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Rutland County Council

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Ladies and Gentlemen,

A meeting of the **HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 22nd March, 2016** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

Recording of Council Meetings: Any member of the public may film, audio-record, take photographs and use social media to report the proceedings of any meeting that is open to the public. A protocol on this facility is available at www.rutland.gov.uk/haveyoursay

A G E N D A

1) APOLOGIES

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 26th January 2016 (previously circulated).

3) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

4) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 93.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received.

Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

5) BCF PLAN 2016-17

To receive Report No. 71/2016 from Sandra Taylor, Health and Social Care Integration Project Manager
(Pages 5 - 38)

6) DIRECTOR OF PUBLIC HEALTH: ANNUAL REPORT 2015

To receive Report No. 67/2016 from Mr Mike Sandys, Director of Public Health for Leicestershire & Rutland
(Pages 39 - 88)

7) EAST MIDLANDS AMBULANCE SERVICE: QUALITY ACCOUNT

To receive Report No. 68/2016 from Paul Benton, Deputy Director of Quality, East Midlands Ambulance Service
(Pages 89 - 170)

8) HEALTH AND WELLBEING PRIORITIES

To receive Report No. 69/2016 from Karen Kibblewhite, Head of Commissioning
(Pages 171 - 178)

9) TRANSFORMING CARE PLAN

To receive Report No. 70/2016 from Yasmin Surti, BCT Implementation Lead for Learning Disabilities, Leicester City Council
(Pages 179 - 232)

10) ANY URGENT BUSINESS

11) DATE OF NEXT MEETING

To be confirmed…

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DISTRIBUTION
MEMBERS OF THE HEALTH AND WELLBEING BOARD:

Mr T King (Chairman)	
Mr R Clifton (Vice-Chair)	
Mr A Mann	Ms A Callaway
Dr A Ker	Mrs H Briggs
Ms J Clayton Jones	Ms J Fenelon
Inspector L Cordiner	Mr M Sandys
Ms R Dewar	Mr T Sacks
Ms T Thompson	Ms Y Sidyot

OTHER MEMBERS FOR INFORMATION

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Report No. 71/2016

Report to Rutland Health and Wellbeing Board

Subject:	**New BCF Plan 2016-17 - Update**
Meeting Date:	**22 March 2016**
Report Author:	**Sandra Taylor, Health and Social Care Integration Project Manager**
Presented by:	**Mark Andrews, Deputy Director for People**
Paper for:	**Note / Approval**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

1 PURPOSE OF THE REPORT (MANDATORY)

1.1 The purpose of this report is to update the Health and Wellbeing Board on progress with developing and submitting the 2016-17 BCF plan for approval and to confirm a method for the health and Wellbeing Board to sign off the 2016-17 plan.

2 INITIAL SUBMISSION, 2 MARCH 2016

2.1 As last year, the first BCF stage was a planning spreadsheet submitted on 2 March (see Appendix 1).

2.2 Feedback was received on this submission from NHS England (Central Midlands) on 10 March (see Appendix 2). This was positive overall and recognised that further work was underway in a number of areas:

2.3

a) Acknowledgement of the additional contributions made by the Local Authority into the BCF programme.
   - This is £185k carried forward from the 2015-16 programme, which it is proposed to spend on three programme schemes (see below).

b) *Work still in progress to gain agreement over use of Care Act Monies and former Carer's Breaks Funding,*
   - RCC made a late proposal to use £85k of carry forward to meet the Care Act condition, alongside £100k of carry forward agreed for case coordination. The Care Act item had not been discussed by the partnership as detail emerged just before the 2nd March submission and was therefore proposed as provisional. The CCG has now indicated that they are comfortable with this approach.

c) Positive action taken with the introduction of 6 new BCF schemes to improve performance
   - This recognises the work done to evolve the programme's schemes based on learning and progress to date (notably a dedicated communication and coordination workstrand, enriched case

coordination for long term conditions, long term condition innovation fund, integrated commissioning as a distinct workstrand).

d) Concern that Social Care protection has reduced from 998,000 to 839,000 a reduction of 23% and the impact that may result from that decision
   - The figure of £998k in the feedback has been an error. In 2016-17, planned social care protection was £684k excluding Disabled Facilities Grant. For 2016-17 it is a higher figure of £839k.

e) Positive ambition by Rutland to stretch performance with non-elective admissions (NEA), residential admissions and effectiveness of re-ablement indicating progression.
   - Targets to be revalidated before 21 March resubmission to ensure they stretch but are realistic.

f) Some mild concern expressed by the panel that no risk sharing agreement is planned for NEA and we will look to the narrative submission to understand the rationale for that decision.
   - At the time of writing, the partnership is considering a modest risk sharing fund focussed on non elective admissions or delayed transfers of care. For context, our NEA performance was good overall in 2015-16 (achieving pay for performance targets in the first three quarters). We have set the same level of target as last year to stay focussed (at the moment -2.4%) and we are planning increased NEA reduction activity in 2016-17 (LTC schemes, admissions avoidance etc).

g) The metric Delayed Transfers of Care remains in development
   - DTOC targets are under review. Percentage anticipated improvement likely to be revised downwards before being submitted next time to ensure they are stretching but realistic.

h) The national conditions of 7 day services, data sharing, joint assessments and managing delayed transfers of care remain areas of development for Rutland over 16/17 and we will look within the narrative submission as to how improvements and more integrated ways of working will be developed.
   - At time of writing, narratives are being worked on.

3 FURTHER SUBMISSION STAGES

3.1 The BCF assurance timetable for 2016-17 is set out below.

Date	Milestones	Lead
2 March	Initial planning template submission - COMPLETE	Rutland partnership
10 March	Individual feedback on initial Excel template received. Second version of Excel planning template released nationally, for submission 21 March	Better Care support

	'Key lines of enquiry' for narrative plans issued – the list of items that will be checked during assessment of narrative plans (see Appendix 3). COMPLETE	
10-21 March	Further development of narrative plan to meet 'Key lines of enquiry' - UNDERWAY	Rutland partnership
21 March	Submit narrative plan and second Excel planning template	Rutland partnership
By 11 April	Feedback to local areas to confirm draft assurance status and actions required. 'Technical assistance' type support to areas	Better Care support
By __ April	Sign-off of BCF plan by Health and Wellbeing Board	Health and Wellbeing Board
25 April	Submit final BCF plans, signed off by HWB Likely to also be a final Excel planning submission.	Rutland partnership
13 May	Final assurance ratings to be issued	Better Care support
30 June	Refreshed, signed s75 agreement to be in place between ELR CCG and Rutland County Council	Rutland partnership

3.2 At the time of writing, the Rutland narrative plan, reviewed previously by the HWB, is being further developed to supply the information set out in the national 'Key Lines of Enquiry' list issued on 10 March, providing, amongst other elements:

a) the local response to meeting the national conditions including a high level delayed transfers of care action plan,

b) a refreshed risk assessment and risk management plan, and

c) key milestones for the year to come.

3.3 The narrative and updated Excel planning document will then be submitted on 21 March (the day before the Health and Wellbeing Board), with feedback forthcoming by 11 April, after which there may need to be further short, sharp remedial work to secure approval.

3.4 The final plan must be approved by the Health and Wellbeing Board by 25 April.

3.5 Agreement is sought from the HWB today for an approval process.

Financial implications:

4.1 Approval of the BCF plan in a timely fashion is vital, not least because it funds

some core aspects of social care activity.

4.2 The national timetable only offers approval after the 25 April. Therefore, all areas will be needing to bridge the gap between the 2015-16 and 2016-17 programming periods. As there is substantial continuity between the programming periods, the 2015-16 programme will in effect be sustained.

Recommendations:

That the board:

1. Notes the progress on the 2016-17 BCF plan preparation and approval process, and initial feedback.
2. Agrees the method of signing off the 2016-17 plan.

Comments from the board: (delete as necessary)

Strategic Lead:	Mark Andrews

Risk assessment:

Time	L	Timetable is very tight, but pragmatic approach being taken.
Viability	L/M/H	
Finance	L	All programmes are in the same position in terms of approval timing. Initial feedback on spending plans has been broadly positive.
Profile	L/M/H	
Equality & Diversity	L/M/H	

Timeline:

Task	Target Date	Responsibility

Template for BCF submission 1: due on 02 March 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 (this 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 in April, and submitted 2pm on 29 April 2016

This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

Introduction

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell
Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

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

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.

The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.

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

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

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 if being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

On this tab please **enter the following information:**
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.
- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.

- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**
- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use rows 93-95 (columns K-L for Q3-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 figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H 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 2015/16 approved BCF plan and 2015/16 Q1 return - 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 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

5b. HWB Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

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

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

CCG - HWB Mapping

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

Template for BCF submission 1: due on 02 March 2016

Better Care Fund 2016-17 Planning Template

Sheet: Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B6) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C10	☐	Yes
completed by:	C13	☐	Yes
e-mail:	C15	☐	Yes
contact number:	C17	☐	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	☐	Yes

Sheet Completed:	Yes

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	E37	☐	Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance.	F37	☐	Yes
Total value of funding held as contingency as part of lcoal risk share to ensure value to the NHS	F47	☐	Yes

Sheet Completed:	Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	☐	Yes
Gross Contribution: £000's	C16 : C25	☐	Yes
Comments (if required)	E16 : E25	☐	N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42	☐	Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54	☐	Yes
Gross Contribution: £000's	C45 : C54	☐	Yes
Comments (if required)	E45 : E54	☐	N/A
Funding Sources Narrative	B61	☐	N/A
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	C70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	C71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73	☐	Yes
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments	D70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	D71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	D72		Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73	☐	Yes

Sheet Completed:	Yes

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B66	☐	
Scheme Type (see table below for descriptions)	C17 : C66	☐	
Please specify if 'Scheme Type' is 'other'	D17 : D66	☐	
Area of Spend	E17 : E66	☐	
Please specify if 'Area of Spend' is 'other'	F17 : F66	☐	
Commissioner	G17 : G66	☐	
if Joint % NHS	H17 : H66	☐	
if Joint % LA	I17 : I66	☐	
Provider	J17 : J66	☐	
Source of Funding	K17 : K66	☐	
2016/17 (£000's)	L17 : L66	☐	
New or Existing Scheme	M17 : M66	☐	
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N67	☐	

Sheet Completed:	

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	☐	Yes
5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	☐	Yes
5.1 - Cost of NEA	E54	☐	Yes
5.1 - Comments (if required)	F54	☐	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	☐	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	☐	Yes
5.2 - Comments (if required)	I68	☐	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	☐	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	☐	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	☐	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	☐	Yes
5.3 - Comments (if required)	I81	☐	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	☐	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	☐	Yes
5.4 - Comments (if required)	Q93	☐	N/A
5.5 - Local Performance Metric	C105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	☐	Yes
5.5 - Comments (if required)	G105	☐	N/A
5.6 - Local defined patient experience metric	C117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	☐	Yes
5.6 - Comments (if required)	G117	☐	N/A

Sheet Completed:	Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	☐	Yes
2) Maintain provision of social care services (not spending)	C15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	C16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	C18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	☐	Yes
1) Plans to be jointly agreed, Comments	D14	☐	Yes
2) Maintain provision of social care services (not spending), Comments	D15	☐	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate, Comments	D16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	☐	Yes
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional, Comments	D18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	☐	Yes

Sheet Completed:	Yes

Template for BCF submission 1: due on 02 March 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.

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

Health and Well Being Board	**Rutland**
completed by:	Sandra Taylor
E-Mail:	staylor@rutland.gov.uk
Contact Number:	01572 758202
Who has signed off the report on behalf of the Health and Well Being Board:	Helen Briggs, Chief Executive

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	
5. HWB Metrics	34
6. National Conditions	16

Template for BCF submission 1: due on 02 March 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Rutland

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 if 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	£370,789
Total Minimum CCG Contribution	£2,061,292
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£2,432,081**

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?	No - in development
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development
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	£665,000
Continuing Care	£0
Primary Care	£0
Social Care	£1,311,000
Other	£456,000
Total	**£2,432,000**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£839,000	£839,000 is the sum spent protecting social work

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

	Expenditure
Mental Health	£0
Community Health	£665,000
Continuing Care	£0
Primary Care	£0
Social Care	£0
Other	£100,000
Total	**£765,000**

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

	Fund
Local share of ring-fenced funding	£585,761
Total value of NHS commissioned out of hospital services spend from minimum pool	£765,000
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£179,239**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	836	861	849	847	3,393
HWB Quarterly Additional Reduction Figure	20	21	20	20	81
HWB NEA Plan (after reduction)	816	840	829	827	3,312
Additional NEA reduction delivered through the BCF	£29,800	£31,290	£29,800	£29,800	£120,690

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	355.1

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	90%

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)
		699.6	600.7	750.8	586.4

5.5 Local performance metric (as described in your approved BCF plan / Q1 return)

	Metric Value Planned 16/17
Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population. Data source: Indicator 2.24i from http://www.phoutcomes.info/search/falls	1663.5

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 return)

	Metric Value Planned 16/17
Do care and support services help you to have a better quality of life? (Note this metric value is a %) Data source: existing question in the Adult Social Care survey. Metric - % who responded yes to survey question Q2b. Numerator –	93.1

6. National Conditions

National Conditions For The Better Care Fund 2016-17	Please Select (Yes, No or No - plan in place)
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development
4) Better data sharing between health and social care, based on the NHS number	No - in development
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	No - in development

Template for BCF submission 1: due on 02 March 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Rutland

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Rutland	£185,789	DFG allocation
Rutland	£100,000	Funds carried forward from 2015-16, to invest in case coordination
Rutland	£85,000	Funds carried forward from 2015-16, to invest in communications and coordination (£30k) and LTC management innovation (£55k)
<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	**£370,789**	

CCG Minimum Contribution	Gross Contribution
NHS East Leicestershire and Rutland CCG	£2,061,292
Total Minimum CCG Contribution	**£2,061,292**

Are any additional CCG Contributions being made? If yes please detail below;	No

Additional CCG Contribution	Gross Contribution	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>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**£0**	

Total BCF pooled budget for 2016-17	**£2,432,081**

Funding Contributions Narrative
For Rutland, the minimum funding will be included in the programme, plus £185k of funding carried forward from the 2015-16 BCF programme. £100k is to trial a case management approach (to help to maximise the potential for change during the next financial year, as set out in the NHS commissioning guidance for CCGs), £30k is for non recurring investment in communication and coordination of activities and £55k is for non recurring LTC innovation costs. A further £100k of funding unspent in 2015-16 will form a general BCF contingency fund, not included here, as there is currently no contingency fund for the programme. If joint commissioning activities lead to further pooled funds, then these will be pooled outwith the current scope of the Rutland BCF s75 agreement.

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?	No - in development	Using the LGA ready reckoner, £78k of revenue needs to be allocated to Care Act duties. The Council has elected to bring £85k of direct payments to carers into the programme to meet this condition. The Council also funds a mental health advocacy contract outside the BCF
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development	See above.
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	

Template for BCF submission 1: due on 02 March 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

Selected Health and Well Being Board:
Rutland

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.
On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B71 - C78); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

					Expenditure							
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Coordination and communication	Other	Prevention & self care	Other		Local Authority			Local Authority	Local Authority Social Services	£30,000	New	
Community prevention and wellbeing services	Other	Support for carers, Prevention & self	Other	Prevention, in the community	Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£187,000	Existing	£179,000
Life planning - prevention	Assistive Technologies		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	£110,000	Existing	£115,000
Life planning - DFGs	Other	DFGs	Social Care		Local Authority			Local Authority	Local Authority Social Services	£186,000	Existing	£104,000
Integrated case management	Personalised support/ care at home		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£40,000	Existing	£23,000
Integrated case management	Personalised support/ care at home		Other	Community health and social care	CCG			NHS Community Provider	Local Authority Social Services	£100,000	New	
Integrated community care for LTCs and high needs	Integrated care teams		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£405,000	Existing	£405,000
Integrated community care for LTCs and high needs	Integrated care teams		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£113,000	New	
LTC management - innovation fund	Personalised support/ care at home		Other	Community health and social care, V	Local Authority			Local Authority	Local Authority Social Services	£55,000	New	
Integrated dementia services	Other	Personalised support/ care at home,	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£50,000	Existing	£50,000
Integrated dementia services	Other	Personalised support/ care at home,	Other	Community based support	Local Authority			Charity/Voluntary Sector	CCG Minimum Contribution	£50,000	Existing	£50,000
Care Act - carers	Support for carers		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£85,000	New	
Integrated urgent response	Intermediate care services		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£125,000	Existing	£225,000
Integrated urgent response	Intermediate care services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£115,000	Existing	£225,000
Integrated hospital transfer and reablement	Reablement services		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£561,000	Existing	£561,000
Integrated hospital transfer and reablement	Integrated care teams		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£135,000	Existing	£25,000
Enablers	Other	IT, workforce, analytics, data sharing	Other	Enablers - various	Local Authority			Local Authority	CCG Minimum Contribution	£34,000	Existing	£34,000
Integrated commissioning	Other	Enabler - integrated commissioning	Other	Commissioning (the activity, not the	Joint	50.0%	50.0%	Local Authority	CCG Minimum Contribution	£0	New	
Programme management	Other	Programme management resource	Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£51,000	Existing	£37,000

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Template for BCF submission 1: due on 02 March 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

Selected Health and Well Being Board: Rutland

Data Submission Period: 2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

Contributing CCGs	% CCG registered population that has resident population in Rutland	% Rutland resident population that is in CCG registered population	Quarter 1: CCG Total Non-Elective Admission Plan*	Quarter 1: HWB Non-Elective Admission Plan**	Quarter 2: CCG Total Non-Elective Admission Plan*	Quarter 2: HWB Non-Elective Admission Plan**	Quarter 3: CCG Total Non-Elective Admission Plan*	Quarter 3: HWB Non-Elective Admission Plan**	Quarter 4: CCG Total Non-Elective Admission Plan*	Quarter 4: HWB Non-Elective Admission Plan**	Total (Q1 - Q4): CCG Total Non-Elective Admission Plan*	Total (Q1 - Q4): HWB Non-Elective Admission Plan**
NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%	18,562	0	18,100	0	19,766	0	18,766	0	75,194	0
NHS Derby CCG	0.3%	0.6%	1,793	5	1,914	5	1,988	6	1,899	5	7,594	21
NHS East Leicestershire and Rutland CCG	9.8%	85.6%	7,312	719	7,543	742	7,427	731	7,429	731	29,711	2,922
NHS South Lincolnshire CCG	2.7%	12.0%	3,649	100	3,689	101	3,689	101	3,609	99	14,636	401
NHS South West Lincolnshire CCG	0.4%	1.5%	2,833	12	2,864	12	2,864	12	2,802	12	11,363	48
Totals		**100%**	**34,149**	**836**	**34,110**	**861**	**35,734**	**849**	**34,505**	**847**	**138,498**	**3,393**

Are you planning on any additional quarterly reductions?	Yes							
If yes, please complete HWB Quarterly Additional Reduction Figures								
HWB Quarterly Additional Reduction Figure		20	21	20	20		81	
HWB NEA Plan (after reduction)		**816**	**840**	**829**	**827**		**3,312**	
HWB Quarterly Plan Reduction %		2.39%	2.44%	2.35%	2.36%		2.39%	
Are you putting in place a local risk sharing agreement on NEA?	No							
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£585,761							
Cost of NEA as used during 15/16 ****	£1,490	Please add the reason for any adjustments to the cost of NEA for 16/17 in the cell below.						
Cost of NEA for 16/17 ****	1							
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

** 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	635.7	363.6	330.5	356.1	Although target is being met this year, we do not propose to sustain the target at the current level. Rationale: small population therefore year
	Numerator	56	33	30	33	
	Denominator	8,809	9,077	9,077	9,292	

*****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'

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15	Planned 15/16	Forecast 15/16	Planned 16/17	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	100.0%	83.3%	90.0%	90.0%	Because target has consistently been exceeded this year, we propose to raise the target somewhat. Small population means that chance va
	Numerator	30	25	27	27	
	Denominator	30	30	30	30	

5.4 Delayed Transfers of Care

- Please use rows 93-95 (columns K-L for Q3-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 figure in cells K94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells K93-O93. Please add a commentary in column H to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1 & Q2) and forecast (Q3 & Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)	Quarterly rate	644.4	1065.1	674.6	675.8	722.6	489.7	962.0	750.8	699.6	600.7	750.8	586.4	Targets to be reviewed following 2 March submission. The Q4 figure is an estimate and
	Numerator	194	311	197	198	211	143	278	220	205	176	220	172	performance may be better or worse. This could also lead to a need to revise targets. The
	Denominator	29,200	29,200	29,200	29,301	29,200	29,200	29,200	29,301	29,301	29,301	29,301	29,334	2016-17 Q3 peak both echoes previous years' patterns and anticipates the potential startup

5.5 Local performance metric (as described in your approved BCF plan / Q1 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 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+ per 100,000 population. Data source: Indicator 2.24 from http://www.phoutcomes.info/search/falls	Metric Value	1663.5	1663.5	To be reviewed prior to second submission.
	Numerator	151.0	151.0	The current metric is challenging in that it only reports annually so there is very little insight into trends to base projections on.
	Denominator	9077.0		

5.6 Local defined patient experience metric (as described in your approved BCF plan / Q1 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 2015/16 approved BCF plan and 2015/16 Q1 return - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Do care and support services help you to have a better quality of life? (Note this metric value is a %) Data source: existing question in the Adult Social Care survey. Metric - % who responded yes to survey question	Metric Value	93.1	93.1	The 2015-16 target was already a stretch target, and was just missed in 2014-15.
	Numerator	125.0	125.0	
	Denominator	135.0	135.0	

Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Rutland

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

Rutland Data Source Used - 15/16	SUS				
	Q1	Q2	Q3	Q4	Total
Rutland 14/15 Baseline (outturn)	657	686	687	685	2,715
Rutland 15/16 Plan	641	668	669	652	2,630
Rutland 15/16 Actual	654	680			1,334

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. Actual Q3 and Q4 data is not available at the point of this template being released.

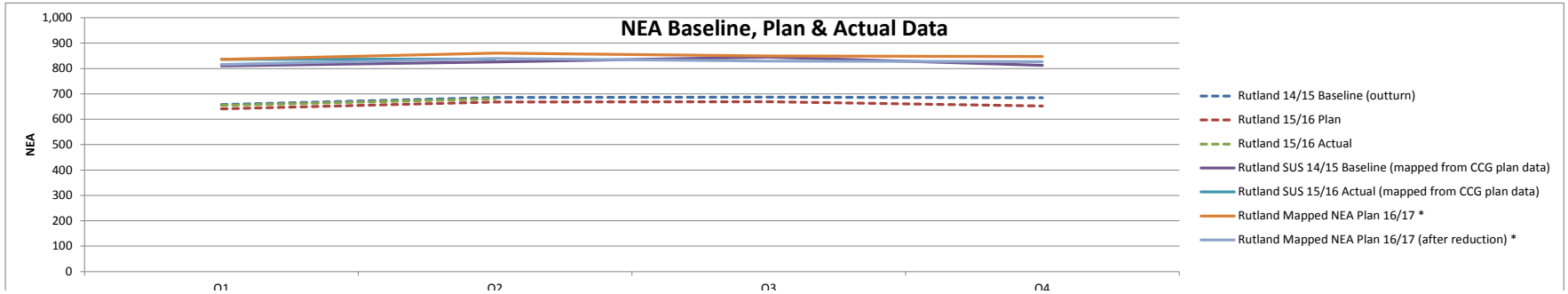
Rutland SUS 14/15 Baseline (mapped from CCG plan data)	**810**	**826**	**845**	**813**	**3,293**
Rutland SUS 15/16 Actual (mapped from CCG plan data)	837	837			1,673
Rutland SUS 15/16 FOT (mapped from CCG plan data)					3,406

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/

Rutland Mapped NEA Plan 16/17 *	**836**	**861**	**849**	**847**	**3,393**
Rutland Mapped NEA Plan 16/17 (after reduction) *	**816**	**840**	**829**	**827**	**3,312**

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Rutland

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/

Template for BCF submission 1: due on 02 March 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Rutland

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

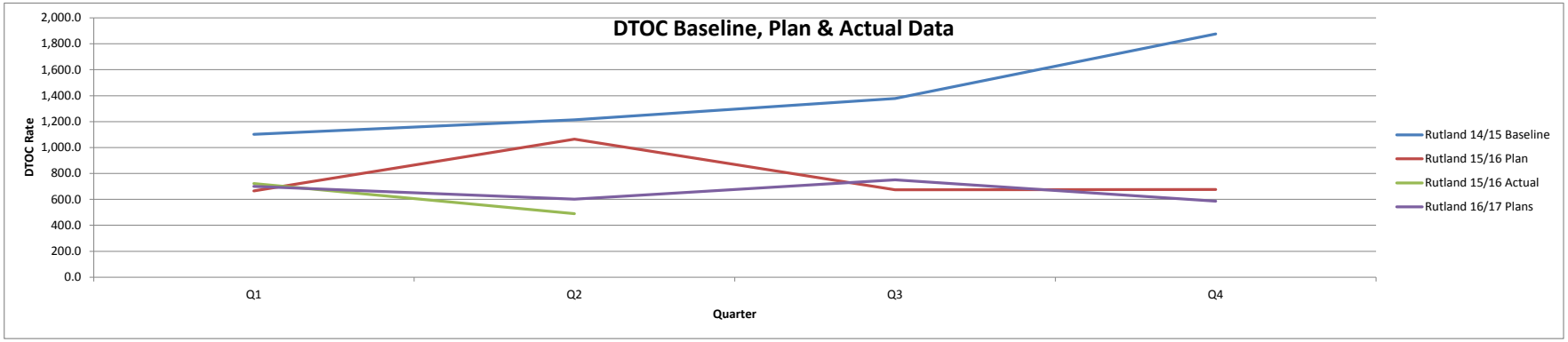
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4	Total
Rutland 14/15 Baseline	1,101.1	1,214.3	1,379.0	1,876.7	5,571.2
Rutland 15/16 Plan	664.4	1,065.1	674.6	675.8	3,079.8
Rutland 15/16 Actual	722.6	489.7			1,212.3

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 Q3 and Q4 data is not available at the point of this template being released.

Rutland 16/17 Plans	**699.6**	**600.7**	**750.8**	**586.4**	**2,637.5**



Template for BCF submission 1: due on 02 March 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Rutland

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, or will be by 31st March 2016. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	Yes	
2) Maintain provision of social care services (not spending)	Yes	
3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	No - in development	Progress has been made locally on 7 day services. A Vanguard project and other integration work is underway currently which will help to inform the need for further changes to deliver a sufficient model of 7 day services to meet Rutland's needs. Therefore, a full plan confirming the gap to be bridged is not yet in place. It will be in place within a quarter.
4) Better data sharing between health and social care, based on the NHS number	No - in development	Rutland's social care teams will have a case management system enabling them to manage NHS numbers as the primary identifier from April 2016 onwards. There is more planning work to do to scope out data sharing needs, also in line with the collocation and closer working of teams which is anticipated.
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	No - in development	We are currently working to collocate relevant social care and community health teams and to integrate them more closely, including through structural alignment of teams. The embedding of a common approach to assessments and care planning, and the establishment of an accountable professional model will be developed as part of this integration. Therefore, the plans are not set out in detail in the 2016-17 programme. We anticipate that a plan will be in place within a
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	No - in development	The s75 Partnership Board on 18 February agreed that a DTOC plan would be developed for Rutland over the next quarter, drawing on the national DTOC toolkit/maturity model and addressing specific local challenges, notably issues arising from high levels of use of out of area acute services and disjoints between respective discharge systems. In parallel, we will seek coherence with the wider Leicester, Leicestershire and Rutland DTOC action plan if one is put in place.

CCG to Health and Well-Being Board Mapping

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	89.7%	88.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.2%	0.4%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.1%	2.9%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.9%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	0.8%	0.5%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	08H	NHS Islington CCG	0.1%	0.0%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.4%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.3%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	94.0%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.7%
E09000004	Bexley	07N	NHS Bexley CCG	93.6%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.5%	1.6%
E09000004	Bexley	08A	NHS Greenwich CCG	7.7%	8.9%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	92.0%	57.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.9%	20.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	2.9%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.1%	18.6%
E08000025	Birmingham	05P	NHS Solihull CCG	15.0%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	87.0%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.6%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.3%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.7%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.8%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.2%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.8%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.7%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	21.5%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.8%	58.4%
E08000032	Bradford	02T	NHS Calderdale CCG	0.1%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.1%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.0%	2.1%
E09000005	Brent	07P	NHS Brent CCG	89.6%	87.2%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.7%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.6%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.2%	0.1%
E09000005	Brent	08E	NHS Harrow CCG	5.7%	3.9%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.4%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.2%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.7%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.8%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.9%	95.3%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.0%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.2%	35.0%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.1%	59.9%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.5%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.2%	0.6%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.8%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%
E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%

E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.3%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.1%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01M	NHS North Manchester CCG	2.0%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.8%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.6%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.4%	0.4%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.8%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.9%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.1%	0.2%
E09000007	Camden	07P	NHS Brent CCG	1.5%	2.2%
E09000007	Camden	07R	NHS Camden CCG	84.6%	88.4%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	6.0%	5.1%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.4%	3.2%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.1%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.1%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.2%	0.5%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.4%	2.0%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.3%	50.6%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.3%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	2.0%	1.3%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.8%	69.4%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.2%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	0.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.9%	74.1%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.1%
E09000001	City of London	08Q	NHS Southwark CCG	0.0%	0.1%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.8%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.4%	53.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	45.7%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.0%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.5%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.6%	93.7%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.7%	2.6%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.4%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Lancashire North CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.3%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.1%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.1%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.2%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.2%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	1.9%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.3%	36.0%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.2%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.0%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.1%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.0%	80.5%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.7%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.4%	0.3%
E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.2%	0.5%

E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.3%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.1%
E10000009	Dorset	11J	NHS Dorset CCG	52.7%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.2%	0.5%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.9%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.6%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000009	Ealing	07W	NHS Ealing CCG	86.7%	90.8%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.7%	2.9%
E09000009	Ealing	08E	NHS Harrow CCG	0.3%	0.2%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.6%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	5.0%	3.7%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.2%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.4%	8.0%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.4%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.5%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.7%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.9%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.5%	90.7%
E09000010	Enfield	08D	NHS Haringey CCG	7.8%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.3%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.4%	11.7%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.8%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.2%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.4%
E10000012	Essex	06T	NHS North East Essex CCG	98.7%	22.4%
E10000012	Essex	08N	NHS Redbridge CCG	3.2%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.3%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	39.6%	98.0%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.7%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.2%	4.3%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.6%	89.9%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.1%	4.5%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.6%	94.6%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.1%	3.4%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.7%
E06000006	Halton	01J	NHS Knowsley CCG	0.1%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	0.9%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.3%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.9%	88.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.8%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.6%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%
E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.4%	14.6%

E10000014	Hampshire	10X	NHS Southampton CCG	5.5%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.7%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.0%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.5%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.6%
E09000014	Haringey	07R	NHS Camden CCG	0.5%	0.5%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.6%
E09000014	Haringey	08H	NHS Islington CCG	2.3%	1.9%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.7%	5.0%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	90.0%	84.3%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.4%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.7%	1.9%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.1%	0.4%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.6%	99.6%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	4.0%	3.3%
E09000016	Havering	08F	NHS Havering CCG	92.0%	95.9%
E09000016	Havering	08M	NHS Newham CCG	0.0%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.5%	0.6%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.1%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.8%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.3%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.9%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.7%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	90.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%
E09000018	Hounslow	07W	NHS Ealing CCG	5.8%	8.0%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.0%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.3%	3.6%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.4%	4.9%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.4%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.2%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.7%
E09000019	Islington	08H	NHS Islington CCG	89.8%	89.0%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.1%	5.1%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	0.9%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	64.1%	93.2%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.1%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.8%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	13.0%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.3%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.5%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.6%	98.5%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.8%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.0%	1.2%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.5%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.8%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.6%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.8%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	99.0%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.1%	0.9%
E08000011	Knowsley	01J	NHS Knowsley CCG	86.9%	88.2%

E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.9%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	86.8%	92.7%
E09000022	Lambeth	08R	NHS Merton CCG	1.2%	0.7%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.0%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	98.9%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.4%	11.9%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Lancashire North CCG	99.8%	12.8%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.0%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.1%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.3%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.5%	31.9%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	42.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.5%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.5%	2.2%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.2%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.6%	2.6%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.3%	40.1%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.7%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.6%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.7%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.3%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.2%	2.0%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.2%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	92.1%	92.5%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.7%	3.7%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.1%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.4%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.6%	19.5%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.2%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.8%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.3%	96.2%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.2%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	00W	NHS Central Manchester CCG	93.7%	36.9%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01M	NHS North Manchester CCG	85.1%	30.3%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01N	NHS South Manchester CCG	93.9%	28.2%
E08000003	Manchester	01W	NHS Stockport CCG	1.5%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.3%	1.8%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.8%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	0.9%	1.4%
E09000024	Merton	08R	NHS Merton CCG	87.7%	81.5%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.5%	10.5%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.0%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.4%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.0%	95.0%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.2%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%
E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%

E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.9%	97.9%
E09000025	Newham	08N	NHS Redbridge CCG	0.2%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.5%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.1%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.8%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.7%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.8%	25.3%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.7%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.1%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.1%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.7%	1.6%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.1%	96.4%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.3%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.7%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.3%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.6%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	85.0%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	94.8%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.1%
E06000018	Nottingham	04M	NHS Nottingham West CCG	5.7%	1.6%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.1%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.5%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.7%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.8%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.1%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.1%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.5%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.4%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	89.3%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.5%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.4%	1.3%
E08000004	Oldham	01M	NHS North Manchester CCG	2.6%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.7%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.2%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.6%	96.1%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.2%	3.9%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.3%	100.0%
E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%

E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.2%	36.6%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.9%	60.1%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.9%	0.8%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.7%	99.0%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	5.0%	7.1%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	92.2%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.5%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.6%
E08000005	Rochdale	01M	NHS North Manchester CCG	1.8%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.8%	0.9%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.7%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.6%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	12.0%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	00W	NHS Central Manchester CCG	0.3%	0.3%
E08000006	Salford	01M	NHS North Manchester CCG	2.1%	1.7%
E08000006	Salford	01G	NHS Salford CCG	93.9%	95.1%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.1%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.2%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	2.8%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.8%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.3%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.6%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.2%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.9%
E08000014	Sefton	01V	NHS Southport and Formby CCG	97.0%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.5%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.5%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.2%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.7%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.2%	6.7%
E06000039	Slough	10T	NHS Slough CCG	96.6%	92.9%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	2.0%	6.8%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.3%	0.3%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05P	NHS Solihull CCG	83.8%	91.7%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.5%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.4%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	4.7%	8.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.0%	89.4%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.1%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.3%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.5%	99.6%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.4%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.6%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%
E09000028	Southwark	07R	NHS Camden CCG	0.5%	0.4%

E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.0%	1.3%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.6%
E09000028	Southwark	08L	NHS Lewisham CCG	1.9%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.5%	88.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.0%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.5%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.6%	1.1%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	91.9%	14.5%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.1%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.8%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	00W	NHS Central Manchester CCG	0.7%	0.6%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	01N	NHS South Manchester CCG	2.9%	1.7%
E08000007	Stockport	01W	NHS Stockport CCG	95.2%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.3%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.8%	98.7%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.3%	0.5%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.5%	16.5%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.3%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.2%	0.4%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.0%	29.6%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.7%	0.7%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.3%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.2%
E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.6%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.5%	0.1%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.2%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.5%	29.6%
E10000030	Surrey	08P	NHS Richmond CCG	0.5%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.9%
E10000030	Surrey	10C	NHS Surrey Heath CCG	99.0%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	7.7%	1.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.3%	3.2%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.2%	6.5%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	86.0%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.1%	0.2%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.3%	98.4%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.6%	1.4%
E08000008	Tameside	00W	NHS Central Manchester CCG	0.5%	0.5%
E08000008	Tameside	01M	NHS North Manchester CCG	6.4%	5.5%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.6%	2.1%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	3.0%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.0%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.2%
E06000034	Thurrock	08F	NHS Havering CCG	0.1%	0.2%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.3%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%
E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.3%	0.2%

E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.8%	0.8%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.7%
E08000009	Trafford	00W	NHS Central Manchester CCG	4.7%	4.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	01N	NHS South Manchester CCG	3.2%	2.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.3%	93.2%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.6%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.7%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.4%	90.7%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.3%	1.2%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.1%	1.5%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.8%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	2.7%	2.9%
E09000032	Wandsworth	08R	NHS Merton CCG	3.0%	1.8%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.8%	93.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.5%	0.3%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.1%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.6%	21.4%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.8%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.1%	66.2%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.7%	23.7%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	9.1%	7.6%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.6%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.2%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.5%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	2.9%	3.1%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	81.6%	71.1%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.5%	23.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.1%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	1.1%	0.8%
E08000010	Wigan	01X	NHS St Helens CCG	3.9%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.7%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.5%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.6%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.9%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.0%	0.5%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.1%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	97.0%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.9%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.5%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.9%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.2%	1.2%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.7%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.1%	0.0%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.5%
E06000041	Wokingham	10W	NHS South Reading CCG	11.1%	9.0%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.9%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.7%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.9%	4.0%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.7%	92.7%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.5%	0.6%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.6%	1.1%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	48.8%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.5%	18.8%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.4%	99.9%

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Sent via email

Sandra Taylor
Rutland Council

09/03/2016

Dear Sandra,

Feedback from BCF Planning Template Submission 1

Following the 2nd March BCF 1st submission of the Planning Template the regional panel met to review the submissions in tandem to the national team analysis.

The regional panel met as per the previously circulated Regional Assurance and Support Process to review area BCF funding contributions, a scheme level spending plan, national metric plans and any local risk sharing agreement and provide initial feedback to areas regarding the:-

- Identification of any errors and anomalies
- Provision of feedback and direction to areas on further plan development
- Identification of any support needs and allocation of one-to-one support to key areas
- Triangulation between BCF and CCG plans
- Consideration of generic support regarding common issues

In relation to the Planning Template submitted by Rutland our feedback highlights:

1) Acknowledgement of the additional contributions made by the Local Authority into the BCF programme.
2) Work still in progress to gain agreement over use of Care Act Monies and former Carer's Breaks Funding
3) Positive action taken with the introduction of 6 new BCF schemes to improve performance
4) Concern that Social Care protection has reduced from 998,000 to 839,000 a reduction of 23% and the impact that may result from that decision
5) Positive ambition by Rutland to stretch performance with non-elective admissions (NEA), residential admissions and effectiveness of re-ablement indicating progression

6) Some mild concern expressed by the panel that no risk sharing agreement is planned for NEA and we will look to the narrative submission to understand the rationale for that decision
7) The metric Delayed Transfers of Care remains in development
8) The national conditions of 7 day services, data sharing, joint assessments and managing delayed transfers of care remain areas of development for Rutland over 16/17 and we will look within the narrative submission as to how improvements and more integrated ways of working will be developed.

To confirm the next submission of the Planning Template and narrative plan is the 21st March. If you require any further support in addition to that provided by BCM Wendy Hoult please let us know.

Yours sincerely

BCF Regional Assurance Panel
Glen Garrod, Trish Thompson, John Sinnott and Wendy Hoult

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		
	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		
Local agreement on funding arrangements	Has the narrative plan submission been signed off by all parties?	See KLOEs 1i and 1ii		
	Does the narrative plan provide a full overview of funding contributions for 2016-17?	Confirmation that an overview of funding contributions set out		
	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		
	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		
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		
	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		
	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		
	The precise aspects of the change the local area is intending to deliver using the BCF?	BCF changes / schemes set out		
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		
	Identification of the opportunity to improve quality and reduce costs, based on segmented risk stratification?	Local opportunity identified		
	A narrative that is bespoke to the local area?	Local narrative set out		
	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		
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		
	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		

	An articulation of the arrangements in place to support joint working?	Joint working arrangements set out		
	Key milestones associated with the delivery of the plan of action in 2016-17?	BCF plan milestones set out		
	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		
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		
	Demonstration that this has been calculated using clear analytics and modelling?	Evidence of how risk share / contingency has been calculated		
	An articulation of non-financial risks associated with not meeting BCF targets in 2016-17?	Non-financial risk sharing set out		
	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		
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		
	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		
	There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan?	E vidnece provider signe dup wqith plans set out in B.1.ii		
	This includes an assessment of future capacity and workforce requirements across the system?	Assessment of future capacity and workforce requirements set out		
	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		
	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		
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		
	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		

	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		
	The local area has included a comparison to the approach and figures set out in 2015-16 plans?	Comparison to 2015-16 set out		
	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		
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		
	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		
	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		
	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		
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		
	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		
	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		
	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		
	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		
	How these changes will impact upon the integration of services?	Link to overall impact on integration described		

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		
	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		
	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		
	A plan with milestones demonstrating how and when this condition will be fully complied with?	Plan with milestones included		
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		
	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		
	These align to provider plans and the longer term vision for sustainable services?	Alignment to provider and longer term planning set out		
	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		
	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		
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		
	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		
	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		
	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		
	Where a risk sharing arrangement has been agreed this is, where appropriate, consistent with guidance?	Risk sharing arrangement set out with reference to guidance		

	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		
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		
	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		
	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		
	This target is reflected in CCG operational plans?	Confirmation provided that this aligns to CCG plans		
	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	Consideration of risk share options included		
	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		
	Clear lines of responsibility, accountabilities, and measures of assurance and monitoring?	Lines of responsibility, accountabilities, and measures of assurance and monitoring set		
	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		
	There has been engagement with the independent and voluntary sector providers?	Engagement with independent and voluntary sector providers on DTOC plan confirmed		
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		
	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		
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		
	ii. Does the narrative plan include an explanation for how this target has been reached?	Approach to setting residential admissions metric plan set out		
	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		
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		
	ii. Does the narrative plan include an explanation for how this target has been reached?	Approach to setting reablement metric plan set out		

	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		
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		
	ii. Does the narrative plan include an explanation for how this target has been reached?	SEE SECTION C8		
	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		

Report No. 67/2016

Report to Rutland Health and Wellbeing Board

Subject:	**Director of Public Health Annual Report 2015-16**
Meeting Date:	**22nd March 2016**
Report Author:	**Co-authored by Rutland Public Health and Rutland County Council staff on behalf of the Director of Public Health, Mike Sandys**
Presented by:	**Mike Sandys**
Paper for:	**Note /Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

The Director of Public Health's (DPH) Annual Report is a statutory independent report on the health of the population of Rutland.

The focus of this year's report is on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

The report uses a family of community centred approaches[1] as a framework and explores the role that communities (both place-based and where people share a common identity or affinity) can have in improving the health and wellbeing of individuals, communities and populations. By doing this it is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Local case studies are used to illustrate how some of these approaches are already in place in Rutland and areas where this can be further developed.

The report also describes the changing demography across Rutland over the next 25 years and in this context the role that communities have in supporting health and wellbeing will become increasingly important over the next few years.

The report clearly outlines the links to the Adult Social Care Strategy, People First Review, Better Care Together and fits well with the intentions described within the Adult Social Care Market Position Statement.

A number of local case studies have been used to illustrate how some of these community approaches are already being used in Rutland and form a basis on which to build.

[1] Public Health England & NHS England. *A guide to community-centred approaches for health and wellbeing*. 48 (2014). at

Financial implications:		
Full implementation of the recommendations of the report will be addressed through the commissioning cycle.		
Recommendations:		
1. That the Health and Wellbeing Board receive the Director of Public Health's Annual Report. 2. That the Health and Wellbeing Board support the recommendations in the report.		
Comments from the board: (delete as necessary)		
Strategic Lead:	Mike Sandys/Tim O'Neill	
Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	
Timeline:		

Task	Target Date	Responsibility

<https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches>

DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT 2015/16

RUTLAND

THE ROLE OF COMMUNITIES IN IMPROVING THE HEALTH AND WELLBEING OF THE POPULATION

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FOREWORD

In my last annual report, I set out the case for focusing on the social and economic factors which underpin health for everyone in Rutland. These include healthy housing, access to quality lifelong education, fair and secure employment and a supportive social circle. Last year's report also set out the roles public health can play: to be a leader in areas where we have a direct influence; to be a partner working alongside others in joint initiatives; and to be an advocate or champion for health in wider spheres.

This year's report seeks to build on this work by looking at how Rutland County Council and partners across the health system can strengthen and enhance the impact that communities have on people's health and wellbeing.

