Children's Services Statement:

'Children in Swindon have the best start in life and grow up in supportive, confident and resilient families and communities'.



Contents:

- 1) Executive Summary – Pg 2
- 2) RYS in Context: Opportunities, Challenges and Partnerships – Pg 3
- 3) Delivering Specialist Services and Justice for Victims – Pg 4-6
- 4) Reducing Offending and Safeguarding Young People – Pg 7-12
- 5) Staff - Pg 13
- 6) YOT Data – Pg 14
- 7) Finance & Resourcing – Pg 15
- 8) Diversity – Pg 16
- 9) Glossary – Pg 17

RESTORATIVE YOUTH SERVICES PLAN 2016-17



YOT Statement:

'Children and young people who have offended, or are at risk of offending, will be offered the opportunities and support they need to become valued and productive members of our community and to repair the harm that they have caused'



NATIONAL PROBATION SERVICE
for England and Wales



1 - EXECUTIVE SUMMARY

Once again I am pleased to introduce this year's Youth Justice Plan in my capacity as Chair of the YOT Management Board. As well as addressing strategic direction and specific targets set by the Management Board across the **Youth Offending Team, young people's substance misuse service U-Turn, and On Trak youth counselling service**, this Plan also reflects changes resulting from the Post Inspection Action Plan signed off by Her Majesty's Inspectorate of Probation in July 2015.

The transition from a pre-inspection to a post-inspection YOT has been built on a number of subtle yet important changes in both governance and operational delivery. My colleagues on the YOT Management Board have been engaged in a series of one to one meetings with staff across RYS to review their areas of specific interest against progress on the ground, a process which has helped drive strategic and operational planning, as well as performance, agreeing local targets, and innovation in practice.

Against this background the work of RYS continues to face many challenges, suggesting that service delivery beyond the scope of this Plan will be heavily influenced by central government, as well as pressures from key funding partners. The YOT, in particular, has already been faced with a reduction in funding from central government of over 38.6% since 2012/13. Other developments include the wide-ranging Taylor review into youth justice services reporting mid Summer and likely to have significance in terms of future operating models and statutory responsibilities under potential new legislation. The national picture relating to the way post 18 offenders are dealt with is also undergoing significant change, and this has an impact on the YOT through a reduction of seconded Probation Officers from two to one, and the loss of £14,067.00 in cash funding.

In spite of these pressures, RYS continues to do well against national and local performance, keeping custodial levels down to single figures, and reducing re-offending rates from their peak in 2014/15. Team morale remains high, helping sustain operational effectiveness and minimising the disruption the caused by changes taking place, including a significant upgrade in the case management system ChildView. I am pleased to report that the Team also has a reputation for driving successes on the back of innovation in practice, including new forms of digital tools for an IT literate generation of young people.

Finally I would like to pay tribute to our volunteers – over 50 are active across a range of activities – cited as team winners in the 2016 Pride of Swindon Awards. I also need to mention our youngest volunteers (aged just 9 and 10) who can be located across several of Swindon's primary schools delivering anti-crime lessons to their peers in an award winning project.

The unique combination of dedicated staff, an effective strategic Board, and trained volunteers from the local community, continues to serve the best interests of young people as part of our 'One Swindon' vision.

Karen Reeve

Head of Children, Families and Community Health



Signature		Date	
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Partnership Signatures

John Gilbert	Job Title	Chief Executive Of The Local Authority	Signature	John Gilbert	Date	
Mark Sellers	Job Title	Superintendent, Swindon Police Operations Local Policing North	Signature	Mark Sellers	Date	
Mark Scully	Job Title	On behalf of National Probation Service	Signature	Mark Scully	Date	
Paul Bearman Gill May	Job Titles	Executive Director of Commissioning, NHS Swindon Clinical Commissioning Group Executive Nurse, NHS Swindon Clinical Commissioning Group	Signatures	Paul Bearman Gill May	Date	

2 - RESTORATIVE SERVICES IN CONTEXT: OPPORTUNITIES, CHALLENGES, AND LOCAL PARTNERSHIPS

'Restorative Youth Services', Swindon Youth Offending Team, Substance Misuse Service U Turn and the Youth Counselling Service On Trak are well placed to meet the Local Authority's drive to greater localism and accountability under the strategic direction 'Stronger Together'. Under this initiative the Council seeks to change the way it operates as a public service, distinguishing between delivery and commissioning but promoting greater cooperation and efficiency via the 'One Swindon' delivery plan. Restorative Youth Services will play a crucial role in supporting their strategic aims for a strong, safe community where fear of crime is low and there is a strong sense of civic pride in making Swindon 'a great place to live and work'. These aims also recognise that the population is becoming more diverse and is forecast to grow from 186,600 in 2007 to 250,000 by 2030. Although the town is recognised for creating an environment for good economic growth, there still remain areas of inequality and deprivation with low aspirations and attainment and this remains a significant challenge, as well as an opportunity to encourage local people to become more self-reliant and participate in decisions affecting their lives.

There are many factors influencing this Plan, including:

National and local funding reductions and pressures. Previous and ongoing reviews into the Youth Justice System, reorganisation and restructuring by partners which have innovative and ongoing impact and affect the way the RYS (particularly the YOT) is resourced by, and continues to work with such partners. The expectations associated with recent HMIP Inspection as well as local audit and QA activity are reflected, as well as the associated expectations regarding greater accountability – both locally and nationally. The wholesale change to our case management system (to ASSET Plus) which will fundamentally change the way the way we assess and plan for working with young people. Innovation and drives towards more use of restorative justice / approaches. A continued focus on QA, First Time Entrants, innovation and ensuring good quality service delivery going forward.

This Plan acknowledges YOT performance to date in each of the key areas associated with prevention, reoffending and custody as well as making the best use of the synergy between the three teams that make up the Restorative Youth Service, as well as with key partners such as Children's Services, Community Safety Partnerships and other criminal justice partners. YOT data, which is regularly reported to, and scrutinised and challenged on the YOT Board, highlight important trends including: the use of our community disposals, a smaller but more complex and risky/ vulnerable cohort of young people subject to Court ordered interventions, and continued and ongoing focus upon children who are Looked After or BME. **U-Turn** continues to see a positive shift away from Class A drug use by young people, but which has been replaced by increasing 'poly drug' use with predominant use of cannabis and alcohol. There has also been a detected increase of the use of 'legal highs' predominantly with the use of 'spice'. **On Trak** has made inroads into decreasing waiting lists/ times for young people to access counselling services but has seen an increase in referrals (monthly via GP or self-referral). Anxiety, self-esteem issues and mental health conditions such as depression continues to feature highly amongst the cohort of young people accessing the service. This has resulted in treatment times becoming longer.

The Plan is underpinned by a highly motivated and trained workforce, as well as a high number of local volunteers. Going forward, with a reducing paid workforce, maintaining and imposing the skills and expertise base of the large cohort of volunteers working with the RYS; working tirelessly with vulnerable young people and their families is of paramount importance. We are committed to a design to see 'the right people, with the right skills in the right place at the right time' – and this includes our valuable volunteer and sessional staff/ colleagues. This plan provides the strategic and contextual setting ensuring our systems and processes are safe; that risk, vulnerability and safeguarding is assessed and well managed; that young people are rehabilitated; that victims have a say; and that our young people who come into contact with the justice system have every opportunity to become valued and productive members of the community. I am confident that we have the right model going forward to ensure staff and volunteers remain focused and stronger by virtue of the partnership formed by the teams that make up Restorative Youth Services.



For more information contact; Matt Bywater - RYS Service Manager mbywater@swindon.gov.uk or refer to the Council's web site <http://www.swindon.gov.uk/>

ON TRAK YOUTH COUNSELLING SERVICE

Our aim is to ensure that young people and their parents are able to access the service for assessment and counselling in a timely way regardless of gender, ethnicity, sexuality or religious or cultural background subject to their assessed needs.

Our Plan is to:

- Aim to triage young person in consultation with health and other services within 10 days of initial referral.
- Reduce the average time it takes from accepting a referral to attending an assessment appointment. (The average for 2014/15 was 60.9 days).
- Reduce the average waiting time from assessment to subsequent first appointment. (The average for **13/14** was 30.6 days).
- Ensure young people are helped to identify their issues and personal risks and are supported to manage or reduce them.
- Client feedback continues to reflect the positively on outcomes for young people accessing the service. 2016/17 presents an opportunity to review processes in consultation with key partners (including targeted mental health) to ensure that young people in greatest need are prioritised and that young people who do not usually access counselling (including BME and young males) are made aware of the opportunities to do so. On Trak is also keen to embrace the digital revolution to reach the new generation of young people.

U-TURN SUBSTANCE MISUSE SERVICE

Our aim is to increase awareness by young people and parents of the service and help keep them safe from harm.

Our Plan is to:

- Encourage awareness of the risks of substance misuse through existing innovative prevention activities. (Legal Highs briefing delivered).
- Ensure young people receive an assessment within 10 days of Referral. (The average for 2014/15 was 84% against a target of 90%).
- Of those assessed, young people commence an intervention within 5 days of the assessment. (Target: 90%> Outturn **13/14** 100%).
- Keep young people engaged with the service, for which a target is set of at least 90%.
- The service continues to deliver support to the education sector in accordance with the traded services initiative, but is seeking new and innovative ways of engaging young people using social media and short educational films as the vehicle. The short film 'Jacks story' is setting the standard for other similar messages to follow.

GENERAL HEALTH AND WELLBEING

Our aim is to:

- To ensure young people are healthy, and have access to relevant services.
- Review agreements and protocols with partners with regard to health provision across partner agencies, including the secure estate.
- Improve the communication skills of young people with specific reference to their speech and language capabilities.

Our Plan is to:

- Agree a protocol for the delivery of Speech and Language services with Saltway.
- Prioritise Children looked after, ensuring they meet with the YOT nurse for an assessment of need.
- Agree protocols with SEN to give young people with particular needs priority to access services.
- Work closely with On Trak, Uturn and other relevant services to ensure a young person is referred within ten days of initial contact.
- Ensure all young people referred to the RYS services have been assessed within 10 days for their suitability for referral to specialist health services.

YOT Health Nurse

- Agree targets around waiting times, relating to the engagement of the young person including children looked after or those in special need, with health services.

The delivery of general health services to young people via Restorative Youth Services continues to perform well against CQC auditing processes. However there are new priorities for 2016/17 around access by more vulnerable groups of young people, including children looked after, which require new processes measured against new targets, as well as the extension of physical wellbeing to include emotional health.

PARENTING

Our aim is to

Parents of young people at risk of offending are offered help voluntarily or if necessary receive a statutory intervention from the parenting worker.

Our Plan is to:

- Set a new ambitious target for engaging parents. (Previous target that at least 20% of parents of young people on interventions are supported against an outturn in 14/15 of 13%).
- Seek innovative ways of raising awareness of the service in order to promote take up.
- Review the methodology used to underpin delivery of the service, taking account of research finding and best practise from elsewhere.
- Provide more detailed qualitative analysis of parental feedback to promote changes in practise.
- Review source of referrals and seek greater involvement from Education schools and colleges as well as other targeted or universal services including Families First.
- Ensure parenting remains a key aspect in the drive to change behaviours and reduce offending or reoffending by young people.

VICTIMS/ RESTORATIVE JUSTICE

Our aim is to

Promote the benefits of Restorative Justice in helping victims and raising the confidence of the public in the youth justice system

Our Plan is to:

- Review processes in order to increase the take up of victims.
- Set a more challenging target for victim engagement against agreed definitions broken down by direct and non-direct RJ.
- Look at best practice and research findings to inform changes in practice.
- Promote greater take up of restorative justice in care homes for the benefit of children looked after including options for training care home staff.
- Examine and publish the profile of young people from disadvantaged backgrounds and BME populations to set targets around interventions.

Restorative Justice remains a powerful and effective means of helping a young offender to take responsibility for their actions, and for reassuring victims that the process has value. Restorative Youth Services is committed to improving the scope of restorative justice, bringing more young people and victims of all ages into the process, and promoting restorative justice across agencies where it can bring about a resolution and avoid the formalities of police processes and entry into the youth justice system.

REDUCING FIRST TIME ENTRANTS

Our aim is to reduce the number of young people who are at risk of offending or anti-social behaviour from entering the youth justice system.

Our Plan is to:

- Work collaboratively with a number of key agencies in the justice and care sectors to keep first time entrants within target (in 2014/15 a total of 122 young people entered the criminal justice system, representing an average 30.5 against the target of 30).
- Promote greater links with specialist or universal programmes where early intervention plays a key part, including the Troubled Families scheme.
- Engage young people in new forms of digital tools, including social media and a bespoke web site to provide 24/7 access to informed information and better access to services aimed at young people.
- Extend the award winning Young Volunteers programme to schools across Swindon.
- Prioritise Children Looked After who are more vulnerable to criminal or anti-social behaviour.

The drive to keep young people out of the criminal justice system is dependent on a close collaboration with many sectors of the welfare and justice system, including police and education. Young people require new ways of engagement to deliver key messages to keep them safe from harm or be made more aware of the risks they face, for which innovation in practice (including the use of new digital tools) is a key focus.

For more information contact;

Dale Colsell - Operational Manager Specialist Services
DColsell@swindon.gov.uk



4 - REDUCING OFFENDING AND SAFEGUARDING YOUNG PEOPLE

RE-OFFENDING

Our aim is to:

Reduce the rate of young people re-offending, offering the opportunities and support they need to become valued and productive members of the community.

Our Plan is to:

- Reduce reoffending rates to below national averages.
- Prioritise the needs of Children Looked After who are especially vulnerable to criminal or anti-social behaviour.
- Intervene within the first four weeks of the first offence.
- Review practices in line with latest research and best practice.
- Treat girls differently in accordance with research findings.

Reoffending rates have risen in recent years as measured against a more challenging and complex cohort of young people. Measures will be taken in 2016/17 to compare performance against the existing (rather than historical) offender population using a new 'live tracker' tool designed for the purpose. The emphasis will also switch to those young people more vulnerable by virtue of their upbringing and physical or emotional condition to help improve their life chances and rehabilitate them into the local community as quickly and effectively as possible.

INTENSIVE SUPERVISION

Our aim is to

Help young people stay out of custody where there is a greater risk of reoffending on resettlement (and an increased risk of harm) by offering courts an intensive level of supervision.

Our Plan is to:

- To continue with the ambitious target of seeing young people complete their ISS programme (in 2014/15 the rate of completion was 44% against a target of more than 55% - representing 4 out of 9 cases).
- To continue to offer ISS, ISS Bail, BSS packages, and ensure that Intensive Referral Orders are continuously available to sentencing on all occasions.
- Publicise the good work that the ISS Team do via newsletters aimed at relevant stakeholders.
- Work collaboratively with Wiltshire YOT to assist with joint intensive interventions that cross boundaries.

ETE

Our aim is to:

Ensure all young people are in suitable education, training or employment at the close of their intervention; and to strengthen links to local colleges and education providers to help inform the process of engaging a young person and assisting with decisions around placements

Our Plan is to:

- Improve performance against the local target of at least 89% of young people in suitable ETE.
- Promote the use of the software programme 'Rapid English' which has a proven record of improving a young person's standard of communication and literacy.
- Promote stronger and more effective links to relevant schemes – including apprenticeships and Police cadets.

Engaging a young person in suitable ETE remains challenging, and the continued secondment of key personnel to the RYS team, including Education Welfare and Youth Engagement, remain critical in meeting the ambitious targets. Other initiatives include the use of a new young person focused web site to promote opportunities for young people.

REMANDS

Our aim is to:

Reduce the number of remands to custody by providing bail and remand support packages which have the support and confidence of Magistrates.

Our Plan is to:

- Review 'what works' in terms of interventions and plans which have the confidence of Magistrates and keep a young person safe from harm and from reoffending while on bail.
- Take special measures to monitor the progress of a young person in custody in order to keep them safe from harm or abuse.
- Introduce new ideas or processes (including IT and social media) to help young people in custody communicate any anxieties or concerns.
- Monitor local targets, which include the need to ensure that less than 9% of all young people on bail are subsequently remanded into custody.
- Keep the costs of remands to within Local Authority budget allocations.
- Ensure ISSP Bail and RLAA packages are widely available to all courts and Remand to Youth Detention Accommodation is only used as a last or only resort.
- Support young people in making bail applications post remand where possible.

CUSTODY

Our aim is to:

Reduce the number of young people receiving a conviction in Court who are sentenced to Custody.

Our Plan is to:

Target: <5% of all sentencing

Outturn 2014/15: 2.3% (Of 173 sentencing occasions 4 young people went to Custody (No BME)).

- Ensure that YOT go above and beyond statutory minimum requirements in terms of seeing young people in custody.
- Ensure YOT attend all Youth Panel meetings - To instil confidence in the Magistrates in relation to Bail packages and other Court orders.
- Monitor concordance data from PSR's – especially "all options" and recommendations for alternatives to custody (including ISS).
- Seek regular feedback from sentencing regarding PSR robustness and quality.
- Launch a new "resettlement offer" aimed at giving all young people leaving custody a genuine and intensive offer of support and guidance post release.

ACCOMMODATION

Our aim is to:

On release from custody and on the completion of community orders - young people are in suitable accommodation.

Our Plan is to:

Target: 96% > Outturn 2014/15: 94% (9 out of 140 relevant cases were not in suitable accommodation).

- Ensure YOT links with Local Authority on sufficiency duty.
- Advocate for a better range of accommodation for young people.
- Ensure reporting to Board in regards to issues/ blocks etc.
- Continue planned resettlement with Housing.
- Imbed protocol with Housing so vulnerable young people taken to them as and when needed.

The YOT and Homelessness Team will manage the risks of housing young people in housing crisis by immediate direct notification between the teams once a young person's housing needs have been made known to their respective team. The Homelessness Team to assess a young person's housing needs on first presentation, where possible, to avoid return appointments.

- We will embed the arrangements in place to assist young people with housing on release from custody by continuing to have positive links with SBC Housing services.

VULNERABILITY

Our aim is to:

Ensure we have robust and high quality assessments, plans and management of vulnerability and safeguarding which are meaningful and reduce any risks which will potentially affect the child or young person's safety or well being.

Our Plan is to:

- Improve staff skills in reflecting, analysing and recording risk of harm and vulnerability issues more widely and in more depth
- Ensure accurate assessments and management about the level of vulnerability of a child or young person.
- Ensure assessment focusses more holistically and not just on child protection issues, suicide and self-harm, especially in pre-sentence reports.
- Ensure the quality of planning at the start of the sentence for work in the community to address safeguarding and vulnerability is of a good standard.
- Reduce delays in the delivery of some specialist interventions.
- YOT team will participate and contribute (CSE and criminal exploitation) to MARP + other Home Office work (EGYV).
- Contribute across boundaries (with Wiltshire YOT).
- Contribute to MASH (Triage)/ Missing young people information sharing.
- Link to updated Social Worker protocols to share knowledge etc.
- Bid to attract DA resource; linking to young perpetrators of DA.
- Work with CAMHS to ensure early identification of mental health issues.
- YOT to review within 1 year its response to the EGYV peer review.
- Ensure the Board are sighted on the EWO's role – Board to be cited on issues – e.g. young people excluded + missing are being proactively alerted to the YOT.
- Explore implementing a system to notify re children excluded/ absent from school and incorporate this into planning.
- Engage an external Youth Justice Consultant to review our safeguarding / vulnerability assessments plans and management to ensure that they are the best they can be and, going forward and in anticipation of ASSETPlus implementation, to ensure that the practice is embedded team-wise.

CHILDREN LOOKED AFTER (CLA)

Our aim is to:

Reduce the incidents of CLA coming into the justice system – and ensure protocols/ policies are followed in respect of out of Court disposals to improve communication and joint working on appropriate cases between YOT and Children's Social Care.

Our aim is to:

- Improve governance relating to Looked After Children, improving links with ICT and Social Care teams such as Family Contact Point.
- Draft an RYS statement reinforcing our corporate parental responsibilities recognising CLA are vulnerable and are not missing out on services etc.
- Challenge out of Borough placements and ensure certainty that the young people in this situation will always be 'looked after' by Swindon (and YOT remains working with such children as a 'Home YOT'.
- Ensure the designated nurse link is maintained.
- Ensure child's voice is heard and shapes service delivery.
- Ensure effective links with Independent Review Officers as well as Children's Social Workers.
- Explore out of Court disposals and ensure they are appropriately used in any case including CLA.

RISK OF HARM

Our aim is to:

Ensure robust and high quality assessments, planning and management of risk of harm are in place, and reviewed and any risk of harm is, where possible, mitigated. To ensure effective YOT participation in Risk Fora such as MAPPA, MARAC and MARP and that risk is reviewed in a timely fashion.

For more information contact;
Melissa Norton – YOT Operational Manager
mnorton@swindon.gov.uk



Our aim is to

- Train Police personnel with regards to intelligence sharing and risk management.
- Ensure improved staff skills in reflecting, analysing and recording risk of harm and vulnerability issues more widely and in more depth.
- Ensure the YOT is fully exploring risk of harm thoroughly and does not underestimate the level of harm a child or young person poses to others and the need to plan to manage this.
- Ensure assessments and plans are reviewed and updated when required.
- Ensure interventions to manage risk of harm are consistently delivered.
- Ensure written guidance or structures in place to help YOT workers manage cases where it was considered a child or young person posed a high risk of harm to others.
- Engage an external Youth Justice Consultant to review our risk of harm assessments plans and management to ensure that they are the best they can be and, going forward and in anticipation of ASSETPlus implementation, to ensure that the practice is embedded team-wise.
- Add quality assurance and updating performance framework (post ASSET Plus) .



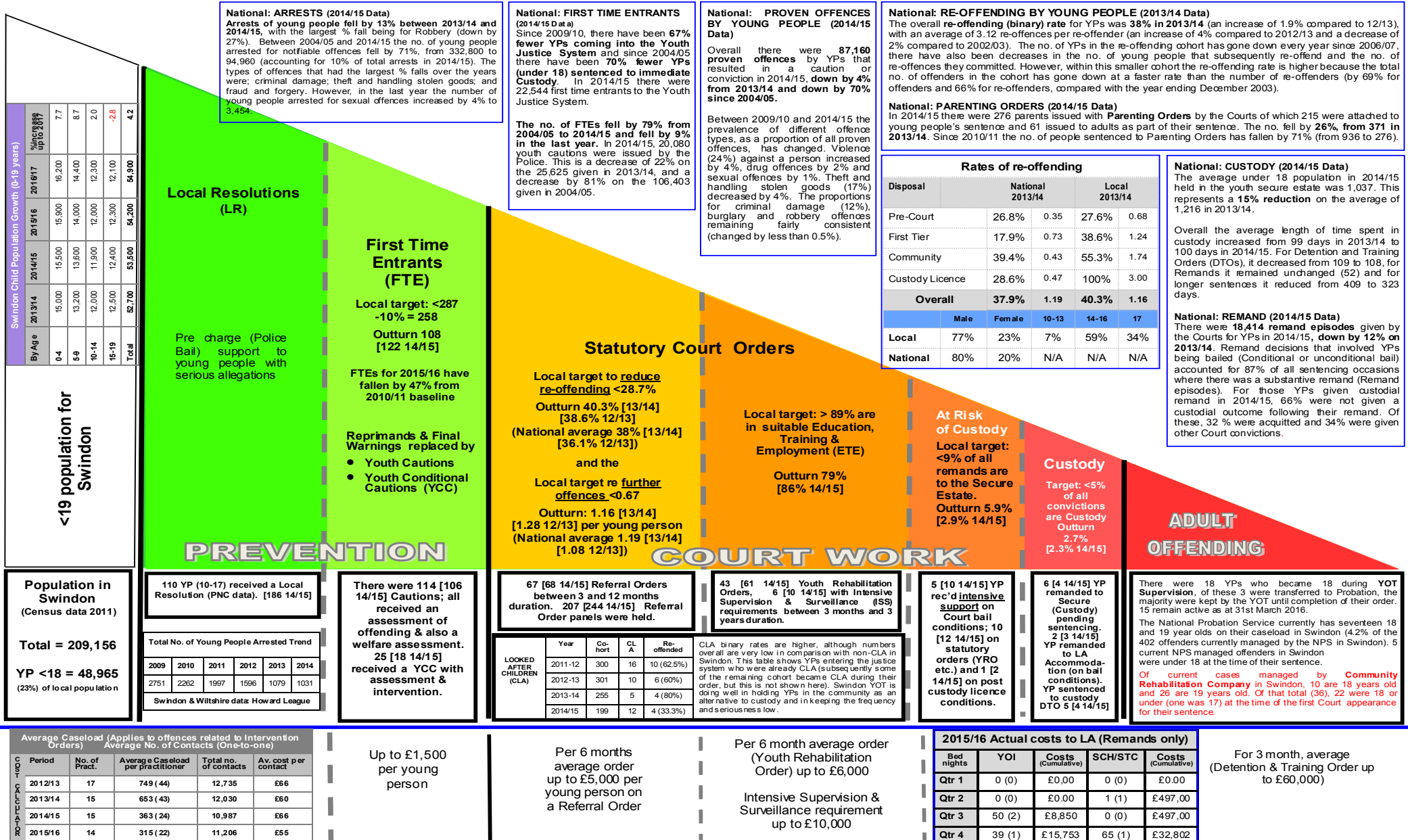
RESTORATIVE YOUTH SERVICES

Service Manager – Matt Bywater



RYS PREVENTION & SPECIALIST SERVICES					YOT COURT,SUPERVISION,THROUGH CARE, REMAND & INTENSIVE INTERVENTION							
Operational Manager Specialist Services – Dale Colsell					Operational Manager YOT – Melissa Norton							
Tony Aldridge Restorative Justice Co-ordinator (YOT P/T)	Dan Collins Youth Engagement Worker (SBC/YOT P/T)	Victoria Harvey Parenting (YOT F/T)	Jill Wells Education Welfare Officer (SBC/YOT P/T)	Denise O’Rafferty YOT Worker (YOT F/T)	Andrew Seddon Probation Officer (Seconded F/T)	Stephanie Gillett Social Worker (Seconded F/T)	Jayne MacLeod Social Worker (YOT F/T)	Gail Martin YOT Worker (YOT F/T)				
POLICE – PROJECT WORK / SCI		SUBSTANCE MISUSE										
Phil Elliott Police Officer (Seconded F/T)	Daniel Vizor Police Youth Justice Worker (Police F/T)	Michael Hadgraft Substance Misuse Worker (U-Turn F/T)	Hannah Woloszczynska Substance Misuse Worker (U-Turn F/T)		Valerie Mathe YOT Worker (Unpaid Work) (YOT P/T)	Karen Sercombe ISS Worker (YOT P/T)	Cathy Hill ISS Worker (YOT F/T)	Paul Hewer ISS Worker (YOT P/T)				
ON TRAK		HEALTH										
Kathleen Kinloch Counsellor (On Trak P/T)	Michael Bizley Counsellor (On Trak P/T)	Rachel Watts/ Alan Dickens Mental Health Practitioner (Oxford Health/ YOT P/T)	Clare O’Driscoll Specialist Speech & Language Therapist (SBC/ YOT P/T)	Rachel Steadman Young People Health Nurse (SBC/ YOT P/T)	Julie Coleman Bail Support and Intensive Interventions Co-ordinator (YOT F/T)	Annette Harvey-Jones Youth Justice Centre Officer-in-Charge (YOT P/T)	Vacancy Adolescent to Parent Violence Worker (F/T)	Vacancy Adolescent to Parent Violence Worker (P/T)				
Rachel Murphy Youth Counsellor (On Trak P/T)	Melanie Richards Youth Counsellor (On Trak P/T)											
COURT ADMINISTRATION, INFORMATION & VOLUNTEERS												
Business Manager – Blair Staynings												
Julie Wordsworth Performance & Information Officer (RYS F/T)	Carla Da Silva PA/Finance Assistant (RYS (F/T))	Jeanette Glover Court Admin/ Reception Supervisor (RYS P/T)	Yvette Bennett Court/ On Trak Admin (RYS P/T)	<u>Volunteers (49)</u> AA - 14 Panel Members – 15 On Trak – 12 Young Volunteers – 8 (Some may have dual roles)	<u>Sessional Workers</u> U-Turn/Troubled Families - 1 ISS/ Reparation – 2 Att. Centre – 2 On Trak – 4	RYS Staff (44 excl. 2 vacancies) and Volunteers (49 active)						
						Ethnicity		Gender				
							Staff	Volunt	Staff		Volunt	
									M	F	M	F
						White	93.2%	89.8%	31.80%	61.4%	16.3%	73.5%
						Mixed	2.3%			2.3%		
						Asian	2.3%	6.1%		2.3%	4.1%	2%
Black	2.3%	4%		2.3%	2%	2%						
Other												

MODEL OF SWINDON YOUNG PEOPLE OFFENDING (YOT 2015/16 DATA)



7 - FINANCE & RESOURCING

Youth Offending Team

Income and budgeted expenditure is as follows:

Agency	Staffing costs (£)	Payments in kind—revenue (£)	Other delegated funds	Total (£)
Local Authority	£136,800.00	£85,000.00	£130,700.00	£352,500.00
Police Service*	£75,000.00	-	-	£75,000.00
National Probation Service	£38,200.00	-	£5,000.00	£43,200.00
Health Service	£32,000.00	-	£19,426.00	£51,426.00
Police and Crime Commissioner*	-	-	£76,994.00	£76,994.00
YJB Grants (Incl. Att. Centre & Unpaid Work)	-	-	£223,353.00	£223,353.00
Other	-	-	67,200.00	67,200.00
Reserves	-	-	£44,200.00	£44,200.00
Total	£282,000.00	£85,000.00	£566,873.00	£933,873.00

YOT BUDGET 2016/17	
Salaries (incl. Unpaid Work & contrib.to U-Turn)	£666,700.00
Equipment	£1,500.00
Accommodation	£0.00
Overheads	£32,500.00
Activity	£3,000.00
Total	£703,700.00

The YOT continues to comply with the requirements of the Crime and Disorder Act in terms of the staffing commitments from the funding partnership. RYS is facing unprecedented levels of funding cut backs, including a reduction in central government grant of £126,000 (38.6%) since 2012/13. These prompted RYS to carry out two internal reviews of its staffing structures, beginning with the management structure. As a result, the post of Manager of the youth counselling service On Trak and Referral Order administrator were deleted with effect from 1 April 2016 resulting in a saving of £60,000 per annum. Setting a balanced budget for 2016/17 has been challenging, and only made possible through the use of the YOT's remaining reserves (of £44,200) on top of actions previously taken, including the holding of vacancies.

New Developments: The YOT is preparing for an upgrade in its case management system ChildView to version 3 in the summer of 2016. This is a pre requisite for implementation of Asset Plus, and for which funds have been ring fenced to meet the costs of planning and delivery (including training). In a separate initiative, a bid to the Swindon and Wiltshire Community Foundation was successful, securing funding over two years for the recruitment of 1.5 fte staff to reduce incidences of adolescent to parent abuse across families in Swindon. The programme requires delivery of a structured intervention (based on the national RESPECT model) as well as the ability to engage and train other professionals – including social workers and health workers – aimed at the sustainability of the programme over the long term. Funding is a total of £129,400, including cost of commissioning specialist support from the RESPECT Programme providers. Other priorities include a continuing investment in the delivery of anti-crime messages across schools using six pupils (an award winning programme) which is now being rolled out across six primary schools in Swindon; commissioning of educational material (including films); innovation in the use of social media to engage young people including a new website; and significant investment in the provision of unpaid work to juveniles in close consultation with courts.

Although the YOT's custody rates remain well below national averages, the YOT Board and the wider partnership are collaborating to reduce costs associated with remands into custody, and plans to support young people following resettlement.

The Substance Misuse Service U Turn - This service is funded from three different sources: Local Authority based Public Health accounts for £75,000, helping to ensure that this service is integrated with wider children's services; Youth Justice grant funding transferred from YOT income to U Turn (£13,000) and Children's Services core funding making a total budget of £125,700.

The Youth Counselling service On Trak - On Trak continues to receive funding in order to meet demands by young people for their services, including increased waiting times. The budget overall is £125,300 (£61,300 from SBC and £64,000 from the CCG) in 2016/17.

These budgets are managed by the Restorative Youth Services Business Manager in partnership with Swindon Borough Council finance.

For more information contact; Blair Staynings - RYS Business Manager BStaynings@swindon.gov.uk



8 – DIVERSITY STATEMENT

Restorative Youth services are committed to:

- Challenging any behaviour that perpetuates discrimination and which limits individuals from realising their potential.
- Ensuring that no one will be discriminated against on the grounds of their race, gender, disability, sexual orientation, age, HIV status, marital status, class, religion or beliefs.
- Carrying out service audits and maintaining monitoring arrangements designed to identify areas of equality development and to support relevant action plans.
- Consulting service users, staff, community groups and partner organisations on developing equality and diversity policies and action plans.
- Tackling areas of discrimination and social exclusion to ensure that all its services are delivered in a fair and equitable manner.
- Securing support of external partners and contractors for its equality and diversity objectives.

A diversity impact assessment of this plan has been completed to ensure that it meets our equality duties and gives proper consideration to how the service will affect the life chances of different groups and the impact the service will have on the 10 Dimensions of Equality. The Plan acknowledges that more can be done to reach out to young people from minority groups using new methods of communication (in particular, an innovation to use new digital tools). The Plan is being widely consulted on, including staff, local community volunteers and key stakeholders as part of the development of the Plan to the YOT Board.

The Plan also encompasses a commitment to greater innovation in order to develop good practice and research, leading to better outcomes for young people and their families in Swindon. Peer reviews, more in depth analysis of data, and a new website for young people, will all help to ensure that services are reaching out to young people and families from all ages, abilities and cultural or ethnic roots, regardless of social and economic background. The Plan includes comprehensive detail of outcomes achieved against national and local targets (as well as trends), and these tools will be evaluated continually throughout 2016/17.

Service users complete feedback at the end of each intervention as well as a percentage are further invited to complete a fuller questionnaire that is sent to an independent body for collation and trend analysis. This includes feedback using an independent process called Viewpoint which gives young people an opportunity to describe their points of view. Data from this analysis helps to inform the Plan. In addition, RYS gathers data for incorporation into performance reports which are analysed quarterly by the YOT Management Board. These include statistical data as well as case studies. Examples can be provided on request.

We believe that the Plan 2016/17 makes it more likely that young people who in the past have not engaged with RYS, will now do so. This is because of changes in emphasis (for example, by working closely with Troubled Families) or due to changes in the way RYS communicates with young people. Children, Families and Community Health Services are also developing a new website for launch in the Summer of 2016 which will encourage young people to learn about the range of services available for them, and the ability to message using 24/7 digital mobile tools at their disposal.

2011 Census data on Swindon Population Ethnicity	Swindon Population aged 10-17 (20,167)	Restorative Youth Services (2015-16 data)			
		YOT – Community Sentence 148 (186)	YOT – Custody 5 (4)	U-Turn 60 (108)	On Trak 91 (110)
White	87.2%	89% (86%)	80% (75%)	91.6% (91.5%)	90% (90%)
Mixed	3.4%	0.7% (2%)	0% (0%)	0% (1.9%)	2% (0%)
Asian	7.6%	1.4% (1.8%)	0% (0%)	0% (1.9%)	2% (3.6%)
Black	1.4%	9% (8.6%)	20% (25%)	1.7% (3.7%)	2% (0%)
Other	0.4%	0% (1.6%)	0% (0%)	6.7% (1%)	4% (6.4%)

RYS Staff (44 excl. 2 vacancies) and Volunteers (49 active)						
Ethnicity	Gender					
	Staff	Volunt	Staff		Volunt	
			M	F	M	F
White	93.2%	89.8%	31.8%	61.4%	16.3%	73.5%
Mixed	2.3%			2.3%		
Asian	2.3%	6.1%		2.3%	4.1%	2%
Black	2.3%	4%		2.3%	2%	2%
Other						

To find out more go to SBC equality@swindon.gov.uk

9 - GLOSSARY

ABC	Acceptable Behaviour Contract	LSCB	Local Safeguarding Children Board	SCI	Swindon Crime Initiative
AIM	Assessment Intervention Moving On	MAPPA	Multi Agency Public Protection Arrangements	SHARP	Safeguarding, Harm and Risk Panel
ASB	Anti-Social Behaviour	MARAC	Multi-agency Risk Assessment Conference	SMU	Substance Misuse
ASSET	Assessment Tool Planning, Interventions & Supervision	MARP	Multi Agency Risk Panel	SOS	Signs of Safety (Safeguarding model of working)
BME	Black & Minority Ethnic	MoJ	Ministry of Justice	STC	Secure Training Centre
CAF	Common Assessment Framework	NEET	Not in Education, Employment or Training	STASTC	See the adult, see the child
CAMHS	Child and Adolescence Mental Health Service	NOMS	National Offender Management Service	TAC	Team Around the Child
CPN	Community Psychiatric Nurse	NPT	Neighbourhood Policing Team	TaMHS	Targeted Mental Health Service
CPS	Crown Prosecution Service	NS	National Standards	U-Turn	Young Peoples drug service
CSP	Community Safety Partnership	PHE	Public Health England	WLCJB	Wiltshire Local Criminal Justice Board
CSPPI	Community Safeguarding & Public Protection Incident	OHFT	Oxford Health Foundation Trust	YEW	Youth Engagement Worker
CV	ChildView Case Management System	On Trak	Youth Counselling Service	YJB	Youth Justice Board
DTO	Detention and Training Order	PACE	Police and Criminal Evidence Act 1984	YOT	Youth Offending Team
ETE	Education, Training and Employment	PCC	Police & Crime Commissioner	YP	Young Person
EWO	Education Welfare Officer	PRAISE	Peer review audit tool	YRO	Youth Rehabilitation Order
FTE	First Time Entrant	PSR	Pre-Sentence Report	<p>Restorative Youth Services comprises the Swindon Youth Offending Team, U turn Young People's Substance Misuse Service and On Trak Youth Counselling Service.</p> <p>To find out more about its work in preventing or reducing crime amongst 10-17 year olds, Substance Misuse work and Counselling simply come along to our Free information Session from 2:00pm to 3:30pm on:</p> <ul style="list-style-type: none"> 6th May 2016 10th June 2016 8th July 2016 5th August 2016 9th September 2016 7th October 2016 11th November 2016 9th December 2016 13th January 2017 10th February 2017 10th March 2017 	
HMCTS	Her Majesty's Courts and Tribunal Service	PVE	Preventing Violent Extremism		
HMYOI	Her Majesty's Young Offenders Institution	RMP	Risk Management Plan		
IOM	Integrated Offender Management	RJ	Restorative Justice		
ISS	Intensive Supervision & Surveillance	RLAA	Remand to Local Authority Accommodation		
KPI	Key Performance Indicator	RO	Referral Order		
LAC	Looked After Children	ROSH	Risk of Serious Harm		
LASCH	LA Secure Children's Home	RYDA	Remand to Youth Detention Accommodation		
LASPO	Legal Aid Sentencing & Punishment of Offenders Act	SAVRY	Specialist Assessment of Violence Risk in Youth		
		SEND	Special Education Needs or Disability		

Dying Well Community Charter

Health and Wellbeing Board

Date: 25 May 2016

Author:	Executive Nurse, NHS Swindon Clinical Commissioning Group
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 Swindon Clinical Commissioning Group (CCG) has placed end of life care as one of its key priorities. Since developing a bid to become a Dying Well Community Charter pilot site in 2014, in which it was unsuccessful, all partners involved have continued to work together to design and implement, with stakeholder support, a local Dying Well Community Charter.
- 1.2 Towards the end of 2014 the National Council for Palliative Care (NCPC), working in partnership with Public Health England, set out the idea of a National Dying Well Community Charter and invited communities to bid to become one of 7 pilots to establish a 'Charter' in their areas. The purpose of the Charter is aimed at helping the local community to work together to improve their support to people with a life-limiting illness, those who support them and those who have been bereaved, something that is fully aligns with Swindon CCG's aims.
- 1.3 The Swindon Dying Well Community Charter (DWCC) sets to outline a visible commitment by individuals, communities and organisations, working together to support the community we all live in, the people with a life-limiting illness, their families and carers. The Charter is a nationally led idea, but the ideas and commitments within it are ones that many local organisations will recognise as important and valid for our local community of Swindon. So a group of local organisations came together to look at how we could create a Swindon Charter. These organisations on the working group include representatives from the Clinical Commissioning Group, Great Western Hospital, Healthwatch Swindon, Prospect Hospice, Public Health Swindon, SEQOL and the Swindon Carers Centre.
- 1.4 The first step was to see if the views contained in the national DWCC reflected local views, so in May 2015 we undertook a local survey and a number of road shows to get the views of local people and what they thought was important to them at the end of their, or a loved ones, life. The responses highlighted that the areas captured in the national DWCC reflected those voiced locally. For us the next stage was to consider what each of the areas meant and what support might help to deliver on some of these issues.

Further information on the subject of this report can be obtained from Robin Butcher, 01793 683700, communications@swindonccg.nhs.uk.

Dying Well Community Charter

Health and Wellbeing Board

Date: 25 May 2016

2. Recommendations

The Board is recommended to:

- 2.1 Sign up to the principles of the Dying Well Community Charter as set out in Appendix 1 to the report.
- 2.2 Support the launch of the Dying Well Community Charter in Swindon, which will encourage local partners, voluntary services and local businesses to consider how they can support the aims of the Charter.

3. Detail

- 3.1 There are five key principles of the Charter which is attached at Appendix 1 to this report:
 - Recognition and Respect
 - Communication
 - Involvement
 - Support
 - Help us plan and do
- 3.2 These categories provide helpful banners under which to bring together all of the work Swindon CCG and its partners have been involved in over recent years to improve EOL care.
- 3.3 The working group has identified a number of local organisation to engage with, setting out the value of the DWCC and looking to secure early sign-up to the Charter before the launch event in May.
- 3.4 In order to support the delivery of the DWCC, the partnership have worked together to:
 - Review opportunities to bring the collective knowledge and support provided in Swindon together in one place, making the information accessible to everyone, to support them to support those they care for.
 - Raise awareness of the Swindon Advance Care Planning document, it is a really simple and easy to use document so we need to make sure its available for everyone to access.
 - Support GPs and other healthcare professionals to know what services and help is already available.
 - Provide training & support where needed.

Further information on the subject of this report can be obtained from Robin Butcher, 01793 683700, communications@swindonccg.nhs.uk.

Dying Well Community Charter

Health and Wellbeing Board

Date: 25 May 2016

- Identify support networks – talking to groups and supporting organisations, raising awareness of the DWCC, its value and what's important to people, as well as getting individuals, groups and organisations to sign up to the Charter and do a little to make a whole lots of difference.
- Create an end-of-life care page for the Swindon My Care My Support website.
- Hold a stakeholder awareness conference in May 2016.

3.5 To build awareness and support of the Charter, we have planned a DWCC stakeholder awareness event to take place on 12th May at Steam in Swindon. At this event, we will be providing an overview of the aims of the Charter, and suggesting opportunities for local businesses and organisations to support in this improvement. Steps for consideration will include:

- Create a Bereavement or Compassionate leave policy (or adapt someone else's).
- Create flexibility in the workplace for those with a life-limiting illness, family member or carer.
- Sign-posting to useful advice and support; communicate what support you have and how to access it.
- Highlight My Care My Support website.
- Support managers in the work place.
- Nominate a single point of contact for key information.
- Feed back to us what changes have been made in six months' time and share your learning.

3.6 The aim is that the stakeholder event will mark the beginning of local organisational buy-in to this critical issue and that the ongoing partnership, led by Prospect Hospice, will continue to provide improved awareness and understanding of EOL care and its development in Swindon.

4. Alternative Options

4.1 All partners are progressing improvements to EOL care, and this Charter provides a helpful banner which to raise awareness of these improvements. The Board could choose not to support the Charter, although that is not recommended.

Further information on the subject of this report can be obtained from Robin Butcher, 01793 683700, communications@swindonccg.nhs.uk.

Dying Well Community Charter

Health and Wellbeing Board

Date: 25 May 2016

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 None.

Legal and Human Rights Implications

5.2 None.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 None.

Diversity Impact Assessment

5.4 Through this partnership, we have been able to co-produce the event, and engage a wider audience as a result.

Risk Management

5.5 None.

6. Consultees

6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None.

8. Appendices

8.1 Appendix 1 – The Dying Well Community Charter.

The Dying Well Community Charter

Principles of care and support

Dying and death remain significant social taboos, despite the inevitable fact that all of us will die one day. Some of us will experience death suddenly; others will die after a period of illness or frailty, which can sometimes be protracted over years.

Whilst many of us hope to die peacefully with dignity, compassionate care, and support for our carers and the people who are important to us, sadly too many people do not have that experience. This continues to be a subject that is frequently perceived as 'too difficult' for individuals, communities and civic society to discuss and so dying is not given priority. Consequently, whilst many people, and carers, understand what is needed to improve the end of life for themselves and the people who are important to them, they struggle to access care and support in coherent and connected ways when they need it.

Dying and death do not happen in isolation from the rest of life. People who are dying may not wish to be isolated and disconnected from their communities. There is more to do to engage communities in the end of life so that those affected by dying and death do not feel abandoned and socially isolated. Care for one another at times of crisis and loss is not simply a task for health and social care services but is everybody's responsibility.

The Dying Well Community Charter provides a visible commitment by individuals, communities and organisations to work together towards the following principles, which should apply for all of us and our communities as we are affected by dying and death.

Recognition and respect

- See dying and death as an important part of our lives.
- Respect each of us and our carers for who we are, how we have lived our lives, the relationships and things that we value, and the legacies we leave behind us.
- Recognise the contribution we may still wish to make to our family, work or community.
- Do everything possible to give us and our carers the level of independence control and participation in decision-making that we wish.
- Treat us always with dignity, respect and compassion.

Communicate

- Communicate with us, our carers, and those who are important to us in kindly words and appropriate manner so that we understand what we are facing and know that you understand.

- Be clear and honest with us, answer our questions as best you can, and tell us what to expect. Where possible and appropriate explain clearly and compassionately the reality that death is coming.
- Talk to us and the people important to us about what we might need in the future, as often as we need you to do this. Respect our pace and recognise that we might not always want to talk about things when you want to.

Involvement

- Listen well to our wishes for the remainder of our lives, including our final days and hours.
- Help and support us and our carers to think ahead to the choices we may face, make decisions about care and support, and give us as many opportunities as we need to do this.
- Remember that we can change our minds about our wishes
- Make sure that our wishes are recorded so that everyone involved in our care and support knows what we want.
- Where we are unable to participate in planning and decision-making, support anybody who has to make decisions on our behalf and ensure they know and understand our wishes and values.

Support

- Make every possible effort to help us to get the end of life support and care we want, including in the place we want to be.
- Encourage and support us to talk about any emotional, cultural, or spiritual needs we may have. Ensure they are respected and met wherever possible.
- Make sure that our carers and people who are important to us are supported before and after we die, including offering information about grief and bereavement and appropriate professional support where possible.
- Recognise and foster sources of care and support within our community.

Help us to **Plan, and Do**

- Give us opportunities to plan our care for the end of life.
- Provide us with someone to coordinate and organise care and support for us and our carers.
- Tell us, those close to us and our carers who to contact for information and support, at any time of day or night, if needed.
- Provide practical support as quickly as possible.
- Do everything possible to alleviate physical, emotional, social and spiritual distress and suffering. Comfort us, our carers and those important to us.

Suicide Prevention

Health and Wellbeing Board**Date: 25 May 2016**

Author:	Senior Public Health Manager, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 Suicide prevention has been a long standing Public Health responsibility and is now the responsibility of the Local Authority. The All Parliamentary Group on Suicide and Self-Harm prevention recommends Local Authorities to undertake a suicide audit, develop an action plan and have a Suicide Prevention Reference Group. The Five Year Forward View for Mental Health for NHS England also recommends that all areas have shared suicide prevention plan by 2017 which is reviewed annual. This report updates the Health and Wellbeing board on the latest profile of suicide in Swindon and outlines actions being undertaken to prevent the occurrence of suicide.
- 1.2 Suicide is a major issue for society and a leading cause of years of life lost. In England, one person dies every two hours as a result of suicide. When someone takes their own life, the effect on their family and friends is devastating. Many others involved in providing support and care will feel the impact.
- 1.3 In Swindon a suicide audit has been carried out regularly since 2009 and the findings used to review and update a Swindon suicide prevention strategy. This work is overseen by the multi-agency Swindon Suicide and Self Harm Prevention Group. The 2016 – 2018 Swindon suicide strategy has been developed and informed by recent suicide audit.

2. Recommendations

The Board is recommended to:

- 2.1 Note the findings of the Swindon Suicide Audit and endorse the strategic recommendations
- 2.2 Recommend to Cabinet and the CCG Board that they note the Swindon Suicide Audit findings and endorse the recommendations and adopt the strategy.

Further information on the subject of this report can be obtained from Frances Mayes, 01793 444677, fmayes@swindon.gov.uk.

Suicide Prevention

Health and Wellbeing Board

Date: 25 May 2016

3. Detail

- 3.1 Suicide is a major issue for society and a leading cause of years of life lost. In England one person dies every two hours as a result of suicide.
- 3.2 The paper outlines the national policy context, the high risk groups and the local suicide prevention governance arrangements. It then reviews the suicide rates for Swindon in comparison to the national, South West and our comparator areas. In all measures the rate for Swindon is slightly higher than England and the South West but not statistically significantly different. It is also not significantly different from our comparator areas.
- 3.3 The suicide rates are reported in three year rolling averages as the numbers are relatively small and subject to large variation year on year which can be misleading if reported on an annual basis. For the past three time periods 2010 - 12, 2011 – 13 and 2012 -14 the suicide rate has risen in Swindon at a slightly higher rate than nationally. The rate has risen for both males and females but the rate for men is nearly three times higher than for women. 73% of deaths by suicide in Swindon were male.
- 3.4 The paper then looks at the local suicide data which shows that there are early indications are that the suicide rate in Swindon may have decreased since 2014. During 2012-14 there were more deaths than expected in younger people (15 -34 year olds) and those over 75 years. However, looking at a longer time period 2006 – 2015 the suicide rates are highest in 30 -34 year olds and 45 -49 year olds.
- 3.5 In Swindon the most common method of suicide for both men and women was hanging followed by poisoning. 77% of people were single, divorced or widowed and 43% were either unemployed, long term sick/disabled or retired.
- 3.6 Of the 108 suicides on the Swindon database (started in 2006), 50% had information recorded on history of self harm, 41% of these had either a life time history of, or had self-harmed in the recent past. 11% had self-harmed within the last 12 months. Swindon has one of the highest rates of emergency admissions due to self-harm in the country.
- 3.7 74% of those on the suicide database had a recording of alcohol use, 26% of those with an alcohol status had ingested alcohol at the time of death. Approximately, 15% had been in contact with secondary care mental health service.
- 3.8 The majority of deaths occurred at the individuals home address (68%) with 6% occurring on transport routes or at car parks.

Further information on the subject of this report can be obtained from Frances Mayes, 01793 444677, fmayes@swindon.gov.uk.

Suicide Prevention

Health and Wellbeing Board

Date: 25 May 2016

3.9 The suicide audit reports that those of non-heterosexual orientation are more at risk of suicide attempts and ideation. The suicide audit also highlights the inequalities experienced by men accessing mental health services. Women are more likely than men to access mental health services for common mental health problems (1 in 5 women and 1 in 8 men). Population-level indicators suggestive of difficulty, distress and disconnection reveal men to be the majority affected. 73% of those who “go missing” from home are men; 87% of rough sleepers are men, men are nearly 3 times more likely than women to become alcohol dependent or report frequent drug use. Men make up 95% of the prison population, have measurably less social support. Over 80% of children permanently excluded from school for behavioural difficulties are boys and boys perform less well than girls at all levels of education.

3.10 In Swindon there appears to be no correlation between deprivation and suicide. Further analysis was undertaken using mosaic analysis. Three mosaic groups accounted for 20% of those who died by suicide in Swindon since 2006. These were described as:

Q63 Streetwise singles: Hard-pressed singles in low cost social flats searching for opportunities;

L52: Midlife stopgap: Maturing singles in employment who are renting sort-term affordable homes;

J45: Bus route renters: Singles renting affordable private flats away from central amenities and often on main roads.

These three groups have commonalities in that they are singles, young/middle aged and are economically challenged.

3.11 The audit reviews key actions contributing to suicide prevention in Swindon currently. These include:

- Training in mental health first aid courses and suicide risk assessment
- The development of self-harm guidelines
- Raising awareness through the Mindful Employer Network
- The review of car park safety
- Participation in the Mental Health Crisis Care Concordat and the Zero Suicide Initiative.
- The development of the self-harm register at GWH, together with information packs on self-harm and postcard scheme.

Further information on the subject of this report can be obtained from Frances Mayes, 01793 444677, fmayes@swindon.gov.uk.

Suicide Prevention

Health and Wellbeing Board

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- Swindon Mind self-harm Counselling Service (formerly PASH) offer counselling to those over 16 who self-harm but also work with schools to raise awareness
- SOBS (Survivors of Bereavement by Suicide) meet regularly in Swindon , they run an annual suicide prevention conference and contribute to the suicide prevention group. They have an initiative to target men who have been bereaved by suicide.
- A review of discharge planning from AWP and an AWP review of prescribing psychiatric medications.
- The development of a perinatal mental health pathways
- Working group established to look at transitions from CAMHS to adult services.
- A men only LIFT psychology course and support by LIFT for those with long term conditions.
- Street triage project linking the police and mental health services,
- Swindon and District Samaritans offering core services and visiting schools and the Job Centre, providing follow up calls to those attending A&E for self-harm
- Health Ambassadors, Community Navigators and Circles of Support all contribute to tackling social isolation. The Street Pastors are active on Friday and Saturday nights. Treehouse Wiltshire provides bereavement support to those aged 0 -25 yrs.
- British Transport Police have linked to our local suicide prevention group and lead on prevention of deaths on the railway.
- Citizen's Advice provided debt advice to over 3000 people in Swindon. Debt is a substantial risk factor for suicide. In addition the Swindon Welfare Benefits and Strategy Group reviews what support can be put in place to mitigate against the negative impact of welfare reforms.
- Links have been made between the suicide prevention group and the Homelessness strategy group led by Swindon Borough Council.
- The Alcohol Support and Advice Project, Street Drinker Project and Dual diagnosis group (Mental Health and Substance misuse) all contribute to supporting groups that are vulnerable to suicide.

Many of the above initiatives target men and the issues that cause men to become at risk of suicide.

Further information on the subject of this report can be obtained from Frances Mayes, 01793 444677, fmayes@swindon.gov.uk.

Suicide Prevention

Health and Wellbeing Board

Date: 25 May 2016

Suicide Prevention Recommendation's

- 3.12 The overarching recommendation is to continue to improve the mental health of the population of Swindon as a whole and to ensure access to high quality mental health services for all those who require them, and particularly those with a history of self-harm and/or recorded suicide intent. This should be done through the implementation of recommendations from the two Swindon Mental Health Joint Strategic Needs Assessments - one for adults and one for children and young people, as well as the national mental health and suicide prevention strategies. The needs of those with a non-heterosexual orientation should be a particular consideration as this report highlights the higher rates of suicidal ideation and attempts for these groups.
1. Ensure that all those working with high risk groups continue to have access to appropriate training on suicide and self-harm, including those working in schools and colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems. Six, two day ASIST suicide prevention training courses will be rolled out over 2016-2018.
 2. Focus mental health promotion and suicide prevention interventions on boys and men. Interventions should be targeted through community locations as well as health settings. The aim is to engage more effectively with men including those who are homeless or suffering from substance misuse issues. This would include the Survivors of Bereavement by Suicide SOBS initiative to engage more with men bereaved by suicide.
 3. Review the Self-Harm Register in the GWH Emergency Department and use data to inform the Swindon suicide audit and prevention strategy. This will include a register for Children and Young People. In conjunction with this a task group to reduce emergency hospital admissions for self-harm will be set up to tackle the high rates in Swindon.
 4. Review substances used for self-poisoning and where possible reduce access to these substances.
 5. Ensure that mental health needs are given equal consideration to physical health needs in those with a long-term health condition, and provide support for self-management and self-care which supports mental wellbeing as well as physical health.
 6. Support campaigns and initiatives to reduce loneliness and social isolation.
-

Further information on the subject of this report can be obtained from Frances Mayes, 01793 444677, fmayes@swindon.gov.uk.

Suicide Prevention

Health and Wellbeing Board

Date: 25 May 2016

7. Work with planners and developers in Swindon to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities.
8. Address the suicide risk associated with homelessness through the establishment of Homelessness forum and links to the homelessness strategy 2016-21.
9. Provide better information and support to those bereaved or affected by suicide; support the media in delivering sensitive approaches to suicide and suicidal behaviour and support research, data collection and monitoring including:
 - Work with the local media in Swindon to encourage responsible reporting of stories around suicide and self-harm and to provide information about sources of support and helplines when reporting suicide and suicidal behaviour.
10. Ensure that interventions implemented as a result of these recommendations are evaluated and learning shared in Swindon and nationally in order to develop the evidence base on what works in suicide prevention.
11. Thematic lessons learnt from agencies route cause analysis of deaths by suicide are shared where appropriate with relevant agencies.

4. Alternative Options

- 4.1 Not to endorse the recommendations.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 Any recommendations made in this report can be resourced within current budget allocations. Where additional resources may be required the appropriate business case will be prepared.

Legal and Human Rights Implications

- 5.2 None.

Further information on the subject of this report can be obtained from Frances Mayes, 01793 444677, fmayes@swindon.gov.uk.

Suicide Prevention

Health and Wellbeing Board

Date: 25 May 2016

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 None.

Diversity Impact Assessment

5.4 All key diversity groups have been considered whilst undertaking this piece of work. The report specifically highlights issues regarding gender, age, disability (particularly long term conditions), sexual orientation which have specific implication for suicide prevention.

Risk Management

5.5 None.

6. Consultees

6.1 This is a multi-agency document with input and consultation from: Police, British Transport Police, Swindon CCG, AWP mental health services, Survivors of Bereavement by Suicide (SOBS), LIFT Psychology, Salvation Army, Mind Self Harm Counselling Service, CGL (substance misuse service), Oxford Health Children and Adolescent Mental Health Service, Great Western Hospital, the Samaritans.

6.2 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None.

8. Appendices

8.1 Appendix 1 - Swindon Suicide Audit, Strategy and Recommendations 2016 – 2018.

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Swindon Suicide Audit, Strategy and Recommendations

2016 – 2018

Frances Mayes

Senior Public Health Manager

Debbie Stott

Public Health Intelligence Analyst/Project Co-ordinator

On behalf of the Suicide Prevention Group.

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1. Introduction

Suicide is a major issue for society and a leading cause of years of life lost. In England one person dies every two hours as a result of suicide. When someone dies by suicide, the effect on their family and friends is devastating and many others involved in providing support and care will feel the impact. Suicides are not inevitable. An inclusive society that avoids the marginalisation of individuals and which support people at times of personal crisis will help to prevent suicides (DH 2012a).

Definition of Suicide

In England and Wales, suicide is defined as a death given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent. (Suicides in England and Wales by Local Authority 2002-2014, ONS 2016) The underlying cause of death is coded by the Office of National Statistics using the World Health Organisations International Classification of Diseases codes (ICD codes) X60-X84 and Y10-Y34. These are based on death certificate. These are the codes used in the Primary Care Mortality Database which has been used extensively to analyse the data (see section 2).

The National Policy Context

A national suicide prevention strategy “Preventing suicide in England: a cross-government outcomes strategy to save lives” was published in September 2012. The strategy outlines two main objectives:

- to reduce the suicide rate in the general population in England
- to provide better support for those bereaved or affected by suicide.

The strategy emphasises the importance of a cross-sector approach to suicide prevention. It highlights six key areas for action to support delivery of its objectives:

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by suicide
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring.

High Risk Groups

Some groups of people are known to be at higher risk of suicide than the general population. The national suicide strategy highlights reducing the risk of suicide in these key high-risk groups as a priority area for action.