As the opening section of the report sets out, people in Rutland are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we focus on preventing ill health, so that the people of Rutland not only live longer lives but also remain healthier for longer. At the same time we have to recognise that more people will need support and help with their health and care needs.

The report describes the changing demography across Rutland over the next 25 years and highlights:

- there will be an estimated 49% growth in people aged 65-84 years and 227% growth in people aged 85 years and over;
- this will be accompanied by a 10% reduction in the number of working age adults (people aged 25-64 years);
- the increase in older people will mean that across Rutland there will be more people living for longer with long term conditions and age related disabilities;
- life expectancy across Rutland is significantly better than the England average, 81 years in 2010-12 for males and 84.7 years for females;
- healthy life expectancy (the number of years lived in good health), is however much lower for males and females at 65.5 years and 70.3 years respectively.

I have included the key headline data from Rutland's Joint Strategic Needs Assessment in Appendix A.

There is a need to work together across the wider health and wellbeing economy, to focus on how we support people to become healthy older people. Communities in Rutland have a valuable role to play in tackling these pressing concerns, through empowering people to help themselves and providing extra support where it's needed. Equally importantly, being part of a strong and supportive community that works together on local issues can in itself provide an enormous boost to people's health and wellbeing.

It is important that Rutland County Council and local health organisations work together in a coordinated approach to engage effectively with communities and to build community capacity. This will help to identify specific local needs and create innovative solutions to Rutland specific issues.

The pages of this report contain some outstanding examples of work to develop healthier communities across Rutland, and my thanks go not only to everyone who has played a part in these projects, but of course to everyone who has contributed to bringing this report together.

I look forward to working with you – whether as a partner organisation or as a member of our communities – to build on this good work over the coming year.

Mike Sandys
Director of Public Health

Executive Summary

This report focuses on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

People in Rutland are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we focus on preventing ill health, so that the people of Rutland not only live longer lives but also remain healthier for longer. At the same time we have to recognise that more people will need support and help with their health and care needs.

It is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Communities are vital building blocks for health and wellbeing and can provide support and assistance in keeping people supported in their own home and community. At an individual level, joining social activities, connecting to others and taking part in local decisions help to keep people healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. It makes economic sense, to build on the capacity of communities. Social return on investment analysis of community development in local authorities has indicated a return of £2.16 for every pound invested, with a value to volunteers of £6 for every pound invested.[16]

INTRODUCTION

Each year the Director of Public Health publishes an independent report on the health and wellbeing of our local population. This report is a statutory duty and intended to inform local strategies, policy and practice across a wide range of organisations and interests. The purpose of the report is to highlight opportunities to improve the health and wellbeing of people in Rutland.

Last year the report focused on wider determinants of health and the social and economic factors that drive health and wellbeing needs for the population, using the 1991 Dahlgren and Whitehead model of the main influences on health and wellbeing (Figure 1).[1] The basis of the model is the concept that some of the factors that influence health are fixed and others can be influenced. The factors that can be influenced are known as the wider determinants of health.

Figure 1: The Determinants of Health

Source: Dahlgren and Whitehead 1992

This report focuses on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

The report explores the role that communities (both place-based and where people share a common identity or affinity) can have in improving the health and wellbeing of individuals, communities and populations. By doing this it is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Confident and connected communities provide the social infrastructure that is necessary for people to flourish. Individual and community empowerment are core components to improving the population's health and reducing

health inequalities. At an individual level, joining social activities, connecting to others and taking part in local decisions help keep us healthy and well.

The role that communities have in supporting health and wellbeing will become increasingly important over the next few years. All public services across Rutland will face a very difficult financial challenge. Cuts to the Revenue Support Grant, a key source of funding for the council, mean there is an extremely challenging time ahead and this is at a time when the need for services is growing. People are living longer, which means that when they need services they need them for longer. Whilst at the moment people are working for a smaller proportion of their lives this also means that there may be more people who can volunteer and support people in communities. As retirement ages increase this pattern may change and there may be less people in the community with the time and capacity to volunteer. Identifying the support required to sustain and develop both formal and informal volunteering in this changing environment will be important in meeting this challenge and ensuring good support is available in communities.

National Drivers

In 2015, Public Health England and NHS England published ***"A guide to community-centred approaches for health and wellbeing"***.[2] This guide summarises recent research and learning on community centred approaches for health and wellbeing, based on the premise that the assets within communities (such as skills and knowledge, social networks and community organisations) are the building blocks for good health and can help to increase people's control over their health and lives. The report groups a new 'family of community-centred approaches' under four different strands (Figure 2):[2]

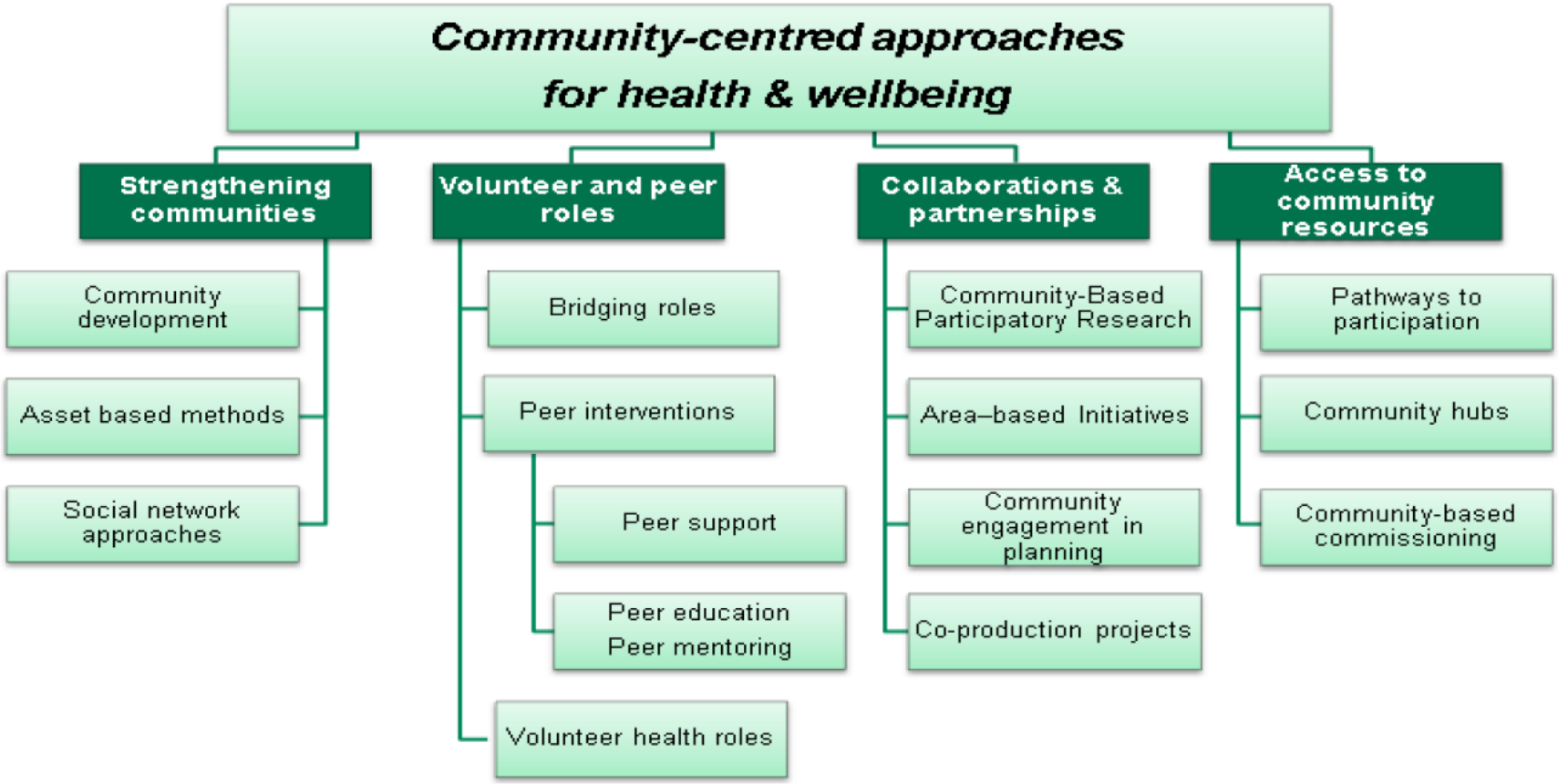
1. **strengthening communities** – building on community capacities to take action together on health and the social determinants of health;

2. **volunteer and peer roles** – enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities;

3. **collaborations and partnerships** - communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation; and

4. **access to community resources** – connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

Figure 2: The family of community-centred approaches for health and wellbeing



The family of community-centred approaches for health and wellbeing (South, 2014)[2]

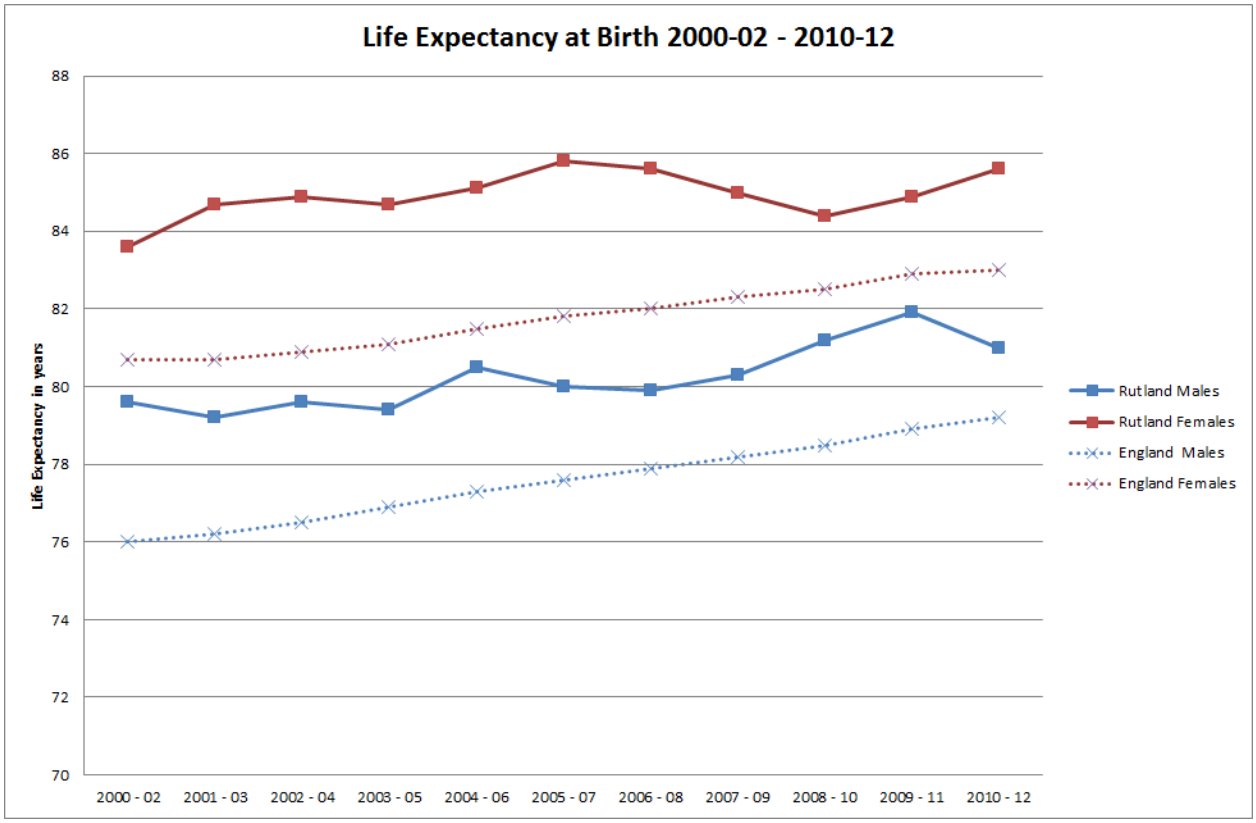
Local Drivers

The ***2015 Rutland Joint Strategic Need Assessment Overview*** describes the changing demography across Rutland over the next 25 years.[3] The key demographic drivers for Rutland are summarised below. Appendix A includes a summary of the key data within Rutland's JSNA.

The health of the people of Rutland

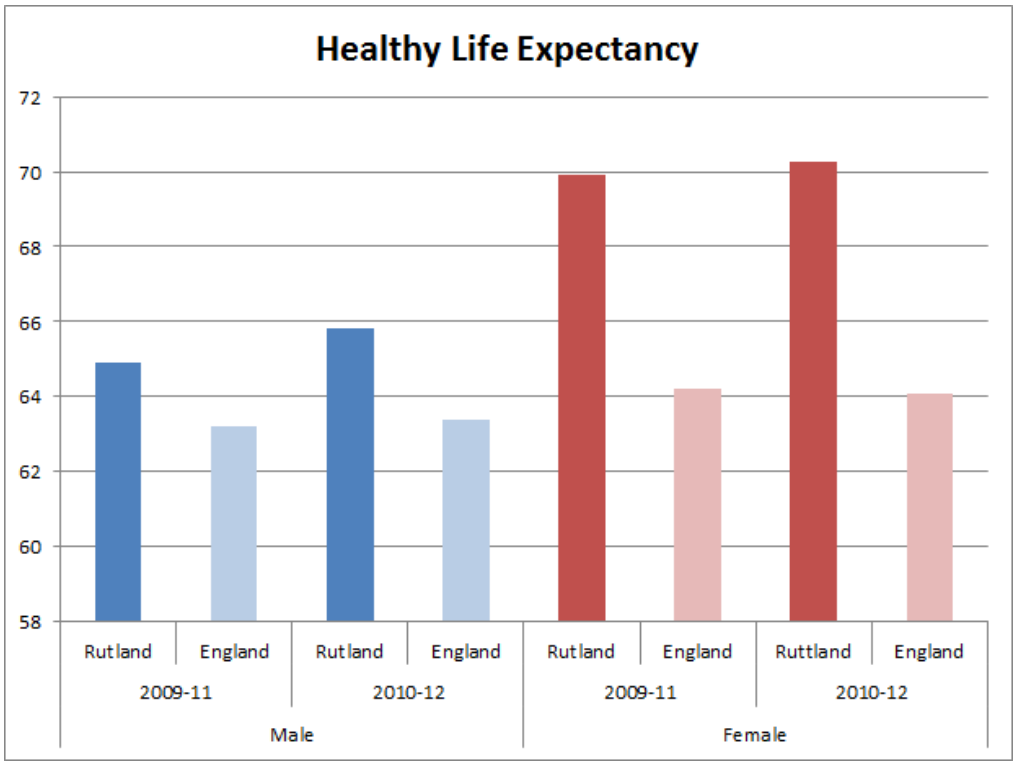
Life expectancy in Rutland continues to improve year on year and in the 10 year period from 2000-2002 to 2010-2012 there has been an increase in life expectancy of 1.4 years for men and 2.3 years for women. Life expectancy in Rutland is significantly better than the England average for both males and females at 81.0 years and 84.7 years respectively.[4]

Figure 3: Life Expectancy at Birth



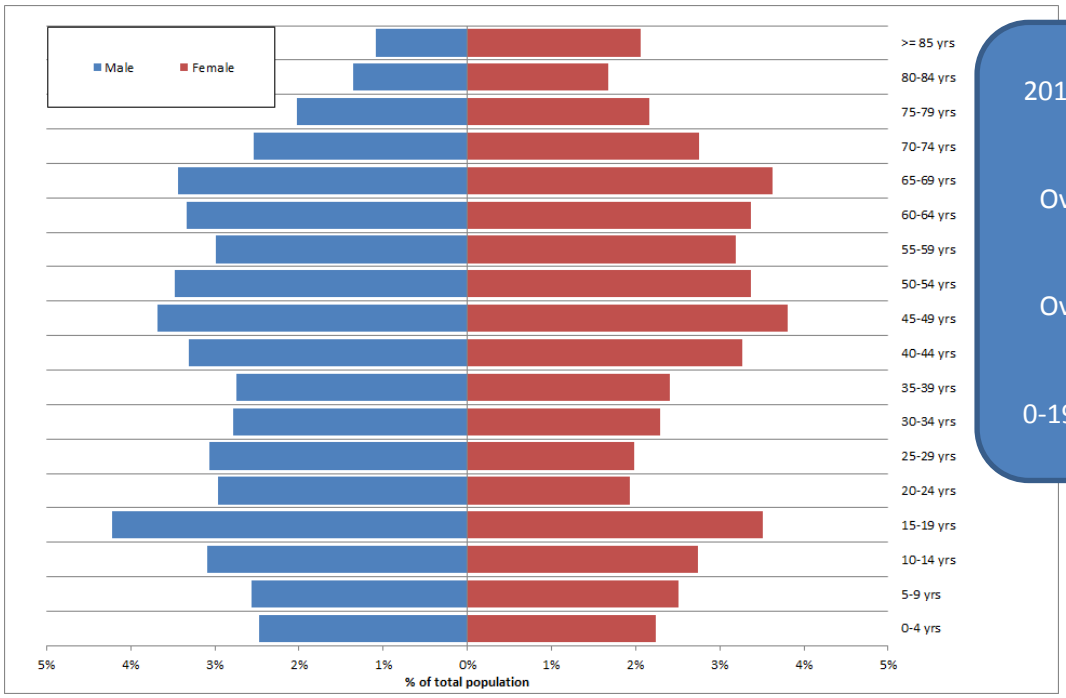
Healthy life expectancy is illustrated in Figure 4. Healthy life expectancy for 2010-12 is 65.8 years for males and 70.3 years for females. For both males and females, a significant proportion of the population will already be affected by poor health before they reach retirement age.[4]

Figure 4: Healthy Life Expectancy



The most significant driver of health needs for the Rutland population is the growing older population. In 2013, the total population for Rutland was an estimated 37,600 people. 8,540 people were estimated to be 65 years and over, and 1,180 were 85 years and over. 8,770 of the Rutland population were under 20 years of age.[5]

Figure 5: Mid 2013 Population Estimates for Rutland



2013 population – 37,600

Over 85 years – 1,180

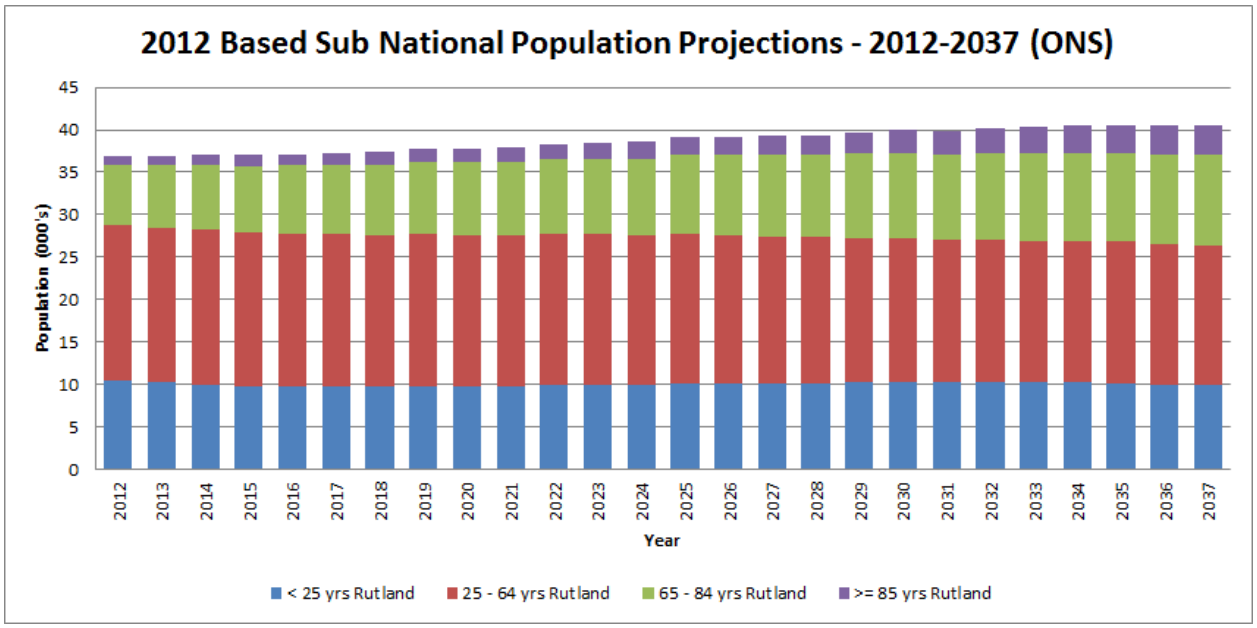
Over 65 years – 8,540

0-19 years – 8,870

The population of Rutland is growing – between 2012 and 2037 (25 years) it has been projected that the total population of Rutland will grow by 10% to over 40,800. However, this growth is not uniform across the age groups with a projected increase of:[6]

- 227% increase in people aged 85 years and over;
- 49% increase in people aged 65-84 years;
- 4% decrease in children and young people aged 0-24 years; and
- 10% decrease in the working age population (25-64 years).

Figure 6: 2012 Based Sub National Population Projections - 2012-2037 (ONS)



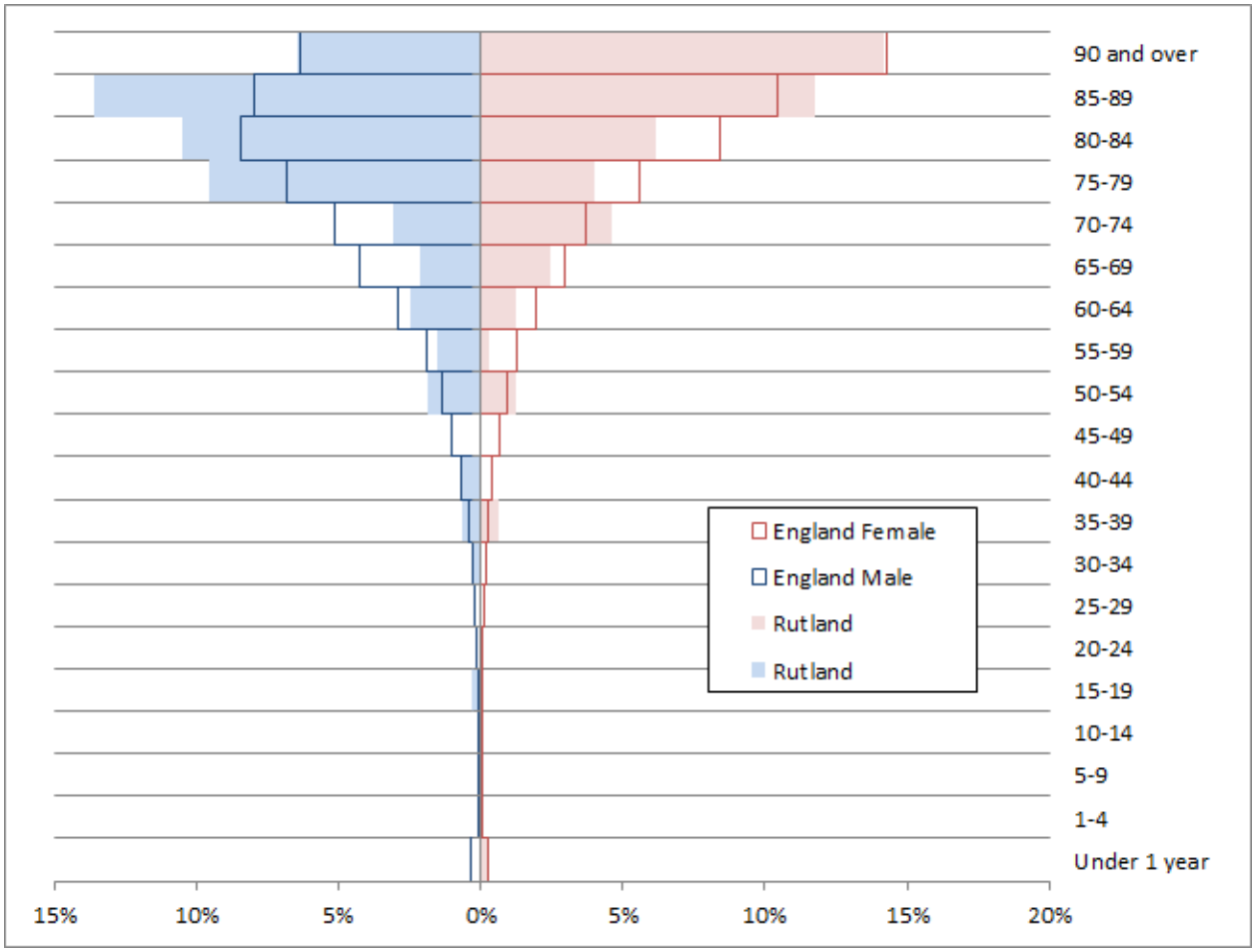
The total population is predicted to grow by 10%.
85 years + growth 227%, 1,100 to 3,600 people.
65-84 growth 49%, 7,100 to 10,600 people.
0-24 reduce by 4%, 10,400 to 10,000 people.

The 25 year time frame that we are looking at is important. The Better Care Together (BCT) Strategy 2014-19, published in June 2014, is a five year strategic plan for Leicester, Leicestershire and Rutland.[7] This five year strategy identifies the changes that are needed to make the health and social care system work more effectively in the immediate future. However, there is a need to consider the longer term care needs for the population. With an ageing population, there is a need to consider the plans that need to be put in place to

manage future health and care needs and demands in the longer term, with a focus on reducing preventable ill health, particularly in working age adults.

The population is living longer than ever before. For males, the most frequent age of death in Rutland is 85-89 years, with 26% of male deaths occurring in this age group. Overall, 75% of deaths in males are over 75 years of age and 85% are over 65 years of age. For females, the most frequent age of death in Rutland is over 90 years of age with 30% of female deaths occurring in this age group. 77% of female deaths occur at over 75 years of age and 92% of female deaths occur at over 65 years of age.[8]

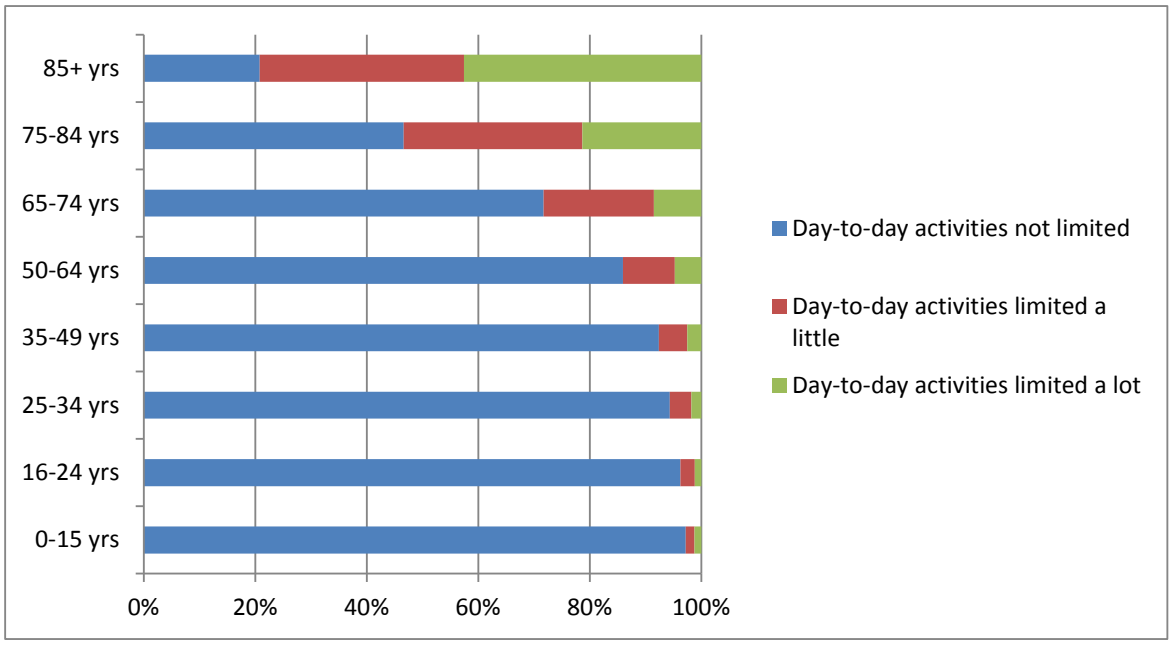
Figure 7: Deaths by Age Group in Rutland and England 2013



Health needs increase with age. The 2011 Census data for Rutland shows us that for people aged 85 years and over, only 21% of the population do not have their activities of daily living limited (ADL) by a long term health problem or disability. Over a third of this age group have their ADL limited a little and over two fifths have their ADL limited a lot. There is a clear correlation with age and as people become older their care needs linked to ADL increase. In terms of absolute numbers, the population with the highest number of people with ADL limited either a little or a lot is the population aged 75-84 years, affecting over 1,300 people. Understanding the population that have health and care needs linked to

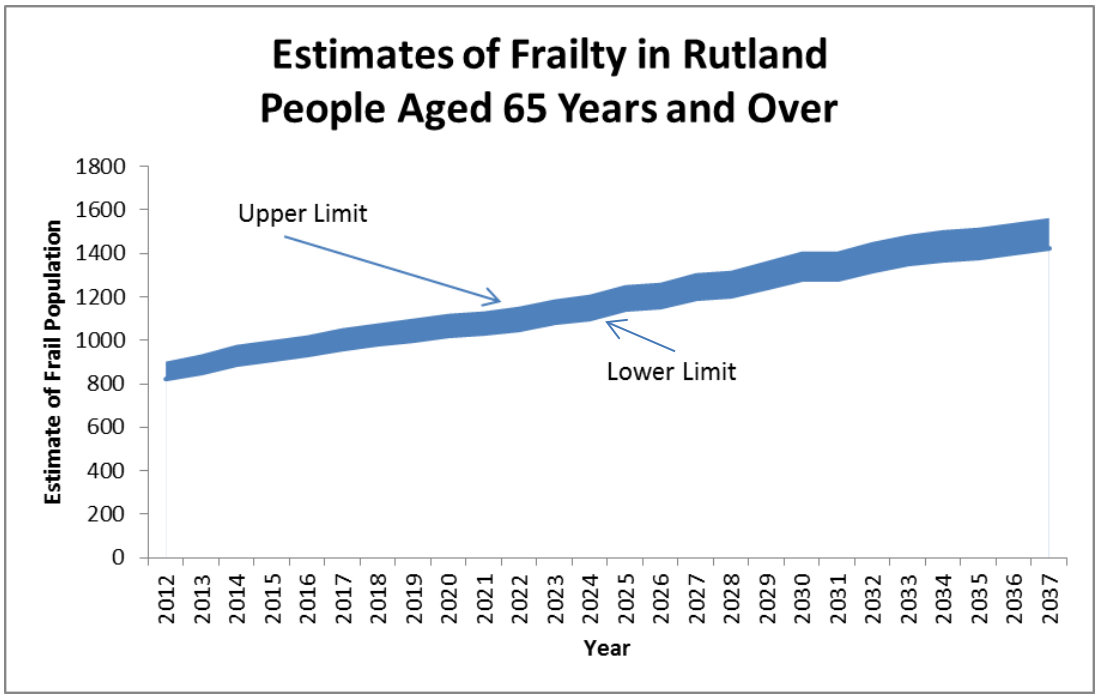
ADL is a useful way to target our preventative services to reduce longer term dependency on services.[9]

Figure 8: Long term health problem or disability by age for Rutland residents, 2011



The increasing older population will drive an increase in the number of people affected by frailty. This is illustrated in Figure 9 which applies an estimate of between 10-11% of the population aged 65 years and over affected by frailty, estimating the number of people in Rutland that are affected by frailty as between 820 and 900 in 2012 and between 1,420 and 1,560 people in 2037.[6] [10]

Figure 9: Estimates of Frailty in Rutland



The population growth patterns have implications for the provision of services for older people. There will be more older people with complex care needs who will require input from all parts of the health and social care system. This will need to be supported by people providing unpaid care through informal caring arrangements. However, the reduction in working age adults suggests that, as well as planning for the increased needs for services, there is a long term need to consider the infrastructure needed locally to support people. Carers will become increasingly significant to the wider health and care system and we will need to ensure that their health and wellbeing needs are addressed. This will be essential to maintaining independence and to support people to manage their own health and care needs with a shrinking network of informal care and support. Supporting people to live independently through appropriate housing provision is also a key enabler for the future sustainability of health and social care. Added to this and in common with many rural areas Rutland has 65% of its areas measured as deprived in terms of access to local services and this will need to be factored in to any service planning.

Rutland County Council

Rutland is changing. As the population grows older and young people with disabilities live longer, there will be additional challenges to keeping Rutland a healthy place to live.

The People First Review set a way forward for services that will meet the needs of individuals, families and our communities.[11] Taking into account the views of the public, it set the vision for the future and committed Rutland to:

- enable individuals and families within our community to achieve their full potential and be safe from harm;
- target services in particular at the most vulnerable and those who need us the most;
- integrate services more closely with the Health and Voluntary, Community and Faith (VCF) Sectors based on care pathways that support independent living;
- be clearer about what individuals, families and our community can expect;
- focus on finding different ways to do things rather than reduce or remove services; and
- adopt an early help and prevention approach.

The **Adult Social Care Strategy** sets the council's vision for everybody to have the best health and wellbeing throughout their life, and access the right support and information to help manage, reduce, prevent or delay the need for care and support.[12] Using the findings from engagement with the people of Rutland, it is clear that health and wellbeing is best promoted within people's own homes and from within people's own communities. By empowering people in Rutland to have choice and control over their lives, the council aims to maximise their wellbeing and independence in their local community, preventing and postponing the need for care and support.

The strategy is based on three themes:

1) Healthy Rutland - Healthy lifestyles are important for everyone from those with pre-existing health conditions or disabilities to those without. A healthy lifestyle will help prevent or delay the onset of long term limiting illnesses. They also prevent the recurrence of problems and reduce further deterioration and the likelihood of intensive or long-term health and social care need. In this respect, supporting people to eat healthily, manage their weight, stop smoking, increase their physical activity and reduce alcohol consumption is particularly important.

2) Independent Rutland – Using the findings from the "People First Review" it is clear that addressing an individual's needs sit within a wider network of personal and social relationships in the community. Connecting individuals with family, friends and community support networks is generally extremely important for people's wellbeing and to prevent or postpone the need for funded care and support services. The council wants to promote personal responsibility and for people to have opportunities to become a greater part of their community through increased opportunities for socialising, gaining personal recognition and building relationships, while remaining in their own homes for as long as possible.

3) A Sustainable Future – The council wants more collaborative working with health and other partners to deliver integrated community health and primary care services to improve health and social care for people. Delivering an integrated health and social care system will ensure services are best suited to local needs and circumstances, enabling people to enjoy good health and wellbeing living at home as independently as possible.

KEY FINDINGS AND RECOMMENDATIONS

Rutland County Council's People First report clearly set out how people would be at the heart of service delivery.[11] The recently published Adult Social Care Strategy and Market Position Statement determines that to achieve this people and communities will need to be engaged in the design and delivery of services.[12] [13] This report is therefore timely as it sets out a framework for developing community based approaches that can improve the health and wellbeing of the population, and provides examples of some of the initiatives that are already happening across Rutland.

The framework outlined in this report is an effective approach for providing communities with opportunities to improve health and wellbeing. However, the very nature of community led approaches means that to be most effective each community will need to be able to develop the community interventions that are most suitable for their needs. Whilst there are some good examples of community engagement in Rutland there are areas where there is less evidence of local activity or of being systematically applied across Rutland. Proposals for more joined up working and better coordination of the range of community services will help ensure a more effective and co-ordinated approach to prevention. The proposal to develop an integrated health and wellbeing service will require community approaches to be central to development and delivery.

With community-centred approaches outcomes are often connected to one another. For example improvements in mental health may have resulted from lifestyle changes. People involved in providing support through community-centred approaches are as likely to benefit from their involvement as the people that are receiving the support. This is illustrated in the case studies that have been used within this report. These links are reinforced where an intervention has worked well. The range of outcomes from each of the community-centred approaches is shown in Table 1.

The case studies presented in the report show many positive outcomes from working with communities. However, not all community-centred approaches will deliver measurable improvements in outcomes for people. Many schemes will not have sufficient evidence to draw firm conclusions or will report mixed results.

Table 1: The range of outcomes from community centred approaches

Individual	Community level	Community process	Organisational
Health literacy – increased knowledge, awareness, skills, capabilities **Behaviour change** – healthy lifestyles, reduction of risky behaviours **Self-efficacy, self-esteem, confidence** **Self-management** **Social relationships** – social support, reduction of social isolation **Wellbeing** – quality of life, subjective and objective wellbeing Health status physical and mental **Personal development** – life skills, employment, education	**Social capital** – social networks, community cohesion, sense of belonging, trust **Community resilience** **Changes in physical, social and economic environment** **Increased community resources** – including funding	**Community leadership** – collaborative working, community mobilisation/ coalitions **Representation and advocacy** **Civic engagement** – volunteering, voting, civic associations, participation of groups at risk of exclusion	**Public health intelligence** **Changes in policy** **Re-designed services** **Service use** – reach, uptake of screening and preventive services **Improved access to health and care services, appropriate use of services, culturally relevant services**

It makes economic sense, to build on the capacity of communities. Using 2011 figures the cabinet office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[14] Time banking can have a net value of £667 per person rising to £1,312 if quality of life is improved.[15] Social return on investment analysis of community development in local authorities has indicated a return of £2.16 for every pound invested,[16] with a value to volunteers of £6 for every pound invested.[16] There is definite potential to offer significant return on investment, however, poor retention of volunteers, high turnover and low levels of ownership can push costs up.

Throughout the report, case studies have been presented that cross many sectors of the community. This work is led by the different organisations that work together across Rutland to improve health and wellbeing. These organisations are collectively represented on Rutland's Health and Wellbeing Board. Support for and acknowledgement of the value and importance of community based approaches is a significant step towards identifying opportunities to work together more effectively to build community capacity. There are some really good examples of local community schemes that are delivering real benefits for local people. However, there are gaps and potential duplication in what is being delivered and opportunities to do more and coordinate more effectively. In particular, community based participatory research; community-based commissioning and co-production projects are approaches where a limited number of case studies and examples of good local practice were found. There is also scope to engage communities more actively in service planning and development.

For community based approaches to have the maximum impact for local people there needs to be good local leadership of this agenda. This will ensure that all communities are able to make best use of the opportunities to build their own local capacity. From a council perspective, there is a need to work together with other public sector agencies and the voluntary sector to increase capacity within local communities to ensure real engagement and a move away from doing things 'to' and 'for' people to 'with' or 'by' them.

Communities are vital building blocks for health and wellbeing. At an individual level, joining social activities, connecting to others and taking part in local decisions help to keep people healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. An equitable health system involves people in determining the big questions about health and care and actively removes barriers to social inclusion. That is why individual and community empowerment have to be core to efforts to improve the population's health and reduce health inequalities.

RECOMMENDATIONS

It is recommended that:

1. That future programmes focus on extending **healthy life expectancy** (the number of years lived in good health) and closing the gap by targeting specific groups with worse health. This should include routine and manual workers, service families, children living in poverty and older people in greater need.

2. The development of community prevention and wellness services provides a good opportunity to measure benefits and impact of services based on a model of building community capacity and resilience to improve health and wellbeing. Mechanisms for evaluating the effectiveness of these services in achieving this should be built in to the service design from the start.

3. Cross agency working and partnerships are extended to more fully involve local people and communities as the next step to increase and improve **community engagement in planning.**

4. **Co-production models** (where service users work jointly with professionals to design and deliver services) are trialled for several projects in Rutland with the aim of developing more suitable services and reducing exclusion.

5. The Council uses a **Health Impact Assessment (HIA)/ Health in All Policies** approach to support local communities in influencing **major** developments and policies. HIA's can facilitate active engagement of local communities in the assessment process and enable consideration of the health impacts of proposals from a range of perspectives so that positive impacts can be increased, negative impacts identified and ways to mitigate these considered.

6. It is made easier for people to find out what services are on offer locally to support health and wellbeing, through better coordination and communication of prevention activities within Rutland.

COMMUNITY CENTRED APPROACHES TO HEALTH AND WELLBEING IN RUTLAND

This report uses the family of approaches, outlined in Figure 2, as a framework to review the evidence for community based working. It also provides examples of where these approaches are being used across Rutland. The report highlights the opportunities to further develop these approaches in Rutland and makes recommendations on ways that partners across the health and wellbeing system can work together to improve health and wellbeing.

1. Strengthening Communities

This group of approaches involves building community capacity to enable community action that will improve health and the social determinants of health.[2] There are a wide variety of community capacity building approaches and evidence has shown initiatives are more effective if they are shaped according to the needs and characteristics of a particular community. Taking this into account, such approaches have been shown to increase social cohesion, creating communities that feel more connected with each other and the wider services in their community.[17] [18] Benefits include the development of skills and knowledge and the building of a more united local voice with an increased sense of being able to rely on friends or relatives for support.[19] Benefits extend beyond the community group involved to the wider community as a whole.[20] Overall, community capacity building has been shown to deliver a net economic benefit.[2]

1.1 Community development

"A long term value-based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion".[21]

A community-led approach to health improvement is concerned with supporting communities to identify and define what is important to them about their health and wellbeing; the factors that impact on their wellbeing and take the lead in identifying and implementing solutions.[22] This results in interventions which aim to bring together a group of people, who often share a common experience or characteristic, for support.[23]

Case Study - Rutland Community Agents - http://www.rutlandcommunityagents.org.uk/

The Rutland Community Agents (RCA) service has been developed as an asset based community development approach. The focus of community agents is to identify and provide support to vulnerable people of all ages building social capital. This includes older people at risk of isolation, those with mental health needs, autistic spectrum disorders or

learning disabilities.

RCA aims to promote social interaction and foster peer networks for a supportive community that improves wellbeing. The service acts as a single point of access, ensuring every contact counts and providing timely advice and local information for people on keeping safe and well and managing their long-term health conditions. This includes greater use of local individual and community solutions, resources and networks, building the resilience of those who need help before they hit crisis and diverting use from formal services.

RCA provides a variety of tailored support needs; from helping with housing, employment, legal advice and finances to holding pop-up clinics, setting-up new community groups and providing volunteer befrienders.

CA service established 24 hour online provision with 4,263 visits since April. The site provides access to online training, self-help toolkits and information on a wide range of topics including; Health, Education, Social Activities, Support, Employment and Lifestyle including support group locators and volunteering opportunities. The site also links to the Rutland Information System, enabling easy identification and access to services that meet Rutland citizens' needs.

As of the October 2015 the RCA service has:

- provided one-to-one advice / signposting to 277 Rutland residents;
- made direct contact with 848 residents through local groups and events where discussions around how the RCA's can support communities took place;
- made 246 referrals to external partner agencies;
- identified 48 new services which have been added to the RCC RIS; supporting self-help and better access to services within Rutland;
- reported 100% of individuals receiving short term advice and assistance have demonstrated progression in their overall health, well-being and quality of life assessed using the Well-being Outcome Star Tool; and
- implemented 9 new groups/events across Rutland including partner drop-in clinics and CCC (Coffee, Cake & Chat) groups in areas where isolation is identified as a core issue.

The Community Health Link Agent has made strong links with relevant partners and is now

working closely with a number of health care professionals to improve hospital discharge and prevent unnecessary admissions. Referrals are being received and support provided to patients from a number of local hospitals and Rutland GP surgeries. To date the HLA has offered advice, assistance and signposting to 83 individuals to support them to sustain their independence. Of these 46 have been supported to leave hospital or prevent a hospital admission.

1.2 Asset based methods

"In an asset based approach, the glass is half-full rather than half empty".[24]

The ethos of this approach is to value and accentuate the positive capabilities of communities, starting with strengths and focusing on local capacity, skills, knowledge, connections and potential. The focus is on building networks, promoting resilience, self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.[25] The aim is to build up community groups and voluntary organisations; their informal associations and networks, their collaborative relationships, their shared knowledge and therefore their social power to make positive changes.

1.3 Social network approaches

"Outcomes include more cohesive and stronger communities, improved self-esteem and people who feel more in control of the decisions that affect them." [26] [27]

These approaches include community organised activities which strengthen social support between members. Interventions both enhance existing networks and create new ones to improve the social links between people. There are health and non-health benefits including reduced illness and premature deaths, improved mental health and resilience, reduced crime and delinquency and positive impacts on employment.[28] The results are more confident and active communities, including increased social engagement, support and more extensive networks.[2]

1.4 Summary

The community agents case study reinforces the importance of the underpinning principles of the "strengthening communities" approaches. It demonstrates the value of building networks and capacity to enable more connected and resilient communities, which can then continue to support each other.

There are also other community based projects being supported throughout Rutland which contribute to strengthening the community, some of which may not be widely known or celebrated. However, much of the available evidence of outcomes is based on small scale case studies. There is a need for a holistic approach to the development and evaluation of these approaches across different communities and partner service providers in the area. There is a gap in the evidence of the benefits of the strengthening communities approaches, both in terms of health and wellbeing outcomes and financially in terms of cost benefits and return on investment to service providers.

It is essential that more innovative approaches to the evaluation of community led approaches are developed and implemented to provide robust evidence of the benefits of these approaches.

2. Volunteer and Peer Roles

This group of approaches focuses on an individual's capacity and competence to provide advice, information and support including organising activities around health and wellbeing in communities. Volunteers or peer supporters are mainly drawn from their local neighbourhood, and receive training to enable them to undertake a health promoting role within their community. Most volunteers are unpaid and deliver this role on a voluntary basis.

There is a long history of volunteering within the UK, with research studies showing participation in volunteering is strongly associated with better health, lower premature death, better functioning, life satisfaction and decreases in the occurrence of depression.[29] Giving to others is one of the five steps to mental wellbeing with volunteering identified as one of the ways to do this.[30] Volunteers are seen as 'active citizens' and there have been a number of examples of highly successful public health volunteer projects ranging from access to contraception in the early 20th century to campaigns on disability rights.[31]

In addition to personal mental and physical health benefits, volunteers gain both formal and informal skills which can, over time increase their employability[32] as well as their confidence and self-esteem.[33] The use of peer educators or community volunteers in health improvement activities can be effective in changing certain health behaviours.[34] Involvement of volunteer led activities requires investment and funding but has been shown to have a positive return on investment.[2]

2.1 Bridging roles

These are usually carried out by volunteers (rather than 'peers') who formally signpost people to services and information, supporting them to improve their health and

wellbeing.[35]

Case study – SmokeScreen Promoter

The Tobacco Free Schools Project is developed and funded by the Public Health Grant. It is a comprehensive school-based programme to prevent the uptake of smoking by young people in Rutland.

Part of the Tobacco Free Schools project is the role of the peer mentor/ youth advocate/ 'SmokeScreen' promoter. The roles vary depending on whether they are developed within primary or secondary schools, and include supporting and advocating for smoke free environments, particularly in homes and cars. They also involve helping to promote the message that not smoking is the norm as most students don't smoke, and using this to encourage those who do smoke to stop and those who don't not to start.

A range of promotion methods are used including creating posters that will be placed around the school or college and entered into an annual poster competition. The overall outcomes of the project include:

- an increase the number of young people who seek assistance to quit smoking;
- a reduction in the number of young people taking up smoking and using tobacco; and
- a reduction in overall smoking prevalence for the population of Rutland.

2.2 Peer based interventions

These interventions aim to capitalise on the social influence of people who share similar experiences or characteristics by recruiting and training people from within the community of interest. This approach develops the capacity of volunteers or peers to become 'agents of change'.

2.3 Volunteer health roles

These are more 'formal' volunteer health roles which are often focused on reducing health inequalities. Volunteers usually receive training to undertake the role and professional support is provided. For example Voluntary Action Rutland (http://www.varutland.org.uk) supports and promotes local voluntary action by providing advice, information, support, training and consultation. They offer a wide range of services to members of the Rutland community and give priority to those most in need. They hold a database of organisations looking for volunteers and people willing to offer voluntary work for the benefit of their community.

Case Study - Breastfeeding peer support service in Rutland 'Breastfeeding Support Rutland'

Breastfeeding Peer Support Rutland offer support to mothers in Rutland. The peer supporters are mothers who have breastfed their babies, or are currently breastfeeding. They are trained to provide other mothers with support via antenatal & postnatal support and regular coffee mornings in Rutland's Children centres.

This project covers the whole of Rutland. The aim of the project is to contribute to increasing breast feeding rates at initiation and 6-8 week duration. Breast feeding peer supporters can support mothers by providing information about the benefits of breastfeeding, thus ensuring that women can make informed decisions on how to feed their baby. For those who have chosen to breastfeed, they can provide advice, support and encouragement when requested.

This project is co-ordinated by the Infant Feeding team at Leicestershire Partnership NHS Trust.

The project currently has 11 active peer supporters with a further 10 mothers who have recently been trained. Breastfeeding Peer Support contributes to an increase in the proportion of mothers breastfeeding in Rutland. A rise from 240 initiating breast feeding in 2013-14 to 282 in 2014-15.[4]

2.4 Summary

These local case studies support the evidence on the positive impact of taking part in volunteering. The evidence highlights the positive impact of volunteering for the volunteer or peer supporter, as well as for the target group or recipient of the support.

Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[14] An analysis of the value of volunteers running activities was £6 to £1 invested to employ a community development worker.[16] This demonstrates potentially a significant return on investment.

Volunteering delivers a whole range of benefits, which include:

- having a positive impact on the community and increasing the connections within that community;
- supporting individuals to make new friends and contacts;
- increasing social and relationship skills;
- improving mental and physical health; and
- improving job skills or providing career experience.

These benefits are in addition to the support that is being provided within the local community through the specific and targeted volunteer and peer roles.

3. Collaboration and partnerships

A key strand of community centred approaches is to engage and work with communities to improve planning and decision making, ensuring a greater focus on 'done with rather than done to'. Collaborative approaches that involve communities and local services working together can range from a one-off consultation to longer term participation in planning and service delivery. Partnerships with communities may include jointly identifying need, agreeing priorities and actions and planning, implementing and evaluating results.[2] There is good evidence that involving communities in the processes of planning, design, decision-making and delivery can improve health and well-being and make policy initiatives more sustainable.[34] Whilst no particular model of community engagement is thought to be more effective than any other,[36] engagement is seen to work best where it is an ongoing cumulative process enabling relationships and trust to build and strengthen over time.[37]

Community collaborations and partnerships can help to address a sense of powerlessness on the part of the community leading to a more resilient, inclusive approach and a more positive view on the way a community feel about their local area.[17] [38] In some areas of work such as social housing, communities that have owned and managed the work have performed better than local authority owned social housing.[39] Community coalitions can contribute to the effectiveness of certain community health improving behaviour change, particularly if they have been involved in the planning of the initiative.[34]

3.1 Community-based participatory research

This is where a partnership between communities, services and researchers work together to identify the needs of the community and develop programmes to meet those needs.

3.2 Area based initiatives

This refers to community based initiatives that are targeted in a particular geographical neighbourhood. This allows plans to be focused on the issues that affect a particular geographical community and that tackle multiple issues that are affecting the area in a holistic way.

Case study - 'Whissendine Good Neighbour Scheme': Local people set up a good neighbour scheme in a Rutland village

The village of Whissendine in Rutland has around 500 houses, a church, a windmill, 2 pubs, a sports club and various community groups. What is doesn't have is a post office, doctor's surgery or until recently a shop. It's a nice place to live and many choose to live there independently as long as they can. A parish plan was initiated in the village, and a questionnaire circulated asking residents how they felt about the village and how they thought it could be improved. Among other things the need for transport and befriending were highlighted. The Rural Community Council -who were assisting with the plan, suggested they set up a Good Neighbour Scheme along the lines of a scheme operating in Leicestershire. A steering group was formed, and a public meeting held where 30 people came forward to volunteer.

The Good Neighbour Scheme in Whissendine was set up in 2010. It is run by local volunteers who support people living in the village. A duty co-ordinator holds a mobile phone, and those requiring assistance ring to make a request and the co-ordinator finds a volunteer to help. Some volunteers provide transport to medical appointments or to social events in the village, others help with small DIY or gardening tasks. Some volunteers befriend, such as dropping in for a chat. The only charges made are for petrol, trips outside the village and parking. The scheme has its own website, advertises monthly in the village newsletter Grapevine, and in 2011 the scheme was awarded a Gold Award for Village Achievement from the Rural Community Council.

Feedback has been very positive, with residents saying they don't know how they managed before, and more than one person saying they feel more confident about living independently in the village in spite of increasing age.

"Most weeks I have a welcome visit from a lady from the Good Neighbour Scheme. As I spend the greater part of each day on my own, it is good to have someone call who is always cheerful, helpful and interesting to talk to."

Initial set-up costs were covered by funding from Rutland Community Spirit and Whissendine Parish Council. A Grass Roots grant via Voluntary Action LeicesterShire (VAL) was also obtained.

The Rural Community Council, who assisted at the beginning, continue to support the scheme. Rutland County Council agreed to be the umbrella organisation for DBS checks, processing them initially free of charge. Voluntary Action Rutland and VAL provided information and training.

3.3 Community engagement in planning

This is an approach that aims to involve local communities in planning and decision making with local government and the NHS. It brings in the insights of the local communities on the issues that are affecting their lives and also means that the local community has a greater sense of ownership of the plans that are developed. Public Health are developing a Health Impact Assessment / Health in All Policies approach to support local communities in influencing major developments and policies that will increase the potential positive impacts and mitigate identified negative impacts.

3.4 Co-production projects

These are projects that seek to develop equal partnerships between professionals and those using health and care services. This approach is similar to many of the other approaches but is focussed on people with established care needs.

Case Study - Health for Kids – Health for Teens

School nurses at Leicestershire Partnership Trust wanted to enable children and young people to 'help themselves' to health in a format of their choice and to provide an extension to their school nursing services. They developed a Health for Kids website: https://www.healthforkids.co.uk/ and a Health for Teens website: https://www.healthforteens.co.uk/. Children and young people were actively involved in co-designing the websites and the websites ensure that children and young people have access to good, sound, safe and accurate information.

Several separate groups of children and young people were involved in focus groups to develop the ideas and topics to be included and in particular shape how they wanted to receive the information. The children designed the characters and games used for the Health for Kids website. In its first 18 months, the Health for Kids website has had more than 39,000 visits and 175,000 page views. In the first week of a new campaign' Move it Boom!' has seen 27,000 page hits and 700 children have signed up to participate and record their activities.

School teachers in Rutland are using the site in lessons and have welcomed the emotions section as an excellent learning tool. Over eleven thousand individuals visited The Health for Teens website in its first 9 months, with 50,000 individual page views. During this time The Health for Teens twitter feed had 769 followers and these are growing steadily. Young people have continued to be involved in its development and as a result a range of additional topics, apps, videos and vlogging (video blogging) facilities are being added to the website. An editorial team of young people is being established and consultations will continue on an ongoing basis to ensure the websites stay fresh and meets the needs of children and young people and that the content and style is always driven by what children and young people want to know about. The website has recently won a communications industry award for the 'Best website' from the Association for Healthcare Communications and Marketing (AHCM). The children and young people have expressed their pleasure at seeing their ideas and views taken on board as can be seen in the video they prepared for several awards

3.4 Summary

These collaboration and partnership approaches can lead to more positive health and wellbeing outcomes and have been shown to improve a sense of belonging to a community (social capital) and to improve a sense of wellbeing. The chance to co-produce services can increase confidence and self-esteem. Using people's local knowledge and experience to design or improve services can ensure they are more appropriate, effective, cost effective and sustainable. They can encourage health enhancing attitudes and behaviours. Individuals and communities can gain a sense of increased control over decisions affecting their lives.[40] There is good evidence of the benefits of working in partnership with communities to enable better planning, decision making and delivery. For these opportunities to be used more widely and effectively statutory organisations and professionals need to be committed to sharing power and decision making and support the development of staff to have the skills, knowledge and values to work in this way.[40] Whilst there are good examples of partnerships and collaboration in Rutland, extending cross agency working and partnerships to more fully involving local people and communities

would be a next step in developing these approaches.

4. Access to community resources

The assets within communities, such as its skills and knowledge, social networks and community organisations, are building blocks for good health. It is important that we enable people and communities to participate, contribute and also access these assets in order to be able to improve their health and wellbeing.

Resources can include anything that may be community based, for example, parks and green spaces or community pharmacies. Parks and green spaces can help to address issues such as obesity, cardiovascular disease, mental ill health or antisocial behaviour.[41] There is evidence that community pharmacies can have an impact upon smoking cessation activities, cardiovascular disease prevention and management of diabetes.[42]

Access to assets can be helped through the provision of local information and services, support groups and organisations which both signpost to support or assist people in getting access to support. Examples include “community hubs” such as children’s centres, community libraries and citizens advice centres.

Using an asset based community development approach starts with the process of locating the assets, skills and capacities of residents, citizens associations and local institutions. This builds up community groups and voluntary organisations; their informal associations and networks, their collaborative relationships, their shared knowledge and therefore their social power to make positive changes.

4.1 Pathways to participation

This covers the many routes that are being developed locally to help people to access interventions that will improve their health and wellbeing. These all build on the assets that already exist within the community – be it the physical assets in the form of parks, green spaces or community centres or the assets that exist in the people that live within these communities through their own experiences and expertise and time. Local examples include “social prescribing” to activities outside of the traditional health sector, which links people up to activities in the community that they might benefit from. For example referral to green gyms or walking schemes for physical activity, food banks and welfare and debt advice.

Case Study - STEP TO IT – an inclusive dance group for girls and boys aged 12-19

"STEP TO IT" is an inclusive dance group for girls and boys aged 12-19 years old with a disability, enabling them to be part of a weekly dance session. The sessions are delivered by Rutland youth dance academy, and supported by Rutland County Council Active Rutland officers. They are held at Brightways Community Centre. The group have performed at the community dance show and even in front of royalty. This year the group won "Project of the year" at Rutland Sports awards.

The session begins with dynamic movement skills, to help refine and improve gross motor skills, and to get those body parts moving! Participants engage their creativity by moving around the room in different ways. The second part of the session is more structured with different routines being built upon every week. The session ends with 5-10 minutes of relaxation and stretching, allowing a focus on the body and spatial awareness as well as time to reflect on what the dancers have just learnt. Comments from users include:

"Step To It has been a brilliant project for me. I've never really been interested in dance or preforming, but I have loved being given this opportunity to learn hip hop/pop by a professional and then being able to perform! It's definitely helped my confidence and self-esteem as I've been able to express myself through dance and get fit at the same time; I hope this group continues and I'd recommend dance to anyone."

"Step to It is a fantastic project of 'feel good' personified! An hour in this environment is developing our daughter's co-ordination, concentration, strength and communication whilst doing something she loves with her peers - a well spent hour! With our daughter's level of learning and physical disability we struggle to find inclusive, ongoing activities that she can realistically access for long enough to experience success. Step To It provides this platform."

The programme is funded through Sport England "Sportivate" funding.

4.2 Community hubs

These are community centres or organisations focused on health and wellbeing that can provide multiple activities to address health or the wider determinants of health.

Case Study - Rutland Food Bank

23rd September 2015 marked the second birthday of Rutland Food Bank. During that time 1500 people have received emergency packs of food to last 3 days and 23.5 tonnes of food collected mostly by the generosity of local people.

In Rutland there are two Foodbanks – on Melton Road in Oakham and Uppingham Parish Church. Both provide a community hub where clients are able to share their experiences and are signposted to agencies who can offer additional help and begin to resolve any underlying problems.

All food given out by the foodbanks is donated. Often this is from schools, churches, businesses, individuals, or through supermarket collections. Supermarket collections help foodbanks engage the public. Foodbank volunteers offer shoppers a 'foodbank shopping list' and ask them to buy an extra item with their shop. This food is then handed to volunteers waiting beyond the checkout who pack it before it is taken to the foodbank warehouse for further sorting and storage. Food is sorted and stored at the warehouse, where volunteers weigh and sort the donated food according to type and 'best before date'. They also check it is undamaged and suitable for use before packing it into boxes for storage.

Professionals from statutory and voluntary organisations such as doctors, health visitors, social workers, Citizens Advice Bureau staff, welfare officers, the police and probation officers, identify people in crisis and issue them with a foodbank voucher. Clients bring their voucher to a foodbank centre where it can be exchanged for three days supply of emergency food. The list of foods in each parcel have been designed by dieticians to provide recipients with nutritionally balanced food.

4.3 Community based commissioning

This refers to a process by which local communities are involved in the commissioning cycle and includes community engagement to understand community needs, and commissioning services through third sector providers. The Council is now focussed on improving prevention and resilience (in line with current key strategies and Better Care Together and Better Care Fund),[11] [12] [13] by supporting people to help themselves, and concurrently building capacity in communities. To do this Rutland are considering using a 'Partnership' approach to commissioning that co-designs services with both providers and our communities.

4.4 Summary

Improving access to community resources has a number of health and wellbeing benefits. Using community assets innovatively increases the awareness of the assets and will generate further use. As people access the benefits of different facilities and services they will start to use treatment and support services more appropriately and to manage their non-clinical needs more effectively. The case studies presented in this section demonstrate significant benefit to people accessing community resources, both as a user of the service and as a citizen contributing to the community based approach.

FEEDBACK FROM RECOMMENDATIONS FOR 2014

In this section we highlight some of the initiatives that have taken place in the past year that are linked to the recommendations from the 2014 report.

The best start in life

- Over 40% of 5 year olds in Rutland were shown to have had experience of tooth decay in the 2012 oral health survey. This is significantly higher than national levels. A project on oral health has been undertaken to provide insight into why levels of tooth decay in children in Rutland are higher than expected and to develop an evidence-based oral health promotion programme for the future.

- Health Visiting and Children Centre staff have proactively promoted the Free Early Education Entitlement for two year olds to eligible families and a 91.6% take up has been achieved. This is expected to help to contribute towards improved School Readiness across the County.

- A multi-agency integrated antenatal, perinatal and post-natal pathway is being developed in Rutland to ensure a holistic approach to all of these services in line with the '1001 Critical Days' cross party manifesto – the goal of which is for every baby to receive sensitive and responsive care from their main caregivers in the first year of life.

Healthy schools and pupils

- School pupils in Rutland are encouraged to contribute to improving the health and wellbeing of children and young people through the use of a 'Whole School Approach' and by making use of the Leicestershire healthy school resources.

- Schools are encouraged to incorporate more physical activity in the curriculum working with Leicestershire and Rutland Sports Partnership, Active Rutland, and Rutland County Council active transport team. Active Rutland has worked with 26 schools and the active transport team supported 360 Year 5 & 6 children to take part in Bikeability Levels 1 & 2 programmes and 10 children to achieve Level 3.

- Schools are encouraged to adopt the Personal, Social and Health Education (PSHE) Association's PSHE programme of study, and that they utilise the new Leicestershire PSHE Toolkit: 'PSHE: Better than Good Enough.'

Economy and employment

- Rutland County Council has established a group on work and health for council employees, and using the National Workplace Wellbeing Charter to benchmark and assess their progress. A staff engagement and health questionnaire had a 63.7% response rate and provided the group with useful insight to inform their work. From the results 3 priority areas were identified and working groups established on mental

health, work environment and communications. This has resulted in a wide range of activity including: policies revised and updated; staff benefits packages further developed; health and wellbeing days, mindfulness taster sessions and courses on Mental Health First Aid held and staff health discussions integrated into managers meetings.

- More widely The County Council has also worked with local employers around green travel planning and provides employers with a range of support to do this including starting greener driving courses for employees who drive for work.

Strong communities, wellbeing and resilience

- Development of a unified prevention model for Rutland has continued and includes plans to further develop a network of community agents procured from the private/voluntary, community and faith sector. In the first 9 months of operation Community Agents have seen 400 individuals and prevented 60 clients admission to hospital or supported their leaving hospital.

- A Falls Summit was held in Rutland as part of the Better Care Fund and included a wide range of participants from public, voluntary and community agencies. This identified that whilst there was already significant activity, there were gaps and there was a need for better coordination, publicity and a clear pathway. These findings are now being used to develop falls prevention work further. Greater integration across health and social care services in Rutland have been achieved by the REACH re-ablement service where occupational therapists, physiotherapists and nurses have worked as a team using individual care plans to maximise independence and wellbeing. This has resulted in less people going into residential care and seen a small drop in hospital admissions.

Active and Safe Travel

- An Active School Travel Health Needs Assessment is being developed for Leicestershire and Rutland. The aim is to understand the perceptions of road safety and road traffic injuries associated with active school travel and how closely these match the real risk in terms of road traffic accidents occurring on the school commute and the benefits in terms of increased physical activity in children.

Access to green and open spaces and the role of leisure services

- The Active Rutland team, supported with Public Health funding, held Rutland Walking and Cycling Festivals, and the Rutland Round. 2015 saw over 300 people participate in week long programme of walking events across Rutland's green spaces. There are 2 Walking for Health accredited groups. The Oakham group has around 20 walkers and the Ketton group has 50-60 walkers each week. 3 additional run leaders have been starting up new sessions for people across the county including programmes for

beginner runners. The established Rutland Water Parkrun averages around 100 participants each week, and to date has seen 720 different runners.

- The Sports Arena held at the annual Rutland Day celebrations based at Sykes Lane had over 5,000 people attend. Local clubs put on sessions for the public to try a new activity and promoted what is on offer across Rutland for people to get involved in.

Warmer and safer homes

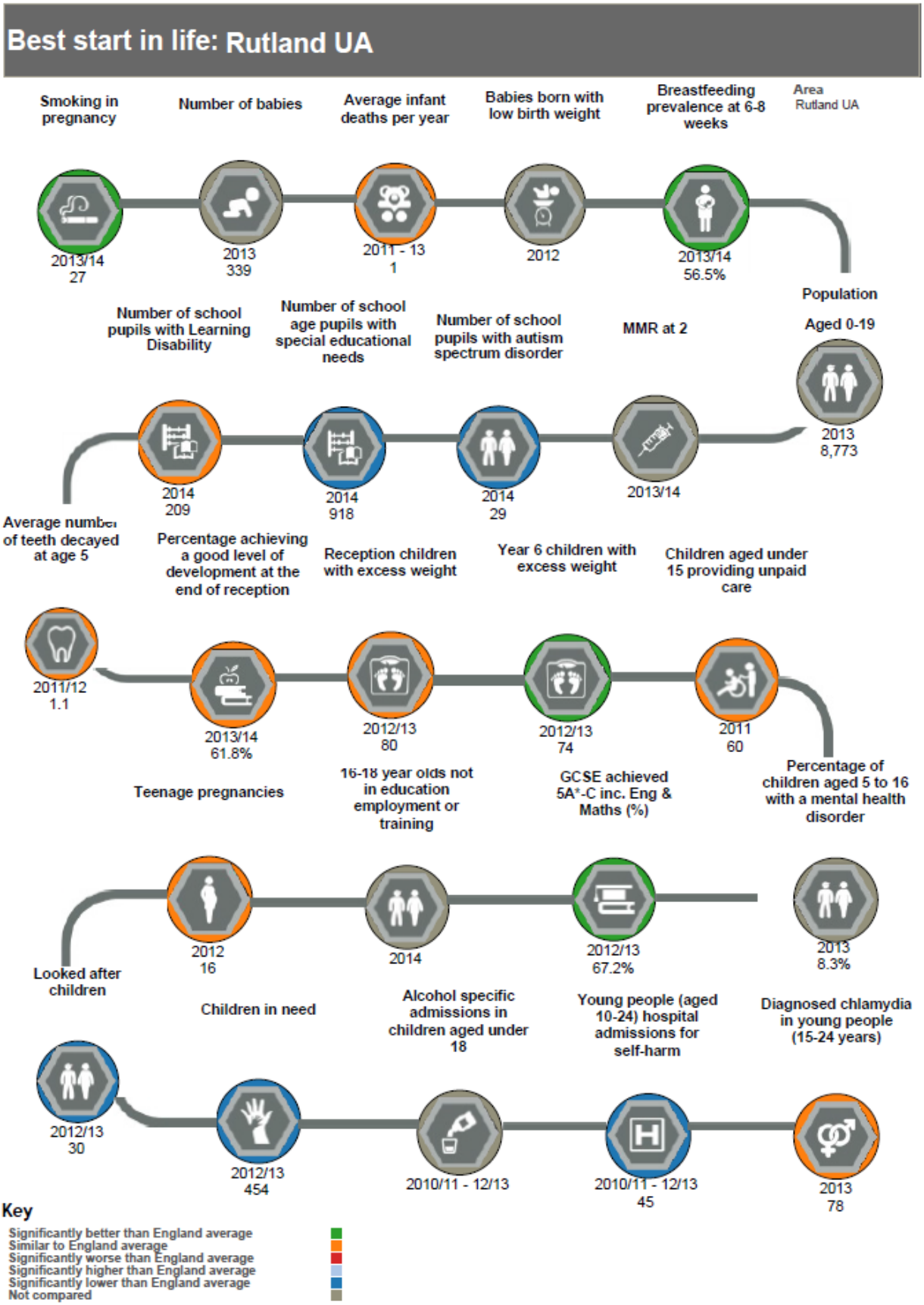
- Rutland Better Care Fund resourced the delivery of the Falls Management Exercise (FaME) programme. This is being evaluated externally through funding from CLAHRC (Collaboration for Leadership in Applied Health Research and Care) funded project. There is also a falls prevention action plan in place.

- In 2014/15 Rutland County Council funded a third party provider to carry out energy audits and advise residents with options to make their homes warmer. Between January 2015 and June 2015 152 visits were carried out within Rutland.

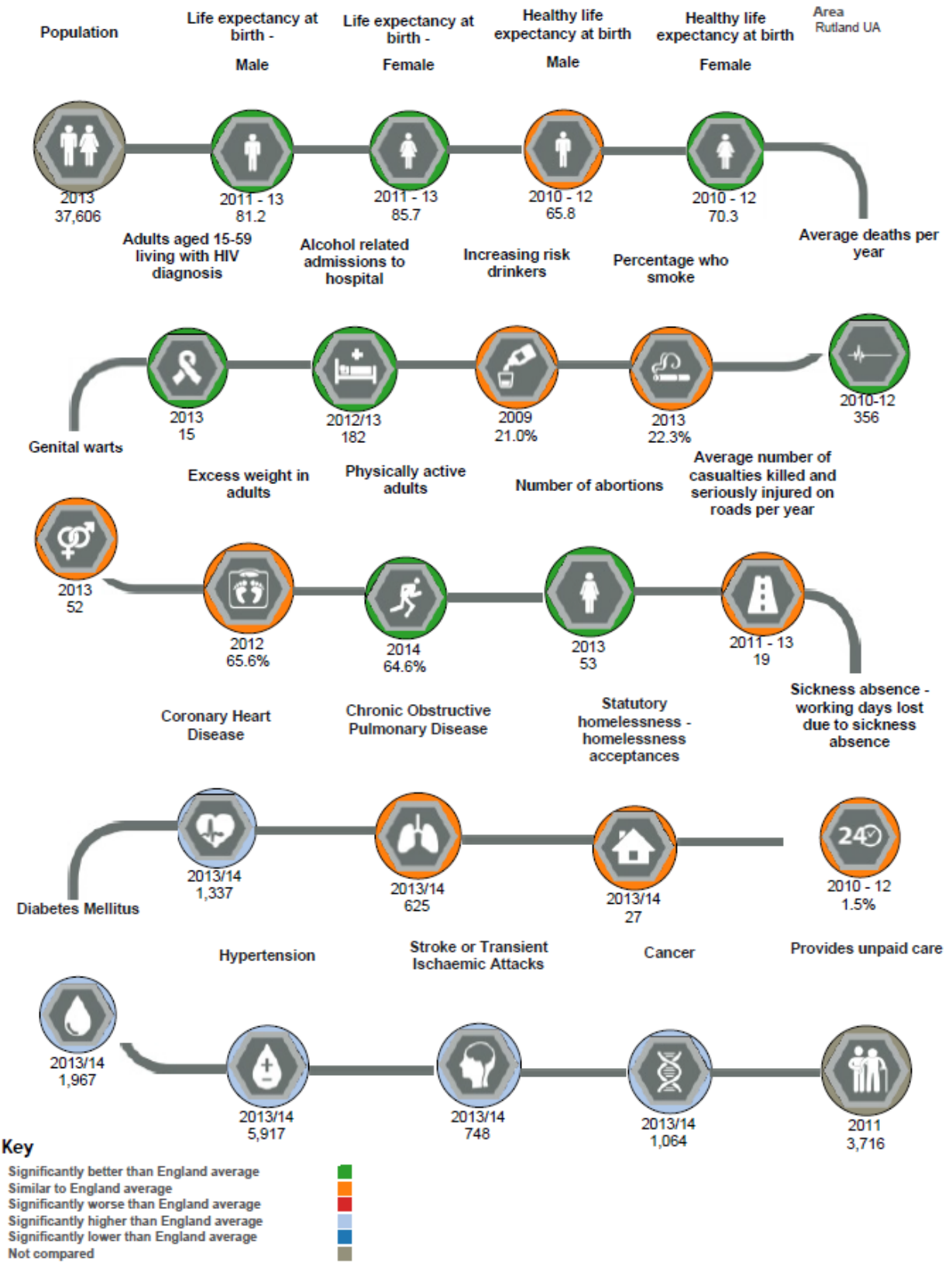
Public Protection and Regulatory Services

- A number of programmes are commissioned to encourage and promote healthy food choices and alternatives to fast food. In Rutland this includes the Family Lifestyle Club (FLiC) and Lifestyle Eating Activity Programme (LEAP). These services are being redesigned to ensure an appropriate model of delivery for Rutland.

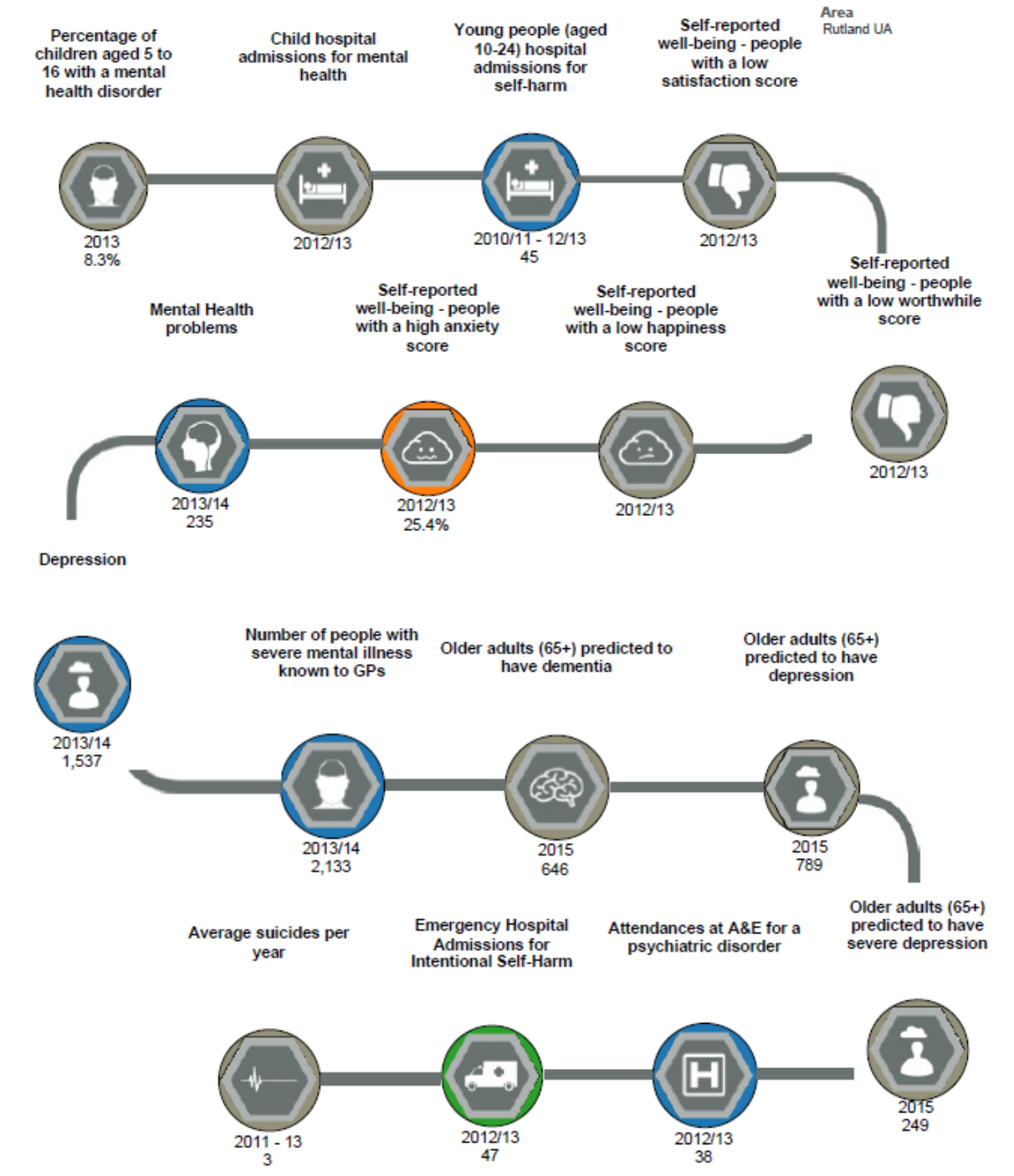
APPENDIX A: RUTLANDS JSNA HEADLINES


Best start in life: Rutland UA
Smoking in pregnancy
Number of babies
Average infant deaths per year
Babies born with low birth weight
Breastfeeding prevalence at 6-8 weeks
Area
Rutland UA
2013/14
27
2013
339
2011 - 13
1
2012
2013/14
56.5%
Population
Aged 0-19
2013
8,773
Number of school pupils with Learning Disability
Number of school age pupils with special educational needs
Number of school pupils with autism spectrum disorder
MMR at 2
2014
209
2014
918
2014
29
2013/14
Average number of teeth decayed at age 5
Percentage achieving a good level of development at the end of reception
Reception children with excess weight
Year 6 children with excess weight
Children aged under 15 providing unpaid care
2011/12
1.1
2013/14
61.8%
2012/13
80
2012/13
74
2011
60
Teenage pregnancies
16-18 year olds not in education employment or training
GCSE achieved 5A*-C inc. Eng & Maths (%)
Percentage of children aged 5 to 16 with a mental health disorder
2012
16
2014
2012/13
67.2%
2013
8.3%
Looked after children
Children in need
Alcohol specific admissions in children aged under 18
Young people (aged 10-24) hospital admissions for self-harm
Diagnosed chlamydia in young people (15-24 years)
2012/13
30
2012/13
454
2010/11 - 12/13
2010/11 - 12/13
45
2013
78
Key
Significantly better than England average
Similar to England average
Significantly worse than England average
Significantly higher than England average
Significantly lower than England average
Not compared

Health and wellbeing of adults: Rutland UA



Mental health: Rutland UA

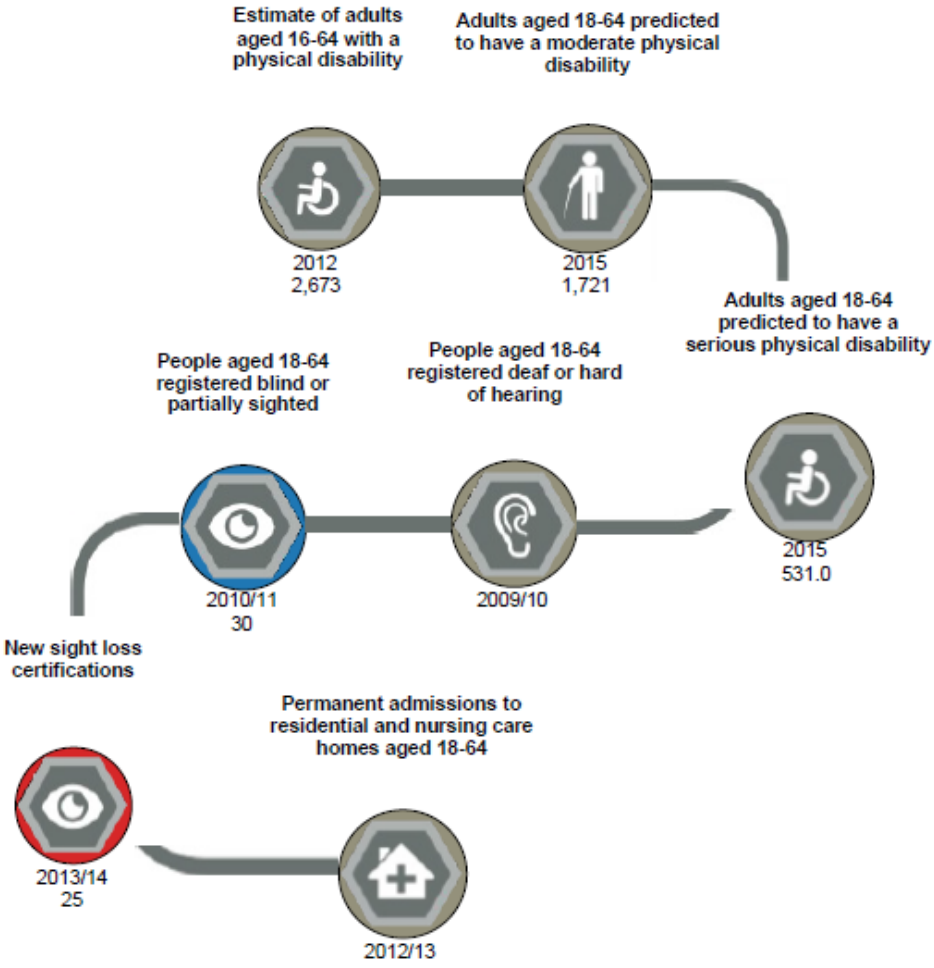


Key

- Significantly better than England average
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Physical and sensory disabilities: Rutland UA

Area
Rutland UA

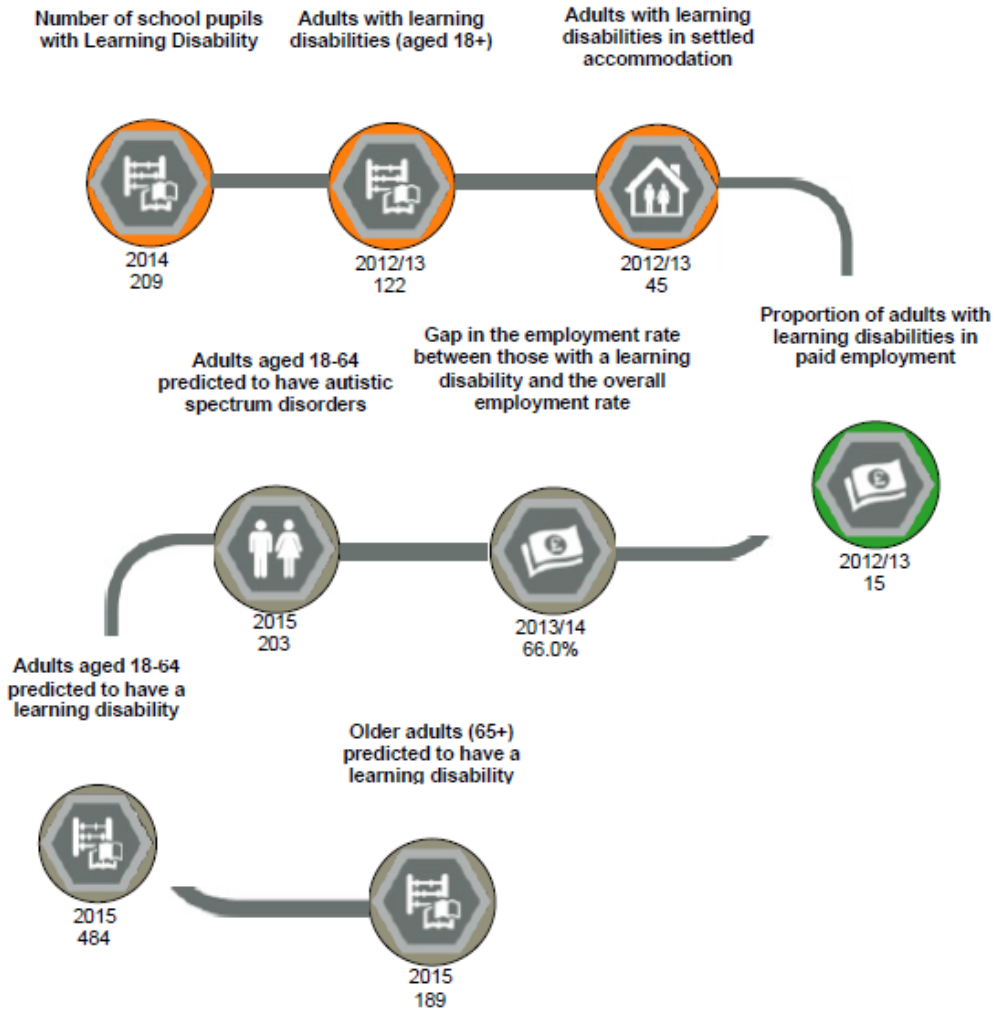


Key

- Significantly better than England average
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Learning disabilities and autism: Rutland UA

Area
Rutland UA



Key

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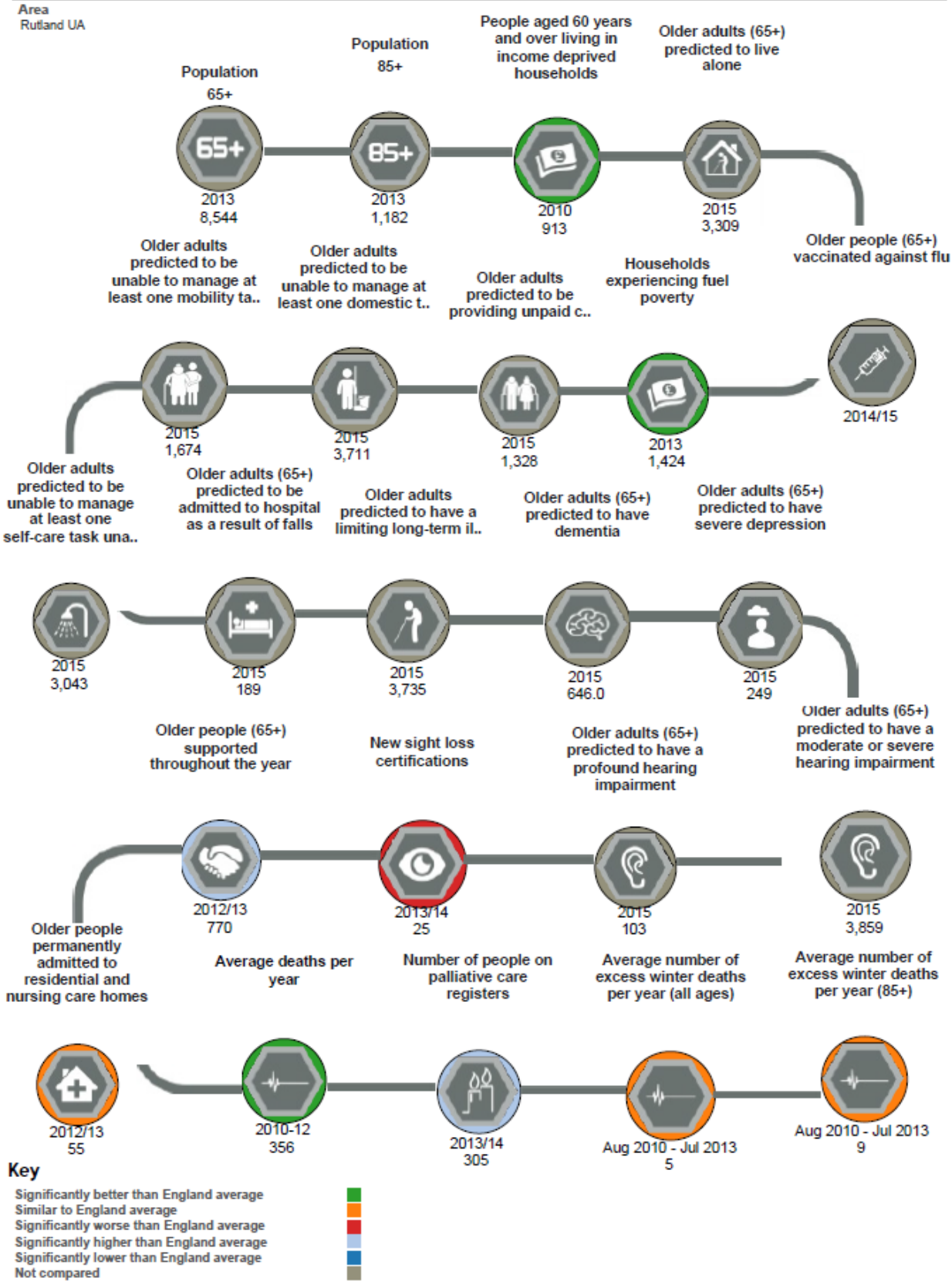
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Issues specific to ageing: Rutland UA



LIST OF ABBREVIATIONS

BCF	Better Care Fund
CCC	Coffee, Cake & Chat
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
DBS	Disclosure Barring Service
DIY	Do it Yourself
FaME	Falls Management Exercise
FFLP	Food For Life Partnership
FLiC	Family Lifestyle Club
GP	General Practice or General Practitioner
HIA	Health Impact Assessment
JSNA	Joint Strategic Needs Assessment
LEAP	Lifestyle Eating Activity Programme
LPT	Leicestershire Partnership Trust
NHS	National Health Service
PHSE	Personal Health and Social Education
RCA	Rutland Community Agents
RIS	Rutland Information System
UK	United Kingdom
VAL	Voluntary Action LeicesterShire
VCS	Voluntary and Community Services

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Report No. 68/2016

Report to Rutland Health and Wellbeing Board

Subject:	**EMAS 2015/16 Quality Account Draft Presentation**
Meeting Date:	**22/03/2016**
Report Author:	**Paul Benton**
Presented by:	**Paul Benton**
Paper for:	**Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:
East Midlands Ambulance Service (EMAS) seeks the views of the Rutland Health and Wellbeing Board for the 2015/16 Quality Account. Paul Benton, EMAS' Deputy Director of Quality, will present the draft report that includes their quality improvements from 2015/16, as well as their priorities moving forward into 2016/17.
Financial implications:
n/a
Recommendations:
That the board: 1. Reviews the information presented, provides feedback on any issues that arise.
Comments from the board: (delete as necessary)

Strategic Lead:	

Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	

Timeline:

Task	Target Date	Responsibility

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East Midlands Ambulance Service NHS Trust

Emergency Care | Urgent Care | We Care

Draft

Quality Account
2015/16

Our Quality Account 2015/16

Content

Page

draft

Introduction

Production note: this section will be completed at the end of the current performing and financial year (1 April 2015 to 31 March 2016).

add signature here

Sue Noyes
Chief Executive

Declaration of accuracy

I confirm that to the best of my knowledge the information presented in our Quality Account is accurate.

add signature here when document complete & all statistics included

draft

Sue Noyes
Chief Executive

About us

East Midlands Ambulance Service (EMAS) provides emergency and urgent healthcare on the move and in the community.