The groups at high risk of suicide are:

- young and middle-aged men
- people in the care of mental health services, including inpatients
- people with a history of self-harm
- people in contact with the criminal justice system
- specific occupational groups, such as doctors, nurses, veterinary workers, farmers and agricultural workers

Local Suicide Prevention Governance arrangements

In Swindon a suicide audit has been carried out regularly since 2009 and the findings used to review and update a local suicide prevention strategy. This work is overseen by the Suicide and Self Harm Prevention Group, chaired by Public Health which reports to the Health and Wellbeing Board. Safeguarding issues are reported to the Adult Safeguarding Board through the Chair of the Suicide Prevention Group who represents the Director of Public Health on the Adult Safeguarding Board. Suicides of those under 18 are reviewed through the Wiltshire and Swindon Child Death Overview Panel. There are also links to the AWP Suicide Prevention Group, Mental Health Crisis Care Concordat Group, Perinatal Mental Health Group and Children and Adolescent Mental Health Services (CAMHS) Strategy Steering Group.

2. Suicides in Swindon

Key points:

- Although the rate of suicide in Swindon appears to have risen between 2010-12 and 2012-14 the rise is not statistically significant.
- The suicide rate in Swindon is in line with the South West, England and Comparator Area's rates.
- The Suicide rate in Swindon has risen faster than in South West and England although year on year data indicates that it may be falling in the last two years.
- Nearly three quarters of deaths by suicide occur in men.
- Compared to England and the South West the rate of deaths for men between the age of 15 -34 years is higher in Swindon and the rate for women over the age of 74 is also higher in Swindon.
- However, the most common age of suicide was 30 -34 year olds and 45 – 49 year olds.
- Nearly half of those who died by suicide were single and only 17% were married.
- 26% of those who died by suicide had ingested alcohol at the time of their death. Many of those identified as having a substance misuse problem were not known to services
- Swindon has significantly high rates of emergency admissions for self-harm compared to England. 11% of those who died by suicide had a record of self-harm within the last 12 months.
- 30% of those who took their own lives had reported suicidal thoughts and 10% had clear intention and plans
- Data on deprivation is inconclusive. In the top 6 wards with the highest crude rate of suicide 3 were in the 4 most deprived wards. However, review of LSOA showed 28% of deaths occurred in the 3 most deprived areas compared to 38% in the 3 least deprived wards. Mosaic data indicated that those who took their own lives may have been economically challenged.
- Statistics from Men's Health Forum show clearly that on many measures men appear to have difficulties, distress and disconnection and that they do not engage as readily as women with mental health services and are less likely to be diagnosed with common mental health conditions.

Death data are usually presented by the date of registration. This is because the death will not be listed in official statistics until it is registered. Many reasons cause a delay in date of occurrence of death to date of registration, for example if the death is investigated by a coroner. It may sometimes be more meaningful when retrospectively examining deaths by suicide to look at the year the death actually occurred to identify if there any trends emerging. However, as the number of people who take their own lives is relatively quite small it can be

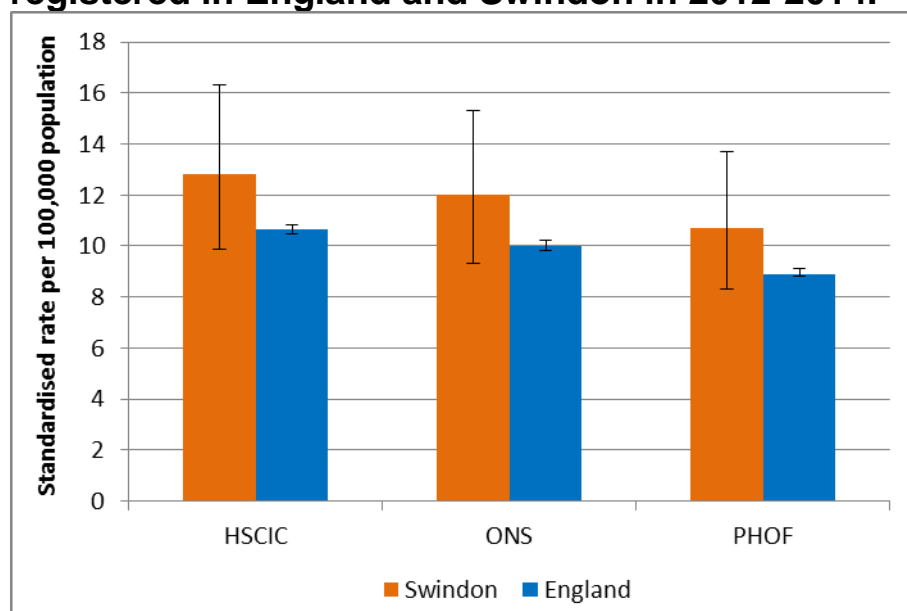
difficult to make statistical inference that the trend has any underlying cause. Throughout this audit, data will be presented by either year of death or year of registration as appropriate and will be labelled clearly.

Official statistics for rates of suicide

National official suicide statistics use directly standardised rates per 100,000 population. This takes into account the age profile of the population so that you can make direct comparisons between the local and national rates and between different areas.

Nationally, there are several organisations that collate information on how many suicides take place across the country. In order to make comparisons between areas, a rate is calculated which takes into account the population structure of an area. The chart below shows 3 different sources of Official Statistics showing the 3 year suicide rate for deaths registered in 2012-2014.

Different sources for age standardised suicide rates for deaths registered in England and Swindon in 2012-2014.



HSCIC = Health & Social Care Information Centre

ONS = Office for National Statistics

PHOF = Public Health Outcomes Framework

The vertical lines at the top of each of the bars on the chart above are confidence intervals and they show the range in which the true suicide rate is likely to lie with 95% certainty. Where the lines overlap there is no statistically significant difference between the two rates.

These different sources use slightly different age ranges to analyse the deaths data and calculate rates which explains the slight variation. Rates from different sources should not be compared to each other. All three sources show Swindon has a statistically similar rate to England.

HSCIC show the highest rates: the rates per 100,000 population are 12.8 for Swindon and 10.6 for England.

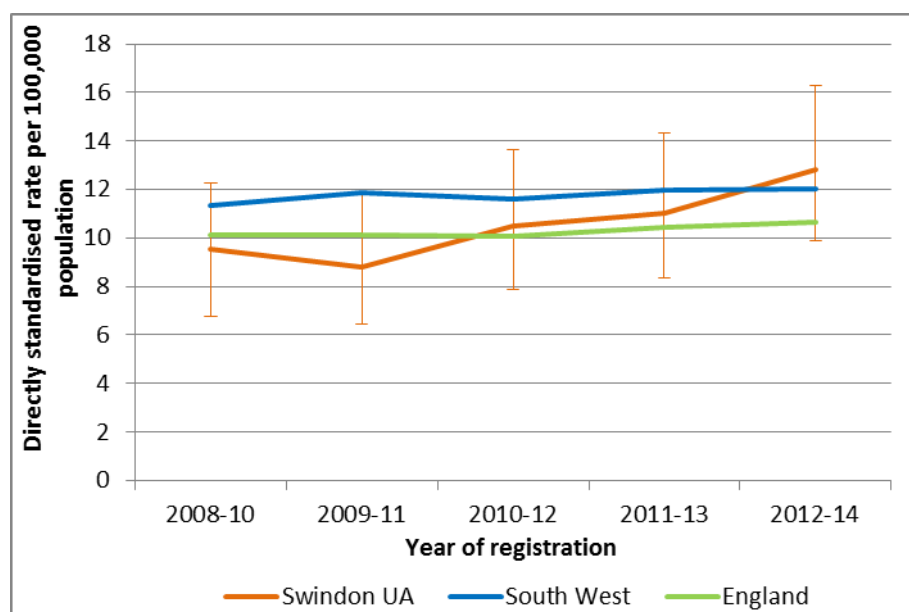
ONS: The rates per 100,000 population are 12.0 for Swindon and 10.0 for England.

PHOF: The rates per 100,000 population are 10.7 for Swindon and 8.9 for England.

This audit will use the HSCIC rates for comparison as these statistics are available for more rigorous analysis at a local level. The graph below shows how the suicide rate has changed between 2008-10 and 2012-14, by year of registration. Although the rate in Swindon has been rising over the past three periods it should be noted that the change is not statistically significant. The chart also shows that the rate has been increasing in England as well.

Because of the relatively low numbers of suicides by unitary authority suicide rates are usually presented as a three year rolling average. This makes it easier to see trends in suicide rates.

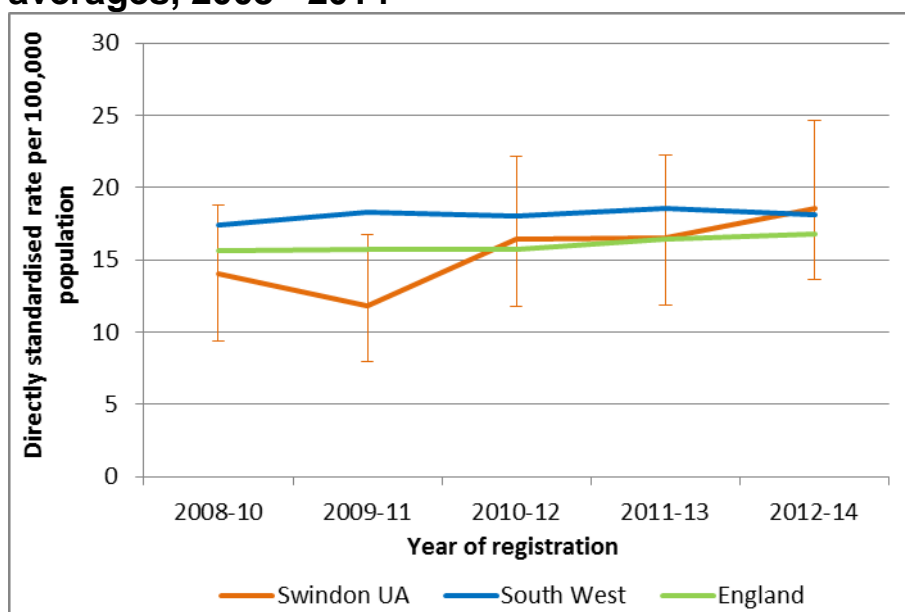
Suicide rates in England, South West and Swindon, 3 year averages, 2008-2014. (All persons)



Source: HSCIC

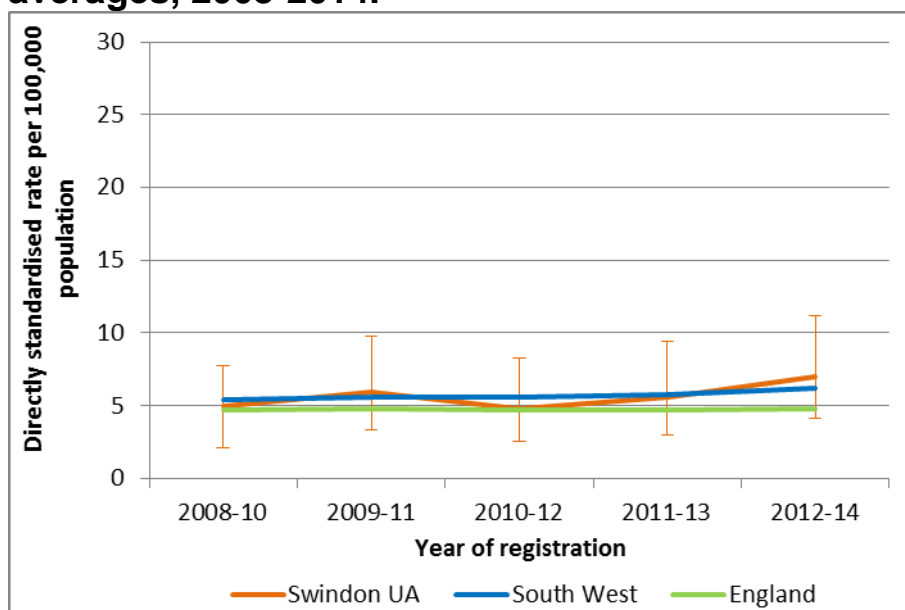
Further analysis by gender has been undertaken below. It should be noted that the Swindon rate for female is not very robust due to the small number of deaths involved. Below the charts show that the suicide rate has risen for both males and females.

Suicide rate in males in England, South West and Swindon, 3 year averages, 2008 - 2014



Source: HSCIC Time trend for directly standardised suicide rate

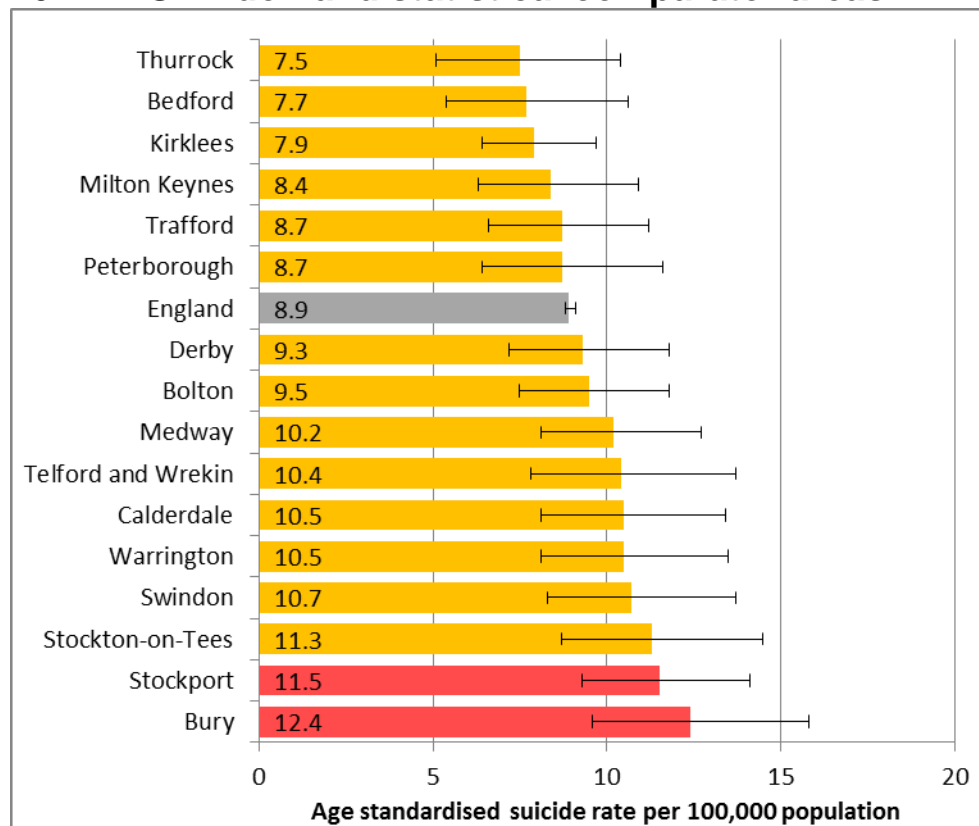
Suicide rate in females in England, South West and Swindon, 3 year averages, 2008-2014.



Source: HSCIC Time trend for directly standardised suicide rate

Below the Swindon rate is compared to areas which are most similar to Swindon population profile. This shows that the suicide rate in Swindon is not statistically different to our comparator areas.

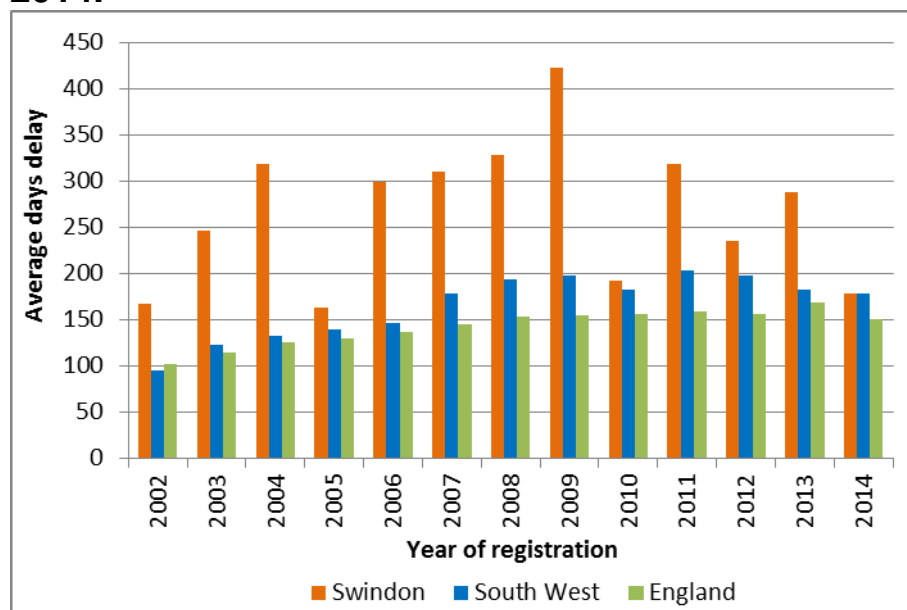
Standardised Suicide rate in persons for deaths registered 2012-2014 in Swindon and statistical comparator areas.



Source: Suicide Profiles, Public Health England. www.fingertips.phe.org.uk

The suicide rate in Swindon increased between 2008-10 and 2012-14. Interpretation of low rates in past years was complicated by a large number of days delay in registration of a death by suicide. The delay in registration is measured by ONS and reported upon by local authority and is the difference in days between the date the death occurred and the date it was registered. The chart below shows the average number of days delay for Swindon, South West and England. From 2010, the average delay for Swindon has been closer to the national and regional averages. However, in 2009 and the period 2002 to 2008, the delays to registration were commonly averaging over 300 days and far above the regional and national values.

Annual average number of days delay from date of death to registration of the death, Swindon, South West and England, 2002-2014.



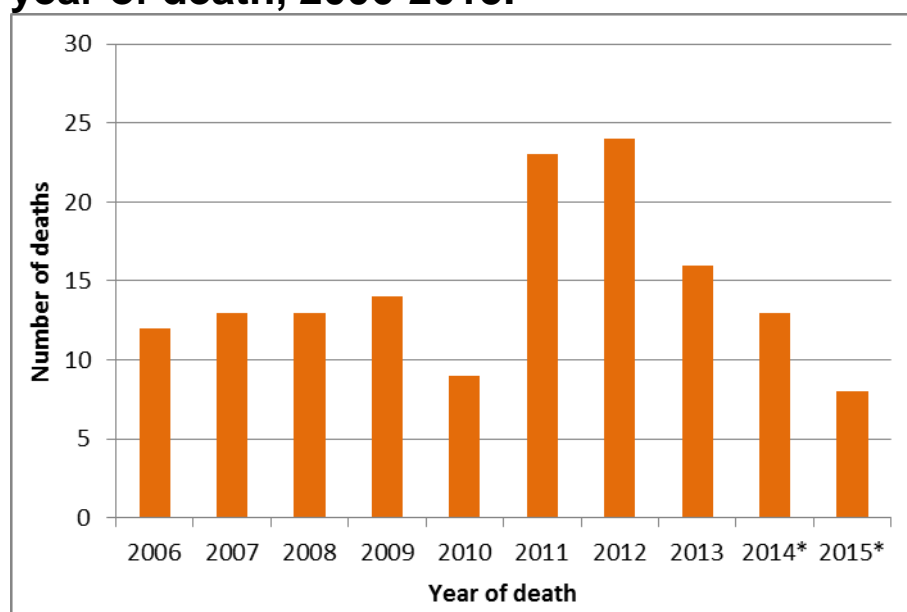
Source: ONS

Swindon suicide audit data

Further analysis of deaths by suicide in Swindon has been undertaken using a combination of the Primary Care Mortality Database (PCMD) and the Swindon Suicide Audit Database. The Swindon database uses information collected from the coroner, the GP, drug and alcohol services, mental health and acute trusts, and Lift Primary Care Psychology service.

The coroner for Swindon and Wiltshire informs the Swindon Borough Council Public Health team when a suicide occurs. The Public Health team then send out requests for information from GPs, psychiatric services, Great Western Hospital (GWH) and drugs and alcohol services. When comparing the number of deaths in the Swindon database to the number in the PCMD, for the deaths taking place in the years 2006-2015, the Public Health team were informed of 76% (n=110) out of a total of 145.

Number of deaths by suicide in Swindon, annual total by year of death, 2006-2015.



*It is likely the data for these years are not complete because not all deaths in these years will be registered at the time of writing this report.

Source: PCMD

The chart above shows that since 2012 the number of suicides per year has decreased. Although the figures for 2014 and 2015 may not be complete the signs are encouraging: this data is not yet included in the three year rolling reporting by national organisation as periods reported earlier in this document.

Gender

Data from the PCMD shows that of deaths from suicide occurring between 2006 and 2015, 73% were men, 27% women.

Number of deaths by suicide in Swindon, 2006-2015, male and female totals

	Male	Female	Total
2006-2015	106 (73%)	39 (27%)	145

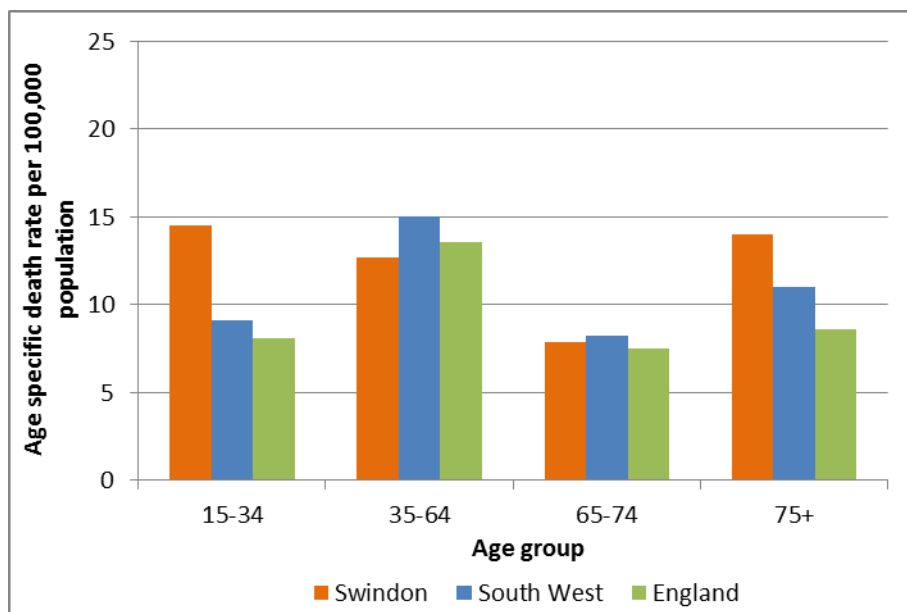
Source: PCMD aggregated by year of death

Age

The PCMD data shows that, for 2006-2015 (date of death), the age at death ranges from 15 to 85 years old. The average age at death for females is 45 years and 44 years for males.

The chart below compares age specific death rates for Swindon, the South West and England for deaths registered in 2012-2014.

All-persons age specific suicide rate in Swindon, South West and England, deaths registered in 2012-2014.

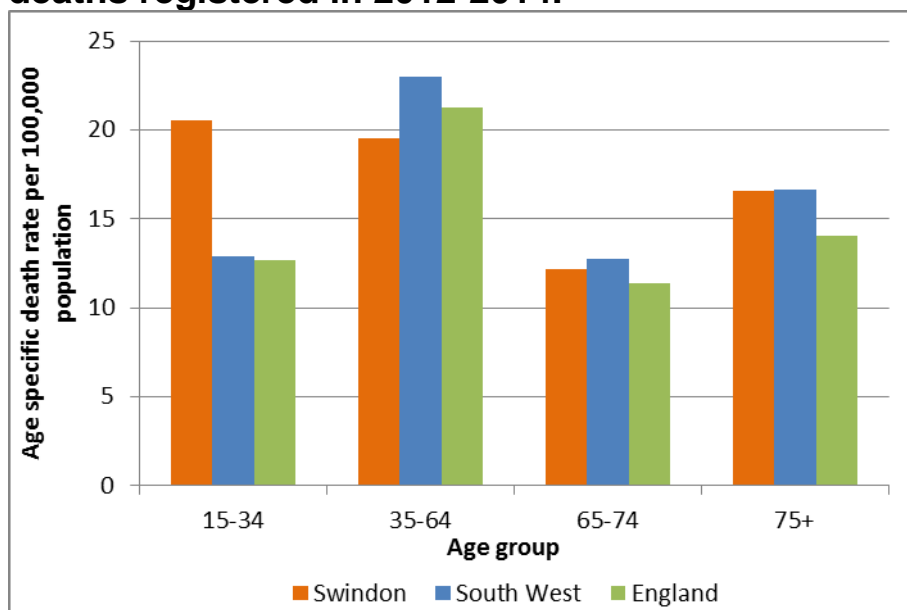


Source: HSCIC

Note: the size of the age ranges varies

For 2012-14 the chart shows that in Swindon there were slightly higher rates for the younger and older age groups but the number of deaths is small and care should be taken when interpreting these findings. The chart below shows that the picture is consistent for males and females, although there is a slightly higher rate for women over the age of 75 than for men of the same age.

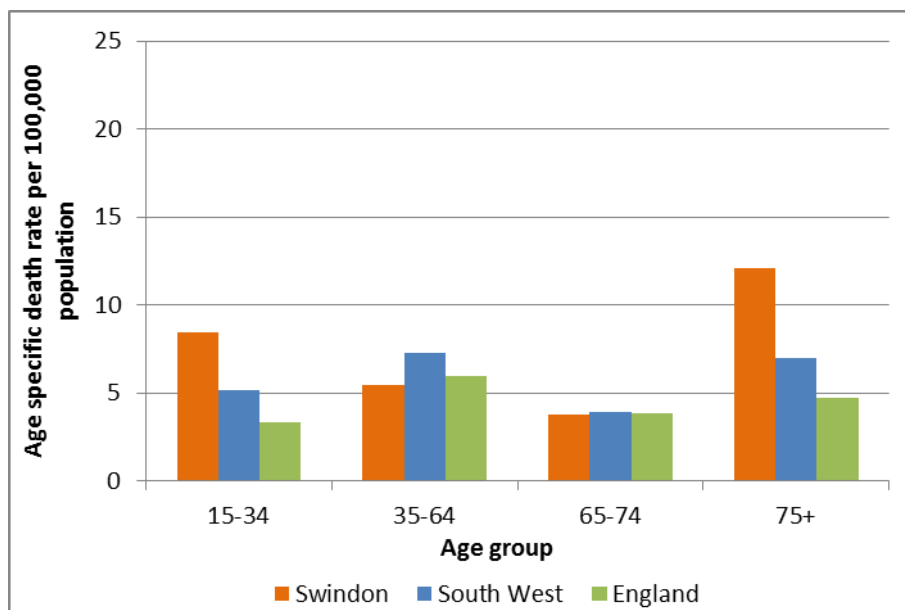
Male, age specific suicide rate in Swindon, South West and England, deaths registered in 2012-2014.



Note: the size of the age ranges varies

Source: HSCIC

Female, age specific suicide rate in Swindon, South West and England, deaths registered in 2012-2014.



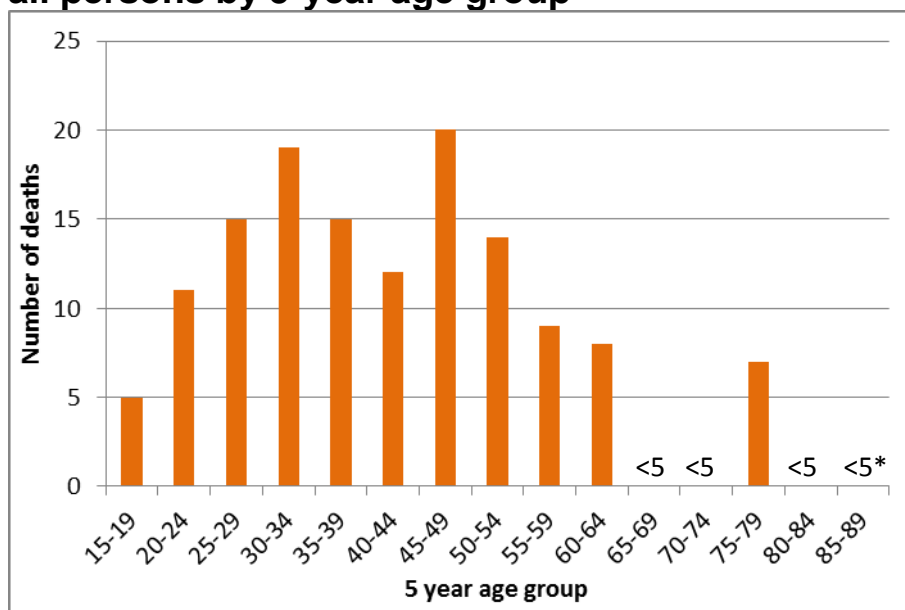
Source: HSCIC

Note: the size of the age ranges varies

*the validity of this rate is uncertain due to the small numbers of deaths involved in the rate calculations.

Further analysis of the suicides by age shows peaks between the age of 30 -34 and 45 -49 years.

Number of deaths by suicide in Swindon, 2006-2015 (year of death), all persons by 5-year age group



Source: PCMD

*suppressed due to data confidentiality these are less than five incidents per category

Method of suicide

Swindon suicides by year of death for the periods from 2006-2015 have been compared with suicides in England registered in 2014

Proportion of deaths by method of suicide

	England (2014)		Swindon (2006 - 2015)	
	Men	Women	Men	Women
Drowning	4.1%	5.6%	*	*
Fall and fracture	4.1%	4.2%	*	*
Poisoning	19.4%	36.6%	33%	36%
Hanging	55.4%	42.0%	50%	44%
Other	17.0%	11.6%	*	*

Source: ONS & PCMD

*suppressed due to data confidentiality these are less than five incidents per category

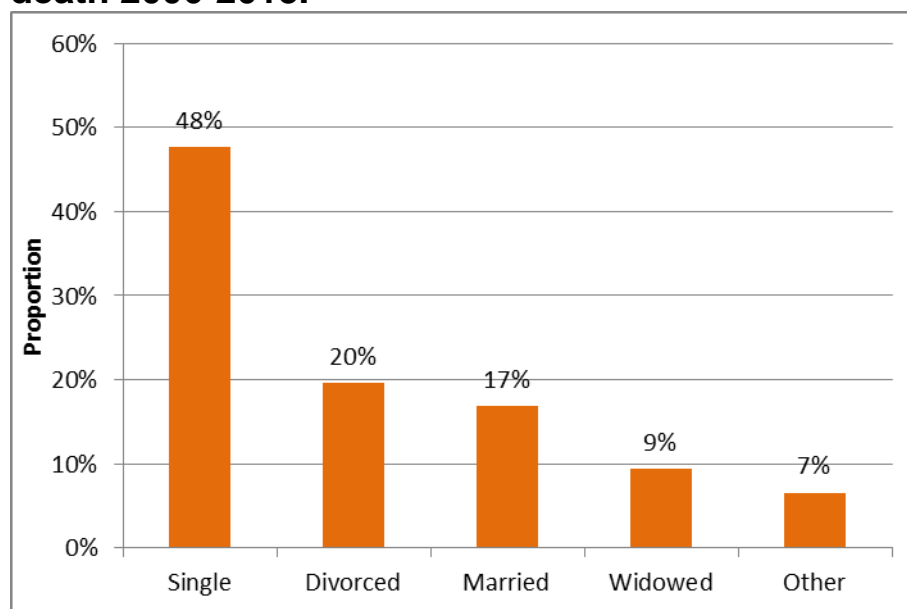
The leading causes of death in Swindon are the same as in England with hanging/strangulation the leading cause of death for both men (50%) and women (44%), followed by poisoning (men 33%, women 36%).

Marital status

74% (n=107) of deaths occurring in 2006-2015 had information recorded for the deceased's marital status. Of this sample:

- 48% (n=51) were single,
- 20% (n=21) were divorced,
- 17% (n=18) were married,
- 9% (n=10) were widowed.

Marital status, (n=107) for deaths by suicide in Swindon, by year of death 2006-2015.



Source: Swindon Suicide Audit Database

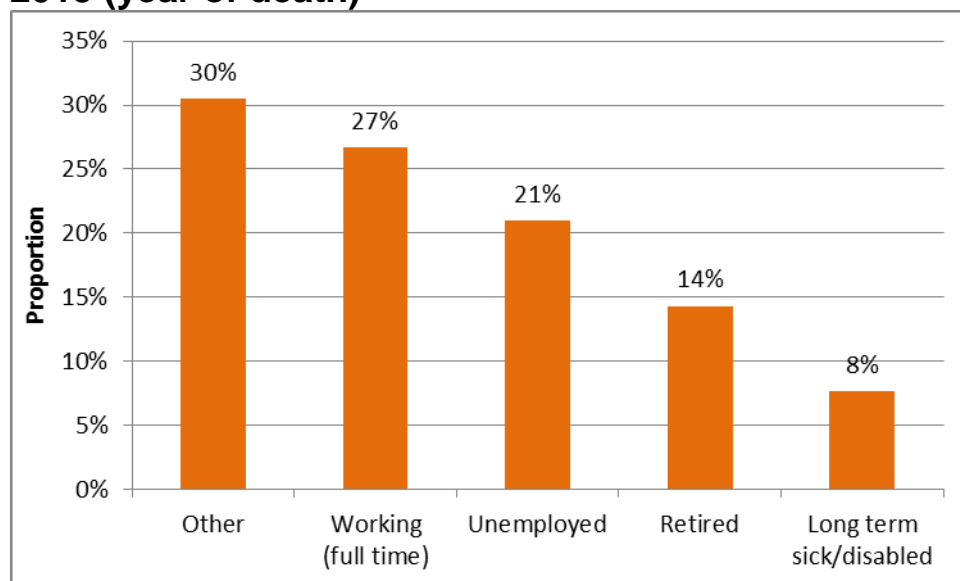
Similar to finding from national data, 17% (n=18) of people in Swindon who took their own life were married, 79% (n=85) were single, separated, divorced or widowed.

Occupational status

72% (n=105) of deaths occurring in 2006-2015 had information recorded on the deceased's occupation. Of this sample:

- 30% (n=32) were other,
- 27% (n=28) were employed full time
- 21% (n=22) were unemployed,
- 14% (n=15) retired,
- 8% (n=8) long term sick or disabled.

Occupational status, (n=105) for deaths by suicide in Swindon, 2006-2015 (year of death)



Source: Swindon Suicide Audit Database

Alcohol

74% (n=108) of the deaths occurring in 2006-2015 had information recorded for whether alcohol was a factor in the suicide. Of this sample, 26% had ingested alcohol around the time of death.

Of the 9 individuals that the GP data highlighted as having a drug or alcohol problem the majority were not known to substance misuse services. However, it should be noted that those who die who are known to substance misuse service may be classified as a drug related death rather than suicide.

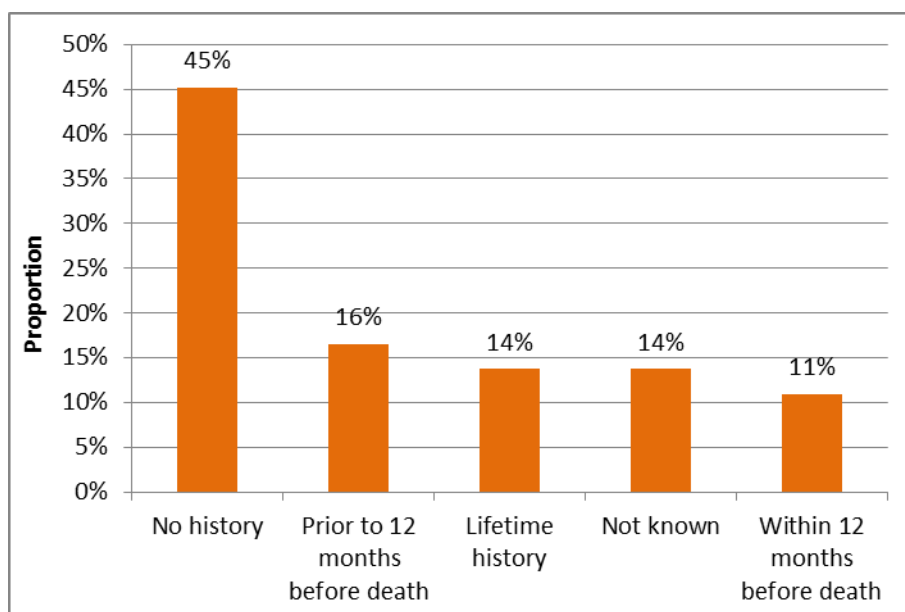
Self-harm history

Data was combined from primary care and psychiatric services to construct a person's history of self-harm. 73 individuals (or 50%) had information recorded on their history of self-harm. This represented 50% of the total on the register.

Of this sample:

- 45% (n=33) had no history of self-harm,
- 16% (n=12) had incidence of self-harm more than 12 months prior to their death,
- 14% (n=10) a lifetime history,
- 11% (n=8) had incidence of self-harm within 12 months of their death.

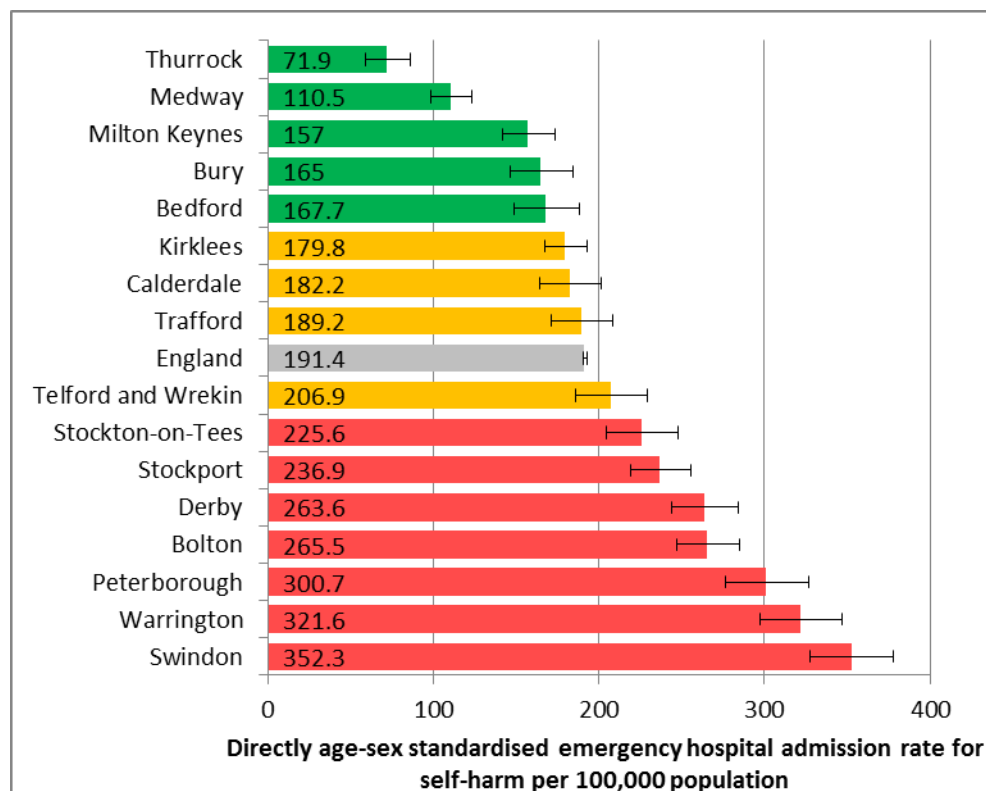
Self-harm history for deaths by suicide in Swindon, 2006-2015 (year of death)



Source: **Swindon Suicide Audit Database (n=73)**

The chart below from the Suicide Prevention Profiles from Public Health England shows the level of emergency admissions due to self-harm. The age-sex standardised rate for Swindon is significantly higher than the England rate and is the highest out of Swindon's statistical neighbours.

Emergency admissions due to self-harm, for Swindon and statistical comparator areas, 2014/15.



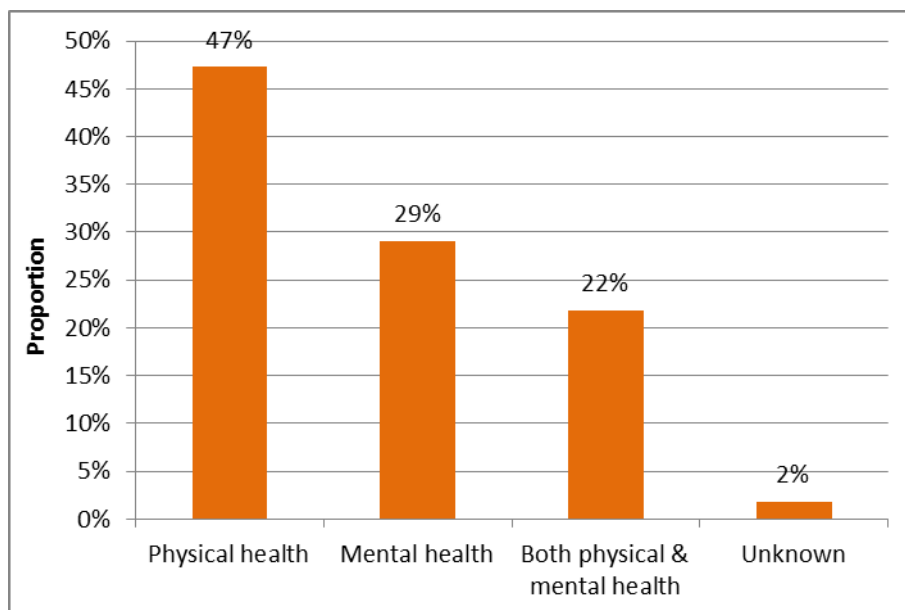
Source: Suicide Profiles, Public Health England age-sex standardised rate per 100,000 population

Contact with GP

45% (n=65) of the deaths occurring in 2006-2015 had information recorded for the date and reason of last visit to their GP. Of this sample, 85% (n=55) were seen by their GP within their last year of their life. Of the people seen in the last year of their life:

- 47% (n=25) for physical health.
- 29% (n=16) were seen for a mental health reason,
- 22% (n=12) for both mental and physical health,

Contact with GP in the last year of life, for deaths by suicide in Swindon, 2006-2015



Source: Swindon Suicide Audit Database (n=55)

Documented suicide risk

41% (n=60) of the deaths occurring in 2006-2015 had information recorded by their GP regarding their suicide risk. Of this sample:

- 68% (n=41) reported no thoughts of suicide or intent,
- 20% (n=12) reported thoughts of suicide but no intent,
- 10% (n=6) reported clear intent and plans.

GP and Psychiatric diagnosis

Data was combined from primary care and secondary psychiatric care to form a summary of diagnoses recorded. 46% (n=66) had information recorded for a diagnosis. Of this sample:

- 44% (n=29) had depressive illness recorded as a diagnosis,
- 11% (n=7) had an alcohol or drug misuse diagnosis recorded,
- 9% (n=6) had another form of mental health diagnosis recorded
- 20% (n=13) had no mental health disorder recorded.

Mental health assessment date, at GP

32% (n=47) of the deaths occurring in 2006-2015 had information recorded by their GP whether a mental health assessment had been completed or not. Of this sample, 77% (n=36) had an assessment date recorded and of these 36 people, 26 (72%) had their assessment completed within the last year of their life.

Contact with acute trust

41% (n=60) of the deaths occurring in 2006-2015 had information recorded for reason for an attendance (attendances include contact at the hospital such as outpatients appointments, inpatient admissions and A&E attendance) at GWH. Of this sample 52% (n=31) had an attendance in the last 12 months of their life and of these 31 people, 12 (39%) attended due to injuries caused from self-harm.

Psychosocial assessment at acute trust

46% (n=67) of the deaths occurring in 2006-2015 had information recorded for whether a psychosocial assessment was completed in GWH. Of this sample 24% (n=16) did have an assessment completed and 20% (n=15) had taken place within their last year of life.

Contact with psychiatric services

17% (n=24) of the deaths occurring in 2006-2015 had information recorded for whether the person was in contact with psychiatric services. Of this sample, 71% (n=17) had contact with psychiatric services within the last year of their life.

Electoral ward of residence of those who died by suicide

Geography –Crude rate based on 2013 ward populations

Ward name	Crude suicide rate	Deprivation rank within Swindon (1=most deprived)
Walcot and Park North	143	1
Lydiard and Freshbrook	124	8
Gorse Hill and Pinehurst	116	3
St Andrews	106	18
Haydon Wick	98	15
Liden, Eldene and Park South	96.8	4
Eastcott	96.8	9
Rodbourne Cheney	95	6
Covingham and Dorcan	86.3	10
Mannington and Western	82.7	7
Wroughton and Wichelstowe	74.5	11
Central	67	5
Priory Vale	65.2	19
Old Town	62.9	14
Penhill and Upper Stratton	62.2	2
Shaw	44.5	17
St Margaret and South Marston	*	13
Chiseldon and Lawn	*	16
Ridgeway	*	20
Blunsdon and Highworth	*	12

Source: PCMD, ONS 2013 ward population estimates, Index Multiple Deprivation 2015
(Department for Communities and Local Government)

Deprivation – based on the LSOA deprivation decile national ranking for residence of the deceased.

Deprivation decile	Number of deaths	Proportion of deaths
1 (most deprived)	10	7%
2	21	14%
3	10	7%
4	18	12%
5	13	9%
6	9	6%
7	8	6%
8	22	15%
9	28	19%
10 (least deprived)	6	4%

Source: PCMD and Index Multiple Deprivation 2015 (Department for Communities and Local Government)

Location of death

All of the deaths occurring in 2006-2015 had a place of death recorded on the PCMD. This data was combined with Swindon audit data to identify the location of the suicide, for example, if the person later died in hospital. This was analysed and coded to the following categories; home (including parent's home), transport route (road or railway), car park, wooded area in Swindon, other and location unknown as the person died in hospital. The table below shows that over two thirds of people who died by suicide, took their own life at home.

Location	Number of deaths (and proportion)
Home	99 (68%)
Other	17 (12%)
Wooded area	12 (8%)
Location unknown (died at GWH)	7 (5%)
Transport route	5 (3%)
Car park	5 (3%)

Source: PCMD and **Swindon Suicide Audit Database**

Stonewall Mental Health Briefing on lesbian, gay and bisexual people.

Research undertaken by Stonewall (2011) shows that gay men are more than six times as likely to attempt to take their own lives as all men. This rises to 10 times as likely for gay men from black and minority ethnic backgrounds and also bisexual men and 14 times for gay and bisexual men with a disability. The report showed that 27% of gay men had thought about taking their own lives in the previous year. This increased for those from BME backgrounds (35%), bisexual men (38%) and gay and bisexual men with a disability (47%). This compares to just 4% for all men.

Research taken out by Stonewall in 2008 found that in the previous year 5% of lesbians and bisexual women say they have attempted to take their own life. This increases to 7% of bisexual women and BME women and 10% of lesbian and bisexual women with a disability. In the previous year 33% of lesbian and bisexual women that thought about taking their own lives. This increased for bisexual women (39%), 41% of black and ethnic minority women and 52% of lesbian and bisexual women with a disability.

The Stonewall School Report 2012 found that nearly one in four (23%) lesbian, gay and bisexual young people have tried to take their own life at some point. Girls are more likely to attempt this than boys (29% compared to 17%). Gay young people who experience homophobic bullying are much more likely to attempt to take their own life than gay young people who are not bullied. The Samaritans report that 7% of all young people have ever attempted to take their own life.

The suicide ideation rate for this group is also very high. 71% of lesbian and bisexual girls, 57% of gay and bisexual boys, 76% of gay and bisexual boys who are black or minority ethnic have considered taking their own life. This compares to 20 -45% of young people in general.

In Swindon we do attempt to collect data on sexual orientation of those who have taken their own lives but the data quality is poor and often not known. With the number of suicides in Swindon being relatively small it is difficult to target interventions specifically at this group. However, individual agencies should ensure that their services are meeting the needs of all diverse groups.

Mental Health Men and Boys – Findings from the Men’s Health Forum

The Swindon and national suicide audits have shown that men are particularly at risk of suicide.

The Men’s Health Forum state that common mental health conditions¹ are diagnosed more frequently in women than in men. At any one time, one in woman in five is believed to meeting diagnostic criteria for a common mental health condition compared with one man in eight. Women are also more likely to receive treatment for a common mental health condition: 29% of women have received treatment compared with 17% of men. For depression specifically, the gap is even wider with one in four women receiving treatment for depression at some point in her life compared to just one man in ten.

However, it is often suggest that for a variety of socio-cultural reasons, men may be less likely than women to recognise emotional and psychological distress in themselves and less likely to seek treatment.

The Men’s Health Forum state that:

“Certainly, there is a case to be made that strong evidence for men’s poorer help-seeking and unacknowledged mental health problems can be found by looking at population data instead of at individual level data. Many population-level indicators suggestive of difficulty, distress and disconnection reveal men to be the majority affected. For example:

¹ Common mental health conditions include anxiety, depression, phobia and obsessive compulsive disorder.

- Over three quarters of those who take their own lives are male (better evidenced in the data not here)
- 73% of adults who 'go missing' from home are men
- 87% of rough sleepers are men
- Men are nearly three times more likely than women to become alcohol dependant (8.7% of men are alcohol dependent compared with 3.3% of women)
- Men are three times more likely than women to report frequent drug use (4.2% and 1.4% respectively)
- More than two thirds of drug related deaths occur in men
- Men make up 95% of the prison population. 72% of male prisoners suffer from two or more mental disorders
- Men are nearly 50% more likely than women to be detained and treated compulsorily as psychiatric inpatients
- Men have measurably lower access to the social support of friends, relatives and community
- Men commit 86% of violent crime and are twice as likely to be victims of violent crime.
- Over 80% of children permanently excluded from school for behavioural difficulties are boys
- Boys are performing less well than girls at all levels of education from primary school to university.”²

Source: Men's Health Forum 2015

Mosaic Analysis

An analysis has been undertaken of the deaths by suicide (2006 – 2015) using Mosaic. It should be noted that low numbers may affect this analysis but there are three main groups who have been identified as having a higher rate of suicide than the others in terms of proportion of households affected.

Mosaic is an Experian product that allows you to examine the demographics, lifestyle, preferences and behaviours of households. It is used by many companies, government departments and local authorities amongst others and is comprised of many datasets modelled together – the Census for example is one major component. Mosaic has 15 groups (the letters) and underneath these, there are 66 types (the numbers). Mosaic uses a descriptor title to describe a particular group and then identify key features of that group. The particular types in Swindon listed below account for about 1 in 5 deaths in Swindon:

O63: Streetwise Singles: Hard-pressed singles in low cost social flats searching for opportunities

Key features:

Singles and sharers
Low cost social flats
1 or 2 bedrooms
Urban and fringe locations
Routine occupations
Shortage of opportunities

² How to make mental health services work for men. Men's Health Forum 2015

L52: Mid-life stopgap: Maturing singles in employment who are renting short-term affordable homes

Key features:

In employment
Homesharers and singles
In employment
Don't have children
Average age 45
Privately renting affordable homes
Mostly terraces

J45: Bus route renters: Singles renting affordable private flats away from central amenities and often on main roads

Key features:

Aged 25 to 40
Living alone or sharing
Rent lower value flats, often 1 bed
Often live near main roads
Further from central amenities
Sourced mobile on Internet

These profiles are interesting particularly when reviewed in relation to the deprivation data above. Whereas there appeared to be no particularly link between deprivation and suicide in Swindon that may be because there maybe individual pockets of deprivation within LSOAs. The three groups described above have commonalities in that they are singles, young/middle aged and are economically challenged.

In terms of numbers of deaths, rather than the rate or deaths, there are two further Mosaic groups which have experienced a high number of deaths but this may be because there are a high proportion of these household in Swindon. Again these two groups are economically challenged.

H: Aspiring homemakers: Younger households settling down in housing priced within their means

Key features:

Younger households
Full-time employment
Private suburbs
Affordable housing costs
Starter salaries
Buy and sell on eBay

M: Family Basics: Families with limited resources who have to budget to make ends meet

Key features:

Families with children
Aged 25 to 40
Limited resources

Some own low cost homes
Some rent from social landlords
Squeezed budgets

3. Key actions and achievements

Can this very long list be broken down into categories or themes? It would help highlight where a lot of work has been done and perhaps where there are gaps?

Key suicide prevention activities and achievements in Swindon include:

Training and resources

- **Mental Health First Aid Courses** which raise awareness of mental health problems and give front line workers more confidence to discuss mental health with clients have been commissioned and are regularly delivered in Swindon by Swindon Mind
- The development of a **suicide risk assessment tool and care pathway** for primary care by Public Health and LIFT Psychology. Distribution of risk assessment tool to all GP Practices in Swindon and training offered to in its implementation. Most practices have taken up the offer of training. The risk assessment tool with training has now been distributed to agencies including substance misuse services and supported housing providers.
- **Self-harm guidelines** for professionals working with young people in Swindon have been developed by Swindon CAMHS and TaMHS and are available with on-going training provided.
- **The Mindful Employer Network** promotes mental health within the workplace and has delivered a workshop on suicide prevention and bereavement to raise awareness of impact for employers. The event was fully booked with 85 attendees from a range of employers in Swindon. The evaluation was very positive which organisations reporting they had taken positive action following the event.

Other Initiatives

- **Mental Health Crisis Care Concordat** was signed in Swindon by a range of different organisations working together to improve how organisations will work together to make sure that people get the help they need when they are having a mental health crisis. These organisations include Swindon CCG, Swindon Borough Council, AWP Mental Health Foundation, Trust, Oxford Health NHS Foundation Trust, Wiltshire Police, South West Ambulance Service, MIND, CRI Substance Misuse Service, GWH NHS Foundation Trust, Seqol and the Wiltshire Police and Crime Commissioner.

It focuses on four key areas:

- **Access to support before crisis point** – making sure people with mental health problems can get help 24 hours a day and that when they ask for help, they are taken seriously.
- **Urgent and emergency access to crisis care** – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- **Quality of treatment and care when in crisis** – making sure that people are treated with dignity and respect, in a therapeutic environment.

- **Recovery and staying well** – preventing future crises by making sure people are referred to appropriate services.

An action plan was developed and a working group established to oversee the implementation of the plan, led by Swindon CCG.

- **The Zero suicide initiative** has been led in the South West by the South West Zero Suicide Collaborative led by Dr Adrian James. The collaborative has provide opportunities for those with lived experience and those involved in preventing suicide to come together and learn about successful suicide prevention initiatives. The concept is that one death by suicide is a death too many. Swindon has been represented at this collaborative and initiatives such as the men only lift course and SOBS Engaging Men project have, in part been influenced by the collaborative.
- **Review of Car Parks** and the closure of the top floor of Wyvern Carpark and subsequent demolition. The work of Swindon Borough Council relating to this was sighted as good practice in national guidance on tackling suicide hotspots.
- **Self-Harm register developed in GWH** – evaluation is currently being undertaken. An information pack has been developed for distribution to adults and young people who self-harm and present at the Accident and Emergency Department . All adults attending A&E for self-harm are offered to take part in the Postcard project which enables the Psychiatric Liaison Service to send a follow up postcard once a quarter for a year to those attending. Evidence from Australia found that this reduced hospital re-attendance.

The CCG has also been working with both Oxford Health NHS Foundation Trust and Avon and Wiltshire Partnership NHS Foundation Trust to ensure care plans are in place for those who regularly attend ED for self-harm to ensure alternative more appropriate support is provided.

Mental Health Services

- The Mental Health Liaison Team at Great Western Hospital (GWH) have been working towards the Commissioning for Quality and Innovation (CQUIN) to improve diagnosis and re-attendance rates of patients with mental health needs in Emergency Departments

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

The work to support the scheme has included:

- Improved, co-produced (with the patient) relapse prevention care plans. It has been our intention that every patient assessed by the Mental Health Liaison Team at GWH following an episode of self-harm, has, on discharge from the hospital, a crisis and contingency plan that describes what follow up (if any) has been arranged and what they can do if they feel unsafe and/or need additional support.
- A program of training for the general hospital staff has been undertaken. The guidelines from the CQUIN were to ensure Emergency Department staff receive training in mental health awareness, assessment and signposting to liaison mental health teams, including basic biopsychosocial self-harm assessments as described in NICE guidance (NICE self-harm CG16). (Two sessions of training were to be offered to all ED departments – this has been far exceeded).
- Access to relevant information through increased AWP access to the Summary Care Record and exploration of local systems to share relevant patient information. The Mental Health Liaison Team document the summary of their assessment in the general hospital notes that includes the discharge plan.

The milestones for achieving the CQUIN targets have been the delivery of training to the Emergency Department staff, a reduction of re-attendances to GWH within 7 days and improved results in clinical audit of crisis and contingency care plans.

- **Discharge planning AWP** are developing an 'inpatient suite' as part of their existing online clinical toolkit for inpatient staff. This will include pre-discharge planning, plus the piloting of a discharge safety checklist.

- **Perinatal mental health**

Some mothers can be at risk of suicide ideation during pregnancy and after the birth of their baby. A multi-agency steering group has been established to develop a perinatal mental health pathway. This pathway has included: Public Health; Swindon CCG; AWP NHS Foundation Trust; GWH NHS Foundation Trust midwifery and obstetrics departments; Oxford Health NHS Foundation Trust; Health visiting; Lift Psychology; GPs/Primary Care; NSPCC

This pathway outlines the roles and responsibilities of different functions and will be implemented and reviewed throughout 2016 – 18 during which additional training will be rolled out.

- **LIFT Psychology service** continues to provide psychological services in Swindon including courses; one to one support; computer based Cognitive Behavioural Therapy and Books on Prescription.
- **LIFT men only course** - LIFT Psychology has set up a Men's Stress course to engage men with mental health difficulties. The course runs for 2 hours a week for four weeks. The content of the course is aimed at helping men to explore, understand and to express their emotions, with the emphasis on male specific difficulties. The course covers stress; depression; anger and anxiety and discusses helpful ways of coping with emotions. Other areas covered are men's 'rules for living' and ways to soften rules and myths of masculinity. There is space in each session to allow discussion and exploration of difficulties. Three courses were run during 2015/16 and the courses

have been well attended with good retention and the feedback has been good with attendees reporting that the sessions are relaxed, informative and engaging, with practical techniques suggested. Attendees thought it was helpful to focus on the subject from a male perspective.

- **LIFT Psychology Support for those with Long Term Conditions.** LIFT provides psychological support for people with long-term health conditions both within the community and in primary care and also within the GWH.

Over the past few years, the service has developed various community-based self-management courses targeting a range of conditions, including chronic pain, fibromyalgia, stroke, multiple sclerosis, diabetes, and most recently Parkinson's disease. These courses run on a regular basis, in various venues in the community to help improve access. They are based on Cognitive Behaviour Therapy and aim to improve people's mental and physical health. All LIFT clinical staff receive in-house training and supervision within this field to enable them to work effectively with this client group. Increasingly numbers of people in Swindon living with long-term health conditions have been accessing LIFT for psychological support over the years, in both an individual and group setting, and are signposted by various disciplines and services locally. There has been excellent feedback from service-users and this form of support is very much valued. LIFT has a good national reputation for this innovative development.

Within GWH, psychological support is funded within the following services: oncology, diabetes, pain management, and the bariatric service. As within the community provision, the support provided is a mixture of group and individual therapy, usually on an out-patient basis but sometimes also for in-patients. The clinical psychologists work closely within the different multi-disciplinary teams, drawing on a range of psychological models to inform their practice, and they also provide psychological training and consultation to their colleagues. It is hoped that the psychology provision within GWH will continue to develop over the coming years, to enable other services there to benefit from this support.

- **Prescribing** – from our audit we saw that 21 were self-poisoning using medication. 7 of these involved Paracetamol either alone or in combination with other substances. The others were a range of difference medications include many for mental health conditions. All prescribers should be aware of the suicide risk of the medications they prescribe. AWP are currently reviewing their policies and protocols around the prescribing of certain medications. This may also be reviewed using information from the self-harm register.
- **Transition** from childhood to becoming an adult is always a challenge. For those with mental health problems who are used to receiving a holistic mental health and wellbeing service it can be particularly challenging. Following the Children and Young People's mental health Joint Strategic Needs Assessment a Mental Health Transitions Group has been established to improve transitions from Children's to adult mental health services and provide support for those who do not will not benefit from adult secondary care services but need some support during transition to adulthood. This group will now link into the wider transitions work taking part in the Council.
- **Street Triage.** The Street Triage project is being piloted for one year from September 2015 – 2016. Essentially it involves mental health professionals working in partnership with police with the aim of:

- Improving access to appropriate services for people experiencing mental health problems
- Improvement in the quality of care received by people experiencing mental health problems and their carers
- Reducing the amount of police time spent dealing with these situations
- Sharing of appropriate information between agencies to ensure that safe and appropriate action is taken
- The inevitable reduction in the amount of inappropriate detentions under Section 136 of the Mental Health Act
- More efficient use of resources by both agencies

In Wiltshire the pilot was initially set up with experienced mental health nurses working alongside police officers and call handlers at their central control room. The team have access to current health records and are able to share relevant, appropriate and proportionate information regarding a person's risk to themselves and/or from others, what support they already access, advance directives, and risk management plans, for example. The Street Triage nurse advise police officers directly and speak with patients, and their carers, and liaise with other health professionals, as appropriate, to ensure that the person is directed towards the correct care pathway by the shortest possible route. From 21st March 2016 the team will be based solely at the Communications Control Room from 08:30 until midnight, 7 days a week. The pilot runs until September 2nd 2016, and subject to evaluation it is hoped that funding can be secured to commission a substantive service beyond this date.