EMAS Vision and Values

It is our vision to play a leading role in the provision, facilitation and transformation of clinically effective urgent and emergency care delivered by highly skilled, compassionate staff, proud to work at the heart of their local community.

We are on a journey transforming from a mainly emergency focussed service, reliant on a single Accident and Emergency contract (e.g. providing blue light responses to 999 calls), to an organisation that provides the most appropriate and effective response to patients. For example: providing care directly, sign posting or referring patients to the best service that can support them in their homes and the community, reducing admission to hospital where appropriate. We will do this by working closely with primary, community, social care, mental health and secondary care services.

This will allow the NHS to deliver more with less and allow EMAS to move into new business areas. We want to be able to deliver a locally focussed service with regional resilience.

Our Values support everything we do.

Respect: Respect for our patients and each other

Integrity: Acting with integrity by doing the right thing for the right reasons

Contribution: Respecting and valuing the contribution of every member of staff

Teamwork: Working together and supporting each other

Competence: Continually developing and improving our individual competence

Our Values help us provide our patients with access to high quality clinical care and services to ensure the best experience and clinical outcome.

People we serve

The East Midlands is undergoing similar demographic changes to the rest of the country: a growing and aging population with ethnicity and health diversities.

There are specific local area differences and challenges such as student populations and areas with specific concentrations of young families or retirees, with significant variations in population densities.

Historically the region's population has been growing fast and this looks set to continue over the next decade, putting pressure on our new and existing services. Health inequalities are marked

draft

across the region, with generally poorer levels of health in the urban centres, as evidenced through Public Health England data.

It must be our priority, together with our commissioners, to ensure equality of service provision to all patients.

The area we cover

We provide emergency 999 and urgent care services for a population of approximately 4.86 million people within the East Midlands region.

This region covers approximately 6,425 square miles and includes the counties of Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire, Northamptonshire and Rutland.

There are large differences in population density across the East Midlands, from the highly concentrated urban areas and more dense population corridor along the M1, to the low density rural areas in the east.

There are several airports within our region, with the largest being East Midlands Airport, serving over 4.2 million passengers each year.

The M1 motorway serves all of the region's county towns with the exception of Rutland.

Two of the UK's mainline railways serve the region, providing regular high-speed services, and there are plans to bring a new high-speed rail line through the East Midlands as part of the High Speed 2 project.

The East Midlands is home to numerous entertainment venues including major sporting venues, national parks and forests, the East Coastline, music festivals and venues, the National Space Centre, and holiday and caravan parks.

Our service

Our annual turnover is £158 million (2015/16) and we are commissioned (paid) to provide services by 22 Clinical Commissioning Groups (CCGs) based across the East Midlands. We deal directly with the A&E contract lead in NHS Hardwick CCG which represents the other CCG's in the region.

We employ over [update at end of year] colleagues, with the majority being frontline Accident and Emergency ambulance personnel.

Patient Transport Services (PTS) are currently provided for people who have routine (non-urgent and scheduled) clinic appointments across North and North East Lincolnshire and parts of Nottinghamshire. Other counties in the region are served by private PTS companies

commissioned by the CCGs (see the new services and innovation section of this Account for more information on PTS developments).

We operate from more than 65 locations across the East Midlands, including two Emergency Operations Centres (EOCs) that host our call handling function in Nottingham and Lincoln, and over 60 ambulance stations across the East Midlands where our colleagues report on and off duty.

Every day we receive approximately 2,000 calls from people dialling 999 and from other healthcare professionals making urgent transport requests.

During 2015/16, our clinicians responded to [update at end of year] calls in our Emergency Operations Centre, and dispatched ambulance clinicians to the patient using our fleet of [update at end of year] vehicles.

We also use [update at end of year] Patient Transport Service vehicles and [update at end of year] Community First Responder vehicles.

In addition to our core services, we provide a range of other key services including:

- Specialist transfers: inter-hospital transfers that include adult critical care or for specialised surgery, paediatric and neo-natal care.

- Hazardous Area Response Team (HART): a dedicated team providing specialised cover for civil contingencies, major incidents and Chemical, Biological, Radiological and Nuclear (CBRN) incidents.

- Emergency Preparedness and Business Continuity (Regional Resilience): a service that ensures we are prepared to deal with a range of civil contingencies and major incidents. It works closely with the six Local Resilience Forums across the region, each of which includes Local Authorities, Police and Fire services. This also ensures business continuity in the event of a civil contingency or other adverse event that affects normal operations.

- Bariatric transfers: specialist services and equipment to transport bariatric patients (our bariatric ambulances can transport patients with a weight of to 50 stone).

- Cycle Response Unit: these individuals carry the same essential life-saving equipment as a fast response car and can reach patients even faster in congested areas. Patients can often be treated on the scene by the Cycle Response Units meaning our ambulance vehicles can be deployed to other life threatening emergency calls.

- Community Access Automated External Defibrillators (AED): we have placed life-saving equipment in local communities across the East Midlands. AEDs are used when someone has gone into cardiac arrest (i.e. when the heart stops pumping blood around the body). The defibrillator gives the heart an electric shock to allow effective cardiac rhythm to be re-established.

- Events Support: a commercially available team that provides support to special events such as sporting, musical and athletic showcases across the region.

- Admission Avoidance Schemes: provided through a number of schemes across the East Midlands including Falls Partnership Services and Mental Health Nurse and EMAS Paramedic in a car.

Review of quality improvements for 2015/16

This quality account demonstrates our achievements for the year 2015/16 and what we are aiming to achieve in the coming year.

We are required to achieve a range of performance outcomes specific to the nature of the services we provide to the public. In addition, we are required to achieve many other organisational responsibilities as laid down by the Department of Health.

Our 2015/16 priorities

We identified the following quality improvement priorities against the three domains of quality, these being:

- Clinical effectiveness
- Patient safety
- Patient experience

Priority 1: Develop the paramedic pathfinder algorithms to support ambulance colleague's clinical decision making with patients suffering falls, general frailty/social care situations, end of life care and Chronic Obstructive Airways Disease.

Priority 2: Develop a frail elderly steering group and action plans to deliver unilateral trust wide schemes with locally agreed pathways to ensure integrated support to individuals who are frail.

Priority 3: Having signed up to the National Mental Health Crisis Concordat, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health action group.

Priority 4: Following the continued improvement of our ambulance card quality indicator 'Return of Spontaneous Circulation (ROSC)' outcomes, we will continue to explore further innovative ways to build upon these achievements.

Priority 5: Having enrolled on the national Sign up To Safety Campaign, we will work to reduce avoidable harm in mental health, maternity and adverse events in the Emergency Operations Centre with a particular focus on delayed responses.

Priority 6: Develop a robust patient forum group and strategy that will ensure that we are working with all of our local communities.

Priority 7: Use the EMAS Listening into Action staff engagement forums to enhance the delivery of compassion in practice and ensure we are promoting and rolling out schemes that will enhance the care we deliver and ensure colleagues are patient focussed.

In this quality account we evidence how these priorities have been met and are progressing.

Commissioning for Quality and Innovation (CQUIN)

Draft

Further funding for EMAS's income in 2015/16 was dependent upon achieving quality improvement and goals through innovation. These have been agreed through EMAS and NHS Hardwick Clinical Commissioning Group (our lead commissioners)

The CQUIN schemes are an opportunity for us to provide services that focus on quality improvements. The benefits of the schemes can be validated and if successful will be provided through the commissioning process

EMAS signed up to deliver the following five schemes and have provided evidence of how these schemes will have impacted on the quality of care that we provide as well as how the work will continue to be supported.

- **Paramedic Pathfinder:** This scheme was introduced in 2014 and rolled out across our service to allow clinicians on scene to access the most appropriate health service available for the patient. Whilst the introduction of Paramedic Pathfinder has been instrumental in reducing the number of patients transported to hospital Emergency Departments (ED), it is incumbent upon EMAS to support efforts to manage patients within the community where it is deemed clinically appropriate and will improve patients outcome and experience. The development of the scheme aims to build upon the success in 2014/15 with a review of alternate pathways across the whole East Midlands. We will be providing commissioners with a broader understanding of the options available to frontline ambulance clinicians, identifying the gaps in provision and capturing which schemes are perceived to be the most successful and clinically effective. In addition, EMAS is keen to develop and pilot a broader range of Pathfinder algorithms to support ambulance clinicians in dealing with patients whom have a greater clinical risk. Following audit and review and on the assurance of their safety and clinical effectiveness, these can then be adopted into future clinical practice in the subsequent year.

- **Mental Health:** Frontline ambulance crews are currently poorly equipped to deal with patients who present with mental health conditions. We will support the educational development of frontline staff with the aim of managing patients presenting with a mental health crisis more effectively and avoiding conveyance by utilising local mental health services. It is proposed that as part of this process an educational package is developed and delivered with key identifiable milestones for achievement, supporting and underpinning frontline staff's knowledge and experience. By utilising this extra skill set our crews will develop more confidence in their own abilities to sign post patients and their families to appropriate receiving facilities rather than transport to ED.

- **Quality Everyday:** Quality Everyday is a method of ensuring that we are focussed on quality at every opportunity. It helps ensure that everyone understands their responsibility to deliver a high quality service. The purpose of Quality Everyday is to provide crews, stations and departments with a coordinated, comprehensive and up to date range of standards which can be measured, providing accurate and timely feedback.

- **Frail Elderly Liaison Officer (FELO):** The FELO scheme is to provide support and care for patients in the community who are frail and elderly. The FELO roles have been to work and facilitate a multi-agency approach to prevent avoidable admissions to the Emergency

Department. Clinical care packages have been designed around an individual's needs. The initiative has been focussed on care, residential and warden controlled facilities.

- **Community Access Defibrillators:** There is a great deal of strong clinical evidence to illustrate that the provision of early basic life support and timely defibrillation can significantly improve the likelihood of a positive outcome. Having access to this vital equipment could have significant improvements in survival rates for patients in the community. By active partnership working, we can strengthen our working relationships in the communities we serve.

New services and innovation

Patient Transport Service

During 2015 the Patient Transport Service for Derbyshire was put out to tender by commissioners. After a lengthy, competitive process, we were announced as preferred bidder in November 2015. Since then EMAS and commissioners have discussed the final contract arrangements. Subject to signing of the contract, the proposed go live date for the new service is currently 1 August 2016.

Blue light services join forces

A new pilot scheme saw EMAS and fire services based in the region work together to save more lives, by launching the UK's first regional Emergency First Responder scheme.

Demand on the Ambulance Service is increasing by approximately 6% year on year. Thanks to successful electrical product safety, public education and safety campaigns, the traditional demand on the fire service is reducing which is why they are able to support this pilot.

EMAS receives a new 999 call every 43 seconds, and in an emergency seconds count. An Emergency First Responder (EFR) is dispatched at the same time as an ambulance and does not replace the usual emergency medical response from EMAS. However, the location of the EFR within local communities could mean they are nearer to the scene in those first critical minutes of the emergency, to deliver life-saving care until an ambulance clinician arrives.

EMAS has trained each EFR to enhance their existing medical care knowledge. They have been trained in basic life support, cardiopulmonary resuscitation (CPR) and oxygen therapy. The EFRs are equipped with a kit which includes oxygen and an automated external defibrillator (AED) to help patients in a medical emergency such as a heart attack, collapse or breathing difficulties. They respond to medical emergencies in a liveried fire and rescue EFR car.

The scheme with all six East Midlands based fire services officially launched in June 2015. There are 23 fire stations involved (Derbyshire: Buxton, Dronfield, Matlock and Staveley; Humberside: Crowle, Kirston Lindsey, Epworth and Winterton; Leicestershire: Ashby, Billesdon, Market Harborough and Uppingham; Lincolnshire: Donington, Mablethorpe, Saxilby, Skegness and Sleaford; Northamptonshire: Daventry, Kettering, Rushden and Wellingborough; and Nottinghamshire: Newark and Harworth).

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The clear ambition of this pilot is to improve the survival rate for people who suffer from a cardiac arrest in the community. Data from the pilot is being reviewed on a monthly basis and we are currently in discussions with the fire service about extending the area covered by this scheme.

Mental health

Following the recruitment of 2 mental health specialists at EMAS, we are developing training sessions and our services to better support staff and our patients.

Some of the projects we are involved in include: the development of a collaborative street triage approach in line with the crisis care concordat principles, better and wider promotion of mental health awareness, provision of a training package on a compassion focused approach to mental health for colleagues in our Emergency Operations Centres, partnership working with the Samaritans on suitable proportionate signposting as clinically indicated, interpreting and learning lessons from risk patterns related to mental health incidents.

In addition we have developed a mental health workbook and disseminated it to all frontline operational staff, to further support our communications campaign to raise awareness.

We have developed a Safe Holding (restraint) Policy which has been presented to the Clinical Governance team for sign off. This links to our work to develop an accredited training package through a national provider on low level physical intervention techniques.

A mental health Directory of Services is being produced in partnership with local commissioners to establish suitable signposting options. We are also developing a dedicated mental health conveyance policy and evidence need with commissioners based on partnership feedback.

EMAS managers are being supported through training and advice to help them recognise and provide support to staff who are experiencing mental health problems. This is supported by close collaboration work with our 2 mental health specialists, equality and diversity mananger and chaplain and health and wellbeing lead.

New processes and technologies

The NHS is facing huge challenges and changes in the forthcoming years and EMAS needs to adapt and reflect this in the way it operates.

Moulding our services around patients is one way to achieve this, as is the development of current models of service and new service offerings.

As well as responding to formal tender opportunities, such as the Derbyshire Patient Transport Service contract mentioned earlier, we continue to engage with CCG's and Transformation Groups across the East Midlands to propose organic service changes.

These changes can be staff related or for example through the introduction of new processes or technologies, such as:

- Remote patient monitoring through telehealth equipment, targeting patients who may have certain conditions such as Chronic Obstructive Pulmonary Disease, diabetes etc, where on-going monitoring is seen as beneficial but can be achieved using technologies and via a web based monitoring platform prior to any physical care interventions.
- Introduction of the Enhanced Clinical Assessment Team in our Emergency Operations Centre to deliver patient care better in non-emergency department settings and reduce demand across the health community. The first service for this initiative went live for Northamptonshire on 29 February 2016.
- A holistic falls assessment protocol. Additional training for frontline clinicians is delivered in cooperation with Northampton University to better assess patients who have suffered a fall but may not require transporting to an Emergency Department. This initiative links across all service providers to deliver the right care as well as identifying prevention opportunities to avoid further falls for the patient.
- Collaborative working with other healthcare providers both in the NHS and private sector to capitalise on key strengths and build the EMAS activity portfolio, staff capabilities and operational resilience.

Enhancing quality improvements and assurance

During 2015/16 we have continued to improve our quality and assurance processes through a variety of ways. We have talked with and listened to our colleagues and patients to identify areas for improvement to help share best practice.

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We reviewed how we measure the standard and quality of care provided and have adopted a ‘quality roadmap’ tool which is aligned to the Care Quality Commission outcome standards, key lines of enquiry, and other pertinent legislation or clinical initiatives.

Quality Everyday was introduced in 2015 as a new programme to ensure we are focussed on quality at every opportunity, and that everyone at EMAS understands their responsibility and contribution to deliver a high quality service. It has now evolved into a robust programme of engagement with senior managers and staff who embark on a quality assurance process which identifies issues locally and through active challenges aims to ensure all key lines of enquiry are acted upon. Quality Everyday provides ambulance crews with a comprehensive, up-to-date range of standards which can be measured, allowing for timely and accurate feedback.

Four strands are included in *Quality Everyday*.

- Central inspections (audits).
- Monthly quality visits.
- Quality newsletter *InFocus.*
- Quality station / base noticeboards.

The *Quality Everyday* noticeboards and updates help improve communication with colleagues via the sharing of key messages, patient feedback, lessons learned from incidents and discussions at our local and strategic Learning Review Groups (protecting the identity of people involved), as well as local clinical updates and performance standards data.

What we want to do better in 2016/17

At EMAS we are working hard to bring about significant improvements to the services we provide. We actively listen to all our colleagues, patients and stakeholders to act on things that did not go well, and also those that had a good outcome, to learn from and reflect on the services we provide.

As in 2015/16, we have identified three domains of quality

- **Clinical effectiveness**
- **Patient Safety**
- **Patient Experience**

Against those we have set five quality improvement priorities for 2016/17.

Clinical effectiveness	**Priority 1:** Cardiac arrest – return of spontaneous circulation (ROSC) and survival outcomes. EMAS has continued to focus its attention upon the improvement of successful ROSC rates in cardiac arrest. During 2016/17 we will: • Continue to develop and improve our cardiac arrest outcomes. • Continue to see our Ambulance Quality Indicators and outcomes around stroke, COPD and asthma improve. • Also see an increase in the presence of frontline clinical supervision to all active resuscitation attempts. **Lead: Medical Director**
Patient safety	**Priority 2:** Sepsis is a worldwide public health issue. In developing nations, Sepsis is the leading cause of mortality, accounting for nearly 80% of deaths. Sepsis kills far more citizens than AIDS, prostate cancer and breast cancer combined. During 2016/17 particular focus will be to: • Identify and treat Sepsis within our patients. • Ensure the formalisation of the EMAS Sepsis Lead, including

	documented objectives and performance measures. • Appoint divisional Sepsis champions (one per division) on a volunteer basis. • Develop a robust action plan to ensure the availability of waveform capnography on a minimum of 95% of frontline operational resources (double crewed ambulance & fast response vehicle). • Work with a partner acute trust to explore the increased pre-hospital use of IV antibiotics in the treatment of Sepsis. **Lead: Director of Quality and Nursing**
	Priority 3: To identify the common themes of all maternity related incidents, and to reduce patient related incidents: • We will aim to see a reduction in severity of all maternity related incidents within our care. • Receive an improvement on aspects of clinical care from maternity units. • Educate all operational workforces in maternity related training. This will be measured by current level of harm, complaints, Serious Incidents, feedback from patients and service users. **Lead: Medical Director**
	Priority 4: To explore the use of alternative pathways in each division by using the pathfinder leads to develop the pathways in each EMAS commissioning area. **Lead: Director of Quality and Nursing**
Patient experience	**Priority 5:** Having signed up to the Mental Health Crisis Care Concordat, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health steering group. We will:

- Continue to build mental health pathways in all divisions
- Embed parity of esteem in EMAS for all patients presenting with mental health issues.
- Ensure that these patient groups receive an appropriate response and are signposted to the appropriate receiving facility.
- Improve the awareness of mental health conditions with our staff.

Lead: Director of Quality and Nursing

Evidence of quality improvements for 2015/16

Priority 1: Develop the Paramedic Pathfinder algorithms to support ambulance colleague's clinical decision making with patients suffering falls, general frailty/social care situations, end of life care and Chronic Obstructive Airways Disease.

Aim	What we did	What we have achieved	Quality Indicators
• To increase the number of services that we access via the Pathfinder Programme to support patients to stay at home rather than go to hospital when admission is not required. • Work in partnership with the Clinical Commissioning Groups and Community and Acute providers in the East Midlands to improve the management of these conditions	EMAS undertook a full review of the alternative care providers to understand the available options for patients to be referred into. A mapping exercise to identify where gaps in provision exist aligned to the calls that EMAS attends. Developed proactive relationships with alternative care providers to initiate discussions and streamline the process of patient referral into these services. Creation of a number	We now have a complete understanding of the options available to all frontline crews for patients who can be managed closer to home. Full mapping of these pathways by CCG area, against the presenting condition of the patient. Production of v3 of the Paramedic Pathfinder Pocket book to be on hand for clinicians when they need to seek options for referral in their area.	Progress of each of these actions and their outcomes is reported through the quarterly CQUIN reports. These reports are shared with Commissioner Colleagues through local Collaborative Commissioning and Quality Assurance Group meetings.

and presenting symptoms. • To reduce unplanned admissions and to provide care closer to home through the use of innovation underpinned by clinical safety. • To use our hear and treat (provided by our Clinical Assessment Team) and see and treat (provided by our ambulance crews) services appropriately.	of condition specific Paramedic Pathfinder algorithms to support clinicians in managing patients within community settings. Continued the programme of clinical training for staff in the Paramedic Pathfinder Tool.	Implemented four pilot schemes to test out the new condition specific Paramedic Pathfinder algorithms. Training of all relevant clinicians in the Paramedic Pathfinder Triage Tool.	

Priority 2: Develop a frail elderly steering group and action plans to deliver unilateral trust wide schemes with locally agreed pathways to ensure integrated support to individuals who are frail.

Aim	What we did	What we have achieved	Quality Indicators
To develop a frail elderly steering group which will work with partnership with commissioners and acute providers within the East Midlands region. To work collaboratively with residential and nursing homes to ensure that residents can access care and	We have developed the frail elderly steering group which incorporates end of life care with representation from key stakeholders including Age UK and care homes. In Northamptonshire we have developed a Frail Elderly Liaison	By reviewing our current falls service we have identified the optimum model of care for our patients. We have also reviewed our end of life care pathways and are working with our commissioners regionally to	Appropriate pathways to ensure patient s can access local services and reduce admissions. Reduced admissions and development of education and training.

support.	officer who works with local care homes and universities to ensure residents can access appropriate health care in their local community and prevent inappropriate admission to hospital.	ensure that best practice is adopted, by ensuring that the key principles of growing old together are adopted. (Improving Urgent Care for Older People, NHS England)	

Priority 3: Having signed up to the National Mental Health Crisis Concordant, we will work collaboratively with local commissioners and relevant stakeholders to implement the agreed priorities within the mental health action group.

Aim	What we did	What we have achieved	Quality Indicators
To concentrate on implementing the mental health triage car in Lincolnshire and to expand the role across the East Midlands. To ensure that our staff in EOC have mental health training in our clinical assessment teams To produce and agree local mental health awareness for all our staff.	Recruited two mental health specialists who have assessed the educational needs of our staff and designed and developed bespoke educational packages for the Trust. These include the mental health workbook, safer holding technique and suitable pathways for patients. They have enhanced the communication skills of staff to enable them to assess and signpost those patients accessing our services who have mental health needs.	A mental health strategy that has been agreed and monitored by commissioners through our mental health steering group. Delivered bespoke training to our EOC and CAT teams, agreeing on an educational strategy that incorporates safer holding techniques and a mental health workbook. Active partnership engagement with our stakeholders through partnership working and Crisis Care Concordats.	Reduced admissions and conveyance to inappropriate care providers. Parity of esteem in the Trust through our strategy, monitored through the mental health steering groups. We have representation and involvement within each locality.

Priority 4: Following the continued improvement of our ambulance care quality indicator 'Return of Spontaneous Circulation (ROSC)' outcomes, we will continue to explore further innovative ways to build upon these achievements.

Aim	What we did	What we have achieved	Quality Indicators
Completion of pit crew training for cardiac arrest management. Increase the presence of fronline clinical supervision to all active resuscitation attempts. Conclude the evaluation of mechanical CPR devices and determine use	Continued expansion of the pit crew strategy for cardiac arrest management. Adopted new pieces of equipment into practice to reduce the inefficiencies during cardiac arrest scenarios. Developed pre and post ROSC pathways for Heart Centres to increase the number of eligible suitable patients. Concluded the evaluation of mechanical CPR devices and reviewed this against the 2015 Resuscitation Council Guidelines.	Provided a consistent and sustained improved ROSC performance throughout the year. Introduced the pre and post ROSC pathways into two of the region's Heart Centres.	Monthly reporting of the ROSC and Survival to Discharge (STD) rates through the Ambulance Care Quality Indicators

Priority 5: Having enrolled on the national Sign Up To Safety campaign, we will work to reduce avoidable harm in mental health, maternity and adverse events in the Emergency Operations Centre with a particular focus on delayed responses.

Aim	What we did	What we have achieved	Quality Indicators

Having signed up to safety campaign our trust will work to reduce avoidable harm for patients presenting with mental health conditions, maternity related incidents, and reduce adverse incidents in EOC with a particular focus on prolonged delays.	Identified our work streams and agreed priorities. Set agreed action plans to reduce harm over the three year period.	Base line data on each aspect of harm, and identified individual clinical leads to drive the relevant actions that have been determined to reduce harm	Monitored through QGC

Priority 6: Develop a robust patient forum group and strategy that will ensure we are working with all of our local communities.

Aim	What we did	What we have achieved	Quality Indicators
Develop a robust patient strategy and forum group that will ensure we work together to develop patient engagement events and have patient representation in key EMAS meetings, to ensure that the patient voice is representative.	Patient and Public strategy in place. Patient Voice forum has been formed and an agreed work plan has been ratified that incorporates a review of our patient complaints process with an agreed schedule of quality visits to ensure a strong patient voice within EMAS. At the AGM we launched the group and encouraged patients to join in order to enhance our patient representation. There are patient representatives on the relevant meetings i.e. Frail Elderly and mental health steering groups.	Strengthened our Patient Voice group by increasing the representation and strengthened the terms of reference to ensure a strong voice within EMAS. Agreed work plan. Patient Representation on key groups Undertaken Quality visits. Provided a patient perspective on key policies and procedures. Reviewed our complaints process and reviewed actual patient complaints	

		to ensure that we are responding appropriately to patient concerns and experiences.	

Priority 7: Use the EMAS Listening into Action staff engagement forums to enhance the delivery of compassion in practice and ensure we are promoting and rolling out schemes that will enhance the care we deliver and ensure colleagues are patient focussed.

Aim	What we did	What we have achieved	Quality Indicators
To continue the roll out of the 'Hello my name is' campaign and to relaunch the Dignity campaign sharing the importance of the dignity pledges and beliefs.	Developed a compassion in practice steering group which has developed a work plan that incorporates the Peer to Peer support with the 'Hello my name is' and dignity pledges to ensure triangulation of actions that enable staff to be treated compassionately, ensuring that patients are treated with dignity and respect. This also is congruent with our Trust values.	We have continued with the roll out and promotion with 'Hello my name is'. During the induction process for staff we have a session on the programme that promotes dignity, respect and the trust values. We have continued to highlight to staff the dignity pledges that we have signed up to ensuring that they remain at the centre of patient care and staff welfare We have appointed an Equality and Diversity manager who is working across the Trust to embed our Trust values and introduce the	Compliments and complaints Quality Everyday Audit visits. Staff surveys Equality and Wellbeing group.

		Equality Delivery System into the Trust.	

What have we done to improve patient safety?

Learning from incidents, experiences and feedback

At EMAS we have an open and honest approach that we proactively communicate to our staff, encouraging them to report good and poor practice. EMAS has a robust reporting system in place where staff can report issues and be confident that they will be taken seriously. This method of reporting helps us to identify learning opportunities ensuring that we learn from mistakes to reduce the risk of it occurring again or replicate best practice into other areas.

Learning is also identified through investigating untoward incidents, serious incidents and complaints. Other sources are patient surveys, compliments, community events, patient focus group and community events.

We share learning across the organisation through our established Strategic Learning Review Group (SLRG). SLRG members, which include senior representatives from all divisions and teams within EMAS, review the feedback to learning and promote the learning outcomes across the service.

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Duty of Candour

EMAS' priority is to deliver safe, prompt care to our patients. We are committed to openness and will always tell patients if something has gone wrong during their care. We encourage a culture which involves acknowledging, apologising and explaining when things go wrong, conducting thorough investigations and ensuring that lessons learned assist in future incident prevention and providing support for those involved. All front line staff will be receiving Duty of Candour training to embed our commitment to openness.

Quality Visits

Quality visits are how the Trust Board members have the opportunity to see what goes on in the Trust by observing patient safety experience and effectiveness.

All the Executive Directors and Non Executive Directors should undertake at least two quality visits each year and these should take place in the county for which they are the lead.

The following areas are visited as part of our quality visits:

- Hospital emergency departments
- EMAS Emergency Operations Centre

- EMAS Training Centres and Headquarters (HQ) including divisional HQs
- Ambulance Stations
- Other Trust Sites e.g.; Falls team, fleet and logistics, HART HQ

The purpose of the quality visits is to:

- Show meaningful visible leadership
- Engage with colleagues and, if possible, patients and their carers
- Triangulate information
- Obtain assurance
- Identify issues/barriers and ideas for solutions
- Communicate key messages

In 2015/16 a total of XXX visits have been undertaken. These visits have been proven successful in engaging frontline staff and providing a board to floor approach where the senior leaders at EMAS engage with operational staff and listen to their concerns.

A template is completed by the Board member to record feedback which is collated into a report and the actions are addressed. The information collated during 2015/16 tells us the following:

What's good?

- Patients were well cared for with their dignity respected by being covered and spoken to kindly.
- Crews were observed to be caring and compassionate to patients and family members.
- One of the visits undertaken by an Executive observed care being delivered to two children and their parent which they felt was positive; the children and their parent given explanations of care.
- 'Rapid turnover' pilot observed as working well in one of the local Emergency Departments.
- Ambulances were observed as being clean and within their deep clean cycle.
- Medicine boxes were secure.
- Equipment was seen to be replaced diligently.
- Consent was observed to be gained by crews before undertaking interventions.
- Patients seen to be treated as individuals and their individual needs taken into account; observed special attention being given to a patient with dementia.

What could be improved?

- Continued education of public on appropriate use of ambulance and 999 calls.
- Ensuring numbers and skill mix meet the demand of the service.
- Joint quality visits by an Executive and a Non-Executive Board member.
- The Executive Board member to be assigned to an area that they are less familiar with.

Serious incidents (SI)

Our transparent approach sees us proactively encourage colleagues to report patient safety incidents in line with a mature safety culture. Reporting allows us to analyse what happened to

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identify and put in place actions to reduce the risk of recurrence. XX of all patient safety incidents (including SIs) reported during 2015/16 resulted in low or no harm which indicates a healthy reporting culture. During the year, EMAS identified XX serious incidents requiring investigation. The general themes are:

1. [enter detail at year end]
2. [enter detail at year end]
3. [enter detail at year end]

The EMAS Trust Board regularly receives an update on the number and type of serious incidents reported. Again supporting our open approach, the Board meeting papers are made available to the public approximately a week before each monthly meeting via www.emas.nhs.uk/about-us/trust-board/

As part of the Serious Incident Investigation process a Root Cause Analysis (RCA) meeting takes place at which the root cause, contributory factors and learning for both individuals and the organisation are established; recommendations and Action Plans are also put in place to prevent reoccurrence. A review of learning and implemented actions is completed every 6 months by the SLRG to provide assurance that the learning and actions are embedded practice and have resulted in service improvement.

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Safeguarding

We continue to prioritise safeguarding as a critical part of providing high quality care. Our approach to safeguarding is based on promoting dignity, rights and respect, helping all people to feel safe and making sure safeguarding is everyone's business. Over the years the safeguarding agenda has continued to grow across EMAS from the Board to frontline staff. It is well embedded and encompasses:

- Prevention of harm and abuse through provision of high quality care.
- Effective responses to allegations of harm and abuse.
- Seeking responses that are in line with local multi agency procedures.
- Using learning to improve service to patients.

Improvements in Safeguarding

Safeguarding remains a priority within EMAS from Board to frontline with the view that safeguarding is everybody's business. EMAS continue to remain committed to the agenda evidenced by increasing referral levels; 2014-2015 saw a higher referral rate with 11414 referrals and 2015-2016 already appears to have even higher numbers. The Safeguarding Triage team enable EMAS to maintain a 24/7 service for all staff who need to raise referrals, they have doubled in size from 5 staff members to 10, enabling more effective and efficient information sharing with health and social care colleagues. The safeguarding coordinators continue to play a vital role coordinating and collating information for EMAS multiagency partners as well as supporting the triage desk.

The Care Act 2014 provided adult safeguarding with a statutory framework for the first time. EMAS have embraced this and updated the policy and procedures accordingly. Staff are given updates on the Care Act through bulletins and will be receiving additional training in the coming months. To further support the changes through the care act EMAS have set up new partnership pathways with the three of the fire services within the region. This enables home assessment by the fire service for those most vulnerable in our society who has two or more fire risks. There is on-going work to look at how this service can be provided across all five regions of EMAS.

The Safeguarding Children's and Young Person Policy was updated to reflect the changes within Working Together 2015. Rapid Response to Child Death is now embedded within the service with referral being made for all children who die or have a poor prognosis, and staff being provided support on scene and as part of the Trauma Risk Management (TRiM) process. EMAS are working on expanding frontline staff working knowledge of female Genital Mutilation (FGM), honour based violence and forced marriage. EMAS have reviewed the themes and lessons learnt from the NHS investigations into matters relating to Jimmy Saville. Following a benchmarking process EMAS are assured that they have taken on board the recommendations that are applicable to provider organisations to ensure we are aware of potential risks from personalities such as Saville and can manage these appropriately. EMAS have received communication regarding the Goddard Enquiry and have ensured that records are protected so that the organisation is able to fully support the inquiry should it be required.

The Safeguarding team continue to play a vital role in educating all new staff joining EMAS and supporting the work force plan with safeguarding induction training. This is being provided by the safeguarding team as well as organisational learning. The education delivered was written and developed by the safeguarding team and has been quality assured by four Local Safeguarding Boards (LSB). The education provided to our staff is unique to EMAS, and provides ambulance centred approach, which supports our call takers and our frontline staff. The Safeguarding Leads and Head of Service for EMAS have contributed towards 53 Serious Case Reviews, SILPs and Domestic Homicide Reviews during 2014-2015 promoting EMAS culture of openness and honestly and supporting multiagency working and learning.

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Evidence for improvements in clinical effectiveness

Part of ensuring good Clinical Governance, is through Clinical Audit. This provides the means by which the Trust ensures quality clinical care, by making individuals accountable for setting, maintaining and monitoring standards. It is focussed around the three domains of quality - clinical effectiveness, patient safety and patient experience

Clinical Audit and Research is led by our Clinical Audit and Research department which reports to the Clinical Governance Group. The department is responsible for developing EMAS' clinical audit programme and ensures that all necessary support for the undertaking of clinical audit is readily available to staff and that progress is monitored.

For Clinical Audit, topics are divided into 4 main types:

- Mandatory
- Discretionary
- Performance driven
- Staff initiation

Clinical audit topics are selected according to priorities which may include some of the following considerations:

1. Is the area concerned of high cost, volume or risk to patients or staff
2. Is there evidence of serious quality problems e.g. patient complaints or high incident rates
3. Is there good evidence available to inform standards i.e. national clinical guidelines
4. Is the problem concerned amenable to change?
5. Is there potential for impact on health outcomes?
6. Is there opportunity for involvement in a national audit project?
7. Is the topic pertinent to national policy initiatives?
8. Does the topic relate to a recently introduced treatment protocol?
9. Subjects raised by Risk Management and Untoward Incident Reporting system

Through clinical performance indicators both national and local our clinical care is assessed and monitored as improvement plans are put into place. The Clinical Audit department works closely with clinicians in order to ensure quality clinical care is embedded into the care we give to our patients.

The department has a pivotal role in ensuring that recommendations from clinical audit are a) distributed to frontline staff to ensure improvement in clinical practice and b) used to drive EMAS' continuous quality improvement aims.

Clinical Audit and Service monitoring plan 2015/16

Audit/monitoring activity	Type	Timescale	Notes	Progress
National Clinical Performance Indicators (nCPIs)	Mandatory - national audit requirement	As per nCPI programme (see appendix X)	National report completed by EMAS Clinical Audit & Research Co-ordinator Topics: • Asthma • Falls in elderly patients • Febrile convulsions • Lower limb trauma. Data collection, analysis of local and national data, report / template preparation and dissemination.	These audits are completed according to the cycle times and presented in the quarterly Clinical Effectiveness report. The most recent report is quarter 2 which overall shows satisfactory progress to improved quality of clinical care. Where improvements

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118				are necessary there is an improvement Plan which shows improvement activity. Data collection has also commenced for a pilot Mental Health/Self Harm nCPI.
Local Clinical Performance and Quality Indicators (LCPIs) – SPC run charts and data tables	Discretionary – local clinical audit project	Monthly	Audits completed by Clinical Audit Department. Topics: • Asthma • Cardiac arrest return of spontaneous circulation (ROSC) • Cardiac arrest survival to discharge • End-tidal CO2 (ETCO2) monitoring • Exacerbation COPD • Falls in elderly patients • Febrile convulsion • Lower limb fracture • Suspected fractured neck of femur • STEMI • STEMI PPCI within 150 minutes • Stroke/TIA	These are local audits which agreed as part of the clinical audit programme at the beginning of the year. The results are presented at the Clinical Governance Group. The audits are broken down to show the position of the different counties,

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119			• Stroke (FAST positive) arrival at hyperacute stroke centre (HASU) within 60 minutes. Data collection, analysis, breakdown by county, report preparation and dissemination.	so that local improvement can be monitored. All stated audits have been completed to time and target and are on-going.
Local Clinical Performance and Quality Indicators (LCPIs) – SPC funnel plot locality comparisons	Discretionary – local clinical audit project	Quarterly	Audits completed by Clinical Audit Department. Topics: • Asthma • Exacerbation COPD • Falls in elderly patients • Febrile convulsion • Lower limb fracture • Suspected fractured neck of femur • STEMI • Stroke/TIA Data collection, analysis, breakdown by locality, report preparation and dissemination	The results of these audits are as above but shown in a different way. The report layout has been updated to show findings in a table rather than showing the funnel plots used to analyse the data.

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Audit/monitoring activity	Type	Timescale		Progress as at December 2015
Ambulance Clinical Quality Indicators (ACQIs)	Mandatory – national performance monitoring	Monthly as per NHS England timetable (see appendix 2)	Audits completed by Clinical Audit Department Topics: • Cardiac arrest (ROSC and survival to discharge). • Stroke (care bundle and arrival at hyperacute stroke centre (HASU) in 60 minutes). • STEMI (care bundle, PPCI within 150 minutes). • Data collection, analysis, report preparation and submission to NHS England/Unify.	These audits are reported in the quarterly Clinical Effectiveness Report, quarter 2 having just been completed and presented at Clinical Governance Group. For Cardiac Arrest (ROSC) there has been a significant step change, which shows improvement over several months.
Clinical Effectiveness Report	Mandatory local service monitoring	Quarterly	Report completed by Clinical Audit Manager • Report that collates all CPI and AQI metrics for the quarter, along with information relating to audit methodologies and criteria, and a clinical effectiveness improvement plan.	The Clinical Effectiveness Report Quarter 2 has been completed and presented to

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				Clinical Governance Group. The report has been updated to reflect the new EMAS report template.
Cardiac arrest annual report	Discretionary local audit / evaluation New Audit report	Annual	Completed by Clinical Audit and Research Co-ordinator • Annual report covering treatment of and outcomes for cardiac arrest patients.	Report for 2014/15 completed and published. Data collection for 2015/16 underway.
Controlled drugs storage and management audit	Local service monitoring	Bi-annual	Audit completed by Accountable Officer for Controlled Drugs for the Trust • Monitoring of correct storage and management of controlled drugs in line with misuse of controlled drug regulations	This audit has been completed and presented to Clinical Governance Group. There are no significant findings.
Controlled drugs usage audit	Local service monitoring	Annual	Report completed by Accountable Officer for Controlled Drugs • Monitoring the use of controlled drugs in line with the duties of accountable officers.	This audit has been completed and presented with the above report to Clinical Governance Group. There are

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				no significant findings.
Trigger Tool Audit	Local Clinical Audit project	Quarterly	Audit completed by Clinical Team Mentors. • Monitoring of agreed criteria essential for quality patient care.	Trigger Tool Report for Quarter 2 presented to Clinical Governance Group. The results show that over 90% of records audited have no triggers.

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So how are the Clinical Audits done?

Clinical Audits are carried out by the Clinical Audit team, using the methodology laid down in the Clinical Audit Policy. Wherever it is possible clinical staff are encouraged to be involved.

The Clinical Audit team collects, scans, and validates all patient report forms (PRFs) for the topic areas listed to ensure that the extracted data is correct, and that free-text areas have been captured. Both electronic and paper patient report forms are included. The validated data are analysed, checked for anomalies, presented in various formats, and disseminated to stakeholders.

As well as providing our Clinical Ambulance Quality Indicators (ACQIs) data (stroke, STEMI and cardiac arrest) to NHS England, and participating in the full national programme of Clinical Performance Indicators (CPIs) – these include asthma, febrile convulsion, and lower limb fracture and a new assessment of falls in the elderly - we maintained and further developed our local programme of Clinical Audit work, thus reviewing and ensuring clinical effectiveness wherever possible.

We now produce monthly reports on all the AQIs and national CPIs, as well as our local CPIs (exacerbation of Chronic Obstructive Pulmonary Disease and suspected fractured neck of femur), which are shared with clinical and operational colleagues. The CPIs are also presented as a quarterly clinical effectiveness report, which compares performance by locality, and brings together all EMAS' clinical metrics in one summary document.

The projects described on the Clinical Audit & Service Monitoring Plan 2015/16 are complete (or are a continuous requirement and are up-to-date). The team also provide clinical information and reports for a number of unplanned and ad-hoc requests, such as freedom of information requests and coroners requests.

To show how the assessment is done the table below gives the definitions for the ACQIs.

Ambulance Quality Indicator	Definition
Cardiac Arrest – ROSC	Of patients who had Advanced or Basic Life Support (ALS/BLS) commenced/continued by ambulance staff following an out of hospital cardiac arrest, the percentage that had a return of spontaneous circulation (ROSC) on arrival at hospital.
Cardiac Arrest – survival to discharge	Of patients who had Advanced or Basic Life Support (ALS/BLS) commenced/continued by ambulance staff following an out of hospital cardiac arrest, the percentage that survived to discharge from hospital.
STEMI – time to PPCI within 150 minutes	The percentage of patients with initial diagnosis of 'definite myocardial infarction' for whom primary angioplasty balloon inflation occurs within 150 minutes of call connected to ambulance service, where first diagnostic ECG performed is by ambulance personnel and the patient was directly transferred to a dedicated PPCI centre as locally agreed.
STEMI _ care bundle	The percentage of STEMI patients who received all appropriate interventions from the attending ambulance clinicians.
Stroke – time to hyperacute stroke unit within 60 minutes	The percentage of FAST positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis within agreed local guidelines, who arrive at a hyperacute stroke centre within 60 minutes of call connecting to the ambulance service.
Stroke – care bundle	The percentage of stroke patients who received all appropriate interventions from the attending ambulance clinicians.

National Clinical Performance Indicators (nCPI)

The National CPIs have seen changes during the year as a new National CPIs are developed and piloted. They are falls in elderly people and mental illness. The reports give more prominence to the data and in particular, the care bundles for each national CPI.

Data Collection and reports

The eleven Ambulance Trusts in England submit data to the National CPI co-ordinator who produces a cycle report using various analytical techniques. The reports that are produced are distributed to the National Ambulance Service Medical Directors (NASMed), as well as to each individual Ambulance Service. Each CPI has a number of indicators based on best practice, examples of which are described below:

Asthma

"On average, 4 people per day or 1 person every 6 hours dies from asthma. It is estimated that approximately 90% of asthma deaths could have been prevented if the patient, carer or health care professional had acted differently."

The CPI has five elements

A1 Respiratory rate assessed
A2 PEFR assessed prior to treatment
A3 SpO2 recorded
A4 Beta 2 agonist administered
A5 Oxygen administered

Single limb fracture

"Extremity fracture is commonly seen in pre-hospital care. They demonstrate a wide variety of injury patterns which depend on the patient's age, mechanism of injury and premorbid pathology"

The CPI has the following four elements

F1 Two pain scores recorded (pre and post treatment)
F2 Analgesia administered
F3 Immobilisation of limb recorded
F4 Assessment of circulation distal to fracture site recorded

Febrile Convulsions

"A febrile convulsion is a seizure associated with fever occurring in a young child. Most occur between six months and five years of age. Febrile seizures arise most commonly from infection or inflammation outside the central nervous system in a child who is otherwise neurologically normal"

This CPI has five elements

V1 Blood glucose
V2 SpO2 recorded (prior to O2 administration)
V3 Administration of anticonvulsant if appropriate
V4 Temperature management recorded
V5 Appropriate discharge pathway recorded

The local CPIs for Chronic Obstructive Airways Disease and fractured neck of femur use a similar methodology as the national CPIs. The table below describes the criteria.

CPI	Inclusion Criteria	Exclusion Criteria	Criterion & Inclusion Criteria
Chronic Obstructive Airways Disease (COPD). 126	Emergency patients suffering from acute exacerbation of COPD.	Transfers Patients whose symptoms resolve prior to ambulance arrival ECP follow up visits after patient has already been treated for the acute episode by a crew.	**C1 Respiratory rate assessed** Where respiratory rate is recorded on the patient record. Can be taken at any time during patient assessment. **C2 Oxygen saturation (SpO2) recorded before treatment** □□Must be recorded before treatment □□Benefit of doubt is given to incidents where observations are carried out within a few seconds of administration of drugs. □□If no treatment is recorded but an SpO2 reading is, this scores a 1. □□If patient (or someone else on scene) has administered treatment before crew's arrival but an SpO2 is recorded this scores a 1. **C3 ECG performed** □□May be a 3 or 12 lead ECG **C4 Beta-2 agonist administered** □□Includes administration of by health professional or patient unless stated that this was NOT EFFECTIVE N.B. Beta-2 agonist in use at EMAS is Salbutamol **C5 Oxygen administered appropriately** □□Where oxygen was administered appropriately for COPD patients – includes cases where O2 was **not** administered because the patient's oxygen saturation was satisfactory i.e. >= 88% □□Includes cases where salbutamol is given by the crew as this is via oxygen driven nebuliser. □□Includes cases where patient is on home oxygen or has been given oxygen prior to crew's arrival. □□Where the patient has not received oxygen via a nebuliser, it must be given only if

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			SpO2 is <88%. □□For SpO2 85-87%, 2-6l/min should be administered via nasal cannulae or 5-10l/min via a simple face mask. □□For SpO2 <85% 15l/min should be administered via a reservoir mask.
N Suspected fractured neck of femur (#NOF) 127	Emergency patients suffering from suspected fractured neck of femur	Transfers	**N1 Heart rate assessed** **N2 Blood pressure assessed** Full blood pressure required - Systolic and Diastolic **N3 Two pain scores** Incidents where two pain scores have been recorded at any time prior to arrival at hospital. The initial pain score must be a number between 0 and 10. The second pain score can be expressed in any of the following ways: □□A number between 0 and 10 □□A visual pain score (this applies to ePRFs and appears as 'the worst pain' or 'a little pain' under the pain part of the vital signs). □□A statement in the free text like 'pain reduced after treatment' or 'pain relieved after treatment' (or 'pain increased after treatment') □□An entry in the Treatment/Reassess section on the ePRF (near the drugs) that says something about pain having been reassessed. **N4 Morphine Given** **N5 Analgesia** N.B. Although paracetamol may also be given as an analgesic, it does not count for the purposes of this indicator. If morphine (or oramorph) is not appropriate, then entonox should be given.

Results and dissemination

These audit results are illustrated using Statistical Process Control methodology, where improvement can be measured over a period of time, with the aim of continuous improvement being seen. This method means the knee-jerk reactions are kept to a minimum, and special situations can be investigated.

The audit reports are presented to the Clinical Governance Group for discussion and approval. The Clinical Effectiveness Group will then form the actions for improvement which will be disseminated in their area. These will be gathered into an overall Improvement Plan which is monitored by the CGG, Quality Governance Committee and the Quality Assurance Group.

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EMAS Research and Development

EMAS' reputation as a leader in pre-hospital research has increased over the past five years. We are now collaborating in more high quality externally funded studies and leads a prestigious £2 million National Institute for Health Research (NIHR) Programme for Applied Research: Pre-hospital Outcomes for Evidence Based Evaluation (PhOEBE) in partnership with the Universities of Sheffield, Lincoln and Swansea.

One of the drivers for increased Ambulance Service research in England has been the National Ambulance Research Steering Group (NARSG), set up in 2007. The role of NARSG is to set a strategy and develop the pre-hospital research agenda for Ambulance Services in England. We are currently collaborating on, or leading a number of research studies, more than half are eligible for registration on the National Institute for Health Research Clinical Research Network Portfolio (NIHR CRN).

Engaged in 5 portfolio studies, a further four funding applications have been successful and received funding from the NIHR programmes during 2015/16.

Research studies eligible for inclusion in the NIHR CRN portfolio are supported by an NHS research infrastructure. The support available includes additional funding and training. To be considered eligible for adoption on the NIHR CRN portfolio a study must be a fully funded high quality research study. Some research is automatically eligible, for example, research funded by the NIHR, NIHR non-commercial partners (e.g., The Health Foundation) or other areas of Government.

Other research (e.g. commercial collaborative research) may also be eligible but will need to undergo a formal adoption process to be considered. Audits, needs assessments, quality improvements and local service evaluations are not eligible for adoption or support.

We have established good working relationships with our East Midlands NIHR Research Design Service, who provides extensive advice and support, through the East Midlands Ambulance Research Alliance (EMARA). EMARA is the strategic research group for EMAS supporting both in-house and external research that aims to develop EMAS as a centre of excellence for patient focused pre-hospital research and evidenced-based practice. Through EMARA we have developed strong links with higher education institutes.

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During the year EMAS has been involved in 17 research studies, some on-going and some which have been completed.

EMAS is collaborating in two major studies:

Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal intubation in the initial airway management of out of hospital cardiac arrest (AIRWAYS-2). AIRWAYS-2 is an NIHR funded study designed to determine the best approach to the management of a patient's airway during an out of hospital cardiac arrest.

Rapid Intervention with Glyceryl trinitrate in Hypertensive stroke Trial (RIGHT2): Assessment of safety and efficacy of transdermal glyceryl trinitrate, a nitric oxide donor, and of the feasibility of a multicentre ambulance based stroke trial.

With these 2 studies and other smaller trials nearly a quarter of EMAS clinicians are now involved in research.

The EMAS research status table to date for year 2015/16 can be found at appendix 3.

Successful research is measured by its effect on patient outcomes. This is achieved in a number of ways through dissemination at conferences, publications and clinical education and training.

The above studies show the variety and scope of research in EMAS. However, successful research is measured by its effect on patient outcomes. This is achieved in a number of ways through dissemination at conferences, publications and clinical education and training. Over the year EMAS clinicians have presented papers or posters at 7 conferences both national and international, and there have been 3 journal publications.

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What we have done to improve patient experience

Compliments

During 2015/16, we received more than XXXX expressions of appreciation from patients or members of the public. This is an increase from previous years. When the colleague can be identified by the information provided, the individual(s) are thanked personally by the Chief Executive in the form of a letter which accompanies a copy of the patient feedback. We are grateful to the patients and their relatives who have been happy to share their experiences at our public Trust Board meetings and with local and national media. We are tremendously proud to be able to promote the achievements of our colleagues in this way and it always gives a real boost to morale.

Continuing improvements to the EMAS complaints system

Following the 2013 Francis Report into Mid Staffordshire NHS Foundation Trust and the Clwyd/Hart Report, EMAS carried out a review of the complaints process to identify actions to improve the way complaints were handled. This improvement has continued throughout 2015/16 as we benchmarked our processes and outcomes across other NHS Ambulance Services nationally, and with additional published advice from the Parliamentary and Health Service Ombudsman.

Changes implemented throughout both the PALS and Complaints and Investigation Teams, including the centralisation of processes and recruitment of additional team members, have helped the service to become more robust and to deliver a higher quality outcome for complainants. Improvement work will continue through 2016/17 to ensure that learning is identified and actions are implemented comprehensively across the Trust further improving the quality of patient care and the complaints service delivered.

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Formal Complaints (FC)

During 2015/16, EMAS identified XXX formal complaints requiring investigation; XXX related to our Accident and Emergency Services (X.XXX% in relation to journeys provided or XX.XX complaints from per 100,000 journeys), and X to our Patient Transport Services (X.XXX% in relation to journeys provided or X.XX complaints from 100,000 PTS journeys).

Following investigation, XX complaints were found to be justified and XX partially justified. The remainder were not justified or not applicable (e.g. the complaint related to a different service).

The general themes related to: [the themes may have changed at the end of this performing year]

- Delayed response and non-conveyance to green category calls
- Staff attitude
- Care management
- Call management

Compliments and complaints received per county during 2015/16:

County	Compliments	Complaints
Derbyshire	XXX	XX
Leicestershire & Rutland	XXX	XX
Lincolnshire	XXX	XX
Northamptonshire	XXX	XX
Nottinghamshire	XXX	XX
Emergency Operations Centre	XXX	XX
Not specific	XXX	XX

All formal complaints require investigation to establish the facts of the case and identify learning for both individuals and the organisation. The investigation also allows us to provide recommendations to prevent reoccurrence. Action plans are completed following each investigation and actions are closely monitored until closure.

General approaches to learning from serious incidents and formal complaints include:

- Communication of key learning points through education, training, communication and awareness.
- Clinical case reviews and reflection of the practice by individuals.
- Amendment to policies, procedures and practices.
- Themes being reviewed by our Learning Review Group which consists of multi-disciplinary membership.

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Ombudsmen Requests

During 2015/16, we received XX requests for information from the Ombudsmen. Of these, the Ombudsmen confirmed XX were not upheld, and XX remain open.

Patient Feedback

During 2015/16 we replaced the previous postal patient surveys for accident and emergency patients, with a programme of patient focus groups and other engagement activities delivered jointly by the EMAS Community Engagement and Patient Experience teams. A series of public engagement events took place during the first two quarters of the year with XXX patients taking part in the EMAS Reputation Audit for 2015.

XX% of patients who took part in the audit stated they had been either satisfied or extremely satisfied with the care received by EMAS.

Six monthly postal patient surveys continue to be undertaken for the North and North East Lincolnshire Patient Transport Service (PTS) patients. Of the XXX surveys sent out during quarters 1 and 2 of 2015/16, we received XX responses (a XX% response rate). XX% of respondents stated they were either likely or extremely likely to recommend our services to friends or family.

From October 2014 all PTS and see and treat patients were issued with a Friends and Family comment card (a national NHS survey), to rate their care via the Net Promoter Score (NPS). The NPS is obtained by asking patients the question, '*on a scale of 0 to 10* (10 is extremely likely and 0 is not at all likely) *how likely would you be to recommend East Midlands Ambulance Service to family and friends?* Based on their reply, patients are categorised into one of three groups: promoters (who gave a 9-10 rating), passives (who gave a 7-8 rating) and detractors (who gave a 0-6 rating).

The Net Promoter Score for EMAS came in at +XX for our 999 A&E services, and +XX for Patient Transport Service.

Patient stories

EMAS captures patients' experience in a variety of ways. One way is by inviting patients and carers into our Trust Board meetings to tell their story. We have included two examples below of where we have done well or where we have identified areas for improvement.

Mrs O's story, reported at the July 2015 EMAS Trust Board meeting:

Whilst being a legitimate PTS patient, Mrs O agreed to also be part of the mystery patient PTS survey. Mrs O recalls that she received appropriate training and guidance and was more than happy to participate. On 2 occasions during May 2015 Mrs O was transported from her home to hospital. Mrs O recalls travelling in four different vehicles, one of which was a private car driven by EMAS volunteer and three were EMAS PTS ambulances. Mrs O stated that all staff were friendly and courteous, introducing themselves to her on arrival. Mrs O reported that all vehicles were clean and comfortable. Mrs O also stated that she did not wait long for either of her 2 return journeys home. Mrs O recalls all staff ensured that her seatbelt was fastened and worn correctly, and that on arrival at home the staff saw her inside the front door of the main building.

Mrs O stated that the PTS booking service was good and helpful and also found the training and guidance offered to undertake the mystery patient survey to be good.

Mrs O has also had cause to call 111 several times recently and an EMAS ambulance has responded. MrsO states that: *the staff who attended were always quick and I was happy with the service*, adding that the crews were '*most fantastic'*.

Mrs O voiced her satisfaction with the service she received from EMAS PTS:

- On all occasions the service from EMAS was timely and pleasant.
- During all journeys the staff were polite, helpful and courteous.

Mrs O said: *'I have had good experiences with EMAS and would encourage others to take part in the mystery patient survey as they can help EMAS to improve. What I think is good, others might not.'*

Work is underway to recruit additional participants for the mystery patient survey to help to identify good practice and potential areas for improvement. Mrs O has agreed to take further part in the survey should she utilise the PTS again in future.

Mr O's story, reported at the December 2015 EMAS Trust Board meeting:

Mr O is 52 years old and lives with his wife. He is a retired retained fire fighter and a former member of the Air Force.

In January 2015, Mr O was outside his home cutting wood with an electric saw using the correct personal protective equipment. Whilst cutting the wood the saw hit a knot and the guard covering the blade was pushed aside. Mr O saw the fingers on his left hand go through the saw. He turned off the saw, went inside and grabbed a towel to wrap his hand, raising his hand above his head. Mr O felt shocked and shouted his wife for help.

Mrs O called 999 at 14.48 but struggled to convey the situation to the call taker due to her panic, so Mr O completed the call. Originally the call was correctly coded as Green 2 (30 minute response time) but was incorrectly downgraded to Green 4 (Clinical Assessment Team (CAT) call within 60 minutes). Mr O was informed that an ambulance would not be provided and to expect a CAT call within 60 minutes. At this time EMAS was in Capacity Management Plan level 3. A double crewed ambulance (DCA) was mobilised at 14.49 and allowed to continue travelling to the scene, arriving at 15.07, a response time of 21 minutes.

During the time between Mr O ending his 999 call and the DCA arriving, Mr O called 111 and was informed that they did not have the authority to override the 999 call decision. Mr O was still on the call to 111 when the DCA arrived. He said *'I felt totally isolated; there was no help or guidance. It was a massive relief when the ambulance arrived. The two ambulance men were professional to a tee, I couldn't fault them.'*

On arrival, when examining Mr O, the ambulance crew realised that he had completely severed the top half of his thumb and it was missing. They went back outside and located the missing digit transferring it to hospital with the patient. The DCA left the scene at 15.23. Mr O received Entonox and Morphine and chose to travel to the Royal Derby Hospital arriving at 15.39. Mr O experienced a good handover and no wait. Since his accident Mr O has undergone 3 surgeries and is currently receiving physiotherapy. Mr O has regained some movement, but unfortunately the reattachment of his thumb was unsuccessful. Mr O still wears a small protective cast in bed and outside of the house and is unable to use cutlery properly.

Mr O states: *'I felt totally let down by the initial 999 call. I felt like no-one wanted to know or help, I was close to despair.'*

PALS received the concern from Mr O following the incident voicing his disappointment with the service he had received from EMAS. Mr O was particularly unhappy with:

- The fact that such a serious injury could be coded as requiring such a non-emergency response.
- Poor communication – Mr O was informed that an ambulance would not be sent, however one had already been mobilised.
- The feelings of helplessness and despair experienced by Mr O when he was told that EMAS would not be sending help.

Mr O said *'I just don't want anyone else to experience what I went through that day.'*

When asked what message he would like to convey to EMAS as a result of his experience Mr O stated: *'I hope something can change as a result of my story to make things better for other patients.'*

When asked about his experience of PALS, Mr O stated: *'I was happy with PALS and the response I received. I had thought I might be fobbed off but I was proved wrong.'*

Two areas were identified as actions for the Training team during the PALS case investigation:

1. The 999 call should have remained as Green 2 and should not have been downgraded. A member of the Training team has addressed this issue with the staff member.
2. The dispatcher should have stood down the DCA mobilised to the call instead of allowing it to travel. Had the call been appropriately downgraded the DCA might have been required for another, more urgent call. A member of the Training team has addressed this issue with the staff member.

In addition to the actions above, following a suggestion made by Mr O at the meeting held with the EMAS Patient Safety and Experience Manager and the Head of Patient Experience and Engagement, the action below has been agreed with the aim of ensuring that if a patient or family is using the first telephone number provided when the CAT call to make a further assessment, there is another number to try. In Mr O's case, had the CAT tried to call back straight away Mr O would have been speaking to NHS111 and would not have been contactable on that telephone number.

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Action	Lead	Deadline
Implement the recording of a second contact telephone number during 999 calls.	Head of Patient Experience and Engagement.	November 2015,

This story illustrates the importance of adhering comprehensively to AMPDS (the system used within the EMAS call centres to process and prioritise 999 calls), and the importance of effective, clear communication.

Extracts from messages of thanks during 2015/16

Letter from Ms B, Lincolnshire: **'***Thank you so much for the care and kindness you showed me last Thursday when I fell at the railway station. You were all wonderful and showed me nothing but kindness and compassion. I could not have been treated any better and I really did appreciate it. Thank you all for doing such a terrific job.'*

Mr AM from Northamptonshire said: *"The first responders who came out in the paramedics car were absolutely fantastic. Both were extremely good with my daughter, putting her at ease while they did what they had to do in assessing her. I wanted to message to tell you how great the paramedics you have on your staff were. She luckily hasn't fractured anything in her spine and is home safe and sound."*

Mrs JD thanked the three paramedics who attended her stepfather in Nottinghamshire in January. She wrote: *"I just want to thank you for the care, reassurance, patients and professionalism that you showed to and gave my stepdad, who I had found on the floor in his flat and was very ill. Thank you also for the way you all dealt with me - in a very compassionate and empathetic way. It helped to bring much needed calmness to the situation. Thank you once again for the service that we received and for your caring attitudes towards the patient, family and friend."*

We've received an email from Nottingham University Hospitals NHS Trust praising the care we give to children. The Children's Major Trauma Dashboard for July to December 2015 show that despite only having one major trauma centre in quite a large geographical region we get a good proportion of children there when compared to other areas. The hospital colleague said: *"EMAS are doing a very good job, and should be told so!"*

Mr VC, from Derbyshire, wrote: *"I wish to send our thanks for the wonderful help the ambulance crew gave to my wife; taking her to the hospital, giving her oxygen to help her breath and taking down details on her health for the hospital doctors. She was treated for pneumonia and is now recovered. I can't thank you both enough."*

Mr AL has praised colleagues in Leicestershire for the care they provided when his twin sons were born early and one needed an urgent transfer to Great Ormond Street Hospital in London. He said: *"The ambulance staff were great, especially those who took him down to London. The speed in which they sorted out an ambulance and the crew definitely had a role in saving his life."*

Extracts from 'could do better' messages

[examples – protecting patient's identity - to be included here]

Community Engagement

The Communications and Engagement Strategy for 2014-2016 was approved by the EMAS Trust Board in November 2014. Our 2015/16 stakeholder engagement plan saw us have a renewed focus on engagement with our Members of Parliament, following the election in May 2015. Through the year we continue to deliver a range of engagement activities to improve patient experiences.

We do this by listening to patient and relatives stories and experiences, capturing their feedback and sharing it with the organisation. This allows us to respond to concerns raised, share praise with colleagues, and identify potential for improvement.

We have increased the public's knowledge and understanding of EMAS by producing materials and distributing them at events, and using social media to help explain:

- How emergency and urgent calls are graded (categorised) and responded to
- Alternative pathways to emergency care
- Where professional medical advice can be gained for non-urgent problems
- Methods of self-care and good health and wellbeing

In addition to attending community events and other health service awareness days, we identified a number of groups which would benefit from direct engagement with EMAS. These included:

- The top three postcodes in the East Midlands for use of our service for serious and non-serious problems (this included deprived areas)
- Carers, including young carers
- Young parents – we worked jointly with SureStart groups

Everyone has a role to play in an emergency and giving first aid within the first few minutes of an incident can make the difference between life and death. The team has trained hundreds of people in emergency life-saving skills through free courses during 2015/16, offered in each county. People attending learn CPR (cardio pulmonary resuscitation used when someone goes into cardiac arrest), the recovery position and how to help someone suffering from a heart attack, choking or a serious bleed.

During July to September 2015, we conducted EMAS' second Reputation Audit. Just under 5,000 people responded to the audit, with 89% saying they were very satisfied or satisfied with the care received from EMAS. 89% of respondents said they would recommend EMAS to

friends and family, 90% said EMAS had improved in some way over the past 12 months, and 90% felt that EMAS has a positive reputation.

Stakeholder relationships have improved over the last 12 months with EMAS attending meetings and events, and inviting individuals or groups to visit us at our premises to build an understanding of our vision and future direction. We have been encouraged by the number of people who have expressed a desire to work with EMAS to ensure improvements continue, and we thank those who have taken the time to recognise the steps taken to date to bring about better care and services for our patients.

Communications and social media

Everyone in our service plays their part in saving lives, from our Ambulance Support Teams to our frontline clinicians, each person works hard to ensure our patients across the East Midlands receive the best possible patient care.

We are eternally grateful to the patients and their family who share their stories and positive experiences with local, regional and, in some cases, national media.

Here are a few examples of the stories that have been promoted this year:

Off duty paramedic hailed hero

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Thanks to a Facebook appeal to 'find his hero' Nick Andrews from Matlock was reunited with the off duty paramedic who saved his life after a serious road traffic collision that closed the M6 for five hours.

Nick said: "Everything happened so quickly. Before I had time to lift my head Kelly was there. I was trapped in the vehicle and in a lot of pain but I didn't lose consciousness because she was there keeping me going. A doctor at the hospital said if I had gone to sleep or passed out I wouldn't have woken up. She truly saved my life and I will forever thank her."

Nick had broken 8 ribs, which had punctured his liver and lung and crushed his heart. His elbow and arm had also been crushed and had to be rebuilt.

Paramedic Kelly Topliss was on her way to West Midlands Safari Park with her family. "I didn't see the crash happen but I knew something was wrong because the traffic suddenly stopped. I got my florescent jacket out of the boot and went over to help."

Nick's wife Tracey said: "You take everything for granted knowing that we have an Ambulance Service. That day Kelly wasn't on duty, she didn't have to get out and do what she did. It shows what a dedicated selfless woman she is."

Derby resident thanks ambulance crew for restarting his heart five times

A Derbyshire resident met the ambulance crew that saved his life after restarting his heart 5 times during a sudden heart attack. EMAS paramedics were called by Kevin Payne, 36, after an onset of central chest pain during the evening in August.

“At first I thought it was heart burn or indigestion, as I’d been to the gym earlier in the day but the pain started radiating to both of my arms,” said Kevin. “It was getting worse and I was very clammy and sweaty- then it became more difficult to breathe.”

The ambulance crew arrived at Kevin’s home and immediately assessed that he needed urgent hospital treatment.

“On the way to the hospital, Kevin suffered a cardiac arrest in the back of the ambulance,” said EMAS paramedic Russell Nelson-Tempest.

“We performed CPR and actually had to use our defibrillator 5 times to shock and restart his heart during the journey. But thankfully, by the time we reached the hospital, Kevin had regained a pretty good level of consciousness.”

“I thank the ambulance crew that saved my life and helped keep me here,” said Kevin. “They do an incredible job and definitely deserve to be recognised for it.”

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Special delivery for paramedic on New Year’s Eve

When Chrissy Lane went into labour on New Year’s Eve she didn’t expect to give birth to her daughter in her own home with the help of a paramedic.

Chrissy, 25, was 41 weeks pregnant (due on Christmas day) when she experienced a worrying bleed. Her husband Tom spoke to her midwife who advised him to call 999 and get Chrissy to hospital as soon as possible.

Northamptonshire paramedic Chloe Civil was nearing the end of her night shift when she got the call to respond. Expecting to be rushed into an ambulance and taken straight to hospital Chrissy was preparing herself to leave when Chloe examined her and saw the baby’s head.

“I remember Chloe telling me we wouldn’t make it to hospital” added Chrissy “I suddenly realised I would be having my baby at home. Chloe was so friendly, it felt so natural to have her there helping me.”

Around 10 minutes after Chloe arrived at the Lanes home, baby Hollie Christine Chloe Lane was born.

“We will always be grateful to Chloe for her involvement in our life. To say thank you we decided to give Hollie ‘Chloe’ as a middle name. We hadn’t considered the name before but wanted her to have a constant reminder of the lady who welcomed her into the world.”

Man had his heart shocked 17 times

When Yvonne Ainsworth found her partner collapsed at home last September she feared the worst. After calling 999 she realised he had gone into cardiac arrest and followed the call handler’s instructions to perform chest compressions to try and keep him alive.

Ambulance crews raced to the emergency. They worked on Patrick for over 50 minutes, using a defibrillator to shock his heart 17 times.

Paramedic Daniel Sneath was first on scene, he said: “Patrick was clearly a fighter. This was a real team effort and everyone on scene worked hard to keep him alive. As we were working on him he continued to show signs that his heart had started but then it would stop again. We kept going until we were able to stabilise him and he was then flown straight to Glenfield.

“By performing CPR as soon as she saw him collapse Yvonne gave Patrick the best chance. Her bravery should be commended for remaining calm in such a scary situation.”

Yvonne said: “Whilst I knew I needed to pump his chest I was terrified by what was happening. The 999 call handler (Joshua Selwood) was so calm and gave me clear instructions helping me stay in rhythm whilst reassuring me that I was doing the right thing. I couldn’t have done it without him.

“It is down to the call handler and paramedics that my Patrick is alive. Some of them had just finished a 12 hour shift but were still willing to stay with us, working on Patrick for over an hour during our moment of need.”

Equality and diversity

Equality, Diversity, Inclusion and Human Rights are at the forefront of our quality agenda. Valuing and promoting equality and diversity are central to the effectiveness of East Midlands Ambulance Service. Our ability to provide quality through equality depends on understanding the diverse communities we serve to plan and deliver services that take account of their needs. If we can fully engage with our communities they will have greater confidence in us and are more likely to accept our professional support and advice. An effective relationship with our communities is therefore vital to ensure both quality and equality.

We deliver a public service and have a duty to ensure equality of access, equality of impact and equality outcomes for all. In other words a service which equally meets the needs of all people we serve. For our staff the right to ensure equality of opportunity for all, to treat people with respect, dignity, fairness and to create a culture which benefits everyone. Underpinning this approach is legislation. The Equality Act 2010, the Public Sector Equality Duty and the Equality Framework (EDS2) help shape the quality agenda thus allowing for effective service delivery and community engagement.

Improving the care environment

We have made numerous improvements as a result of learning from a wide-range of sources including serious incidents, complaints and patient experience surveys. Some examples are shown below, with more to feature in the EMAS Strategic Learning Review Group Annual Report.

draft

- ✓ Pre hospital sepsis screening tool revised.
- ✓ New medicine management procedure covering the recording, issuing and restocking of medicines to stations and vehicles.
- ✓ Cardiac arrest on scene checklist and addition of adrenaline PGD for haemodynamic support post return of spontaneous circulation.
- ✓ On-going work to further align acceptance criteria of ACP's to that of amber outcome on paramedic pathfinder to increase non conveyance with appropriate care. ACP's participating includes Skegness Urgent Car Centre (UCC), Ilkeston Community Hospital, Ripley UCC, Loughborough UCC and Nottingham UCC.
- ✓ Mental Health and suicide risk awareness training for our Clinical Assessment Team raising consciousness of appropriate priority to attend callers in crisis.
- ✓ Hospital handover delays Emergency Department Standard Operating Procedure
- ✓ Revised trigger tool used to audit 1:30 patient report forms with increased robustness of parameters around COPD management, capnography and pain management.
- ✓ Revised diagnosis of death procedure and resuscitation decisions policies to give greater emphasis and enablement for clinicians to respect the wishes of patients.
- ✓ Improved Mental Health triage and training packages for EMAS staff, designed to improve the triage and outcome of all mental health patients.
- ✓ Improved resilience for our Emergency Operations Centres in the event of the IT systems crashing. This includes better paper process, monthly system upgrades and testing of resilience and the introduction of tabards for specific roles.
- ✓ Early escalation for patients that have called 999 more than once within 30 minutes. These calls will be escalated early to a clinician for further triage.

- ✓ Introduction of 24 hours a day Regional Operations Manager within the Emergency Operations Centre to give support management of key issues relating to demand and response.
- ✓ Improved business continuity plans.
- ✓ New mental health referral pathway with the Samaritans charity.

draft

Appendix 1 - Workforce

We have developed a new People Strategy with a vision to develop and support our people to be highly skilled, motivated, caring and compassionate professionals proud to be part of the EMAS family.

Our aim is to develop EMAS as an Employer of Choice. We will achieve this by ensuring a safe and healthy workplace where colleagues feel valued, their views are heard, that they have a sense of purpose and direction, are able to reach their full potential and contribute to achieving our strategic vision and objectives.

The People Strategy Framework reflects our approach to developing positive employment relationships with our staff and is modelled on recognised motivational theory – Maslow's Hierarchy of Needs, ensuring a person centred approach in its development, and acknowledgement of the range of mutually reinforcing factors that impact on motivation and satisfaction.

Desired Outcomes of the Strategy include:

- Planning and Attraction: Comprehensive and integrated workforce planning that supports the delivery of the right care, with the right resource, in the right place and at the right time.
- Retaining and Valuing: Positive employment relationships where individuals value the contribution of each other, wish to remain working with at EMAS and recommend EMAS as a place to work.
- Development and Career Progression: An engaged, committed, motivated and skilled workforce that has the capability to deliver effective patient care and drive organisational development, improvement and transformation.
- Exiting: To manage those who exit the EMAS sensitively and effectively, ensuring feedback contributes to organisational learning and development.

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We have strengthened our workforce plans to ensure our focus on capacity and capability to support transformation to the new service model and achievement of the quality-improvement programme. This will provide assurance that we have the right number of resources with the right skill mix required to meet operational demand, ensure business continuity and meet the regional and national standards.

More frontline staff

We have a wide variety of frontline personnel at EMAS, who as part of a team provide professional healthcare services to the people of the East Midlands all day, every day. Examples of the different role types can be found under the careers section of our website www.emas.nhs.uk

During the year we experienced an 11% turnover rate of frontline staff and our recruitment plan reflects the rate needed to maintain establishment and skill mix.

In line with our Workforce Plan, during 2015/16 we recruited and trained 30 emergency care assistants, 257 technicians, 57 paramedics, 42 staff for our Emergency Operations Centre (control) across both Emergency Medical Dispatch and Clinical Assessment Team roles, and 78 other staff in support functions. This included an increase in overall staffing by 155.

Career progression opportunities have been increased for our existing frontline workforce, and a major recruitment and education campaign has been launched. This includes a range of options including:

- Trainee technicians
- Emergency care assistant to technician
- Technician to paramedic

Supporting young people at the start of their career

We continued to support the national apprenticeship programme by recruiting apprentices into a range of enabling service and operational support positions. Since 1 April 2015, we have recruited 13 apprentices who have taken up roles in our enabling services. Of the apprentices that completed their schemes in 2015/16, 5 went on to successfully secure roles within EMAS. In addition, 53 members of our current establishment commenced an apprenticeship within their current role to enhance and progress career development.

Values based recruitment improves quality of care

Through our recruitment campaigns we have ensured a values-based approach focussed on attitudes, behaviours and ability. While assessment of ability has remained an integral component of the recruitment process, it is now widely recognised that employees' values, attitudes and behaviours have a significant impact on the quality of care and patient experience.

To better support values-based recruitment, we have employed a number of strategies during the year including education and training for recruiting managers, values-based interview techniques, questions to explore attitude and behavioural factors, use of psychometric instruments, assessment centres, and patient and stakeholder involvement.

Education and development

In December 2013, we developed our People Capability Framework to define the competencies, attitudes and behaviours for staff and managers at every level. The framework supports leadership and management development; cultural development and underpins workforce planning, values-based recruitment, education and training, appraisals and succession planning.

We have continued to offer leadership programmes and master classes to existing and aspiring managers and have facilitated a level 4 business administration course for existing administrators within the service.

During 2015/16, our Education Team continued to support the annual essential education programme supporting essential standards of quality and safety, statutory and mandatory requirements, and clinical updates.

Continued delivery of the rolling programmes for clinical staff resulted in an additional 65 staff completing the Pre-Hospital Assessment and Disposition Education programme and a further 51 staff becoming accredited mentors to support newly-qualified paramedics in practice.

The modernised national Emergency Response Driving Course in conjunction with our new awarding body FutureQuals has been implemented from January 2016. The clinical award to replace the IHCD Ambulance Aid award is in development nationally to be rolled out from April 2016. Work has continued through the year on a partnership arrangement with Coventry University for our internal Technician to Paramedic route for a Foundation Degree leading to registration as a Paramedic. We will see the first cohorts start early in the new financial year.

Staff Support and Wellbeing

During 2015/16 EMAS has progressed with initiatives to enhance staff support and wellbeing within the Trust. Key achievements are detailed below.

Staff Support:

- Peer to Peer – In February 2015 the Peer to Peer (P2P) and Pastoral Care Worker (PCW) support network was launched with 90 volunteer staff from across EMASt trained in supporting and signposting colleagues to further support where required. During 2015/16 the P2P/PCW support network has grown from strength to strength demonstrated through 1024 support contacts being made during quarter 1 to quarter 3 (Q1 241 contacts, Q2 386 contacts, Q3 397 contacts). With the demand for support increasing a recent recruitment drive for more P2P/PCW volunteers has created an additional 70 more volunteers awaiting training to expand the staff support provision at EMAS
- Trauma Risk Management (TRiM) – As part of the staff support initiatives within EMAS was the introduction of the TRiM. It was was launched in May 2015, initially with 16 TRiM practitioners (including 2 TRiM managers) expanding in September/October 2015 to 48 TRiM practitioners (including 10 TRiM Coordinators) operating across EMAS supporting staff who have been exposed to traumatic situations.
- Induction – Staff support information sessions are now integrated into all induction courses for new staff joining EMAS to ensure awareness of the different support mechanisms that are available.
- Internal Support Network Groups – LGBT support group launched in March 2015 and continues to represent and support employees from the lesbian, gay, bisexual and/or transgender community. The Disability and Carer's Group launched in December 2015 and the BME support group is currently in development launching March 2016. These support groups focus on issues poignant to individuals and provide a 'group voice' and support mechanism for staff within their community.
- Mediation Service – EMAS provides an internal mediation service to employees who are experiencing conflict, frustration or disagreement with another employee or manager. The mediation service provides an informal approach to resolving issues in an aim to avoid escalation or formal processes being initiated. In the first year of operation the service

received 13 contacts (May 2014 – March 2015). This service has continued to be offered during 2015/16.
- Lead Chaplain (established in February 2015) providing pastoral support to any employee when required.

Health and Wellbeing:
- Mental Health Awareness - In May 2015 EMAS' wellbeing fortnight focused on mental health support and information. During 2015/16 EMAS has been working with MIND on the Blue Light Programme to recognize the prevalence of mental health within emergency service personnel and promote mental health awareness within the emergency services. This has resulted in EMAS taking part in a mental health webinar and 'blue light champion' volunteers from across EMAS to support the promotion, acknowledgment and acceptance of mental health.
- Occupational health – EMAS has continued to work in collaboration with our contracted occupational health provider to ensure the provision of a high quality, prevention focussed, and comprehensive occupational health service. This includes line by line reviews with PAM and the HR team accessing each individual case. Sickness/Attendance action plans continue to be monitored through the Workforce Committee and Intensive Support Board.
- Sickness/Attendance – EMAS has continued to actively manage sickness absence in accordance with the Managing Attendance Policy. An alternative duties framework has been developed at EMAS, a day 1 referral service to the physiotherapy helpline (PhIL) is in operation to help reduce the incidence of musculoskeletal injury and absence, and each individual on long term sickness has a specific care pathway and rehabilitation plan which is managed through the long term sickness process. To support the reduction of incidences of work related stress and mental ill health EMAS continues to enhance the staff support provision across EMAS as mentioned previously.
- Declaration of Tobacco Control – This Pledge is aimed at encouraging organisations to commit to taking action on tobacco. EMAS' commitment to health promotion is evidenced by the signing of the tobacco pledge in March 2016 with smoking cessation promotion and support accessible to any member of staff who requires support to stop smoking.
- Seasonal influenza vaccination programme 2015 – This year EMAS vaccinated 51.2% of staff against the seasonal flu virus. This was a 2% increase in staff vaccinated compared to the 2014 programme with EMAS appearing in the top three best performing Ambulance Trusts throughout the campaign.

Staff engagement

Through the 2015 staff engagement programme, Listening into Action (LiA), we continued to mobilise and empower colleagues to lead and drive change both locally and at an organisational level, and embed LiA as 'the way we do things around here'.
EMAS LiA year 2 utilised a core divisional approach to cascading the LiA ethos throughout the service. The Divisional General Managers adopted the LiA process into their engagement plans and with the help of their local management teams and Human Resources business partners to develop ideas that came from our colleagues.

In addition, LiA has been instrumental in gaining success in organisational projects, including:

- Expansion of the P2P/PCW network.

- Development of the TRiM training.
- Aide Memoire for new starters.
- Buddy scheme for new emergency care assistants in Leicestershire/Northamptonshire.
- GRS at home (a software package that allows colleagues to access their shift details).
- Team Leaders starting and finishing shifts at a designated station in Nottinghamshire.
- Development of a new solo response bag (due for completion early 2016).
- Laverick Award, in memory of a colleague who tragically passed away, to recognise children for acts of bravery.

LiA has enabled matters of concern to colleagues to be raised and addressed, has improved staff engagement and involvement, and facilitated staff leadership to drive change and improvement.

In addition to these innovations the LiA leads have travelled the length and breadth of EMAS holding numerous 'breakfast/cake/tea with the Chief' events hosted by our Chief Executive Sue Noyes. These events represent a real commitment to engage our colleagues on frontline, in our control centres, at divisional headquarters and in enabling services too.

Planning for LiA year 3 is in progress.

Positive impact

A number of initiatives came to fruition during 2015/16, including:

- Continued provision of our Occupational Health (OH) and Employee Assistance programme focussed on taking proactive and preventative measures to support staff wellbeing.
- A range of education and training programmes to support management capability were available for staff and managers.
- Targeted local leadership development for team leaders and managers (ongoing)
- Embedding of Listening into Action and a range of staff support mechanisms.

There is a planned Health and Wellbeing Topic of the Month with the 12 month schedule being prepared for launch in April 2016.

NHS Staff Opinion Survey

The annual NHS Staff Opinion Survey was conducted by the Picker Institute on behalf of EMAS. Picker also administered the survey for 5 other ambulance services enabling us to have some comparative data ahead of the Department of Health report which details results from other parts of the NHS.

Our response rate for 2015 was 25.4%. The average response rate for the 5 other Ambulance Trusts was 34.6%. The response rate was disappointing given the efforts by the Organisation Development and Communications teams to publicise the survey in a positive way.

Over 77% of the 745 EMAS responses in this year's survey were from frontline staff (including Emergency Operations Centre and Patient Transport Service).

How do we compare to other services?

A comparison could be drawn between EMAS and the average for all 'Picker' Ambulance Trusts on a total of 60 questions. The survey showed that EMAS is:

- Significantly better than average on 19 questions.
- Significantly worse than average on 7 questions.
- The scores were average on 40 questions.

Have we improved since the 2014 survey?

A total of 60 questions were used in both the 2014 and 2015 surveys. Compared to the 2014 survey, EMAS is:

- Significantly better on 18 questions.
- Significantly worse on 2 questions.
- The scores show no significant difference on 40 questions.

Overall the results are positive and the majority of staff look forward to going to work (figure 1), are enthusiastic about their job and are of the view that time passes quickly when they are working (figure 2). Immediate managers are demonstrating more supportive behaviours (figure) and far more staff feel recognised and supported and work (figure 6).