Other Services

- **Swindon and District Samaritans** provide a number of local services on top of the core Samaritans telephone service. Swindon Samaritans is open six days a week and certain times for those who prefer to drop in. Swindon outreach service also visits the Job Centre once a week to offer support to job seekers. They also visit local schools speaking to 15 -16 year olds to raise awareness of the Samaritan's service. The Swindon Samaritans also link with AWP mental health trust psychiatric liaison service at GWH offering follow up phone calls for patients who have attended A&E in emotional distress. Samaritans outreach also work with Earlstoke Prison offering support to the peer listening service offered by prisoners. They also provide cordless phones for both prisoners and the prisoner listeners to contact the Samaritans. Swindon and District Samaritans are a member of the Suicide Prevention Group.
- **Localities** within Swindon Borough Council has three teams that as, part of their work, have a specific aim to improve the mental health of its clients, some of whom speak of suicidal thoughts. The Health Ambassadors, Community Navigators and Circles of Support Team offer a free and confidential service that works with someone on individual goals. Some of the biggest challenges that we face can be devastating on our wellbeing, these include loneliness, feeling disconnected from our community, coping with a crisis, living a chaotic life and deteriorating physical health.
 - **The Health Ambassadors** offer six 1:1 sessions to improve physical health and this includes: healthy eating, reducing alcohol, stopping smoking and learning new skills. Nearly all clients to date have been monitored and have expressed improved wellbeing by the end of the service. Befrienders are also used to support people access community events and help them gain confidence.

- **Community Navigators** are based in GP surgeries and work with people with long term health conditions. They offer 1:1 support to facilitate improved self-care and self-management of their condition(s) to improve quality of life and reduce demand on statutory services. The Community Navigators meet clients in their own home and build a picture of how long term health conditions impact on a person and their family/friends. Through supported goal setting and introduction to new voluntary support resources and community networks, clients are empowered to make positive change and improve their health and wellbeing.
- **Swindon Circles** is a volunteer befriending scheme which seeks to support isolated older people across Swindon primarily those in social housing. Volunteers offer regular social contact with an emphasis on connecting with other people, local groups and services and getting out and about, where this is possible and practical. Many of the Swindon Circles clients may be in a state of anxiety exacerbated by their social isolation and some report feeling of uselessness, depression and low mood. Clients can be recently bereaved or experiencing physical health issues that are impacting on their ability and confidence to be amongst others or getting out and about. Many relay that their volunteers make an essential difference through the social contact, brightening their day and giving them something to look forward to. Volunteers often report a positive mood change and new outlook from their clients.
- **Treehouse Wiltshire** was launched in October 2015 as an independent charity providing bereavement support to those aged 0 – 25 yrs and their families living in Swindon or Wiltshire. They offer:
 - Telephone advice and support to parents and professionals
 - Direct work with children and young people either at home or school
 - Opportunities for children and families to meet and share their experiences at group events
 - Referrals for more specialised help
- **British Transport Police** have joined our local suicide prevention group which has given us links into suicide prevention opportunities on the railway line running through the Borough of Swindon. Although there have been no fatalities within the Borough of Swindon in the last two years there have been 8 threats or attempts. 8 in 2014 and 4 in 2015. There is now British Transport Police presence at Swindon Station.
- **Swindon Street Pastors** go out into Swindon town centre on Friday and Saturday nights usually from 10pm – 4am. The aim is to be a visible presence on the street contributing to a safer Swindon. Swindon Street Pastors work in partnership with the local council, statutory agencies and the local churches. A typical night involves 4 street pastors walking the streets of the town centre engaging with people of all ages in the pub and club scene. Street pastors spend time listening to people and offering practical assistance where appropriate. Practical assistance can include giving 'space blankets' to those who are cold, 'lollipops' to young people, safety alarms to women, 'flip-flops' to those struggling with high heels at the end of a night and by assisting vulnerable people to get home. Swindon street pastors will help those who are homeless usually by signposting to other appropriate organisations such as the Swindon Night Shelter. We also signpost those with addiction or relationship problems to appropriate organisations. In the last year we have put in over 2,592 patrol hours, over a 1,000 glass bottles picked up, given out over 216 flip-flops and an estimated 3,000 people cared for, listened to and helped home safely.

- **Swindon Mind Self Harm Counselling Service (formerly PASH)** is a free confidential service, supporting individuals with self-harm issues from the age of 16 years. There is an initial offer of a 10 week 1-1 counsellor which can be extended for a further 10 weeks if required. Patients can re-refer if their self-harming behaviour returns but the emphasis is on recovery, resilience and discharge from the service. The service sees, on average 100, clients per year. The service also raises awareness and understanding about self-harm in the community and provides advocacy on behalf of some clients.
- **SOBS (Survivors of Bereavement by Suicide) group** is now well established. In the past two years they have welcomed 70 referrals to their groups. Currently there are two groups that run on a monthly basis, an evening group on the first Thursday and a morning group on the third Thursday of each month. SOBS also run regular workshops for survivors. Swindon SOBS pioneered an **Engaging Men initiative** which aimed to provide support for men. This is now run in Gloucester but men from Swindon are invited to take part. Swindon SOBS have also been instrumental in supporting other areas such as Weston-Super-Mare and Bath to set up their own groups. SOBS are also working to raise awareness and provide support for homelessness. This includes an advent project providing necessities for homeless people in Swindon, support to the Tree house Bereavement Service. A memorial tree has been planted at Swindon crematorium in memory of all those who have lost their life to Suicide in Swindon. Swindon SOBS have in a short space of time become a leader in support for those bereaved by suicide advising on the Swindon and Wiltshire Suicide Prevention Groups and speaking at regional conferences on the topic.

For the last two years 2014 and 2015 SOBS have hosted a Suicide Prevention Conference in Swindon

- **The Citizen's Advice Bureau (CAB)** provides advice and guidance to many individuals many of who have debt problems. Of the 8,000 plus people CAB work with every year between 3,000 and 3,500 people each year report debt problems. Around 40% of their clients report disability or long term health problems (16% categorise these as mental health related). The specialist benefits caseworkers primarily assist people to appeal decisions in relation to disability benefits and are seeing a continued trend towards people with mental health problems being initially turned down for Employment and Support Allowance (ESA) but being put into the support group on appeal. This is one area where without specialist help the client is unlikely to be able to overturn an initial decision. The four biggest debt issues reported currently are: Council Tax arrears 16%; Rent arrears 12% and rising); Credit Cards 8% and unsecured personal loans 7% (and rising).

At Risk Groups

- **Homelessness** in Swindon has increased over the last few years. The Swindon Homelessness strategy has been developed 2016 -2021 has been agreed and within this strategy there are strong links to mental health and substance misuse issues. One of the recommendations of the strategy is to re-establish the Homelessness Forum – a multi-agency forum to oversee the implementation and effectiveness of the strategy. This will include the Suicide Prevention Lead.
- **Family Debt** During 2013 National Welfare Reforms were introduced which potentially had a financial impact on individuals and families. Swindon Borough Council and its

partners have been supporting claimants who have been impacted. The main changes have been the reduction in Council Tax Benefit, the under-occupancy changes in Housing Benefits for claimants in the Social Rented Sector, the Benefits Cap of £20,000 and the commencement of Universal Credit. The claimants impacted have been offered support in finding employment from Job Centre Advisors, budgeting support from the Citizens Advice Bureau, college courses on employment skills and budgeting, assistance in using online applications from the Libraries, support from Benefits Officers, Housing officers and welfare advisors employed by other Social Landlords, Local Welfare Payments from the Council and an increase in Discretionary Housing Payments granted (using Housing Revenue Account Funds). There is currently a further Welfare Reforms Bill going through Parliament and the Swindon Welfare Benefits and Strategy Group will be discussing what other support can be offered to anyone impacted by any further changes over the next few months.

- The **Alcohol Support and Advice Project (ASAP)** started in March 2015 and has been funded by One Swindon. The project is hosted by CRI. ASAP is an innovative programme modelled on the success of other ambassador and champion projects to provide a sign-posting outreach initiative providing peer support, motivation and guidance or help in recognising alcohol misuse and the impact it has on others. We have a Recovery Co-ordinator and 4 volunteer part-time Recovery Motivators who are working in North Swindon, Parks and Highworth to provide support and advice to those affected by Alcohol. This group can be particularly susceptible to suicide ideation. The volunteers are all previously unemployed or receiving benefits and have experience of alcohol misuse either directly or indirectly. They are paid for a few hours a week below the benefits threshold.
- The **Street Drinkers Project** secured funding from One Swindon in 2015 -16 to tackle the impact of street drinking on individuals, communities and businesses. Street drinkers have multiple needs and issues that are addressed by a spectrum of public services and third sector organisations. This project will employ an experienced Recovery worker who will use multi-agency intelligence to identify and target persistent street drinkers and work with partners to provide support regarding accommodation; alcohol and drugs; finance, benefits and debt; children and family issues; mental and physical health; education, training and employment; attitude, thinking and behaviour. In addition a Doctor and Nurse led drop-in (referral only) wet clinic will be provided with a designated area where individuals can consume restricted amounts of alcohol in a safe environment and can receive help and support to address their alcohol or other issues. Outcomes that will be monitored include reduction in alcohol and drug use, reduction in individual arrests, reduction in reported Anti-Social Behaviour (ASB), and reduction in hospital admissions for the cohort. This project is due to start in early 2016/17.
- A **dual diagnosis** (substance misuse and mental health) care pathway has been developed for mental health and substance misuse services and primary care. There is an established Dual Diagnosis Group that meets quarterly to discuss dual diagnosis issues which arise for services. This group has provided training for all staff working with this client group. There is also a practitioner group that meets regularly to discuss individual cases and concerns.

The Drug Related Death and Harm Reduction Group reviews all drug related deaths and links with the Suicide Prevention Group through the joint chair. Records show that at least 20% of those who died from a drug related death were either in contact with or had been in contact with mental health services.

Safeguarding and Risk Management Development in Swindon

- In 2014, taking the learning from a Safeguarding Adult Review (SAR) Swindon identified a number of findings, including 'The lack of a recognised and understood multi-agency framework for case planning and decision making in Swindon leads to inconsistent and reactive practice; resulting in inconsistent and ineffective support to vulnerable people'. In response to the findings, the partners within the Local Safeguarding Adults Board have established the development of a multi-agency risk assessment process to ensure effective case planning and decision making to promote safety and wellbeing of high risk adults in relation to adults with multiple needs.
- **Swindon Risk Enablement Panel (REP)** The agencies in Swindon recognise that there are a small number of individuals who have multiple needs and maybe at risk of significant harm but fall outside of the criteria for Adult Safeguarding investigations or who have made capacitated decision not to engage with enquire. In the first instance it remains the responsibility of each professional to engage with the individual and offer interventions in a persistent and effective manner. The multi-agency process will only be enacted when all other interventions have not produced an improvement in outcomes for the individual adult.

The Risk Enablement Panels purpose is to support the individual and staff to reach agreement around risk decisions and management of those risks which can be managed. The Risk Enablement Panel acts in an advisory capacity and can make recommendations on what would be reasonable in terms of managing risks while balancing the rights of all concerned. The REP does not seek to reverse decisions that may have been previously assessed and agreed by staff and managers, rather it offers a reflective space for consultation, reconciliation, problem solving and agreement in cases where the levels of risk raises concern.

4. Recommendations and actions for 2016 - 18

The recommendations set-out below have been informed by the findings of this Swindon suicide audit and build on the work undertaken to-date in Swindon. They have been informed by the national suicide strategy "Preventing suicide in England: a cross-government outcomes strategy to save lives" in September 2012 (DH 2012a) and the evidence this document sets out for interventions that work locally.

An overarching recommendation is to continue to improve the mental health of the population of Swindon as a whole and to ensure access to high quality mental health services for all those who require them, and particularly those with a history of self-harm and/or recorded suicide intent. This should be done through the implementation of recommendations from the two Swindon Mental Health Joint Strategic Needs Assessments - one for adults and one for children and young people, as well as the national mental health and suicide prevention strategies. The needs of those with a non-heterosexual orientation should be a particular consideration as this report highlights the higher rates of suicidal ideation and attempts for these groups.

Specific recommendations to reduce suicide rates in Swindon from 2016 - 18 are to:

1. Ensure that all those working with high risk groups continue to have access to appropriate training on suicide and self-harm, including those working in schools and

colleges, emergency departments, other emergency services, primary care, care environments and the criminal and youth justice systems. Six, two day ASIST suicide prevention training courses will be rolled out over 2016-2018.

2. Focus mental health promotion and suicide prevention interventions on boys and men. Interventions should be targeted through community locations as well as health settings. The aim is to engage more effectively with men including those who are homeless or suffering from substance misuse issues. This would include SOBS initiative to engage more with men bereaved by suicide.
3. Review the Self-Harm Register in the GWH Emergency Department and use data to inform the Swindon suicide audit and prevention strategy. This will include a register for Children and Young People. In conjunction with this a task group to reduce emergency hospital admissions for self harm will be set up to tackle the high rates in Swindon. This should include service user feedback from attenders on what could make a difference.
4. Review substances used for self-poisoning and where possible reduce access to these substances.
5. Ensure that mental health needs are given equal consideration to physical health needs in those with a long-term health condition, and provide support for self-management and self-care which supports mental wellbeing as well as physical health.
6. Support campaigns and initiatives to reduce loneliness and social isolation.
7. Work with planners and developers in Swindon to include suicide risk in health and safety considerations when designing multi-storey car parks, bridges and high-rise buildings that may offer suicide opportunities.
8. Address the suicide risk associated with homelessness through the establishment of Homelessness forum and links to the homelessness strategy 2016-21.
9. Provide better information and support to those bereaved or affected by suicide; support the media in delivering sensitive approaches to suicide and suicidal behaviour and support research, data collection and monitoring including:
 - Work with the local media in Swindon to encourage responsible reporting of stories around suicide and self-harm and to provide information about sources of support and helplines when reporting suicide and suicidal behaviour.
10. Ensure that interventions implemented as a result of these recommendations are evaluated and learning shared in Swindon and nationally in order to develop the evidence base on what works in suicide prevention. Capturing the views of those who have attempted suicide on what could make a difference.
11. Thematic Lessons learnt from agencies route cause analysis of deaths by suicide are shared where appropriate with relevant agencies.

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Mental Health Street Triage Update

Health and Wellbeing Board

Date: 25 May 2016

Author:	Police and Crime Commissioner
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 This report provides an update on the Mental Health Street Triage Pilot which has been in operation since 14 September 2015.
- 1.2 The report explains some of the changes that have been made during the pilot and highlights the successes of the pilot so far.

2. Recommendations

The Board is recommended to:

- 2.1 Note the positive impact the pilot has had for both for the service user and partner agencies, and to consider options for enabling the scheme to continue after the pilot is due to conclude in September 2016.

3. Detail

- 3.1 Street Triage initially began with a total of 11 pilot sites in the UK in 2012 & 2013 and has proved so successful that by 2015 most Police Force areas either operate their own Street Triage service or are considering putting one in place. Following a successful bid for funding to NHS England by Swindon Clinical Commissioning Group, the Street Triage pilot in Swindon and Wiltshire was introduced on 14 September 2015.
- 3.2 The Swindon and Wiltshire pilot provides a mental health professional based in the police control room to assist with ensuring an individual in crisis receives the most appropriate support, achieved by offering professional advice, accessing health information and liaising with other care services. Additionally, at the start of the pilot a mental health professional was also based at Gablecross Police Station in Swindon from Thursday through to Sunday evening. The professional at Gablecross provided the additional option of face to face contact with police officers and/or service users in Swindon, where appropriate.
- 3.3 The pilot had a clear set of aims and objectives, including:
 - Rapid assessment of a situation to ensure the appropriate pathway is identified
 - Reduce both costs and the time spent managing mental health incidents for both police and health services

Further information on the subject of this report can be obtained from Mike Hughes, Mental Health Liaison Officer, Wiltshire Police, michael.hughes@wiltshire.pnn.police.uk

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Reduce the number of S136 detentions and increase the conversion rate of remaining detentions by identifying suitable, less restrictive alternatives

Improve the experience and outcome for service users

Improve training, awareness and joint working relationships between police and health professionals

- 3.4 In meeting these aims and objectives, within the first 6 months the Street Triage Team assisted with 2,744 calls or episodes, of which 67% involved a service user who had previous or current contact with mental health services.
- 3.5 Approaching the 6 month point of the pilot, the operating structure of the scheme was reviewed and it was clear that the number of times when it proved necessary for the Street Triage member to have face to face contact with a service user was relatively low. During the first 6 months, in all incidents where the Street Triage member had direct contact with the service user, only 25 were face to face, compared to 176 occasions where the team member spoke directly to the service user via the telephone. Experience showed that by getting the right advice from the right professional at the right time, the number of times when a medical professional was required at scene was low.
- 3.6 Consequently, it was decided to remove having someone at Gablecross Police Station and use this resource to increase the operating hours in the control room from 1400hrs to midnight to 0830hrs to midnight. Throughout the pilot the scheme has operated 7 days a week in the control room as data analysis showed a constant level of mental health demand throughout the week.
- 3.7 The change in operating hours began on 21 March and increased the proportion of identified mental health incidents the team is able to assist with from approximately 60% of all incidents to nearly 90%.

Successes so Far

- 3.8 In the 6 months prior to the start of the pilot, the number of S136 detentions averaged 1.03 per day. In the 6 months following the introduction of the pilot, this has decreased to 0.83 per day. This decrease is even more significant given that it has come at a time when both police and health colleagues perceive mental health demand to have increased significantly.
- 3.9 Importantly, as well as a decrease in the use of S136 overall, the conversion rate of S136 detentions i.e. the proportion which led to hospital admission, has increased during this period from 23% to 33%. It may be argued that this increase in conversion rate is due to officers using their S136 powers more appropriately. Due to the assistance and intervention of the Street Triage Team, officers are now in a much more favourable position to consider alternatives to

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S136, compared to previously when many officers would have felt S136 was the only option.

- 3.10 Since the start of the pilot, data collated by the Street Triage Team highlights that they have assisted with avoiding a further 190 potential S136 detentions. By providing professional advice and speaking directly to the service user, the Street Triage Team has ensured that rather than an officer potentially using S136, they have ensured a more appropriate, less restrictive, outcome. This includes referral to appropriate mental health service such as PCLS or Intensive Service, admission to general hospital, appointment with GP or signposting to other services. In many cases, a phone conversation between the Street Triage member and the service user has negated the need for any urgent referral.
- 3.11 As a new service, it has taken time for officers to fully understand and appreciate the service Street Triage offers. However, at the half way stage of the pilot it is clear that officers are now remembering to think 'Street Triage' and to seek their advice before taking action at the scene of a mental health incident. The Street Triage Team has built up an excellent working relationship with police staff within the control room and with police officers on the ground. Within the control room, the Street Triage members are seen as an integral part of the communications team and their assistance has proved invaluable.
- 3.12 As officers have become more accustomed to seeking advice and guidance from the Street Triage Team, this is being reflected even more in the number of S136 detentions each month. In February 2016, the number of S136 detentions was approximately 30% less compared to the same period the year before, and at the time of writing this report March 2016 is on course to show a similar, if not greater, decrease compared to the previous year.

Feedback and Case Studies

- 3.13 To illustrate the effectiveness of the prompt intervention of the Street Triage Team, two brief examples where their assistance has provided an alternative outcome to S136 are included within appendices 1 and 2. Both incidents occurred with Swindon.

Evaluation

- 3.14 To ensure a thorough and independent evaluation of the Street Triage pilot, the Service Evaluation Team from the University of West of England has been employed to conduct the evaluation. As well as analysis of data collated by both the Street Triage Team and Wiltshire Police, the team has conducted interviews with police officers, health professionals and service users in order to capture the views of those who have had involvement with the service.
- 3.15 It is hoped the first draft of the evaluation report will be available during May and this will be shared with appropriate parties at the earliest opportunity.

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Future Work

- 3.16 The pilot has continued to evolve since its introduction in September 2015 and it is wider than simply dealing with incidents when someone is in crisis. Rather than being purely a reactive service, the Street Triage Team and Wiltshire Police are working together to be a proactive service, providing assistance to both service users and other agencies, in order to ensure that wherever possible an issue or incident can be successfully managed without someone getting to the point of crisis.
- 3.17 To achieve this aim, the Street Triage Team is continuing to build on relationships with mental health colleagues to establish crisis and contingency plans which can be translated into Risk Management/Care Plans that can be used by police. The Team is also continuing to explore how Street Triage integrates with other Access services.
- 3.18 Although there is currently no longer a mental health professional based at Gablecross Police Station, options are still being considered as to how an 'outreach' function could in the future be provided within Swindon and Wiltshire. This would not necessarily be only for emergency crisis incidents but also for non-emergency, reoccurring issues where a joint police and health intervention may prove beneficial. Of course, the extent of any future outreach function of the team depends greatly on future funding.

4. Alternative Options

- 4.1 As with other Street Triage schemes across the country, the Swindon and Wiltshire pilot has provided significant benefits to both service users and partner agencies. It has clearly helped to build better working relationships between police and health services and has led to a decrease in use of S136 across the Wiltshire Police Force area in recent months.
- 4.2 To continue the work of Street Triage, further funding will be required and the level of this will determine the service which could be offered in the future. Having someone based in the police control room has proved invaluable, ensuring any incident is dealt with by the most appropriate professional or agency, in as short a time as possible. Evidence gathered by NHS England from other Force areas reinforces the view that a control room based model has proved to be the most successful option, providing best value for limited resources.
- 4.3 There is however still scope for providing an 'outreach' service where a member of the Street Triage team is able to provide face to face contact where required. This presents more of a challenge in a largely rural county such as Wiltshire compared to large metropolitan areas such as Birmingham where a Street Triage car has proved successful.

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4.4 Given its central location within Wiltshire, the police control room in Devizes potentially provides a central hub where, in addition to providing advice and guidance over the telephone, a member of the team could also respond to any incident within Wiltshire and Swindon where appropriate. Whilst the time of day would be an obvious factor, the member of the team would be able to attend the scene in any of the major hubs within the county within 30 to 40 minutes. Experience in Swindon has shown that the number of incidents when this would be necessary is relatively low, but such an option would provide a service able to tackle the most challenging circumstances.

4.5 The ability to provide an outreach service however cannot be at the cost of the service provided within the control room. Any outreach function would rely on sufficient staffing to ensure there is still someone within the control room able to centrally coordinate all reported mental health incidents.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 Street Triage pilot funding ends September 2016.

Legal and Human Rights Implications

5.2 None.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 Impact on partner services and individuals included in the report.

Diversity Impact Assessment

5.4 No adverse or significant issues have been identified to date.

Risk Management

5.5 No specific risks were identified at this stage for the report.

6. Consultees

6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None.

8. Appendices

8.1 Appendix 1 – Case Studies

Further information on the subject of this report can be obtained from Mike Hughes, Mental Health Liaison Officer, Wiltshire Police, michael.hughes@wiltshire.pnn.police.uk

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Case Study 1 - Male threatening to commit suicide

2309hrs – police receive a call from girlfriend of male, stating he was threatening to take an overdose. Male was distraught over the recent suicide of his father.

2315hrs- Street Triage check health records for relevant information regarding male's health. Police officers despatched to the scene.

2323hrs – Officers arrive at scene and begin talking to male.

2326hrs – Street Triage speak to male via the telephone.

2332hrs – Street Triage advise officers that male is now a lot calmer and willing to engage.

2335hrs – Officers and Street Triage agree to take male to his mother's address.

2357hrs – Further update from Street Triage who confirm they have again spoken to male on the telephone to check on his welfare. They have agreed that no further action is required tonight and they will contact the male again the following day to discuss if any follow up is required.

Following the incident, the officer provided feedback:

The person was in crisis and wanted to end his life.....the support given to the individual (by Street Triage) was fantastic. The person received a call from Street Triage and then a further call later to ensure their safety and for reassurance....Whilst I can provide an initial response, having the Street Triage Team who can immediately look at the health aspects giving appropriate and professional advice is an invaluable asset to the response teams and the Force as a whole.

Case Study 2 - Missing Person who had threatened to commit suicide

1403hrs – caller reports to police that family member has stated he is going to kill himself by jumping from a road bridge.

1412hrs- Street Triage confirm that male is not currently open to mental health services but has previously been seen by secondary services following previous overdose. Male has previously been detained under S136 but not admitted to hospital.

1619hrs – Male located but refuses to exit vehicle and will not engage with officers.

1738hrs – After many repeated attempts, Street Triage makes contact with male on the telephone.

1838hrs – After speaking to male for an hour, Street Triage confirm that male is now feeling calmer. Male states he has not been taking his medication and feels this may have impacted on his mood. Male agrees to Street Triage making a referral to PCLS, stating he now feels safe for this evening.

1840hrs – Male returned to Swindon by officers and male will be contacted by PCLS in the morning.

The inspector in charge of the search for the high risk missing person stated after the incident:

Attending officers and triage staff in the control room linked in brilliantly.....Once they had safely detained the male, Street Triage spent about an hour on the phone to him, talking everything through and they avoided a 136 with a referral made for him for contact in the morning.

It was a really good result and a great example of how triage is cutting time and saving resources.

As feedback above suggests, it is highly likely that without the proactive involvement of the Street Triage Team both of these incidents would have resulted in a detention under S136

Independent Domestic Violence Advisor Pilot Project - Update

Health and Wellbeing Board

Date: 25 May 2016

Author:	Police and Crime Commissioner
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 This report sets out details of progress of the Hospital Independent Domestic Violence Advisor (IDVA) and GP Outreach Worker pilot project for consideration by the Board.
- 1.2 The report details some of the challenges involved in developing the project and some of the achievements of the service to date in supporting individuals affected by Domestic Abuse (DA).

2. Recommendations

The Board is recommended to:

- 2.1 Note the progress of the pilot project.
- 2.2 Support continuation of strong links between health services and specialist support for people affected by Domestic Abuse, including consideration in future commissioning decisions.

3. Detail

Background

- 3.1 The Health IDVA/Outreach pilot project was established as a transformation project for the One Swindon Project Board. IDVA/Outreach posts support women who are risk of further harm through DA. The aim of the project was to support individuals who may disclose DA when accessing GP or other health services or on admission to GWH.
- 3.2 The intended benefits of the project included:
 - 3.2.1 Increased access to confidential specialist support for victims,
 - 3.2.2 Improved awareness of DA, and access to DA support services for medical staff,
 - 3.2.3 Early intervention to reduce repeat victimisation and to reduce repeat hospital admissions/GP consultations,

Further information on the subject of this report can be obtained from Office of the Police and Crime Commissioner, 01380 861540, pcc@wiltshire.pcc.pnn.gov.uk.

Independent Domestic Violence Advisor Pilot Project - Update

Health and Wellbeing Board

Date: 25 May 2016

- 3.2.4 Identification of individuals who may not otherwise access support services.
- 3.3 Previous national research into evaluating the impact of co-locating IDVAs in hospitals (Safe Lives Themis Research 2013) has shown that they are able to reach a more vulnerable group of victims, including younger victims, victims with complex needs, victims who have a higher usage of Accident and Emergency departments and victims who make fewer reports to the police.
- 3.4 The Health IDVA posts have been in place since June 2015. There has been a challenge in partnership arrangements for delivery of this pilot where one partner is initially funding (PCC) another is leading on oversight (SBC) and another is hosting (GPs/GWH), and the service is provided by a voluntary sector organisation. Some of these challenges have now been resolved and are included in the report.

GP Based Outreach Worker

- 3.5 The outreach worker is based in GP surgeries. At the moment practices involved include Abbey Meads Medical Centre, Hawthorn Medical Centre, Kingswood Surgery, Ashington House Surgery, Priory Road Surgery and Great Western Surgery. Carfax Health Enterprise have recently joined the project and Moredon Medical Centre and Eldene Health Centre have both expressed an interest.
- 3.6 In the last 6 months of 2015/16 there were 51 referrals to the Outreach service, 34 came from GPs, the others came from other health professionals or self referrals. Referrals from GPs have continued to increase during the life of the project.
- 3.7 Patients attend the IDVA 'drop-in' at their surgery at the suggestion of their GP, Midwife or Health Visitor or as a result of seeing advertising. Referrals have also been made through GP attendance at Child and Adult safeguarding boards.
- 3.8 Training on the impact and issues involved in DA has been delivered to Clinical and administration staff.
- 3.9 The service is being accessed by clients who do not wish to report DA to the Police, but are at risk of further harm.
- 3.10 In December 2015 the IDVA attended a practice managers meeting at Swindon CCG and received positive feedback on the project with other GP practices being interested in accessing support and training.
- 3.11 It is worth noting that during the recent Domestic Homicide Review (DHR) in Swindon it was identified that the victim had disclosed DA to her GP and had not contacted other agencies, although the police were eventually involved.

Further information on the subject of this report can be obtained from Office of the Police and Crime Commissioner, 01380 861540, pcc@wiltshire.pcc.pnn.gov.uk.

Independent Domestic Violence Advisor Pilot Project - Update

Health and Wellbeing Board

Date: 25 May 2016

GWH based IDVA

- 3.12 The hospital IDVA gained access to work at GWH in October 2015. The service supports high risk victims identified on admission to hospital as a result of DA. The IDVA conducts and reviews risk assessments, develops safety and support plans and also signposts to other relevant support services. The IDVA also provides training to other professionals.
- 3.13 Since 6th October 2015 the service has received 49 referrals of patients in the hospital (to 03.03.16). One of the main aims of this service is to reduce repeat admissions. One individual that has accessed the service was admitted 15 times between May and December 2015 as a direct result of experiencing DA. Working collaboratively with other professionals in ED and with CRI a successful result was obtained for that individual.
- 3.14 The IDVA 'hot-desks' within GWH which creates some challenges when staff wish to refer, or patients wish to access services in a confidential manner. Telephone contact is also difficult because of challenges to use mobiles, however a bleep system is now in place to allow hospital staff to access the service.
- 3.15 There have also been challenges in making the service known to staff. This is now improving, particularly in ED and Maternity. Posters and leaflets have also been produced and distributed around the hospital.
- 3.16 The presence of the IDVA post has been welcomed by hospital staff at GWH. Feedback from a Staff Nurse stated 'I think this (project) is working really well. The IDVA has managed to form some relationships with patients not used to engaging. I know other staff members including doctors, and specialist nurses in other fields have used the IDVA and found her to be extremely useful and helpful.'
- 3.17 A Safeguarding Nurse at GWH also stated 'The IDVA at GWH is a real asset, allowing staff to concentrate on the medical issues knowing that specialist support will be available for the victim. There has been an increase in referrals to the Multi-Agency Risk Assessment Conference (MARAC) from the hospital. Between January and March 2016 there have been 6 high risk cases referred. Some of these victims have never engaged with either the hospital or other services for their DA issues before
- 3.18 A case study of an individual victim, who regularly accessed hospital services, is included at Appendix 1.

Further information on the subject of this report can be obtained from Office of the Police and Crime Commissioner, 01380 861540, pcc@wiltshire.pcc.pnn.gov.uk.

Independent Domestic Violence Advisor Pilot Project - Update

Health and Wellbeing Board

Date: 25 May 2016

Future Arrangements

- 3.1 Funding is secured for 2016/17 through the PCC for the continuation of the pilot. Discussion will take place with all relevant partners as to how this scheme could be funded from 17/18 onwards. SBC will continue to monitor the success of the project throughout 2016/17, including assessing equality characteristics of individuals accessing the service in comparison to other DA provision.

4. Alternative Options

- 4.1 Alternative option would be to return to health professionals at GWH and GP surgeries referring into support services based in non-health settings.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 These are outlined in the report.

Legal and Human Rights Implications

- 5.2 No adverse or significant implications have been identified.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 The aim of the project is to improve health outcomes and reduce harm.

Diversity Impact Assessment

- 5.4 The service is provided to all individuals.

Risk Management

- 5.5 There are no significant risks indicated.

6. Consultees

- 6.1 SBC, Swindon Women's Aid, hospital staff.
- 6.2 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 Safe Lives Themis Research June 2013 #1.

Further information on the subject of this report can be obtained from Office of the Police and Crime Commissioner, 01380 861540, pcc@wiltshire.pcc.pnn.gov.uk.

Independent Domestic Violence Advisor Pilot Project - Update

Health and Wellbeing Board

Date: 25 May 2016

8. Appendices

8.1 Appendix 1 - Case Study: Sandra's Story.

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Sandra's Story

'Sandra' is 40 years old with a history of declining physical health issues, many relating to drug and alcohol use. She was previously in prison for drug trafficking.

She moved to Swindon after being released from prison to make a fresh start. She became involved in a relationship with another drug user and began to decline over a course of approximately six years due to perpetrators drugs misuse and her own drinking to manage the situation.

Her two daughters were removed and placed with paternal grandparents. She had no trust in support services. Sandra had no other family around her and whilst she recognised the abuse in the relationship, she was reluctant to make change because, as she saw it, the perpetrator had also provided her with 'care' when no-one else did.

Her partner was able to isolate her. Sandra was physically, emotionally and psychologically abused.

Sandra regularly came to the attention of the Police and Swindon Women's Aid and other services due to the abuse in the relationship but declined to engage.

Victim was admitted to GWH as a result of further physical abuse.

In GWH the IDVA was able to approach Sandra after staff raised concerns regarding her injuries and obtained her consent to talk.

The IDVA made a good connection with the victim as a result of being able to see her within a safe environment face to face and build trust. The IDVA continued to visit her regularly whilst on the ward to build up a therapeutic relationship. This proved to be successful and on discharge Sandra continued to work with the IDVA, even initiating contact when she had concerns.

On-going engagement eventually enabled Sandra to break away from the relationship and start moving towards some autonomy

Sandra was referred to MARAC for support, and was supported to make an application to move into more appropriate accommodation which would remove her from the immediate vicinity and away from the perpetrator. This gave her increasing independence. She continued to work with Swindon Women's Aid (SWA) and other services over a period of 5 months.

Sandra was also supported through the court process. Since the court case SWA have received no further concerns. We are not aware of any re-admission to GWH, and there has been no contact from the Police raising concerns of further abuse.

If the Health IDVA had not been available in GWH at the time of this Sandra's admission she would have continued to not engage with services.

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Annual Report of the Education Strategy Board

Health and Wellbeing Board
Date: 25 May 2016

Author:	Head of Education, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 This report provides information on the work of the Swindon Education Strategy Board which was set up in July 2015. The Board is chaired by the Regional Schools Commissioner (RSC) for the South-West, Sir David Carter, and its membership consists of the major education stakeholders within Swindon. These include local authority representatives, leaders of headteacher groups, Swindon teaching school alliance, and other representatives for example from the College sector and governance. Its role is to support school improvement within Swindon and to ensure that there is a strong partnership between the RSC and the local authority. The Board has met five times since July 2015 with agendas including analysis of school results in national tests and examinations, inspection outcomes, and also looking at other data such as that on exclusions. Schools are asked to make short presentations at these meetings too, with the schools presenting either being categorised by Ofsted as “requiring improvement” , being recognised as having challenging issues to address, or having good practice to share. Recommendations arise out of the Education Strategy Board meetings to address any matters raised as appropriate.
- 1.2 This report is necessary to inform members of the Board on the progress being made with a key recommendation arising out of the Ofsted inspection in December 2014 of the Swindon School Improvement function. This highlighted the need for there to be much closer working with all involved in school improvement in Swindon and that there needed to be much closer collaboration and communication with the office of the RSC.
- 1.3 The work of the Swindon Education Strategy Board is a key strand of the vision for Swindon. Priority 2 states that Swindon will “offer education opportunities that lead to the right skills and right jobs in the right places”. As part of this, pledge 17 states that we will “improve educational attainment in particular at ages 16-19 so we are above the average in England within 5 years”.

2. Recommendations

The Board is recommended to:

- 2.1 Note the contents of this report.
- 2.2 Request that a further report be presented in spring 2017 once further information on the impact of the Swindon Education Strategy Board is available.

Further information on the subject of this report can be obtained from Peter Nathan, 07467 440955, pnathan@swindon.gov.uk.

Annual Report of the Education Strategy Board

Health and Wellbeing Board

Date: 25 May 2016

3. Detail

- 3.1 The Swindon Education Strategy Board (SWEB) first met in July 2015. Its terms of reference state that it “has a long term role as an overarching body taking collective responsibility for all children and young people in Swindon, ensuring consistently high outcomes by coordinating the work of all educational organisations in the area engaged in raising standards and improving outcomes for children and young people”. A key driver for the setting up of the Board has been the changing educational landscape nationally in terms of the number of academies that have been set up. Swindon has a high number of academy schools which are independent state funded schools outside of local authority control. Most academies in Swindon do continue to work with the local authority because the local authority has a range of statutory responsibilities for children and young people, and academies also buy into a range of traded services offered by the local authority.
- 3.2 Swindon Borough Council’s arrangements for supporting school improvement were inspected in December 2014 by Ofsted and a number of recommendations were made for improvement. These included to “increase accountability by implementing the proposed Education Strategy Board” and to “ensure that concerns about standards and leadership in academies are referred promptly and directly to the RSC so that standards rise at the end of Key Stage 4 and all secondary pupils have access to education that is at least good”. The reference to secondary education was made because all but one secondary school has academy status and the proportion of schools judged good or better was (and is) low compared to other local authorities (55% against a national average of 74%). At the time of the Ofsted inspection of Swindon Borough Council, the proportion of primary schools judged to be good or better was below the national average but this has now improved and is just above the national average (87% against a national average of 86%). A further outcome of the Ofsted inspection of Swindon Borough Council was that there needed to be closer working between stakeholders such as the Swindon Teaching School’s Alliance, the local authority and other quality education providers.
- 3.3 The terms of reference of the SWEB sets out the roles of the key stakeholders involved in school improvement in Swindon. All of these stakeholders sit on the Board and these include local authority representatives, leaders of the Swindon head teacher groups, the Swindon Teaching School Alliance, National College of Leadership, Teaching and Learning representative, and College and governor representation. The vision for the Board is “For every child irrespective of background, to fulfil their potential through the best education possible”. It also has two high level success criteria. These are “to champion excellence so that every school should be at least a good school and a high percentage of schools should be judged good or outstanding” and to ensure “that educational standards should be amongst the best nationally at every phase of education with all pupils equipped to be lifelong learners”. Because of the high number of academy
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Further information on the subject of this report can be obtained from Peter Nathan, 07467 440955, pnathan@swindon.gov.uk.

Annual Report of the Education Strategy Board

Health and Wellbeing Board

Date: 25 May 2016

schools in Swindon, the SWEB needed to include strong representation from the office of the RSC which is why the board has been chaired by Sir David Carter, the RSC for the South-West. It is interesting to note that this model of Strategy Board has now been adopted across the south-west and is likely to be introduced nationally.

- 3.4 The SWEB has met five times with meetings usually taking place each term. The initial meetings focused on scrutinizing baseline information such as on outcomes from public examinations and tests, Ofsted inspection outcomes, exclusions data and other local information provided by officers. At each meeting, there have been presentations from 2 or 3 schools. These presentations have been mainly from schools judged by Ofsted as requiring improvement but have also included schools with good practice or improving. The focus has been on their plans for improvement or further improvement. The Board discussed the presentations and may make recommendations for further support or endorses the current support in place. For example, the work of Ferndale Primary School with Ruskin School was acknowledged with the agreement to move the two schools into a multi-academy trust. Improvements in the outcomes of Nova Hreod and Swindon Academy were discussed with recommendations for dissemination amongst other secondary schools. Data highlighted the need for further work to address the relatively low achievement of white disadvantaged pupils and this is being taken forward with the Swindon Association of Secondary Headteachers.
- 3.5 The SWEB is still in its early days as a Board. Its minutes are circulated to all schools in the Borough and there are reports back to the various headteacher groups. One of the key outcomes has been the closer working relationships that now exist between the RSC and the local authority. The RSC is now in a position to know any concerns (and successes) there are with Swindon schools, particularly in the secondary sector. There are also much stronger relationships between the Swindon Teaching Schools Alliance and the local authority, for example with specific support now commissioned for key schools and also a new headteacher induction and mentoring programme being put in place. The SWEB also provides a more local accountability mechanism highlighting key issues but with support being able to be provided as identified.

4. Alternative Options

- 4.1 The work of the SWEB will be closely monitored for its effectiveness and impact. There were no alternative options considered at the time as this was a recommendation arising out of the inspection by Ofsted of Swindon Borough Council's support for school improvement function.

Annual Report of the Education Strategy Board

Health and Wellbeing Board

Date: 25 May 2016

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

5.1 None.

Legal and Human Rights Implications

5.2 None.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

5.3 None.

Diversity Impact Assessment (DIA)

5.4 No DIA has been completed in support of this report as its purpose is to provide an update to the members of the Health and Wellbeing Board of work undertaken and does not ask for any decision to be made that will affect current or future service provision.

Risk Management

5.5 There are no risk management implications.

6. Consultees

6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

7.1 None.

8. Appendices

8.1 None.

Health and Wellbeing Board Provider Forum

Health and Wellbeing Board

Date: 25 May 2016

Author:	Director of Public Health, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 The Swindon Health and Wellbeing Board had resolved to establish a Provider Forum to ensure engagement of key stakeholders providing health and social care services in Swindon. The forum was to be led by providers
- 1.2 The Swindon Health and Wellbeing Board took the considered decision not to have providers as actual members of the Health and Wellbeing Board but with the intention to develop a secondary mechanism in the form of a Provider Forum.

2. Recommendations

The Board is recommended to:

- 2.1 Note the establishment of the Provider Forum and its contribution in influencing and contributing to the agenda to improve the health and wellbeing of Swindon residents across the health and social care system.

3. Detail

- 3.1 The Provider Forum for Swindon's Health and Wellbeing Board was established in June last year following a workshop event held with a number of major health and care providers.
- 3.2 The workshop explored the purpose, role and operating principles of the Provider Forum building on what providers believed was an established strong and effective partnership across Swindon.
- 3.3 Three priority areas of focus were identified and agreed by the providers that they felt would support the Health and Wellbeing Board and delivery of the Health and Wellbeing Strategy:
 - 3.3.1 Exploring Workforce solutions
 - 3.3.2 Bringing prevention to the fore to impact on demand
 - 3.3.3 Capacity planning for the future
- 3.4 Terms of Reference (attached at Appendix 1) outline the aim and objectives of the forum and list the membership. The group meet every 6 weeks.

Further information on the subject of this report can be obtained from Cherry Jones, 01793 444681, cherryjones@swindon.gov.uk.

Health and Wellbeing Board Provider Forum

Health and Wellbeing Board

Date: 25 May 2016

4. Alternative Options

- 4.1 Not to have a Provider Forum.
- 4.2 Providers to be invited onto the Health and Wellbeing Board.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 Although there are no financial or procurement implications as a result of this report it should be noted that the forum does provide the opportunity for a more collaborative and cohesive approach to service provision across the health and social care system in Swindon.

Legal and Human Rights Implications

- 5.2 There are no specific Legal or Human Rights implications arising from this report.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 None identified.

Diversity Impact Assessment

- 5.4 A Diversity Impact Assessment has not been completed for this report.

Risk Management

- 5.5 There are no significant risks indicated.

6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 – Swindon's Health and Wellbeing Provider Forum Terms of Reference.

Swindon's Health and Wellbeing Provider Forum

Terms of reference

The health and wellbeing Board vision is:

‘Everyone in Swindon lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities’

Purpose of the Forum:

We exist to develop and strengthen connections in a less formal environment between providers which results in true influence of the Health and Wellbeing Board (HWB) and enables, encourages and promotes creation of innovative solutions to Swindon's challenges.

Agreed Priority areas of Focus:

Exploring Workforce solutions

Bringing prevention to the fore to impact on demand

Capacity planning for the future

Members:

Rotating chair

Organisation
Chief Executive. Prospect Hospice
Chief Executive. Swindon Carers
Chief Executive. Great Western Hospital NHS Trust
Director of Public Health, SBC
Director. Carewatch
Voluntary Action Swindon.
Swindon Carers
Chief Officer, Swindon & Wilts Local Pharmaceutical Committee
Chief Executive. SEQOL
Director of Adult Social Care, SBC
Medical Director, Wessex Local Medical Committees

Head of Service, CAMHS. Swindon, Wilts, Bath and North East Somerset, Oxford Health
Chief Executive. Great Western Hospital NHS Trust
Chairman, Swindon Care Homes Association
Clinical Director. Avon and Wiltshire Mental Health Trust
Chief Fire Officer. Dorset and Wiltshire Fire and Rescue.
Accountable Officer. NHS Swindon Clinical Commissioning Group

Better Care Fund 2016

Health and Wellbeing Board

Date: 25 May 2016

Author:	Interim Director Adult Social Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 Swindon submitted the Better Care Fund (BCF) Plan 2016/17 to the Department of Health and Department for Communities and Local Government on 21 March 2016. The Better Care Fund provides financial support for the closer integration of health and social care.
- 1.2 The BCF Plan was approved by the BCF, with the condition that more detailed information is supplied to NHS England around the Swindon Delayed Transfers of Care Programme. This was submitted in April 2016. The BCF Financial Plan is attached at Appendix 1 and the updated Swindon BCF narrative (Appendix 2) can be found on the Council's website at:
<http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&MId=7298&Ver=4>.
- 1.3 The Government requires that the BCF Plan 2016/17 is considered by the Health and Wellbeing Board.

2. Recommendations

The Board is recommended to:

- 2.1 Note the Better Care Fund submission for 2016/17 which has been submitted to NHS England and Better Care Fund.

3. Detail

- 3.1 Detail is provided in Appendix 1 and Appendix 2.

4. Alternative Options

- 4.1 The option of not having a Better Care Fund Plan is rejected as it would mean that there is no agreed plan and no further allocation of funding for Swindon for 2016/17.

Further information on the subject of this report can be obtained from Sue Wald, 01793 465713, swald@swindon.gov.uk.

Better Care Fund 2016

Health and Wellbeing Board

Date: 25 May 2016

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 The planned expenditure is built into the budget planning process for the Clinical Commissioning Group (CCG) and Swindon Borough Council (SBC) for 2016/17. Other financial implications are detailed in the reports at Appendix 1 and Appendix 2.

Legal and Human Rights Implications

- 5.2 There are no specific Legal or Human Rights implications arising from this report. The section 256 and 75 agreements are a legal contract that outlines the responsibilities of both the CCG and SBC through the aligned and pooled budget arrangement.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 None identified.

Diversity Impact Assessment

- 5.4 None provided.

Risk Management

- 5.5 Risks have been identified as well as mitigating actions which are part of the draft revised Better Care Fund Narrative Plan.

6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 – Better Care Fund Financial Plan.
- 8.2 Appendix 2 – Better Care Fund Narrative which can be found on the Council's website at:
<http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&MId=7298&Ver=4>.

Further information on the subject of this report can be obtained from Sue Wald, 01793 465713, swald@swindon.gov.uk.

Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: Guidance

Overview

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17, which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Timetable

The submission and assurance process will follow the following timetable:

- NHS Planning Guidance for 2016-17 released – 22 December 2015
- BCF Allocations published following release of CCG allocations – 09 February 2016
- Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
- BCF Planning Return template, released – 24 February 2016
- First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:
 - 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 2016**

This should be read alongside the timetable on page 15 of Annex 4 - BCF Planning Requirements

Introduction

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

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

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks

- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.

The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B7) will change to 'Complete Template'.

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

1. Cover

The cover sheet provides essential information on the data for which the template is being completed, verified and signed off. The intention of your Health and Wellbeing Board (HWB) or Local Authority team should be that the correct data is prepopulated through the rest of the template.

All data that has been pre-populated in the yellow cells has been taken from submission 2 templates submitted by Health and Well-Being Boards, where a submission 2 template was not received the submission 1 data has been used instead."

On the cover sheet please **enter the following information**:

- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information**:

- In cell E37 please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources
<p>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-re/transformations-fund/bcf-plan</p> <p>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.</p> <p>On this tab please enter the following information:</p> <ul style="list-style-type: none"> - 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 relative to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contributions' 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. <p>- 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.</p> <p>16. 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.</p> <ul style="list-style-type: none"> - Please use column C to respond to the question from the dropdown options; - Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.
4. HWB Expenditure plan
<p>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.</p> <p>On this tab please enter the following information:</p> <ul style="list-style-type: none"> - 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) <p>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.</p>
5. HWB Metrics
<p>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.</p> <p>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.</p> <p>On this tab please enter the following information:</p> <ul style="list-style-type: none"> - 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 F64 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary) - In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure. - Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure. - Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure. - Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required. - You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.
5b. HWB Metrics Tool
<p>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.</p> <p>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:</p> <p>https://www.england.nhs.uk/ourwork/futurehhs/deliver-forward-view/</p>
6. National Conditions
<p>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.</p> <p>On this tab please enter the following information:</p> <ul style="list-style-type: none"> - For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017. - Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently. - Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
CCG - HWB Mapping
<p>The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.</p>

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
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Complete Template

1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C10	<input type="checkbox"/>	Yes
completed by:	C13	<input type="checkbox"/>	Yes
e-mail:	C15	<input type="checkbox"/>	Yes
contact number:	C17	<input type="checkbox"/>	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	F47	<input type="checkbox"/>	Yes

Sheet Completed:

Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	<input type="checkbox"/>	Yes
Gross Contribution: £000's	C16 : C25	<input type="checkbox"/>	Yes
Comments (if required)	E16 : E25	<input type="checkbox"/>	N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42	<input type="checkbox"/>	Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54	<input type="checkbox"/>	Yes
Gross Contribution: £000's	C45 : C54	<input type="checkbox"/>	Yes
Comments (if required)	E45 : E54	<input type="checkbox"/>	N/A
Funding Sources Narrative	B61	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72	<input type="checkbox"/>	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73	<input type="checkbox"/>	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?	D70	<input type="checkbox"/>	Yes
Comments	D71	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73	<input type="checkbox"/>	Yes

Sheet Completed:

Yes

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B266	<input type="checkbox"/>	Yes
Scheme Type (see table below for descriptions)	C17 : C266	<input type="checkbox"/>	Yes
Please specify if 'Scheme Type' is 'other'	D17 : D266	<input type="checkbox"/>	Yes
Area of Spend	E17 : E266	<input type="checkbox"/>	Yes
Please specify if 'Area of Spend' is 'other'	F17 : F266	<input type="checkbox"/>	Yes
Commissioner	G17 : G266	<input type="checkbox"/>	Yes
if Joint % NHS	H17 : H266	<input type="checkbox"/>	Yes
if Joint % LA	I17 : I266	<input type="checkbox"/>	Yes
Provider	J17 : J266	<input type="checkbox"/>	Yes
Source of Funding	K17 : K266	<input type="checkbox"/>	Yes
2016/17 (£000's)	L17 : L266	<input type="checkbox"/>	Yes
New or Existing Scheme	M17 : M266	<input type="checkbox"/>	Yes
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N266	<input type="checkbox"/>	Yes

Sheet Completed:

Yes

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43	<input type="checkbox"/>	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45	<input type="checkbox"/>	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45	<input type="checkbox"/>	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45	<input type="checkbox"/>	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	<input type="checkbox"/>	Yes

5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	<input type="checkbox"/>	Yes
5.1 - Cost of NEA	E54	<input type="checkbox"/>	Yes
5.1 - Comments (if required)	F54	<input type="checkbox"/>	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	<input type="checkbox"/>	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	<input type="checkbox"/>	Yes
5.2 - Comments (if required)	I68	<input type="checkbox"/>	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	<input type="checkbox"/>	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	<input type="checkbox"/>	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	<input type="checkbox"/>	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	<input type="checkbox"/>	Yes
5.3 - Comments (if required)	I81	<input type="checkbox"/>	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	<input type="checkbox"/>	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	<input type="checkbox"/>	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	<input type="checkbox"/>	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	<input type="checkbox"/>	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	<input type="checkbox"/>	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	<input type="checkbox"/>	Yes
5.4 - Comments (if required)	Q93	<input type="checkbox"/>	N/A
5.5 - Local Performance Metric	C105	<input type="checkbox"/>	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	<input type="checkbox"/>	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	<input type="checkbox"/>	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	<input type="checkbox"/>	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	<input type="checkbox"/>	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	<input type="checkbox"/>	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	<input type="checkbox"/>	Yes
5.5 - Comments (if required)	G105	<input type="checkbox"/>	N/A
5.6 - Local defined patient experience metric	C117	<input type="checkbox"/>	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	<input type="checkbox"/>	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	<input type="checkbox"/>	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	<input type="checkbox"/>	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	<input type="checkbox"/>	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	<input type="checkbox"/>	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	<input type="checkbox"/>	Yes
5.6 - Comments (if required)	G117	<input type="checkbox"/>	N/A

Sheet Completed:

Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	<input type="checkbox"/>	Yes
2) Maintain provision of social care services (not spending)	C15	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	<input type="checkbox"/>	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	<input type="checkbox"/>	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	<input type="checkbox"/>	Yes
1) Plans to be jointly agreed, Comments	D14	<input type="checkbox"/>	Yes
2) Maintain provision of social care services (not spending), Comments	D15	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	<input type="checkbox"/>	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	<input type="checkbox"/>	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	<input type="checkbox"/>	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20	<input type="checkbox"/>	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	<input type="checkbox"/>	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	Swindon
completed by:	Sue Wald
E-Mail:	swald@swindon.gov.uk
Contact Number:	7824550407
Who has signed off the report on behalf of the Health and Well Being Board:	Brian Mattock Lead Member Adults

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:

Swindon

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	£2,308,700
Total Minimum CCG Contribution	£12,149,161
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	£14,457,861

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	£0
Community Health	£6,160,446
Continuing Care	£0
Primary Care	£0
Social Care	£5,882,754
Other	£2,415,500
Total	£14,458,700

Please confirm the amount allocated for the protection of adult social care

Expenditure
£5,882,754

If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.

Funding for adult social care, demand management, Care Act and Social care capital is included in this figure

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

	Expenditure
Mental Health	£0
Community Health	£6,159,830
Continuing Care	£0
Primary Care	£0
Social Care	£4,985,256
Other	£1,003,700
Total	£12,148,785

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

	Fund
Local share of ring-fenced funding	£3,452,447
Total value of NHS commissioned out of hospital services spend from minimum pool	£12,148,785
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	£8,696,338

5. HWB Metrics
5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	5,644	5,703	5,705	5,581	22,632

HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	5,644	5,703	5,705	5,581	22,632
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	735.5

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 %	92.9%

5.4 Delayed Transfers of Care

Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
		983.9	787.1	636.7	572.2

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

	Metric Value
	Planned 16/17
Learning Disability clients receiving a review to establish potential to move out of residential care	70.0

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

	Metric Value
	Planned 16/17
ASCOF 1A Quality of Life	18.7

6. National Conditions

	Please Select (Yes, No or No - plan in place)
National Conditions For The Better Care Fund 2016-17	
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 (DTC) 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:

Swindon

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
Swindon	£1,411,700
Swindon	£897,000
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
<Please Select Local Authority>	
Total Local Authority Contribution	£2,308,700

CCG Minimum Contribution	Gross Contribution
NHS Swindon CCG	£12,149,161
Total Minimum CCG Contribution	£12,149,161

Are any additional CCG Contributions being made? If yes please detail below; No

Additional CCG Contribution	Gross Contribution
<Please Select CCG>	
<Please Select CCG>	

Comments - please use this box clarify any specific uses or sources of funding
voluntary sector funding contribution to BCF
disabled facilities grant allocation

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

<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	£0

Total BCF pooled budget for 2016-17	£14,457,861
--------------------------------------------	--------------------

Funding Contributions Narrative
The funding for schemes has been maintained for social care with an additional £200k uplift for discharge to assess. There was a mistake in the first submission which has been rectified. The CCG is developing a contract with the acute provider on a risk share basis. The uplift in demand and emergency care is funded from CCG core budget and not the BCF. The CCG has control over the 60% of revenue allocated to health scheme in the BCF as 40% of revenue in the BCF is for social care related schemes. The 60% of BCF health related funding will be directed at acute spent if this is required in order to meet demand. There is therefore no specific risk share with Swindon Borough Council in relation to emergency admission as those schemes are not joint funded. There has been significant challenge in Quarter 3 and 4 to reduce non elective admissions. The CCG has therefore allocated additional funding for non elective activity in the contract proposal for 2016/17. The target is therefore to halt the rise in admissions rather than reduce admissions

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	

Sheet: 4. Health and Well-Being Board Expenditure Plan

4. HWB Expenditure Plan

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	Expenditure		Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) existing schemes	
						if Joint % NHS	if Joint % I.A						
Integrated Crisis & Rapid response	Intermediate care services		Community Health		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£480,000	Existing	£480,000	
Respite and Telecare	Respite and Telecare		Community Health		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£176,000	Existing	£176,000	
Enhanced Voluntary Sector Capacity	Other	Voluntary Sector Support	Other		Voluntary Sector Support	Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£1,403,800	Existing	£1,403,800
Community & Residential Rehabilitation	Intermediate care services		Community Health		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£1	Existing	£1	
Preventing hospital admission and effective discharge	Personalised support care at home		Community Health		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£2,831,000	Existing	£2,831,000	
Careers Support	Support for carers		Community Health		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£388,000	Existing	£388,000	
Capital Obsolete	Other	Home adaptations	Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£0	Existing	£0	
Alternative Community Based Health	Intermediate care services		Community Health		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£2,399,466	Existing	£2,399,466	
Housing demand in ABC	Other	Enhanced care packages	Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£0	Existing	£0	
Care Act	Support for carers		Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£0	Existing	£0	
Integrated Crisis & Rapid response	Intermediate care services		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£751,166	Existing	£751,166	
Respite and Telecare	Respite and Telecare		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£624,381	Existing	£624,381	
Enhanced Voluntary Sector Capacity	Other	Voluntary Sector Support	Other		Voluntary Sector Support	Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£0	Existing	£0
Community & Residential Rehabilitation	Intermediate care services		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£550,895	Existing	£550,895	
Preventing hospital admission and effective discharge	Personalised support care at home		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£1,279,599	Existing	£1,279,599	
Careers Support	Support for carers		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£461,670	Existing	£461,670	
Capital Obsolete	Other	Home adaptations	Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£0	Existing	£0	
Alternative Community Based Health	Intermediate care services		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£1,000	Existing	£1,000	
Housing demand in ABC	Other	Enhanced care packages	Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£909,964	Existing	£909,964	
Care Act	Support for carers		Social Care		Joint	100.0%	0.0%	Local Authority	CGG Minimum Contribution	£468,800	Existing	£468,800	
Integrated Crisis & Rapid response	Intermediate care services		Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£0	Existing	£0	
Respite and Telecare	Respite and Telecare		Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£0	Existing	£0	
Enhanced Voluntary Sector Capacity	Other	Voluntary Sector Support	Other		Voluntary Sector Support	Joint	0.0%	100.0%	Charity/Voluntary Sector	Local Authority Social Services	£1,411,790	Existing	£1,411,790
Community & Residential Rehabilitation	Intermediate care services		Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	CGG Minimum Contribution	£0	Existing	£0	
Preventing hospital admission and effective discharge	Personalised support care at home		Social Care		Joint	100.0%	0.0%	Charity/Voluntary Sector	Local Authority Social Services	£0	Existing	£0	
Careers Support	Support for carers		Social Care		Joint	0.0%	100.0%	Charity/Voluntary Sector	Local Authority Social Services	£0	Existing	£0	
Capital Obsolete	Other	Home adaptations	Social Care		Joint	0.0%	100.0%	Local Authority	Local Authority Social Services	£997,000	Existing	£997,000	
Alternative Community Based Health	Intermediate care services		Social Care		Joint	0.0%	100.0%	Charity/Voluntary Sector	Local Authority Social Services	£0	Existing	£0	
Housing demand in ABC	Other	Enhanced care packages	Social Care		Joint	0.0%	100.0%	Charity/Voluntary Sector	Local Authority Social Services	£0	Existing	£0	
Care Act	Support for carers		Social Care		Joint	0.0%	100.0%	Charity/Voluntary Sector	Local Authority Social Services	£0	Existing	£0	

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 three 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 dropdowns 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 contribute to 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. 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.