Figure 1

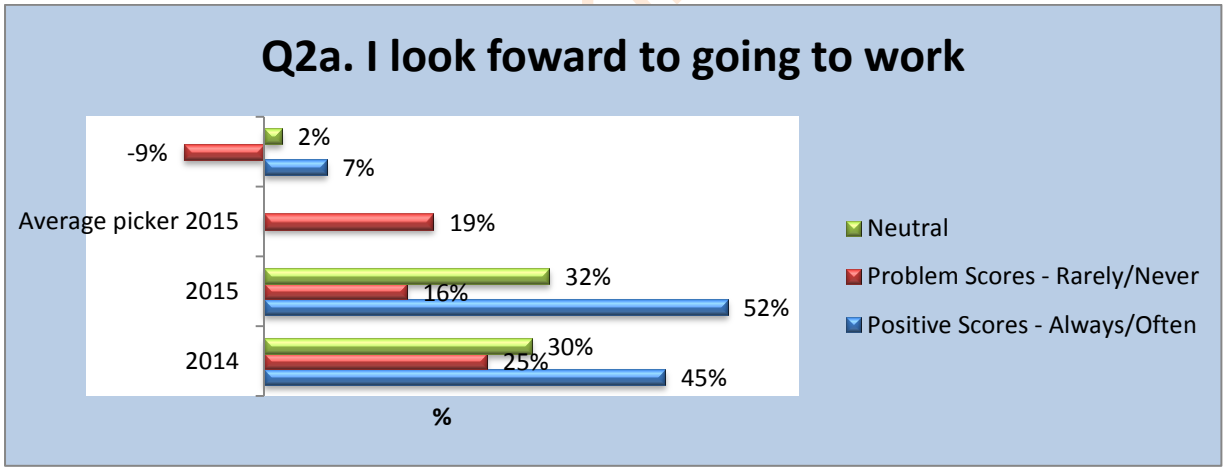


Figure 2

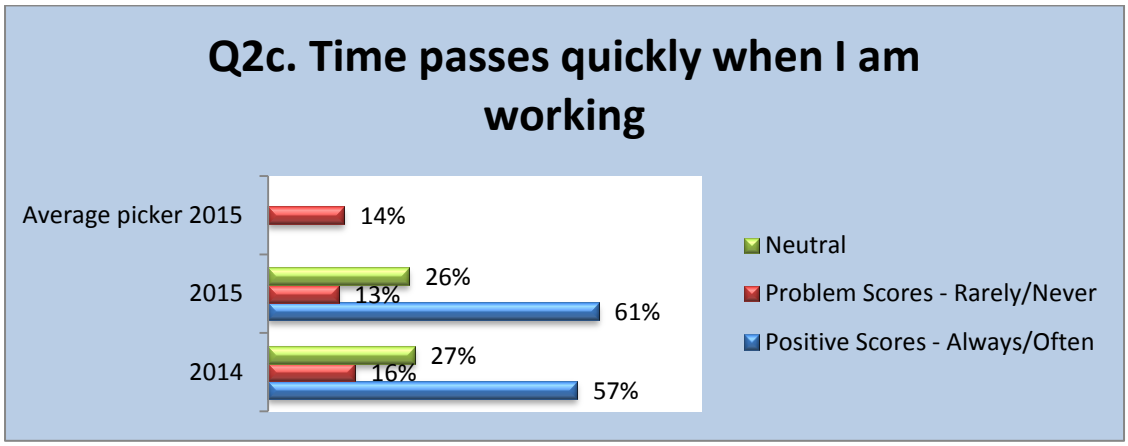


Figure 3

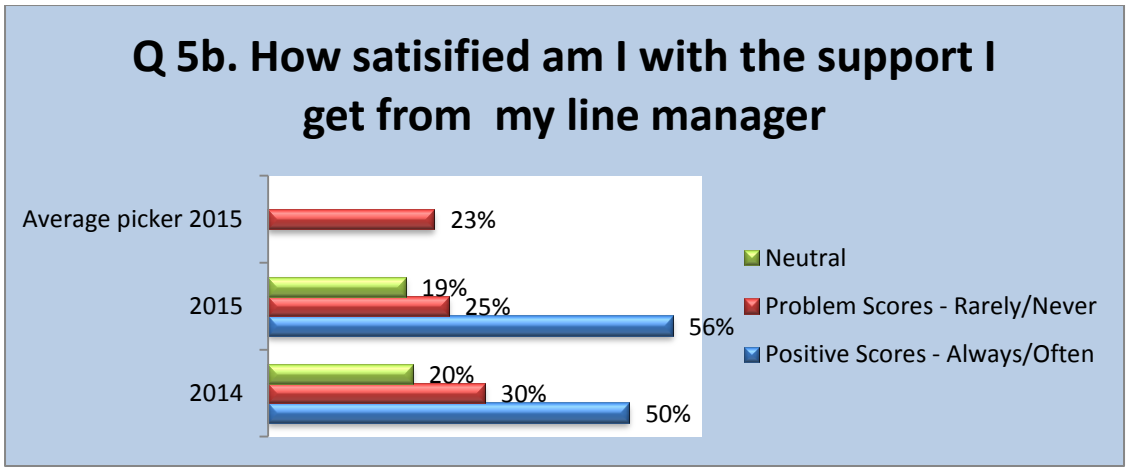
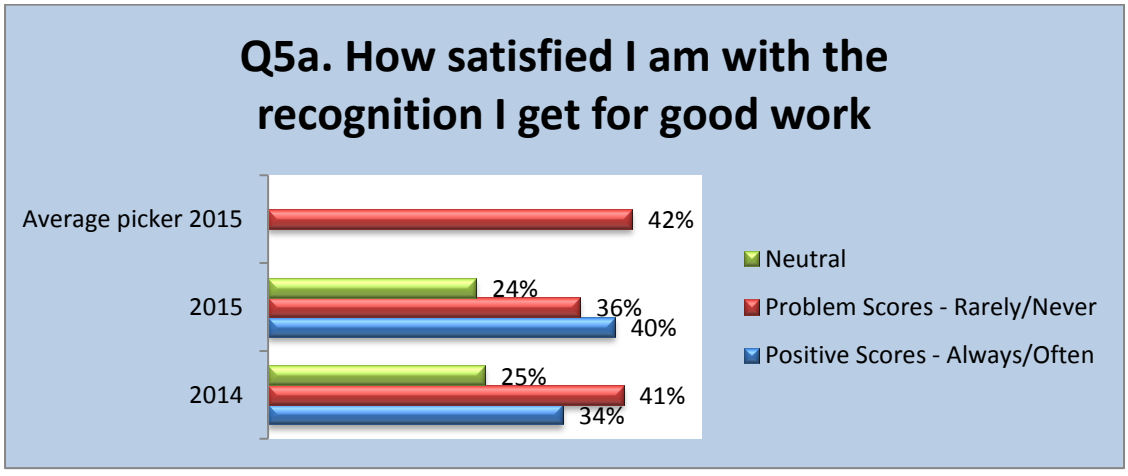


Figure 4



The results provide an indication of the areas for improvement. Amongst those are the 2 that have slipped back since the previous year:

- Staff feeling satisfied with the quality of care they give.
- Appraisal/performance review not adequately addressing development needs.

Additional areas of challenge are also identified in the ratings given for:

- Have you put yourself under pressure to come to work despite not feeling well enough, 94% of respondents saying yes.
- Do you work additional unpaid hours' with 10% of respondents in EMAS reporting on more than 11 hours vs 5% for other Ambulance Trusts. This figure needs further diagnosis with outputs being fed into the trust organisational development plan.

In relation to Equality and Diversity the responses were generally more positive than the previous year, however there is a challenging increase in staff feeling discriminated against on the grounds of age and disability along with a slight increase against sexual orientation. The survey findings have been shared with the Equality and Diversity Manager for further consideration.

The National Survey results are a direct extrapolation of the Picker results discussed above and the areas of strength and challenge are similar and continue the encouraging trends already discussed.

Of particular note is that the national staff engagement score has again increased, despite the well-publicised extreme operational pressures and is likely to have been influenced by the continuing LiA, tea with chief, awards and commendation initiatives as well as the support networks provided by P2P and TRiM. The 2015 engagement score is shown in Graph 5.

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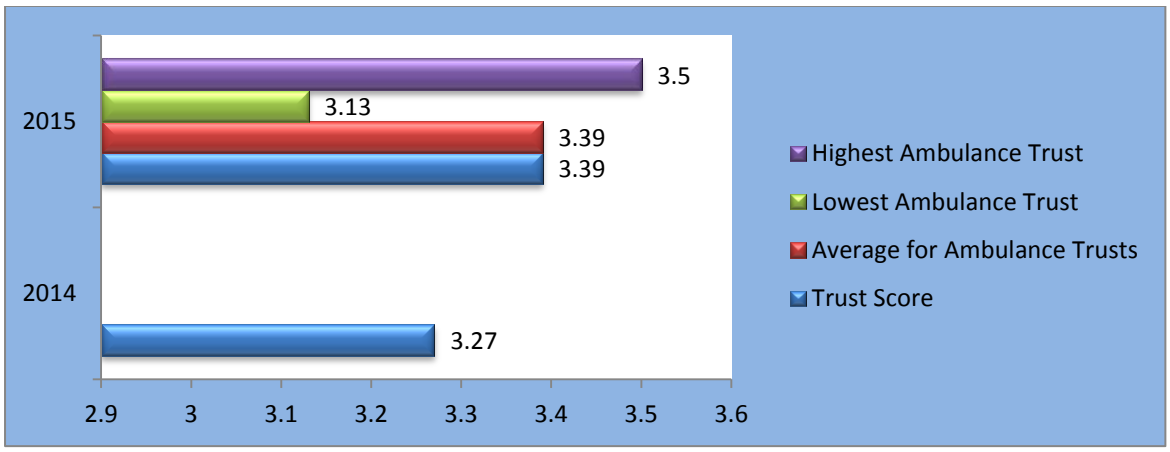
Graph 5



The National Survey also identifies 5 areas where EMAS is stronger than all other Ambulance Trusts amongst which are Percentage of staff reporting errors, near misses or incidents witnessed in the last month and Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month. These indicate that we are witnessing less errors, near misses or incidents and are reporting them more often than the other Trusts. These figures along with the data in Percentage of staff experiencing harassment, bullying or abuse from

patients, relatives or the public in last 12 months and Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months, indicate that our reporting, investigation and prosecution strategy is effective when compared to other Ambulance Trusts. It is noted that there is a worrying trend of violence and harassment towards staff from these groups increasing both locally and nationally.

Summary

There are some key challenges and these will be addressed using targeted plans to address areas of concern. Actions in response to this report will also be incorporated into the EMAS Engagement action plan.

Next Steps

- The survey findings will inform the development of our Organisational Development and Workforce Transformation Plan.
- The Organisational Development and Workforce Transformation Plan will be submitted to the Better Patient Care Transformation Board and Workforce Committee for approval in March 2016.

The Equality and Diversity Manager will review the NHS Staff Opinion Survey findings in line with the Workforce Race Equality Standard to ensure findings inform the Equality and Diversity Action Plan for 2016/2017.

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Appendix 2 – IG Toolkit

Our Information Governance Toolkit assessment overall score for 2015/16 was [to be updated on 31 March when the final submission is made].

The EMAS Head of Information Governance is responsible for collating, checking and uploading evidence to support the Information Governance Toolkit for our service. Assurance on the process to collect the evidence is overseen by the EMAS Information Governance Group, chaired by the Senior Information Risk Owner (SIRO), which is accountable to the Finance and Performance Group.

Requirements within the Information Governance Toolkit were assessed by Internal Audit in February 2016 who were able to provide significant assurance that there is a sound system in place to support Information Governance.

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Appendix 3 – Research and Development

EMAS research status to date for year 2015/2016

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
Epidemiology and outcome from out of hospital cardiac arrest	NIHR Portfolio	Professor Gavin Perkins University of Warwick	British Heart Foundation Resuscitation Council UK	To develop a standardised approach to collecting information about out of hospital cardiac arrest and how outcomes are followed up to confirm if a resuscitation attempt was successful.	This is a national study involving all Ambulance Services in England and Wales. The OHCAO project team are supporting the services to assist with improvements in data capture, quality and quantity. EMAS has continued to provide data for this data-base.	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Preventing repeat hypoglycaemic episodes in people with type 2 diabetes: The hypo ambulance study	NIHR Portfolio	Professor Kamlesh Khunti University of Leicester	NIHR CLAHRC (Collaborations for Leadership in Applied Health Research and Care).	To implement and evaluate the effectiveness of a diabetes specialist nurse (DSN) led intervention following a call out of an ambulance to treat a hypoglycaemic episode.	The EMAS Research team are working alongside the University of Leicester and is about to train paramedics in the study protocol. Patients will be recruited after the end of March.	Expected recruitment: 100
Pre-hospital	NIHR	Professor	NIHR	To develop new ways of	This is a five year programme	None. This

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Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
Outcomes for Evidenced Based Evaluation (PhOEBE): Developing new ways of measuring the impact of Ambulance Service care **Work Package 2 – Data Linkage**	Portfolio	Niroshan Siriwardena University of Lincoln & East Midlands Ambulance Service NHS Trust	Programme Grants for Applied Research.	measuring the impact of Ambulance Service care to support quality improvement through monitoring, auditing and service evaluation.	and is currently in year four. The systematic review on pre-hospital care outcome measures, the consensus study to identify measures relevant to patients and NHS staff, and the qualitative review are complete and in the process of being written up. The data linkage element of the study, linking pre-hospital data with other data sources (e.g., Hospital Episode Statistics and national mortality data) to create a single data set, is in progress.	study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Understand variation in rates of Ambulance Service 'non-conveyance of patients to an emergency department'	NIHR Portfolio	Professor Alicia O'Cathain University of Sheffield	NIHR Health Services and Delivery Research Programme (HS&DR).	This study aims to identify the determinants of variation between and within Ambulance Services for three different types of non-conveyance: 'hear and treat', 'see and treat' and 'see and convey elsewhere'. The study will explore the determinants of potentially inappropriate	This study is now completed.	Expected recruitment: 22

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Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
155				non conveyance for the 3 types. The study will also seek to understand organisational variation in the provision of 'hear and treat' within Ambulance Services and specifically explore the different types of non-conveyance rates for respiratory problems.		
Impact of closing Emergency Departments in England	NIHR Portfolio	Dr Emma Knowles University of Sheffield	NIHR HS&DR	The aim of the study is to establish the implications of closing, or downgrading Emergency Departments on the population and emergency care providers and in doing so provide the public, the NHS and policy makers with the necessary evidence to inform decision making about future Emergency Department closures.	This study is currently in progress	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study
Improving pre-hospital pain management:	Non-portfolio Doctoral Study	Dr Mohammad Iqbal	Internally funded (EMAS)	The study aims to test the reliability and validity of the PROMPT and then to evaluate its effectiveness	The study is in the process of being written up following the analysis the data collected.	Expected recruitment: 77

Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
development and validation of a patient and practitioner reported outcome measure for pain treatment (PROMPT)				in pre-hospital pain management. The study aims to find out how reliable and valid the new tool is for assessing pain in the pre-hospital setting.		
Using National Early Warning Scores to support paramedic decision-making: Modelling and improving effectiveness of pre-hospital ambulance	Non-portfolio Doctoral evaluation study	Nadya Essam	University of Lincoln Research Investment Fund Internally funded (EMAS)	The overarching aim is to investigate the feasibility, usefulness and effectiveness of NEWS to support paramedics' decision-making to transport or treat patients closer to home (i.e. see and treat, see and refer or treat and refer).	The study has completed the first part of the qualitative phase – interviews, focus groups and observations. An application for the quantitative data has been made to the Health and Social Care Information Centre.	Expected recruitment: 22

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Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
transport to hospital						
Pre-hospital Care of Patients After a Suspected Seizure: Incidence, Patient Characteristics Costs	Non-portfolio research	Dr Zahid Asghar	University of Lincoln	The study aims to determine the incidence, patient characteristics and costs of suspected seizure and which clinical factors predict transport to hospital in the pre-hospital (ambulance) setting.	This study is using routinely collected data to quantify the number of emergency incidents dealt with by EMAS in 2011/12. Analysis is currently in progress. Further work will include linking ambulance data to HES data. It is hoped that further collaborative work will inform discussions into the development of ambulance clinical performance indicators for epilepsy.	None. This study does not involve taking consent from patients and therefore is considered a non-recruiting study.
Cluster randomised trial of the clinical and cost effectiveness of the i-gel supraglottic airway device versus tracheal	NIHR Portfolio	Professor Jonathan Benger	NIHR Health Technology Assessment (HTA) Programme	AIRWAYS-2 aims to determine the best approach to the management of a patient's airway during an out of hospital cardiac arrest.	The study began in 2015 and has recruited 767 patients during the year with 317 paramedics involved.	Expected recruitment 1550 (250 paramedics & 1350 patients)

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Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
intubation in the initial airway management of out of hospital cardiac arrest (AIRWAYS-2)						
Rapid Intervention with GTN in Hypertensive Stroke Trial 2(RIGHT 2)	NIHR Portfolio	Professor Philip Bath	British Heart Foundation	The purpose of this study is to determine whether early use of GTN within 4 hours of suspected ultra-acute stroke, and continuing administration once daily for a further three days, is associated with improved outcome.	The study commenced in 2015 and has recruited 27 patients.	Expected recruitment: 150
Understand the implementation, organisation of centralised specialist services: the reconfiguration of major	NIHR Portfolio	Professor Justin Waring	The Health Foundation	The study aims to understand the reconfiguration of major trauma services within the East Midlands region of the English NHS to identify lessons for similar service reconfigurations based on centralisation of specialist services into regional	This project is currently in set up within EMAS. Recruitment to the study is expected to commence in May 2015.	Expected recruitment: 15

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Project	Type	Chief Investigator	Funding Organisation	Overarching study aim	Status	Recruitment
trauma service in the East Midlands				centres.		

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Appendix 4 – CQC registration

During 2014/15 the Care Quality Commission consulted on new inspection arrangements for Ambulance Services.

EMAS was inspected under these new arrangements in October 2015.

We are currently awaiting the CQC's report following the inspection, and confirmation of the date for the CQC Quality Summit.

draft

Appendix 5 – Third Party Statements

Statements to be posted here once received from Health Overview Scrutiny Committees, Healthwatch groups and EMAS members.

draft

Appendix 6 – EMAS Trust Board

The main role of the EMAS Trust Board is to guide the overall strategic direction of our Ambulance Service, to ensure we can meet our current challenges, establish and achieve our objectives and plan effectively for the future.

Our Trust Board has overall corporate responsibility for how EMAS runs.

Our Trust Board is led by our Chairman and comprises of Executive and Non-Executive Directors.

Executive Directors are responsible for managing our affairs on a day-to-day basis, while Non-Executive Directors provide essential balance with their skills and expertise in the public and private business sectors to complement those of our Executive Directors.

Chairman
Pauline Tagg

Non-Executive Directors
Stuart Dawkins, Rachel Morrison, Karen Tomlinson, Vijay Sharma and William Pope

Chief Executive
Sue Noyes

Director of Operations
Richard Henderson

Medical Director
Bob Winter

Director of Nursing & Quality
Judith Douglas

Acting Director of People
Kerry Gulliver

Director of Finance
Richard Wheeler

Director of Information and Performance
Will Legge

draft

Director's responsibilities in respect of the Quality Account

The EMAS Trust Board has been involved in identifying the quality indicators, agreeing the content and endorsing the content of this Quality Account. We have developed our quality priorities and indicators in conjunction with our stakeholders and our staff. Non-Executive Directors continue to play a pivotal role in providing challenge and scrutiny, assessing our performance and contributing to our future strategy.

Statement of Directors' responsibilities in respect of the quality account

NHS Trusts are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements). In preparing our Quality Account, the Trust Board has ensured that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with Department of Health guidance.

draft

The Directors of the Trust Board confirm to the best of their knowledge and belief that they have complied with these requirements in preparing this Quality Account. This has been confirmed through a resolution of the Trust Board.

The Core Quality Account Indicators

Performance standards

During 2015/16, we received XXXX,XXX emergency 999 and urgent calls. Our accident and emergency crews responded to XXX,XXX of these calls, which equates to ,XXXX face to face responses every day. Of these, XXX,XXX were Red (serious, life threatening) calls.

There are two national performance standards for Red calls. The first requires us to respond to at least 75% of incidents in eight minutes or less, the second requires us to provide a support vehicle within 19 minutes or less for 95% of calls.

During 2014/2015, we achieved a response rate of XX.XX% Red 1 and XX.XX% Red 2 (response within eight minutes) and XX.XX% (support vehicle within 19 minutes) across the East Midlands – see the at-a-glance guide to our response to 999 calls on the back cover of this account.

The performance standards hit for each division of EMAS during 2015/16 is as follows:

	Red 1	Red 2	A19
Derbyshire	%	%	%
Nottinghamshire	%	%	%
Lincolnshire	%	%	%
Leicestershire & Rutland	%	%	%
Northamptonshire	%	%	%

We accept that more work needs to be done in 2016/17 to achieve both the 75% and 95% standards.

Clinical Quality Indicators

On 1 April 2011, the Department of Health introduced new national targets for Ambulance Services, including 11 new Clinical Quality Indicators introduced for non-life threatening calls.

This means we are measured on how we treat patients and the outcomes of any treatment rather than just timeliness. By monitoring performance in this way, we are able to identify good practice and any areas which need improvement. Examples of the quality measures are:

- outcome following a heart attack or stroke
- proportion of calls dealt with by telephone advice or managed without transport to A&E (where clinically appropriate)

You can read more about Clinical Quality Indicators in the Clinical Audit section of this Account.

Glossary

A&E
Accident and Emergency, also referred to as A&E, is a hospital or primary care department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. Also referred to as ED or Emergency Department.

AMPDS
Advanced Medical Priority Dispatch System is a medically-approved, unified system used by EMAS to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.

Audit
A continuous process of assessment, evaluation and adjustment.

BPC
Better Patient Care – EMAS Quality Improvement Programme

Board
EMAS Trust Board of Directors made up of Executive and Non-Executive members responsible for all that EMAS does.

Clinical Commissioning Group (CCG)
Clinical commissioning groups (CCGs) are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England.

Commissioners
NHS organisations that effectively purchase services from EMAS, based on the identified health needs of their local population. NHS Erewash Clinical Commissioning Group is the 'lead commissioner' for EMAS. That is, they (on behalf of all the Clinical Commissioning Groups in our area) negotiate what level of income EMAS will receive – and, alongside this, what quality measures we are expected to achieve as set out in our service level agreement.

CPI
Clinical Performance Indicator is a way to measure quality.

CQC
The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the interests of people detained under the Mental Health Act.

CQI
Clinical Quality Indicators, a set of 11 indicators introduced to the Ambulance Service by the Government from 1 April 2011 as measures of clinical quality.

CQUIN

Commissioning for Quality and Innovation, known as CQUIN, is a payment framework that makes a proportion of NHS service providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for all of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere.

DIVISON/S
Operational areas with autonomy to make decisions about the provision of local services under the umbrella of EMAS' corporate vision, goals and objectives. Our divisions are aligned to the counties we serve (see below)

ECA
Emergency Care Assistants respond to emergency calls as part of an accident and emergency crew or at times as a first responder, using skills and procedures that they have been trained and directed to do.

ECP
The role of Emergency Care Practitioners utilises the skills of paramedics and other professionals (such as specialist nurses with additional skills) to support the first contact needs of patients in unscheduled care. They are employed primarily by Ambulance Services.

ED
Emergency Department is a hospital or primary care department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. Also referred to as Accident and Emergency or A&E.

EMAS
East Midlands Ambulance Service, also referred to as EMAS, is part of the NHS and provides emergency and urgent for the six counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. Patient Transport Services are provided in North and North East Lincolnshire and parts of Nottinghamshire.

EMICS
East Midlands Immediate Care Scheme is made up of a group of volunteer doctors who assist the Ambulance Service on emergency call-outs.

EOC
Emergency Operations Centre (control) at East Midlands Ambulance Service. One based in Nottingham and one based in Lincoln. These centres receive the emergency and urgent 999 calls and dispatch ambulance crews to them or give 'hear and treat' advice via the Clinical Assessment Team (paramedics and nurses who work in the control centre).

HCPC
Health and Care Professions Council – A UK health regulator. It was created by the Health Professions Order 2001 to protect the public by setting and maintaining standards for the professions it regulates.

IPC
Infection Prevention and Control provides specialist infection prevention and control support and advice for all clinical and support services.

IG
Information Governance is the way by which the NHS handles all organisational information, in particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

JRCALC
Joint Royal Colleges Ambulance Liaison Committee - its role is to provide robust clinical speciality advice to UK Ambulance Services and other interested groups

LiA
Listening into Action staff engagement programme

NHS
National Health Service. Established in 1948 to provide free state primary medical services throughout the United Kingdom.

NICE
National Institute for Health and Clinical Excellence. The health technology assessment body in the UK providing guidance to clinicians relating to authorised treatments, devices, diagnostics and techniques.

NHS Institute for Innovation and Improvement
Supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership.

PALS
Patient Advice and Liaison Service – offers confidential help, advice, support and information and are responsible for any compliments and complaints.

ROSC
Return of Spontaneous Circulation. Following a period when the heart stops, providing life support is aimed at restoring the body's circulation.

SBAR
Situation, Background, Assessment, Recommendation. A structured communication tool used to share clinical information.

SI
Serious Incident

STEMI
ST Elevation Myocardial Infarction is a heart attack.

draft

Our Quality Account

2015/16

We welcome your comments about our Quality Account.

Please contact us using the details below:

East Midlands Ambulance Service NHS Trust
Trust Headquarters
1 Horizon Place
Mellors Way
Nottingham Business Park
Nottingham, NG8 6PY

Call	0115 884 5000
Email	communications@emas.nhs.uk
Visit	www.emas.nhs.uk
Follow us on Twitter:	@EMASNHSTrust

To receive this information in large print, audio or in another language, please call us on 0115 884 5807

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Report No. 69-2016

Report to Rutland Health and Wellbeing Board

Subject:	**Health & Wellbeing Board Development and Priorities**
Meeting Date:	**22nd March 2016**
Report Author:	**Karen Kibblewhite**
Presented by:	**Karen Kibblewhite**
Paper for:	**Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

Strategic Objective

Meeting the health and wellbeing needs of the community

1. The Role of Health and Wellbeing Boards

1.1 Health and Wellbeing Boards were introduced in 2011 as statutory bodies with democratic accountability to lead and direct work to improve the health and wellbeing of the local population. The main functions of the health and wellbeing boards are:

i. to assess the needs of their local population through the joint strategic needs assessment (JSNA) process;
ii. to produce a local health and wellbeing strategy as the overarching framework within which commissioning plans are developed for health services, social care, public health and other services which the board agrees are relevant;
iii. to promote greater integration and partnership, including joint commissioning, integrated provision, and pooled budgets where appropriate.

2. Existing Priorities within the Joint Health & Wellbeing Strategy

2.1 The existing Rutland Joint Health and Wellbeing Strategy, developed four years ago identified 3 themes, within which there were a number of priorities:

Theme 1: Giving children & young people the best possible start
Priorities: i) Vulnerable Families;
ii) Vulnerable Teenagers;
iii) Emotional health and wellbeing of children, young people and their families.

Theme 2: Enable people to take responsibility for their own health
Priorities: i) Obesity;
ii) Smoking;
iii) Alcohol.

Theme 3: Help people live the longest healthiest life they can

Priorities: i) Frail elderly;
ii) Dementia
iii) Cancer
iv) Depression and anxiety
v) Wider determinants of health

2.2 The Strategy pre-dates both Better Care Together and Better Care Fund and the focus on Health and Social Care Integration.

3. Potential Priorities

3.1 There are three key drivers for health and wellbeing work in Rutland currently:
- Health and social care integration
- Better Care Together (BCT)
- Better Care Fund (BCF)

3.2 In addition the new requirement of Sustainability and Transformation Plans (STP) within the NHS planning guidance for 2016/17 requires five year plans to be developed by health and care partners by summer 2016. The agreement is that the footprint of this plan local plan will mirror BCT, that is cover Leicester, Leicestershire and Rutland, and that the BCT Programme Office will coordinate the plan's production. The STP will be wider than the 9 current workstreams of BCT.

3.3 The JSNA Overview also identified several additional areas for focus some of which are already included within the BCF and/or BCT workstreams:
1) Planning care for an ageing population
2) Dementia
3) Carers
4) Obesity
5) Children's oral health
6) Factors affecting access to information and advice, including access to preventative services.

3.4 It is suggested therefore that the HWB focuses on the following two areas on which it can have a real impact:

1) Helping people to manage their own primary and secondary prevention
2) Extending healthy life expectancy

3.5 In addition, partners are asked to suggest other priority areas for discussion and agreement. Appendix A contains the latest Public Health Outcome Framework data to support this discussion, along with the recommendations for the Director of Public Health Annual Report.

4. Moving Forward

4.1 Reviews of HWBs by the LGA and Kings Fund have noted that those Boards which have greatest impact are those with a clear sense of purpose about their outcomes. They have:

- a dynamic view of the needs of the local population

- a clear joint health and wellbeing strategy
- focus on a small number of relatively high-impact changes

4.2 Success factors of high-functioning HWBs include:

- investing time in building relationships
- being flexible
- clarity on the role of stakeholders

Further information from the LGA/Kings Find reviews is in Appendix B.

4.3 The HWB also has a role in challenging partners to ensure that they are working towards these priorities and reviewing their individual work and priorities within this wider context, and understanding system wide impacts of individual service or provider performance.

4.4 Key Questions for Discussion

- How can we ensure system leadership with collective responsibility for *local* outcomes?
- Are we future planning based on clear evidence of need? How can we improve this?
- Do we effectively join up the CCG and Council priorities, commissioning and decision-making, driving the agenda for BCT and BCF accordingly?
- Do we have the right balance between addressing local needs and the wider determinants of health, and the BCT - and in future - the STP drivers?
- Do we lead the discussions on system redesign, involving the key partners in identifying opportunities, reducing costs and ensuring effective care pathways? Do we understand the implications for Rutland where these discussions are on an LLR footprint?
- How can we monitor and support the health messages and impact across the widest possible system in Rutland, ensuring links to housing, leisure and wider quality of life services?

Financial implications:

There are no specific implications of identifying priorities themselves, although there may be financial implications attached to specific pieces of work.

Recommendations:

That the Board:

- Discuss the key questions and consider how the HWB is meeting Rutland's needs and priorities for focus and development.

Strategic Lead:	Karen Kibblewhite

Risk assessment:

Time	L	The discussion will support appropriate work planning and is in line with good practice recommendations for high performing Health & Wellbeing Boards.
Viability	L	Once priorities have been identified, they will be woven through existing work and plans.
Finance	L	There are no additional financial implications of identifying the development needs of the HWB and priorities themselves.
Profile	M	The development and priorities identified will drive the Health and Wellbeing Board's work and will be public-facing.
Equality & Diversity	L	Full Equality Impact Assessments will be completed for individual pieces of work.

Appendix A – Public Health Data & Recommendations

1. Public Health Outcomes Framework (PHOF) Data

The report is embedded here:

Rutland_PHOF_updates_February_2016.pdf

Data on the PHOF for Rutland can be accessed at:

http://www.phoutcomes.info/

2. Director of Public Health Annual Report Recommendations

The recommendations for the current DPH Annual Report:

1. That future programmes focus on extending **healthy life expectancy** (the number of years lived in good health) and closing the gap by targeting specific groups with worse health. This should include routine and manual workers, service families, children living in poverty and older people in greater need.

2. The development of community prevention and wellness services provides a good opportunity to measure benefits and impact of services based on a model of building community capacity and resilience to improve health and wellbeing. Mechanisms for evaluating the effectiveness of these services in achieving this should be built in to the service design from the start.

3. Cross agency working and partnerships are extended to more fully involve local people and communities as the next step to increase and improve **community engagement in planning.**

4. **Co-production models** (where service users work jointly with professionals to design and deliver services) are trialled for several projects in Rutland with the aim of developing more suitable services and reducing exclusion.

5. The Council uses a **Health Impact Assessment (HIA)/ Health in All Policies** approach to support local communities in influencing **major** developments and policies. HIA's can facilitate active engagement of local communities in the assessment process and enable consideration of the health impacts of proposals from a range of perspectives so that positive impacts can be increased, negative impacts identified and ways to mitigate these considered.

6. It is made easier for people to find out what services are on offer locally to support health and wellbeing, through better coordination and communication of prevention activities within Rutland.

Appendix B – LGA and Kings Fund Reviews of Health & Wellbeing Boards

The LGA has produced a number of reports to support Health & Wellbeing Boards. This appendix draws out some of the key points from their guidance.

The LGA note that HWBs should embody the principles of prevention, personalisation, choice and integrated services to inform commissioning of health and care.

What a good HWB looks like

Among the essential characteristics of effective HWBs are:

Shared Leadership

- an equal partnership of local commissioners with mutual recognition of the skills that each partner brings to the table
- a willingness to move away from institutional cultures and ways of doing business towards a common understanding of what matters
- bringing together a wide range of local and national agencies to make a demonstrable impact on outcomes
- designing and delivering services that take account of the wider determinants of health
- recognition of the crucial role of providers in identifying solutions to local health challenges.

A strategic approach

- shared ownership of a strategic approach to joined-up commissioning
- focusing on a manageably small number of local priorities that will have maximum impact on health outcomes
- designing services which are population- orientated, co-designed, person-centred, addressing inequality and disadvantage, and based on evidence
- focusing on services which are integrated, accessible, innovative, safe and of high quality
- working at a pace and scale that makes sense locally, for example, building on existing community provision and conforming with local planning priorities for the area.

Engaging with communities

- working with local communities in developing a vision and strategies for service design and redesign
- being jointly accountable to local residents.

Collaborative ways of working

- openness and transparency in the way they operate
- pooling and sharing risks as well as budgets where mutually agreed
- sharing data and intelligence
- having good working relationships with service providers
- making and encouraging the best possible use of new technologies
- sharing information to monitor progress and measure impact.

The reports from which the above are taken can be found at:

http://www.local.gov.uk/documents/10180/6869714/L15-254+Making+it+better+together+-+A+call+to+action+on+the+future+of+health+and+wellbeing+boards/311885a4-5597-4007-8069-46bc2732d6a2

http://www.local.gov.uk/documents/10180/7632544/L16-5+HWBs+engaging+effectively+with+providers/5faeded5-feb8-4af9-86a6-b0dc4cb5ef9b)

Report No. 70/2016

Report to Rutland Health and Wellbeing Board

Subject:	**Transforming Care**
Meeting Date:	**22nd March 2016**
Report Author:	**Yasmin Surti**
Presented by:	**Sandy McMillan & Yasmin Surti**
Paper for:	**Note/Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

Background

1. In October 2015 NHS England, ADASS and the LGA published a Transforming Care national implementation plan and associated service model "Building the Right Support".

2. The plan outlines three key expectations from Commissioners; implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

3. The national plan described the expectation of the development of area Transforming Care Partnerships. Each partnership is to consist of CCGs, NHS England's specialised commissioners and local authorities, and will cover the whole of England. Leicestershire has been aligned as a TCP with Leicester and Rutland.

4. To support local areas with transitional costs, NHS England will make available up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners. In addition to this, £15 million capital funding will be made available over three years. Transformational funding will be awarded based on a bidding process.

5. The Transforming Care Partnership was formally agreed as a function of the BCT LD work stream in December 2015. Sandy McMillan, Assistant Director (Leicestershire County Council) has been identified as the Senior Responsible Officer (SRO) to lead this area of transformation, along with Jim Bosworth, Assistant Director (East Leicestershire and Rutland CCG) who has been identified as the Deputy SRO.

Current Situation

6. The Joint Transformation planning template, the Route map and Finance template were submitted to NHSE on the 8th February and 14th March 2016.

7. Key outcomes of the plan are:
    - Strengthen community crisis response services and reduce use of commissioned inpatient beds;

- Increase community based accommodation;
- Develop personal health budgets and integrated budget offer;
- Redesign Short break provision;
- Strengthen the Autism pathway;
- Develop the workforce.

8. The national plan outlined key planning assumptions including the expectation that no area should need more inpatient capacity than is necessary to cater for:

    - 10-15 inpatients in CCG commissioned beds (such as those in assessment and treatment units) per million population;
    - 20-25 inpatients in NHS England-commissioned beds (such as those in low, medium or high-secure units) per million population.

    .

9. As of 20th January 2016 the number of CCG commissioned inpatient facilities exceeded the upper planning assumption at 26 beds per million adult population taking into consideration inpatients in LD specialist and MH specialist provision.

10. Specialised Commissioning inpatient beds are within the expected range.

11. A total of £1.2 million has been requested from the national TC programme to support the implementation of the plan with the three key financial priorities being the recruitment of a PMO for the Transforming Care plan, a Transforming Care coordinator whose role will be to case track and manage those in the LLR TC cohort and a whole age Positive Behavioural Support Planning Resource for LD and Autism

12. Plans will aim to reduce the CCG commissioned inpatient beds from the current level of 26 to 12 beds by March 2019.

    a) To support this, work has already begun to strengthen community based admission avoidance services and to target Care and Treatment Review (CTR's) for both inpatients and those deemed at risk of admission.

    b) Assuming some local transformation funding it is proposed the following key staff are recruited to ensure plan delivery:

        - A senior project manager to co-ordinate delivery.
        - A care co-coordinator with responsibility to support discharge back to local provision from independent hospital and specialised commissioning placements.

13. Final submission of the plan is due on the 11th April 2016.

Health and Wellbeing Strategy

14. The Transforming Care Plan links directly to Theme Priority 4. Making Health and Social Care Services more Accessible - Hospital Discharges:
    - People may stay in hospital longer than is medically required
    - Avoidance of hospital admissions

Financial implications:

1. NHSE has indicated it up to £30 million of transformation funding over three years, with national funding conditional on match-funding from local commissioners. In addition £15 million capital funding will be made available.

2. NHSE have recently released a Finance FAQ. Key points to note are:

    a. This is live guidance subject to change & whilst it provides some clarification on financial underpinning it also raises some questions.

    b. Further clarification is needed on how NHS England specialised commissioning budgets will be aligned to local partnerships

    c. It indicates access to transformation funds will be on a bid basis so no guarantee all areas get some. This poses a risk to local delivery of the plan.

    d. It appears to leave to local discretion level of NHS dowries payment for patients discharged after 5 years in hospital.

3. LLR TC investment consists of:

    - Enhancement of the LD Outreach team: £398,000 per annum.
    - LD Implementation manager supporting the TCP across 3 CCG's:£40,500 per annum.
    - LD Support Officer for Assuring Transformation Data collection and coordination of CTRs: £27,000 per annum.
    - Post diagnostic support service for people with Autism with an intellectual disability: £400,000 (business case submitted, terms and conditions not agreed).

Recommendations:

That the Health and Wellbeing Board:

1. Note the work undertaken to develop the TC plan.
2. Note the update on the financial implications.
3. Make comments to inform future iterations of the plan.
4. Delegate authorisation to the Transforming Care Partnership to submit the final plan on the 11th April, subject to approval from respective governing bodies.

Comments from the board: (delete as necessary)

Strategic Lead:		
Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	
Timeline:		

Task	Target Date	Responsibility

Joint transformation planning template- Leicester, Leicestershire and Rutland (LLR)

1. Mobilise communities

Governance and stakeholder arrangements

Describe the health and care economy covered by the plan

PROVIDER MARKET:
Social care:
Social Care commissions a range of independent and voluntary sector providers through block contract and Framework agreements. These include residential care, supported living, day time activities and more enabling services such as employment and volunteering services for people with learning disabilities and or autism. An increasing number of services/providers are commissioned directly by individuals and or their families through the use of direct payments.

Healthcare :
The majority of LLR healthcare services are provided by NHS Leicestershire Partnership Trust (LPT) including through block contract arrangements**:**

- Primary care Liaison Nurses
- Community Learning Disability Teams
- LD Outreach Team (Adults)
- Learning Disabilities Service for Families, Young People and Children (CAMHS LD Team)
- Autism assessment and support services
- Agnes Assessment and Treatment Unit
- Health residential Short-breaks provision
- Liaison and Diversion services (L&D)
- Forensic Mental Health Services
- Community, rehabilitation and inpatient mental Health services

Inpatient services:

NHS provision:
Children & Young people – LPT provide a NHS England funded (Tier 4) inpatient unit at Coalville hospital which admits up to 10 children and young people between the ages of 11 - 18 who have mental health issues. This includes support for those with a Learning Disability associated with mental health. Young people from LLR may be placed there or at another unit across the Midlands and East region. There are no specialist units in the region for young people with eating disorders or requiring a Psychiatric Intensive Care Unit (PICU).

Adults - LPT provides the main geographical facility called the Agnes Unit. This unit has 20 beds but only 16 are currently commissioned- four individual pods each with four en-suite bedrooms. 8 beds are people who need longer term support and who are either on the forensic care pathway or have been repatriated to Leicester from out-of-county placements. The other 8 beds are for patients who need shorter term admission for assessment and treatment. This is either planned or as an emergency due to crisis situations that may arise in the community. There will also at any one point be undiagnosed people with autism within the LPT main acute mental health Bradgate Unit.

Independent sector:
There are no specific adult independent sector LD inpatient facilities in LLR geographical area. There was a former Castlebeck Learning Disabilities inpatient facility in Melton Mowbray called Croxton Lodge (and

was little used by local commissioners in its previous role). However this site is now owned by Partnerships in Care and is now an acquired Brain Injury facility.

In relation to Mental Health, a private provider (Inmind) run Sturdee Community Hospital based on the southern outskirts of the city. This is a 38 service providing inpatient recovery based treatments to male and female service users who suffer with complex mental health needs. The hospital comprises of locked rehabilitation bed and semi-independent apartments. There is currently one locally funded placement for an individual with Autism at this unit.

Where treatment and rehabilitation needs cannot be met by NHS Leicestershire Partnership Trust, some placements are made in regional and national facilities run by providers such as Cambian Healthcare and St. Andrews. These are classed as 'Alternative Hospital Placements (AHPs)

Rehabilitation services
Apart from the Agnes Unit, LPT have 2 mental health inpatient rehabilitation units (Willows and Stewart House) which provide support to people with Autism and learning disabilities where the primary need is Mental Health. There are currently 2 local placements for individuals with autism and mental health needs.

'Step Through' supported living
A Grant from the Department of Health to support Transforming Care has been used to develop a step through provision in the community and secure properties to provide long term tenancies. Working with Affinity Trust 2 flats have been developed to provide short term tenancies with comprehensive, person centred support for people who are either at risk of being admitted to an inpatient setting following a breakdown in accommodation, are clinically fit for discharge and would benefit from a transitional period to support discharge or would benefit from a short period of intensive support away from their long term accommodation.

Acute Hospital liaison workers
Three nurses are employed by the main acute hospital (UHL) to provide support and advice on good practice to staff, young people and adults with mild to profound learning disabilities (this will include prisoners with learning disabilities who are accessing UHL hospitals) and/or their families whilst the person is an inpatient or out patient at UHL's three hospital sites

COMMISSIONING ARRANGEMENTS:
Adults
The three CCG's collaboratively commission community and inpatient Learning disabilities healthcare services from both Leicestershire Partnership Trust and University Hospitals Leicester.

Arden and GEM Commissioning Support Unit are commissioning by CCG's to manage the eligibility framework for CHC, S117 and AHP and case management of patients eligible for 100% healthcare funding.

The 3 CCG's are part of a regional collaborative commissioning framework for the provision of locked and unlocked mental health and learning disabilities rehabilitation services. LPT is the only provider from Leicestershire on this framework

In 2014 the Better Care Together (BCT) Learning Disabilities programme was developed. BCT is a significant programme of work which will transform the health and social care system in LLR by 2019. This work stream was developed as a direct response to expectations of the Winterbourne Action Plan and Transforming care Programme.

The development of Personal Health Budgets (PHB's) is being undertaken jointly by the 3 CCG's in collaboration with local Councils. East Leicestershire and Rutland CCG host a PHB Team.

Leicestershire County Council, Rutland County Council, WLCCG and ELRCCG have pooled budgets arrangements for the commissioning of packages of care, with Social care leading on Case management or those who are either joint funded or 100% social care funded. 100% health funded cases are managed through the local are CSU.

Leicester City CCG and Leicester City Council do not currently have any pooled arrangements but are exploring options to minimise discharge delays related to determination of health and social care funding eligibility. A memorandum of understanding is in development that will underpin any current and future joint commissioning processes and arrangements.

The finance work stream has been tasked to support this work by scoping the likely effects financially, including the shifts from specialist to each CCG and secondary to each LA and a detailed risk assessment and advice on how we will consider either pool or co-manage budgets.

We have jointly developed a Leicester, Leicestershire and Rutland Autism Strategy 2014 to 2019.

WHAT ARE KEY COMMISSIONING BLOCKS?

- Majority of existing healthcare provision by local NHS Trust (LPT) is currently block funded, meaning development of more flexible commissioning arrangements will require some double funding during transformation periods.
- A high cost and inflexible PFI on local Assessment and Treatment which is a significant financial implication on redesigning services.
- Historical intuitional approaches to services for patients and carers including dominance of Health and county building based short breaks services.
- Separate approved provider framework models in health and Social care making market management and driving up quality more difficult.
- Underdeveloped provider market for people with high levels of challenging or risky behaviour.
- Separate NHS England and CCG commissioning arrangements can cause delays in stepping down individuals from low secure inpatients facilities.
- Current arrangements to determine CHC and social care funding eligibility can cause delays in discharge.