[illegible]

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, readmission avoidance.
Intermediate care services	Community based services 24/7. 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, readmission 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:

Swindon

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)

[illegible]

No

If yes, please complete HWB Quarterly Additional Reduction Figures

HWB Quarterly Additional Reduction Figure

HWB NEA Plan (after reduction)

HWB Quarterly Plan Reduction %
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

No

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

£3,452,447

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 ****		
----------------------------	--	--

Additional NEA reduction delivered through the BCF

HWB Plan Reduction %	
----------------------	--

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 12th April 2016.

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: <https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx>

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	676.2	736.8	736.8	735.5	Residential care admissions continue to be challenging. Therefore existing target is maintained
	Numerator	218	245	245	251	
	Denominator	32,235	33,253	33,253	34,126	

****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 suppressed 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 1 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 %	93.2%	96.9%	92.9%	92.9%	The current performance is already in relation to reablement is already amongst the best in the country. It is therefore not feasible to increase the target further
	Numerator	40	63	65	65	
	Denominator	45	65	70	70	

*****Any numerator or denominator less than 6 has been suppressed 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				Comments
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	842.6	867.2	910.0	872.2	1068.1	1295.8	1252.5	1157.6	983.9	787.1	636.7	572.2	Following a diagnostic by NHS England, partners in swindon have agreed a delayed Discharge Programme and Action Plan. This has targets to reduce delays in relation to Great Westernm Hospital and swindon intermediate care. The total reduction based on bed days in the DTOc Programme is that ther ewill be no more than 4,000 days lost in 2016/17. The reason for quarterly variation is to front load the reduction and to then flat lined as agreed with NHSE. The BCF target includes mental health and therefore does not fully match the DTOC Programme
	Numerator	1,439	1,481	1,554	1,507	1,824	2,213	2,139	2,000	1,700	1,360	1,100	1,000	
	Denominator	170,776	170,776	170,776	172,776	170,776	170,776	170,776	172,776	172,776	172,776	172,776	174,768	

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
Learning Disability clients receiving a review to establish potential to move out of residential care	Metric Value	70.0	70.0	We wish to change the definition to ensure 70% of service users have a review in the year to reduce high cost care packages across all LD sevice users
	Numerator	28.0	420.0	
	Denominator	30.0	600.0	

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
SCOF 1A Quality of Life	Metric Value	18.7	18.7	data for 2015/16 is not yet available so this target is an estimate to be confirmed once results of annual survey are known
	Numerator	60,000.0	60,000.0	
	Denominator	3,135.0	3,135.0	

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:

Swindon

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

Swindon Data Source Used - 15/16	SUS					
	Q1	Q2	Q3	Q4	Total	
Swindon 14/15 Baseline (outturn)	6,022	6,386	6,250	5,854	24,512	
Swindon 15/16 Plan	5,826	6,169	5,955	6,007	23,957	
Swindon 15/16 Actual	6,077	6,187	6,178		18,442	

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.

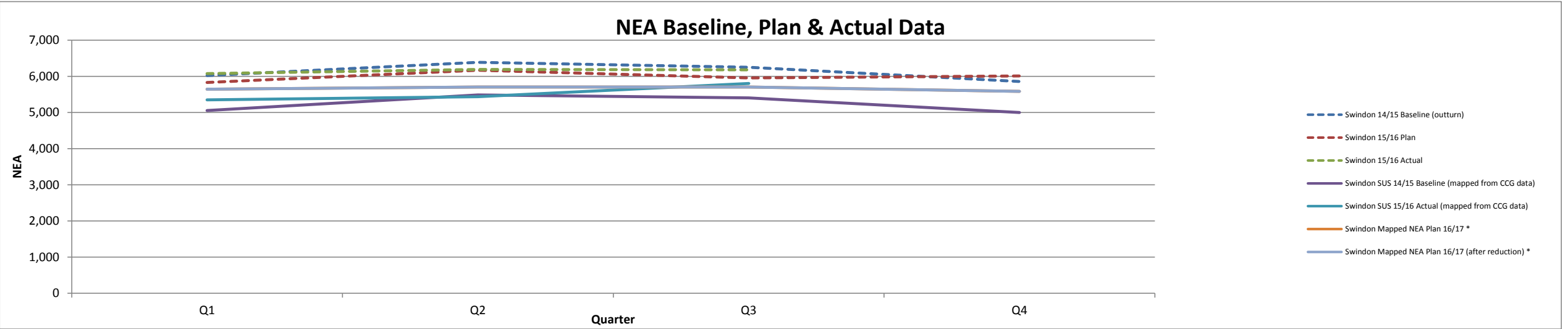
Swindon SUS 14/15 Baseline (mapped from CCG data)	5,055	5,483	5,402	4,997	20,936
Swindon SUS 15/16 Actual (mapped from CCG data)	5,348	5,434	5,803		16,585
Swindon SUS 15/16 FOT (mapped from CCG data)					21,926

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/>

Swindon Mapped NEA Plan 16/17 *	5,644	5,703	5,705	5,581	22,632
Swindon Mapped NEA Plan 16/17 (after reduction) *	5,644	5,703	5,705	5,581	22,632

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



5.4 Delayed Transfers of Care

Q1	Q2	Q3	Q4
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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:
Swindon

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.

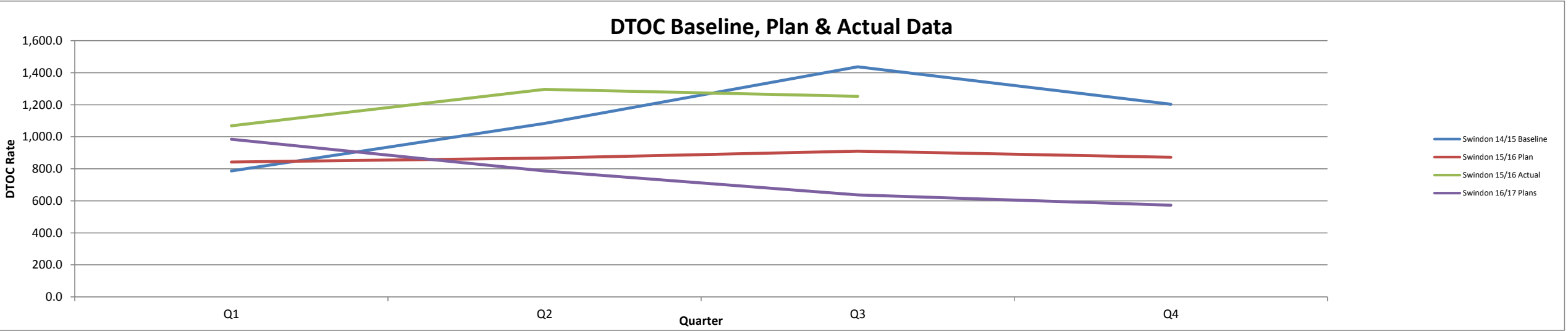
For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be 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/>

Swindon 14/15 Baseline	787.1	1,083.8	1,437.2	1,203.3
Swindon 15/16 Plan	842.6	867.2	910.0	872.2
Swindon 15/16 Actual	1,068.1	1,295.8	1,252.5	

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.

Swindon 16/17 Plans	983.9	787.1	636.7	572.2
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Template for BCF submission 3: due on 03 May 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:
Swindon

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.

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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, Wharfedale 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 Sedgfield 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, Wharfedale 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, Wharfedale 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 and 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%

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Version 8 : 25 4 2016

Better Care Fund planning 2016-17

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Swindon
Clinical Commissioning Groups	Swindon
Boundary Differences	CCG area covers Shrivenham, the community health services for Shrivenham are excluded from this plan
Date agreed at Health and Well-Being Board:	March 2016 by Chair of Health and Wellbeing Board
Date submitted:	21 March 2016
Minimum required value of BCF pooled budget 2016-17	£12,150,000 CCG contribution £897,000 LA contribution
Total agreed value of pooled budget 2016-17	£14,458,700
2016-17	£12,150,000 CCG contribution £2,308,700 LA contribution Total £14,458,700

b) Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	Swindon CCG
By	Dr Peter Crouch
Position	Clinical Chair
Date	March 2016

Signed on behalf of the Council	Swindon Borough Council
By	Cllr Brian Mattock
Position	Deputy Leader of the Council
Date	March 2016

Signed on behalf of the Health and Wellbeing Board	Swindon
By Chair of Health and Wellbeing Board	Cllr David Renard

Date	March 2016
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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
Health and Wellbeing Strategy	Statutory Plan to improve the health and well-being of the people in Swindon http://www.swindon.gov.uk/sc/sc-healthmedicaladvice/Pages/sc-healthmedicaladvice-Health-and-Wellbeing-Strategy.aspx
JSNA 2013-2022	Joint Strategic Needs Assessment for Swindon http://www.swindonjsna.co.uk/
One Swindon	The Community Strategy and Vision for Swindon http://www.oneswindon.org.uk/cs/Pages/default.aspx
Adult Care Strategy	Our strategy for managing demand for adult services http://ww5.swindon.gov.uk/moderngov/mgConvert2PDF.aspx?ID=46045
Strategy for care (CCG)	The vision how care and support needs to change to improve the health of people in Swindon http://www.swindonccg.nhs.uk/media/file-browser/Swindon%20CCG%20Strategy%20for%20care.pdf
CCG One Year Operational Plan 2016/17	Swindon CCG Operational Plan 2016/17 http://www.swindonccg.nhs.uk/index.php/list-of-events/attend-a-governing-body-meeting/governing-body-papers
Joint Commissioning Intentions and update 2015/16	Swindon Health & Wellbeing Board meeting 27 th May 2015 http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&MId=6849&Ver=4 Health & Wellbeing Board Meeting 9 th December 2015 http://ww5.swindon.gov.uk/moderngov/ieListDocuments.aspx?CId=933&MId=6889&Ver=4

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
- b) What outcomes are we striving to achieve?

We have combined the requirements for section a and b in the following analysis and description of our vision

1. Vision

Our joint vision for people in Swindon is enshrined in the Health & Wellbeing Strategy

To ensure that everyone lives a healthy, safe, fulfilling and independent life and is supported by thriving and connected communities

Our plan supports the CCG mission

To optimise the health of the people of Swindon and Shrivenham

We have aligned our joint resources to support the health, wellbeing, mental health, education and care of children, families and adults in the community to achieve the mission of both organisations.

This Plan is also aligned with the work being progressed by the One Swindon Board.

We have been involved in discussions with the public, patients, GP practices, providers, voluntary sector, other stakeholders, children and young people, and the Youth Forum in the development of the documents referred to above. The Better Care Fund Plan is a summary of jointly agreed areas of priority. Specific service redesign workshops were held on mental health, carers and community based support for older people.

Service users stated that their priorities are:

- Improved advice and information about services for carers and parent carers
- A simplified assessment process for service users and carers
- Community support for people discharged by specialist mental health services and a seamless link between voluntary and third sector providers and specialist services
- Support for older people who are isolated
- Improved patient flow within the hospital discharge process

The findings have been incorporated into this plan.

We have a long history of integrated commissioning and integrated service delivery for health and social care. Our future plans will now be revised in light of the Five Year Forward Plan.

Our vision for the Better Care Fund builds on our successful integration and is part of the forthcoming Sustainability and Transformation Plan for Swindon and the new planning footprint including Wiltshire and Bath & North East Somerset.

We are a single unitary local authority (Swindon Borough Council), one CCG (Swindon

CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Swindon Borough Council is the Local Housing Authority.

Our track record in providing integrated commissioning and delivery has been recognised in Swindon becoming one of 10 members of the national Public Service Transformation Network Areas.

We have jointly commissioned services through National Health Services Act 2006 Section 75 Agreements since 2008. The Agreement renewed in 2015 comprises total funding of £47m from the CCG and £89m Swindon Borough Council (SBC), a total of £136m. Services are commissioned through a joint commissioning team reporting to both the Accountable Officer in the CCG and the Director of Adult Social Care/Director Children's Services. All services are commissioned against an agreed Joint Commissioning Plan and monitored by a Joint Commissioning Board. The Better Care Fund is a separate pool within the S75 of £14.5m, with the balance of funding being within aligned pools.

Integrated services for children are established, bringing together community health, education and social care services in a single co-located service, managed in an integrated way within Swindon Borough Council.

We already have an established community provider providing integrated health and social care services, SEQOL, which was established in 2011.

We recognise that our demographic challenges as an expanding town with an ageing population mean we have to go further in the way that integrated services are commissioned and provided. In particular, we need to align the community and third sector closely to SEQOL and Great Western Hospital so that clear integrated pathways are in place for all our patients.

The contract for the community health and social care provider SEQOL comes to an end on 31st March 2016. In preparation, the CCG and Swindon Borough Council (SBC) started market engagement events, engagement with stakeholders, staff, voluntary sector, patients and the public in summer 2015.

In addition, the Local Government Association commissioned Newton Europe to undertake a diagnostic into further improvements in integration of health and social care in relation to reducing emergency admission, delayed discharges and improving patient flow.

The findings from this have been taken into consideration to shape the future provision of community health and social care services with closer integration with the acute pathway. Swindon Borough Council and the CCG took reports to the Governing Board and Cabinet to service notice and secure a new model in line with the Five Year Forward View.

A 12 months' notice was served on 16th February 2016 and an advert for the tender was published in March 2016.

In light of the strategic direction and the Special Educational Needs Reforms, Swindon Borough Council transferred Learning Disability social work services from SEQOL to the Council in October 2015 and wider social work services will transfer by February 2017

2. What will be different in 2020 for services and people?

Swindon will have grown substantially by 2020 with a population of over 250,000 by 2026 (including Shrivenham) from a current population of 220,000. We already have a lot of community based health services that are delivered in the homes of residents, such as fluids, medication and antibiotics through our Virtual Ward and home visiting services. We will be delivering more services in the community, such as delivering health care in people's homes where this is safe to do through for example the Virtual Ward working closely with care homes. At present, many older people do not have a health care plan addressing their long term health conditions.

Living in Swindon in 2020 will mean that you can expect to live longer than the English average, with less risk of avoidable death, in better health and with the support of your neighbourhood and community. More of your integrated health and social care provided by community nursing services, home care and social workers will be planned in advance as part of a new life-long health plan and will be preventative, replacing much that is currently emergency care and avoidable. This will be done in a coordinated way with primary care

By 2020 everybody in Swindon is working together with a common set of values and principles based on respect, giving people choice, collaboration and innovation, where people are encouraged to think what they can do themselves, what help they have within their family and community and what they still need help with. When people need help it will be personalised, offering choice and control.

Outcomes for service users and patients will improve

- Emergency hospital admissions will be avoided for specific groups of patients, particularly those suffering from diabetes and heart conditions
- More patients will be able to leave hospital without delay
- Fewer older people will be admitted to residential care, through support provided at home and flexible housing with care, reducing isolation amongst older people
- Reablement will be an integral part of all domiciliary care and will mean that fewer patients will be re-admitted to hospital
- More people with a learning disability will be able to find employment through support commissioned from the voluntary and third sector and in partnership with our Skills For Employment.

2.1 Prevention and self help

We already understand the population of Swindon at a locality/ward area and at GP practice level. We have some preventative and self-help services in place such as a third phase of community navigators and befriending support for a small number of older people.

By 2020 preventative and self-help integrated services are in place locally to engage and

support individuals. In 2019 this will mean that for individuals:

- We will offer a genuine choice of care setting for those whose mobility, functionality or health is impaired or for those with serious and terminal illness who are preparing for death
- Home will mean your own home, with us using new practice and technology that enables you to be at home
- Our vision is to support you to live life to the full within your community despite the long term conditions you may have thus avoiding institutionalised care in a community setting.

In 2020 you, your parents and carers know where to access information and support in your community, services and online through My Care My Support and the Swindon Advice and Support Centre. Carers for people with support needs are well supported through joint investment in the Carers Centre and short term breaks.

If you are older, we want to support you in making a positive contribution to your community by encouraging you to help others. This could be helping in a playgroup or being a good neighbour. You are engaged in self-help groups, local activities and you are able to volunteer. Older people say that they feel safe in their community. Where possible the entrance to residential and nursing care is delayed and housing opportunities such as homes for life, supported housing and extra care housing are used extensively.

You will have access to a range of programmes designed to improve your health, from healthy eating and healthy exercise (ranging from cycling to sports activities and recreational swimming to walking and gardening schemes); to smoking cessation programmes; to cultural activities, all of which have been shown to benefit health and wellbeing and extend quality of life. We will encourage you to volunteer to help deliver these services and promote community health champions.

Most studies identify self-care as representing 98% of the total health care needed across a population at any given time. We have invested in self-care and self-management of patients through the Health Improvement Team and community navigators. We need to develop more support through the voluntary and community sector to support patients in managing their health conditions.

Public Health initiatives such as health ambassadors work well in promoting health and wellbeing, specifically healthy eating, exercise, smoking cessation and reduction in drug and alcohol misuse. By 2020 we want Public Health to be working closely with General Practice providing a short consultation that can lead to more people quitting smoking. Brief intervention has been particularly successful in smoking cessation and drug and alcohol misuse. Community navigators have demonstrated that they improve the quality of life of individuals, reduce isolation and avoid some health costs. During 2016 we will continue to develop and evaluate the model to determine its cost effectiveness.

An example of how life will be different in 2020

Self-care and prevention 2016

Andrea is living in Penhill, one of the most deprived areas in Swindon. She has three children and an older mother suffering from diabetes living nearby. She is unemployed

and on a low income. Her middle child is overweight and the youngest child's speech development is poor. She has few friends or relatives and feels often low and depressed, caused by stress and anxiety.

Self-care and prevention 2020

Andrea's children were supported by the health visitor from before birth. She receives information from My Care My Support which the Health Visitor pointed her to. The Health Visitor shows her what local parent led groups are available. In discussions with other parents, she has made new friends and joined adult learning activities. She has found a carers' support group run locally where she can discuss caring for her mother. Meeting new parents in the area and other carers means that she feels supported and part of her community.

2.2 Urgent care – moving from unplanned care to planned care

We have community navigators linked to GP practices where if you are at high risk of a hospital admission, your GP or community nurse is able to refer you to review your health, social and emotional wellbeing and develop a plan with you.

The evaluation in January 2016 demonstrated that community navigators working with 235 clients. A cost benefit analysis has been completed demonstrating a small cost reduction on emergency admissions. The model will be extended until June 2017 with further evaluation before considering mainstreaming.

If you are a patient with a long term health condition and identified as at very high risk of hospital admission, your GP will draw up a health care plan with you rather than refer to a community navigator.

If you have need for rapid access to treatment for a minor illness and cannot treat this yourself through rest or use of medication, then this will be through a combination of your local pharmacy or by appointment through the urgent care centre, contacted through your GP surgery and open 0800 to 2000 seven days a week or within two GP led urgent care clinics (SUCCESS programme). These clinics operate 0800-2000 during weekdays but hours are being extended to include weekends from March 2016 for a trial period.

If you need a home visit this is available in future from a dedicated service able to offer a visit at any time 0800 to 2000, rather than as commonly happens now with home visits having to wait until the end of a GPs working day (again part of our SUCCESS programme)

If you need to access emergency services, then you may be seen by a 'GP at the scene' who will assess whether you can be safely treated at home. If you need to go to the local hospital you can expect to be seen and your treatment commence or to have been admitted within a maximum of four hours within either a GP/Nurse Led urgent care clinic or the Emergency Department at GWH. Patients will be directed to the right department depending on whether you need to see a GP urgently, have a minor injury, require an urgent diagnosis and outpatient appointment, require a medical assessment, require urgent treatment, need to be admitted, need resuscitation or immediate surgery or need to be kept under observation and review. Within this we have developed a new model of care - our 'Fix Me Hub' (urgent care centre on the acute hospital site). The 'Fix Me Hub'

is fully established and has significantly prevented admissions. Between April and January 2016, 19,765 patients used the Urgent Care Centre, an average of 65 patients a day and 23,454 patients have accessed services operating as part of the SUCCESS programme.

There are strong links between the provider of integrated community health and social care services and all partners, particularly the local hospital, care homes, voluntary sector and primary care. We have invested in My Care, My Support website at <http://www.mycaremysupport.co.uk/> giving advice and information about health and social care as well as a community based advice service. As explained above we have also worked to improve urgent care.

By 2020 advice and information will have been fully available to all for a number of years, so that patients are well informed and know where to find health care urgently. We will have increased capacity in the Virtual Ward and extended the treatment of relevant medical conditions within the community (minor illness) in order to prevent admission to hospital. There is more to do to improve urgent care.

Currently we still have issues with patient flow as well as discharge processes. Over the past year the delays in health services have reduced but delays due to social care increased. We know that delays are due to length spent on completion of assessment, waiting for domiciliary care, residential and nursing care. Our additional capacity is used by prescription of high care packages. In December 2015 the delays due to social care increased to 9.1 per 100,000. However this includes delays in mental health which accounted for 40% of delays.

In the next 12 months, through the Delayed Discharge Programme, we will have reviewed and revised admission and discharge management processes and invested in systems to reinforce clinical decision making at point of admission. Discharge from hospital will be better-co-ordinated. Nursing homes and care homes will have well-trained staff and will provide community based nursing interventions, reducing the need for hospital admissions. Nursing homes and residential homes work together with health and social care to facilitate speedy hospital discharge. A new contract will be in place for domiciliary care.

An example of how life will be different in 2020

Urgent care 2016

Patrick lives at home. He is 85 years old and his health is poor, suffering from high blood pressure and heart disease. When his health deteriorates due to an infection, he is admitted to hospital and given antibiotics intravenously. He is isolated and visits his GP frequently.

Urgent care 2020

All GPs in Swindon know of community services and the referral process. Patrick is identified at high risk of hospital admission. The community services meet him and discuss his health, his regular drinking and how he can better look after himself. Using My Care My Support, Patrick is allocated a volunteer to befriend him. A plan is made so that if he has another infection he can be given antibiotics intravenously with the help of a community nurse. This means that when Patrick suffers from an infection, he is cared for at home and not admitted to hospital.

2.3 Long term conditions

In 2020 if you have one or more long term conditions you will have support from those with the same condition. Informed through primary care, community services and web based information, you will be encouraged to take control of your condition whilst being routinely monitored by your primary care team which will include support from your community and the voluntary sector. You will have rapid access to specialist healthcare (including community based specialists, out of hospital and community care and outpatient clinics at the hospital) to avoid the need for emergency care and hospital admission.

Currently we have people living in areas of Swindon such as Penhill, Pinehurst, Parks, Toothill, Gorse Hill and Moredon with high levels of poor health and little access to advice and information. From our data we know that many people in those areas prefer information given to them face to face. We know that the number of older people with long term conditions will rise substantially from 35,000 now to approximately 40,000 by 2020 (see section 3).

In 2020 those people who live in the most deprived areas will be receiving additional signposting and support through community champions so that they are better able to care for themselves and able to seek the most appropriate support at the right time.

Recognising increased demand and priority of dementia care, in 2015/16, the CCG has worked with GPs to manage more routine diagnosis and management of those with dementia. Performance against the national 28 day diagnosis target has been reduced to 4-6 weeks. Currently we know that we have 2,000 people diagnosed with dementia and that this is due to double to almost 4,000 by 2030.

By 2020 Swindon will be a dementia friendly community. Older people suffering from dementia have good diagnosis in place with support groups operated in the community and more use of dementia cafés and activities. Community and social care providers support people suffering from dementia and are skilled and sensitive to their needs.

End of Life care in the community will be established as currently too many people die in hospital and patients have told us they would prefer to be at home.

We currently have a good nursing service which supports children with long term health needs in the community and at home. However, our admissions for children to hospital are high. In 2015/16, a review of Children's Services in the Acute, Community and Mental Health services will be taking place. A review of urgent care in paediatrics has informed changes in operational structure and care delivery in 2015/16. Urgent care for paediatrics will be part of an overall review in 2016/17, supporting a new model of care delivery.

During 2015/16, the key focus for community services has been progress towards maintaining sustainable services which support people in the community and prevent hospital admissions.

By 2020 children and young people with long term health needs are supported in the community by refocusing the hospital children's outreach team to work closer with GPs and community health services so children can be at home. Parents are able to access

enhanced primary care services (Children's and Young Person Clinic commissioned 0800 – 2000 in the SUCCESS centre) so that hospital admissions are prevented.

An example of how life will be different in 2020

Living with dementia in 2016

Doris lost her husband 3 years ago. She lives on her own and her son and his family are a 2 hour drive away. Doris is a member of her local church but has only a few friends. Following a fall when she broke her arm, Doris returns home after 3 weeks in hospital. Over the next few months her son notices that Doris becomes more forgetful, seems more anxious and does not participate as much in activities. After 4 months she is diagnosed with dementia and becomes very isolated. She deteriorates rapidly. Her son increases the care package.

Doris has another fall and is found by a neighbour wandering outside. Her son is becoming increasingly concerned about her safety. In discussing the situation with Doris, Doris moves into residential care near her son's family.

Living with dementia in 2020

Swindon has an active network of locally based groups and the churches play a very active part with dementia champions. Following the loss of her husband, the local church volunteer visits Doris and encourages her to continue to come to church functions. The volunteer collects Doris for the weekly lunch and women's group. Doris's son is aware of the church volunteer. He notices Doris getting more forgetful. He contacts the local advice and information service about activities in her area. Doris maintains her independence for another two years.

As she seems to be significantly more forgetful Doris is diagnosed with dementia. Her son is able to access information online and discuss help with Doris. Following deterioration in her health, Doris is not able to manage living on her own in her house as she starts wandering. Her son is able to make a referral for extra care housing through the advice and information service. A care team is on site and support is tailored to her needs. The church volunteer continues to collect Doris from her extra care flat and take her to church groups. Doris is able to live with support in extra care housing and admission to residential care is delayed.

2.4 Mental Health & Learning Disability

In 2020 if you have a learning disability and are supported by social workers you will have a personalised plan and personal budget in place. You and your carers have fully participated in the plan and own the outcomes to be achieved. You will be supported to be the best you can be with skill development, education, training and employment opportunities identified and pursued. Where possible you are living within the community in supported housing with local support. Community support through volunteers and wellbeing coordinators will support you if you do not require specialist social work support.

If you have a learning disability or mental illness you are enjoying leisure and culture and have opportunities for employment. More of you say that you feel safe.

Carers say that they have been fully involved and are positive about the quality of support and services they receive.

We currently have a diverse sector of voluntary and community groups which have not been as effectively coordinated as we would like. This means that we have a gap in offering individual support for those recovering after specialist mental health support, a gap in services reducing isolation and a gap in offering employment support for those with a learning disability. We support about 667 people with a learning disability through social care. 192 of those live in residential care, a proportion higher than in other areas. The number of people with a learning disability is expected to rise by 30 people each year as life expectancy rises and a larger number of young people become the responsibility of adult social care each year.

In 2020 the voluntary and community sector provision for people with a learning disability and those with mental ill health has been reshaped and implemented so that support is preventing conditions from getting worse and more people access employment and training opportunities. Links with specialist learning disability and mental health services are well established. The principle for services will be wellbeing coordination, therapeutic and volunteer support.

In 2020 we will have reduced the number of people with mental illness being admitted to an acute ward when presenting with mental health problems and we will have built on the many services in the local community that are amongst the best in the country and need to continue to be supported. Mental health services will be delivered locally with a strong focus on early intervention and recovery. We will have wellbeing coordinators working in voluntary organisations, bringing together specialist and community services for people being discharged and those at risk of mental illness and learning disability

An example of how life will be different in 2020

Mental health 2016

Diana has suffered from depression for a number of years. She has been referred and allocated to the specialist mental health services three times in the past. The usual pattern is that she is discharged after a period of months when she has stabilised. Once discharged she only has access to her GP. She is re-admitted to mental health services after 6 months.

Mental health 2020

As part of the discharge process, mental health workers start discussing with Diana how she copes at home and what causes the deterioration in her mental health. Well before discharge, the mental health worker discusses the wellbeing co-ordinator role with Diana. Diana meets the wellbeing coordinator with her mental health worker. Together they establish a plan around how the three of them will work together before and after Diana's discharge. The wellbeing co-ordinator introduces Diana to a job club and Diana works as a volunteer three mornings a week after discharge. Her mental health improves through the new friendships she makes as a volunteer. Her mental health improves and she is not re-admitted to mental health services.

2.5 Being a carer

In 2020 as a carer, you will have been made aware by your GP, your health visitor or social worker about the support offered by the Carers' Centre. You will have been offered an assessment to discuss with you what help you may need. You or your family can complete a self assessment questionnaire on line. You have been offered short term breaks to help you with caring and you feel valued and supported. Your GP has discussed your health with you and you know that you can receive a health check in the community. As a parent carer you know that advice and information is available and you are supported by a multi-agency team. In your local area there are groups that support you. Support through short term breaks and community groups is flexible and based on what you need.

The Census 2011 estimated that there are 19,500 carers in Swindon. We currently commission support for carers from the Swindon Carers Centre and there is an increasing number of short term breaks. We have a system in place which ensures that carers can give all the care details of their loved one. This is called the Emergency Card. If a carer is ill or unable to care, the social work teams have access to the care needs of the individual.

From April 2015, the Care Act means that all carers can request an assessment of their needs. We have invested additional resources into the Carers' Centre to give advice, complete assessments and offer group and individual support. Carers will be able to do this online or through skilled support from the Swindon Carers' Centre as well as SEQOL, and the Mental Health provider Avon and Wiltshire Mental Health Trust. Carers will have support that is flexible, outside of Monday to Friday. A personal budget enabling carers to have choice and control is offered. Informal support is available in local areas. We recognise that as carers of people with a learning disability become older, we need to review the support they are offered to support them.

By 2020 we will have evaluated the Carers Strategy and implemented new actions taking account of the views of carers through their involvement, involvement of the carers centre and the analysis of our data.

b) What outcomes are we striving to achieve? –

In Section A we have already outlined the difference service users will experience, using illustrative examples and referring to evidence within the JSNA. We have engaged public and patients in a range of workshops which are described in section 8. Our work on the Adult Care Strategy, the Joint Commissioning Plan 2014/15 and the Five Year Strategic Plan for the CCG were all based on discussions with the Patient and Public Forum. This led to the following priority outcomes:

- **Enhancing quality of life for people with long term conditions** (such as diabetes and dementia) by commissioning services that appropriately support patients' and carers' needs and help them manage their own conditions and maintain them to live in their own homes for as long as possible and avoid unnecessary hospital admissions.
- **Helping people to recover following illness** through better patient flow to ensure that people are given the care and support required in the most efficient and appropriate care settings at the right time, across health and social care. This will also

mean commissioning direct access to planned care seven days a week.

- **Improving patient experience and safety** improving access, quality and safety of services.
- **Reducing health inequalities** in Swindon working with other partners e.g. One Swindon, Health and Wellbeing Board, Swindon Borough Council and NHS England to ensure voluntary, private and public sectors are working together to support the most disadvantaged communities and households.
- **Preventing people from dying early** including preventing disease in the first place. Early diagnosis and appropriate treatment of disease can also reduce premature death.

- 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?

We already have an integrated provider of community health and adult social care in place. The provider is jointly funded and its services in relation to reablement and community health will continue to be funded from the Better Care Fund.

Community health and social care

Community health services are part of social work teams. Care is coordinated around the individual. A Single Point of Access is already in place as well as integrated hospital discharge services, a rapid assessment service (DART) as well as the Virtual Ward and 'Fix Me Hub'. A joint contract is in place across Swindon CCG and Swindon Borough Council supporting carers as well as jointly funded carer's breaks.

Our ambition for our integrated care model is first and foremost driven by our daily appreciation of the delays and confusion in healthcare delivery caused by the current disintegrated model of care delivery, despite our best efforts to ensure the patient experience is right first time for everyone. The most common complaint from both patients and clinicians is that every pathway of care has too many points where care must be handed over to another organisation, that these handover stages cause confusion and delay, that delay results in poor healthcare and also discontinuity of provision, that the resulting communication between healthcare professionals and health and social care could be better and needs new systems to improve it.

The commissioning of the voluntary and third sector is led by the joint commissioning arrangements. This funding is also part of the Better Care Fund as well as support to carers.

DART was developed by the integrated discharge team to reduce length of stay in hospital of people who need support through equipment, reablement or community nursing but don't need complex assessments. A review has taken place of the DART team in 2016, and a joint plan is being developed with DART to reduce delayed transfers of care. This will be implemented from April 2016.

Through DART and the Integrated Hospital Discharge team, social work services are available 7 days a week supported by the brokerage and contracts team in adult commissioning.

A range of public health initiatives such as smoking cessation, health ambassadors, work with black and ethnic minority communities are already in place and will be strengthened through our joint community capacity work targeting healthy lifestyles and a reduction in risk taking behaviour such as alcohol and drug misuse.

The Better Care Fund will build on the work that Swindon has already started and comprise the following schemes in 2016-17:

All services are delivered within the community and in community based locations.

Urgent care

An Urgent Care Programme Board was established in February 2016, where GWH Trust, community provider, Swindon Borough Council and Swindon CCG meet fortnightly to resolve pressures within the system and ensure that the target is met. The Senior Reporting Office for the Urgent Care Programme Board is the Executive Nurse Director at the CCG.

The Aim of 2015/16 in the CCG Operational Plan were to develop a number of initiatives which would help to manage capacity and consider how these initiatives would work within a more integrated model if proven successful. This has included a stronger triage model for minor illness and minor injury through analysis. A pilot of a Rapid Response Unit (RAU), a service with enhanced diagnostic capability to treat ambulant patients supporting admission and attendance avoidance at ED has been completed.

Both of these services, coupled with support for *on the day* demand through the SUCCESS programme in primary care has managed overall urgent care demand successfully through 2015/16. It is believed that each of these services have delivered compound effect and has helped to inform a new urgent care model. This has maintained flat growth in Urgent Care demand to Emergency Department throughout the year.

The new model is based on fewer points of access into what is a large, diverse and skilled set of services which are currently used in an integrated way to manage demand. The new model is based on rapid sign posting from a single access point to treat patient in the right place within the system rapidly to avoid escalating need. This model has been jointly developed with provider in community and the hospital.

The aims for management in urgent care will build on this work:

- Developing the initial phases of implementation for the new model of single point of access
 - More management of minor injuries / illness within community settings
 - Greater utilisation of alternatives to admission for all presentations to ED
 - Development of integrated models of ambulatory care between hospital and community through RAU and the ambulatory care unit
 - Specialist consultations pulled to patient need to support community treatment
 - Development of Right Care II framework for Ambulance services to support the new model
 - Development of the SUCCESS model relative to *on the day* demand
- Work with providers to articulate a new workforce model which supports overall

demand and shared resources between providers

- Contractual arrangements so all aspects of commissioned capacity can be used flexibly
- Development of estates and facilities to support the implementation of the new model
- Rapid access developed for End of Life care which is highly responsive to patient need and choice
- Mental health services local targets will be changed to better reflect Parity of Esteem and support for overall system. This in both Mental Health Liaison and the Intensive Service
- Working with the hospital to develop the *Right Care, Right Bed* initiative
- CQUINs this year with focus on capacity and demand management across system and promote integrated working moving toward becoming an Accountable Care Organisation in Swindon

The Urgent Care Target for 2016/17 is 98% of people will be seen and discharged from A&E within 4 hours.

Long term conditions

Review of care pathways for Diabetes, Dementia, cancer, heart failure, stroke, COPD through on-going redesign process so that services appropriately meet the demand created through better diagnosis and increased awareness for dementia, better treatment for cancer, diabetes and COPD.

The increasing prevalence of LTCs is highlighted within the JSNA. The financial pressures facing health and social care into the future indicates a radically new approach is required to tackle this trend.

Respiratory/COPD: A Quality Improvement Plan has been developed for 2016/17, this will include working with providers to review;

- the diagnosis and management pathway in general practice according to NICE clinical guidelines.
- the local COPD Oxygen and Pulmonary Rehabilitation services.
- identifying improvements on how acute care can integrate closer with the COPD community service with patients experiencing frequent exacerbations who need more pro-active management.
- use of overtreatment with inhaled corticosteroid when used above the optimal level.

Diabetes: Following a clinically-led service review which took place in the acute trust in November 2015, a comprehensive report detailing key recommendations that should be considered in 16/17. The opportunity to move towards developing and adopting a community-led model of care that incorporates the whole system will be a priority for the CCG and providers. By delivering this model of patient care, this will not only manage patients appropriately with the right care provider and in the right setting at the right time, but also support primary care. A “community-led” model of care in this context is defined as one that comprises a community of healthcare stakeholders across acute, primary, community and voluntary care to respond to the health needs and inequalities

experienced by the Swindon diabetes population. In such a model of care, this type of community leadership is maintained irrespective of care settings.

Self-care and prevention

During 2014/15 Swindon CCG and Swindon Borough Council (SBC) submitted a bid to the national Transformation Challenge Award (TCA) to expand the CN team in 2015/16. Following approval by the Governing Body on 22nd January 2015 to continue the pilot for a second year, arrangements were made to commission the Health and Well Being Team at Swindon Borough Council to provide 14 Community Navigators (CN) for all 26 practices, emphasising the need to promote and enable self-care and management for those patients with long term conditions and to facilitate engagement with existing voluntary services available including Swindon Circles of Support.

Indications from the patient feedback suggests that this phase of the pilot has contributed to the improvement in the health and well-being of the individuals and empowered them to access other sources of support to help them manage their condition and reduce their social isolation.

Feedback from the Community Navigators and the Provider Management Team suggests that this phase of the pilot has been well structured and supported, and whilst the variable engagement of practices has been disappointing, the CN's remain positive about the impact and changes they have made to individuals in terms of the management of their long term condition and life styles.

Reshaping of provision in the voluntary and third sector to improve health and well-being is being undertaken. Advice and information service as well as a website offering information is in place. Voluntary sector organisations supporting those with a learning disability, mental illness, carers and support services are co-located in the centre of Swindon. We will continue to promote the advice and information service so that people can make plan and make choices for themselves.

Reducing a growing burden of lifestyle related ill health and cancer particularly due to physical inactivity, obesity and smoking that we want to address through increasing community capacity to tackle the wider determinants in relation to housing and employment. Swindon has higher rates of smoking, alcohol consumption, physical inactivity and obesity in areas of disadvantage, which in turn leads to higher incidence of heart disease and diabetes in those communities. We continue to invest in initiatives that tackle health inequalities throughout the life course. We will be commissioning volunteer befriending and engagement services to reduce social isolation so older people remain linked to their communities for as long as possible.

Improving the health of children by reducing child obesity to below 19% in year 6 to prevent long term ill health, improving children's emotional health, reducing paediatric admissions and will ensure targeted support for children and families.

A review of Children's Services in the Acute, Community and Mental Health services will be taking place. A review of urgent care in paediatrics has informed changes in operation structure and care delivery in 2015/16. This review has suggested, in a similar way to overall urgent care delivery, the rapid response and integration with community urgent care successfully supports demand management. Urgent Care for paediatrics will be part

of an overall review in 2016/17 supporting a new model of care delivery.

Key tasks which will be completed:

- Continuation of SUCCESS children's clinic to support *on the day* demand
- The monitoring of specialist advice line for primary care and community clinicians and its effect on admissions / attendance
- Re-design of the urgent care pathway between Urgent Care Centre, Paediatric ED and PAU
- An overall service review of children's services to inform new models of care.
- Rapid End of Life care pathway response and increased care options for children and their families

Children's Mental Health Care: A review of CAMHS / TAMHS provision under the Joint strategic needs assessment has informed changes and a transformation plan which will be carried out over the next five years in line with the national review of Children's Mental Health Services. This service re-design will make the service more responsive and create measures which give more clarity around outcomes.

Improving mental health through wellbeing co-ordination and improved work between voluntary and third sector mental health services and secondary mental health services.

Dementia: Recognising increased demand and priority of dementia care, the CCG have worked with General Practitioners to manage more routine diagnosis and management of those with dementia. Performance against the national 28 day diagnosis target has been challenging in recent years, however we have now secured a new model of care which will support ongoing delivery in the future. Within the dementia strategy there is a model for specialised treatment and management of more chronic and specialist requirements. This is being delivered now via a Specialist Dementia Team in AWP.

Improving health, social and emotional development of people with a learning disability so that health outcomes improve, people live and are supported locally and find suitable employment and training.

Supporting Carers: Developing an extended assessment and information sharing supporting carers including young carers. Reviewing all services to ensure they adequately provide for the needs and rights of carers and ensuring carers are aware of support and short term breaks available to them.

Swindon Clinical Commissioning Group and Swindon Borough Council already have a National Health Services Act 2006 Section 75 Agreement in place. As the Better Care Fund is largely funds from existing budgets, many of the services are already funded. If the Better Care Fund was not in place then the following community based services could be at risk:

- Community health services
- 7 day working in adult social care
- Reablement support and accelerated discharge from hospital through access to care packages 7 days a week

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

The Better Care Fund Plan is based on a thorough analysis of need of the population in Swindon. It addresses the key challenges, which are evidenced below:

- Reducing emergency admissions to hospital by strengthening our urgent care plans
- Reducing delayed transfers of care across health and social care by 50% , in particular due to completion of assessment, admission to residential and nursing care and access to domiciliary care
- Reducing emergency admissions and improving health of those with long term conditions through community based support, advice & information, community based support, community navigators
- Strengthening reablement services for those discharged from hospital including 7 day working in social care and health
- Improving locally based support for people with a learning disability
- Improving advice, information, assessment and support for carers
- Addressing the needs of an ageing population and improving health inequalities.

The vision, priorities and schemes are based on an analysis of data from the JSNA, literature search and best practice nationally. The schemes were also identified in Swindon's application to become a Health Pioneer. As we already have joint commissioning plans in place, the majority of schemes were already referenced in the Joint Commissioning Plan 2015/16. New schemes have been included in the CCG One Year Operational Plan 2016/17.

We are a single unitary local authority (Swindon Borough Council), one CCG (Swindon CCG, representing 26 member practices in Swindon and Shrivenham), a single acute Trust in the Town (Great Western Hospitals NHS Foundation Trust), one mental health provider (Avon and Wiltshire Mental Health Partnership NHS Trust, who have established a clinical directorate that just serves Swindon), one emergency patient transport provider (South Western Ambulance Service NHS Foundation Trust) and one network of voluntary sector organisations (Voluntary Action Swindon or VAS).

Integrated services for children bringing together community health, education and social care services in a single co-located service and managed in an integrated way.

The data below outlines the challenges in detail which we will continue to address in an integrated way through the schemes outlined in Section 4 of this plan.

Swindon faces significant population growth over the next 10 years as the data below shows. We will see a larger rise than nationally amongst children under five and older people with long term conditions, both of whom are high users of primary and secondary health services. Looking at our demographics, we can see the unique consequences of the growth in our industries in the 1980s and 1990s with a materially larger proportion of our people being in the 30-64 age groups. Forecasts between 2001 and 2011 also show

that we would see the over 85 population grow at a much faster rate than the rest of the population due to increased life expectancy.

Risk stratification has identified those patients most at risk of admission and services are in place to provide enhanced support. In addition national data shows that Swindon has high rates of unplanned admissions for asthma and diabetes, and an increasing mortality rate for respiratory diseases. Programmes of work are in place to work with patients with diabetes with a focus on self-management, improved foot care and ophthalmology screening. Respiratory patients self -management, increased capacity for tele health services and specialist community support services

Population changes

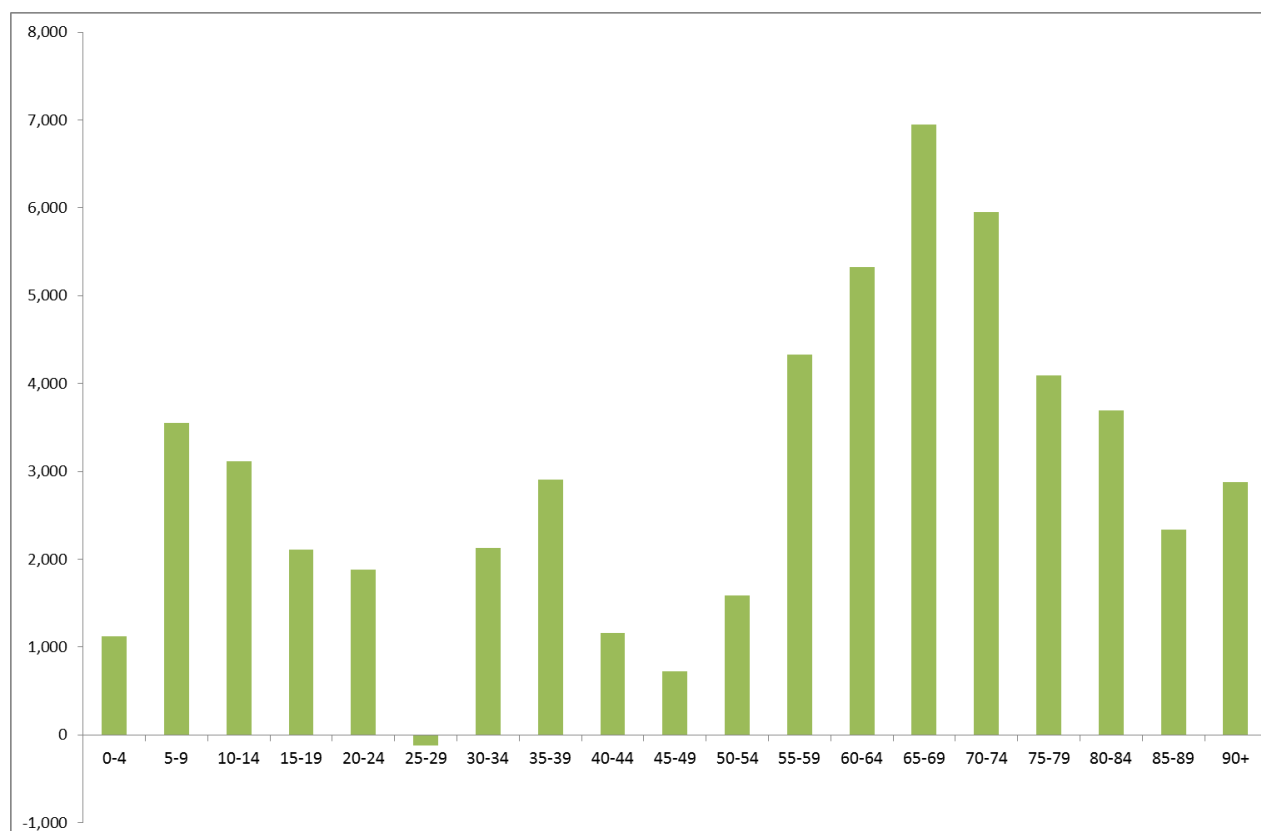
The population of Swindon by mid-2011 was estimated to be 209,700, an increase of approximately 29,600 persons from 2001 representing a growth rate of 16%, the highest in the South West. In Swindon, to take account of the planned additional 25,000 new homes between 2012 and 2026 policy-led projections were produced based on population data from the Office for National Statistics (ONS) and Swindon District's housing targets to 2026 from the Local Plan.

The key facts from these projections are:

- Swindon's population could increase to 240,000 persons by 2021, and 265,400 by 2031, equivalent to growth of approximately 14% from 2011 to 2021, and a further 10% from 2021 to 2031.
- From 2011 to 2031, births are projected to average approximately 2,900 per year, deaths approximately 1,700 per year, and net migration approximately 1,800 per year.
- The largest increase in persons will be in the 65 to 74 age group, projected to be 12,900 more by 2031. However, the 85+ age group will have the largest growth rate at approximately 136%.
- By 2031 the population aged over 65 is projected to grow by 25,900 persons to reach a total of 55,000 by 2031, accounting for 46% of total population growth.
- The working age population (16-64) is also projected to grow by approximately 21,600 persons to reach a total of 160,800 by 2031, accounting for 39% of total growth.
- The age group from 0-4 is projected to grow by 1,100 to reach a total of 15,300 by 2031.
- The population of school-age children aged 5-18 is projected to grow from 34,900 in 2011 to 43,000 in 2031, and overall, the population of children aged 0-18 will grow from 49,100 in 2011 to 58,300 in 2031.
- Overall, the age structure of the population is projected to change with significantly higher growth in the older age groups than in the younger groups. This will result in an increase in the ratio of children and older people to working age people so that by 2031 for every one person under the age of 16 or aged 65+ there will be

1.5 persons of working age instead of 2 persons of working age in 2011.

Chart 1: Projected change by 5 year age group from 2011 to 2031



Population Forecast

Age Group	2010	2015 Projection	2022 Projection
People aged 0 to 4 years	14,805	14,926 +0.8% from 2010	15,437 + 4.3% from 2010
People aged 65+ years	28,857	32,944 +14.2%	38,721 +34.2%
People aged 75+ years	13,892	15,556 +12%	19,391 +40%
People aged 85+ years	3,865	4,681 +21.1%	6,161 +59.4%
Total Population	201,053	211,102 +5%	231,867 +15.3%

Future Projections for Population 65 +

Number of over 65s in Swindon projected to have:-	2011	2015	2020	2025	2030	% Increase 2011 to 2030
• Dementia	2,014	2,289	2,734	3,265	3,941	95.7%
• A long-standing health condition caused by a stroke	673	767	877	1,023	1,191	77.0%
• A limiting long-term illness	13,599	15,412	17,526	20,397	23,762	74.7%
• A fall leading to the need for support	7,716	8,777	10,119	11,698	13,786	78.7%
• A BMI of 30 or more	7,582	8,670	9,717	11,057	12,835	69.3%
• Diabetes	3,617	4,133	4,686	5,379	6,279	73.6%

Based on national population projections, which are show less growth in Swindon's elderly population because they don't take new housing into account, the following projections of the number of over 65s projected to have certain conditions have been calculated. These numbers can be regarded as conservative estimates if the prevalence of these conditions remains unchanged in future years. Many elderly people will have more than one of the above conditions.

Number of over 65s in Swindon projected to have:	2015	2020	2025	2030	% increase 2015 to 2030
Dementia	2,280	2,727	3,259	3,979	75%
A long standing health condition caused by stroke	766	890	1,042	1,228	60%
A long-term illness limiting day to day activities a lot	7,745	9,005	10,694	12,653	63%
An admission to hospital because of a fall	677	792	957	1,124	66%
A BMI of 30 or more	8,683	9,927	11,398	13,272	53%
Type 1 or Type 2 diabetes	4,135	4,787	5,525	6,494	57%

The proportion of BME people in Swindon UA, in approximate terms, doubled from 8.5% (15,344 people) in 2001 to 15.4% (32,128 people) in 2011. The broad BME proportion reported in Swindon in the 2011 Census varied greatly from 48.2% in Central to 5.6% in Blunsdon & Highworth. Among school children in 2014, the proportion of children from a minority ethnic group in Swindon was 21.7%, more than the 11.3% in the South West and but less than the 27.8% in England. Maternity data supplied by the Great Western Hospital NHS Trust for births to women resident in Swindon, in the 2 years up to 31st October 2014, showed that 28% were to women from a minority ethnic group.

Using the provisional outturn 2014/15 data, Swindon is spending £508.55 per older person on Physical Support and Sensory Support (PS&SS) 65+ social care. This is in line with the South West average of £508.38. The actual proportion of Adult Social Care (ASC) spend on PS&SS in Swindon at 25% is lower than the South West average at 31% but this is due to Swindon having a smaller 65+ population. The actual amount we spend per person on the 65+ population is in line with the average.

Life expectancy

In Swindon, in 2012-14, life expectancy is 79.5 years for males and 83.0 years for females, which is similar to England. Males in Swindon will spend 80.7% of their lives in good health, to around 64 years, whereas women will only spend 75.8% in good health, to around 63 years. At age 65, life expectancy for males in Swindon is an additional 18.5 years compared to 21.1 years for females. However, there is almost no difference between sexes in the remaining length of time spent in good health (9.4 years compared to 9.8 years). Causes of premature mortality in Swindon are changing. In 2001-03, 36% of deaths under 75 were from cancer and 30% from cardiovascular disease (CVD) but by 2012-14, 41% were from cancer and 23% from CVD.

Meanwhile, the gap in life expectancy between the least and most deprived has reduced significantly amongst the female population but risen slightly amongst the male population. In the most deprived areas of Swindon, men die on average 9.7 years earlier and women 4.0 years earlier than those in the least deprived areas. Reducing gender related health inequalities remains a top priority.

The growth in people from Black and Minority Ethnic Communities to 15% places even greater emphasis on the development of approaches to healthcare design and delivery that reach out to and are guided by our new communities. The greatest growth has been in communities who are also vulnerable to diabetes and cardiovascular disease in the Asian community (both of which are priorities for new interventions in 2014-2019 therefore).

In addition, we have undertaken significant analysis of our population and our demand for

health and social care. Based on analysis from Public Health we know that:

- At the end of 2014/15, 24,147 people aged between 40 and 74 had taken up the offer of a NHS Health Check, 39.6% of those eligible (England average 37.9%) - The NHS Health Checks programme is monitored monthly and improvements identified to improve take up based on regional best practice. A new service specification for GP practices is being developed including surveys of health check effectiveness by patients which can then be used to develop the service.
- Cancer Screening coverage – cervical cancer 72.4% (England average 73.5%) - The Public Health team link to Public Health England campaigns to boost uptake as well as working with providers locally to look at ways to improve coverage.
- Mortality from communicable diseases 74.1 per 100,000 population (England average 63.2) – This includes the number of deaths from certain infectious and parasitic diseases as well as from influenza and pneumonia. SBC have initiatives to reduce fuel poverty and provide grants for improvements to heating for those on low incomes. The CCG also sent out a Keeping Well and Staying Safe booklet to every household this winter with advice on reducing winter illness and the risks of respiratory disease.
- Preventable sight loss – age related macular degeneration (124.4 per 100,000 age 65+) and sight loss certifications (41.1 per 100,000) – It is difficult to know whether low rates of certification and prevalence are due to genuine lack of need or lack of services / access to services. The JSNA Steering Group commissioned a JSNA which looked at sight loss to understand the local need more fully.
- Incidence of TB – 10.1 per 100,000 (England average 13.5). This is expected as higher rates tend to be concentrated in larger cities.

Improving health, particularly female health, and reducing health inequalities between the least and most disadvantaged amongst our male population remain the top priorities as described in the Joint Health and Wellbeing Strategy 2013-16.

Population analysis and use of services

Our analysis of Experian Mosaic has identified that five of the 69 categories are significant users of healthcare, namely elderly living in isolation, elderly in social care housing in isolation, families with young children on benefits, in social housing or in overcrowded conditions. These same groups also present as major users for other agencies within Swindon, hence our One Swindon joint programme of transformation. These groups are often clustered at street level rather than ward level and live in households in every ward in Swindon. The need to deliver more support to those who are most disadvantaged in our communities at household level has seen the development of schemes in support of families as well as the community navigator and mental health and wellbeing coordinator interventions.

Full analysis at household level shows that there are particular groups who use adult services most.

Adult Social Care

Data was provided on SBC's Adult Social Care services, from November 2010 – April 2014. This included all community care packages (broken down by type of package/service), as well as average weekly costs of care at a household level. The top 5 customer types for Adults Social Care are E18, G29, F23, M59, and E19.

Table 4: Adult's Social Care (ASC), top 5 customer types (by service type)

Mosaic Type	Day Care	Direct payment	Domiciliary	Equipment/Adaptations	Other	Personal Budget	Professional Support	Residential Perm
E18	£10,799	£773	£12,856	£22,974		£373	£19,832	£17,324
G29	£18,337	£567	£11,634	£2,822		£880	£1,672	£34,154
F23	£14,403	£5,716	£5,459	£1,364	£12	£783	£3,291	£31,454
M59	£7,902	£1,387	£30,324	£8,139	£563	£8,051	£1,686	£359
E19	£9,759	£2,475	£22,386	£12,024	£82	£4,633	£754	£2,668

Pink cells indicate the top 5 highest average weekly cost by service type

E18 people are classified as having moderate incomes, typically occupying large inter-war semi-detached properties. They are less resilient in the face of recessions with one or both parent possibly losing income during these times. They are internet savvy and this could help them to access services where needed. E18 are not appearing as the 'top' type for any other service, so it would be worth exploring why they are so prevalent for Adult Care.

G29 occupy larger terraces but lead busy professional lives. With high internet usage they will access services they need for their families. Both G29 and E18 are accessing Adult Social Care services far higher than their modelling would indicate – whether this is due to increasing need combined with awareness of what is available to them should be the focus of further in depth research.

F23 looks to be accessing ASC services for two distinct age groups – young people with difficulties and the elderly (likely to be parents of the type rather than the type itself). This type are, again, very internet savvy, and are early middle aged parents living in relatively large housing.

M59 is one of the most heavily deprived elderly types with extremely high levels of need. This type would probably be expected to be top of this category; however, the address matching process has not been able to match people to residential care homes. Even without the 'full' match it has still entered the top 5 for need.

E19 is very similar to E18; vulnerable during recessions but with higher levels of education and experience than 18 so possibly more likely to retrain and return to the job market.

The chart showing the type of service required by age holds no surprises with learning disabilities predominant at younger age ranges, mental health concentrated between the young and old and physical disabilities dominating heavily for the elderly. The extremely large numbers for this last category show quite clearly the large volume of service requests, yet the overall highest financial pressures occur due to learning disabilities – this is therefore was a priority for the Better Care Fund in 2014/15.

SEQOL

SEQOL provided data on all patient contacts and episodes, between November 2010 and April 2014. There could be many contacts to a patient episode, much like there could be many episodes to patient spells in secondary care activity, but usually only one referral per episode. Data on costs was not provided.

The top 5 types for SEQOL are M59, J45, B05, L54 and M56.

Table 5: SEQOL, top 5 customer types (by age)

Mosaic Type	0-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80-89	90-99	100+	Total	% HH	Expected	High/Low
-------------	-----	-------	-------	-------	-------	-------	-------	-------	-------	-------	------	-------	------	----------	----------

														Visits	
M59			42	8	96	103	427	135	235	686	15		1.85	8261	41343
J45	43	271	267	655	687	158	353	103	107	284	85	49604	5.08	22687	8810
B05	64	46	147	225	364	743	131	606	151	444	38	28611	2.74	12247	16364
L54	13		6		96	448	234	731	129	344	50	26631	2.06	9199	17432
M56	41	31	13	192	217	598	231	874	882	466	37	25681	1.67	7484	18197

Pink cells indicate the top 5 highest instances by age

It is interesting that 'E18 and 19' do not feature in SEQOL's list, despite being the top group for Adult Social Care.

M56, M59, B05 and L54 are all elderly types and looking at the dominant age ranges it is no surprise that these are the prime requesters of SEQOL services (although M59 dominates).

J45 are white collar workers likely to have suffered ill health as a result of work/working practices. Data on service type was also provided; community/district nurse is by far the key service type with a huge number of visits compared to any other area. All types are using these services higher than the modelled percentage would indicate but this is likely to be due to the direct need of these more elderly types. Therefore our advice and information services will use this information to target information in such a way that these groups of people receive information to manage their health and social care needs in a way that corresponds to their preferences

GWH

GWH provided data on all hospital admissions *that require a stay* between November 2010 and November 2013. This does not include day visits. The data provided included principal ICD (international classification of diseases) codes, to enable us to draw out some analysis on primary condition alongside customer type. Full costs at household level were provided.

Due to having such a comprehensive dataset, this is best seen as a top 10 rather than a top five. The top 5 (10) types for GWH are: J45, H35, E19, B05, J47 (K51, E21, M59, M56, O68). Appendix 5 shows the breakdown by age and by condition.

Table 6: GWH Hospital admissions, top 10 customer types (by cost)

Mosaic Type	Total	% HH	%HH/Spend	High/Low
J45	£9,686,184	5.08%	£6,978,493	£2,707,691
H35	£8,482,290	9.38%	£12,899,093	-£4,416,803
E19	£7,621,444	4.72%	£6,482,606	£1,138,838
B05	£6,081,844	2.74%	£3,767,244	£2,314,600
J47	£5,738,012	2.54%	£3,493,755	£2,244,257
K51	£5,479,954	3.22%	£4,422,417	£1,057,537
E21	£5,403,529	4.08%	£5,606,537	-£203,008
M59	£5,225,330	1.85%	£2,541,049	£2,684,281
M56	£4,712,106	1.67%	£2,302,121	£2,409,985
O68	£4,482,675	2.70%	£3,717,656	£765,019

J45 present as the highest cost customer type to the hospital. Typically low income but

low unemployment, this is a relatively deprived group. Analysis by age shows it is patients aged 66 – 85 that are triggering the highest costs.

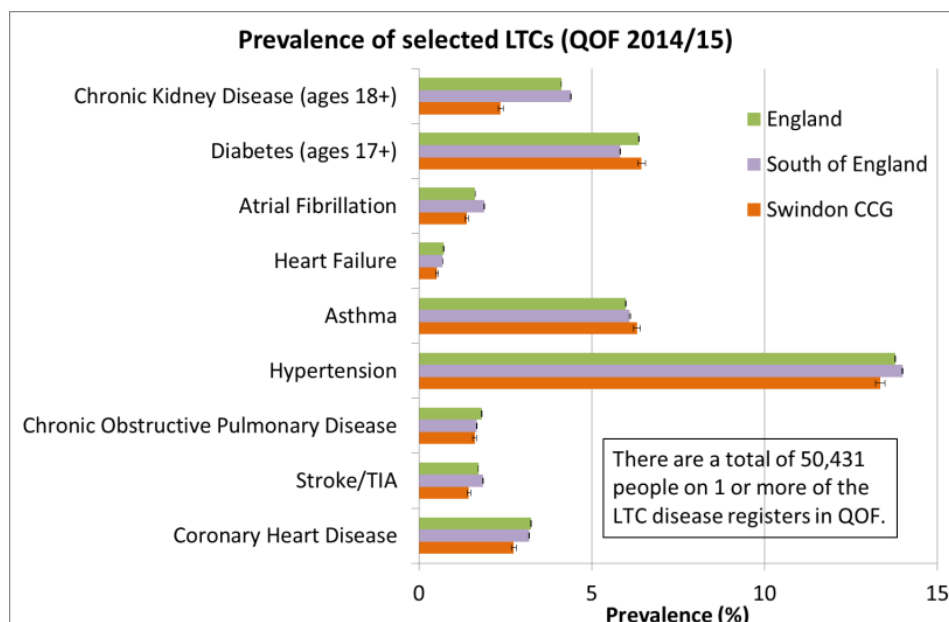
By age, costings break down into two main groupings – pregnancy-related stays, therefore young adults plus children, in types H35 and O68 and the elderly, who make up the other types. This is also reflected in the principal ICD codes, which have several codings to do with pregnancy and several for lung, heart problems, fitting of pace makers etc. Interestingly, one of the other principal categories relates to dental care which has some implications for overall service provision/take-up.

Normalising the actual service usage against the Mosaic household percentage shows that again H35, whilst using a lot of services, is under represented whilst others are heavily over represented.

Given the nature of the conditions affecting the elderly further work investigating how to interact with health promotion activities before they reach this age range may prove highly beneficial and will be incorporated into the community capacity scheme of the BCF.

Long term Conditions

Meanwhile, in 2001, 27,476 people reported having a long term condition which limited them in some way. A similar question was asked in the census in 2011 and the reported figure has risen to 32,302. This is a very slight rise *in percentage terms* from 15.2% to 15.3%, suggesting that, despite a significant change in the age demographics between 2001 and 2011 (48.6% growth in the over 85 age group), this has had little if any impact on the overall prevalence of those with long term limiting illness. The number of patients on a long-term conditions disease register with a Swindon GP was 50,431 in 2014/15¹. The key impact of our ageing population has been in the number of residents who have **multiple conditions** and their **degree of debilitation**, neither of which is collected as part of the Census, but information on both is now available through our investment in risk stratification.



Whilst the overall number of Swindon residents living with a long term condition has increased in line with our overall population, some conditions such as diabetes and respiratory disease have grown faster than that partly due to near doubling of minority

¹ QOF data

groups where the prevalence of these conditions is higher, whilst other conditions such as dementia and stroke are forecast to increase at a faster rate than our overall population due to the faster rate of growth of our older and minority populations. The above increases will put additional pressure on individuals, households, their families, carers and support networks. Those with a long term limiting condition are two to three times more likely to also develop depression.

Our investment in community nursing, SUCCESS, community navigator and support for older people through voluntary and third sector organisations are part of our plan to address this. More detailed information is included in the CCG 5 Year Strategic Plan.

Demands on adult social care

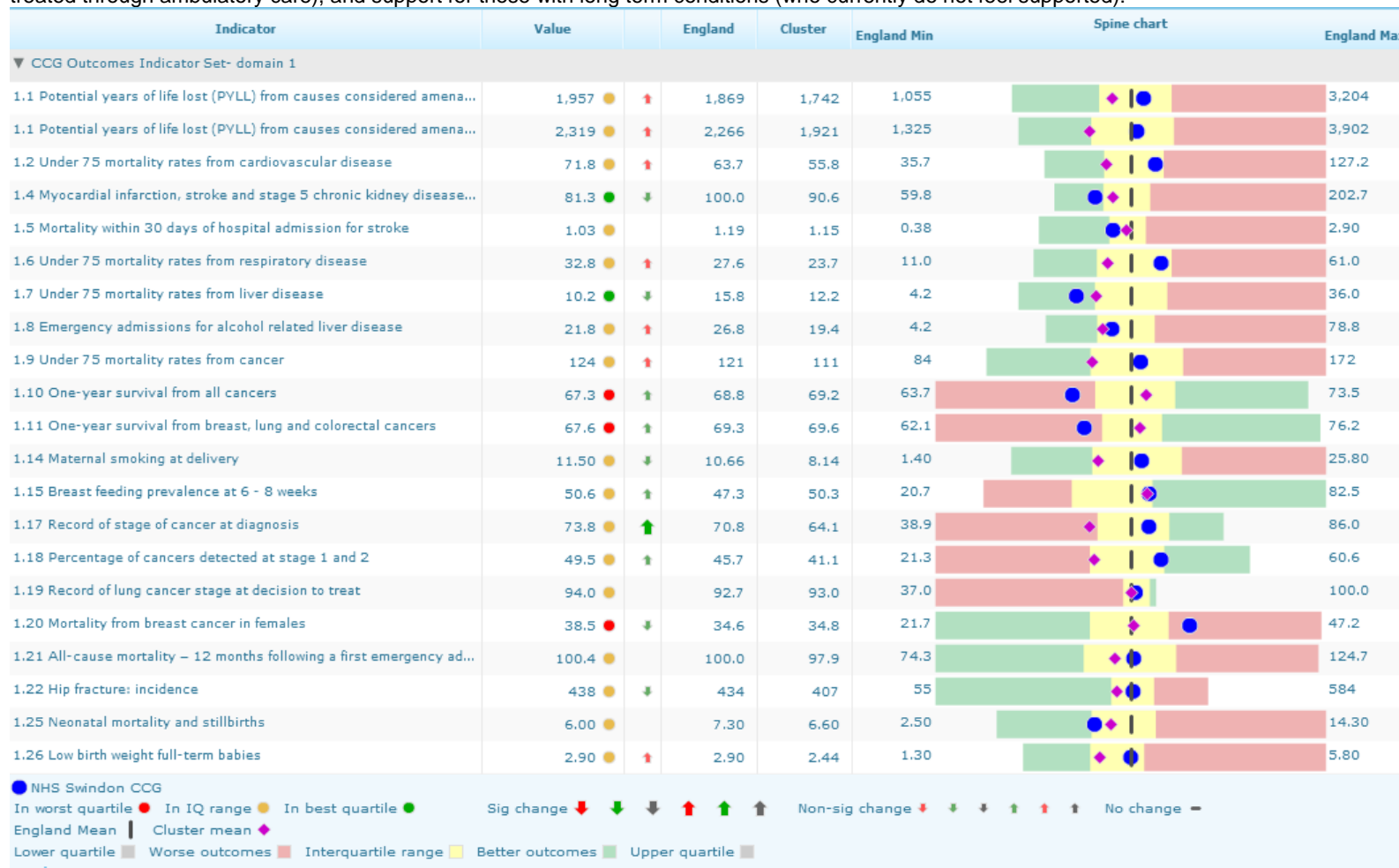
There were 676 people with a learning disability supported by Adult Social Care in January 2016 and 1,200 older people. Modelling by Swindon Borough Council on increases in demand estimates an additional 60 older people for 52 weeks of the year each year until 2016. Thereafter, it is likely that this number increases due to the demographic changes outlined above. We are also experiencing more complex health needs for Older People and in 15/16 have seen a significant increase in the value of packages of care. An additional £1.6m has been allocated in the 16/17 budget to meet increased demand for Older People.

Our spend on older people is the lowest amongst similar authorities at £992 per head of population. We support more people living at home and similar numbers in residential care.

When we examine the satisfaction rates, we have a higher proportion of older people saying they feel isolated. Reducing isolation is therefore a priority for our work with older people.

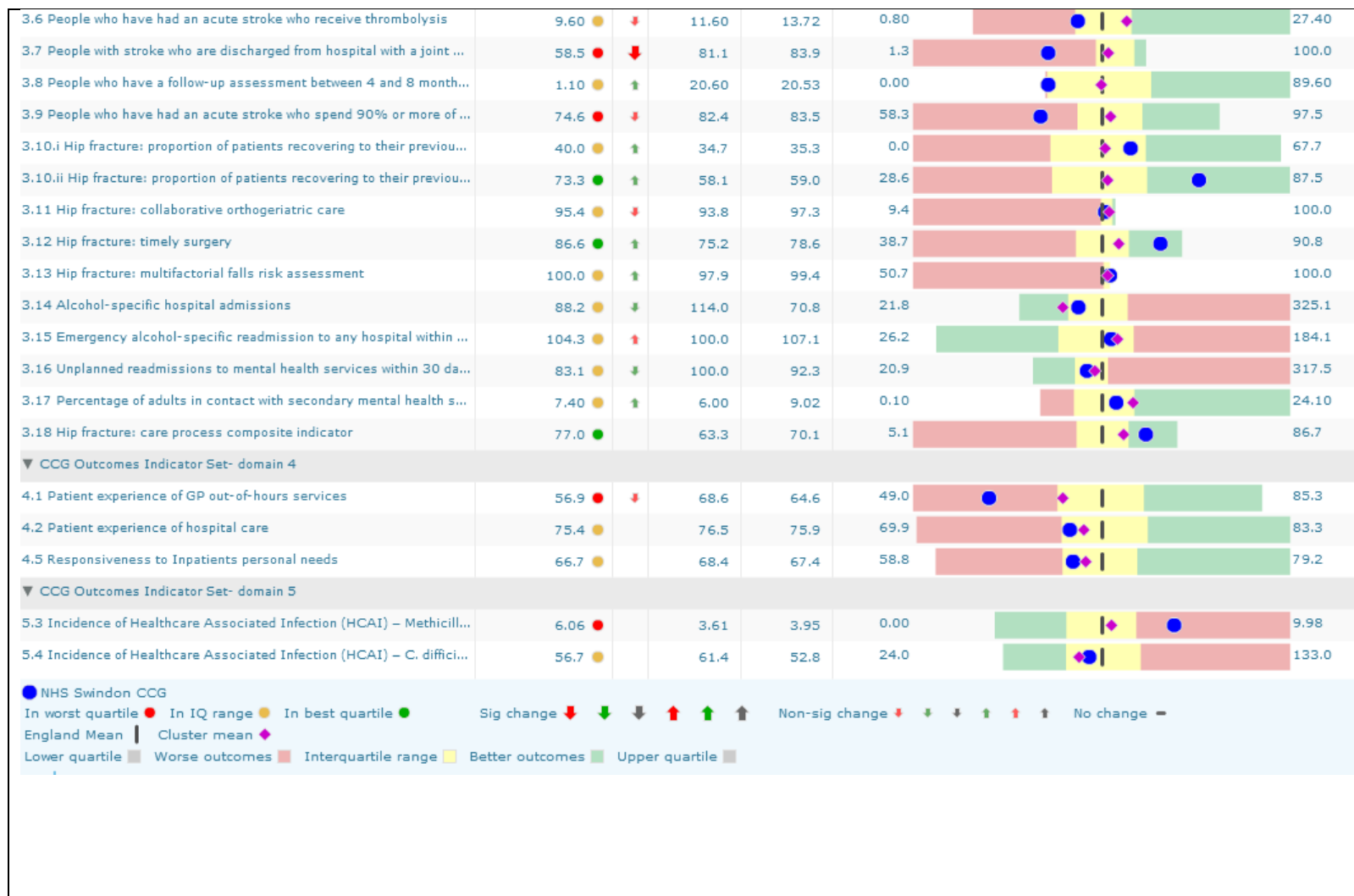
OUR POPULATION AND PERFORMANCE²

We have set improvement targets over the next five years for every outcome in all 5 domains but 3 in particular require additional attention and intervention: **Potential Years of Life Lost**, **Avoidable emergency admissions** (including unplanned admissions for chronic conditions that can be treated through ambulatory care), and support for those with long term conditions (who currently do not feel supported):



² From tools on this NHS England website: <https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/> accessed 4/3/16

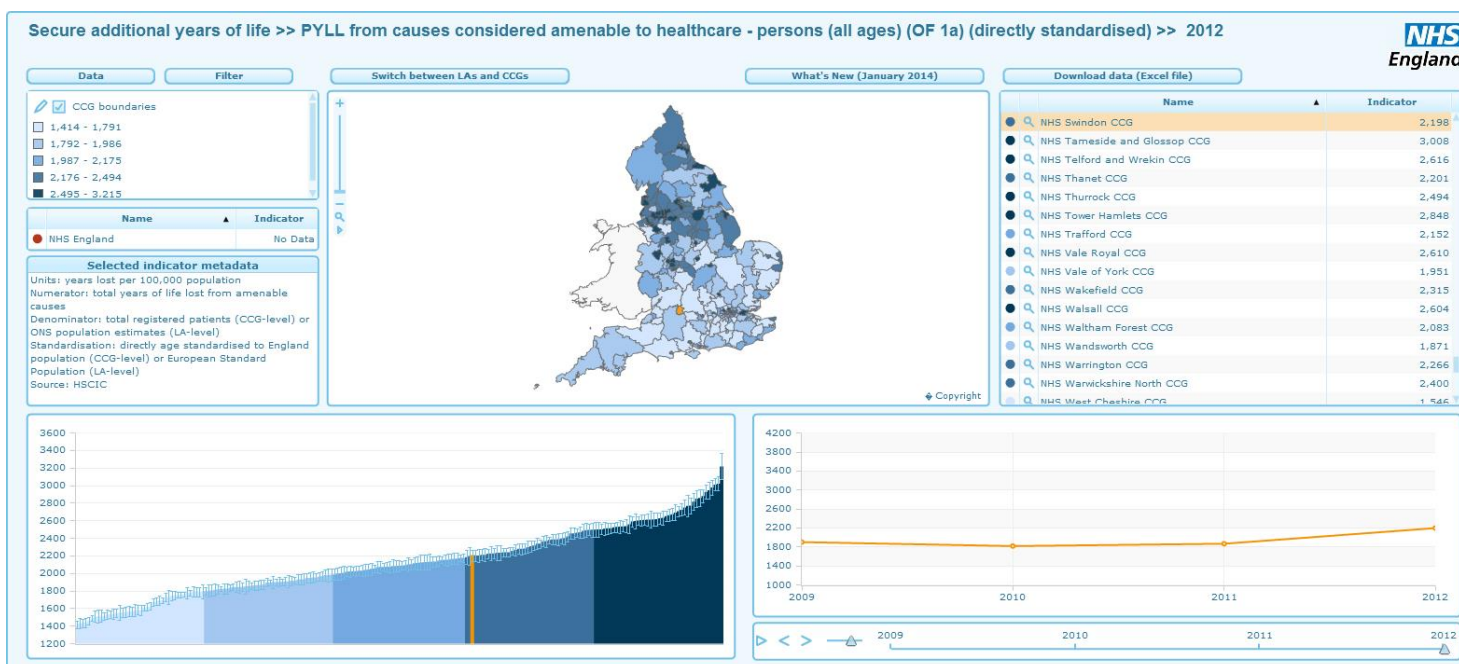
Indicator	Value		England	Cluster	England Min	Spine chart	England Max
▼ CCG Outcomes Indicator Set- domain 2							
2.1 Health-related quality of life for people with long-term conditions	0.74	● ↓	0.74	0.77	0.63		0.81
2.2 Proportion of people who are feeling supported to manage their c...	60.9	● ↓	64.4	63.7	50.6		75.3
2.5 People with diabetes diagnosed less than a year referred to struc...	13.80	● ↑	19.01	17.12	0.00		66.10
2.6 Unplanned hospitalisation for chronic ambulatory care sensitive ...	867	● ↓	806	628	114		1,578
2.7 Unplanned hospitalisation for asthma, diabetes and epilepsy in u...	275	● ↓	325	265	71		738
2.8 Complications associated with diabetes	81.2	● ↓	100.0	83.2	63.8		164.3
2.9 Access to community mental health services by people from Bla...	1,066	● ↓	2,201	1,633	658		5,283
2.10 Access to psychological therapies services by people from Bla...	1,867	● ↑	956	798	242		2,882
2.11a Percentage of referrals to Improving Access to Psychological ...	38.9	● ↓	42.8	44.8	17.6		64.6
2.11b Percentage of referrals to Improving Access to Psychological ...	51.6	● ↓	60.8	61.9	24.8		76.8
2.11c Percentage of referrals to Improving Access to Psychological ...	8.50	● ↑	6.20	5.79	3.20		10.80
2.15 Health-related quality of life for carers, aged 18 and above	0.80	● ↑	0.80	0.81	0.72		0.85
2.16 Health-related quality of life for people with a long-term mental ...	0.51	● ↓	0.53	0.56	0.34		0.75
▼ CCG Outcomes Indicator Set- domain 3							
3.1 Emergency admissions for acute conditions that should not usua...	1,364	● ↑	1,272	1,072	252		2,368
3.2 Emergency readmissions within 30 days of discharge from hospi...	11.9	● ↑	11.9	11.5	8.9		14.5
3.3 Elective Hip replacement (Primary) procedures - patient reporte...	0.45	● ↑	0.43	0.44	0.34		0.50
3.3 Elective knee replacement (Primary) procedures - patient report...	0.32	● ↑	0.32	0.32	0.21		0.37
3.3 Elective groin hernia procedures - patient reported outcomes me...	0.10	● ↑	0.09	0.09	0.02		0.13
3.3 Elective varicose veins procedures - patient reported outcomes ...	0.08	●	0.09	0.05	-0.02		0.16
3.4 Emergency admissions for children with lower respiratory tract in...	383	● ↑	400	351	94		743
3.5 People who have had a stroke who are admitted to an acute strok...	40.0	● ↓	58.7	58.5	27.3		84.9



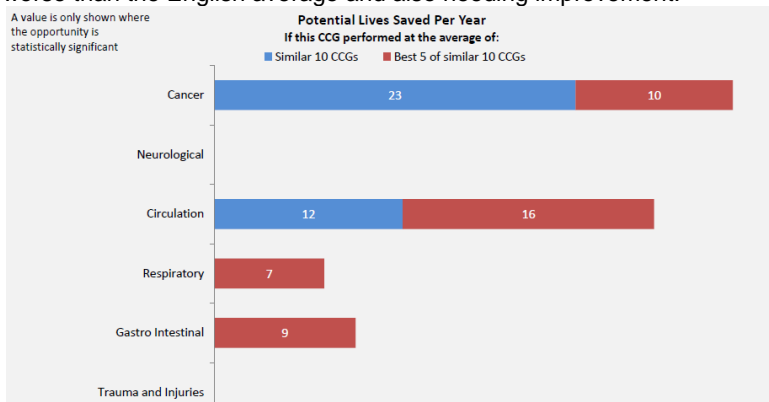
AREAS FOR IMPROVEMENT

Potential years of life lost (PYLL) and saved

Swindon's PYLL has moved from being best tertile to worst tertile in the single year of 2012 and our ambition is to return to the best tertile position at 1800 or where the local community was in 2010. With the exception of diabetes (female deaths working age) and respiratory disease (under 75 for both genders), mortality through avoidable deaths are fewer in Swindon than the English average. In 2009 (the latest year for which we have national statistics with which to compare), less than one per cent of the Swindon population died with the main causes of death being: RTA amongst children followed by congenital abnormalities; suicide was the main cause of death in the 15 to 34 age group; then coronary heart disease for men from 35 onwards and for women over the age of 65. For women aged between 35 and 64, breast cancer was the leading cause of death.

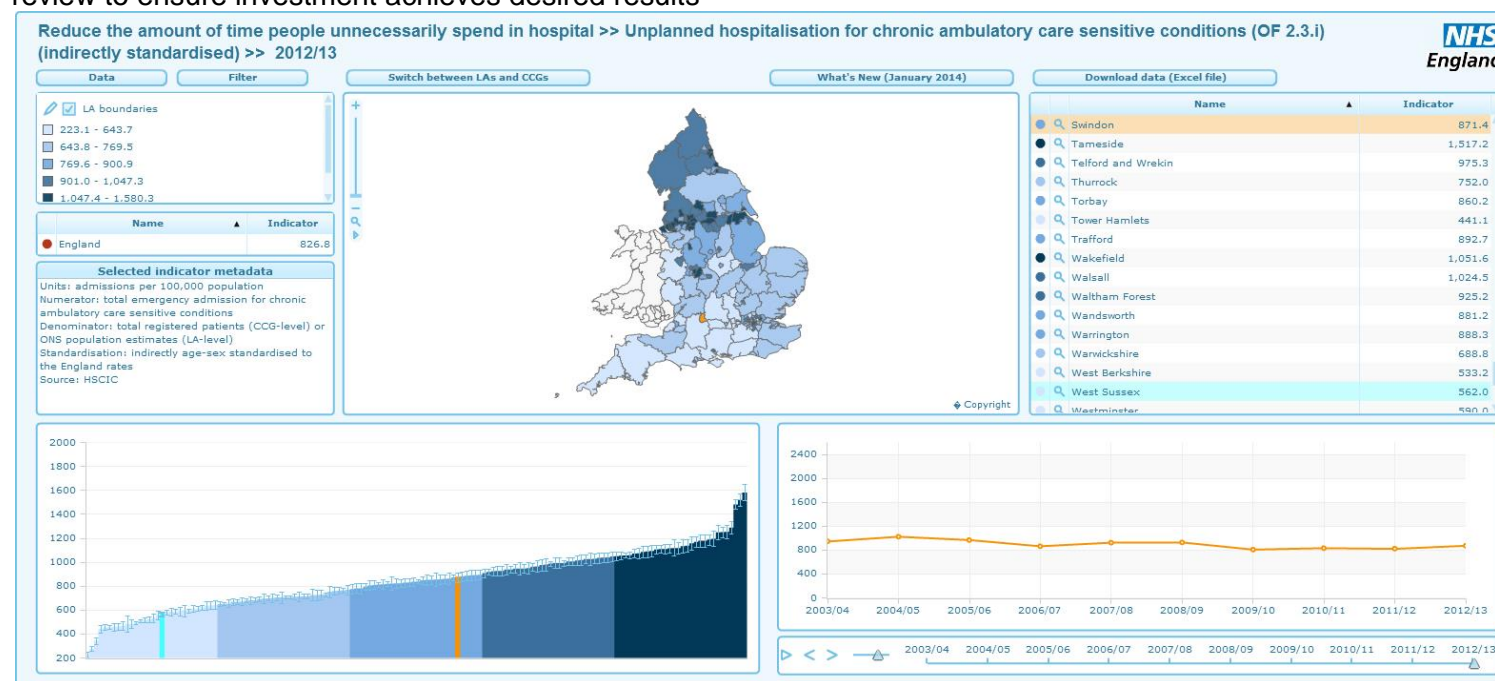


The main opportunities for intervention are in cancer and circulatory disease (see below) with under 75 mortality from respiratory disease being worse than the English average and also needing improvement:



Avoidable emergency admissions

The Joint Strategic Needs Assessment spoke of a growth in admissions but did not differentiate between unplanned and planned admission. Recently in 2013/14 our emergency admissions have grown. Our GP referral rate has averaged around 5% between 2007-2014 and this has seen a growth in planned admission of 5% as well per annum, the overall impact is a growth slightly higher than our population growth, which is unaffordable in the long term. The CCG 5 year strategy supported by the Better Care Fund is an ambitious programme of change for both referral management and greater use of technology to allow specialist consultation to happen within primary care and the community to achieve a 15% reduction in emergency admission over 5 years. The CCG 5 year strategic plan also analyses spent by condition, disability and disease as our spent is not achieving the improvement in outcomes we aspire to. This is an area of work for review to ensure investment achieves desired results



In assessing the likely growth in **demand** for healthcare, we have gone back to our population and the impact we predict from population growth on each of our programmes of spend, the impact of additional housing investment in the latter years of our strategy and the potential impact of changes in our demography and levels of deprivation.

Some conditions will see more growth than others due to the forecast age distribution of our population and this is shown in the table below. Taking mental health as an example, we have assumed significant growth in Dementia at 5.03% growth per annum and built this into our mental health programme, as well as factoring in a growth in depression in those living longer with a limiting or chronic illness, but this is partly offset by our assumption of nearly zero population driven growth in demand in the young and working age population. We acknowledge the Parity of Esteem initiative and will work with our providers to achieve this.

Forecast growth in demand and indicative programme spend

This is based on age profile of users of services

Programme	2011-2012 (%)	2012-2013 (%)	Annual growth estimate	Projected spend before inflation, developments and efficiencies					
				2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019
Mental health	14.69%	14.05%	3.83	37.3	37.3	38.7	40.2	41.7	43.3
Circulation	10.52%	11.56%	4.05	31.8	33.1	34.4	35.8	37.3	38.8
Genitourinary	7.08%	7.05%	4.04	19.5	20.2	21.1	21.9	22.8	23.7
Gastrointestinal	6.46%	6.68%	1.39	17.9	18.2	18.4	18.7	19.0	19.2
Cancer	6.46%	6.33%	4.11	17.5	18.2	19.0	19.7	20.5	21.4
Neurological	6.46%	5.20%	3.62	14.3	14.8	15.4	15.9	16.5	17.1
Musculoskeletal	6.35%	7.70%	4.04	21.2	22.1	23.0	23.9	24.9	25.9
Respiratory	5.83%	6.19%	3.44	17.0	17.5	18.2	18.8	19.4	20.1
Learning disability	5.73%	2.35%	0	14.5	14.5	14.5	14.5	14.5	14.5
Maternity	5.21%	5.37%	1.39	15.0	15.2	15.4	15.6	15.9	16.2
Endocrine	4.38%	4.43%	3.87	12.2	12.6	13.1	13.6	14.1	14.7
Dental	3.96%	4.34%	1.39	11.7	11.8	12.0	12.2	12.3	12.5
Trauma and injuries	3.96%	4.80%	2.01	13.0	13.2	13.5	13.8	14.0	14.3
Vision	3.44%	3.62%	4.04	10.0	10.4	10.8	11.2	11.7	12.2
Skin	2.92%	3.74%	1.01	10.0	10.1	10.2	10.3	10.4	10.5
Infectious diseases	1.77%	1.99%	1.39	5.4	5.4	5.5	5.6	5.7	5.8
Poisoning	1.56%	1.26%	1.11	3.3	3.4	3.4	3.4	3.5	3.5
Neonatal	1.46%	1.36%	0	3.6	3.6	3.6	3.6	3.6	3.6
Hearing	1.04%	0.99%	2.01	2.7	2.7	2.8	2.8	2.9	2.9
Blood disorders	0.73%	0.99%	1.11	2.6	2.7	2.7	2.7	2.7	2.8
Remove maternity, neonatal, mental health and LD									
Totals (including specialist services)				209.9	216.5	223.4	230.4	237.8	245.4
Overall growth in demand (%)					3.15	3.15	3.17	3.18	3.19

4) PLAN OF ACTION – PROGRESS AT MARCH 2016 - Key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Swindon already has integrated joint commissioning and delivery in place. This is supported by Section 75 Agreements for adult social care, community health and mental health services. These agreements were revised in 2014 so that a new Section 75 is in place with a schedule for the Better Care Fund from 1st April 2015 for five years. The Better Care Fund is a schedule of the section 75 agreement and this Plan will form part of the schedule for 2016.

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
1	Integrated Crisis and rapid response Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	Urgent care workshop to reduce length of stay in hospital	Review of Crisis and Single Point of access in view of care Act requirements Implement 7 day working in therapy services at the front door linked to rapid response services through additional OT and therapy services	Ensure Crisis services and rapid response use on line self assessment process for social care so that there is a speedy assessment process	Improve e-communication between secondary, primary and community care (crisis support, carer support, hospital discharge schemes, reablement, social care support 24/7)	Crisis and reablement services have been integrated and released additional capacity. Self assessment tool has been tested and roll out started in customer services. 7 day social work and OT services in place in hospital with access to domiciliary care bridging services at weekend.
2	Enhanced Reablement People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	Analysis of end of year data for reablement 2013/14 completed with 330 people supported during the year	Additional £70k investment in reablement services to increase capacity Research into older people social care services commissioned to identify future commissioning priorities	Continue investment in reablement services Implement findings from audit of reablement services and determine whether research into older people needs changes the service model	Implement findings from audit of reablement services and determine whether research into older people needs changes the service model	Additional investment in reablement, Fessey made. Review of reablement completed and shared with SEQOL. Reablement principles to be included in domiciliary care tender published March 2016

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
3	<p>Community navigators and enhanced voluntary sector capacity The role of the community navigator will be to coordinate a holistic plan for patients at high risk of hospital admission. Patients with long term conditions are identified through risk stratification which is in place in all GP surgeries.</p> <p>Wider community capacity Commissioning of mental health third and voluntary sector contracts to support demand for health and social care services</p>	<p>Development and establishment of community navigator project</p> <p>First evaluation of community navigator pilot</p> <p>Tendering of community based mental health services</p>	<p>Second evaluation of community navigator to be completed to establish potential for roll out and cost effectiveness of the model</p> <p>Risk stratification implemented</p> <p>Roll out to further GP practices in Locality 2 Implementation of over 75 year old funding to GP practices to establish care plans for all frail older people</p> <p>Community based mental health services through voluntary and third sector in place</p> <p>Commissioning of home from hospital enhanced service</p> <p>Circles of Support supporting older people on low care packages</p>	<p>Further development dependent on second evaluation of community navigator</p> <p>Older people workstream commences to explore community based support and reduce admissions to residential care</p> <p>Tendering of befriending services for older people</p> <p>Testing of advocacy specification for older people, mental health and learning disabilities</p>	<p>Implementation of new befriending service</p> <p>Community navigator supporting 220 patients with individual care plans identified through risk stratification at the end of Q3. Some reduction in emergency admissions has been seen from this cohort</p> <p>Tendering of advocacy specification for older people, mental health and learning disabilities</p> <p>Evaluation of home from hospital services</p>	<p>Community navigator evaluated and extended to June 2017</p> <p>Tender on befriending delayed so it could be coordinated with GWH commissioned service.</p> <p>Befriending services in place through Red Cross, Age UK and Circles of Support. Meeting with voluntary sector to reduce fragmentation and scope new tender</p> <p>Advocacy service extended in 2015 to meet care Act requirement. New tender April 2016</p> <p>Evaluation completed and new tender late spring 2016</p> <p>Circles of Support supporting 50 older people</p>

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
3 cont..	The development of a single database My Care, My Support that can be accessed by the patient and workers in development of support	Co-location of voluntary and community sector and launch of 'My Care My Support' Advice and Information services for adult social care and community health services in place, meeting requirements of Care Act	Development of online self assessment lined to My care My Support for service users	Implementation of online self assessment	Evaluation of use of online self assessment for service users in first 6 months	My Care My Support live at http://www.mycaremysupport.co.uk/ Self assessment questionnaire live in hospital social work team and review team.
Page 247 4	Community Rehabilitation Scheme (Fessey) Nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly.	Implementation of residential reablement services	Additional 16 discharge to assess beds to support patient flow with additional therapy to support regaining of skills	Evaluate discharge to assess models and determine future funding into 2015/16		Evaluation of Fessey and Discharge to Assess beds completed and part of Delayed Discharge Programme. Additional D2A beds have been in place since July 2015.
5	Enhanced hospital discharge We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week.	Re-design workshops: mental health, carers, diabetes, COPD, and dementia	Implementation of ECIST findings with improved hospital discharge service Urgent care workshop to promote patient flow	Review and revise admission and discharge management processes and invest in systems to reinforce clinical decision making at point of admission	Implement any findings from reviews to ensure speedy discharge from hospital and reduce delayed discharge	7 day social work funded, additional manager post funded, DART model evaluated and report shared with SEQOL and GWH. New system to be implemented 1.4.2016 Delayed discharge of care have continued to be high for social care. The main reasons are completion of

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
						<p>assessment, awaiting domiciliary care and residential and nursing care. An additional 1,500 domiciliary care per week (20% increase) has been purchased by social care as well as additional beds in residential care. NHS England completed a diagnostic in December 2015. In response a programme of work has been established with several work streams to reduce delays. Weekly meetings of CCG and GWH are taking place at executive level to resolve barriers to discharge. Weekly operational meetings are taking place to resolve operational barriers with daily discussions on individual patients.</p> <p>Delays due to social care for GWH and SWICC Intermediate care based on days lost were:</p> <p>October 2015: 268 days November 2015: 261 days December 2015: 287 days</p> <p>A target has been set to reduce days lost by 50% by 31.3.2017</p>

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
6	Learning disability We will re-commission services by shifting towards a supportive living model by stimulating the local market and expanding both occupational and educational opportunities. A project team is in place from January 2014.	Learning disability workstream established Enhanced learning disability transition planning implemented	Learning disability research commissioned to determine improved transition planning and reduction in use of residential care Development of community based housing support to reduce use of residential care	Implementation of improved transition process from children to adult services for those with a disability Establishment of action plan to address findings from commissioned research	Re-commission community based support and supported accommodation for people with learning disabilities	Learning disability work stream completed, service transferred to SBC. Five transition link workers recruited. Transition working group to be evaluated
7	Carers Support in place to ensure good assessment and support services are in place	Carers workshop on current provision and planning for care Act completed Steering Group to implement requirements of Care Act established	Development of common assessment process for carers Development of on line carers assessment Increased capacity for carers assessment through work with carers centre	Implementation of carers assessment on-line	Implementation of carers support in relation to Care Act duties Monitor and assess impact of online self assessment for carers	Carer assessment in line with Care Act implemented, additional capacity funded in carers centre, increase in carers' assessments delivered, additional support for carers funded. Carers' self assessment designed, awaiting implementation of IT solution.
8	Capital allocation for social care		Contract for on line self assessment for service users agreed	Capital used to support implementation of care act duties in relation to financial systems	Capital used to support implementation of care act duties in relation to financial systems	Capital programme delivered
9	Implementation of new responsibilities under the		Development and	Implementation of social	Implementation of	Care Act implementation

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
	Care Act 2014 We will be implementing the required systems under the Health & Social Care Bill and prepare systems for an increase in financial assessments and self-assessments. Wherever possible we will be investing in new technology to automate processes as quickly as possible.		implementation of Care Act requirements in relation to carers and assessments Workforce development workshops on personalisation and Care Act Business case for 7 day working in social care agreed and implemented	care self-assessment on-line Development of financial assessment systems in relation to Care Act Workforce development implementation to meet new duties	financial systems in relation to Care Act Continued workforce development in relation to the Care Act	delivered, safeguarding single point of access established in SBC, care Act training delivered, new assessment Care Act compliant. Workforce development delivered.
10 Page 250	Supporting independence and reducing length of stay in hospital Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians	Schemes already fully implemented	Dementia Strategy action plan in place Dementia ward opened in GWH	Continued improvements to patient flow across the health system	Continued improvements to patient flow across the health system	Dementia team established and operational 1.12.2015. Dementia Strategy in place, steering group established, Diagnosis waiting time reduced to 6 weeks.
11	Alternative community based health services preventing hospital admissions Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting	Development and initiation of SUCCESS centres Development of business case for 'Fix Me Hub' Development of ambulatory pathways for the frail elderly	Full operation of the SUCCESS Centre Implementation of personal health budgets GP led initiatives for older people over the age of 75 years with care planning and nurse led services in place	Continued operation of SUCCESS model	Delivery of community based support for older people with long term health conditions including rapid access clinics and live telephone consultations Implementation of schemes to mitigate	SUCCESS centres delivered with increased appointments. 10,047 SUCCESS appointments, 675 of which were home visits in Q3. All practices are now able to book electronic appointments for SUCCESS

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
Page 251		Out of hospital strategy developed			<p>demand for 2016/17 based on data analysis under taken in 2014/15</p> <p>Rapid Assessment Unit - 464 patient contacts in Q3, new pathways operational from October 2015 which increase flows of patients</p>	<p>ALL GP practices able to book electronic appointments</p> <p>Urgent Care Programme Board established with workstreams to reduce hospital admissions, including maximising home based support</p> <p>Front Door model for ED has been reviewed and patients attending with a minor illness are streamed to neighbouring Urgent Care Centre (from Dec 2015)</p> <p>Communications Strategy developed and commenced December 2015 which supports prevention messages and public understanding of alternative services.</p>
	<p>12 Adult social care support for older people and those with a learning disability</p> <p>Increase in care packages due to demographic pressure. Work with residential and nursing providers to increase access to health care within</p>		Data analysis of demand by older people for acute and residential care services and responding action plan	Implement recommendations from research to manage demand for older people services	<p>Extend lifelong health planning to planning for retirement</p> <p>Implement recommendations from research to manage demand for older people services</p>	<p>Service insourced and additional management recruited. Caseload reviewed and reshaped, training delivered. Exception panel continued. Transition to be evaluated Older people work stream established to manage</p>

Ref no.	Scheme	Milestones Q1/2 2014/15	Milestones Q 3/4 2014/15	Milestones Q1/2 2015/16	Milestones Q3/4 2015/16	Progress at March 2016
	homes so that admissions to hospital reduce					demand which increased by 205 in 2015/16

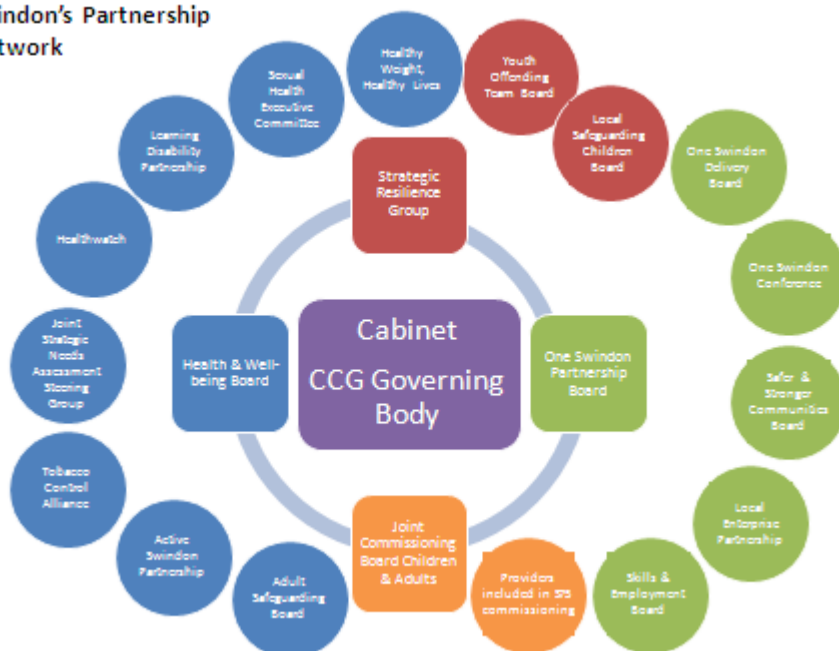
b) Please articulate the overarching governance arrangements for integrated care locally

Swindon has two National Health Services Act 2006 section 75 Agreements for the commissioning of adult health and social care services including mental health and commissioning of health, education and social care services for children. A joint commissioning plan bringing together all our joint priorities as well as a delivery plan is in place. These are reviewed six monthly and renewed annually by the Joint Commissioning Group referred to below.

Governance arrangements to monitor the section 75 Agreements are already in place through the Joint Commissioning Group (JCG). The CCG and Swindon Borough Council, including Public Health are members of the JCG. Meetings of the Group take place monthly. The Group reports through to the Health and Wellbeing Board at every meeting. The Better Care Fund sits as a pooled fund within the Section 75 Agreement and is monitored by the JCG. The existing Section 75 Agreements have been refreshed to take account of the new arrangements.

The Joint Commissioning Group Terms of Reference have been amended to provide a link to the Health & Wellbeing Board who agreed the Better Care Fund. There are also links between the Better Care Fund and the Operational Resilience and Capacity Plan and the Swindon Strategic Systems Resilience Group which is the new whole system network designed to bring together multiple stakeholders from across Swindon and Wiltshire and replaces the Strategic Change Forum.

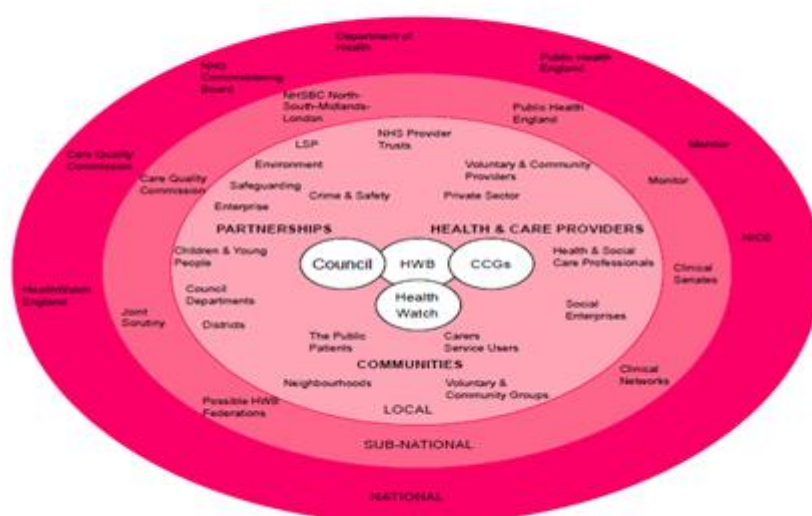
Swindon's Partnership Network



Purposeful partnerships

Partnership	Purpose
Health and Well-being Board	<ol style="list-style-type: none"> 1. Assess the needs of the local population and lead the Joint Strategic Needs Assessment 2. Develop a joint Health and Well-being Strategy based on the Joint Strategic Needs Assessment 3. Promote integration and partnership across areas, including through promoting joined-up commissioning plans across the NHS, social care and public health 4. Support joint commissioning and pooled arrangements where all parties agree this makes sense
One Swindon Partnership Board	<ol style="list-style-type: none"> 1. Develop and work towards the shared long term vision for Swindon 2. Focus resources on achieving the shared medium term outcomes for Swindon 3. Promote effective multi-agency working across Swindon 4. Understand Swindon's people and places and make the strategic changes required to realise the shared vision and outcomes e.g. a community budget

Health & Well-being Board: key relationships



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

Operationally, the delivery of the Better Care Fund Plan is through the CCG Executive Management Team and the Joint Commissioning Group. Joint membership of both groups is in place. Joint reports go to the Joint Commissioning Group as well as progress reports against the Joint Commissioning Plan. A progress report has been submitted to the JCG and the Health and Wellbeing Board in November 2015.

Each of the Better Care Fund schemes is part of either the CCG Interventions or the Adult Demand Programme. Project managers and workstream leads are in place for each scheme. New workstreams were established for Carers development in partnership with the Carers' Centre. This has resulted in a revised Care Act compliant Carers Assessment, a streamlined process for carers' breaks, and carers post within the hospital discharge team.

The delivery of joint community health and social care services is monitored through a monthly contract meeting. There are contractual arrangements in place for escalating performance issues.

GPs are provided with real time information from SEQOL that will inform practices on the activity of the community health service that has been involved in for their patients.

Delivery of workstream targets is reported to the Joint Commissioning Group and CCG executive team. Delivery issues and risks are reported to the relevant Board where remedial actions will be agreed.

d) **List of planned BCF schemes for 2016-17**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme	Governance
1	Integrated Crisis and rapid response Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	SEQOL contract management and reports to the Joint Commissioning Group.
2	Reablement Service and Telecare People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	As above.
3	Enhanced voluntary sector capacity In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts. Mental health wellbeing co-ordinators have been introduced through the commissioning of mental health third and voluntary sector contracts. A website has been developed, http://www.mycaremysupport.co.uk/ , to provide information and advice to the public, staff and voluntary sector partners.	Joint workstream CCG Reports to the Joint Commissioning Group. Vulnerable Adults Programme Board
4	Community and Residential Rehabilitation and Discharge to Assess We are funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital	Vulnerable Adults Programme Board

[illegible]

	<p>information for carers, welfare benefits advice as well as support groups. There is a GP outreach post. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and further investment has been made to deliver the requirements of the Care Act. Development of improved assessment process for carers and improved access to health checks.</p>	
7	<p>Capital Grant Adult Social Care Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare. We will continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.</p>	Joint Commissioning Group
8	<p>Community Health aimed at reducing emergency admissions Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting</p>	CCG Interventions Programme and SEQOL contract management
9	<p>Managing increase in demand for adult social care Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce</p>	Vulnerable Adults Programme Board
10	<p>Implementation of new responsibilities under the Care Act 2014 The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of</p>	Joint Commissioning Group

	<p>the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health & Social Care Bill. We have invested in new technology to allow on line self assessment and information and advice through www.mycaremysupport.co.uk</p>	
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Better Care Fund Plan 2016/17 Action Plan

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
1	Integrated crisis and rapid response Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.	Review use of Discharge to Assess beds alongside Fessey rehabilitation beds to reduce length of stay in Fessey Commission rapid response as part of re-commissioning of community and social care services, publication of process	Implement findings from review to assist with rehabilitation and start re-commissioning process for fessey Commission rapid response as part of re-commissioning of community and social care services	Complete re-commissioning process for rehabilitation at Fessey, crisis and rapid response services Complete commission rapid response as part of re-commissioning of community and social care services	Implement new service model Implement new service model	
2	Reablement Service and Telecare People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital.	Maintain reablement capacity at 29 patients and £28 per hours and include principle in domiciliary care tender	Complete domiciliary care tender	Implement mobilisation of new model for domiciliary care including enabling patients to gain new skills	Implement new contract including enabling patients to gain new skills	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
3	Enhanced voluntary sector capacity Commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts. Mental health wellbeing co-ordinators have been introduced through the commissioning of mental health third and voluntary sector contracts.	Re focus community navigator scheme Shape specification for home from hospital, befriending and reducing isolation contracts Amend specification for mental health in the voluntary sector to include autism and dual diagnosis	Monitor community navigator scheme Tender home from hospital, befriending and reducing isolation services Complete implementation of new specification	Monitor community navigator scheme Complete tender home from hospital, befriending and reducing isolation services and mobilise for new service Monitor implementation of amended mental health specification	Evaluation of community navigator completed and decision made about future service Monitor first quarter performance of new service Monitor performance of amended mental health specification	
4	Community and residential rehabilitation and Discharge to Assess Funding nursing assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. This programme is now established.	Review use of Discharge to Assess beds alongside Fessey rehabilitation beds to reduce length of stay in Fessey	Implement findings from review to assist with rehabilitation and start re-commissioning process for Fessey	Complete recommissioning process for rehabilitation at Fessey, crisis and rapid response services	Implement new model	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
5	<p>Preventing hospital admissions and effective discharge</p> <p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week.</p> <p>Integrated Discharge Team comprising of health and social care is in place. Since November 2013 a Discharge Assessment and Referral Team (DART) has been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. The Virtual Ward will be working closely with the hospital discharge services</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to bridging and D2A at weekend so that there is speedy access to social care packages seven day a week.</p> <p>Implement findings from review of DART/IDT</p> <p>Re-commissioning of community and social care services, publication of process</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Ensure access to bridging and D2A at weekend so that there is speedy access to social care packages seven day a week.</p> <p>Start plan of transferring management of social work to SBC and monitor implementation of DART processes</p> <p>Tender evaluation of re-commissioning of community and social care services</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Bridging principle part of mobilisation of domiciliary care tender</p> <p>Start Transfer social work and social care staff to SBC</p> <p>Complete tender of community health and social care services</p>	<p>Continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible.</p> <p>Bridging principle part of new domiciliary care service</p> <p>Complete Transfer social work and social care staff to SBC</p> <p>Implementation of new models of care following completion of tender</p>	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
Page 263	and the Single Point of Access to both avoid admissions and enable speedy discharge. Virtual Ward, Intermediate Treatment beds (SWICC), Hospital Discharge services and 7 day working for clinicians.					
	<u>Additional Scheme for 2016-17 - Delayed Transfer of Care Programme</u>					
	<p>Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30.9.16, with planned reduction of current numbers by at least 50%.</p> <p>Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges and prevention of admission</p>	<p>Implement delayed discharge programme with fortnightly project team and Programme Board meetings.</p> <p>Implement workstreams from Newton Europe and urgent care Programme</p>	<p>Complete delayed discharge programme with fortnightly project team and Programme Board meetings.</p> <p>Implement workstreams from Newton Europe and urgent care Programme with work streams and monitor performance</p>	<p>Monitor completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust workstreams to maintain performance</p> <p>Implement workstreams from Newton Europe and urgent care Programme with work streams and monitor performance. Adjust programme based on evaluation of performance</p>	<p>Monitor completed delayed discharge programme with monthly project team and Programme Board meetings. Add and adjust workstreams to maintain performance</p> <p>Implement workstreams from Newton Europe and urgent care Programme with work streams and monitor performance. Adjust programme based on evaluation of performance</p>	
6	Carers' Support					
	A joint carers' contract is already in place which was	Monitoring of carers contract and	Monitoring of carers contract and	Monitoring of carers contract and	Monitoring of carers contract and	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
Page 264	tendered in 2012/13. The Carers' Centre provides advice and information for carers, welfare benefits advice as well as support groups. There is a GP outreach post. Young carers' support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and further investment has been made to deliver the requirements of the Care Act. Development of improved assessment process for carers and improved access to health checks.	implementation of new carer post in hospital discharge process Testing of online carer assessment	implementation of new carer post in hospital discharge process Training and start implementation of online carer assessment	implementation of new carer post in hospital discharge process Training and start implementation of online carer assessment	implementation of new carer post in hospital discharge process Training and start implementation of online carer assessment	
	7 Capital Grant adult social care Capital allocations fund the disabled facilities grant scheme which is operated by Swindon Borough Council. It also funds large items of social care equipment required through	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	Continue investment in technology to support self-care and prevention and enable people with a disability to live as independently as possible.	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
	the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare.	possible.				
8	Community Health aimed at reducing emergency admissions Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, nurse home visiting	Evaluation of Rapid response, single point of access and commission as part of community and social care tender Evaluate SUCCESS and rapid response to determine future funding	Complete tender of Rapid response, single point of access and commission as part of community and social care tender Evaluate SUCCESS and rapid response to determine future funding	Complete tender of Rapid response, single point of access and commission as part of community and social care tender Evaluate SUCCESS and rapid response to determine future funding	Mobilisation and implementation of new contract Evaluate SUCCESS and rapid response to determine future funding	
9	Managing increase in demand for adult social care Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	Continue to improve social work decision making on care packages by implementing vulnerable adults programme and demand management	

Ref no.	Scheme	Milestones Quarter 1 2016	Milestones Quarter 2 2016	Milestones Quarter 3 2016	Milestones Quarter 4 2016/17	Progress at June 2016
	access to health care within homes so that admissions to hospital reduce	demand management. Share demand data with HWB Provider Forum				
Page 266	Implementation of new responsibilities under the Care Act 2014 The funding provided within the Better Care Fund has contributed towards the cost of implementing the requirements of the Care Act. These include carers' support, advocacy and safeguarding. We have implemented the required systems under the Health & Social Care Bill. We have invested in new technology to allow on line self assessment and information and advice through www.mycaremysupport.co.uk	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Tender advocacy service , implement online assessment	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Complete tender advocacy service , implement online assessment	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Mobilise for new advocacy service , implement online assessment	Continue to increase adverts and advice and information on My care My Support, mobilise voluntary sector to give advice and support. Monitor new advocacy service , implement online assessment	

5) RISKS AND CONTINGENCY 2016/17

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? <i>Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely</i>	Potential impact <i>Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact</i> <i>And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)</i>	Overall risk factor <i>(likelihood *potential impact)</i>	Mitigating Actions
Risk 1: Demand at a higher rate than population growth assumption of 2.8 - 3.2%	4	5 Not achieving reduction of 3.5% will result in a CCG pressure of £1m. The schemes within BCF are already part of SEQOL block contract. Therefore CCG will allocate funding for over performance for acute health care from 2016/17 allocation (CCG risk).	20	Focus on self-care and prevention through My Care, My Support and Voluntary sector commissioning – Acting Director Adult Social Services by 31 3 2017 A range of health led interventions addressing unplanned admission to hospital outlined in CCG 5 year Sustainable Transformation Plan – Lead Accountable Officer CCG by June 2016
Risk 2: Community based self-care pilots too small to impact on demand	5	4 No financial impact as community navigator for 2016/17 will be funded from national transformation fund. If there is over performance in adult social care (SBC risk) or acute health care (CCG risk) then these will be funded by core budget from SBC and	20	Link of community navigator and mental health wellbeing coordination schemes to maximise impact, Acting Head of Adult Social Services. SUCCESS scheme and nurse led home visiting services funded by CCG core budget. Lead

		CCG core budget outside of BCF respectively		Accountable Officer CCG June 2016
Risk 3 Demand outstrips capacity in reablement services	4	3 £1.7m allocated for demand in older people by SBC for 2016/17.SBC risk	12	Spot purchasing of bridging packages through Better Care Fund allocation from BCF. Re-commissioning of domiciliary care services through prime contractor model Head of Commissioning Children & Adults (start April 16)
Risk 4 Patients continue to go to A&E rather than community alternatives leading to increased hospital admissions	5	4 Not achieving reduction of 3.5% will result in a CCG pressure of £1m. the schemes within BCF are already part of SEQOL block contract. Therefore CCG will allocate funding for over performance for acute health care from 2016/17allocation (CCG risk)	20	Communication strategy, close work between GP practices and community health services. Distribution of information materials, promotion of online advice and information and targeted media using MOSAIC data– April 2016 Associate Director of Commissioning (Out of Hospital)
Risk 5 Political resistance to change	2	5 No measurable financial impact	10	Cross Party Lead Member Advisory Group in place monitoring adult change programme. Good political ownership and multi-agency ownership of vision and strategy through Health & Wellbeing Board and JCG from April 16- Interim (DASS) and Clinical Chair

Risk 6 Cultural change required from staff across public sector	4	4 No measureable financial impact	16	Multi agency workforce development programme across Swindon on managing expectation and managing change through redesign workshops and workforce development. Actions throughout 2016/17 Head of Commissioning Children & Adults
Risk 7 Capacity to drive pace of change under developed	4	4 No measurable financial impact as all schemes have project management allocated already	16	Additional programme management in place for urgent Care and DTOC Programmes from January 2016
Risk 8 NHS Provider viability - Potential risk to small and medium size providers during tendering of services and the potential of service disruption	3	3 Likelihood assessed as remote – no financial risk quantified (CCG risk)	9	Publication of tender for community services and social care as well as domiciliary care in March 2016 following soft market testing and provider engagement in 2015

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

There is a formal risk sharing process in place between the CCG and Great Western Hospital linked to the delivery of QIPP schemes and over performance against the contract. Mitigating schemes continue to be developed to ensure that we are able to

manage the demand for unscheduled care and the Swindon Strategic Resilience Forum will review this on a monthly basis.

Swindon Borough Council agrees to undertake work with those care homes in Swindon that have been identified with the highest hospital admissions based on data to be supplied by Swindon CCG. Further discharge to assess capacity will be secured if patient flow issues are identified by sourcing additional nursing beds in care homes locally.

In developing and quantifying the projected financial and service benefits from the programme of schemes a full PMO process has been followed. Operational risk is managed by the organisation sponsoring the scheme, with an executive officer being accountable for delivery of each scheme. Risk registers are in place for every scheme and are regularly monitored and reviewed both during the formation and implementation phases.

In identifying schemes, and quantifying the potential benefits, a structured approach has been followed and a standard methodology used to risk assess the potential financial benefits and risks. Third party evidence has been used wherever possible to support changes proposed and where lacking, financial benefits have been risk adjusted. For example, activity prices and volume shifts are based on local systems experience and historical data.

Standard tools have been used to ensure that any proposed benefits are probability weighted and projects are treated objectively. Although much of this has been process driven, management judgement has also had to play its part. The expected benefits of schemes are monitored and reported against on a monthly basis so remedial actions can be taken in a timely fashion.

Each partner takes the risk for over performance in the areas as follows:

If targets for admission to residential care are not achieved in 201/17 for adult social care, then the Council's core budget will cover an increase in demand. This is not likely as data analysis has shown that although more people were admitted, the length of stay reduced and therefore there are no adverse financial impact

- Additional £200k has been allocated from the BCF for discharge to assess. Demand over and above this figure will be met by Swindon Borough Council. SBC has committed through the DTOC Programme to reduce delays due to social care by 50% in 2016/17 based on bed days in GWH.
- The CCG has allocated growth funding for GWH from its core budget including additional demand for emergency admissions. The CCG allocation of the better care fund excluding capital is 60% compared to 40% for social care related schemes. Swindon Borough Council agreed to this figure which is less than 50% so that the potential 10% could be aimed at reducing emergency admissions. Swindon Borough Council agrees that if emergency admissions rise over target that the CCG share of BCF of 60% can be used to fund demand for hospital care. If the target of 3.5% reduction in hospital admission is not met, then the CCG will budget for over performance from its allocation as schemes within the BCF form part of the SEQOL block contract.

6) ALIGNMENT

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

This plan links closely to the strategies and plans referenced in Section 1 of this document.

The Urgent Care Programme, the DTOC Programme and CCG Interventions include community navigators, the SUCCESS scheme, Rapid Assessment Unit and Urgent Care Centre. These interventions will contribute to the reduction in emergency admissions to hospital.

As explained elsewhere the Better Care Fund brings together schemes which are part of the SEQOL contract, CCG Interventions and the Vulnerable Adults Programmes. It develops the schemes further to address our joint priorities. These schemes are also aligned with the Swindon Operational Resilience and Capacity Plan.

Personal budgets in social care have been implemented with over 63% of the population in receipt of a personal budget.

Personal Health Budget (PHB)

In conjunction with SBC the CCG has developed a plan for implementing Personal Health Budgets (PHBs). This should support the NHS England objectives of there being between 50,000 and 100,000 people having a PHB in place by 2020/21. Specifically the plan will have milestones for improving patient choice by 2020 using PHBs.

Phase One - (January 2016 to May 2016) is proposed to be used to support the procurement process of a new CHC provider, to develop CCG operating and governance processes and procedures and to ensure the CCG has in place its Local Offer by 1st April 2016. This Phase will also be used to work with SBC in identifying around 20 individuals (adults and/or children) in receipt of CHC/CC who would benefit from a PHB. Support from NHS England will be utilised in assessing the current cost of CHC/CC care packages for these 20 against PHB care packages calculated using an agreed budget tool (e.g. budget the Manchester Decision Support Tool (DST), and in progressing these people onto a PHB. Early indications are that financial efficiencies could be achieved through PHB's whilst outcomes for individuals improve.

This Phase would also be used to commission third party brokerage support (e.g. DHI Swindon) in the full PHB set up with individuals including Direct Payment set up, support planning, budgeting etc. Individuals requesting a PHB during Phase One will be managed through the existing CHC team within SBC.

During this Phase, it is expected that a low number of individuals will be suitable or choose to take up a PHB although the finance resource required to manage these within the CCG will be high. Therefore, and whilst CCG systems and processes are being developed, this Phase proposes that the third party also manages the finance responsibilities associated with each PHB on behalf of the CCG. The CCG shall retain its full responsibility for all decisions relating to the PHB.

To support accelerating PHB implementation, a specialist - currently supporting the

national IPC programme - has been successfully secured from NHS England (South West) at no cost to the CCG. This specialist will provide expert PHB advice and support to both the CCG and individuals identified for a PHB and those who choose to have a PHB. In addition, free support from Enham Trust has been offered in the provision of brokerage support although this is likely to be limited to two or three individuals. For subsequent roll out of the PHBs the CCG will need to procure brokerage support.