Describe governance arrangements for this transformation programme

The Transforming Care partnership footprint replicates an existing partnership Better Care Together (BCT) programme developed in 2014. BCT is a significant programme of work which will transform the health and social care system in LLR by 2019

Key partners

CCGs:
Leicester City CCG
East Leicestershire and Rutland CCG
West Leicestershire CCG

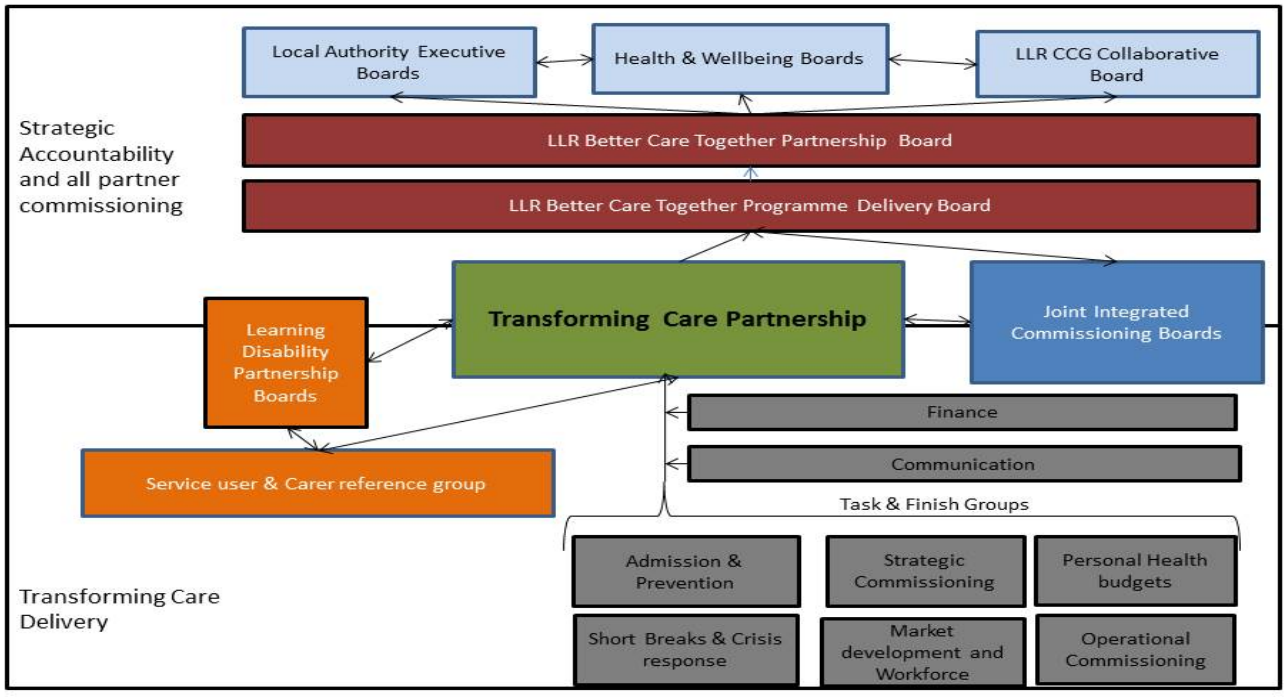
Councils:
Leicester City Council
Leicestershire County Council
Rutland County Council

NHS England:
Specialised commissioning

CSU:
Arden/ GEM Commissioning Support Unit

Service user and Carers representatives

LLR Transforming Care Governance Chart



MEMBERSHIP
It is envisaged membership of the Transforming Care Partnership Board will evolve as the programme develops, however core membership will include from:

- People with Learning Disabilities and/or Autism and carers* (see note below)

- Family Carer
- The 3 Local Authorities (adults and children)
- The 3 Clinical Commissioning Groups (adults and children)
- Leicestershire Partnership NHS Trust
- University Hospitals of Leicester NHS Trust
- Leicestershire Constabulary
- Health Education East Midlands
- NHS Specialised Commissioning
- NHSE Transforming Care
- Any other groups or individuals identified by the Board

*There will be a direct mechanism to ensure co-production and full engagement with People with Learning Disabilities and/or Autism through the Service User and Carer Reference Group. There will also be a place for a family carer representative to sit on the board.

The Transforming Care Partnership Board and the Service User and Carer Reference Group will regularly attend the 3 Learning Disability Partnership Boards and other forums/events to ensure engagement with the wider service user and carer population.

The primary purpose of the Transforming Care Partnership Board is to:

- Provide a partnership approach and oversight for the delivery of the local Transforming Care Programme to radically transform care for people with learning disabilities and/or autism who display behaviours that challenge across LLR;
- Build on the work already being undertaken locally through Better Care Together to reduce the focus of care from bed based care to community care;
- Lead and manage the successful implementation of the new model of care by March 2019 which focuses on simplifying the system and enhancing support to people in the community in order to prevent hospital admissions;
- Report to NHS England, Scrutiny and Health and Well Being Boards on progress on the delivery of the Transforming Care agenda;
- Ensure that the outcomes of the programme are delivered and evaluated;
- Provide a partnership approach to the programme and to provide a route for escalation of issues and risks in relation to the delivery of the programme.

The TCP Board is aligned to the Mental Health Better Care Together Work stream and will also work very closely with the LLR Children's and Young People Better Care Together work stream to ensure their plans support the Transforming care agenda with a view to achieving the following outcomes:

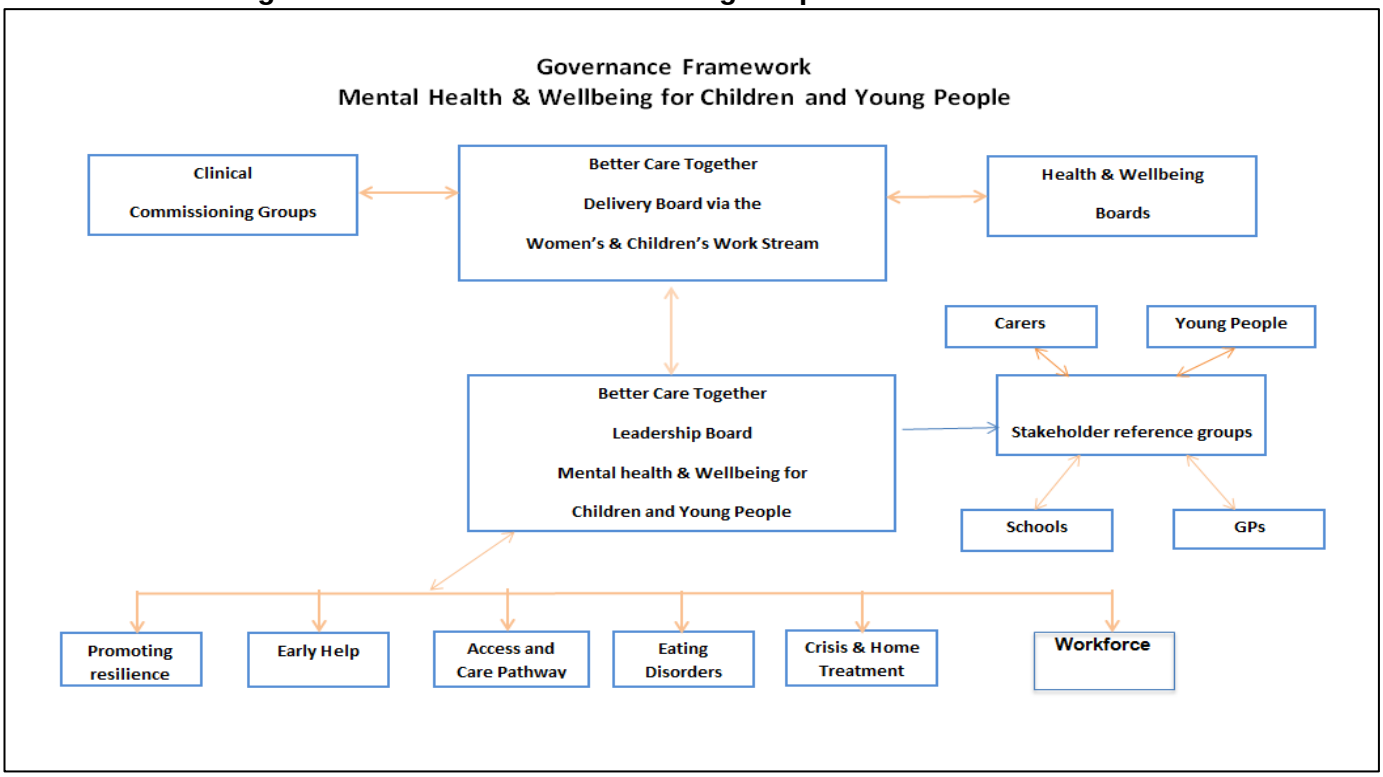
- Improved health and wellbeing for children supported into adulthood
- Improved life expectancy throughout their lives for the children we support
- Integrated working across secondary , primary and community to reduce duplication of structure and maximise productivity
- Age appropriate service across LLR
- More children and young people who have coordinated care.

To do this we will:

- Review what CAMHS capacity is required
- Develop options to facilitate greater integrated working between all sectors
- Develop a strategy around optimising children's life changes through public health interventions,

Health and Wellbeing

Governance Arrangements for Children's and Young People



Describe stakeholder engagement arrangements

Adults

The TCP plans align with the Better Care Together Plans for Learning Disabilities and Mental Health in LLR as a result of which people with lived experience specifically have been engaged in influencing and agreeing local planning on this agenda since August 2014 through:

- The Better Care Together Learning Disability Service User and Carer Reference Group.
- We Think – self advocate group
- The Partnership Board Carers Group

These include individuals who previously lived in an NHS setting and family carers who have experience of supporting a loved one with learning disabilities, autism and mental health who may also display behaviours that challenge.

In addition to this the implementation lead, supported by members of the reference group regularly attends the Learning Disability Partnership Boards, The LLR Autism Partnership Board and other forums/events to provide updates on progress and to ensure an ongoing opportunity to input and influence local planning. A family carer has been an active member of the Better Care LD Steering Group since 2014, an arrangement that will continue under the auspices of TCP.

Public engagement has been to be through a series of events, social media activity and newsletters under the existing Better Care Together structures that have been in place since 2014.

As with public engagement, there is an existing mechanism of engagement with both adults and children's providers and commissioners of services that support people with learning disabilities and family carers. A

series of clinical summits, co designed and delivered with people with lived experience family carer were held in the autumn of 2015 to enable any staff member of any of these organisations to learn more about the plans ask questions and provide their input via focussed workshops. Providers and commissioners also continue to be involved through bespoke meetings and via their representation on the 3 Learning Disability Partnership Boards and the LLR Autism Partnership Board.

People with lived experience, family carers, providers and commissioners will be further engaged through the development of a Market Position Statement to provide an understanding about how services need to change or be developed in order to support greater community inclusion and support.

Children and Young People
There is a strong commitment to collaborative working with young people and families which has resulted in long established forums that directly feed into local planning and development, for example :

- The Leicestershire Family Voice which represents parents and carers of children with disabilities, as well as specific support groups for parents of children on the autism spectrum.
- The Big Mouth Forum which represents disabled young people with a range of needs
- The Parent and Carers Forum

The voice of young people with lived experience of mental health problems contributed directly to the Transformational Plan for children and young people's mental health through strengthening elements on tackling stigma, and engagement with schools. Looked after children raised specific issues about being placed in residential or hospital units outside the region and difficulties in accessing mental health support. There will be specific reference groups for parent/ carers and for young people so that they can continue to influence the implementation of the transformational plan, and hold organisations to account.

A detailed Communications and Engagement Plan is being developed to ensure the ongoing involvement of all stakeholders and will include:

- People with lived experience, carers and families being involved throughout the programme
- Continued to support & engage individuals, carers and the general public
- Continuous engagement with hard to reach groups such as BME communities
- Continuous engagement with stakeholders including health and social care professionals providers and other stakeholders
- Events bringing stakeholders together to inform and further develop and deliver the plan

Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

The We Think Self Advocates Group, the Partnership Board Carers Group, the Speaking up for Health Group and the Communication Network have been involved in co designing the plan as have the 3 Learning Disability Partnership Boards who receive regular updates and vice versa.

There is an established a service user group for children and young people, which includes learning disabilities sand autism, who are accessing or have accessed support from the CAMHS service. Called "Evolving Minds". The group has been involved in the co-design of crisis and home treatment services for C&YP and contributed at the launch event for the Child Mental Health Transformational Plan.

Further events are being planned to ensure ongoing engagement as the plans unfold. These will consider the plans in the whole as well bespoke elements of the plan, for example developing the models for short breaks provision.

2.Understanding the status quo

Baseline assessment of needs and services

Provide detail of the population / demographics

The local Transforming Care Partnership covers the geographical area of Leicestershire and Rutland. Based on the 2011 Census the total population was just over a million (1,017,697). The GP registered adult population (18 plus) is just over 853,000.

LD and Autism population forecast for Leicester. Leicestershire and Rutland (LLR)

We have detailed learning disabilities population information, broken down to district council and CCG boundaries in a core dataset developed by Leicestershire County Public Health Department in October 2015.

The tables below have been taken from PANSI data projections for adult needs and service information, population projections aged 18-64 predicted to have a learning disability, by age, projected to 2030 for LLR. The data highlights a steady increase in the overall LD population, but the numbers displaying challenging behaviour remaining fairly static.

LD Baseline Estimates for LLR

Table produced on 22/02/16 15:32 from www.pansi.org.uk version 8.0

People aged 18-64 predicted to have a learning disability, by age	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a learning disability	3,004	2,988	2,828	2,808	3,072
People aged 25-34 predicted to have a learning disability	3,292	3,309	3,372	3,331	3,185
People aged 35-44 predicted to have a learning disability	3,189	3,171	3,159	3,314	3,398
People aged 45-54 predicted to have a learning disability	3,385	3,398	3,268	3,023	3,025
People aged 55-64 predicted to have a learning disability	2,697	2,726	3,007	3,197	3,066
Total population aged 18-64 predicted to have a learning disability	15,567	15,592	15,634	15,673	15,746

LIVING WITH A PARENT LLR

Table produced on 22/02/16 15:32 from www.pansi.org.uk version 8.0

People aged 18-64 predicted to have a moderate or severe learning disability and be living with a parent, by age	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to be living with a parent	458	456	433	438	482
People aged 25-34 predicted to be living with a parent	364	366	373	368	352
People aged 35-44 predicted to be living with a parent	311	309	310	324	333

People aged 45-54 predicted to be living with a parent	174	174	166	154	158
People aged 55-64 predicted to be living with a parent	53	54	60	62	58
Total population aged 18-64 predicted to be living with a parent	1360	1359	1342	1346	1383

MODERATE OR SEVERE LD LLR

Table produced on 22/02/16 15:32 from www.pansi.org.uk version 8.0

People aged 18-64 predicted to have a moderate or severe learning disability, and hence likely to be in receipt of services, by age	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have a moderate or severe learning disability	693	690	657	661	728
People aged 25-34 predicted to have a moderate or severe learning disability	708	711	724	717	685
People aged 35-44 predicted to have a moderate or severe learning disability	801	797	794	834	856
People aged 45-54 predicted to have a moderate or severe learning disability	760	762	733	682	690
People aged 55-64 predicted to have a moderate or severe learning disability	585	592	654	690	659
Total population aged 18-64 predicted to have a moderate or severe learning disability	3,547	3,552	3,562	3,584	3,618

CHALLENGING BEHAVIOUR LLR

Table produced on 22/02/16 15:33 from www.pansi.org.uk version 8.0

People aged 18-64 with a learning disability, predicted to display challenging behaviour, by age, projected to 2030	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 with a learning disability, predicted to display challenging behaviour	50	50	48	48	52
People aged 25-34 with a learning disability, predicted to display challenging behaviour	60	60	61	60	57
People aged 35-44 with a learning disability, predicted to display challenging behaviour	59	58	58	60	62
People aged 45-54 with a learning disability, predicted to display challenging behaviour	65	65	62	58	57
People aged 55-64 with a learning disability, predicted to display challenging behaviour	53	54	59	64	61

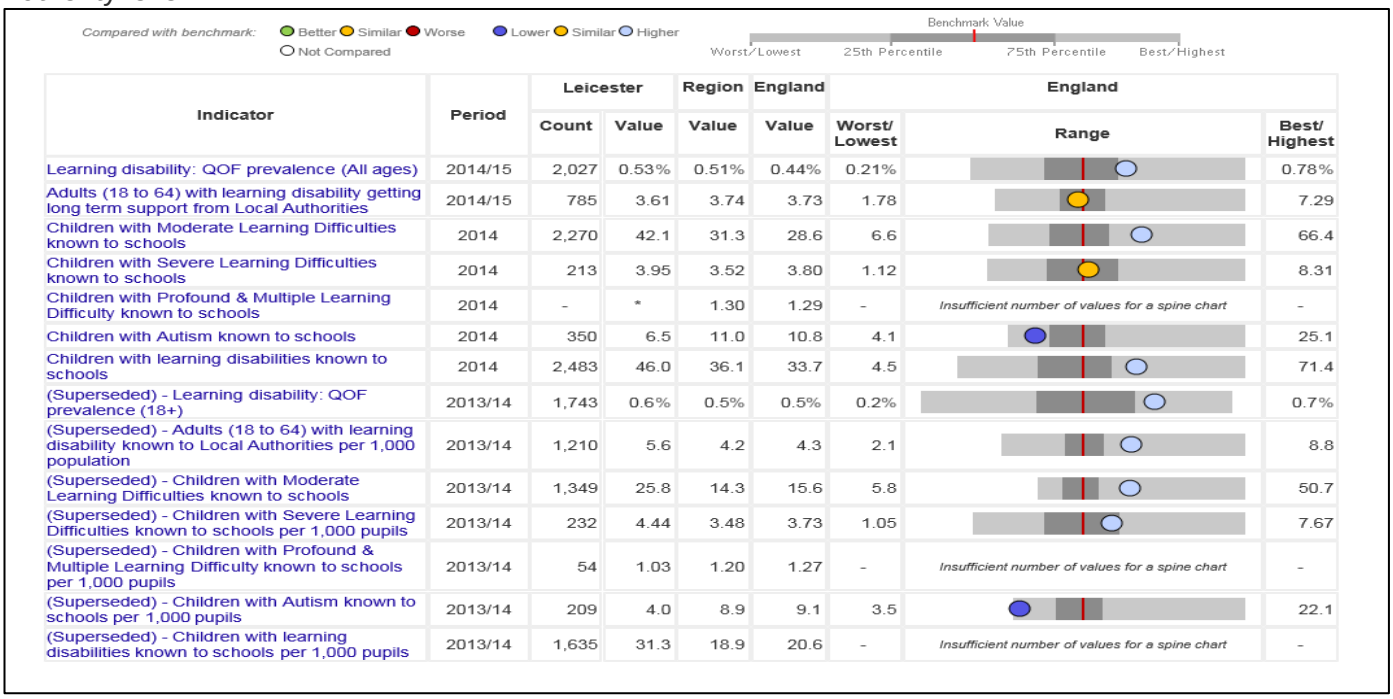
Total population aged 18-64 with a learning disability, predicted to display challenging behaviour	287	287	288	290	289

The prevalence rate for people with a learning disability displaying challenging behaviour is 0.045% of the population aged 5 and over.

AUTISTIC SPECTRUM FOR LLR					
Table produced on 22/02/16 15:33 from www.pansi.org.uk version 8.0					
People aged 18-64 predicted to have autistic spectrum disorders, by age and gender, projected to 2030	**2014**	**2015**	**2020**	**2025**	**2030**
People aged 18-24 predicted to have autistic spectrum disorders	1134	1131	1074	1069	1169
People aged 25-34 predicted to have autistic spectrum disorders	1314	1320	1359	1356	1296
People aged 35-44 predicted to have autistic spectrum disorders	1291	1285	1275	1329	1377
People aged 45-54 predicted to have autistic spectrum disorders	1443	1441	1375	1272	1265
People aged 55-64 predicted to have autistic spectrum disorders	1188	1198	1316	1390	1331
Total population aged 18-64 predicted to have autistic spectrum disorders	6370	6375	6399	6416	6438

Learning Disabilities profiles

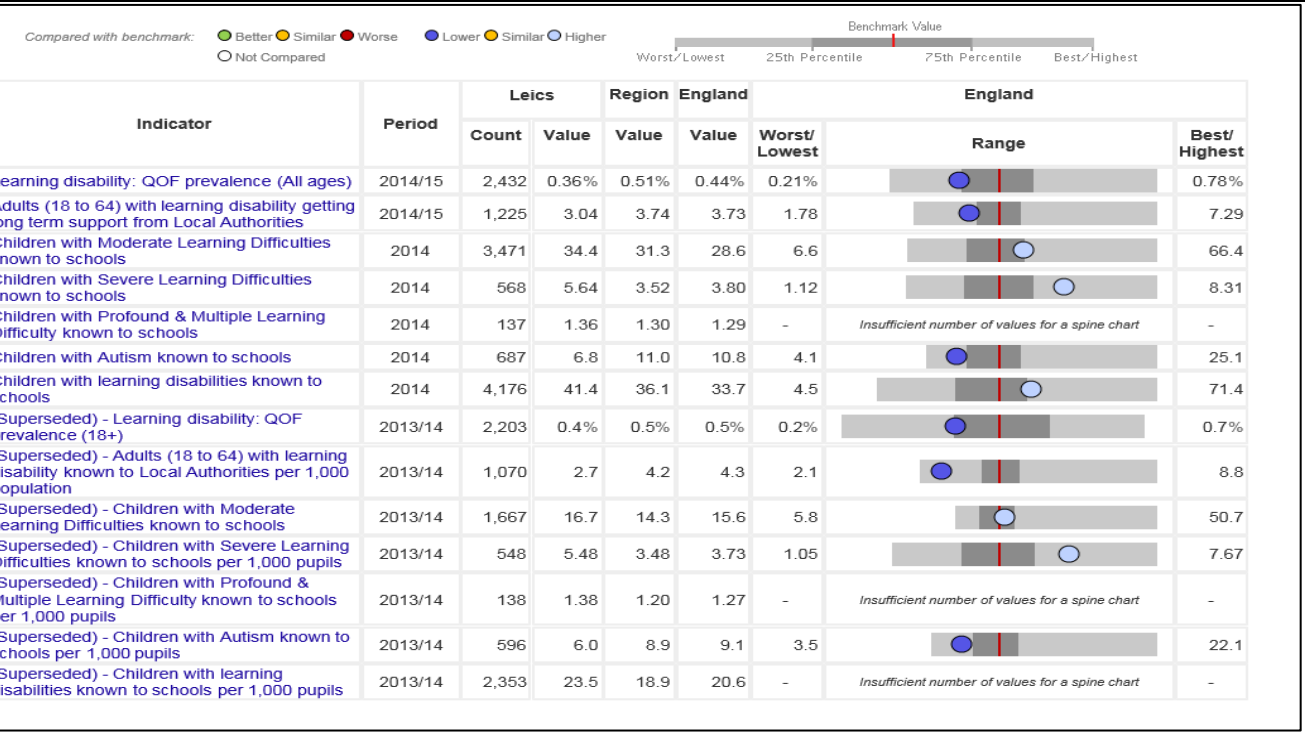
Public Health England have also produced a range of data about people with learning disabilities at Local Authority level:



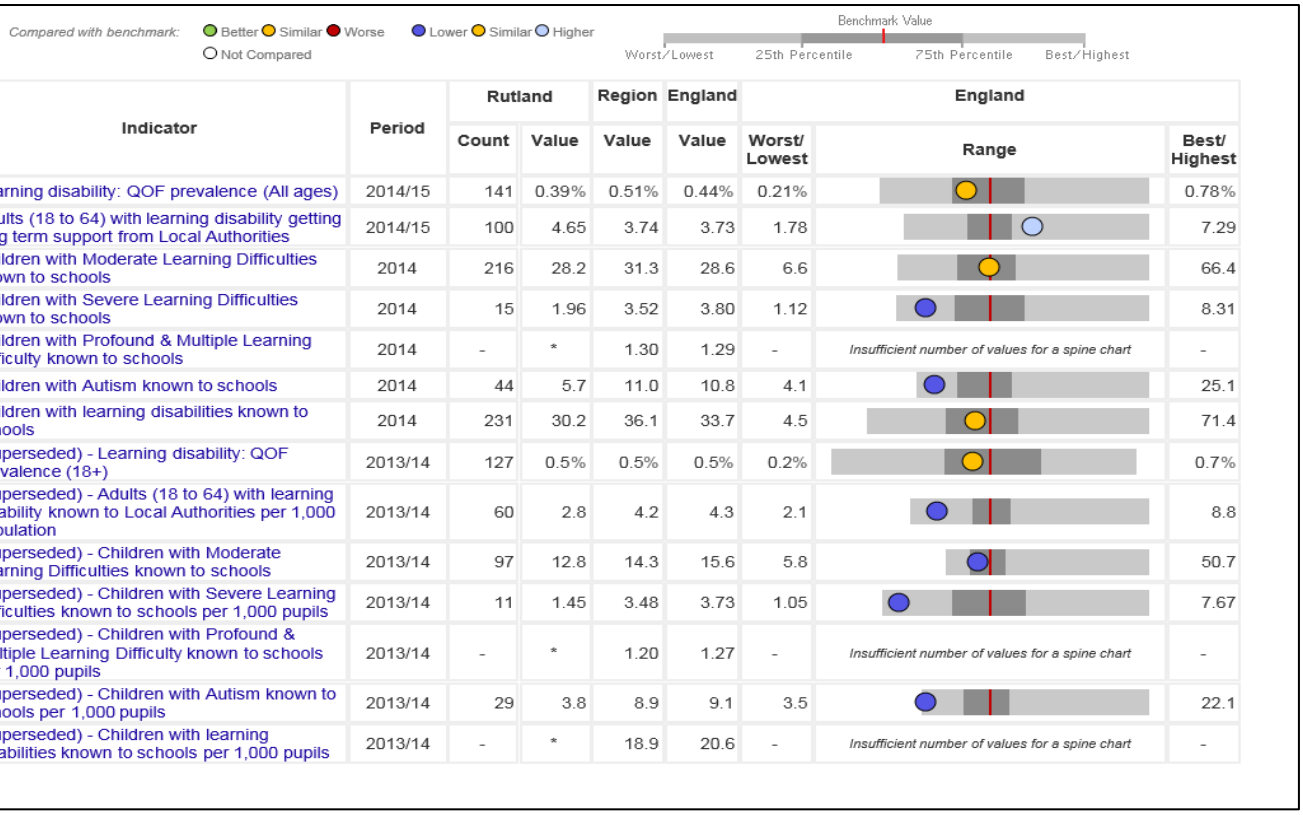
Compared with benchmark: Better / Similar / Worse — Lower / Similar / Higher — Not Compared

Benchmark Value: Worst/Lowest | 25th Percentile | 75th Percentile | Best/Highest

Indicator	Period	Leicester		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	2,027	0.53%	0.51%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	785	3.61	3.74	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	2,270	42.1	31.3	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	213	3.95	3.52	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	-	*	1.30	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	350	6.5	11.0	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	2,483	46.0	36.1	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	1,743	0.6%	0.5%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	1,210	5.6	4.2	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	1,349	25.8	14.3	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	232	4.44	3.48	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	54	1.03	1.20	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	209	4.0	8.9	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	1,635	31.3	18.9	20.6	-	*Insufficient number of values for a spine chart*	-



Indicator	Period	Leics		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	2,432	0.36%	0.51%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	1,225	3.04	3.74	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	3,471	34.4	31.3	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	568	5.64	3.52	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	137	1.36	1.30	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	687	6.8	11.0	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	4,176	41.4	36.1	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	2,203	0.4%	0.5%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	1,070	2.7	4.2	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	1,667	16.7	14.3	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	548	5.48	3.48	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	138	1.38	1.20	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	596	6.0	8.9	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	2,353	23.5	18.9	20.6	-	*Insufficient number of values for a spine chart*	-



Indicator	Period	Rutland		Region	England	England		
		Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Learning disability: QOF prevalence (All ages)	2014/15	141	0.39%	0.51%	0.44%	0.21%		0.78%
Adults (18 to 64) with learning disability getting long term support from Local Authorities	2014/15	100	4.65	3.74	3.73	1.78		7.29
Children with Moderate Learning Difficulties known to schools	2014	216	28.2	31.3	28.6	6.6		66.4
Children with Severe Learning Difficulties known to schools	2014	15	1.96	3.52	3.80	1.12		8.31
Children with Profound & Multiple Learning Difficulty known to schools	2014	-	*	1.30	1.29	-	*Insufficient number of values for a spine chart*	-
Children with Autism known to schools	2014	44	5.7	11.0	10.8	4.1		25.1
Children with learning disabilities known to schools	2014	231	30.2	36.1	33.7	4.5		71.4
(Superseded) - Learning disability: QOF prevalence (18+)	2013/14	127	0.5%	0.5%	0.5%	0.2%		0.7%
(Superseded) - Adults (18 to 64) with learning disability known to Local Authorities per 1,000 population	2013/14	60	2.8	4.2	4.3	2.1		8.8
(Superseded) - Children with Moderate Learning Difficulties known to schools	2013/14	97	12.8	14.3	15.6	5.8		50.7
(Superseded) - Children with Severe Learning Difficulties known to schools per 1,000 pupils	2013/14	11	1.45	3.48	3.73	1.05		7.67
(Superseded) - Children with Profound & Multiple Learning Difficulty known to schools per 1,000 pupils	2013/14	-	*	1.20	1.27	-	*Insufficient number of values for a spine chart*	-
(Superseded) - Children with Autism known to schools per 1,000 pupils	2013/14	29	3.8	8.9	9.1	3.5		22.1
(Superseded) - Children with learning disabilities known to schools per 1,000 pupils	2013/14	-	*	18.9	20.6	-	*Insufficient number of values for a spine chart*	-

These indicate some variation across the Partnership. Compared to the national average:

Leicester- there is a higher prevalence of people with learning disabilities and a higher than average number of adults getting support for the local authority. There is a higher than average number of children with moderate learning disabilities supported by school, but lower than average number of children with

Autism.

Leicestershire- There is lower prevalence of people with learning disabilities but a higher than average number of children with severe learning disabilities known to schools.

Rutland- Prevalence is lower than average but a higher than average numbers are supported by the local authority. The number of children with learning disabilities and autism known to schools is below the national average.

In line with the national service model (Annex c) we recognise the starting point should be a focus on those who are most at risk of inappropriate responses by services. We have therefore scoped number fitting into this categories, as indicated in the national service plans as at **31st January 2016**:

Service area	Unit type	City	County	Rutland	Totals
Hospital setting	NHS England funded specialised commissioning (adults)	5	6	0	**11**
	NHS England specialised commissioning (Children's)	0	0	0	**2**
	CCG funded Specialist LD Units	8	3	0	**11**
	CCG funded generic acute MH bed admissions	1	1	0	**2**
	CCG funded complex care and rehabilitation beds	0	3	3	**3**
	CCG funded Out of LLR alternative hospital placements (AHP's)	3	7	0	**10**
Out of area Care Homes (Adults)	LA or Joint funded out of LLR placements (Adults)	23	42	11	**76**
	CHC funded out of area placements	4	1	1	**6**
Out of area placements (Children)	Children in 52 week educational placements	6	2	0	**8**
	Looked after children's on other establishments	4	0	1	**5**
Specialist Community support challenging Behaviour from LD Outreach Team (2015) Adults)	Urgent Referral *	46	33	3	**82**
	Community Team referrals**	74	62	3	**139**
	Community Team referrals**	74	62	3	**139**

** leading to 14 admissions*
***leading to 13 admissions*

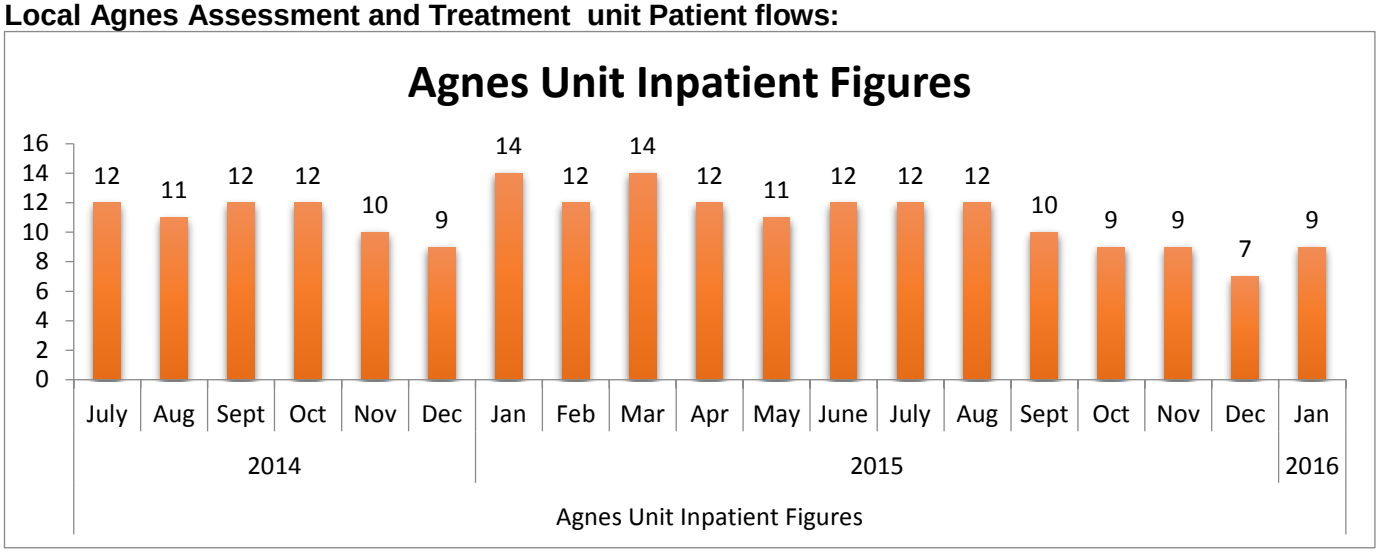
Analysis of inpatient usage by people from Transforming Care Partnership

NHSE specialised commissioning inpatients
Information provided by NHSE Specialised Commissioning at 9th March 2016 suggested there were 13 inpatients assigned to the three CCG's. However there have been several iterations of data therefore the **data must be validated**.

Responsible CCG	Unit Name	Level of Security
NHS LEICESTER CITY CCG	Hazelwood House	Low
NHS LEICESTER CITY CCG	Alpha Hospital, Bury	Low
NHS LEICESTER CITY CCG	Beech House - Huntercombe	Low
NHS LEICESTER CITY CCG	St Andrews - Nottinghamshire	Low
NHS LEICESTER CITY CCG	Oaktree Manor	Low
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	Cheswold Park	Medium
NHS EAST LEICESTERSHIRE AND RUTLAND CCG	Broadland Clinic	Medium
NHS WEST LEICESTERSHIRE CCG	St Andrews - Nottinghamshire	Low
NHS WEST LEICESTERSHIRE CCG	Broadland Clinic	Medium
NHS WEST LEICESTERSHIRE CCG	Calverton Hill	Medium
NHS WEST LEICESTERSHIRE CCG	St Andrews - Northampton	Low
NHS Leicester City CCG	St Andrews – Northampton (CAMHS)	low secure beds
NHS Leicester City CCG	St Andrews – Northampton (CAMHS)	low secure beds

Six adults are in low secure units and will be potentially suitable for discharge over the next 3 years.
Joint CTR's are now being undertaken with NHSE Specialised Commissioning Team to profile and understand the needs of patient's considered ready for discharge. This will help ensure the provider market is shaped to enable the sustainable transfer of individuals.

Local Agnes Assessment and Treatment unit Patient flows:



Based on data of all discharges and transfers from the Agnes Unit in the past 17 months the length of stay was as follows:

Length of Stay	Number of Patients
1 month or less	21
Between 1-3 months	13
Between 3- 6 months	12
Between 6-12 months	2
Over 12 months	6

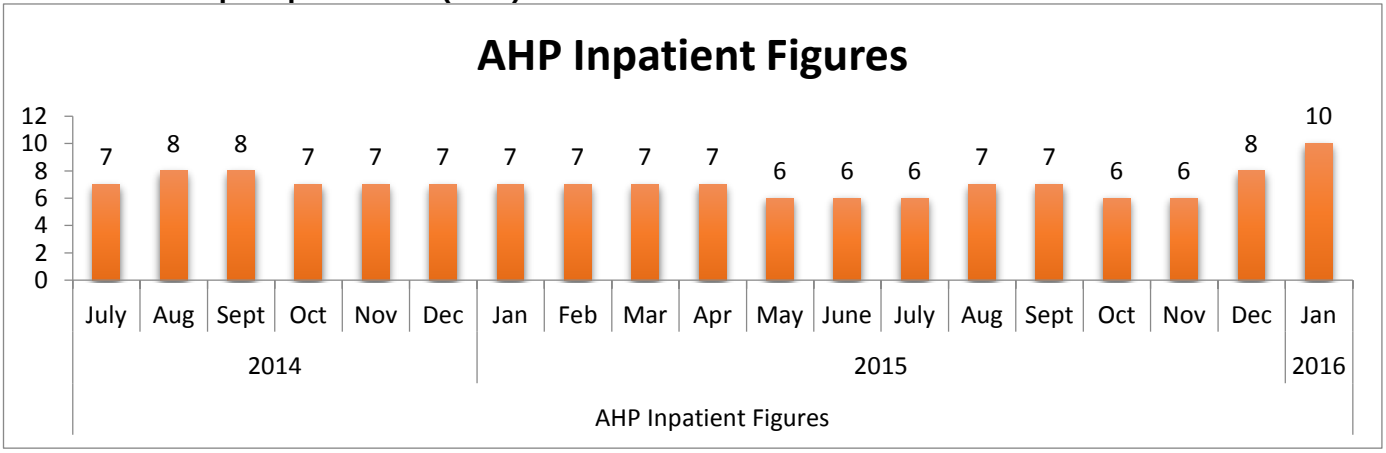
For current inpatients as at 01/03/16

Length of Stay	Number of Patients
1 month or less	3
Between 1-3 months	4
Between 3- 6 months	1
Between 6-12 months	2
Over 12 months	2

The unit currently has two long stay patients undergoing rehabilitation. The remainder have been short to medium stay patients. In 2015 a significant number of short stay admissions have been made despite the intervention of the LD outreach team, indicating current service arrangements are not effective.

Two individuals have been identified as 'revolving door' in last 12 months. One was due to poor management by a residential care home, which has been addressed and the second relates to the individuals personality disorder.

Alternative Hospital placement (AHP) flows:



Below is a summary of placement if current placements:

Provider	Location	Admission Date
Brookdale	Milton Park Independent Hospital ,Bedford	01/10/2009
Cambian	Sherwood Lodge, Notts	20/09/2011
Danshell	Newbus Grange Hospital, Darlington	08/05/2012
Cambian	Oak Court, Fairview Hospital, Essex	14/06/2013
Inmind	Sturdee Hospital, Leicester	21/08/2014

Cambian	Sherwood Lodge, Mansfield, Notts	29/06/2015
Huntercombe	Ashley House, Market Drayton, Staffordshire	16/12/2015
Cambian	Sherwood Lodge, Shire brook, Notts	16/12/2015
Cambian	Cambian Cedars, Birmingham	18/01/2016
St Andrew's	Thornton Ward, Northampton	18/01/2016

Five AHP placements have been made within the last year. These have all been patients stepping down from specialised commissioning low secure units to CCG funded locked facilities. The decision to step down these patients to locked facilities has primarily been made by specialised commissioning and current providers, with it appears limited exploration of local facilities. Some of this step down has been to a locked unit run by the same provider on the basis they will be able to provide some continuity of care.

Net importer or exporter?
Given there are limited independent inpatient facilities within the Partnerships geographical boundary, overall we consider ourselves a small net exporter.

Describe the current system

1. **People with a mental health problem which may result in them displaying behaviours that challenge:**

Adults: Assessment services are provided by NHS Leicestershire Partnership Trust LPT. Those with an intellectual disability and autism are supported by community learning disabilities services. Those with Autism and no intellectual disability do not receive dedicated ongoing support from healthcare but some social work support.

Children & Young People: Those with Autism and Asperger's without an intellectual disability are primarily supported the generic LPT CAMHS team.

2. **People with a severe learning disability who display self-injurious or aggressive behaviour :**

Adults: Primarily supported by LPT services including:

- Primary care Liaison Nurses
- Community Learning Disability Teams
- LD Outreach Team (Adults)
- Agnes Assessment and Treatment Unit
- Health Short-breaks provision

Children and Young People: those with a moderate or profound learning disability and representing with mental health problems are supported by a dedicated CAMHS LD Team. They provide input through an outpatient service which can be supplemented to if necessary using our outreach team. They also respond to crisis situations requiring intense intervention within the home and / or inpatient admission.

3. **People who display risky behaviours which may put themselves or others at risk (e.g. fire setting, abusive, aggressive or sexually inappropriate behaviour:**

Adults: supported either by LPT Agnes Assessment and Treatment Unit (particularly as part of a step down from secure services) or by LPT community and inpatient Forensic Mental Health services:

Children and Young People: supported by LPT specialist CAMHS community and inpatient services

4. **People who display behaviour which may lead to contact with the criminal justice system- often with lower support needs, from disadvantaged backgrounds, personality disorder:**

Adults: supported by LPT Community Mental Health and liaison/diversion services. This includes a Triage Car staffed by Leicestershire Police and a mental health nurse to ensure a quick response and the most effective treatment for the individuals concerned, thus avoiding the Criminal Justice Route wherever possible.

Children: Local Youth Offending Teams (YOTs) have CAMHS worker embedded within them.

5. **People who have been inpatient care for a very long time, having not been discharged when NHS Campus or long stay hospitals were closed:**

We do not have any individual in this category to our knowledge.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

Local NHS Trust Assessment and Treatment Unit
The inpatient provision for People with Learning disabilities is delivered from a 20 bedded unit called the Agnes Unit. We have been advised by NHS Partnership Trust that it is a PFI building so does not have a CGA attached to it.

Currently, 16 out of the 20 beds are commissioned towards the assessment and treatment of individuals with Learning disabilities presenting with Challenging behaviour and/or Mental health problems. As part of the BCT planning, clinical models have been developed with an objective on reducing the reliance on inpatient units by intensive care and Crisis management in the Community. This will lead to a reduction in a reduction of 4 beds over 2017/18.

It is recognised that a high cost and inflexible PFI on local Assessment and Treatment is a significant challenge on our current ability to redesigning services. During 2016/17 the partnership will need to detailed consideration to the ability to further reduce the local assessment and treatment bed base over the next 3 year and whether it is viable to continue provision at the Agnes Unit?

Independent sector inpatient facilities:
There are no specific adult independent sector LD inpatient facilities in LLR geographical area so no specific estate challenges have been identified.

Where treatment and rehabilitation needs cannot be met by NHS Leicestershire Partnership Trust, some placements are made in regional and national facilities run by providers such as Cambian Healthcare and St. Andrews. Therefore there will be a need to work with regional partnership to understand the impact of their plans for independent sector provision on our patients in these facilities.

Short Breaks provision
Short breaks bed based provision currently includes:

- 15 health beds in three unit run by NHS Leicestershire Partnership Trust
- 28 social care beds in the county across 4 sites based in: Melton (6 beds), Wigston (6 beds), Hinckley (10 beds), Coalville (6 beds)

As part of BCT planning, various models of short break provision are being scoped with a view to improving the offer, choice and access of more local, community based person centred short break provision responsive to Service user/carer needs, including for those directly purchasing through the use of their Health, Social Care or Integrated Personal Budget. This includes those who need crisis support in the community as a result of a deterioration in mental health which does not require an inpatient stay and emergency provision in the event that the carer is unable to provide care for a short period of time.

Future models will be determined further to consultation stake holders, including people with learning disabilities and family carers. This is planned for the autumn of 2016.

Housing in the community
There is a particular challenge to develop appropriate long term accommodation for people with significant challenging behaviour or behaviour that poses a risk to others and develop or identify suitable long term housing.

The TCP includes two unitary Local Authorities (Leicester City and Rutland) and a 2 tier Local Authority (Leicestershire) which means innovative solutions are needed working in partnership with Local Housing Providers, Registered Social Landlords, Independent Sector Providers and the 6 district councils who are responsible for housing within the area alongside the City and Rutland.

Our planned market position statement will also support this challenge ensuring the availability of high quality support to compliment the development of a range of accommodation models to meet identified local needs.

What is the case for change? How can the current model of care be improved?
Taking into account key legislative and practice changes which have implications for all people with a Learning Disability, in response to the Winterbourne View Reports in 2012, partners across LLR started a journey to transform care for people with Learning Disabilities and or autism who display behaviour that challenges through the Better Care Together program work.

Services and plans for Transforming Care/ Better Care Together Learning Disability Work Stream

Our existing service	What are we going to do?	Our outcomes in 5 years
• High use of specialist services and under - developed offer from universal and preventative services • Too many people accessing long-term inpatient and residential services • Carer support and short breaks are inconsistent and not sufficiently integrated • Poorly developed market leading to over-priced package provision - we need to work together to manage and develop the learning disabilities market	• Joint market management and development • Develop integrated personal budgets to match support better to needs • Develop local community services • Consider the pooling of health & social care budgets • More consistent whole life approach across children and adult services • Better support for universal and primary care services • Develop more integrated pathways and short break provision	• All individuals will have the opportunity for a health and social care assessment • Fewerr people in institutional care • All individuals eligible will have a health & social care personal budget • More people will live in their own homes / individualised accommodation • More people will opportunities to access employment, education and social support • More people will be able to live in their locality

However it is recognised much more work is needed to further develop services, embed processes, shape the provider market and to ensure that services are sustainable for the future. The model of care for adults is in its early stages and it is recognised through our engagement work, that much more work is needed to:

- Reduce the reliance on inpatient care through person centred flexible care
- Transfer care into a community setting that offers high quality and safe services
- Develop community support models to focus on prevention, integration, care planning, crisis plans, places of safety and further develop housing and services to ensure that high quality services and capacity are available when needed
- Develop and retain the right workforce who have the necessary skills and knowledge across patient pathways to support clients in the community
- Improve integration and communication across the system and for organisations, professionals and teams to work better together to ensure that the care that is commissioned and provided is centred around the individual but also that consideration is given to the

families and carers who provide a vital service to support people keeping and staying well.