Phase Two - It is expected that Phase Two will run concurrently to Phase One from March onwards. In the main, this Phase will incorporate the appointment of a new CHC provider and third party brokerage service. Phase Two will have all CCG operating and governance processes and procedures in place and a plan established that supports PHB rollout. Further expansion beyond individuals in receipt of CHC/CC shall be covered during Phases Two and Three.

It is expected that during Phase Two, the new CHC provider will be managing requests for a PHB and in identifying individuals who would benefit from a PHB. The CCG will continue to oversee progress of PHB implementation and the numbers of individuals requesting and receiving a PHB and in meeting its statutory obligations.

Phase Three - Work is required to understand how expansion of PHBs can be achieved among other health groups (e.g. Learning Disabilities, Mental Health, Long Term Conditions, End of Life) and, in particular, how monies can be released from block contracts and placed into a PHB. Further, understanding of Integrated Personal Commissioning (IPC's) – an approach to joining up health and social care and education for children and capitated payments – is also required. Development around these will be covered in Phase Three.

During all Phases, the CCG will be part of the NHS England (South West) networking membership and will access training and support in regard to all areas of development.

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

This plan builds on the agreed priorities of:

- Health & Wellbeing Strategy
- The 5 year Strategic Plan 2014- 2019 for CCG and the CCG Operational Plan for 2016/17
- Swindon Borough Council Vision, Priorities and Pledges 2015-2030
- The Commissioning Intentions 2015/16, which have been discussed with providers and have been developed jointly with Swindon Borough Council;
- The Joint Commissioning Plan which brings together the priorities for both the CCG and Swindon Borough Council. The priorities of this plan have also been shared and discussed with the voluntary and community sector.

There are no discrepancies between the BCF plan and the CCG 1 and 5 year plans.

They are aligned in terms of their priorities and key deliverables.

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

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The CCG submitted an expression of interest in co-commissioning primary care. The main impact that co-commissioning would have on the BCF schemes is in respect of how primary care is commissioned to ensure that enhanced services are aligned with the priorities of the health and social care community in Swindon.

Schemes are discussed with primary care at Locality Forums, and GPs were involved in the development of services to support patients identified through risk stratification. There are GP representatives in the Urgent Care Working Group and schemes are discussed at the CCGs clinical Leadership Group.

Work on the management of patients at risk of an emergency admission; the role of the accountable GP and the development of care plans can also be considered as part of the co-commissioning work.

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)

Swindon Borough Council uses its core budget allocation and the additional funding of the Better Care Fund to promote integrated working across health and social care. We are joint partners in the National Health Services Act 2006 section 75 Agreements with Swindon Clinical Commissioning Group.

We have an annual Joint Commissioning Plan which sets out our joint priorities and funding of services included in the Section 75 Agreements. The Joint Commissioning Plan's priorities are refreshed in light of the JSNA and the Health & Wellbeing Strategy annually. The Joint Commissioning Plan is reviewed annually and demonstrates the outcomes that have been achieved across health and social care for the benefit of the people of Swindon.

We are defining the protection of adult social care as maintaining eligibility criteria for adult social care in line with the Care Act 2014.

Funding from the Better Care Fund for increase in demand is used to protect adult social care as well as investment in existing schemes. Eligibility criteria are described in detail

on My Care My Support website accessible for carers, patients and service users.

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

Swindon Borough Council is proposing an investment of £1.6m in care packages for older people in its core budget for 2016/17. Savings have been identified against supported housing schemes, transport costs, and efficiencies within the Social Enterprise. Additional funding of £935k has also been provided for Older People residential care and domiciliary care to fund the cost of the increase in the minimum wage and pension implications.

Swindon already has a joint health and social care integrated social enterprise. Funding from the Better Care Fund has been used to increase care packages to meet demographic growth in 2015/16. Specific schemes to protect adult social care are support for carers, crisis support and integrated care, community capacity building and increase in care packages to support hospital discharge. Schemes protecting adult social care account for £4,986 revenue funding including the allocation for the implementation of the Care Act.

An advice and information service has been launched as well as a service directory on line (My Care My Support) to give the public and patients access to up to date information. This is aimed at promoting independence and choice. The voluntary and third sector is commissioned to improve self-help and prevention for carers, those at risk of mental ill health and older people.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services.

We confirm that £4,986k has been allocated for schemes which protect spending in adult social care but also supports effective hospital discharge. In particular, the schemes protect adult social care funding for crisis intervention, 7 day working, effective discharge from hospital, reablement services and telecare. £929,954 has been allocated to meet the growth in demand for older people services in adult social care (Schemes 1, 2, 4, 5, 9). The capital allocation is in addition to this of approximately £930k, so that the total for adult social care is £5.8m

£460k was allocated within the BCF in 2015/16 to contribute to the implementation of the Care Act. This funding is still included within the 16/17 BCF and has now been increased to £468,800 as per the scheme below. This includes Safeguarding Team, Advocacy, Carers' Support and Advice and Information.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Investment by the Local Authority in advice and information web based information and

an Advice and Support Service at Sanford House commissioned from Swindon CAB. An online self-assessment has been developed and is currently being used by staff before being rolled out to the public, including self funders in 2016. Increases in demography in social care have been modelled through the Adult Demand programme and the analysis was published in papers to the Health Overview and Scrutiny Committee in September 2013 and December 2013 www.swindon.gov.uk.

Workstreams were established for the implementation of the Care Act for carers, self-assessment, workforce development and financial planning. This work has been completed and necessary changes in policies and procedures adopted. Additional funding has been allocated for safeguarding duties, advocacy, deferred payment system has been revised as well as increase in workforce development so that care Act duties are met

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

£809,570 has been identified within the BCF to support carers. A contract is already in place to provide community based support. This was based on best practice and developed with carers. A budget for the provision of short term breaks, emergency access to support and emergency card details are in place. A workshop was held with carers to develop the menu of support and ensure the assessment process is developed in partnership. A workstream in relation to carers is in place as part of the Care Act implementation and reports into the Adult Demand programme and CCG Interventions.

The Carers' Centre has GP liaison workers and will be based in the Swindon Advice and Support centre raising awareness amongst the voluntary and third sector of carers needs. Additional scheme to support carers in hospital discharge process and carer support have been developed as part of the carers workstream.

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

In 2016/17 additional funding of £200k has been provided within the BCF to provide for inflation and also some additional funding (£115k) to contribute toward the increase in demand that is being experienced. This is particularly in relation to hospital discharge and more complex social care needs. If funding is not allocated to the schemes agreed then there is likely to be an impact on reablement services, delayed discharge, 7 day working in social care and support to carers and eligibility criteria for social care.

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

The Better Care Fund investment for adult social care is used to fund 7 day working for social care within the hospital discharge teams. Social workers, verification and access to care packages are now in place 7 days a week. Community health services are accessible 7 days a week. 7 day working is also in place for OT and community health services within the hospital discharge team, reablement services and in the intermediate care services (SWICC).

7 day working is also identified as part of a discharge CQUIN with our health providers and is recognised as a key piece of work identified by the ECIST review of GWH and is included in the Operational Resilience and Capacity Plan.

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

We are using the NHS number as primary identifier for correspondence across health and social care services. SEQOL is a joint health and social care provider and the NHS number is used and recorded on the Social Care Information system (SWIFT) and Capita One. SWIFT and Capita One are owned by Swindon Borough Council so that commissioners and providers have access to the NHS number for both children and adults. A project manager has been employed by Swindon Borough Council to lead on system development in relation to social care and supporting information governance work so that the NHS number is used consistently.

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))

We will be adopting Open API and Open Standards as part of the SUCCESS project we have commissioned an interoperability platform that allows communication between different primary care systems, secondary care and social care systems. This is not Open API but is secure provider interface technology which is being developed locally through bespoke software. The Digital Roadmap submitted to NHSE by CCG outlines our detailed work on digitalisation.

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, and professional clinical practice and in particular requirements set out in Caldecott 2.

Information sharing protocols will be in place. Consent will be asked for by SEQOL for all patients and social care service users so that information can be shared. SEQOL, SBC and CCG will all meet relevant information governance requirements.

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

GP will be the lead professional for all patients over the age of 75. Assessing patients according to need continues to be a vital component of our Long Term Conditions (LTC) generic model and key to the delivery of good LTC management. By using a risk prediction approach it is possible to identify those people who are the most regular users of health services (both primary and secondary care) and are at risk of re-admissions to hospital), then stratify them according to complexity of need and commission cost effective interventions to meet those needs. NHS Swindon made an investment in implementing a risk stratification tool in all GP surgeries. GP practices will be involved in identifying opportunities for commissioning interventions that could reduce the risk of a hospital admission. Community matrons prioritise patients with long term conditions for care management in the community which are the top 5% of patients identified by risk stratification

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

All patients with long term conditions and identified as high risk through risk stratification tool will be on the Community Matron caseload. GP LES in place supporting risk stratification.

As part of the GP contract, the GP practices are identifying the accountable GP for the over 75s and those patients identified with complex needs. The risk stratification tool is being used by practices to identify those patients that need a care plan.

The over 75s funding is supporting the roll out of support to patients identified at risk and needing support through their care plan.

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

Risk stratification will identify patients in need of case management supported by community matrons, practice attached community navigators who are supported by a database of available community, voluntary sector and neighbourhood support.

5% of patients identified in risk stratification have a plan in place and all over 75 year olds with long term conditions have a joint care plan.

Care Line provides holistic information for care and refers all requests for service to

SEQOL. Detailed advice and information for service users is in place through My Care, My Support. SEQOL provide joint community health and social care teams and there is a single assessment process already in place with a single SEQOL professional allocated to meet health and care needs.

Workforce development

Having the right staffing numbers, skills and values are fundamental to fulfilling our commitment to provide a safe, compassionate, high quality and responsive urgent and emergency care system. Ensuring this presents challenges though, in particular, national and local shortages of healthcare workers, people are living longer with a range of long term conditions putting greater demands on health services, the shift from hospital centric to community based, person-centred care and the increased focus on the provision of NHS services across the 7 day week. However, these challenges will be factored into the plans to deliver this strategy.

Supporting this strategy, the CCG has established a Workforce Steering Group which will oversee that national policy themes and recommendations relating to workforce are being implemented. The Workforce Steering Group brings together commissioners, education, acute, primary, social and community care. The key areas of work during 2016/17 include:

- Whole system sight of health and social care provider workforce plans and identifying gaps in the current workforce that may impede new ways of working
- Scoping of the Community and Urgent Care workforce model so they are patient-centric, not service-led, ensuring full patient engagement and participation
- Addressing barriers (e.g. employment contracts) to allow the workforce to work flexibly across Swindon geography
- Testing models of an integrated workforce across health organisations
- Designing and profiling the future workforce based on population health needs
- Ensuring sustainable and flexible local workforce planning and access to Continuing Professional Development opportunities in collaboration with our Local Education and Training Board, Health Education England (HEE) and Local Government Association
- Establish the Community Education Provider Network (CEPN) from HEE funding that will bring Primary Care organisations and its workforce together (e.g. GPs, Nurses, Pharmacists) to access multi-professional education and training as well as inter-professional working and learning.

The Workforce Steering Group, reporting to the Systems Resilience Group, shall measure and evaluate workforce planning progress against a number of its objectives to improve recruitment and retention, reduce agency staff, reduced gap between health and care assistant roles and the graduate nurse, joint training across providers

8) 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

Our service users, patients, carers and public have been involved in the run up to, and the complete development of the better care fund plan. We have involved each group in different stages of the above commissioning cycle by:

Across Swindon and Shrivenham, mechanisms are in place for engagement with patients, service users and the public through a number of events, meetings and surveys, examples include:

- The CCG attending Swindon youth partnerships events, which offered the opportunity to hear from those working directly with youth groups, and their experience to date within Swindon.
 - Swindon Borough Council Carer's engagement event Swindon Borough Council convened the second of its Carer's engagement events, which the CCG participated in. Carers and other voluntary groups were updated on work and progress around carers support.
 - Community Navigator patient review and the Community Optometry pathway patient feedback.
 - The CCG's AGM for 2014/15 took place in July 2015. It was well attended by a good cross section of the Swindon population with 40 members of the public and representatives from in and around Swindon. The second part of the meeting was dedicated to seeking the audiences' experiences with community services which kick started a two month engagement exercise looking at the Community Service Provision in Swindon. This was the first of many engagement events for the provision of community services engagement programme.
1. Provision of Community Services Engagement: Swindon Borough Council and the CCG engaged with a range of organisations, the public, patient and carer groups to gain feedback on their experiences of community health and social care services. We were keen to hear from all individuals who have experience of using Swindon Community Services or other local community providers to capture detailed feedback on what works well, and what improvements could be made to services in the future.
 2. The CCG is in the second year of delivering its five year Communications and Engagement Strategy. The strategy is reviewed on a yearly basis to ensure it is still relevant and to report on achieved activities.
 3. GP member practices receive a fortnightly newsletter providing them with information and areas where they need to undertake actions.
 4. The CCG's Governing Body has a lay member for patient and public involvement and this person also chair's the CCG's Patient and Public

Involvement Forum. Representatives from Swindon Borough Council are also members of the Governing Body.

5. Seeking wide representation of local groups and patients to take part in the CCG's Patient and Public Involvement Forum (this is a committee of the CCG's Governing Body), this group provides continual positive challenge and improvement to the way we operate, and engage with our local population. It seeks to assure the Governing Body that the CCG is effectively engaging with a wide range of groups and individuals. The Forum meets on a monthly basis and is looking to hold more of its meetings in different community settings.
6. Working closely with our local GP Patient Participation Groups (PPG), to seek feedback on healthcare in Swindon for primary care users, and their experience of hospital, community and mental health services in Swindon.
7. Working closely with Healthwatch Swindon, to seek feedback on Healthcare in Swindon and jointly taking part in engagement roadshows.
8. Listening to our providers and third sector groups, as a result of this we are seeking to increase the access to services. Examples include working closely with the Carer's Centre in Swindon regarding the rollout of the Better Care Fund and the development of a CQUIN with SEQOL to target the hard to reach populations of Swindon.
9. The CCG produces a monthly Patient and Public Involvement Newsletter which provides the organisation with the opportunity to promote national campaigns such as Be Clear on Cancer and the Shingles vaccination. SCCG also shares local health news and updates from the organisation.
10. The CCG has updated its [website](#) to make it more user friendly and provide increased information on patient and public involvement activities. There is now a facility on the website for the text to be translated into different languages.
11. Gap analysis work is continuing to take place to identify equality and diversity gaps with the population we serve.
12. The CCG has invested in a free post address, this will allow the CCG to receive a greater amount of public feedback, and will also encourage people to take part in our patient surveys when we are carrying out evaluations throughout the year.
13. My Care My Support was developed with service users as well as the development of the advice and information service. Personalisation training has been held with staff. Support to carers was increased through a new contract and additional funding. The carers' assessment was simplified and supported with access to short term breaks.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The main acute provider for Swindon CCG is Great Western Hospitals NHS Foundation Trust (GWH), Swindon commissions circa 60% of their activity.

GWH and the wider health economy has worked closely with the Emergency Care Intensive Support Team (ECIST), Newton Europe and the NHS England review of delayed Discharge to identify the key areas of focus to build resilience into the urgent care system within Swindon.

Scheme	Commencement date	Additional capacity impact	BCF/ORCP/QIPP
Integrated crisis and rapid response	Commenced	No additional capacity impact as modelled into the table above	BCF
Reablement service and telecare			BCF
Enhanced voluntary sector capacity			BCF
Community and residential rehabilitation and Discharge to Assess			BCF
Preventing hospital admissions and effective discharge			BCF
Carers' support			BCF
Capital Grant Adult Social Care			BCF
Community health aimed at reducing emergency admissions			BCF
Community navigator	Pilot in place, roll out additional practices 1/10	Reduction of 200 admissions per month	
Practice over 75's schemes	1 October		
SUCCESS model			

Safer 7 day working bundle		ORCP being reviewed by CCG with new proposals to be published in finalised 1 Year Operational Plan 2016/17	ORCP
7 day front door physiotherapy, OT and social work service (ED)			ORCP
Frail Elderly pathway – include 8 bedded unit, hotline for GPs and therapy services			ORCP
Expansion of SEQOL Urgent Care Centre to stream minors away from ED			ORCP
Pharmacy service to provide drugs to an extended hours IV service			ORCP
Increased hospice at home capacity			ORCP

The impact of schemes will be reviewed on a monthly basis by the Swindon Strategic Resilience Group (executive level group with representation from all partners); where concerns are identified mitigating schemes will be agreed. One area already identified which could be mobilised to support management of any increased demand, is the purchase of further 'discharge to assess' beds, and this has been agreed with Swindon Borough Council. A scheme to work with nursing homes has already been identified and mobilised during 2015/16.

Schemes are supportive to meet the parity of esteem for mental health, community navigator is an example of a scheme that will benefit those with a mental health problem, supporting them to negotiate the system in relation to their physical health issues.

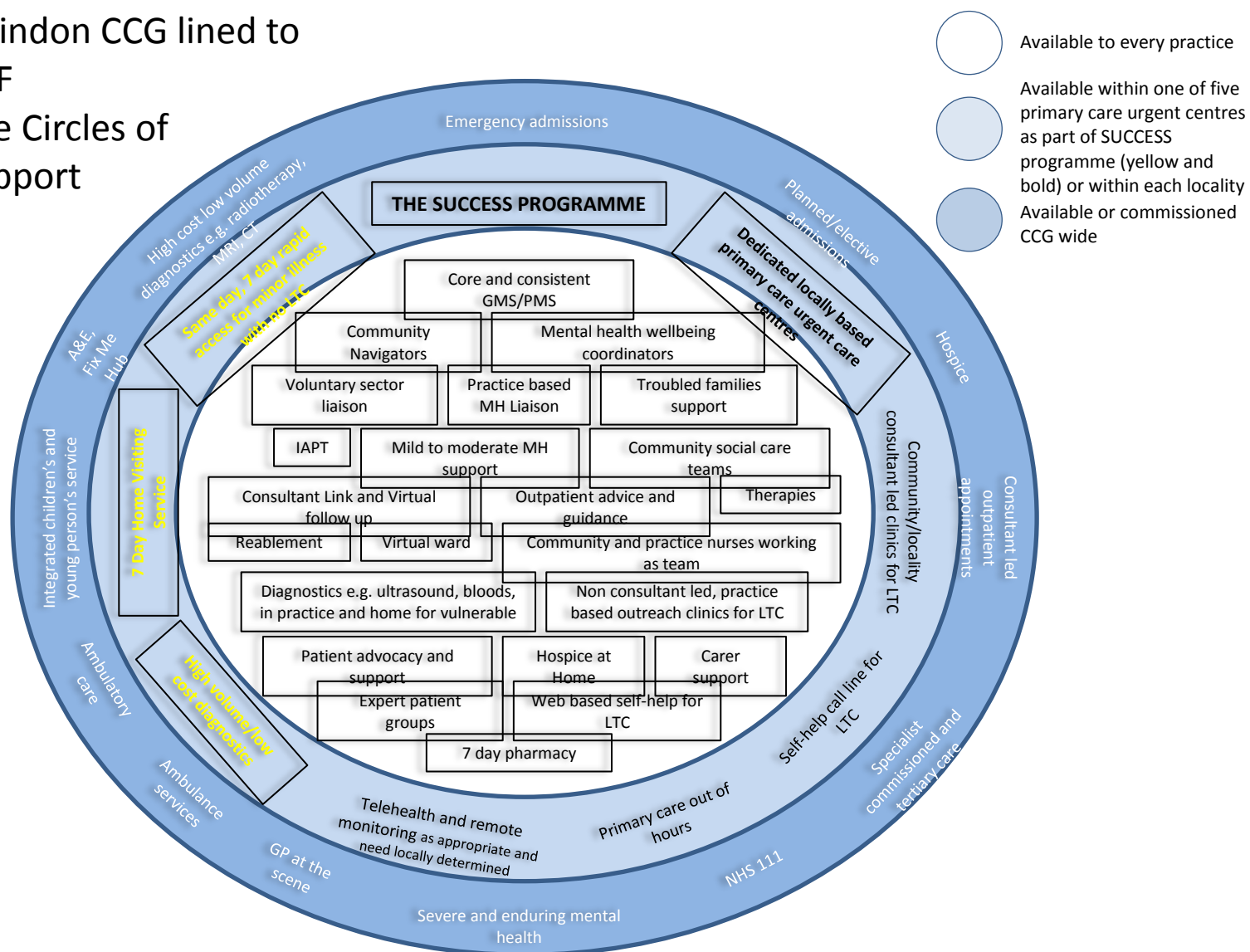
The Better Care Fund is one strand of how system resilience and service redesign will be delivered, this plan is consistent with the Operational Resilience and Capacity Plan and QIPP (as demonstrated in the table above).

Outcome measures at provider level will include

- A contribution towards reduction in hospital admission so that admissions reduce by 3.5%.
- A contribution towards a reduction in admission to residential care to 736.8 per 100,000
- 50% reduction in DTOC delays by 31.3.17
- New elderly care ambulatory pathway in place with a 72 hour length of stay for agreed cohorts
- 4 hour NHS Constitution standard is met

Swindon CCG lined to BCF

The Circles of Support



The diagram above describes all of the initiatives in Swindon across the health and social care system to promote health and wellbeing reduce the reliance on acute hospital services and facilitate hospital discharge. Starting from the outside in dark blue are the Swindon wide commissioned services. In particular the GP at the scene supports the reduction in emergency admission . A GP is based with the ambulance service and treats those patients within primary care and the Virtual ward so that emergency admission is avoided.

The second ring in light blue includes the services provided through the SUCCESS programme. The SUCCESS centre started opening in Moredon in October 2014. GP practices across Swindon can book urgent appointments electronically for patients in the evening and weekends who cannot be seen in primary care thereby further reducing hospital admissions. The service works closely with Scheme 10 and 11 outlined below which are the community health and virtual ward services Scheme 10 and 11 are further supported by the nurse led home visiting services which started in November 2014 and are funded from the over 75 allocation of funding to GP practices.

All services in the inner ring are based around GP practices to promote the health and well-being of the population ranging from preventative services such as promoting well-being coordination to services supporting hospital discharge (scheme5) through Home from hospital.

ANNEX 1 – Detailed Scheme Description for 2016/17

Scheme 1
Scheme name: Integrated Crisis and rapid response
What is the strategic objective of this scheme?
<p><i>Crisis support to prevent admission to hospital and enable those who leave hospital. Access to assessment facility for people discharged from hospital linked to reablement so that length of stay in hospital reduces and people are able to regain their skills as quickly as possible.</i></p> <ul style="list-style-type: none"> • Reduction in emergency admissions by having 24/7 access support to social care at a time of crisis with access to social work support packages • Reduction in admissions to residential and nursing care through access to social work services and packages at a time of crisis and 24/7 • The scheme will fund social care costs and protect social care services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted?

<ul style="list-style-type: none"> • Single point of access to crisis support provided by SEQOL and based at Great Western Hospital. The team is staffed by qualified nurses and social workers as well as health and social care assistants. A telephone triage services directs referrals to the correct professional. Immediate access to assessment, crisis beds, care packages and overnight crisis support. • This service is part of the integrated health and social care services provide by SEQOL • The patients targeted as those with long term health conditions and social care needs who require support immediately to avoid hospital admission or long term nursing and residential care and patients who are at immediate harm without the provision of support
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL with links to Great Western Hospital (GWH)
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Crisis support as part of the Single Point of access is regarded as good practice nationally so that social care service users can be supported as quickly as possible avoiding admission to permanent residential care and hospital. The majority of schemes within this plan are aimed at prevention and promoting integration. However, there remains a group of older people with long term health conditions who require support due to the number of complex health needs they have. As a crisis occurs it is important to have an integrated approach and access community health and social care so that a hospital admission can be avoided Audit Commission <i>Older people – independence and well-being</i> , 2012
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £1,181,105
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
<u>2016/17 benefits</u> <ul style="list-style-type: none"> • A contribution towards reduction in hospital admission so that admissions reduce by 3.5%. • A contribution towards a reduction in admission to residential care to 736.8 per 100,000
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum
Quarterly report to Joint Commissioning Group

What are the key success factors for implementation of this scheme?

Existing scheme funded from NHS Transfer to LA
Contribution 580 admission and readmission reduction in hospitals and admission avoidance of residential care.

Scheme 2

Scheme name: Reablement Service and Telecare

What is the strategic objective of this scheme?

- Reduction in admissions to residential and nursing care through access to reablement services
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates through reablement and access to telehealth and tele care
- The scheme will fund social care costs and protect social care services

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

People will regain skills as quickly as possible without the need for on-going support. This will be provided from an integrated service including OT and therapists with direct referrals from the Hospital Discharge team to enable speedy discharge from hospital

- Our reablement service has two elements, a domiciliary service and a residential placement service, both are commissioned and provided through Seqol, who provide a reablement domiciliary care service in peoples own homes to help people regain skills lost through injury or illness.
- Single integrated reablement service staffed by OT, health and domiciliary care workers. The service is located at GWH close to SWICC (Intermediate Care Centre – step up, step down). Additional funding means that the service now operates 7 days a week and has additional staffing for winter pressure.
- The service is targeted at patients discharged from hospital to home where a package of support is likely to reduce the need for long term care and residential

care
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, Provider: SEQOL with links to Great Western Hospital (GWH)
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>Reablement services have been successful in reducing the need for long term care packages by enabling individuals to regain their skills.</p> <p><u>Domiciliary Reablement</u> From April to the end of December 2015, a total of 180 social care clients have received an episode of domiciliary reablement, helping them to build their own capabilities and helping them maintain independence. Of the clients who received reablement domiciliary care above, 80 accessed it following a hospital discharge, 88 came via a community/ other route and 10 were a diversion from hospital and 2 are not recorded. Of those 180 people, 150 were over the age of 75.</p> <p>At the end of March 2015, there were 186 patients on telehealth with over 56,000 monitored non-face to face contacts.</p> <p>This shows this prevention service is achieving the right outcomes in helping them maintain their own independence for as long as possible. There is a large body of research evidence supporting this approach Audit Commission, <i>Assistive Technology: independence and well-being</i>, 2004; Elkan R et al <i>Effectiveness of Home Based Support for Older People</i>, BMJ 2001; SCIE <i>At a Glance 52: Reablement</i>, March 2012</p>
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £706,961
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Existing scheme funded from £545k NHS Transfer to LA, £162k CCG Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support. Contribution to the figures quoted in particular readmission reduction with 330 people

supported and 130 people through telehealth, discharge to assess beds of 19 in scheme 4. Creating better patient flow without necessarily resulting in a financial benefit

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum
Quarterly report to Joint Commissioning Group

What are the key success factors for implementation of this scheme?

Measure/Metrics 2016/17:

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

Actual 2014/16: 88.9%

Forecast 2015/16: 92.9%

Planned 16/17: 92.9%

Existing scheme funded from £545k NHS Transfer to LA, £162k CCG
Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support.
Contribution to the figures quoted in particular readmission reduction with 330 people supported and 130 people through telehealth, discharge to assess beds of 19 in scheme Creating better patient flow without necessarily resulting in a financial benefit.

Scheme 3

Scheme name: Enhanced Voluntary Sector Capacity

What is the strategic objective of this scheme?

- Supporting people to lead independent and healthy lives for longer by reducing social isolation and providing community based support.
- Reduction in emergency hospital admission through access to community based support in the third sector such as befriending, time banks and community navigator support
- Improving quality of life for the population and users of social care and health services

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Commission voluntary sector and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local contracts.

Mental Health wellbeing coordinators have been introduced through the commissioning of mental health voluntary and third sector contracts.

- All voluntary sector contracts across the CCG and Swindon Borough Council are joint for mental health and vulnerable adults.
- The model of care is community based support through the third and voluntary sector promoting health and well-being, mental health, support for people with a learning disability, befriending and reducing social isolation. In particular we will commission voluntary and community based support linked to localities and GP practices. Supporting volunteers reduces the need for some targeted and specialist services. Community and voluntary sector groups provide important flexible services either informally or as part of local strategy. Voluntary sector organisation providing advice and support, promoting mental well-being, advocacy, support for carers and support planning for those with a direct payment are co-located in the centre of Swindon. This also gives the opportunity for health checks in addition to advice and information
- All services are aligned to the CCG Strategic Plan and the Adult Demand Strategy.
- The role of the community navigator will be to coordinate a holistic plan for patients at high risk of hospital admission. Referrals will be made by GPs based on high risk patients including those over the age of 75 identified from risk stratification tool. The community navigator makes contact with the patient and agreed a joint plan. A plan is put in place with the support from various sectors and agencies to deliver this package of assistance.
- To support the above, the second strand of the project and meeting the Care Act requirements, is the development of a single database www.mycaremysupport.co.uk that can be accessed by the patient and the link worker in assembling the package of support.
- Targeted support is commissioned from the council's Locality team to pilot Circles of support for older people and carers in order to reduce social isolation. A dedicated befriending service will be commissioned in 2015
- The cohort of service users targeted by the provision of community based support are taken from risk stratification and an analysis of adult social care customer cohorts using household level data from MOSAIC
 - Older people over the age of 75 with long term health needs
 - People suffering from mental ill health
 - People with a learning disability needing support in finding training and employment
 - Older people at risk of social isolation

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council, CCG Provider: Voluntary and third sector
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>There is extensive evidence from Think Personal Act Locally as well as Joseph Rowntree Foundation that investing in community capacity and self-help increases the resilience of individuals to improve their health, JFR <i>Commissioning Care and Support for Older People</i>, July 2013; RSA 2020 Public Services Hub <i>The New Social Care Strength Based Approaches</i>, May 2013 Swindon is building on evidence from NE London on community navigators and has included this in the development of well-being co-ordinators in the recent tender of community mental health services provided by the third sector. Circles of support is funded by NESTA to develop community resilience and capacity through supporting older people on low care packages, RSA 2020 Public Services Hub <i>The New Social Care Strength Based Approaches</i>, May 2013 ; NIHR <i>Research Findings : Older people's prevention services: 2013</i></p> <p>A local evaluation of community navigators found that There was an overall reduction of the costs to health care for those older people included in the scheme based on a three months follow up leading to an £80,000 for 4 community navigators in the first year.</p>
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £ 1.003,800 BCF with an additional £1.411,700 from Swindon Borough Council core budget added to the BCF
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
<p>2015/16 benefits</p> <p>123 admissions avoided leading to a saving of £226,000 through primary care self help, nurse led home visiting. This is supported by Community Navigator each supporting 16 patients at any one time and 60 for each navigator per annum , leading to 240 patients in 2014/15. In 2015/16 a minimum of 240 patients will be supported.</p> <p>100 older people supported through Circles of Support in 2014/15 and 2015/16.</p> <p>Befriending service not yet established, so no baseline or anticipated number of beneficiaries as this would be agreed through tender.</p>

All community support services making a contribution to improving quality of life for individuals ASCOF 1A to reach 18.7 in 2015/16.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly joint contract performance meeting with voluntary and third sector,
escalation of issues to Strategic Resilience Forum
Quarterly report to Joint Commissioning Group

What are the key success factors for implementation of this scheme?

Existing scheme funded from CCG and LA budgets. Good networks of voluntary sector provision will be key to success as well as co-location of the sector
Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support.

Scheme 4

Scheme name: Community and Residential Rehabilitation and Discharge to Assess

What is the strategic objective of this scheme?

- Reduction in admissions to residential and nursing care through access to residential reablement services
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates by using residential and nursing home beds as part of 'discharge to assess' models of care

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Fund nursing and assessment beds with enhanced health care so that patients can be discharged from hospital more quickly. This programme is now established.

- This is the residential and discharge to assess part of our reablement service, provided through Seqol, who provide a reablement domiciliary care service in people's own homes to help people regain skills lost through injury or illness.
- The service is targeted at patients discharged from hospital to assessment beds. It offers temporary placements to support those in need of a slower more

<p>intensive episode of support. This element of reablement has only been in place since the beginning of the 2014 and now has 19 beds. Additional beds are accessed in the private nursing sector during winter pressures</p> <ul style="list-style-type: none"> The service is targeted where a package of support is likely to reduce the need for long term care and residential care and a medical discharge is agreed but further assessment in the community is required to establish the correct nature of the on-going support package.
<p>The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioner: Swindon Borough Council, Provider: SEQOL</p>
<p>The evidence base Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>Reablement services have been successful in reducing the need for long term care packages by enabling individuals to regain their skills.</p> <p>The residential reablement service was new in 2014 and supported 37 people in total to regain their independence. 89% of people were aged 75 or over, and again the majority (26 people) had no mainstream services prior to their episode of reablement, and of those, 22 (59.5%) needed no mainstream service following.</p> <p>From April to end of December 2015, there were 66 people who completed an episode of residential reablement equating to a total of 3,533 days of reablement. Of those people, 48 received residential reablement following a hospital discharge, 8 came via a community/other route, and 4 were a diversion from hospital and 6 were not recorded. 61 out of the 65 were over the age of 75.</p> <p>Discharge to assess and intermediate care schemes are now seen as a key element of good patient flow. The Audit Commission found that 9% of older patients in hospital who are fit to leave hospital remain in acute care; <i>SCIE Research briefing 12: Involving individual older people in the discharge process from acute to community care</i>, February 2005.</p>
<p>Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £550,805</p>
<p>Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below</p>
<p>A contribution to a reduction in hospital admission by 3.5 % focusing on reducing re-</p>

<p>admissions through improved discharge to assess process A contribution to a reduction in delayed discharge by 1.2% using discharge to assess beds to improve patient flow</p> <p>There will be 19 discharge to assess beds throughout the year funded from BCF with the aim of rehabilitation and avoiding adult social care spent on residential care. The length of stay will vary depending on nature of complexity. In 2013/14 the length of stay was 19 days.</p>
<p>Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>
<p>Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Group</p>
<p>What are the key success factors for implementation of this scheme?</p>
<p>Existing scheme funded from £551k NHS Transfer to LA.</p> <p>Admission and readmission avoidance 240 patients supported by community navigators in 2015/16 and 100 older people through volunteering support.</p> <p>Contribution to the figures quoted in particular readmission reduction with 330 people supported and 130 people through tele health, discharge to assess beds of 19 in scheme 4 Creating better patient flow without necessarily resulting in a financial benefit. Benefit is cost avoidance rather than cashable savings.</p>

Scheme 5

Scheme name: Preventing hospital admission and effective discharge

What is the strategic objective of this scheme?

- Reduction in admissions to residential and nursing care through 7 day working in social care and community health services
- Reduction in delayed discharge and thereby improving patient flow and reducing re-admission rates by accessing care packages for older people and protecting adult social care spent

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- We will continue to fund seven day social work, nursing and OT capacity to enable patients to be discharged as quickly as possible. We will ensure access to brokerage and verification services so that there is speedy access to social care packages seven day a week. Integrated discharge team comprising of health and social care is in place. Since September 2013 a Discharge Assessment and Referral Team (DART) has also been in place to avoid admission and discharge as early as possible. Both services operate 7 days a week and work closely with hospital clinicians. We will be reviewing home from hospital support so that any delay is avoided and a community support package is in place. The Virtual ward will be working closely with the hospital discharge services and the Single Point of access to both avoid admissions and enable speedy discharge. Additional funding for care packages will be available to enable speedier discharge. Adult social care will be working 7 days a week as part of the Integrated Hospital discharge team and DART.
- The target group are patients with social care needs who require a care package. The majority of these are older people over the age of 75

Data for 2015/16 (at February 2016)

Adults admitted into permanent residential or nursing care per 100K population: 6 younger adult admissions, 1 person with physical disabilities, 1 person with learning disabilities and 4 younger adults with mental health issues. This is 7 fewer than in 2014/15.

Adults admitted into permanent residential or nursing care per 100K population: It is recognised that the admissions indicators are joint indicators with commissioning and both providers to ensure the strategies are in place and working to support only necessary and appropriate admissions. In 2014/15, there was a total of 169 admissions, 147 older people, 20 older people with mental health needs and 2 with a learning disability. This is an increase of 17 people up on the same period in the previous year.

[Further information on Additional Scheme for 2016-17 - Delayed Transfer of Care Programme](#)

Progress and data July 2015 – December 2015

Aim: Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30.10.16, with planned reduction of current numbers by at least 50% of days lost by Quarter 3 and Quarter 4 2016/17

Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges.

Background Data:

Delays due to social care and health for GWH and SWICC Intermediate Care based on days lost were:

July 2015 – December 2015 monthly average : 537 days (226 days NHS and 311

days Social care)

Objectives

NHS England undertook an Enquiry regarding Delayed Transfers of Care in Swindon in December 2014 following high levels of delays at Great Western Hospital for health and social care. Commissioners and Providers are committed to ensuring that the NHS England Enquiry findings are considered in line with the detailed work undertaken with Newton Europe which has provided a comprehensive analysis of performance and detailed evidence base of issues around Delayed Transfers of Care in Swindon.

Delayed Transfers of Care have continued to be high for social care until December 2015. The main reasons are completion of assessment, awaiting domiciliary care and residential and nursing care.

Data on Delayed Transfers of Care is shared and validated weekly between SEQOL, GWH and Swindon Borough Council. The data is taken from GWH delays, Swindon Intermediate Care Centre (SWICC) and in patients at Avon and Wiltshire Mental Health Trust. All data is then reconciled monthly before being submitted to NHS England. Each patient is recorded individually with the reasons for delay and the number of days.

In summer additional domiciliary bridging services and pilot nursing beds were commissioned to help support the discharge process and reduce delays. Locally Swindon has increased provision of domiciliary care by 1,500 hours per week, a 20% increase.

The Better Care Fund Scheme has funded part of the increase in capacity but Swindon Borough Council also made additional investment available of £1.6m into older people care packages

DTOC Programme

In order to achieve a sustainable reduction in delayed discharges and following the visit by NHS England which focused on the Swindon delays rather than Wiltshire, a DTOC Programme was established in January 2016, and is a joint programme between Swindon Borough Council, Swindon CCG, Great Western Hospital and SEQOL. Wiltshire are invited to the DTOC Programme as some service overlap. The programme focus on Great Western Hospital because this is where the highest levels of delays were identified in the summer and autumn 2015.

The DTOC Programme focuses on the short and medium term challenges of delayed transfers of care. Short term is defined as the next 3-5 months, and medium term 9 months. The work and its outputs provide the platform for the implementation of the recommendations that form the NHS England investigation into delayed transfers of care in Swindon and Newton Europe's system wide diagnostic work on Delayed Transfers of Care.

The DTOC Programme will improve system alignment, overall governance, structures and processes, and in doing so, ensure a sustainable reduction in delayed

transfers of care.

The Programme Board for the DTOC programme reports to the System Resilience Group (SRG) who use the data and information to support wider health and care work across Swindon. The accountability for strategic planning is with the SRG.

The DTOC Programme has 7 workstreams:

- Domiciliary Care Provision – to commission a new domiciliary care and community support service based on an outcomes model
- Delayed Discharge Out of Area – to reduce delays for discharge of patients who are the responsibility of other CCGs, agreeing a protocol and escalation processes
- Communication, Choice and Training – to ensure that all staff and managers across the system understand the discharge process, routes of escalation, roles and responsibilities, and menu of discharge options.
- Review of DART and IDT Team – to review the DART process so that there is clarity over roles and responsibilities and delays are minimised
- Reablement – to agree the shape of reablement service and a lower unit cost and thereby increase capacity, and to agree prioritisation of patients to ensure speedy discharge
- Discharge to Assess/Community Beds – ensure there is clarity over criteria and process for all bed based provision in the community so there is patient flow, and that a commissioning strategy is in place for community bed based provision
- Care Homes – to prevent avoidable admission to hospital from care homes and ensure speedy discharge at the earliest opportunity.

DTOC Programme Progress Report at April 2016

As outlined above the delayed discharges were high in Quarter 1 – 3 2015/16. It has been challenging to analyse trends as data has fluctuated significantly month on month. For example, the lowest month in 2015 was April 2015 with 479 days whilst December 2015 was the highest number.

Since the establishment of the Programme Board in January 2016, the data shows that despite winter and high demands for non elective admissions, delayed discharges have reduced month on month in relation to Great Western hospital and SWICC due to active management by commissioners and providers of individual patients

In quarter 4 2015/16 delayed discharges for GWH and SWICC were as follows:

January 2016: 416 days
 February 2016: 257 days
 March 2016: 252 days

NHS England also measures the percentage of days lost at GWH across the system. The delayed Discharge Programme has also impacted on this data, particularly for Swindon as the table below demonstrates and percentage increases for Wiltshire and other areas which are outside of the remit of the BCF Plan. However overall the data for GWH is shows a downward trajectory :

<i>Patients at Thursday Daily DToC Snapshot</i>	7-Jan	14-Jan	21-Jan	28-Jan	4-Feb	11-Feb	18-Feb	25-Feb
Swindon	11	17	11	18	15	6	6	6
Wiltshire	5	5	15	9	8	12	11	11
Other	8	11	7	4	5	7	6	6
ALL	24	33	33	31	28	25	23	23
Acute beds occupied	468	467	465	470	454	458	447	447
% DTOC ALL	5.1%	7.1%	7.1%	6.6%	6.2%	5.5%	5.1%	5.1%
% DTOC Swindon	2.4%	3.6%	2.4%	3.8%	3.3%	1.3%	1.3%	1.3%
% DTOC Wilts	1.1%	1.1%	3.2%	1.9%	1.8%	2.6%	2.5%	2.5%
% DTOC Other	1.7%	2.4%	1.5%	0.9%	1.1%	1.5%	1.3%	1.3%

<i>Patients at Thursday Daily DToC Snapshot</i>	3-Mar	10-Mar	17-Mar	24-Mar	31-Mar
Swindon	10	10	6	5	7
Wiltshire	13	7	11	18	5
Other	7	4	13	13	9
ALL	30	21	30	36	21
Acute beds occupied on snapshot date	471	467	464	471	452
% DTOC ALL	6.4%	4.5%	6.5%	7.6%	4.6%
% DTOC Swindon	2.1%	2.1%	1.3%	1.1%	1.5%
% DTOC Wilts	2.8%	1.5%	2.4%	3.8%	1.1%
% DTOC Other	1.5%	0.9%	2.8%	2.8%	2.0%

The published data for delayed discharges nationally is adversely affected by mental health delays submitted by AWP without verification by the local authority.

October 2015: 195 days
 November 2015: 153 days
 December 2015: 173 days

Discussions have taken place with AWP and an agreed discharge monitoring system has been put in place.

Target 2016/17 BCF

Target setting for the Better Care Fund has to be seen in the context of the DTOC Programme.

The Better Care Fund Plan sets a DTOC target for health and social care including mental health.

The target for 2016/17 is 5,100 bed days including mental health and 4,000 without mental health. The target for quarter 1 and quarter 2 2016/17 have been set linked to the reduction in delays for GWH (Appendix 2). A detailed monthly trajectory has been produced which links the BCF target to the DTOC Programme target and the GWH high risk monitoring and target. This means that appendix 2 models a monthly trajectory of all three targets:

- BCF target (target 3)
- DTOC programme target based on days delayed by reason (target 1)
- NHSE target of reducing delays at GWH to 3% (target 2)

The BCF (target 3) quarterly target is

Q1: 983.9 (1,700)

Q2: 787 (1,360)

Q3: 636.7 (1,100)

Q4: 572.2 (1000)

The DTOC Programme (target 1) as agreed with NHS England, is only based on delays for Health and Social Care in relation to GWH and Swindon Intermediate Care (SWICC). This means that the actual days are reduced to (see appendix 2) :

Q1: 1370

Q2: 1047

Q3: 826

Q4: 788

The aim is to flat line delayed discharges based on days to 266 days per month across Health and Social Care by end of October 2016 and to maintain this for winter 2016/17. The current data for quarter 4 outlined on the previous page demonstrates that this is realistic given current performance during winter and high demand for emergency care. Given the fluctuations in data due to small numbers, partners in Swindon have decided on an average percentage reduction in delays rather than trying to model a fluctuating picture which is unlikely to be accurate.

In addition the DTOC Programme will contribute to reducing the total percentage of days lost at GWH to 3% (target 2) recognising that Swindon used 60% of the beds leading to a rate of no more than 1.8% average for the month for Swindon.

The data in the table 86 shows that Swindon delays are reducing and that the swindon contribution to the 3% is achievable. There is a challenge for Wiltshire and other neighbouring CCGs to support this target with detailed plans for Wiltshire. We

would expect these to be reported to the SRG as the systems leadership group and within the Wiltshire BCF.

The following outline below shows the achievement of the DTOC programme in Quarter 4 2015/16

Workstream 1: Re-commissioning of domiciliary care

The tender will be published in April 2016. The due date for the completion of the tender is October 2016. This date was reviewed in line with legal advice. Clarification questions can be asked as part of process.

The model of Home First has been agreed with SEQOL and in consultation with Wiltshire, and consultation with existing providers has been completed.

Swindon CCG has agreed additional funding for adult social care as part of the Better Care Fund to enable investment into care packages.

Workstream 2: DTOC Out of Area

Meetings have been held with Berkshire and Oxfordshire CCG and Wiltshire CCG are actioning a meeting and liaison with Gloucestershire CCG. There is an agreement for clear points of escalation and increased attendance with GWH site management SILVER calls weekly to progress any blockages. The site team report the OOA repatriations and they have improved as a result and we are awaiting figures on this from the site team.

Workstream 3: Communication, Choice and Training

Key outcomes include implementation of a 'Choice' policy resulting in a reduction of delays due to choice by 50%, resolving issues identified by staff and having a documented resolution in place, ensuring there is consistent response to issues escalated and putting in place an agreed and signed off discharge protocol. An agreed discharge protocol has been signed off by GWH and SEQOL. An agreement has been reached on how a 'choice' policy will be disseminated to staff alongside a communication plan.

An integrated DTOC Governance Group has been established at GWH including representatives from DART, OT, Physiotherapy and Ward Matron to drive forward interdisciplinary communication and discharge planning and to monitor progress against agreed targets.

Daily DTOC reports and escalation process in place. This process needs to embed.

Daily coding agreed from 2nd week February, fully operation March 16. GWH, Seqol and SBC have set up a weekly oversight management group to ensure DTOC reporting process is embedded and operating.

Medway information system to provide baseline performance report on discharge timescales and DART referrals. Further work on Choice Policy and CHC process

identified.

GWH has created a new page on the Intranet to support the DTOC programme and to provide staff with resources and information to support patient flow and discharge: [http://gwh-intranet/unscheduled-care/patient-flow-and-discharge/delayed-transfers-of-care-\(dtoc\)-programme.aspx](http://gwh-intranet/unscheduled-care/patient-flow-and-discharge/delayed-transfers-of-care-(dtoc)-programme.aspx)

GWH DTOC Governance Group has identified need for further clarification on CHC and so a new action has been added. Confirmed list of F-Codes which are now on Medway to provide comprehensive feedback on reasons for delays. Lorraine Austen (LA) confirmed a meeting is scheduled for Tuesday 19th April. GWH website is being used to communicate changes and will include the monthly newsletter. GM will send the flow chart on CHC funding and decision making plan to LA. Will also be looking at putting on data around medically fit for discharge to actual day of discharge; the aim is to get the 'green to go number' down.

Workstream 4: Review of DART and IDT team and process

This workstream has incorporated a review of the social work function within DART to ensure patients are discharged home where possible. DART Review confirmed that DART would return to the original model. This will take to week of 25 April 2016. DART process will now remove the timescales of triage within 24 hours. Discussions have taken place between SW, HM and RR about taking out inbuilt delays – agreed that complex cases to go direct to social worker. SW confirmed that if someone is going back home to the same place with the same package of care, there is no need for an assessment to be carried out.

Action Plan being developed in response to DART review by Seqol. This will be circulated w/c 11.4.16

Rapid Response now has access to Bridging Services so that admissions can be avoided. Seqol also has a community nurse in the front door team and this will be reviewed.

Work to be done around DART and non-acute health delays. There are also delays around community services. Some work to be done in GWH to understand the referral pathway from the Seqol community position in order to aid social worker perspective.

GWH has made some internal changes to support patient flow. Now want to look at how patient flow and DART work together. There is a piece of work to be done on non-acute Health patients around clarification of discharge from the ward, through DART, and to the final destination. Alison Koster has been nominated from GWH, Louise Tapper as Health Commissioner and Jill Kick from DART.

Workstream 5: Reablement Reshaping

Progress included within Domiciliary Care specification, and workstream closed. Paper based audit of reablement undertaken and findings raised at Commissioner /

Provider meeting 2.3.16. Further work now required on how Seqol submit information.

Additional reablement hours now available through restructure but additional work still required to fully utilise funding.

Workstream 6: Discharge to assess beds, residential reablement and SWICC

- Plan to decrease number of private D2A further and link with closure of Florence House
- Discussions with Seqol to increase D2A provision in Fessey House and Fessey to become the only D2A provision. 2 delirium beds now available in Whitbourne.
- Contact and brokerage officers assigned to review usage of D2A service with a view to increase usage of Fessey and consolidate private sector beds to providers able to support discharge 7 days a week.
- Further workstream developed for further collaborative working between hospital social work, reablement, Bridging and D2A in the nursing sector.

Workstream 7: Care Homes

- March 2016 - Meeting with CCG Community Contract Lead, SEQOL continence nurse, GWH Urgent Care Matron and GWH Programme Director for Community Integration for advice around continence products as GWH do not have continence nurse specialty. Pathway will be for all new continence patients who are referred to SEQOL continence service as part of the patient's discharge arrangements.
- Seqol Continence service reviewing referral source from Care Homes, including whether patient went home via GWH to Care Home and then referred to the service. Review meeting mid-April.
- March 2016 - Identified Care Home issues, and action plan developed and discussed with Programme Board. New (reminder) generic pathway to access specialist nurses to be developed by 22nd April.
- March 2016 - IV pathway / training for Nursing Homes who want to pilot giving IV fluids or IV antibiotics in development. Specialist Nurse Lead (Jo Boyd) has started discussions with community nurses re communication flyer and access to Seqol services. Jo to update Louise Tapper 18.4.16. This will be shared with Wiltshire to ensure consistency.
- Seqol to confirm number of people in Nursing/Care homes with a Community Matron care plan.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

DTOC Project Team for delivery of each of the 7 workstream packages to an agreed set of deliverables and timetables. Each workstream has a nominated lead who is responsible for delivery of the work.

Reporting to: DTOC Programme Board with representatives from Swindon Borough Council, Swindon CCG, Wiltshire Council and CCG, Great Western Hospital NHS Trust, SEQOL who will oversee the changes to systems and services to deliver a sustainable reduction in delayed transfers of care.

Reporting to: System Resilience Group

Commissioner: Swindon Borough Council,
Provider: SEQOL

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Integrated hospital discharge is regarded as good practice. The team is located within GWH and is implementing the relevant findings from the recent ESIS review in 2014. ESIS review of Great Western Hospital was positive about the impact of the DART team in improving patient flow and reducing admissions to hospital. Adult social care commissioning works closely with the teams to ensure that there is no delay in accessing adult social care packages. Research has shown that many older people in hospital have multiple health issues and that the length of stay is directly related to the age and complexity of health and care needs Cornwell et al *Continuity of care for older hospital patients, a call for action*, Kings Fund March 2012. Integrated discharge planning within hospitals has been identified as good practice in order to prevent hospital re-admissions, for example Kings Fund *Continuity of care for older hospital patients, a call for action*, March 2012 ;

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£4.109,559

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits 2016/17

A contribution to a reduction in hospital re-admission to 3.5%

A contribution to a reduction in admission to residential care to 736 per 100,000

The model cost for a care package for an older person is approx. £7,500 per annum, which means this scheme is able to support an additional 77 older people in 2015/16.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?
<p>Monthly joint contract performance meeting with SEQOL and CCG, escalation of issues to Strategic Resilience Forum</p> <p>Quarterly report to Joint Commissioning Group</p>
What are the key success factors for implementation of this scheme?
<p>Targets: Delayed Transfers of Care per 100,000 population aged 18+ 2016/17 (BCF target 3)</p> <p>Q1: 983.9 (1,700)</p> <p>Q2: 787 (1,360)</p> <p>Q3: 636.7 (1,100)</p> <p>Q4: 572.2 (1000)</p> <p>This includes Mental Health and Community Health Services. The DTOC Programme as agreed with NHS England, is only based on delays for Health and Social Care in relation to GWH and Swindon Intermediate Care (SWICC). This means that the actual days are reduced to (BCF target 1):</p> <p>Q1: 1370</p> <p>Q2: 1047</p> <p>Q3: 826</p> <p>Q4: 788</p> <p>50% in social care DTOC by 31.3.17</p> <p>50% in delays by 31.3.17</p>

Scheme 6
Scheme name: Carer Support
What is the strategic objective of this scheme?
<ul style="list-style-type: none"> Supporting carers so that their quality of life improves and they enjoy their caring role Carers feeling supported and are able to maintain their own health
<p>Overview of the scheme</p> <p>Please provide a brief description of what you are proposing to do including:</p> <ul style="list-style-type: none"> What is the model of care and support? Which patient cohorts are being targeted?
<ul style="list-style-type: none"> A joint Carers' contract is already in place which was tendered in 2012/13. The Carers' Centre provides advice and information for carers, welfare benefits

<p>advice as well as support groups. Young carers support is provided by the same voluntary organisation and was part of the same tender. Outcomes for carers continue to improve. Additional investment was made available in April 2012 for short term breaks for carers and the investment has been maintained.</p> <p>Development of improved assessment process for carers and improved access to health checks. The Carers' Centre has a number of full time, part time and volunteer staff. There is now a GP liaison service and carers champions in GP surgeries. As part of the BCF we want to improve the number of carer assessments, short term breaks and hospital discharge through a dedicated resource.</p> <ul style="list-style-type: none"> • All carers are targeted through this service which will be co-located with other voluntary sector service in the centre of Swindon •
<p>The delivery chain</p> <p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioner: Swindon Borough Council, CCG</p> <p>Provider: Carers' Centre and private sector</p>
<p>The evidence base</p> <p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>.</p> <p>Extensive national research is available to support the evidence base for carer support. Carers' assessments support personalisation, helping to maintain the independence & resilience of service users and their carers being supported within the community.</p> <p>As well as the two main community health and social care providers, the Swindon Carers Centre completes assessments, which are then validated by an SBC care manager.</p> <p>The target for the year was 30% Although we achieved just below at 29.2% which equates to 1374 carer's assessments being completed. In addition to these, 3.8% of carers were offered but declined an assessment during the year.</p> <p>Therefore we will be providing on line and face to face support to increase the number of carers assessments which are completed each year and thereby increasing appropriate support.</p> <p>Continuity of care for older people is important especially as part of the hospital discharge process. The Carers centre has a GP outreach post and GP's have carer Leads in all Swindon Surgery. The model of a carers workers within a hospital discharge services was evaluated positively in Leeds and cited as good practice in the Kings Fund <i>Continuity of care for older hospital patients, a call for action</i>, March 2012; SCIE Research briefing 12 <i>Involving individual older people patients and their carers in the discharge process</i>, February 2005, Carers Act 2004</p>
<p>Investment requirements</p>

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £809,570
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
2015/16 benefits Improving the health and wellbeing of carers through assessment of needs and support in their caring role 750 carers assessments completed by SEQOL and AWP, 1000 carers assessments completed by Carers centre, SEQOL and AWP. Discharge post to support 250 carers per annum through hospital discharge process
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Quarterly performance meeting with carers centre, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Group
What are the key success factors for implementation of this scheme?
Existing scheme funded from NHS Transfer to LA and CCG allocation Prevention schemes resulting in delay for care and improved quality of life for carers. Cost avoidance rather than cashable savings

Scheme 7

Scheme name: Capital Grant Adult Social Care

What is the strategic objective of this scheme?

- Appropriate equipment and adaptations to support people living independently for as long as possible and ensure a good quality of life

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Capital allocations fund the Disabled Facilities Grant scheme which is operated by Swindon Borough Council and meets our statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

Capital allocations contribute towards the joint Integrated Community Equipment Store for children and adult services as well as investment in telehealth and telecare through the funding of major items of equipment. We will continue investment in

technology to support self-care and prevention and enable for this a disability to live as independently as possible.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: Swindon Borough Council Provider: SEQOL Disabled Facilities Grants are managed by Swindon Borough Council.
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Capital required to ensure equipment and / or adaptations to support hospital discharge and maintain people living at home is in place
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £897k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Approximately 2,000 items of equipment are given to service users and carers each year. This is an existing funding scheme to support people at home and ensure care home have appropriate equipment to prevent injuries such as pressure sores and maintain their independence for as long as possible.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum Quarterly report to Joint Commissioning Group
What are the key success factors for implementation of this scheme?
Existing scheme funded from capital allocation

Scheme 8

Scheme name: Community Health aimed at reducing emergency admissions

What is the strategic objective of this scheme?

- | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Reduction in hospital re – admissions through use of step up and step down beds • Reduction in delayed discharge through use of step up and step down beds • This is one of the largest investments of the BCF into community health services because based on research these schemes have been effective in avoiding hospital admissions and reducing delayed discharge. In addition to the virtual ward, Swindon also invests in a number of urgent care schemes through CCG base budget funding. |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- | |
|-------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> - What is the model of care and support? - Which patient cohorts are being targeted? |
|-------------------------------------------------------------------------------------------------------------------------------------------------|

<i>Continued development and enhancement of a range of community based support such as the Single Point of Access, SUCCESS, Nursing Home Visiting</i>

<p>This scheme includes our existing provision of Virtual Ward, Intermediate Treatment beds (SWICC), Hospital discharge services and 7 day working for clinicians, single point of access.</p>

<p>SWICC are two wards providing step up and step down beds in a separate building on the site of Great western Hospital. There are two wards. Forrest ward is a 30 bed unit taking hospital discharge patients with the aim of rehabilitation so that admission to residential and nursing care is avoided. At the Falcon Acute Stroke Unit at Great Western Hospital the specialist stroke multidisciplinary team, which includes physiotherapists and Occupational Therapists, work with patients on stroke therapy assessment and rehabilitation just days or weeks after the stroke has happened.</p>

<p>Some people go to Forest Ward in-patient rehabilitation at SWICC, and its team skilled in stroke rehabilitation starts setting goals with people straight away. This includes planning for discharge, supported by our seven-days-a-week community stroke team, who assist people to adjust to the effects of having a stroke. Orchard ward is a 26 bed unit as a step up facility to avoid hospital admission.</p>

<p>The virtual ward is supporting patients at home through a nurse led home visiting service. Over 1200 patients were discharged between April and June 2014 and thereby avoiding hospital admissions</p>

<p>The target patients for Virtual Ward and Orchard are older people with long term health conditions, whose health has suddenly deteriorated but who can be supported outside an acute setting. The target population for Forrest is patients being discharged from hospital. Consultants support patient care in both wards if the need arises.</p>

The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Commissioner: CCG Provider: SEQOL,
The evidence base Please reference the evidence base which you have drawn on <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>.</p> <p>There is extensive research supporting the implementation of intermediate care and virtual ward environments. SCIE <i>Research briefing 12: Involving individual older people in the discharge process from acute to community care</i>, February 2005. 1,200 patients were discharged from the Virtual ward in the first quarter of 2014/15 with an average length of stay of 13 days against a target of 21 days. The bed occupancy in both Forrest and orchard has been 97% with an average length of stay in Orchard of 14 days and 32 days in Forrest. This demonstrates the effectiveness in the service to improve patient flow.</p>
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £2,389,446
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
<p>2015/16 benefits</p> <p>A contribution to a reduction in hospital re-admission by 3.5%</p> <p>A contribution to a reduction in delayed discharge by 1.2%</p> <p>The Virtual ward is estimated to have 4,800 discharges in a year. Orchard and Forest ward are estimated to have an occupancy of 97%. It is difficult to estimate the number of patients as length of stay varies depending on the needs of the patients.</p>
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
<p>Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum</p> <p>Quarterly report to Joint Commissioning Group</p>
What are the key success factors for implementation of this scheme?
<p>This is an existing scheme. Appropriate referrals from GPs are critical to the success of the virtual ward.</p>

Creating better patient flow without necessarily resulting in a financial benefit. Benefit is cost avoidance rather than cashable saving with 4,800 discharges and 97% occupancy.

Scheme 9

Scheme name: Managing Demand in Adult Social Care

What is the strategic objective of this scheme?

- Meeting the demand for increasing demographic growth in older people social care services and enabling people to live independently for as long as possible.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

- Increase in care packages due to demographic pressure leading to reduced length of stay in hospital. Work with residential and nursing providers to increase access to health care within homes so that admissions to hospital reduce
- Modelling showing due to population changes explained in section 3, an additional 60 older people per year in need of adult social care services and 30 people with a learning disability. The local authority is targeting work in learning disabilities to reduce demand and ensure efficient and effective delivery. This is planned to mitigate against demand by £3.2m for 2015/16. This additional funding of £800k from BCF is to ensure eligibility criteria can be maintained.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner: Swindon Borough Council,
Provider: SEQOL, Voluntary and Third Sector

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Section 3 outlines the increase in population of older people and those with long term conditions which will increase demand for adult social care. This allocation is not a specific scheme but enables care packages to be delivered. Taking an average

cost of £7,500 per service user per year, then an additional 106 people can be supported.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£929,954

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Maintaining people to live independently as long as possible. At a cost of £7,500 per care package per annum a total of 106 additional service users can be supported per annum, currently approximately 1,200 older people are supported per annum

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum
Quarterly report to Joint Commissioning Group

What are the key success factors for implementation of this scheme?

New scheme, project management support for implementation of savings schemes, work force development so that community based resources are used to maximum capacity. Support for an additional 106 older people with potential to reduce delayed discharge.

Scheme 10

Scheme name: Implementation of Care Act 2014

What is the strategic objective of this scheme?

- Personalisation, choice and support for people in need of adult social care so that they are able to lead fulfilling lives and reach their potential and their quality of life improves

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

<p>.</p> <p>We will be implementing the required systems under the Health & Social Care Bill and prepare systems for an increase in financial assessments and self-assessments. Wherever possible we will be investing in new technology to automate processes as quickly as possible. We will focus on</p> <ul style="list-style-type: none"> • On line assessment • Carers assessment • Increased advocacy for older people • Advice and information and promotion of well-being • Deferred payment scheme • Preparation for changes to financial support
<p>The delivery chain</p> <p>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved</p>
<p>Commissioner: Swindon Borough Council, Provider: SEQOL, Voluntary and Third Sector</p>
<p>The evidence base</p> <p>Please reference the evidence base which you have drawn on</p> <ul style="list-style-type: none"> - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
<p>.</p> <p>Statutory requirements of Care Act 2014</p>
<p>Investment requirements</p> <p>Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</p> <p>£468,800</p>
<p>Impact of scheme</p> <p>Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan</p> <p>Please provide any further information about anticipated outcomes that is not captured in headline metrics below</p>
<p>Implementation of the Care Act and meeting statutory guidance. As guidance has not been finalised it is not possible to estimate the potential benefits. However, we have already implemented an advice and information web site and service as well as commissioning of carers support and assessment, We estimate that improving access to services for service users and carers through improved assessment, improved advice and information and 7 day working in social care will also improve the quality to life of individuals (ASCOF 1A to 18.7 in 2015/16)</p>
<p>Feedback loop</p> <p>What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</p>
<p>Monthly contract performance meetings with SEQOL, escalation of issues to Strategic Resilience Forum</p> <p>Quarterly report to Joint Commissioning Group</p>

What are the key success factors for implementation of this scheme?
New scheme, project management support for implementation of new guidance, ICT infra-structure, work force development. Additional investment to meet Care Act requirements

**Joint document of Swindon Borough Council, Swindon CCG, Great Western Hospital,
SEQOL and Wiltshire Council**

Version	Modifications	Author	Date
V01		Alan Rosenbach/Sue Wald	11/01/2016
V02	Additions by Gill May and Louise Tapper	Louise Tapper	14/01/2016
V03	Accepting changes	Sue Wald	15/01/2016
V04	SEQOL changes	Sue Wald/Heather Mitchell	18/01/2016
V05	GWH amendments	Adrian Griffiths	18/01/2016
V06/7	SRG amendments with NHS England	Sue Wald	20/1/2016
V08	DTOC Programme Team meeting	Victoria Guillaume	3/2/2016
V09	Amendments	Sue Wald	5/2/2019
	Final amendments		

Project Initiation Document (Version 09)	
Project Name: Delayed Transfers of Care Programme Project Sponsor: Sue Wald Project Manager: Louise Tapper/Victoria Guillaume Start Date: 18 th January 16 Completion Date: September 2016	
Objectives	
<p>The DTOC Programme will focus on the short and medium term challenges of delayed transfers of care (DTOC). Short term is defined as the next 3 – 5 months, medium term 9 months. The work and its outputs will provide the platform for the implementation of the recommendations that form the NHS England investigation into delayed discharges in Swindon and Newton Europe's system wide diagnostic work on Delayed Transfers of Care. The Programme Board for the DTOC Programme will report to the System Resilience Group who will use the information and data to support wider health and care work across Swindon. The accountability for strategic planning will be with the SRG and not this programme of work</p>	
Anticipated Benefits	
<ul style="list-style-type: none"> – Reduction in delayed discharge for health and social care to 3 per 100,000 population each thereby halving the current rate and 50% of days lost due to health and social care – Reduction of non-DTOC delays to half of current numbers for GWH and Intermediate Care SWICC to – Strengthened relationships with care sector providers to prevent admission and ensure speedy discharge – Improved communication on system challenges, changes and improvements on Delayed Transfer of Care (DTOC) for both health and care staff – Delivery of safe, effective and resilient social care services – Reduced hospital length of patient stay and improved patient flow from the GWH ED; improved performance against the ED 4 Hour patient waiting time target 	
Scope	

In scope:

- Service models to ensure the speedy and safe discharge of patients thereby reducing delay and hand offs within discharge systems and processes
- Staffing challenges in the care sector including training and support to care home and home care sector

Out of scope:

- Strategic plans for housing
- Equipment Services
- Continuing Health Care arrangements
- Prevention of hospital admission included in urgent care programme
- Actions relating to single agencies only
- System Wide Five Year Strategic Plan
- Mental Health DTOC (This is part of a separate piece of work with AWP and commissioners)

Deliverables/ Outcomes

- Sustainable reduction in number of DTOC and non-DTOC delays across the health and care system by 30/9/16 (planned reduction of current numbers by at least 50%)
- Agreed programme of work with clear outcomes and timelines for implementing the Newton Europe recommendations as these apply to delayed discharges.

Dependencies

This work links to the following programmes:

- Link to SBC Transformation Programme; Meeting the Needs of Vulnerable People' with work streams reporting to both programme boards
- Link to programme of GWH programme 'Right Patient, Right Bed'
- Link to Urgent care programme focusing on prevention of hospital admission
- Link to commissioners' Urgent Care Strategy
- Link to 5 year Strategic Plan led by Swindon CCG

Assumptions

The working assumption is that the changes to be implemented and sustained will be made, as the CCG and SBC are recommending to Governing Body and Cabinet working towards greater integration of acute and community health services; the other assumption is that services and systems will be simplified and made easier for people using services and families.

Project Board Structure & Terms of Reference

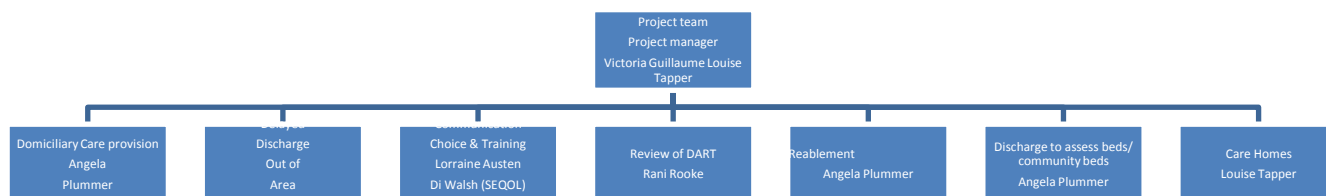
System Resilience Group



<p>Delayed Transfer of Care Programme Board Members</p> <p>Swindon SBC - Sue Wald (Senior Responsible Officer SRO)</p> <p>Swindon CCG – Gill May</p> <p>Wiltshire Council and CCG - Carolyn Hamblett, James Roach</p> <p>Great Western Hospital NHS Trust - Lorraine Austen</p> <p>SEQOL - Heather Mitchell</p>

<p>Terms of Reference</p> <p>Purpose</p> <p>The Board will oversee the changes for system and service changes to deliver a sustainable reduction in the delayed transfers of care.</p> <p>Aim</p> <p>To improve the system alignment, overall governance, structures and processes and in doing so to ensure a sustainable reduction of delayed transfers of care.</p> <p>Governance</p> <p>The Board will meet fortnightly over the next 9 months and report to the Strategic Planning Group fortnightly and SRG monthly and other key stakeholders. The Board will take the learning and ensure it is applied where relevant to other programmes where there are clear and obvious dependencies. The Board will also have an effective communication plan around its role, work and functions.</p>

<p>Project Team and Work Packages (orange are existing SBC work streams)</p>



Terms of Reference

Purpose

The project team will be responsible for the delivery of the work packages to an agreed set of deliverables and timelines. Each work stream has a nominated lead who is responsible for the coordination of the work, produce fortnightly highlight reports

Administrative support will be provided to each work stream.

Aim

The work packages will include all the key staff that can champion change and who can communicate the benefits for people using services, families and staff.

Governance

The project team will meet fortnightly and report to the Programme Board on the on going progress linked to the work packages. The Team will also have an effective communication plan around its role, work and functions. Each work stream will have a detailed work plan in place, a summary of which is outlined below. The work stream lead will be responsible for the agreement of the detailed work plan against which **a fortnightly highlight report is produced.**

A summary report of progress against milestones, barriers and risks will be agreed by the project team and presented by the project manager to the Programme Board.

Communication Updates

Name	Title	Organisation	Contact Details
Sue Wald	Interim DASS	SBC	swald@swindon.gov.uk

Cost Estimates			
<i>[Any significant expenditure that will be associated with delivering the project]</i>			

DTOC Programme Workstreams

Workstream 1: Re-commissioning of domiciliary care (Recommendation 8, 19, 29)

Recommendation 8 - that the two Local Authorities (Wiltshire and Swindon) create a project, jointly with the CCGs to, where possible, align pathways and procedures in the light of known best practice. This project to be completed before October 2016.

Recommendation 19 - that, subject to the Local Authorities confirming that they are using all financial levers available to them to maximise funding for Adult Social Care in general, and Home Care in particular, whole system partners urgently consider how to prioritise further expenditure (particularly within the Better Care Fund) on Home Care Commissioning for those areas where home care hours are still in short supply (a targeted approach to differential pay rates for different areas might help to make this affordable).

Recommendation 29 - that the new specification for any retendered Home Care Services should specify the commencement of packages of care during the morning wherever possible.

Workstream lead: Angela Plummer (aplummer@swindon.gov.uk)

Workstream members:

SBC: Rani Rooke/Angela Plummer

GWH: Lorraine Austen

SEQOL: Sandie Parsley

Wiltshire Council: James Cawley

Aim

To establish the principles for bridging services working in partnership with Wiltshire Council to build on the 'Home First' model

To commission a new domiciliary care and community support service based on an outcomes model learning from Wiltshire experience

Objectives

Given the difficulties in commissioning domiciliary care capacity in the market and learning from the experience of Wiltshire Council of moving towards an outcome based contract, Swindon Borough Council wishes to commission a new model of domiciliary care through a new tender in 2016.

The requirement is for a prime contractor provider who will coordinate, manage and deliver both directly and indirectly domiciliary care and community support in Swindon, working with us to overcome barriers and deliver a new model of care and support.

Linking domiciliary care closely to community support by including the requirement to develop volunteering, befriending and initiatives to reduce isolation, support planning and review

All domiciliary care to be person centred and enabling service users to regain skills and maintain their

independence

Key Outcomes to be achieved

Improved capacity within domiciliary care to deliver hours required per week to meet need
 Reduce admissions to residential and nursing care by maintaining people at home
 Appoint prime provider for domiciliary care and support services

No	Milestone Description	Owner	Start and Due Date	Status
	Draft specification complete and gateway for tender	Angela Plummer	15.1.2016	G
	Route to procurement agreed	Angela Plummer	15.1.2015	G
	Model of Home First agreed with SEQOL and in consultation with Wiltshire	Rani Rooke	28.2.2016	
	Consultation with existing providers started	Angela Plummer	29.1.2016	G
	Publication of tender	Katey Magee	1.3.2016	
	Completion of tender	Katey Magee	30.8.2016	
	Cabinet budget setting for Council	Sue Wald	10.2.2016	G
	CCG to consider additional funding for adult social care as part of BCF to enable investment into care packages in discussion with Director of Social Services	Nicki Millin	1.3.2016	

Workstream 2: Delayed Discharge Out of Area (Recommendation 9)

Recommendation 9 - that, within four weeks, summit meetings take place, with each of the surrounding Local Authorities, including all the relevant Chief Executives and backed by thorough data analysis, to agree optimal arrangements for avoiding DToC. Should such arrangements not be forthcoming as a result of those meetings, the matter to be escalated to the two relevant government departments for resolution.

Workstream lead: Thomas Kearney CCG (seniorcommissioningmanager@swindonccg.nhs.uk)

Workstream members:

CCG

Gloucestershire CCG

Oxfordshire CCG

Berkshire CCG

GWH: Emma Cavill and Linda Power

Aim

To reduce the delays for discharge of patients who are the responsibility of other CCGs

Objective

Agree protocol with each out of Area CCG to ensure patients are discharged within 48 hours of the patient's medically fit date.

Agree single point of contact with each CCG and point of escalation

GWH to share lost bed days information due to OOA DTOCs with lead CCG to monitor progress, identify themes and agree escalation process where required

Key Outcomes to be achieved

Reduction by 50% in the number of delayed patients and days from out of area placements
Agreed protocol and escalation process

No	Milestone Description	Owner	Due Date	Status
	Issue invitation to neighbouring CCGs with patients at GWH	Thomas Kearney	15.2.2016	
	Establish number of patients delayed by month and by CCG for 2015 and number of bed days	Adrian Griffiths	22.2.2016	
	Agree immediate actions at meeting with CCGs to reduce delays	Thomas Kearney	28.2.2016	
	Agree protocol and escalation route for patients from those CCGs	Thomas Kearney	15.3.2016	

Workstream 3: Communication, Choice and training (Recommendation 6,10, 11, 30)

Recommendation 6 - that the Executive Officers of GWH, whilst retaining their approach to devolved accountability to clinical operational teams, walk the wards on a daily basis in order to ascertain the effectiveness of that devolved approach in driving rapid change.

Recommendation 10 - that there be an urgent review of the roll-out of the revised Choice policy to consider whether it can gain traction quickly enough, and to also consider whether additional alternatives should be commissioned.

Recommendation 11 - that, within four weeks, a system is established to create a readily accessible 'Issues Log' so the staff at all levels can raise operational issues (not specific to a particular patient) and

receive feedback from an appropriate member of the executive as to how the issue is (or is not) being addressed. This Log to be a standing information item at the primary governance meeting for this pathway.

Recommendation 30 - that the system for logging issues suggested in Recommendation 11 above should be used to collate examples of these different experiences with a view to establishing a common understanding.

Workstream lead: Lorraine Austen (lorraine.austen@gwh.nhs.uk)

Workstream members:

SBC: Rani Rooke

GWH: **Lorraine Austen/Emma Caville**

SEQOL: Jill Kick/Val Timms

Aim

To ensure that all staff and managers across the system understand the discharge process, routes of escalation, roles and responsibilities and the available menu of discharge options including criteria for each provision including SWICC and discharge to assess options

To ensure all staff across the system are able to report issues hindering discharge so that these can be addressed and resolved by senior managers

To ensure the system escalation of silver and gold calls is reviewed to provide assurance to front line staff of timely and clear response to issues raised

Objectives

Staff across the system are aware of the discharge options including those in the community and ward staff able to restart packages

The discharge protocol is clearly understood by all staff across the system involved in discharges
There is clarity over capacity assessment, safeguarding and best interest decisions so that misunderstandings/interpretations do not delay a discharge

Staff are confident in the implementation of the choice policy and patients and families are involved in discussions at the earliest opportunity

Staff are able to report system wide issues and report that there has been a response to those issues
All social work staff across GWH and SWICC work as a team with access to all assessments and plans so that workers on duty are able to deal with all discharge issues

There is a named point of escalation for all social work, acute health and community health during the week and at weekends to resolve issues

There is senior co-ordination of discharges across 7 days

The 5 day rolling forecast is used to support capacity planning and system flow.

Outcomes

Choice policy effectively implemented resulting in a reduction of delays due to choice

Issues identified by staff have a documented resolution in place

Issues that are escalated result in a consistent response

Agreed discharge protocol in place and signed off

No	Milestone Description	Owner	Due Date	Status
	Final sign off of discharge protocol by GWH and SEQOL	Sue Wald	29.1.2016	Green complete
	Agreed communication plan with SEQOL and GWH of discharge protocol with front line staff	Lorraine Austen/Jill Kick	15.3.2016	
	Agreement how choice policy will be disseminated to staff and communication plan	Lorraine Austen/Jill Kick	15.2.2016	completed
	Safeguarding and mental capacity assessment briefing note to social work staff	Doug Bale/John Hughes with Victoria Guillaume	15.2.2016	
	Monthly commissioning newsletter	Victoria Guillaume	28.2.2016	
	Establishment of issue log process and dissemination (Patient Flow admin)	Lorraine Austen	15.2.2016	
	Monthly operational review of discharge process	Rani Rooke	10.2.2016 (start)	G
	Communication process agreed for messages from other work streams through project team meetings	Victoria Guillaume	3.2.2016	G

Workstream 4: Review of DART and IDT team and process (Recommendation 8, 12, 13)

Recommendation 8 - that the two Local Authorities (Wiltshire and Swindon) create a project, jointly with the CCGs to, where possible, align pathways and procedures in the light of known best practice. This project to be completed before October 2016.

Recommendation 12 - that, within two weeks, the Chief Executives of GWH and SEQOL with the Swindon ADASS consider the evidence, above, regarding the functioning of DART alongside any other evidence sought from their own staff, and agree, in writing 'one version of the truth' for dissemination to front-line staff. The purpose of this is to dispel inaccurate and negative stereotypes whilst at the same time identifying areas of dysfunction to be fixed immediately.

Recommendation 13 - that, in line with the new electronic referral system, Key Performance Indicators are established for the various stages of referral and assessment within DART

Workstream lead: Rani Rooke (rrooke@swindon.gov.uk)

Workstream members:

SBC: Rani Rooke

GWH: Lorraine Austen

CCG: Louise Tapper

SEQOL: Jill Kick

Wilshire CCG/Council: Carolyn Hamblett

Aim

To review the DART process so that there is clarity over roles and responsibilities and delays are minimised; to ensure patient specific data, in terms of progress through the process, is readily available to the Trust and wider health and social care system

To develop KPIs to enable performance management of process delays

To achieve a 50% reduction in non DTOC delays attributed to DART services

To review the social work function within DART to ensure patients are discharged home where possible

That key communication leads are established for each hospital ward to liaise with DART

To review the role and responsibilities of GWH physio and occupational therapy teams to ensure effective interface with wards, DART and IDT to drive timely and safe discharge; to achieve improved integration of Trust, DART and therapy services

Objectives

To review the MDT and DART process and identify avoidable blockages, delays and hand offs to existing processes

To agree improvements to reduce identified built in process delays

To ensure clear communication about the DART process which is to be disseminated through work stream 4; to ensure visibility of patients' discharge via the DART process on Hospital whiteboards and at Board Rounds

To define the role and responsibilities of GWH occupational therapy and Physiotherapy teams

To agree across Swindon and Wiltshire the DART model and the role of social work within this. For Swindon this also includes social work in SWICC

To agree when new DART process can commence

To agree documentation, communication and managerial processes across 7 days

Outcome

DART process is agreed , documented and disseminated with clarity for patients who are responsibility of the ward and those who need to be triaged by DART

KPIs agreed, implemented and reported weekly and monthly, including patient delays and patient medically fit dates.

No	Milestone Description	Owner	Due Date (TBC)	Status
	Agree scope of review across all partners and how review will be conducted	Rani Rooke	22.1.16	G Review already underway
	Review actual service delivery against January 15 specification	Rani Rooke with AP and LT	8.2.16	G
	Review process complete including review of pathways to access other services	Rani Rooke	1.2.2016	G
	GWH to review the timeliness of ward based discharges that are not led by DART	Lorraine Austen	22.2.2016	
	Include requirement for 7 day working within DART and IDT and access to brokerage	Rani Rooke	22.1.2016	G
	Ensure real time information of patients within DART who had MDT, medically optimised and safe to discharge	Jill Kick	22.2.2016	
	Ward to be informed of Care Package availability in advance of 'on the day'.	Jill Kick	22.2.2016	
	Forecasting model to be rolled out for whole system to ensure faster capacity planning & discharge management.	Sharon Gerry Giles de Burgh	28.2.16	
	Review process complete including review of pathways to access other services	Rani Rooke	1.3.2016	
	Review Wiltshire DART model to understand difference between models	Rani Rooke	22.1.16	G completed
	Report review process to commissioners with action plan to address findings	Rani Rooke	1.3.16	
	Implement revised model	Rani Rooke	1.4.16	
	KPI agreed with monthly reporting agreed	Rani Rooke	7.3.2016	

Workstream 5: Reablement reshaping (Recommendation 18)

Recommendation 18 - that, for Swindon, unless there is evidence that expansion would not reduce the Reablement waiting list, or would not significantly impact on downsizing Home Care packages, these services should be expanded as a matter of urgency. Between now and 1 April any such expansion will be at an additional cost which might reasonably be shared between all the whole system partners. From 1 April onwards the continued expansion of this team would need to be funded through a strategic approach to pathway redesign throughout the spring and summer, aligned with a commissioning plan to reduce spending, particularly next winter, with regard to hospital beds. For Swindon, this should happen irrespective of the decision about the future provider of community services.

Workstream lead: Angela Plummer

Workstream members:

SBC: Rani Rooke

CCG: Louise Tapper

SEQOL: Sharon Gerry

Aim

To agree shape of reablement service and a lower unit cost than the current £30 per hour and thereby increasing capacity

To agree prioritisation of patients onto reablement and review of patients to ensure speedy discharge from the service, particularly of self funders

To ensure that the reablement ethos is incorporated within the new domiciliary care specification to ensure all new service users are re-abled as standard.

Objectives: -

Reablement service is reshaped and business case received that is cost effective

Patients on reablement service with have timely reviews completed

Clear process for charging self funders is in place

Outcomes

Increase capacity within reablement so more than 29 patients can be supported at any one time

Ensure all self funders are charged the cost of the service once reablement episode has been completed

No	Milestone Description	Owner	Due Date	Status
	Receipt of business case by SEQOL to commissioners	Sharon Gerry	25.1.2016	Green complete
	Further review of specification and pathways for reablement and link with rapid response and RAU	Angela Plummer	12.2.2016	
	Review of domiciliary care specification to ensure reablement focus	Angela Plummer	18.1.2016	Green complete

	Agreement of funding if any by wider system	Caroline Gregory	1.3.2016	
	Agree with SEQOL process of charging patients on reablement once assessment is completed of future needs including full cost recovery of self funders who have refused an alternative on-going package – completed.			
	Protocol agreed by SEQOL for self funders and system implemented	Sharron Gerry	25.1.16	Ongoing, update requested

Workstream 6 Discharge to assess beds, residential reablement and SWICC (Recommendation 25, 26, 28)

Recommendation 25 - that Swindon CCG jointly with Swindon Council, conduct (within four weeks) a review of the function and operating procedures of their locally commissioned community beds (other than residential and nursing homes) with a view to clarifying function (against a backdrop of near continual escalation) and, where necessary apply additional rehabilitation resources to secure better and faster Reablement.

Recommendation 26 - that, over the next six months, a new Commissioning Strategy be produced (preferably jointly between Swindon and Wiltshire CCGs and Local Authorities) with a view to securing sufficient community beds of the various types (perhaps starting with dementia) over the next two, five, and 10 years. This would include the re-provision of those units that are no longer fit for purpose.

Recommendation 28 – that Key Performance Indicators be established for D2A services.

Workstream lead: Angela Plummer

Workstream members:

SBC: Rani Rooke, Angela Plummer

CCG: Louise Tapper

SEQOL: Sharon Gerry

GWH: Lorraine Austen

Aim

Ensure there is clarity over criteria and process for all bed based provision in the community so there is patient flow

Commissioning Strategy in place for community bed based provision

Objectives

To ensure criteria for each community bed are clearly understood by wards and social work staff
Commissioning strategy is developed which includes use of community beds and discharge to assess capacity

Review all current service users in receipt of D2A services and either move to mainstream services or home

Fessey House – reduce the number of current residential beds and purchase through private sector but develop Fessey or Whitbourne into all D2A

Completing the assessment for those service users in D2A beds, the intention is to reduce this capacity and evaluate the appropriateness of those who received the service. Review longer term use of Whitbourne House

KPI developed and agreed

Outcomes

Agreed and implemented commissioning strategy with KPI agreed and monitored

The redesigned service is embedded within GWH MDT assessment and discharge planning

No	Milestone Description	Owner	Start and Due Date	Status
	Review with CCG the specification for SwICC	Angela Plummer /Louise Tapper	January 2016	Amber
	Review criteria for access to Fessey House reablement beds	AP/RR	Feb 16	Amber
	Review length of stay in all rehab/reablement units with onward destination to ensure best use of beds	AP	9 th Feb	Amber and awaiting full information from Seqol
	Analyse information on number of residential and nursing placements over the last 12 months and tender for block within appropriate settings	AP	2 nd Feb start with tender timescale to be agreed	Amber
	Review life span or Whitbourne House without significant investment – consider if D2A would be better in Whitbourne due to life span	AP	2 nd Feb	Amber
	Link potential future D2A beds with new provision in Swindon from June onwards	AP	18 th Jan	Amber
	KPI for community beds already in existence and reported in SEQOL contract meeting monthly		Completed	
	Access for care home managers to senior manager on call at	Lorraine Austen	4.2.2016	G Care homes

	GWH to resolve issues where re-admission can be avoided			to be briefed
	Clinical support from Rapid Assessment Unit, virtual ward and Out of Hours GP for patients in D2A beds	Louise Tapper	1.3.2016	
	Locum social worker in place that providers can ring directly to ensure timely social work assessment of patient	Rani Rooke	8.2.2016	G completed

Workstream 7: Care homes**Workstream lead:** Louise Tapper**Workstream members:**

SBC: Rani Rooke

CCG: Louise Tapper

GWH: Lorraine Austen

SEQOL: Diane Blake

Care home members

Aim

To prevent avoidable admission to hospital from care homes and ensure speedy discharge at the earliest opportunity

Objectives

Identify with care homes issues that can be improved to prevent hospital admission

To agree the necessary protocols and implementation for IV fluids and antibiotics

To ensure that care homes receive the necessary discharge notes, medication and equipment for patients discharged from hospital

To agree the communication between wards and care homes so patients are able to return at the earliest opportunity

To design and implement the necessary training and support for care home staff

To liaise with CCG Care Homes project

Support care homes to understand the range of alternative services provided by SEQOL and others which will assist with preventing unnecessary admissions/attendances at GWH.

Outcomes

Reduction in delay in discharges to care homes from hospital

Improved awareness of out of hospital services,
Increased use of community and voluntary based support,
Patient's health and wellbeing has improved and they feel more in control.

No	Milestone Description	Owner	Due Date	Status
	Six weekly review meetings with care homes	Rani Rooke	2.2.2016	Green
	Written agreement between CCG, SEQOL and GWH over continence pads and continence assessments	Louise Tapper	15.2..2016	Green
	Set out protocol between community nursing and care homes on wound care and tissue viability services	Louise Tapper Di Blake SEQOL Carolyn Bell CCG	28.2.2016	
	Protocol to establish how IV fluids can be administered in nursing homes supported by the SEQOL CIVT Service.	Louise Tapper	15.3.2016	
	Protocol of how IV anti biotics can be administered in care homes supported by the SEQOL CIVT Service. Test protocol with Kingscourt	Louise Tapper	28.2.2016	
	Review the support offered by community nursing with patients in care homes including nursing homes in written protocol	Louise tapper Diane Blake	13.3.2016	
	Support to patients with long term conditions I care homes: - Business case to be developed for named matron for care homes to prevent hospital admission through training, oversight of antibiotics and proactive care plans. Consider role of community geriatrician in supporting care homes (End of life care delivered by Prospect hospice is preventing hospital stays and could be a model for this)	Louise Tapper with Diane Blake	30.4. 2016	

	Monthly dissemination of training opportunities offered by SEQOL and GWH for care home staff	Di Walsh and Lorraine Austen	December 2015 and monthly dissemination	Green completed. 20 nurses attended SEQOL training on revalidation
	Circulate format of a common nursing assessment to care homes to be recirculated	Angela Plummer	22.1.2016 8.2.2016	Completed and re-issued
	Agreed communication process of existing residents admitted to hospital from care homes so that care homes are informed throughout the stay of the resident. Starting point for care homes will be DART administration but then needs to be passed to wards for ongoing communication	Lorraine Austen	28.2..2016	
	Explore role of volunteers in supporting discharge to care homes	Lorraine Austen	1.3.2016	
	Contract between care homes and Rapid Response Team so patients have assessment and move on plan in place	Diane Blake	1.4.2016	
	Placement team to share with individual care home manager and area manager where there has been a delay in completing assessments by care homes on a case by case basis	Placement Team	Start 8.2.2016	

Individual actions identified in NHS England report which will be reported to programme Board to ensure completion

Recommendation	Milestone Description	Owner	Due Date	Status
Recommendation 1 - that all parties bring together their planning resources for a very urgent reconciliation of all existing plans and sub-plans with regard to the Unplanned Care Pathway: within one week to produce a Transformation Plan which clearly identifies each task, its objectives, the additional resources to be	Accountable Officer Swindon CCG to lead Strategic Plan for Swindon. Two Programmes for Discharge and Front Door established	Accountabl e Officer CCG	30.1.2016	G comple ted (PID)

brought to bear, the task owner, target milestones, and Key Performance Indicators of achievement (even if these are only inputs or outputs). For complex items to produce sub-plans identically structured within a further two weeks.				
2- That project managers be appointed either from within existing resources, or externally, in sufficient numbers to provide support and project acceleration for each project that requires a sub-plan (or some other indicator of project complexity).	Project managers identified and named in PID Nicki to review	CCG	18.1.2016	G completed
3 -That, if interagency relationships are considered sufficiently trusting to allow it, a Senior Responsible Officer at Chief Executive level is appointed to oversee all aspects of the new Transformation Plan and is given power to escalate quickly to fellow Chief Officers any matters, small or large, where milestones are not being met.	Identify SRO to oversee all aspects of new Transformation Plan Urgent Care Working Group becomes Urgent Care Programme Board	Sue Wald Gill May	20.1.16	G completed
4 -That the existing hierarchy of meetings with regard to the Unplanned Care Pathway is subject to a two-week review with the aim of consolidating meetings to reduce time commitments, increasing added value, creating empowered chairpersons, flattening the structure, and ensuring that Very Senior Managers can be actively involved weekly, or fortnightly at least, in both the scrutiny of progress and driving change.	Hierarchy of Unplanned Pathway is subject to a two-week review Fortnightly meetings for Strategic Planning to be reshaped to include report on both programmes (DTC and Urgent Care)	SRG monthly Strategic Planning Group fortnightly	20.1.16	G
5 -That, as far as possible, the timetable for exploring the commissioning of an 'Accountable Care Organisation' be compressed to move to a decision as quickly as possible.	Report to CCG Governing Body and Cabinet on future commissioning intentions for community services	Nicki Millin Sue Wald	21.1.2016 and 10.2.2016	G completed
7 - That the GWH workforce planning strategy is subject to a two-week review followed by an urgent presentation to the Trust's Board to secure support for	Submission of Trust workforce plans to GWH Board; incorporation of specialty workforce plans	Chief Operating Officer GWH/ Director of		G

initiatives aimed at addressing the shortages early in 2016 with the objective of achieving a permanent workforce with normal vacancy rates before next winter.	within business plans.	HR		
14 - That, as part of 'Right Patient Right Bed' the Medical Director of GWH engages with Consultants to secure their immediate co-operation regarding the 'two patients per ward target', and a system for monitoring the achievement of that target.	Right Patient Right Bed and implementation of two patients per ward target and monitored by GWH Programme Board Maximise morning discharges, "home for lunch" use of discharge lounge, and prospective discharge planning at Board Rounds.	Chief Operating Officer GWH	Already established	G
15 - That the two CCGs, either separately or preferably together, review and if necessary start a project to redesign, the Older Persons Urgent Care Pathway to incorporate the notion (in line with best practice) that where ever possible a patient's treatment should be completed in a setting other than GWH.	Review of Older Persons Urgent Care Pathway -	Swindon and Wiltshire CCG's Gill May with GWH Geriatrician	Commenced.	
16 - That the issue of End-Of-Life fast track should be escalated to a meeting between Chief Executives, with their advisers, within a week (in the evening if need be) to produce a solution that enables such care to be available within 48 hours. If this cannot be achieved it should be reported to the Governing Bodies of all the system partners at their next available meeting.	End of Life working group have drafted end of life operational flow chart to support timely coordination and support to meet patients preferred choices and wishes as to where they wish to die and be cared for.	Gill May	30.1.2016	G
17 - That Swindon urgently consider the merits of the Wiltshire approach to CHC check listing.	Swindon CCG and SBC to consider the merits of the Wiltshire approach to CHC check listing	Paul Bearman Angela Plummer	22.2.16	
20 - That any future plans regarding Integrated Working seek opportunities to utilise a different skills mix to create where possible more attractive jobs to meet intensive personal care needs.	Workforce Steering Group established. Work plan in place to scope workforce review across care pathways and future scenario planning.	Gill May	Commenced follow up 4.2.2016	G
22 -That an enlarged reviewing team	Establish and implement	Angela	30.1.2016	G

revisit all existing Home Care packages, starting with the largest, to see if there is further scope for meeting patients' needs in other ways and thereby release some Home Care hours for new patients. This team may also be able to comment as to whether the packages were scoped correctly in the first place.		robust review process of high cost care packages and those on bridging. Workstream in place with SBC programme	Plummer		
23- That, within four weeks, Swindon's housing department receive, from NHS partners, case studies illustrating the time wasted on viewing inappropriate accommodation, and within a further two weeks, report to the relevant Overview and Scrutiny Committee (and back to the NHS partners) what they intend to do about this problem.		GWH and SEQOL to send case studies of patients with housing issues to SBC Housing department GWH to sign off protocol with Housing	Jill Kick/Emma Caville Nick Kemmet with Lorraine Austen	15.2.2016	
24 - That the business case for additional Patient Flow Coordinators be prioritised for immediate completion but must take into account the need for this function to apply to in-county patients as well as out-of-county. That, assuming the business case is sufficient, implementation of growth should be prioritised using agency staff, and/or further secondments as necessary in the first instance.		Case for substantive recruitment of patient flow ward clerks to be developed.	Chief Operating Officer GWH	28 2 2016	
27 - that the use of the electric vehicle for transporting patients between GWH and SWICC be reinstated, or some similar cost-effective arrangement be put in place.		GWH and SEQOL to consider how to respond to suggestion of electric vehicle supported by SEQOL. To be part of GWH transport plan	Chief Operating Officer GWH/ CE SEQOL		
31 - That a more vigorous and planned approach be taken to the implementation of the national imperative for seven-day working.		GWH to develop plans for extended 7 day working by senior medical staff, pharmacy and therapy services. 7 day working in place for DART and social work. Brokerage 7 day working	Chief Operating Officer GWH Angela Plummer	18.1.2016	G for community services and social work/brokerage
Additional		DTOC CQUIN to be	Louise Tapper	31.3.16	

	developed for 2016-17			
Additional				

BCF Planning 2016-17

Plan Assurance Summary

Key Information

HWB Name	SELECT
DCO Team	SELECT
Local Government Region	SELECT
NHS England Commissioning Region	SELECT

Better Care Manager	
DCO Team assurance lead	
Local Government assurance lead	

Plan Development Assessment

Total KLOEs Assessed	0	0%
No. of KLOEs fully met	0	0%
No. of KLOEs partly met	0	0%
No. of KLOEs not met	0	0%
Overall plan development rating	SELECT	

Risk to Delivery Assessment

Automatically generated guideline risk	#DIV/0!
Proposed final risk rating	Moderate risk

Matrix for Determining Approval Status

Risk to delivery	Low Moderate system challenge Good record of delivery			
	Medium Moderate system challenge Some record of delivery			
	High High system challenge Poor record of delivery			
		Low Does not answer all minimum KLOEs	Medium Answers all minimum KLOEs but with further work required	High Comprehensively answers all minimum KLOEs

Plan Development

Suggested categorisation key

- Not approved
- Approved with support
- Approved

Plan approval status

SELECT

Checkpoint
Completed by
Date

SELECT

Planning requirement	Full information required, or Key Line of Enquiry to be answered	Assurance checklist	Addressed/Answered	Where??
Narrative plan submitted for assurance at a regional level	First submission of narrative plan to the DCO team on date requested	Confirmation from DCO team		
	Submission signed by the local CCG(s) and local authority	Signed submission from LA & CCG		p1
	Final submission of narrative plan to the DCO team on date requested	Confirmation from DCO team		
	Submission signed off by local CCG(s), local authority, and the Health and Wellbeing Board	Signed final submission from LA, CCG and HWB chair		Page 1
Local agreement on funding arrangements	Has the narrative plan submission been signed off by all parties?	See KLOEs 1i and 1ii		Page 1
	Does the narrative plan provide a full overview of funding contributions for 2016-17?	Confirmation that an overview of funding contributions set out		p1, p63-65, p74-100for BCF schemes 16/17
	Does this set out any changes from funding levels in 2015-16, and how these have been agreed?	Confirmation that plan includes consideration of changes and process		p1, p63-65, p74-100for BCF schemes 16/17
	Does this include an assessment of the impact of these changes on services?	Confirmation that some assessment of the impact of changes has been conducted		p35 Progress Against Plan of Action at 2016, and BCF schemes 16/17 p74-100
The local vision for health and social care services	A clear articulation of the local vision for health and social care services?	Local vision for health and social care services set out		p3-17
	A description of how the BCF plan contributes to the local implementation of the vision of the Five Year Forward View and the move towards fully integrated health and social care services by 2020?	BCF set within context of longer term strategic health and care planning		p3-17
	A clear comparison between current state and planned state post-plan delivery, described in terms of changes to patient and service user experience and outcomes?	Changes to be delivered through BCF plan set out, with consideration of impact		p3-17, p46-49 and p74-100
	The precise aspects of the change the local area is intending to deliver using the BCF?	BCF changes / schemes set out		p46-49 and p74-100
An evidence base supporting the case for change;	A clear and quantified understanding of the precise issues that the BCF will be used to address in the local area?	Data driven explanation of issues BCF plan is addressing		p18-34
	Identification of the opportunity to improve quality and reduce costs, based on segmented risk stratification?	Local opportunity identified		p67-8
	A narrative that is bespoke to the local area?	Local narrative set out		p5-17
	Data that supports the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery?	Case supported by use of data		p18-34

A coordinated and integrated plan of action for delivering that change;	A description of the specifics of the overarching governance and accountability structures in place locally to support integrated care?	BCF governance and accountabilities set out		p43-45
	A description of the specifics of the management and oversight in place to support the delivery of the BCF plan?	BCF management and oversight set out		p43-45 and individual schemes p74-100
	An articulation of the arrangements in place to support joint working?	Joint working arrangements set out		p4, p43-45
	Key milestones associated with the delivery of the plan of action in 2016-17?	BCF plan milestones set out		p50-56
	A fully populated and comprehensive risk log, with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally?	Risk log in place		p57-60
A clear articulation of how they plan to meet each national condition;	See next section.	N/A		
An agreed approach to financial risk sharing and contingency.	A quantified pooled funding amount, if any, that is 'at risk'?	Risk share / contingency identified		p57-60
	Demonstration that this has been calculated using clear analytics and modelling?	Evidence of how risk share / contingency has been calculated		p57-60
	An articulation of non-financial risks associated with not meeting BCF targets in 2016-17?	Non-financial risk sharing set out		p57-60
	An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements?	Overall risk sharing approach and mechanisms set out		p57-60
Plans to be jointly agreed	The BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the HWB area, is signed off by the HWB itself, and by the constituent Councils and CCGs?	See KLOE 1.iv		p1
	In agreeing the plan, CCGs and local authorities have engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people?	Engagement of health and social care providers set out		p1-5
	There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan?	Evidence of provider sign dup with plans set out in B.1.ii		p1-5 and p74-100
	This includes an assessment of future capacity and workforce requirements across the system?	Assessment of future capacity and workforce requirements set out		page 68
	The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences?	Implications for local providers set out		p7-17
	As the Disabled Facilities Grant (DFG) will again be allocated through the BCF, local housing authority representatives have been involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social	Engagement of local housing authority representatives evidenced		p4

Maintain provision of social care services	Local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16?	Approach to supporting social care set out		p13-14, p63-65
	The definition of support has been agreed locally and, as a minimum, maintains in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16?	Definition of support set out and agreed		p13-14, p63-65
	In setting the level of protection for social care the local area has ensured that any change does not destabilise the local social and health care system as a whole?	Consideration of impact of set definition		p13-14, p63-65
	The local area has included a comparison to the approach and figures set out in 2015-16 plans?	Comparison to 2015-16 set out		p35-41 and p46-49
	The approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14?	Consistency with DH guidance confirmed		p63-64
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.	They will provide, or have a plan in place to provide, 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care?	Plan for providing 7-day services set out		p47, 66 and p83-92
	This approach will prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week?	Approach to providing out of hospital service 7 days a week set out		p47 and p83-84
	Their approach will support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care?	Impact of approach on discharge detailed		p47 and p83-92
	The approach is underpinned by a delivery plan for the move to seven-day services, which includes key milestones and priority actions for 2016-17.	Delivery plan set out		p83-92
Better data sharing between health and social care, based on the NHS number	That the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care?	Approach to ensuring right cultures, behaviours and leadership are place in palce		p66-68
	They are using the NHS Number as the consistent identifier for health and care services, and if they are not, that they have a plan to do so?	Use of NHS number as consistent identifier set out or plan in place		p66-68
	They are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls?	Approach to pursuing systems that speak to each other set out		p66-68
	They have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place?	IG controls for sharing information in line with guidance set out		p66-68

	They have ensured that local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights (In line with the recommendations from the National Data Guardian review)?	Approach to communication with local people on use of their data set out		p66-68
	How these changes will impact upon the integration of services?	Link to overall impact on integration described		p4
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	Identify which proportion of the local population will be receiving case management and named care coordinator?	Proportion of the local population that will be receiving case management and named care coordinator confirmed		p67-8
	Identify dementia services as a particularly important priority for better integrated health and social care services, supported by care coordinators (for example dementia advisors)?	Dementia identified as important priority, supported by care coordinators		p9-10
	A description of plans for health and social care teams to use a joint process to assess and plan care?	Plans for joint assessment and care planning set out		p12-17
	A plan with milestones demonstrating how and when this condition will be fully complied with?	Plan with milestones included		p67-8
Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	The impact of local plans has been agreed with relevant health and social care providers?	Evidence of agreement provided		p1
	There has been public and patient and service user engagement in this planning, as well as plans for political buy-in?	Evidence of engagement and buy-in provided		p1-4
	These align to provider plans and the longer term vision for sustainable services?	Alignment to provider and longer term planning set out		p1-4 and p13-17
	Mental and physical health are considered equal, and plans aim to ensure these are better integrated with one another, as well as with other services such as social care?	Approach to better integrating mental and physical health set out		p13-17
	Demonstration of clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans?	Explanation of alignment of CCG, BCF and provider plans set out		p1-4
Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	The local area has agreed how they will use their full share of the £1 billion that had previously been used to create the payment for performance element of the fund, in line with the national condition guidance?	Approach to meeting national condition confirmed		p1-4 and BCF expenditure return
	This is clearly set out within the summary and expenditure plan tabs of their BCF planning return template?	Figures in planning return match the explanation in the narrative plan		Planning Tool and p74-96
	In reaching agreement they have considered whether a local risk sharing arrangement is required, supported by analysis of the likely risk of unplanned activity in the area based on their track record of performance?	Approach to setting risk share arrangements, including analysis of previous NEA performance, set out		p57-60

	This analysis is data driven and includes consideration of the long term trend in admissions and the success of schemes implemented to date?	Impact of trends and of schemes to avoid admissions both considered		p18-19
	Where a risk sharing arrangement has been agreed this is, where appropriate, consistent with guidance?	Risk sharing arrangement set out with reference to guidance		n/a
	NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-elective ambition, continue in a manner consistent with 15-16?	Impact on any schemes funded by the previous P4P fund set out		n/a
Agreement on local action plan to reduce delayed transfers of care (DTOC)	The local area has developed a local action plan for managing DTOC?	Local DTOC action plan set out		p52-52 and p83-92 DTOC Project Plan agreed by NHS England and can be provided if required.
	The local area has established their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts?	Local DTOC target set out with link to actions		p84
	The plan is within the context of the overall System Resilience Group plan for improving patient flow and as a result performance, acknowledging action is required by all partners both in hospital and in the community (e.g. reducing avoidable admissions, effective in-hospital management and timely and safe discharge)?	Link between this action plan and SRG planning set out		p83-92
	This target is reflected in CCG operational plans?	Confirmation provided that this aligns to CCG plans		p83-92 and CCG are partner on DTOC Programme Board
	The local area has considered the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities (with reference to the track record of performance) ?	Consideration of risk share options included		n/a
	In agreeing the plan, CCGs and local authorities have engaged with the relevant acute and community trusts and are able to demonstrate that the plan has been agreed with the providers?	Engagement with providers on DTOC plan confirmed		CCG and GWH on DTOC Programme Board, p83-92
	Clear lines of responsibility, accountabilities, and measures of assurance and monitoring?	Lines of responsibility, accountabilities, and measures of assurance and monitoring set out		p83-92 and included in detailed DTOC Programme plan
	They have taken account of national guidance and best practice (as set out in technical guidance)	Consideration of national guidance and best practice set out		p83-92 and DTOC Programme Plan agreed by NHS England

	There has been engagement with the independent and voluntary sector providers?	Engagement with independent and voluntary sector providers on DTOC plan confirmed		p83-92 and DTOC Programme Plan agreed by NHS England
Non-elective admissions (General and Acute)	i. Has a target been set for this metric as part of the BCF Planning Return template?			
	ii. Does the narrative plan include an explanation for how this target has been reached?	Approach to setting NEA plan set out		p83
	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	Previous performance and impact of schemes set out		p47 and p83-92
Admissions to residential and care homes;	i. Has a target been set for this metric as part of the BCF Planning Return template?	Confirmation from national team that KLOE has been met		p75
	ii. Does the narrative plan include an explanation for how this target has been reached?	Approach to setting residential admissions metric plan set out		p74-76
	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	Previous performance and impact of schemes set out		p74-76
Effectiveness of reablement;	i. Has a target been set for this metric as part of the BCF Planning Return template?	Confirmation from national team that KLOE has been met		p76-78
	ii. Does the narrative plan include an explanation for how this target has been reached?	Approach to setting reablement metric plan set out		p76-78
	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	Previous performance and impact of schemes set out		p35-36, p76-78
Delayed transfers of care;	i. Has a target been set for this metric as part of the BCF Planning Return template?	Confirmation from national team that KLOE has been met		p83-92 and appendix 1 page 98
	ii. Does the narrative plan include an explanation for how this target has been reached?	SEE SECTION C8		p83-92 appendix 2 and 3
	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	SEE SECTION C8		p83-92 appendix 2 and 3

Template for assessing risk to delivery of BCF plans		HWB:		SELECT					
Assessment questions		Assessment answer		Select from the drop-down menu		Any other comments		Free text	
DRIVERS OF LOCAL HEALTH AND SOCIAL CARE ECONOMY RISK STATUS									
The following questions will be used to generate an automatic guideline risk rating for the local health and social care economy.									
NHS Commissioning organisations		Assessment						Comments	
Please Add the name of all CCGs who are part of the BCF plan		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>							
Q1. What is the current financial status of the relevant CCG(s) responsible for commissioning health services?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
Q2. What is the projected financial status of the relevant CCG(s) responsible for commissioning health services over the BCF delivery cycle (2016-17)?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
Q3. What is the current agreed assurance rating for the CCG?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
AUTOMATICALLY GENERATED GUIDELINE RISK RATING FOR HEALTH COMMISSIONER STABILITY									
Local authority commissioning stability		Assessment						Comments	
Please add the name of all Local Authorities who are part of the BCF plan		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>							
Q4. What is the year on year trend in the number of LA commissioned adult social care packages and placements in 15-16 compared 2014-15?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
Q5. What level of risk is associated with financial and service based pressures on social care in the area?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
AUTOMATICALLY GENERATED GUIDELINE RISK RATING FOR SOCIAL CARE STABILITY									
NHS Provider finances		Assessment						Comments	
Please add the name of all providers you have identified as key to the delivery of the BCF plan		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>							
Q6. What is the current financial status of providers of NHS services that are a key element of BCF plans?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
Q7. What is the projected financial status of providers of NHS services that are a key element of BCF plans over the BCF delivery cycle (2014/15 and 2015/16)?		<div>SELECTSELECTSELECTSELECTSELECTSELECTSELECT</div>						<div>Please add any comments here</div>	
AUTOMATICALLY GENERATED GUIDELINE RISK RATING FOR PROVIDER FINANCES									
NHS Providers in special measures or in breach		Assessment						Comments	
Q8. Are any of the providers you have identified above are either: a) a Foundation Trust in breach of their licence conditions; or b) an NHS Trust in Special Measures?		<div>SELECT</div>						<div>Please add any comments here</div>	
Overview		Assessment						Comments	
AUTOMATICALLY GENERATED GUIDELINE RISK RATING ACROSS ALL AREAS									
MODERATED RISK RATING FOR THE LOCAL HEALTH AND SOCIAL CARE ECONOMY									
NARRATIVE ASSESSMENT: What other material factors are there that have an impact on the overall riskiness of the local health and social care economy?		<div>Please add narrative here</div>							
Q9. WHAT IS THE PROPOSED RISK RATING FOR THE LOCAL HEALTH AND SOCIAL CARE ECONOMY? Based on the automatically generated guideline rating (cell F49), and the narrative assessment (cell F53), what is your proposed risk rating for this local health and social care economy?		<div>Moderate risk</div>						<div>Please add any comments here</div>	

Guidance sheet	
Guidance / Areas to consider	
Please list all CCGs who are part of the BCF plan	
Use data on forecast 2016-17 outturn accounts for each CCG. 'In balance' should include a 0.5% tolerance.	
Use data on 2017-18 forecasts from the current operational planning process.	
Please refer to current NHS England assurance ratings for CCGs.	
This automatically generated rating assumes each CCG has an equal weighting. If an unequal weighting of CCGs means the overall rating should change, this should be considered in CELL F53 (Narrative assessment)	
Guidance / Areas to consider	
Local Authorities are asked to provide this assessment. 'No change' to be defined as within 0.5% of previous year.	
Local authorities are asked to self-assess themselves on this question, and invited to articulate their assessment with a narrative answer which references the below selected indicators, bringing in other data/evidence as appropriate: <ul style="list-style-type: none">- Extent of financial pressure from demography on the 2016-17 net adult social care budget. And to what extent will the identified demographic pressure be funded- Spend on prevention services that can be accessed by people that did not cross your councils FAcS Eligibility threshold in 2014/1, 2015-16 and 2016-17- Percentage of ASC savings in comparison to overall council savings- Level of savings planned from the council's expected total net budget and net adult social care budget in 2016-17, and source (ie efficiency / increased income from charges / service reductions)	
Guidance / Areas to consider	
For FTs use data on 2014-15 position from the FTC database of audited Trust returns. For NHS Trusts use 2014-15 outturn from audited accounts. 'In balance' is defined as within 0.5% of turnover.	
For FTs use data on 2015/16 forecast CoSRR rating provided. For this purpose 1-2 equals high risk, 3 equals medium risk; 4 equates to low risk. For NHS Trusts, DCO teams should seek a view from regional TDA / NHS Improvement colleagues.	
This automatically generated rating assumes each identified Provider has an equal weighting. If an unequal weighting of Providers means the overall rating should change, this should be considered in CELL F53 (Narrative assessment)	
If there is any NHS Trust in special measures, or FT in breach of their licence answer Yes.	
This rating is automatically generated based on the answers above. There is the opportunity to revise this in light of other evidence below.	
Guidance / Areas to consider	
Please provide any other evidence that a material impact on the overall risk status of the local health and social care economy. This may include the following considerations: Is your view of the future different to these official ratings, if so why? Are there any likely future transactions or changes to organisational form that may impact these answers? Are there any major capital programmes underway that will impact the local health and social care economy in 2015/16 and 2016/17? What is current (Q1) non-elective activity compared to plan / forecast? Are their detailed delivery plans underpinning LA, CCG and Provider delivery? Are the alternatives to acute non-elective admissions likely to be up and running from 1st April 2016? Do any of the providers, CCGs or LAs exert a disproportionate influence over the local health and social care economy which means they should be weighted more heavily? Is this economy part of a Success Regime site?	
Based on the automatically generated risk rating and your answers to the above, please provide your assessment of the risk rating for the local health and social care economy. A high risk economy is one in which the conditions make it very difficult to deliver a stable plan and in which the capacity of commissioning and providing organisations to deliver is severely limited. A Moderate risk economy is one in which conditions pose a challenge, either in the form of some pressures on delivery capacity or some other instability. A Low risk economy is one on which providers and commissioners are stable and high performing and there are no other external factors that create a significant risk.	

HWB Name	DCO Team
SELECT	SELECT
Barking and Dagenham	Central Midlands
Barnet	Cheshire and Merseyside
Barnsley	Cumbria and the North East
Bath and North East Somerset	East
Bedford	Lancashire and Greater Manchester
Bexley	London
Birmingham	North Midlands
Blackburn with Darwen	South Central
Blackpool	South East
Bolton	South West
Bournemouth & Poole	Wessex
Bracknell Forest	West Midlands
Bradford	Yorkshire and the Humber
Brent	
Brighton and Hove	
Bristol, City of	
Bromley	
Buckinghamshire	
Bury	
Calderdale	
Cambridgeshire	
Camden	
Central Bedfordshire	
Cheshire East	
Cheshire West and Chester	
City of London	
Cornwall	
County Durham	
Coventry	
Croydon	
Cumbria	
Darlington	
Derby	
Derbyshire	
Devon	
Doncaster	
Dorset	
Dudley	
Ealing	
East Riding of Yorkshire	
East Sussex	
Enfield	
Essex	
Gateshead	
Gloucestershire	
Greenwich	

Hackney
Halton
Hammersmith and Fulham
Hampshire
Haringey
Harrow
Hartlepool
Havering
Herefordshire, County of
Hertfordshire
Hillingdon
Hounslow
Isle of Wight
Isles of Scilly
Islington
Kensington and Chelsea
Kent
Kingston upon Hull, City of
Kingston upon Thames
Kirklees
Knowsley
Lambeth
Lancashire
Leeds
Leicester
Leicestershire
Lewisham
Lincolnshire
Liverpool
Luton
Manchester
Medway
Merton
Middlesbrough
Milton Keynes
Newcastle upon Tyne
Newham
Norfolk
North East Lincolnshire
North Lincolnshire
North Somerset
North Tyneside
North Yorkshire
Northamptonshire
Northumberland
Nottingham
Nottinghamshire
Oldham

Oxfordshire
Peterborough
Plymouth
Portsmouth
Reading
Redbridge
Redcar and Cleveland
Richmond upon Thames
Rochdale
Rotherham
Rutland
Salford
Sandwell
Sefton
Sheffield
Shropshire
Slough
Solihull
Somerset
South Gloucestershire
South Tyneside
Southampton
Southend-on-Sea
Southwark
St. Helens
Staffordshire
Stockport
Stockton-on-Tees
Stoke-on-Trent
Suffolk
Sunderland
Surrey
Sutton
Swindon
Tameside
Telford and Wrekin
Thurrock
Torbay
Tower Hamlets
Trafford
Wakefield
Walsall
Waltham Forest
Wandsworth
Warrington
Warwickshire
West Berkshire
West Sussex
Westminster
Wigan

Wiltshire
Windsor and Maidenhead
Wirral
Wokingham
Wolverhampton
Worcestershire
York

LG Region	NHS England Commissioning Region
SELECT	SELECT
East Midlands	London
East of England	Midlands and East of England
London	North of England
North East	South of England
North West	
South East	
South West	
West Midlands	
Yorkshire and Humber	

SELECT

Not met

Partially met

Fully met

SELECT

Low - Does not answer all minimum KLOEs

Medium - Answers all minimum KLOEs but with further work required

High - Comprehensively answers all minimum KLOEs

SELECT

NOT APPROVED

APPROVED WITH SUPPORT

FULLY APPROVED

SELECT

1

2

3

SELECT

In surplus

In balance

In deficit

SELECT

Assured

Assured with support

Not assured

SELECT

Increased provision

No change

Decreased provision

SELECT

High risk

Medium risk

Low risk

SELECT

Yes

No

LA Code	SELECT	CCGs
E09000002	Barking and Dagenham	
E09000003	Barnet	
E08000016	Barnsley	
E06000022	Bath and North East Somerset	
E06000055	Bedford	
E09000004	Bexley	
E08000025	Birmingham	
E06000008	Blackburn with Darwen	
E06000009	Blackpool	
E08000001	Bolton	
E06000028	Bournemouth	
E06000029	Poole	
E06000036	Bracknell Forest	
E08000032	Bradford	
E09000005	Brent	
E06000043	Brighton and Hove	
E06000023	Bristol, City of	
E09000006	Bromley	
E10000002	Buckinghamshire	
E08000002	Bury	
E08000033	Calderdale	
E10000003	Cambridgeshire	
E09000007	Camden	
E06000056	Central Bedfordshire	
E06000049	Cheshire East	
E06000050	Cheshire West and Chester	
E09000001	City of London	
E06000052	Cornwall	
E06000047	County Durham	
E08000026	Coventry	
E09000008	Croydon	
E10000006	Cumbria	
E06000005	Darlington	
E06000015	Derby	
E10000007	Derbyshire	
E10000008	Devon	
E08000017	Doncaster	
E10000009	Dorset	
E08000027	Dudley	
E09000009	Ealing	
E06000011	East Riding of Yorkshire	
E10000011	East Sussex	
E09000010	Enfield	
E10000012	Essex	
E08000020	Gateshead	

E10000013	Gloucestershire
E09000011	Greenwich
E09000012	Hackney
E06000006	Halton
E09000013	Hammersmith and Fulham
E10000014	Hampshire
E09000014	Haringey
E09000015	Harrow
E06000001	Hartlepool
E09000016	Havering
E06000019	Herefordshire, County of
E10000015	Hertfordshire
E09000017	Hillingdon
E09000018	Hounslow
E06000046	Isle of Wight
E06000053	Isles of Scilly
E09000019	Islington
E09000020	Kensington and Chelsea
E10000016	Kent
E06000010	Kingston upon Hull, City of
E09000021	Kingston upon Thames
E08000034	Kirklees
E08000011	Knowsley
E09000022	Lambeth
E10000017	Lancashire
E08000035	Leeds
E06000016	Leicester
E10000018	Leicestershire
E09000023	Lewisham
E10000019	Lincolnshire
E08000012	Liverpool
E06000032	Luton
E08000003	Manchester
E06000035	Medway
E09000024	Merton
E06000002	Middlesbrough
E06000042	Milton Keynes
E08000021	Newcastle upon Tyne
E09000025	Newham
E10000020	Norfolk
E06000012	North East Lincolnshire
E06000013	North Lincolnshire
E06000024	North Somerset
E08000022	North Tyneside
E10000023	North Yorkshire
E10000021	Northamptonshire

E06000048	Northumberland
E06000018	Nottingham
E10000024	Nottinghamshire
E08000004	Oldham
E10000025	Oxfordshire
E06000031	Peterborough
E06000026	Plymouth
E06000044	Portsmouth
E06000038	Reading
E09000026	Redbridge
E06000003	Redcar and Cleveland
E09000027	Richmond upon Thames
E08000005	Rochdale
E08000018	Rotherham
E06000017	Rutland
E08000006	Salford
E08000028	Sandwell
E08000014	Sefton
E08000019	Sheffield
E06000051	Shropshire
E06000039	Slough
E08000029	Solihull
E10000027	Somerset
E06000025	South Gloucestershire
E08000023	South Tyneside
E06000045	Southampton
E06000033	Southend-on-Sea
E09000028	Southwark
E08000013	St. Helens
E10000028	Staffordshire
E08000007	Stockport
E06000004	Stockton-on-Tees
E06000021	Stoke-on-Trent
E10000029	Suffolk
E08000024	Sunderland
E10000030	Surrey
E09000029	Sutton
E06000030	Swindon
E08000008	Tameside
E06000020	Telford and Wrekin
E06000034	Thurrock
E06000027	Torbay
E09000030	Tower Hamlets
E08000009	Trafford
E08000036	Wakefield
E08000030	Walsall

E09000031	Waltham Forest
E09000032	Wandsworth
E06000007	Warrington
E10000031	Warwickshire
E06000037	West Berkshire
E10000032	West Sussex
E09000033	Westminster
E08000010	Wigan
E06000054	Wiltshire
E06000040	Windsor and Maidenhead
E08000015	Wirral
E06000041	Wokingham
E08000031	Wolverhampton
E10000034	Worcestershire
E06000014	York

SELECT	Providers
NHS Airedale, Wharfedale and Craven CCG	
NHS Ashford CCG	
NHS Aylesbury Vale CCG	
NHS Barking and Dagenham CCG	
NHS Barnet CCG	
NHS Barnsley CCG	
NHS Basildon and Brentwood CCG	
NHS Bassetlaw CCG	
NHS Bath and North East Somerset CCG	
NHS Bedfordshire CCG	
NHS Bexley CCG	
NHS Birmingham Cross city CCG	
NHS Birmingham South and Central CCG	
NHS Blackburn with Darwen CCG	
NHS Blackpool CCG	
NHS Bolton CCG	
NHS Bracknell and Ascot CCG	
NHS Bradford City CCG	
NHS Bradford Districts CCG	
NHS Brent CCG	
NHS Brighton and Hove CCG	
NHS Bristol CCG	
NHS Bromley CCG	
NHS Bury CCG	
NHS Calderdale CCG	
NHS Cambridgeshire and Peterborough CCG	
NHS Camden CCG	
NHS Cannock Chase CCG	
NHS Canterbury and Coastal CCG	
NHS Castle Point and Rochford CCG	
NHS Central London (Westminster) CCG	
NHS Central Manchester CCG	
NHS Chiltern CCG	
NHS Chorley and South Ribble CCG	
NHS City and Hackney CCG	
NHS Coastal West Sussex CCG	
NHS Corby CCG	
NHS Coventry and Rugby CCG	
NHS Crawley CCG	
NHS Croydon CCG	
NHS Cumbria CCG	
NHS Darlington CCG	
NHS Dartford, Gravesham and Swanley CCG	
NHS Doncaster CCG	
NHS Dorset CCG	

NHS Dudley CCG
NHS Durham Dales, Easington and Sedgefield CCG
NHS Ealing CCG
NHS East and North Hertfordshire CCG
NHS East Lancashire CCG
NHS East Leicestershire and Rutland CCG
NHS East Riding of Yorkshire CCG
NHS East Staffordshire CCG
NHS East Surrey CCG
NHS Eastbourne, Hailsham and Seaford CCG
NHS Eastern Cheshire CCG
NHS Enfield CCG
NHS Erewash CCG
NHS Fareham and Gosport CCG
NHS Fylde & Wyre CCG
NHS Gateshead CCG
NHS Gloucestershire CCG
NHS Great Yarmouth and Waveney CCG
NHS Greater Huddersfield CCG
NHS Greater Preston CCG
NHS Greenwich CCG
NHS Guildford and Waverley CCG
NHS Halton CCG
NHS Hambleton, Richmondshire and Whitby CCG
NHS Hammersmith and Fulham CCG
NHS Hardwick CCG
NHS Haringey CCG
NHS Harrogate and Rural District CCG
NHS Harrow CCG
NHS Hartlepool and Stockton-on-Tees CCG
NHS Hastings and Rother CCG
NHS Havering CCG
NHS Herefordshire CCG
NHS Herts Valleys CCG
NHS Heywood, Middleton and Rochdale CCG
NHS High Weald Lewes Havens CCG
NHS Hillingdon CCG
NHS Horsham and Mid Sussex CCG
NHS Hounslow CCG
NHS Hull CCG
NHS Ipswich and East Suffolk CCG
NHS Isle of Wight CCG
NHS Islington CCG
NHS Kernow CCG
NHS Kingston CCG
NHS Knowsley CCG

NHS Lambeth CCG
NHS Lancashire North CCG
NHS Leeds North CCG
NHS Leeds South and East CCG
NHS Leeds West CCG
NHS Leicester City CCG
NHS Lewisham CCG
NHS Lincolnshire East CCG
NHS Lincolnshire West CCG
NHS Liverpool CCG
NHS Luton CCG
NHS Mansfield and Ashfield CCG
NHS Medway CCG
NHS Merton CCG
NHS Mid Essex CCG
NHS Milton Keynes CCG
NHS Nene CCG
NHS Newark & Sherwood CCG
NHS Newbury and District CCG
NHS Newcastle North and East CCG
NHS Newcastle West CCG
NHS Newham CCG
NHS North & West Reading CCG
NHS North Derbyshire CCG
NHS North Durham CCG
NHS North East Essex CCG
NHS North East Hampshire and Farnham CCG
NHS North East Lincolnshire CCG
NHS North Hampshire CCG
NHS North Kirklees CCG
NHS North Lincolnshire CCG
NHS North Manchester CCG
NHS North Norfolk CCG
NHS North Somerset CCG
NHS North Staffordshire CCG
NHS North Tyneside CCG
NHS North West Surrey CCG
NHS North, East, West Devon CCG
NHS Northumberland CCG
NHS Norwich CCG
NHS Nottingham City CCG
NHS Nottingham North and East CCG
NHS Nottingham West CCG
NHS Oldham CCG
NHS Oxfordshire CCG
NHS Portsmouth CCG

NHS Redbridge CCG
NHS Redditch and Bromsgrove CCG
NHS Richmond CCG
NHS Rotherham CCG
NHS Rushcliffe CCG
NHS Salford CCG
NHS Sandwell and West Birmingham CCG
NHS Scarborough and Ryedale CCG
NHS Sheffield CCG
NHS Shropshire CCG
NHS Slough CCG
NHS Solihull CCG
NHS Somerset CCG
NHS South Cheshire CCG
NHS South Devon and Torbay CCG
NHS South East Staffs and Seisdon Peninsular CCG
NHS South Eastern Hampshire CCG
NHS South Gloucestershire CCG
NHS South Kent Coast CCG
NHS South Lincolnshire CCG
NHS South Manchester CCG
NHS South Norfolk CCG
NHS South Reading CCG
NHS South Sefton CCG
NHS South Tees CCG
NHS South Tyneside CCG
NHS South Warwickshire CCG
NHS South West Lincolnshire CCG
NHS South Worcestershire CCG
NHS Southampton CCG
NHS Southend CCG
NHS Southern Derbyshire CCG
NHS Southport and Formby CCG
NHS Southwark CCG
NHS St Helens CCG
NHS Stafford and Surrounds CCG
NHS Stockport CCG
NHS Stoke on Trent CCG
NHS Sunderland CCG
NHS Surrey Downs CCG
NHS Surrey Heath CCG
NHS Sutton CCG
NHS Swale CCG
NHS Swindon CCG
NHS Tameside and Glossop CCG
NHS Telford and Wrekin CCG

NHS Thanet CCG
NHS Thurrock CCG
NHS Tower Hamlets CCG
NHS Trafford CCG
NHS Vale of York CCG
NHS Vale Royal CCG
NHS Wakefield CCG
NHS Walsall CCG
NHS Waltham forest CCG
NHS Wandsworth CCG
NHS Warrington CCG
NHS Warwickshire North CCG
NHS West Cheshire CCG
NHS West Essex CCG
NHS West Hampshire CCG
NHS West Kent CCG
NHS West Lancashire CCG
NHS West Leicestershire CCG
NHS West London (K&C & QPP) CCG
NHS West Norfolk CCG
NHS West Suffolk CCG
NHS Wigan Borough CCG
NHS Wiltshire CCG
NHS Windsor, Ascot and Maidenhead CCG
NHS Wirral CCG
NHS Wokingham CCG
NHS Wolverhampton CCG
NHS Wyre forest CCG

SELECT

2gether NHS Foundation Trust
 5Boroughs Partnership NHS Foundation Trust
 Aintree University Hospitals NHS Foundation Trust
 Airedale NHS Foundation Trust
 Alder Hey Children's NHS Foundation Trust
 Ashford and St Peter's Hospitals NHS Foundation Trust
 Avon and Wiltshire Mental Health Partnership NHS Trust
 Barking, Havering and Redbridge University Hospitals NHS Trust
 Barnet and Chase Farm Hospitals NHS Trust
 Barnet, Enfield and Haringey Mental Health NHS Trust
 Barnsley Hospital NHS Foundation Trust
 Barts Health NHS Trust
 Basildon & Thurrock University Hospitals NHS Foundation Trust
 Bedford Hospital NHS Trust
 Berkshire Healthcare NHS Foundation Trust
 Birmingham and Solihull Mental Health NHS Foundation Trust
 Birmingham Children's Hospital NHS Foundation Trust
 Birmingham Community Healthcare NHS Trust
 Birmingham Women's NHS Foundation Trust
 Blackpool Teaching Hospitals NHS Foundation Trust
 Bolton NHS Foundation Trust
 Bradford District Care Trust
 Bradford Teaching Hospitals NHS Foundation Trust
 Bridgewater Community Healthcare NHS Trust
 Brighton and Sussex University Hospitals NHS Trust
 Buckinghamshire Healthcare NHS Trust
 Burton Hospitals NHS Foundation Trust
 Calderdale and Huddersfield NHS Foundation Trust
 Calderstones Partnership NHS Foundation Trust
 Cambridge University Hospitals NHS Foundation Trust
 Cambridgeshire and Peterborough NHS Foundation Trust
 Cambridgeshire Community Services NHS Trust
 Camden and Islington NHS Foundation Trust
 Central and North West London NHS Foundation Trust
 Central London Community Healthcare NHS Trust
 Central Manchester University Hospitals NHS Foundation Trust
 Chelsea and Westminster NHS Foundation Trust
 Cheshire and Wirral Partnership NHS Foundation Trust
 Chesterfield Royal Hospital NHS Foundation Trust
 City Hospitals Sunderland NHS Foundation Trust
 Colchester Hospital University NHS Foundation Trust
 Cornwall Partnership NHS Foundation Trust
 Countess of Chester Hospital NHS Foundation Trust
 County Durham and Darlington NHS Foundation Trust
 Coventry and Warwickshire Partnership NHS Trust

Croydon Health Services NHS Trust
Cumbria Partnership NHS Foundation Trust
Dartford and Gravesham NHS Trust
Derby Hospitals NHS Foundation Trust
Derbyshire Community Health Services NHS Trust
Derbyshire Healthcare NHS Foundation Trust
Devon Partnership NHS Trust
Doncaster & Bassetlaw Hospitals NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Dorset Healthcare University NHS Foundation Trust
Dudley and Walsall Mental Health Partnership NHS Trust
Ealing Hospital NHS Trust
East and North Hertfordshire NHS Trust
East Cheshire NHS Trust
East Kent Hospitals University NHS Foundation Trust
East Lancashire Hospitals NHS Trust
East London NHS Foundation Trust
East Midlands Ambulance Service NHS Trust
East of England Ambulance Service NHS Trust
East Sussex Healthcare NHS Trust
Epsom and St Helier University Hospitals NHS Trust
Frimley Park Hospital NHS Foundation Trust
Gateshead Health NHS Foundation Trust
George Eliot Hospital NHS Trust
Gloucestershire Care Services NHS Trust
Gloucestershire Hospitals NHS Foundation Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Great Western Hospitals NHS Foundation Trust
Greater Manchester West Mental Health NHS Foundation Trust
Guy's & St Thomas' Hospital NHS Foundation Trust
Hampshire Hospitals NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Heart of England NHS Foundation Trust
Heatherwood and Wexham Park Hospitals NHS Foundation Trust
Hertfordshire Community NHS Trust
Hertfordshire Partnership University NHS Foundation Trust
Hinchingsbrooke Health Care NHS Trust
Homerton University Hospital NHS Foundation Trust
Hounslow and Richmond Community Healthcare NHS Trust
Hull and East Yorkshire Hospitals NHS Trust
Humber NHS Foundation Trust
Imperial College Healthcare NHS Trust
Ipswich Hospital NHS Trust
Isle of Wight NHS Trust
James Paget University Hospitals NHS Foundation Trust
Kent and Medway NHS and Social Care Partnership Trust

Kent Community Health NHS Trust
Kettering General Hospital NHS Foundation Trust
King's College Hospital NHS Foundation Trust
Kingston Hospital NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Community Healthcare NHS Trust
Leeds Teaching Hospitals NHS Trust
Leicestershire Partnership NHS Trust
Lewisham and Greenwich NHS Trust
Lincolnshire Community Health Services NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Liverpool Community Health NHS Trust
Liverpool Heart and Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
London Ambulance Service NHS Trust
Luton and Dunstable University Hospital NHS Foundation Trust
Maidstone and Tunbridge Wells NHS Trust
Manchester Mental Health and Social Care Trust
Medway NHS Foundation Trust
Mersey Care NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Mid Staffordshire NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
Milton Keynes Hospital NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
Norfolk and Suffolk NHS Foundation Trust
Norfolk Community Health and Care NHS Trust
North Bristol NHS Trust
North Cumbria University Hospitals NHS Trust
North East Ambulance Service NHS Foundation Trust
North East London NHS Foundation Trust
North Essex Partnership University NHS Foundation Trust
North Middlesex University Hospital NHS Trust
North Staffordshire Combined Healthcare NHS Trust
North Tees and Hartlepool NHS Foundation Trust
North West Ambulance Service NHS Trust
North West London Hospitals NHS Trust
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust
Northern Devon Healthcare NHS Trust
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust
 Nottingham University Hospitals NHS Trust
 Nottinghamshire Healthcare NHS Trust
 Oxford Health NHS Foundation Trust
 Oxford University Hospitals NHS Trust
 Oxleas NHS Foundation Trust
 Papworth Hospital NHS Foundation Trust
 Pennine Acute Hospitals NHS Trust
 Pennine Care NHS Foundation Trust
 Peterborough and Stamford Hospitals NHS Foundation Trust
 Plymouth Hospitals NHS Trust
 Poole Hospital NHS Foundation Trust
 Portsmouth Hospitals NHS Trust
 Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
 Queen Victoria Hospital NHS Foundation Trust
 Rotherham Doncaster and South Humber NHS foundation trust
 Royal Berkshire NHS Foundation Trust
 Royal Brompton and Harefield NHS Foundation Trust
 Royal Cornwall Hospitals NHS Trust
 Royal Devon and Exeter NHS Foundation Trust
 Royal Free London NHS Foundation Trust
 Royal Liverpool and Broadgreen University Hospitals NHS Trust
 Royal National Hospital For Rheumatic Diseases NHS Foundation Trust
 Royal National Orthopaedic Hospital NHS Trust
 Royal Surrey County Hospital NHS Foundation Trust
 Royal United Hospital Bath NHS Trust
 Salford Royal NHS Foundation Trust
 Salisbury NHS Foundation Trust
 Sandwell and West Birmingham Hospitals NHS Trust
 SELECT
 Sheffield Children's NHS Foundation Trust
 Sheffield Health and Social Care NHS Foundation Trust
 Sheffield Teaching Hospitals NHS Foundation Trust
 Sherwood Forest Hospitals NHS Foundation Trust
 Shrewsbury and Telford Hospital NHS Trust
 Shropshire Community Health NHS Trust
 Solent NHS Trust
 Somerset Partnership NHS Foundation Trust
 South Central Ambulance Service NHS Foundation Trust
 South Devon Healthcare NHS Foundation Trust
 South East Coast Ambulance Service NHS Foundation Trust
 South Essex Partnership University NHS Foundation Trust
 South London and Maudsley NHS Foundation Trust
 South Staffordshire and Shropshire Healthcare NHS Foundation Trust
 South Tees Hospitals NHS Foundation Trust
 South Tyneside NHS Foundation Trust

South Warwickshire NHS Foundation Trust
South West London and St George's Mental Health NHS Trust
South West Yorkshire Partnership NHS foundation trust
South Western Ambulance Service NHS Foundation Trust
Southend University Hospital NHS Foundation Trust
Southern Health NHS Foundation Trust
Southport and Ormskirk Hospital NHS Trust
St George's Healthcare NHS Trust
St Helens and Knowsley Hospitals NHS Trust
Staffordshire and Stoke on Trent Partnership NHS Trust
Stockport NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust
Surrey and Sussex Healthcare NHS Trust
Sussex Community NHS Trust
Sussex Partnership NHS Foundation Trust
Tameside Hospital NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Black Country Partnership NHS Foundation Trust
The Christie NHS Foundation Trust
The Clatterbridge Cancer Centre NHS Foundation Trust
The Dudley Group NHS Foundation Trust
The Hillingdon Hospitals NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
The Princess Alexandra Hospital NHS Trust
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
The Rotherham NHS Foundation Trust
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton NHS Trust
The Walton Centre NHS Foundation Trust
The Whittington Hospital NHS Trust
Torbay and Southern Devon Health and Care NHS Trust
United Lincolnshire Hospitals NHS Trust
University College London Hospitals NHS Foundation Trust
University Hospital of North Staffordshire NHS Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Foundation Trust
Walsall Healthcare NHS Trust

Warrington and Halton Hospitals NHS Foundation Trust
West Hertfordshire Hospitals NHS Trust
West London Mental Health NHS Trust
West Middlesex University Hospital NHS Trust
West Midlands Ambulance Service NHS Foundation Trust
West Suffolk NHS Foundation Trust
Western Sussex Hospitals NHS Foundation Trust
Weston Area Health NHS Trust
Wirral Community NHS Trust
Wirral University Teaching Hospital NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
Wye Valley NHS Trust
Yeovil District Hospital NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

		Cumulative Target																																				
GWH	Monthly DTOC targets from baseline July - December 2015	BCF Target 1 monthly trajectory days lost at GWH and SWICC by reason																																				
		Cumulative Target																																				
		Baseline		Cumulative Target																																		
		July - December 2015		Monthly	baseline	April target -10%		May-15%		June -20%		July -30%		August -35%		September -40%		October -45%		November - 50%		December		January		February		March		Total 16/17								
		NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS	NHS	SS							
		A) Completion of assessment (70% reduction)	73	446	7	22	6.3	19.8	6.0	18.7	5.6	17.6	4.9	15.4	4.6	14.3	4.2	13.2	3.9	12.1	3.5	11.0	2.1	6.6	2.1	6.6	2.1	6.6	2.1	6.6	47.3	148.5						
		B) Public Funding	16	82	2	13	1.8	11.7	1.7	11.1	1.6	10.4	1.4	9.1	1.3	8.5	1.2	7.8	1.1	7.2	1.0	6.5	1.0	6.5	1.0	6.5	1.0	6.5	1.0	6.5	15.1	98.2						
		C) Further non acute NHS care (including intermediate care, rehabilitation etc)	127	0	21	0	18.9	0.0	17.9	0.0	16.8	0.0	14.7	0.0	13.7	0.0	12.6	0.0	11.6	0.0	10.5	0.0	10.5	0.0	10.5	0.0	10.5	0.0	10.5	0.0	158.6	0.0						
		D) Care Home placement - Residential Home	54	349	9	58	8.1	52.2	7.7	49.3	7.2	46.4	6.3	40.6	5.9	37.7	5.4	34.8	5.0	31.9	4.5	29.0	4.5	29.0	4.5	29.0	4.5	29.0	4.5	29.0	68.0	437.9						
		Dii) Care Home placement - Nursing Home	223	495	37	83	33.3	74.7	31.5	70.6	29.6	66.4	25.9	58.1	24.1	54.0	22.2	49.8	20.4	45.7	18.5	41.5	18.5	41.5	18.5	41.5	18.5	41.5	18.5	41.5	279.4	626.7						
		E) Care package in own home	350	719	58	120	52.2	108.0	49.3	102.0	46.4	96.0	40.6	84.0	37.7	78.0	34.8	72.0	31.9	66.0	29.0	60.0	29.0	60.0	29.0	60.0	29.0	60.0	29.0	60.0	437.9	906.0						
		F) Community Equipment/adaptions	119	17	20	3	18.0	2.7	17.0	2.6	16.0	2.4	14.0	2.1	13.0	2.0	12.0	1.8	11.0	1.7	10.0	1.5	10.0	1.5	10.0	1.5	10.0	1.5	10.0	1.5	151.0	22.7						
		G) Patient or family choice	374	74	62	12	55.8	10.8	52.7	10.2	49.6	9.6	43.4	8.4	40.3	7.8	37.2	7.2	34.1	6.6	31.0	6.0	31.0	6.0	31.0	6.0	31.0	6.0	31.0	6.0	468.1	90.6						
		H) Disputes	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0						
		I) Housing - patients not covered by NHS and Community Care Act	62	0	10	0	9.0	0.0	8.5	0.0	8.0	0.0	7.0	0.0	6.5	0.0	6.0	0.0	5.5	0.0	5.0	0.0	5.0	0.0	5.0	0.0	5.0	0.0	5.0	0.0	75.5	0.0						
		Total	1398	2182	226	311	203.4	279.9	192.1	264.4	180.8	248.8	158.2	217.7	146.9	202.2	135.6	186.6	124.3	171.1	113.0	155.5	111.6	151.1	111.6	151.1	111.6	151.1	111.6	151.1	1700.7	2330.5						
		DTOC target to reduce GWH days lost to 3% across health and social care Target 2					5%		4.90%		4.70%		4.50%		4%		3.50%		3%		3%		3%		3%		3%		3%		0							
		Swindon target 1.8% health and social care based on 60% of beds occupied by swindon					3.00%		2.90%		2.80%		2.70%		2.40%		2.10%		1.80%		1.80%		1.80%		1.80%		1.80%		1.80%		0							
		Wiltshire and other CCG areas 1.2% based on 40% occupied beds					2%		2%		1.90%		1.80%		1.60%		1.40%		1.20%																			
		BCF DTOC Targets 3									Combined						combined						Combine								combined							
							April		May		June		quarter 1		July		August		September		quarter 2		October		November		December		quarter 3		January		February		March		quarter 4	
		BCF days lost monthly target across health and social care including mental health					600		570		530		1700		490		450		420		1360		367		367		366		1100		334		333		333		1000	
		ASCOF 2 c(i) delays of people per rate of 100,000 NHS and Social care as of the last Thursday of the month 236 patients = 15.7 rate achieving rate of 6 per 100,000 combined and ASCOF 2 C (i) part 2 3 per 100,00 for social care					99.0	137= 9.1	16.0	23.0	9.0	9.0	8.0	8.0	7.0	7.0	6.0	6.0	5.0	5.0	4.0	4.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3	3		

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Total Number of DToC Days per Month

	Attributable to NHS			Attributable to SS			Attributable to Both		
	SWICC	GWH	Total	SWICC	GWH	Total	SWICC	GWH	Total
A) Completion of assessment	0	27	27	0	30	30	0	3	3
B) Public Funding	5	1	6	0	4	4	0		0
C) Further non acute NHS care (including intermediate care, rehabilitation etc)	0	35	35						
Di) Care Home placement - Residential Home	0	7	7	0	6	6			
Dii) Care Home placement - Nursing Home	28	18	46	16	31	47	0	4	4
E) Care package in own home	8	9	17	1	2	3	0		0
F) Community Equipment/adaptions	3	6	9	0		0	0		0
G) Patient or family choice	6	1	7	0		0			
H) Disputes	0		0	0		0			
I) Housing - patients not covered by NHS and Community Care Act	0	1	1						
Total	50	105	155	17	73	90	0	7	7

Total Number of DToC Patients on Last Thursday of Month

	Attributable to NHS			Attributable to SS			Attributable to Both		
	SWICC	GWH	Total	SWICC	GWH	Total	SWICC	GWH	Total
A) Completion of assessment	0		0	0	1	1	0	0	0
B) Public Funding	1		1	0		0	0	0	0
C) Further non acute NHS care (including intermediate care, rehabilitation etc)	0	4	4						
Di) Care Home placement - Residential Home	0	1	1	0		0			
Dii) Care Home placement - Nursing Home	0		0	1		1	0	0	0
E) Care package in own home	1		1	0		0	0	0	0
F) Community Equipment/adaptions	0	1	1	0		0	0	0	0
G) Patient or family choice	2		2	0		0			
H) Disputes	0		0	0		0			
I) Housing - patients not covered by NHS and Community Care Act	0		0						
Total	4	6	10	1	1	2	0	0	0

Total Number of DToC Days per Month

	Attributable to NHS			Attributable to SS			Attributable to Both		
	SWICC	GWH	Total	SWICC	GWH	Total	SWICC	GWH	Total
<i>A) Completion of assessment</i>	16	4	20	0	28	28	0	0	0
<i>B) Public Funding</i>	3	2	5	0	1	1	0	0	0
<i>C) Further non acute NHS care (including intermediate care, rehabilitation etc)</i>	0	46	46	-	-	-	-	-	-
<i>Di) Care Home placement - Residential Home</i>	0	12	12	0	26	26	-	-	-
<i>Dii) Care Home placement - Nursing Home</i>	3	32	35	23	6	29	0	0	0
<i>E) Care package in own home</i>	6	8	14	0	1	1	0	0	0
<i>F) Community Equipment/adaptions</i>	2	1	3	4	3	7	0	0	0
<i>G) Patient or family choice</i>	9	6	15	0	0	0	-	-	-
<i>H) Disputes</i>	0		0	0	0	0	-	-	-
<i>I) Housing - patients not covered by NHS and Community Care Act</i>	0	15	15	-	-	-	-	-	-
Total	39	126	165	27	65	92	0	0	0

Total Number of DToC Patients on Last Thursday of Month

	Attributable to NHS			Attributable to SS			Attributable to Both		
	SWICC	GWH	Total	SWICC	GWH	Total	SWICC	GWH	Total
<i>A) Completion of assessment</i>	0	0	0	0	3	3	0	0	0
<i>B) Public Funding</i>	0	1	1	0	0	0	0	0	0
<i>C) Further non acute NHS care (including intermediate care, rehabilitation etc)</i>	0	3	3	-	-	-	-	-	-
<i>Di) Care Home placement - Residential Home</i>	0	0	0	0	0	0	-	-	-
<i>Dii) Care Home placement - Nursing Home</i>	0	0	0	1	2	3	0	0	0
<i>E) Care package in own home</i>	2	0	2	0	0	0	0	0	0
<i>F) Community Equipment/adaptions</i>	0	0	0	1	1	2	0	0	0
<i>G) Patient or family choice</i>	0	1	1	0	0	0	-	-	-
<i>H) Disputes</i>	0	0	0	0	0	0	-	-	-
<i>I) Housing - patients not covered by NHS and Community Care Act</i>	0	0	0	-	-	-	-	-	-
Total	2	5	7	2	6	8	0	0	0

Consideration of Joint Commissioning Group Minutes

Health and Wellbeing Board

Date: 25 May 2016

Author:	Interim Director Adult Social Services, Swindon Borough Council
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 To allow the Health and Wellbeing Board to consider the issues arising from the meetings of the Joint Commissioning Group held on 2 February, 1 March and 3 May 2016. The meeting of the Joint Commissioning Group in April was cancelled.

2. Recommendations

The Committee is recommended to:

- 2.1 To review the discussions held and issues arising from the meetings of the Joint Commissioning Group held on 2 February, 1 March and 3 May 2016, and where appropriate request additional information or reports in relation to issues raised.

3. Detail

- 3.1 The Health and Wellbeing Board is invited to consider issues arising from the minutes of the Joint Commissioning Group held on 2 February, 1 March and 3 May 2016 and to request additional information and/or reports on issues raised.

4. Alternative Options

- 4.1 None.

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 This report has no financial or procurement implications.

Legal and Human Rights Implications

- 5.2 This report has no legal or Human Rights considerations.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 None.

Further information on the subject of this report can be obtained from Sue Wald, 01793 465713, swald@swindon.gov.uk.

Consideration of Joint Commissioning Group Minutes

Health and Wellbeing Board

Date: 25 May 2016

Diversity Impact Assessment

- 5.4 No Diversity Impact Assessment is required at this stage.

Risk Management

- 5.5 No risk management issues have been identified at this stage.

6. Consultees

- 6.1 This covering report collates the minutes of the Joint Commissioning Group at their meetings on 2 February, 1 March and 3 May 2016. The items discussed at those meetings were / will be consulted upon as appropriate, so no further consultation is required for this report.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 - Minutes of the Joint Commissioning Group held on 2 February 2016.
- 8.2 Appendix 2 – Minutes of the Joint Commissioning Group held on 1 March 2016.
- 8.3 Appendix 3 – Minutes of the Joint Commissioning Group held on 3 May 2016.

Joint Commissioning Group
Notes of 2nd February 2016 Meeting

Present:

Sue Wald (SW), Sheila Baxter (SB), Cherry Jones (CJ), Paul Bearman (PB), Matthew Hawkins (MH), Louise Tapper (LT), Thomas Kearney (TK), Gill May (GM), Jackie Walker (JW), Sarah Bright (SB). Joy Kennard (JK), Angela Plummer (AP), Lynn Frith

Apologies: Caroline Gregory (CG) Peter Nathan (PN), Nicki Millin (NM),

<i>Item</i>	<i>Description</i>	<i>Action</i>
1.	<p>Matters arising and Minutes</p> <p>Update on outstanding actions :</p> <p>MH Transformation Plan January submission going today</p> <p>CCG undertaking full review of children's health service provision with terms of references to be agreed with Sarah Bright leading. Joy to brief Mark Green</p> <p>Domiciliary care gateway paper circulated today</p> <p>Care home meeting today, action plan developed as part of DTOC programme board. Delayed discharge visit by NHS England resulted in a programme approach to discharge from hospital. Sue to circulate Project Initiation Documents</p> <p>There will also be a programme for Urgent Care and Gill will circulate the project initiation document</p> <p>Calculation of hourly rate for residential and nursing care for SBC – providers asking for 10% , care home providers rate agreed of 6%. Conversations with domiciliary care providers are continuing, currently asking for 9%, there is 3% in the budget.</p> <p>AWP discharge process – There are still issues over discharge process and disagreement over figures. Gill May attended a meeting with AWP and will advise whether there is a forum for discussion. Sue also to discuss with James Cawley from Wiltshire Council who have similar issues and potential for a joint letter.</p> <p>AWP have asked to transfer 90 open cases of older people in care homes. Sue and Angela stressed that these are cases that have to be case managed under the Care Act 2014. There are also mental health transition cases which are not always picked up by AWP when an assessment is required under the Care Act 2014. Angela, Sheila and</p>	<p>TK</p> <p>JK</p> <p>SW</p> <p>SW</p> <p>AP/TK</p>

<i>Item</i>	<i>Description</i>	<i>Action</i>
	Thomas to meet next week to take forward. There is a need to review the secondment agreement and service specification for social work within AWP.	
2.	<p>Finance</p> <p>SBC</p> <p>The forecast outturn position across Children & Adults Commissioning as at the end of December 2015 is an underspend of £371k. This is £700k lower than the £1,087k forecast in Oct 15.</p> <p>Children's forecast position has deteriorated - now over spent by £2.6m. A contributory factor is the issue around staffing and placement availability.</p> <p>SBC budget 2016/17</p> <p>Jackie circulated a set of slides outlining SBC position with pressures of £7.75m for adult & children social care and a savings target of £6.5m which includes the social care precept of £1.5m. Flagged up pressures around dom care and residential care. Sector anticipating significant cost pressures from having to pay above living wage to attract staff plus impact of changes in 'national NI contributions; and pensions. Still awaiting confirmation of the public health grant allocation.</p> <p>CCG budget 2016/17</p> <p>Allocation received for CCG finance which is an uplift but also requirement to invest in acute care. Overall savings target for CCG around £10m – 13m if all pressures are to be funded. Discussed the proposed investments including the development of business cases for paediatric therapies; Paediatric SALT; MASH. Also need to add £20k for safeguarding adults. AWP – SAFER staffing investment need to be understood; ORCP programme spend needs to be clarified to confirm value for money.</p> <p>Currently the CCG has a vacancy for a Joint Children Commissioner and this needs to be resolved.</p> <p>Education</p> <p>LF raised the cost pressures for the group to be aware of new providers are bidding to open new special schools and there are likely to be an additional 160 new school places. This could bring new autism patients to Swindon. There is going to be a need to recognise the responsible commissioner. There is a need to review special educational needs in Swindon and link into developing a new JSNA for SEN. Also need to consider the transitions agenda.</p>	<p>TK</p> <p>TK/LF</p>

Item	Description	Action
3.	<p>Performance</p> <p>Adults – key performance concerns reported were: Permanent admissions to care homes; Acceptable waiting times for assessment; Acceptable waiting times for assessment – contact to start of assessment within 5 days; Waiting times for packages of care.</p> <p>AWP Clients receiving self-directed support Adults in contact with mental health services settled accommodation Acceptable waiting times for assessment – contact to start of assessment within 5 days; Waiting times for packages of care. Snapshot of delayed discharges attributable to Social care.</p> <p>Children's Performance SEN data is now being collected and this will be incorporated into the report going forward.</p>	LF
4.	<p>Area inspection special educational needs</p> <p>LF flagged that SEN may be due for an inspection.</p> <p>Named CCG lead identified for any potential inspection – nominated Nicki Millin as Accountable Officer and Gill May, Executive Nurse.</p>	
5.	<p>BCF planning guidance</p> <p>Awaiting publication of the national guidance and allocation</p>	
6.	<p>Wheel chairs and equipment</p> <p>LT had no specific issues to report.</p>	
7.	<p>Personal health budgets</p> <p>Update on the PHB project provided, recognition that the Local Health Offer will need to be agreed at the March Health and Wellbeing Board. Proposed that this is brought to the attention of CAG. CCG has a plan to develop a pilot with a cohort of CHC eligible cases who are in domicilliary</p>	CJ

Item	Description	Action
	care who might benefit from a PHB.	
8.	<p>Transformation Plan</p> <p>Joint plan for Wiltshire and Swindon, recognition that Wiltshire has a significant number of individuals in placements whereas Swindon have not had any in the last year. Plan needs to be submitted by the 8/2/16 and signed off by Health and Wellbeing Board.</p> <p>From April the work relating to LD health; psychology; and psychiatry will be with the CCG rather than SBC. TK will be leading on this for the CCG. Processes required to be in place for 1st April for referrals, funding etc relating to all health placements that currently sit with the CHC and Health Team.</p>	
9.	<p>AOB</p> <p>CJ updated that notice had been given on the collaboratively commissioned SW programme for behavioural change for tobacco control provided by PHA (Public Health Action). There had been challenge from centre on this decision.</p>	
10.	<p>Future meetings</p> <p>March 2016</p> <p>Risk register review</p> <p>'Free School' update - LF</p>	

Joint Commissioning Group
Notes of 1st March 2016 Meeting

Present:

Sue Wald (SW), Sheila Baxter (SB), Cherry Jones (CJ), Paul Bearman (PB), Louise Tapper (LT), Thomas Kearney (TK), Gill May (GM), Lynn Frith

Apologies: Caroline Gregory (CG) Peter Nathan (PN), Nicki Millin (NM), Jackie Walker (JW), Sarah Bright (SB). Joy Kennard (JK), Angela Plummer (AP), Matthew Hawkins (MH),

<i>Item</i>	<i>Description</i>	<i>Action</i>
1.	<p>Matters arising and Minutes Update on outstanding actions :</p> <p>MH Transformation Plan submitted and positive feedback. Gill May taking senior leadership role for Swindon with support from Elaine Turner. Handover with Wiltshire and performance information to be sought from SEQOL each month. Matched funding proposal to NHSE has been submitted to help implement the plan.</p> <p>CCG undertaking full review of children's health service on the agenda</p> <p>PID for Urgent care and DTOC circulated</p> <p>Domiciliary care provider meeting this morning, SBC aiming to offer 5%</p> <p>AWP discharge and performance issues. Letter sent by Sue Wald to AWP. Delayed discharge still not resolved. Meeting planned for this Friday</p> <p>DTOC: PID signed off by NHSE, Project Team and programme Board established and meeting. Baseline data by month established for each reason across Health and Social Care. Monthly targets to be agreed this week at Programme Board. Days lost have seen a small reduction over the last three months.</p>	
2.	<p>Finance SBC</p> <p>The forecast outturn position across Children & Adults Commissioning as at the end of January 2016 has deteriorated due to a number of transition cases which had not been fed into financial planning. Out turn now expected to be slightly over budget of £173k. Children's services overspend reduced to £2.5m</p>	

<i>Item</i>	<i>Description</i>	<i>Action</i>
	<p>SBC budget 2016/17</p> <p>SBC budget now agreed with increase in Council tax and precept at 3.99%. The overall position for adult services is a slight increase to mitigate effect of living wage. Main savings to continue to come from Learning Disabilities. There could be further in year austerity measures.</p> <p>CCG budget 2016/17</p> <p>Allocation received for CCG finance which is an uplift but also requirement to invest in acute care. Overall savings target for CCG around £10m – 13m if all pressures are to be funded.</p> <p>BCF budget 2015/16</p> <p>BCF budget summary for December 2015 circulated separately to CCG finance in February 2016. Agreement that £100k from befriending allocation would go to CCG for hospital discharge. Quarter 3 return agreed with CCG Finance and circulated.</p>	
3.	<p>Children's Review</p> <p>Terms of references circulated, children's health services have been circulated to Karen Reeve and mark Green. TOR to be circulated to Peter Nathan. Project lead to be confirmed by CCG</p>	JK GM
4.	<p>Recruitment of Children's Commissioner</p> <p>Formal offer made to Caroline Little for the Strategic Commissioner Voluntary sector. Sue to speak to Caroline this week over resignation from CCG so that recruitment can proceed.</p>	
5.	<p>SEQOL – contract query and CQRM update</p> <p>This was issued on community nursing last week on missed visits. The quality meeting focused on review of community nursing teams and neighbourhood working, wound care. Action plan drafted, further milestones to be submitted by SEQOL. Failure to deliver on milestones would result in performance notice. Audit on wound care to be undertaken by Academic Health Science Network and Welsh Centre for Innovation on Wound Care</p> <p>Performance dashboard circulated.</p>	
6.	<p>AWP – CQC inspection in May 2016 (Gill May)</p> <p>Follow up inspection due in May 2016. Quality Improvement Group chaired by TDA which is monitoring the CCG action plan. Minutes of this quarterly meeting shared with JCG. Hayley Richards appointed as CEO.</p> <p>Locally Simon Manchip resigned as clinical director. Action Plan for Swindon due to come from Paula May as Operational Director. Newlands</p>	

Item	Description	Action
	Anning acting as local Director.	
7.	DToC – position and progress with AWP Following letter by Sue Wald, DTOC progress drafted and to be shared with Rani Rooke to produce a robust plan. Positive work on inpatient support and no out of area beds used. This needs to include a Choice Policy, Mental health Act 117 After Care Discharge Plan. Sue to try and meet Newlands this Friday with Angela and Thomas K. There is a need for clear minutes and actions, which CCG is offering to minute. Sue to circulate GWH discharge protocol and data validation process.	SW
8.	Community service procurement update Notice has been served, CCG hosting a joint programme board . Sue to be SBC representative with Jackie/Angela Draft advert to be agreed across SBC and CCG. Sue to ask Geraldine Ward from SBC procurement <ul style="list-style-type: none"> - LD health services could transfer to AWP as part of the psychology and psychiatry services. Louise taper to share service specification - IAPT : Needs conversation with IAPT whether these services are included in the PIN notice - CCG recruiting Transformation Director – interviews next week 	
9.	CCG Planning update for 2016/17 and STP One year CCG Operational Plan P due on Wednesday. Plan to be shared so that it can be cross referenced to BCF. PWC have run two sessions on Sustainable Transformation Plan which will need to be done with Wiltshire and BANES. Public Health working on a neighbourhood profile but Cherry needs clarity over number of neighbourhoods and geographical boundaries.	PB
10.	Panel terms of reference update Mapping of mental health, CHC and children's panel with agreed TOR, representation and decision making authority, non contractual agreement for placements/support packages. Gill May to identify lead for this.	GM
11.	s75 KPI activities report for AWP Vulnerable adults programme report on mental health has risk identified	

Item	Description	Action
	which needs rewording. Sheila to pick up with John Hughes	
12.	<p>Performance</p> <p>Adults – key performance concerns reported have not changed since December and continue to be were: Permanent admissions to care homes; Acceptable waiting times for assessment; Acceptable waiting times for assessment – contact to start of assessment within 5 days; Waiting times for packages of care.</p> <p>AWP Clients receiving self-directed support Adults in contact with mental health services settled accommodation Acceptable waiting times for assessment – contact to start of assessment within 5 days; Waiting times for packages of care. Snapshot of delayed discharges attributable to Social care.</p> <p>Children's Performance Next meeting</p>	
13.	<p>BCF planning guidance</p> <p>BCF planning guidance was issued last week and template on Wednesday with submission this Wednesday. Template agreed by EMT and SBC. Uplift of £397k for Swindon, to be used for inflation SBC, £110k discharge to assess, Rapid Assessment Unit</p> <p>Text currently being refreshed in light of One year Operational Plan and Five Year Strategic Transformation Plan. Submission of 2016/17 Plan end of March. Sue to circulate draft so that sections on urgent care, data and risk register can be updated as well as new plan with quarterly milestones. Finance template going to HWB next week.</p>	
14.	<p>AOB.</p> <p>Free School' update – 3 application submitted for 150 place school of which 20 places planned to be residential. Bids will be available tomorrow. DfE decision likely to be September 2016.</p> <p>DfE monitoring visit on SEN, delay in completion of Education Health and Care plans within 20 weeks. Capacity within speech and language, OT and paediatric therapy seem to be contributing to the delay. Performance information to come to the next meeting. Lynn to bring report on this to the next meeting. This would be an issue in any forthcoming inspection</p>	LF

Item	Description	Action
	<p>Sexual health services to be commissioned from GWH as part of a Section 75</p> <p>Swindon not successful in Healthy Town bid but part of the programme</p> <p>Health based provision will move to Public health from Localities</p> <p>Public health outcomes framework published this week and life expectancy inequality gap widened among men in swindon is second highest in South West. Immunisation for pneumonia low in Swindon</p>	
15.	<p>Future meetings</p> <p>March 2016</p> <p>Risk register review</p>	

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Joint Commissioning Group
Notes of 3rd May 2016 Meeting

Present:

Sue Wald (SW), Sheila Baxter (SB), Cherry Jones (CJ), Louise Tapper (LT) Lynn Frith, Jackie Walker (JW), Joy Kennard (JK), Angela Plummer (AP),

Apologies: Caroline Gregory (CG) Peter Nathan (PN), Nicki Millin (NM), Matthew Hawkins (MH), Paul Bearman (PB), , Thomas Kearney (TK), Gill May (GM),

<i>Item</i>	<i>Description</i>	<i>Action</i>
1.	<p>Matters arising and Minutes</p> <p>The minutes circulated for 1st March 2016 stated 2nd February 2016. Sue to circulated 1st March 2016 minutes</p> <p>Update on outstanding actions :</p> <p>CCG review of children's health services terms of reference were circulated and follow up meeting to discuss TOR with children's services</p> <p>AWP DTOC: meeting held with AWP to resolve monthly data submission. Some issues remaining, see below</p> <p>SEN: therapy capacity on the agenda</p>	
2.	<p>Speech and Language and Paediatric Therapy</p> <p>Wait time for speech and language and paediatric therapy for children awaiting assessment including relating to education health & care Plan means children are delayed to 26 – 32 weeks. The requirement to meet the advice within 6 weeks for children awaiting EHCP is not being met. Agreed for amended paper to go to Gill May and to Executive, total amount requested is £100k</p>	MG/G M
3.	<p>CAMHS</p> <p>Children's Services have requested that looked after children are prioritised by CAMHS and not clear that priority is given. Joy agreed to chase Michelle Maguire on the outcome of the audit into looked after children. Adult services are also identifying that CAMHS is referring children over 18 very late to AWP. Sheila is going to raise in CAMHS Transition Group with AWP.</p>	JK/SW
4.	<p>Perinatal Mental health Development Plan</p> <p>Sheila reported on this development which has been led by Public health with the initial development Plan and pilot pathway launched 6th – 10th June 2016 and piloted for 12 months. It was agreed to include dual diagnosis for women with mental health and a learning disabilities and for the document to be amended. LD health to be invited to the project</p>	SB

Item	Description	Action
	group	
5.	TB Needs assessment Cherry introduced the paper on the TB needs assessment across BANES, Wiltshire and Swindon. Cherry is going to email CCG to ask for with a named lead.	
6.	BCF First BCF submission positively received but changes needed to DTOC Plan. No changes to BCF budget. BCF will form a new schedule 2016/17 in section 75 BCF was re- submitted on Friday and will go onto the Health & Wellbeing Board website. Sue to circulate with the minutes	SW
7.	DTOC GWH and SWICC now reporting daily, weekly and monthly AWP – still not receiving monthly information from AWP to Adult Social Care. DTOC will be continue to be raised at AWP contract meeting including the need for early discharge planning, prompt data reporting including monthly data. CQIN to be shared with SBC	SB
8.	AWP Section 136 location was raised by Adult Social care in relation to plans by AWP. It was agreed that AWP would need to produce a consultation document over changes to existing provision. Sheila to raise with AWP lack on consultation on proposals and need to have time for partners to respond once consultation document is available.	SB
9.	Finance SBC Outturn position was very challenging with savings achieved of over £6m and an overspent of £590k across children and adult commissioning SBC budget 2016/17 COMMISSIONING budgets for adult social care has to deliver savings of £5.5m, most of which are on learning disabilities and halting rise in demand on older people CCG budget 2016/17 CCG has submitted plans for QIPP savings of £8m. Sustainable Transformation Plan (STP) First submission of plan produced for BANES, Wiltshire and Swindon with final plan showing financial sustainability due end of June BCF end of year 2015/16 Out turn of BCF 205/16 to be finalised and to be reported to June meeting. It is not anticipated that there will be significant changes to	JW

<i>Item</i>	<i>Description</i>	<i>Action</i>
	December position	
10.	AOB. Angela raised an individual LD/mental health case to be discussed with AWP. Angela also raised the use of the Green Light Toolkit SEN Inspection framework has been published and is on the Ofsted/CQC websites	AP/SB
11.	Future meetings 7th June 2016 Risk register review SEN self assessment	

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Health and Wellbeing Board Terms of Reference

Health and Wellbeing Board

Date: 25 May 2016

Author:	Director of Law and Democratic Services
Wards:	All
Locality Affected:	All
Parishes Affected:	All

1. Purpose and Reasons

- 1.1 The report sets out for consideration the co-opting of a lay member to the Board as a voting member.
- 1.2 The report also sets out proposals for the lay member co-opted to the Board to become its Chair.

2. Recommendations

The Board is recommended to:

- 2.1 Appoint Mr Brian Mattock to the Board as a voting, co-opted lay member of the Board.
- 2.2 Recommend to full Council:
 - 2.2.1 The adoption of the revised Health and Wellbeing Board Terms of Reference (as set out in Appendix 1) to reflect that future meetings of the Board may be chaired by the co-opted lay member.
 - 2.2.2 That the Director of Law and Democratic Services be authorised to amend the Role Definition for the Chair of the Health and Wellbeing Board in Part 5 Section 4 of the Council's Constitution, in consultation with the Leader of the Council.

3. Detail

- 3.1 The Health and Social Care Act 2012 establishes Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities. Swindon's Health and Wellbeing Board was established in April 2013.
- 3.2 Mr Brian Mattock has been a voting member of the Board since its establishment, and he was the Cabinet Member with portfolio responsibility for adults' health throughout that time. Mr Mattock ceased to be a councillor following the May 2016 elections, and the Chair of the Board, Councillor David Renard, is keen to keep him involved and to make best use of his considerable knowledge but asking the Board whether it would wish to co-opt him on to the Board.

Further information on the subject of this report can be obtained from Vicki Yull, 01793 463603, vyull@swindon.gov.uk.

Health and Wellbeing Board Terms of Reference

Health and Wellbeing Board

Date: 25 May 2016

- 3.3 In the event that Mr Mattock is co-opted, Councillor Renard would also wish the Board to consider at its next meeting whether Mr Mattock should be elected to Chair of the Board in his place as the pressures on Councillor Renard's time are increasing as the decisions the Council faces are becoming more complex, challenging and controversial.
- 3.4 The Vice-Chair of the Board, Dr Peter Crouch (Clinical Chair of the NHS Swindon Clinical Commissioning Group), has been consulted on these proposals and fully supports them.
- 3.5 Section 194(8) of The Health and Social Care Act 2012 provides for the Health and Wellbeing Board to appoint such additional persons to be members of the Board as it thinks fit. Mr Brian Mattock is being put forward as a lay member, and the Board is being asked to appoint him as a voting co-opted member. The proposed amendments to Section 6 of the Board's Terms of Reference, which would be required as a result of this decision, have been shown in tracked changes in Appendix 1.
- 3.6 There are no provisions in the Act, or the Regulations made under that section (The Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny Regulations 2013)) as to who must chair meetings of the Board. However, the current Terms of Reference state that meetings will be chaired by the Leader of the Council, or by the Vice-Chair in their absence and it is proposed that the Board may also be chaired by a lay member. Should the Board support this, this will require an amendment to the current Terms of Reference. The proposed amendments to Section 7 of the Board's Terms of Reference are attached at Appendix 1, and will have to be adopted by full Council at its meeting on 14 July 2016 or at an earlier Special Committee meeting if appropriate.
- 3.7 Part 5 Section 4 of the Council's Constitution contains a role definition for the Chair of the Health and Wellbeing Board. These proposals will require some amendments to this document and it is suggested that the Director of Law and Democratic Services be authorised to amend the role definition, in consultation with the Leader of the Council.
- 3.8 If these proposals are endorsed, Councillor Renard will remain as a nominated deputy for the Cabinet Member representatives on the Board, and will retain on overview of the Board's work as Leader of the Council.

4. Alternative Options

- 4.1 The Board could agree to maintain the status quo. However, the Board's knowledge base and capacity would be lower if the recommendations are not agreed.

Further information on the subject of this report can be obtained from Vicki Yull, 01793 463603, vyull@swindon.gov.uk.

Health and Wellbeing Board Terms of Reference

Health and Wellbeing Board

Date: 25 May 2016

5. Implications, Diversity Impact Assessment and Risk Management

Financial and Procurement Implications

- 5.1 There are no financial or procurement implications.

Legal and Human Rights Implications

- 5.2 Legal and Human Rights considerations have been taken fully into account in compiling this report. It is considered that the recommendations are consistent with Convention rights.

All Other Implications (including Staff, Sustainability, Health, Rural, Crime and Disorder)

- 5.3 There are no specific implications that relate to staff, sustainability, health, rural, crime and disorder within this report.

Diversity Impact Assessment

- 5.4 A Diversity Impact Assessment has not been completed for this report since no change in the level or nature of services is being proposed.

Risk Management

- 5.5 There are no risk management implications.

6. Consultees

- 6.1 The Board Director, Resources (Section 151 Officer) and Director of Law and Democratic Services (Monitoring Officer) are consulted in respect of all reports.

7. Background Papers

- 7.1 None.

8. Appendices

- 8.1 Appendix 1 – Health and Wellbeing Board Terms of Reference containing proposed amendments.

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Swindon Health and Wellbeing Board

Terms of Reference

1 Introduction

The Health and Social Care Act 2012 establishes Health and Wellbeing Boards as a forum where key leaders from the health and care system work together to improve the health and wellbeing of their local population and reduce health inequalities.

The Swindon Health and Wellbeing Board is made up of a collection of people from different organisations (including the NHS, the local authority officers and elected members, the Clinical Commissioning Group and the voluntary sector), who will work together on issues to do with being healthy and feeling well. The Board aims to find out what people in Swindon need to be healthy and feel well and work together to agree a strategy (plan) that will promote positive change towards making things happen. The Health and Wellbeing Strategy will help the Health and Wellbeing Board plan services to do with being healthy and feeling well and that make it easier for everyone to get the care they need. The Board also aims to reduce the health differences between poorer and better off groups across Swindon (health inequalities).

It is the responsibility of commissioners (who hold the budget) that their commissioning plans are supportive of the priorities identified in the Health and Wellbeing Strategy and the local needs of our population, and it is the responsibility of the Health and Wellbeing Board to ensure that they do.

The Health and Wellbeing Strategy will provide the priorities and objectives against which the success of the Health and Wellbeing Board can be measured.

The Health and Wellbeing Boards primary role is to provide strategic leadership to improve the health and wellbeing of Swindon's population (both adults and children) and to reduce the inequalities in health experienced by some communities. It aims to:

- Ensure delivery of improved outcomes for the people of Swindon bringing together national health and social care policy in conjunction with local priorities.
- Achieve democratic legitimacy and accountability, and empower local people to take part in decision-making about local health and wellbeing.
- Ensure the development of integrated working across the health and care system.

2 Purpose

The purpose of the Board is to improve the health and wellbeing of people of all ages resident in the borough of Swindon, and to reduce health inequalities in Swindon.

3 Underlying Principles

- shared leadership of a strategic approach to the health and wellbeing of our local communities
- a commitment to driving real action and change to improve services and outcomes
- parity between Board members in terms of their opportunity to contribute to the Board's deliberations, strategies and activities
- shared ownership of the Board by all the members (with commitment from their nominating organisations) and accountability to the communities it serves
- openness and transparency in the way that the Board carries out its work
- inclusiveness in the way it engages with patients, service users and the public
- recognition of safeguarding (adults and children) as everyone's business and a cross-cutting theme ensuring that all people in Swindon are safe and their wellbeing protected
- promotion of integrated commissioning and working across health and social care

4 Key responsibilities

The key responsibilities of the Board are:

- To provide collective leadership, set strategic direction, prioritise local activity, and present comprehensible plans of what will be done locally, where possible and deemed appropriate by the Board, to address needs and improve health and wellbeing in alignment with the One Swindon priorities, outcomes and principles.
- To prepare the Swindon Joint Strategic Needs Assessment which identifies the local health and wellbeing needs of our population ensuring:
 - effective and meaningful engagement and dialogue with local communities and service users
 - joined up intelligence from local partners and stakeholders
 - Inclusion of comprehensive safeguarding data analysis
- To prepare the Swindon Joint Health and Wellbeing Strategy.
- To promote partnership and integration of commissioning and service delivery across health, social care, public health and other service areas including but not limited to housing, leisure and transport in conjunction with One Swindon and the Swindon Joint Health and Wellbeing Strategy.
- To ensure that the plans of local and regional commissioners, including the NHS Swindon Clinical Commissioning Group commissioning plan, promote the delivery of the Swindon Joint Health and Wellbeing Strategy wherever appropriate.

- To monitor, evaluate and annually report on the NHS Swindon Clinical Commissioning Group performance as part of the Clinical Commissioning Groups annual assessment by NHS England.
- To measure progress against local plans including NHS Swindon Clinical Commissioning Group Plan, the Joint Health and Wellbeing Strategy and other supporting plans and request action is taken to improve outcomes when monitoring indicators show plans or initiatives are not working.
- The One Swindon Board will be accountable for ensuring that One Swindon and the One Swindon Delivery Plan support the delivery of the Swindon Joint Health and Wellbeing Strategy.
- The Board will advise the One Swindon Board on strategic matters of health and wellbeing.
- The Board will refer the Commissioning Plans back to the Clinical Commissioning Group or to NHS England if they do not take sufficient account of the Swindon Joint Health and Wellbeing Strategy.
- Board members are accountable to each other for mobilising and co-ordinating partners and identifying available resources to deliver agreed priorities.
- To ensure the development and implementation of the National Health Services Act 2006 Section 75 Agreements including the Better Care Fund. Manage these partnership arrangements and in particular:
 - a. Make recommendations to Cabinet and the Clinical Commissioning Group Board as to commissioning of services.
 - b. Monitor and ensure delivery of and evaluate health, social care, education and other related services for adults, children and young people in Swindon on behalf of Clinical Commissioning Group and Swindon Borough Council and such other relevant services as Clinical Commissioning Group and Swindon Borough Council may from time to time agree.

The work programmes of the Swindon Health and Wellbeing Board, the relevant Overview and Scrutiny Committee, and Healthwatch Swindon will be shared and loosely aligned to create pathways for influence, whilst maintaining independence and the role of scrutiny.

5 Role of the board

In order to deliver its responsibilities, the Board may decide to establish a sub-committee and delegate functions to them.

The Board will do the following:

Coordinate partnership working

- Bring together NHS, public health and social care leaders with members of the local population and democratically elected representatives.
- Promote integration of business action plans of partner organisations where appropriate.
- Co-ordinate information sharing across partners.
- Co-ordinate commissioning decisions to reflect the priorities identified by the Board including the use of joint commissioning and pooled budgets where appropriate.
- Provide regular reports to the One Swindon Board.
- Consult with service users and carers about service developments which will affect them.
- Work with the Local Safeguarding Children and Adult Boards to ensure all partners promote the safety and welfare of children, young people and vulnerable adults, and receive an annual report from the Safeguarding Boards.
- Monitor the performance of the National Health services Act 2006 Section 75 Agreements including:
 - a. overseeing the work of the Joint Commissioning Group by reviewing and monitoring the six monthly performance reports which will be provided to them by the Group.
 - b. carrying out an Annual Review which will describe how commissioned services have performed, and include commentary on performance of providers, financial pressures and changes in need or service delivery. It will also set out commissioning intentions for the coming year and agreements for developing joint working.
- Optimise effective and efficient working to avoid partner organisations duplicating each other's work.
- Link with the voluntary and community sector.

Identify local needs

- Lead the development of the Joint Strategic Needs Assessment which identifies local health and wellbeing needs and priorities.

Set strategic direction and prioritise and communicate actions

- Prioritise actions, based on the agreed strategic direction, joint commissioning strategies and Joint Strategic Needs Assessment, to meet the needs of the current population and avoid compromising the wellbeing of future generations.
- Communicate actions in publically available action plans.

Performance monitor

- Evaluate performance against locally agreed priorities.
- Evaluate performance against nationally set outcomes frameworks for the NHS, public health and social care.
- Scrutinise any local major service redesign of the NHS.
- Produce annual reports of progress in relation to above action plans, in order that the Board is publically accountable for delivery of these actions.

6 Membership

The membership will consist of:

The Leader of the Council
 Cabinet Member for Health and Social Care
 Cabinet Member for Children's Services
 Shadow Member for Health and Social Care or Children
 Healthwatch Swindon Executive representative
 NHS Swindon Clinical Commissioning Group Accountable Officer
 NHS Swindon Clinical Commissioning Group Clinical Chair (Vice-Chair)
 NHS Swindon Clinical Commissioning Group Executive Nurse
 NHS England Executive representative
 Third Sector representative
 Police and Crime Commissioner (Wiltshire)
 Such Lay Members as the Board may appoint (co-opted and voting)
 Chief Executive of Swindon Borough Council (non-voting)
 Director of Adult Social Care / Children's Services (non-voting)
 Director of Public Health (non-voting)

All members of the Swindon Health and Wellbeing Board are voting members, except for officers of Swindon Borough Council, and as such will be governed by Swindon Borough Councils Code of Conduct.

All members or co-opted members must notify the Council's Monitoring Officer of Disclosable Pecuniary Interests and are prohibited from participating in discussion or voting on any matter relating to their interest.

7 Procedures

Meetings of the Board will be chaired by the Leader of the Council (or by the Vice-Chair in their absence) or by a lay member.

A quorum shall be four members (at least one from NHS Swindon Clinical Commissioning Group and one from Swindon Borough Council). Each member is required to attend at least four of the five scheduled Health and Wellbeing Board meetings per year. Members of the Board will nominate a deputy who will attend in their absence and have delegated authority, wherever possible and appropriate, to make decisions. Nominated deputies will form part of the quorum.

The Board will operate in accordance with the Council's existing decision-making framework and normal council budget setting processes. A decision to exercise any further local authority functions by the Health and Wellbeing Board would therefore need to be taken by the appropriate decision-making body (e.g. Cabinet or Council), and a further report would be required for this.

8 Review Arrangements

The Swindon Health and Wellbeing Board Chair will lead an annual effectiveness review.

APPROVED: 11 March 2015

NEXT REVIEW: 27 May 2015

REVIEW HISTORY:

Inaugural Terms of Reference: approved 10 July 2013

First Review: May 2014

Second Review: January 2015