- Improve pathways to reduce delays and preventable escalations of needs, including admissions.

In relation the specific cohorts:

1. **People with a mental health problem which may result in them displaying behaviours that challenge:**
   - A need for an overall a 'whole life' preventative approach is with a much greater emphasis of addressing or reducing the impact of challenging behaviours from a young age.
   - In relation to the Autism Care Pathway a need to develop ongoing specialist support to individuals with Autism without an intellectual disability
   - In relation to Children a need to improve early detection services and improve crisis response and home treatment services when crisis situation arise.

2. **People with a severe learning disability who display self-injurious or aggressive behaviour :**
   - A need to refocus and enhance the LD Outreach team to ensure it is better able provides appropriate crisis and community support to support admissions avoidance.
   - A need to review the care pathway into Agnes Unit given the variation to the access, with admissions directly from the Community Teams & LD Outreach Team with neither maintaining patient responsibility following admission. The latter does not support early discharge.
   - A need to review and transform our short breaks health and social care provision from a one size fits all building based model to person centred and flexible support model, which young people and carers are increasingly requesting.
   - A need to develop individual and personalised services through increasing the number of individuals local Personal Health and Integrated Budgets offer for people identified at risk of admission and build on our baseline of 4 people with LD currently on a PHB.
   - A need to review local health and social care funding arrangements, to ensure they support early discharge from assessment and treatment units.
   - A need to strengthen links between children's, transition and adult services to support planning for accommodation need in adulthood.

3. **People who display risky behaviours which may put themselves or others at risk (e.g. fire setting, abusive, aggressive or sexually inappropriate behaviour**
   - A need to review community forensic support services to ensure the needs of this cohort can be met.
   - A need to further develop accommodation and the provider market for people with high support needs arising from challenging or risky behaviour – both step through and longer term community based provision
   - The opportunity to consider the role of the Agnes Unit in 'resettling' people who have been in hospital for many years and need to be stepped down from low secure units

4. **People who display behaviour which may lead to contact with the criminal justice system- often**

with lower support needs, from disadvantaged backgrounds, personality disorder

- A need to strengthen community based crisis response and home treatment services for both adults and children.
- A need to explore the feasibility of developing a 'Crisis House' facility for 'revolving door' inpatients with lower support need as an alternative to hospital admission.
- A need to develop the local Personal Health and Integrated Budgets offer for this group as some individuals will be able to develop approaches to manage their own care.

3.Develop your vision for the future

Vision, strategy and outcomes

Describe your aspirations for 2018/19.

Vision

Our overall vision is that all people with a learning disability and/or autism should have a good life that meets their needs, aspirations, respects their rights, and keeps them independent in their local communities.

We will deliver our vision by:

1. Providing more proactive, preventative care, with better identification of people at risk and early intervention
2. Empowering people with a learning disability and/or autism to manage their own care through the expansion of personal budgets, integrated budgets and personal health budgets and through independent advocacy
3. Supporting family members of children with a learning disability (under 18 year olds) to care for them home, and the provision of high-quality social care with appropriate skills
4. Providing greater choice and security in appropriate housing.
5. Ensuring access to activities and services that enable people with a learning disability and/or autism to lead a fulfilling, purposeful life (such as education, leisure)
6. Ensuring people with a learning disability and/or autism whose behaviour challenges are able to access mainstream health services (including mainstream mental health services in the community)
7. Providing specialist multi-disciplinary support in the community, including intensively when necessary to avoid admission to hospital
8. Ensuring that services aimed at keeping people out of trouble with the criminal justice system are able to address the needs of people with learning disabilities and/or autism, and that the right specialist services are in place in the community to support people with a learning disability and/or autism who pose a risk to others
9. Providing local hospital services that are high-quality and assess, treat and discharge people with a learning disability as quickly as possible.

This will be supported by our wider Children and Young People ' Futures in Mind ' strategy, who's vision is that by 2020, every child and young person in Leicester, Leicestershire and Rutland will be able to affirm

the following:

Self- care and prevention	*Early help and primary care*	*Specialist care*
My family and I are able to look after my emotional and mental wellbeing and development day to day. *I learn about mental health and how to protect myself at school or college.* *We can access trusted self-care advice when and where we like including websites, education settings, GPs and children's centres* *My parents / carers have access to support and guidance* *I am confident in talking about issues which affect my mental health*	*We can get high quality support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised.* *I will be able to make informed choices about the kind of help I would like.* *I and those who care for me will be listened to.* *I will be supported to become resilient and independent.* *I and my carers will be helped to navigate the system and services.* *I am involved in peer support groups and community networks in my area.*	*I will be helped by a specialist team quickly if my mental health problems are serious* *I will receive support which is safe, reliable and tested.* *I will be involved in setting my own treatment goals and deciding if I am getting better.* *With my consent, services will work together with me and my family to give us the best support.* *I will be involved in decisions to transfer or reduce my care.*

How will improvement against each of these domains be measured?
We plan use all the indicators in Appendix A , the LD SAF outcomes measures for people and the impact of changes to service models on the wider population to monitor progress.

In addition we identified the following key outcomes as markers of progress:

Adults:

- Increase in number of people with learning disabilities on integrated or Personal Health Budgets
- Reduction in the number of patients needing hospital admission, (measured by monitoring outcomes of blue light/pre-admission/ post admission Care and Treatment Reviews)
- Reduction on DTOC levels
- Use of and the evaluation of the effectiveness of the Step Through facility

Children and Young People:

- The number of children and young people assessed by the specialist CAMH service.
- Hospital admission rates for children for self-harm and attempted suicide

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.
In terms of describing what good looks like, partners have adopted the "Driving Up Quality" standards and the service model is structured on nine core principles:

1. I have a good and meaningful everyday life
2. My care and support is person-centred, planned, proactive and coordinated
3. I have choice and control over how my health and care needs are met

4. My family and paid support and care staff get the help they need to support me to live in the community
5. I have a choice about where I live and who I live with
6. I get good care and support from mainstream health services
7. I can access specialist health and social care support in the community
8. If I need it, I get support to stay out of trouble
9. I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high quality and I don't stay there longer than I need to

'Golden threads' which run consistently through the principles which are expected to be reflected in commissioning strategies are:

Quality of life – people should be treated with dignity and respect. Care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations; it should be about maximising the person's quality of life regardless of the nature of their behaviours that challenge. There should be a focus on supporting people to live in their own homes within the community, supported by local services.

Keeping people safe – people should be supported to take positive risks whilst ensuring that they are protected from potential harm, remembering that abuse and neglect can take place in a range of different environments and settings. There should be a culture of transparent and open reporting, ensuring lessons are learned and acted upon.

Choice and control – people should have choice and control over their own health and care services; it is they who should make decisions about every aspect of their life. There is a need to 'shift the balance of power' away from more paternalistic services which are 'doing to' rather than 'working with' people, to a recognition that individuals, their families and carers are experts in their own lives and are able to make informed decisions about the support they receive. Any decisions about care and support should be in line with the Mental Capacity Act. People should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well.

Support and interventions should always be provided in the least restrictive manner. Where an individual needs to be restrained in any way – either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible, in line with Positive and Proactive Care.

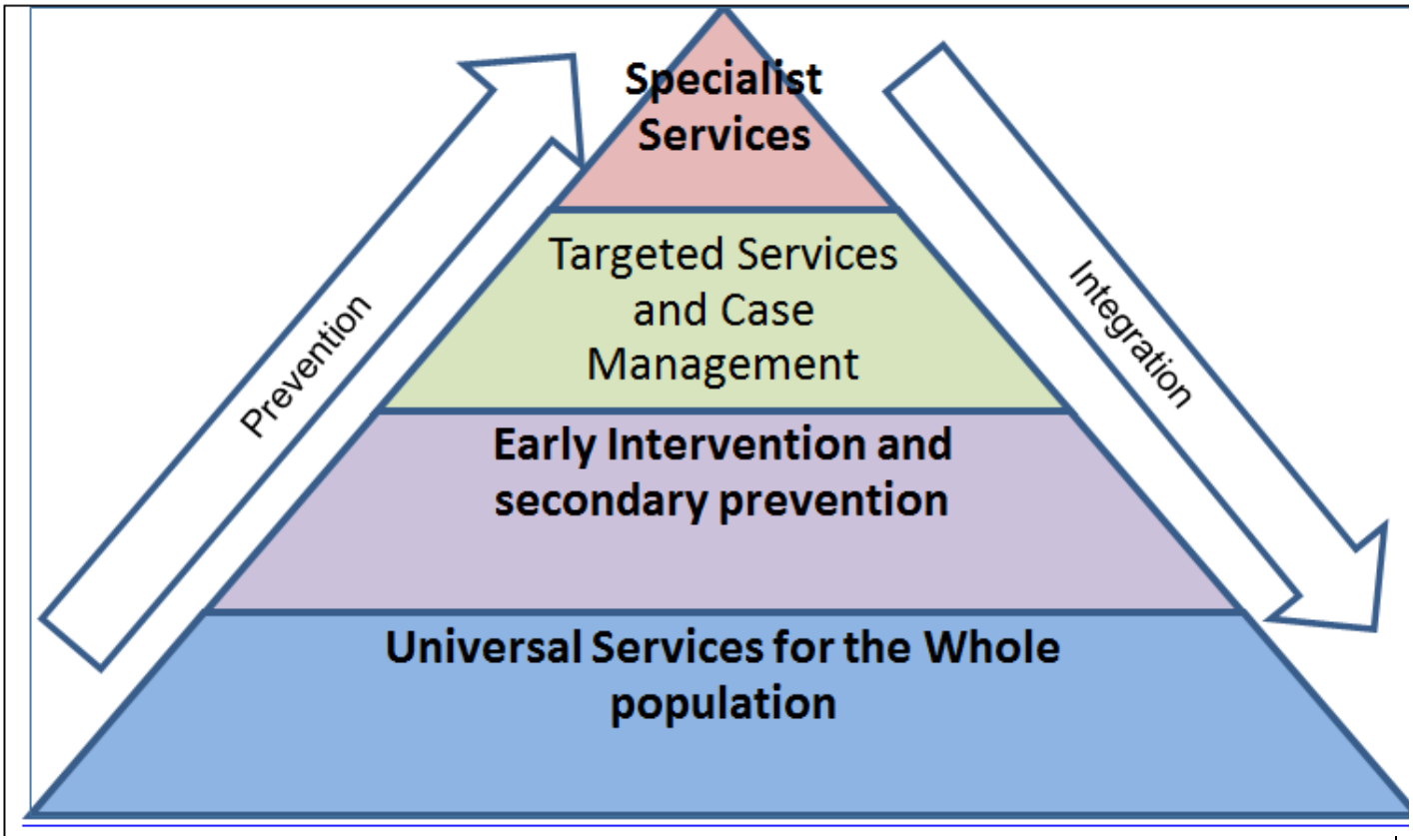
In addition, we will use the 14 core principles The recently published Core Commissioning Tool, Ensuring Quality Services as a basis for commissioning practice, emphasising the need for education, health and social care to work together to deliver a whole life approach to support:

1. Positive Behavioural Support
2. A whole systems life course approach
3. Prevention and early intervention
4. Family carer and stakeholder partnerships
5. Function based holistic assessment
6. Behaviour that challenges is reduced by better meeting needs and increasing quality of life
7. Support for communication
8. Physical health support
9. Mental health support
10. Support for additional needs
11. Specialist local services
12. Safeguarding and advocacy
13. Workforce
14. Monitoring quality

4.Implementation planning

Proposed service changes (incl. pathway redesign *and* resettlement plans for long stay patients)

Overview of your new model of care



Under our new model of care the extent of community provision relative to inpatient provision will be much more extensive than it is now. Community provision will be focused on three cohorts

Cohort	Description	Services
The wider learning disability and autism population	This is the cohort that is currently unknown to services, with the exception of primary care. Mainstream services and community networks will need to support people with a learning disability and/or autism living well in the community without the need for specialist services for those with learning disabilities and/or autism where possible.	• Annual health checks • Primary care liaison nurses • Targeted health promotion (using risk stratification tools) • Third sector Health promotion and facilitation • Improved access to mainstream services including education, employment and housing • Main Acute hospital liaison support services • Advice and Information • Local Offer
The current community	The community provision will need to keep people with a	• Care and Treatment Reviews if at risk of admission

cohort	learning disability and/or autism living well in communities, preventing deterioration in their wellbeing and crises so that their need for residential care and inpatient services is reduced to when they are the best option for the person concerned.	• Enhanced LD Outreach Team • Personalised services through PHB's. • Dedicated Autism support services • Personalised respite care options • CAMHS multi agency First Response service • Specialist community CAMHS service for children with moderate to severe learning disabilities & related MH needs • Peer support networks • Access to short breaks for those living with at home
The current in-patient cohort, including those in forensic settings	The community provision will need to effectively accommodate those previously served by inpatient settings, so that the people concerned can improve their quality of life, and the quality of care and support is improved so that they can stay living in the community and any inpatient admissions are minimised.	• Care and Treatment Reviews • Personalised services through PHB's • Dedicated Care co-ordinator (discharge planning NHSE and Independent Hospital placements) • Enhanced and expanded Outreach Team • Supported housing schemes including ' step through' • Independent advocacy • Access to short breaks for returning to the family home • Community Forensic support services for people with LD and related MH needs.

Our new model of care we be delivered through the following initiatives:

Providing more proactive, preventative care, with better identification of people at risk and early intervention

- Continuous development and promotion of a secure CCG web based at 'risk of admission' register to support early identification of those at risk of admission to hospital. This will include children and young people at risk of admission.

- Year on year increase in the take up of Learning Disabilities annual health checks and associated Health Action Plans in particular ensuring screening for long term conditions, cancer and dementia.

- Using population based risk stratification tools to identify patient on GP's learning disability register that have significant comorbidities which would benefit from increased primary care support.

- We will commission a LLR multi-agency "First Response" service which will assess the level of distress and risk facing a child, young person or family, and co-ordinate the right intervention and support.

- We will ensure all person centred care and support plans for adults and Education, Health and Care Plans (EHC) for children, will include crisis and contingency arrangements.

- Scoping the need to commission the voluntary and community sector to work alongside primary

care on health promotion- running a series of programmes aimed at encouraging and supporting people with learning disabilities and their family carers to live healthier lifestyles

Empowering people with a learning disability and/or autism, for instance through the expansion of personal budgets and personal health budgets and independent advocacy.

- Clear targets to increase the number of people with a learning disability on an integrated or Personal Health Budget over the next 3 years.
- To expand the use of personal Health Budgets for families of children with complex care needs
- Developing the provider market to support individuals with high support needs through personal budgets.
- To strengthen information, advice and support services to support our Personal Health Budgets offer for people with learning disabilities who have high support needs, building on learning from local and national best practice.
- To develop regional circles of support to support sharing of good practice and outcomes and allow users and carers to 'tell their story'
- Review need to enhance advocacy services to act as a key enabler for new models of care when individuals are undergoing a significant change, in particular for those in inpatient facilities, at risk of admission or going through transition.

Supporting families to care for their children at home (under 18 year olds), and the provision of high-quality social care with appropriate skills

- We will implement the LLR 'Transformational Plan and Implementation Plan for the Mental Health & Wellbeing of Children and Young People 2015-2020' which aims to improve early prevention help and specialist support services, including those with a learning disability and associated mental health needs
- Commission a specialist community CAMHS service for children with a moderate to severe learning disabilities and related mental health difficulties.
- We will develop training programmes in child mental health for social care practitioners and others working with children and families.
- Developing early intervention programmes for families and carers of people who challenge, including evidence based parent training programmes and associated skills training.
- Development of peer support networks to provide support to other families.

Providing greater choice and security in housing.

- Evaluation of the effectiveness of the recently established 4 unit local 'step through' facility.
- To work with housing and support providers to further develop 'step though' accommodation, particularly for those with significant challenging behaviour or behaviour that poses a risk to others.
- To further develop a choice of long term housing, including small scale supporting living to support step through and independent living. The development of additional step through provision will require market development and additional capital investment.

- To develop a 'needs assessment' the housing needs of people with learning disability, including those with autism and those being released from prison.

- Develop options to support people locally who are currently resident in out of area placements; including young people returning to Leicester from school placements.

Ensuring access to activities and services that enable people with a learning disability and/or autism to lead a fulfilling, purposeful life (such as education, leisure)

- To increase life opportunities through the use of personal budgets

- Develop and range of initiatives to support employment and volunteering opportunities

- Through local partnerships work with local colleges and support providers to increase education opportunities for young people with profound and multiple learning disabilities

- Improve communication standards and accessibility information for community services.

- Development of peer support networks to provide support to other individuals and their families.

Ensuring people with a learning disability and/or autism whose behaviour challenges are able to access mainstream health services (including mainstream mental health services in the community)

- Review current building based short breaks provision in order to develop person centred and flexible provision. Initially to pilot PHB for short breaks provision with young people coming though transition in 2017/18.

- Implement LLR Autism Strategy 2014-2019 including commissioning a post diagnostic support service for those people without an intellectual disability.

- Improve communication standards and accessibility information within GP Practices

- Reviewing the effectiveness and level of need for liaison support workers within the main acute hospital and enhance this if necessary

- Develop an alert (e.g. flagging systems) between GP practices and mainstream acute hospitals to ensure reasonable adjustments are made when required a person with a learning disability is admitted to hospital

Providing specialist multi-disciplinary support in the community, including intensively when necessary to avoid admission to hospital

- Refocused and enhanced LD Outreach team with the purpose of enhancing the intensity of care and support in the community and therefore reduce the likelihood of admission by
  - Increase the Outreach working hours to a 7 day service 8am to 9pm, when most crisis have been identified to occur
  - Employ dedicated therapy staff within team
  - Strengthen the admission pathway by expecting the involvement of the Outreach team in all patients considered as risk of hospital admission, and therefore improve the likelihood of intensive community based care.
  - Maintaining outreach team involvement during any inpatient admission to support early discharge.

- Through the Future in Mind transformational fund we will commission a LLR multi-agency intensive community and home treatment services. These services will operate extended hours seven days a week, and will provide home visits and intensive work with the young person, their carers and other agencies such as school or social care. The aim will be to reduce and avoid admission to either ED or mental health in-patient units and also support planned discharge from in-patient units

- Review recently established LLR blue light, pre-admission and inpatient Care and Treatment policy and practice to improve efficiency and effectives.

- Consider the need for further enhancements to the LD Outreach Team to increase service specialism in supporting people at risk of admission.

- Scope the need to develop a LLR Learning Disabilities crisis intervention service or facility which provides intense support for a short period in a time of crisis, preventing admission into a hospital setting

Ensuring that services aimed at keeping people out of trouble with the criminal justice system are able to address the needs of people with learning disabilities and/or autism, and that the right specialist services are in place in the community to support people with a learning disability and/or autism who pose a risk to others

- Working with local police teams to ensure they are aware of people with a learning disability and/or autism who pose a risk to themselves or others and who key contacts are.

- Building on existing strong local liaison and diversion services, including the street triage service.

- Develop basic awareness training programmes for criminal justice organisations on meeting the need of people with learning disabilities and/or autism.

- Review the role of the Agnes Unit in being able to support the 'resettlement' people from low secure forensic units back into the community

- To review need to enhance current community forensic support services to meet needs of individual stepping down from secure services.

Providing hospital services that are high-quality and assess, treat and discharge people with a learning disability as quickly as possible.

- Current plans to reduce the number of short stay assessment and treatment beds from 8 to 4 (Overall unit bed size from 16 to 12) by 2019.

- We will ensure there is a community (pre-admission) CTR or blue light meeting take place before any proposed inpatient admission.

- Ensure all assessment or treatment admissions will have a clear stated purpose and expected outcomes.

- All admissions to the local Agnes Unit be case managed by the LD Outreach team to support any early discharge

- In relation to children and young people the need to work as part of regional collaborative commissioning arrangements to strengthen the provision of in-patient facilities within our region and ensure that there are good protocols for partnership working between Tier 3 and Tier 4

commissioners and providers.

What new services will you commission?

Planned	For scoping/ dependent on funding
• LLR multi-agency "First Response" service which will assess the level of distress and risk facing a child, young person or family, and co-ordinate the right intervention and support. • CAMHS Crisis Resolution and Home Treatment Service • Increased number of integrated and Personal Health Budgets for people at risk of admission due to a learning disability or associated mental health needs or for respite care purposes. • Advice and support brokerage services to support the development of Personal Budgets. .	• Third sector primary healthcare facilitation services • Specific advocacy services for those undergoing significant change, in particular for those in inpatient facilities, at risk of admission or going through transition • Support for sector workforce and implementing Positive behaviour practice and admission avoidance approaches through care and Treatment reviews. • New 'step through' supported accommodation provision • LLR Crisis intervention service or facility to provide intensive support for a few weeks at times of crisis, preventing admission into a hospital setting. • Review need to enhance SALT provision with the LD Outreach Team

What services will you stop commissioning, or commission less of?

- Reduction on local A &T unit short stay beds (Two in 2017/18 and two in 2018/19). We plan to further review opportunities for further reduction in local Assessment and Treatment short stay beds following strengthened community services being in place
- OOA independent inpatient placements, only made in exceptional circumstances
- Building based short breaks linked to development of more flexible and person centred provision including Personal Budgets/ Integrated Budgets/ Personal Health Budgets.

What existing services will change or operate in a different way?

- Micro-commissioners and community support providers will work to local Care and Treatment Review policies to support admissions avoidance.
- Refocused and enhanced the LD Outreach team to support admissions avoidance and early discharge.
- Specialist Autism service expanded and enhanced in order to provide ongoing holistic support to people with and without intellectual disability.
- Review the role of the Agnes Unit in being able to support the 'resettlement' people who have been in hospital for many years.

Describe how areas will encourage the uptake of more personalised support packages

The CCG's are establishing **dedicated PHB team** hosted with East Leicestershire and Rutland CCG to develop our local offer. This team include a learning disabilities nurse whose remit is support an increase in

the number of people with a learning disability on an integrated or PHB.

Our plan for the expansion of integrated and PHBs to people with learning disabilities includes :

- Children and young people with learning disabilities and who have significant health needs who could be offered personal budgets (or personal health budgets) to enable them to remain living in the community and avoid out of area placements.

- People with learning disabilities and mental health needs. For example, people with learning disabilities who are on the Care Programme Approach would be a readily identifiable group who might benefit from a PHB to support them at home or in supported housing.

- People with learning disabilities who are inpatients and those at risk of admission.

- Identify other LD groups with significant health needs that might benefit from a personal health budget.

The targets for people with learning disabilities to be on an integrated or PHB is as follows:

	15/16	16/17	17/18	18/19	19/20	CCG total
ELR CCG	1	15	15	15	15	61
LC CCG	1	17	17	17	17	69
WL CCG	1	16	16	16	16	65
					Overall total	195

In relation to children and families the vision is to put young people and their families in control of the planning process across 4 outcomes by shifting control through the Local Offer. Post 14 reviews have a planning structure to focus on the following 4 outcomes using a person centred approach:

- Better outcomes for health
- Better outcomes for education, training and work,
- Better outcomes for developing independence and housing options
- Better outcomes for community access and inclusion

What will care pathways look like?
We plan to employ a care co-coordinator with specific responsibility to support discharge back to the local provision for patients in AHP's and specialised commissioning placements.

To support this we have initially scoped Discharge arrangements for LD patients from Specialised Commissioning local Assessment & Treatment Unit/ Alternative Hospital Placements:

Transforming care - Discharge arrangements for LD patients from Specialised Commissioning local Assessment & Treatment Unit/ Alternative Hospital Placements			
Resource	**Process**	**Funding responsibility**	**Notes**
Specialised commissioning unit to specialised commissioning unit			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning responsible, region may	
Specialised commissioning to local ATU			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning to CCG	
Specialised commissioning to Step Down			
Planned & agreed through CTR & CHC (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Agnes Unit (Local Assessment & treatment unit) to Step Down			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Agnes Unit (Local Assessment & treatment unit) to Community (family,			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Agnes Unit (Local Assessment & treatment unit) to Specialised			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning responsible region may change	
Alternative Hospital Placement (AHP - GEM) to **Agnes Unit**			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	GEM to CCG	
Alternative Hospital Placement (AHP - GEM) to **Step Down**			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Alternative Hospital Placement (AHP - GEM) to **Step Down**			
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Alternative Hospital Placement (AHP - GEM) to **Community** (family, res. care,			
Planned & agreed through CTR (MH Act applies)	Direct discharge, consider section 17 leave or CTO	CCG/GEM assessment / LA Section 117 applies	community support including Back-up & contingency plans
Planned & agreed through CTR (Informal patient)	Direct discharge	CCG/GEM assessment / LA	community support including Back-up & contingency plans
Alternative Hospital Placement (AHP - GEM) to Specialised			
Planned & agreed through CTR (MH Act applies)	Direct transfer, no section 17 leave	Specialised commissioning responsible region may change	

There are slightly differing care pathways for locally funded health and social placements in Leicester, Leicestershire and Rutland; however these will not make it any more difficult for people to access the right support in the right place and at the right time.

How will people be fully supported to make the transition from children's services to adult services?

The SEND Reforms of 2014 required the production of a coordinated Education, Health and Care Plan (EHCP) for children and young people aged 0-25 who require one due to the complexity and severity of their special educational needs and/or disability (SEND). This plan must include an assessment of all education, social care and health needs and a description of the provision that must be made to meet these identified needs.

The planning process is person centred and fully involves the young person and their family, with a clear focus on outcomes and life aspirations. Taking a holistic approach ensures that all aspects of the young person's life are integrated, with commissioners discussing and agreeing funding allocations to meet needs in a joined up way.

Providing control of funding though person budgets and direct payments offers up the opportunity for families to help reshape the local market of provision and encourages commissioners to listen and respond to these needs by unlocking resources tied up in block contracts. Diversifying the local market will provide a broader range of choices for young people to ensure their outcomes can be met in ways that best suit them, this in turn will ensure best value, reduce unnecessary spend and deliver an improved quality of life for the young person and their family.

- We will have a clearer understanding of the future accommodation needs of young people coming through transition with a learning disability and/or autism.
- We will develop options to support people locally who are currently resident in out of area placements; including young people returning from school placements
- Future 52 week placements will only be made out of area in exceptional circumstances where needs cannot be met locally. A confirm and challenge process will be put in place before OOA placements are made.

How will you commission services differently?

- Dependent on transformation funding, a dedicated care co-ordinator will be employed with specific responsibility for discharge planning for suitable CCG and specialised commissioning funded inpatients.
- To further integrate and strengthen health and social care funding pathways in order to reduce funding barriers to early discharge.
- To drive up and manage quality of independent provision by jointly commissioning care and support providers.
- Developing the independent and third sector market to meet needs of people with high support needs through Personal Health Budgets.
- Develop more innovative commissioning arrangements based on achieving outcomes rather than block or activity based contracts.
- To scope opportunities for moving away from block arrangement NHS Leicestershire Partnership Trust LPT to support development of person centred services, particularly for respite care provision.

How will your local estate/housing base need to change?

Local NHS Trust Assessment and Treatment Unit
Currently, 16 out of the 20 beds are commissioned towards the assessment and treatment of individuals with Learning disabilities presenting with Challenging behaviour and/or Mental health problems. 4 of these beds have never been used and as part of the BCT planning, clinical models have been developed with an objective of further reducing the reliance on inpatient units by intensive care and Crisis management in the Community. This will lead to a reduction in a reduction of 4 beds over 2017/18 bringing the total number of beds in use to 12 beds.

It is recognised that a high cost and inflexible PFI on local Assessment and Treatment is a significant challenge on our current ability to redesigning services. During 2016/17 the partnership will need to detailed consideration to the ability to further reduce the local assessment and treatment bed base over the next 3 year and whether it is viable to continue provision at the Agnes Unit?

Independent sector inpatient facilities:
There are no specific adult independent sector LD inpatient facilities in LLR geographical area so no specific estate changes have been identified.

Where treatment and rehabilitation needs cannot be met by NHS Leicestershire Partnership Trust, some placements are made in regional and national facilities run by providers such as Cambian Healthcare and St. Andrews. Therefore there will be a need to work with regional partnership to understand the impact of their plans for independent sector provision on our patients in these facilities.

Short Breaks provision
Short breaks bed based provision currently includes:

- 15 health beds in three unit run by NHS Leicestershire Partnership Trust
- 28 social care beds in the county across 4 sites based in: Melton (6 beds), Wigston (6 beds), Hinckley (10 beds), Coalville (6 beds)

Short breaks (respite services) are currently provided by health and social care, with no consistency of cost or outcome. There is therefore a need to review the provision that is currently available with a view to increasing the choice and availability of short breaks to support carers of people with a learning disability and/or autism. This is also further supported by the increased take up of Personal Budgets in social care and the development of Health Personal Budgets allowing people more choice and flexibility about how, where and when they receive their support.

Our intention is to review all short break provision across LLR, which includes Health Short Breaks currently provided by Leicestershire Partnership NHS Trust at Rubicon Close, Gillivers and 1 The Grange. We will consult with people who use/ may use short break services on future options, based on the information we gather from current and potential service users, carers, commissioners and providers of services.

We will continue to ensure that people's health and social care needs are appropriately met but with greater flexibility. Our desired outcome is to provide a wider range of short break options that enable carers to have a break and provide a stimulating and enjoyable experience for the person accessing the service. Individuals should not be restricted to accessing particular short breaks because of their needs or because of the way in which services respond to their needs.

As part of BCT planning, various models of community short break provision are being scoped, with a view to improving the offer of more locally based short break provision responsive to Service user/carer needs.

Housing in the community
There is a particular challenge to develop appropriate long term accommodation for people with significant

challenging behaviour or behaviour that poses a risk to others and develop or identify suitable long term housing.

We have already started work with housing colleagues within Leicester City council and with District Councils to raise awareness of future needs and in individual cases look at potential options. We have also started exploring housing opportunities with independent sector providers.

Our planned market position statement will also support this challenge.

Alongside service redesign (e.g. investing in prevention/early intervention/community services); transformation in some areas will involve 'resettling' people who have been in hospital for many years. What will this look like and how will it be managed?

- We plan to employ a care co-coordinator with specific responsibility to support discharge back to the local provision for patients in AHP's and specialised commissioning placements. This post holder will work closely with NHS England/ CEM CHC Team/ providers to develop pen pictures of individuals suitable for resettlement and associated future accommodation needs.

- To use recently developed 'Step through' supported living.

- To review the role of the Agnes Unit in 'resettling' people who have been in hospital for many years supporting Step down and potential use of Agnes Unit.

- To review need to enhance current community forensic support services to meet needs of this cohort

How does this transformation plan fit with other plans and models to form a collective system response?

This plan closely aligns with:

- LLR 'Transformational Plan and Implementation Plan for the Mental Health & Wellbeing of Children and Young People 2015-2020'
- The 'local offer' for personal health budgets, and Integrated Personal Commissioning (combining health and social care
- The Leicester City Learning Disabilities Joint Commissioning Strategy 2015-19
- The LLR Autism Strategy 2014-19
- Leicester, Leicestershire and Rutland action plan to enable delivery of shared goals of the Mental Health Crisis Care Concordat
- Leicestershire County Council Commissioning Strategy 2016– 2020
- Better Care Together Strategy 2014-19

Any additional information

5.Delivery

Plans need to include key milestone dates and a risk register

What are the programmes of change/work streams needed to implement this plan?
To ensure delivery of this 3 year programme we will employ through transformational funding:

- A senior project manager (NHS Band 8a) to co-ordinate delivery of the plan.

- A care co-coordinator (NHS Band 7) with specific responsibility to support discharge for patients in AHP's and NHSE specialised commissioning placements.

We have identified the need of the following work streams to support deliver:

No.	Work stream	Key Deliverables	Key enablers	Supporting resources
1	**Admission & Prevention**	• Secure web based Admission Avoidance Register • Mainstream CTRs • Provide training and briefings for partners organisations	Quality leads with each CCG: Fiona Pimm LCCCG Anne Scott ELRCCG Alison Cain WLCCG	LD support officer within ELRCCG
2	**Strategic Commissioning**	• Scoping of integrated assessment, care management, commissioning and budgets • Better understanding of children's and autism cohort • Ensure people with a learning disability and/or autism and family carers are engaged and able to influence the scope and shape of the programme	CCG's/ LA's: Cheryl Bosworth ELRCCG John Singh LCCCG Yasmin Surti Leic. City Council Amanda Price Leics. County Council Emma Jane Perkins Rutland Council	Transforming Care Partnership Project manager
3	**Operational Commissioning**	• Enhanced and outreach support team staffed and operational by April 2016 • Support GP practices to implement health checks from 14+ • Safeguarding to prevent unnecessary admissions • Develop Person centred assessment and support planning • Explore Discharge to Assess model for in-patient services	LA's/LPT: Avinash Hiremath, LPT Tracey Burton Leics County Council Ranjan Ravat Leic. City Council	Programme Discharge care coordinator
4	**Market Development & Workforce**	• Develop and publish a health and social care Market Position Statement • Development of new local community based services • Support mainstream services to make reasonable adjustments • Develop a quality assurance scheme supported by experts by experience • Providers and carers trained and provided with tools to avoid admission	Sally Goadby Leicestershire Social Care Development group Nicola McCormack HEEM Christine Collymore Skills for Care	Workforce development post hosted by LSCDG
5	**Personal Health Budgets**	• Produce information and advice in accessible formats • Scope the potential for	CCG's/ LA's/LPT: Joyce Bowler ELRCCG Mariyam Sidik	Hosted PHB team with ELRCCG progressing

		integrated personal budgets • Support to help individuals and families manage their personal health budget • Provide support to assist people with learning disabilities and/or autism to communicate their needs and aspirations • Develop consistent and tailored advocacy support	ELRCCG	programme. Team includes a LD Nurse
6	**Short Breaks & Crisis Response**	• Scope the potential for a crisis intervention service • Develop enhanced support for carers, including short break provision • Support the decommissioning of inpatient beds	CCG's/LPT/ LA's Cheryl Bosworth ELRCCG Jane Martin LPT	BCT intern assigned to project manage work stream
7	**Finance**	• To identify total CCG, local authorities and NHS England Specialised funding available to support transformation • Scoping the likely effects financially, including the shifts from specialist to each CCG and secondary to each LA • Provide a detailed risk assessment and advice on how we will consider either pool or co-manage budgets • Ensure plans are being delivered within the financial resources available to partners • To develop a local NHS dowries policy framework for people who have been inpatients for more than five year at April 2016 & ready for discharge	CCG's/ LA's/NHSE Richard George Leic. County Council Daniel MacSwiney ELRCCG NHSE- tbc	Finance lead for each organisation to be allocated
8	**Comms and Engagement**	• To engage on plans with local LD Partnership Boards and BCT users and carer reference group • To undertake wider public engagement on plans (e.g. Online) • To develop a communication strategy to support the programme • To provide comms and engagement support to specific programme initiatives (e.g. Short breaks plans)	Rebecca Oakley Leicester City Council	

A detailed communication and engagement plan will be developed on this plan is agreed.

The Estate strategy to support the plan will be developed by the strategic commissioning work stream during 2016/17.

Through the Better Care Together programme we have already undertaken a workforce impact statement (see Annex B). This will form the basis of our workforce development plan.

Who is leading the delivery of each of these programmes, and what is the supporting team.

The LLR Transformation Care Partnership Board provides assurance of delivery of the programme and oversees progress across all the agreed work streams.

Its membership includes:

- Senior Responsible Owner (SRO), Sandy McMillan, Leicestershire County Council
- Deputy SRO, Jim Bosworth, East Leicestershire and Rutland CCG
- Clinical Lead, Avinash Hiremath, Leicestershire NHS Partnership Trust
- Learning Disabilities Implementation Manager, Cheryl Bosworth, East Leicestershire and Rutland CCG
- Implementation Lead, Yasmin Surti, Leicester City Council
- Specialised Commissioning Lead, Marcus Callaghan
- NHS England Lead, Russell Woolgar
- Head of Strategic Commissioning, Sue Wilson, Leicestershire County Council
- Head of Strategic Commissioning, Kate Galoppi, Leicester City Council
- Operational Team Manager, Emma Jane Perkins, Rutland County Council
- Steph Chapman, Family Carer, Better Care Together Public and Patient Involvement LD Lead

What are the key milestones – including milestones for when particular services will open/close?

2016-17	• Enhanced and redesigned LD outreach team fully operational April 2016 • Develop a PHB pilot for short break provision (as an alternative to residential provision). • Commission CAMHS Crisis Resolution and Home Treatment Service • Issue a Market position statement
2017-18	• 2 short stay beds closed Agnes Unit • Enhanced Autism service providing able to provide ongoing support to those with and without intellectual disability operational • Implement new health respite commissioning models • Scope need and feasibility of developing LLR Crisis intervention service or facility
2018-19	• Further 2 short stay beds closed Agnes Unit
	•

What are the risks, assumptions, issues and dependencies?

Risk No.	Category of Risk *(e.g. financial, reputational)*	Risk *(Include any assumptions made)*	Impact (1-5)	Probability (1-5)	Risk Score (1-25)	Mitigation actions
1	Programme Funding	Failure to secure central transformation funds to support programme RISK; lack of resources to deliver programme	5	2	10	Seek early clarity from NHSE on allocation of transformation funding. Consider secondment roles within Partnership to help deliver programme
2	Project Focus	The project is multi-faceted – requiring collaboration across organisational and professional boundaries RISK: Failure to successfully collaborate	5	2	10	Dedicated senior project manager to be appointed from transformational funding. Focus on defined, affordable, deliverables in key areas and delivery through identified work streams.
3	Programme Board membership	Ability to establish appropriate level of stakeholders on the board RISK: Not having suitable stakeholders and thus not having intended level of views and opinions.	5	1	5	Ensure stakeholders are hand-picked and agreed in.
4	Commitment	Programme requires high level of commitment from stakeholders RISK: Failure to maintain commitment and attendance	4	2	8	Ensure meeting dates are agreed in advance and circulated with appropriate notice.
5	Enhancing LD Outreach Team	Recruitment of additional nursing and therapy staff to outreach team RISK: Failure to mobilised enhanced service for April 2016	5	2	10	Monthly meeting with service to support mobilisation of enhanced service
6	Review of Short Breaks provision	Failure to remodel current building based model given previous attempts RISK: Development of personalised models and impact on take up of PHB	4	3	12	Close project management of work stream and strong consultation plans to be developed. Develop a phased approach with initial PHB pilot focusing on young people going through transition.

7	Care & Treatment Reviews	Failure to implement Care and Treatment Reviews and Positive follow work plans appropriately. RISK: Admission avoidance options not fully considered in individual cases	**4**	**2**	**8**	Dedicated post within each CCG to managed CTR process Training for health and social care staff on CTR process.
8	ATU buildings cost	Managing cost of PFI funding on Agnes Unit whilst reducing bed numbers and exploring alternatives uses. RISK: Financial sustainability of programme & being able to develop community resources	**4**	**4**	**16**	Consider transitional funding to support service redesign. LPT to explore future options for Agnes Unit as part of their Estates Strategy.
9	Workforce Skills	Required workforce skills and capacity do not develop sufficiently	**3**	**3**	**9**	Development of sector wide workforce development plan in 2016.

What risk mitigations do you have in place?

See above table

Any additional information

6.Finances

Please complete the activity and finance template to set this out (attached as an annex).

End of planning template

Annex A – Developing a basket of quality of care indicators

Over the summer, a review led by the Department of Health was undertaken of existing indicators that areas could use to monitor quality of care and progress in implementing the national service model. These indicators are not mandatory, but have been recommended by a panel of experts drawn from across health and social care. Discussion is ongoing as to how these indicators and others might be used at a national level to monitor quality of care.

This Annex gives the technical description of the indicators recommended for local use to monitor quality of care. The indicators cover hospital and community services. The data is not specific to people in the transforming care cohort.[1]

The table below refers in several places to people with a learning disability or autism in the Mental Health Services Data Set (MHSDS). This should be taken as an abbreviation for people recorded as having activity in the dataset who meet one or more of the following criteria:

1. They are identified by the Protected Characteristics Protocol - Disability as having a response score for PCP-D Question 1 (Do you have any physical or mental health conditions lasting, or expected to last, 12 months or more?) of 1 (Yes – limited a lot) or 2 (Yes – limited a little), and a response score of 1 or 2 (same interpretation) to items PCP-D Question 5 (Do you have difficulty with your memory or ability to concentrate, learn or understand which started before you reached the age of 18?) or PCP-D Question 13 (Autism Spectrum Conditions)
2. They are assigned an ICD10 diagnosis in the groups F70-F99, F84-849, F819
3. They are admitted to hospital with a HES main specialty of psychiatry of learning disabilities
4. They are seen on more than one occasion in outpatients by a consultant in the specialty psychiatry of learning disabilities (do not include autism diagnostic assessments unless they give rise to a relevant diagnosis)
5. They are looked after by a clinical team categorised as Learning Disability Service (C01), Autistic Spectrum Disorder Service (C02)

[1] Please refer to the original source to understand the extent to which people with autism are categorised in the data collection

Indicator No.	Indicator	Source	Measurement[2]
1	Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator	Mental Health Services Data Set (MHSDS)	Average census calculation applied to: • Denominator: inpatient person-days for patients identified as having a learning disability or autism. • Numerator: person days in denominator where the following two characteristics are met: (1). Face to face contact event with a staff member flagged as the current Care Co-ordinator (MHD_CareCoordinator_Flag) in preceding 28 days; and 2. Care review (Event record with MHD_EventType 'Review') within the preceding 12 months.
2 222	Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget (Not possible to include people with autism but not learning disability in this indicator)	Short and Long Term Support statistics	This indicator can only be produced for upper tier local authority geography. Denominator: Sum of clients accessing long term support, community services only funded by full or part direct payments, managed personal budget or commissioned support only. Numerator: all those in the denominator excluding those on commissioned support only. Recommended threshold: This figure should be greater than 60%.
3	Proportion of people with a learning disability or autism readmitted within a specified period of discharge from hospital	Hospital Episodes Statistics (HES) and Assuring Transformation datasets. Readmission following discharge with HES main	HES are the long established and most reliable indicator of the fact of admission and readmission. • Denominator: discharges (not including transfers or deaths) from inpatient care where the person is identified as having a learning disability or autism • Numerator: admissions to psychiatric inpatient care within specified period

[2] Except where specified, all indicators are presumed to be for CCG areas, with patients allocated as for ordinary secondary care funding responsibility.

		specialty - Psychiatry of Learning Disabilities or diagnosis of a learning disability or autism.	The consultation took 90 days as the specified period for readmission. We would recommend that this period should be reviewed in light of emerging readmission patterns. Particular attention should be paid to whether a distinct group of rapid readmissions is apparent. NHS England is undertaking an exercise to reconcile HES and Assuring Transformation data sets, to understand any differences between the two. At present NHS England will use Assuring Transformation data as its main source of information, and will be monitoring 28-day and 12-month readmission.
4 223	Proportion of people with a learning disability receiving an annual health check. (People with autism but not learning disability are not included in this scheme)	Calculating Quality Reporting Service, the mechanism used for monitoring **GP** Enhanced Services including the learning disability annual health check.	Two figures should be presented here. • Denominator: In both cases the denominator is the number of people in the CCG area who are on their GP's learning disability register • Numerator 1. The first (which is the key variable) takes as numerator the number of those on their GPs learning disability register who have had an annual health check in the most recent year for which data are available • Numerator 2. The second indicator has as its numerator the number of people with a learning disability on their GPs learning disability health check register. This will identify the extent to which GPs in an area are participating in the scheme
5	Waiting times for new psychiatric referral for people with a learning disability or autism	MHSDS. New referrals are recorded in the Referrals table of the MHSDS.	• Denominator: Referrals to specialist mental health services of individuals identified in this or prior episodes of care as having a learning disability or autism • Numerator: Referrals where interval between referral request and first subsequent clinical contact is within 18 weeks
6	Proportion of looked after people with	MHSDS. (This is	Method – average census.

	learning disability or autism for whom there is a crisis plan	identifiable in MHMDS returns from the fields CRISISCREATE and CRISISUPDATE)	• Denominator: person-days for patients in current spell of care with a specialist mental health care provider who are identified as having a learning disability or autism or with a responsible clinician assignment of a person with specialty Psychiatry of Learning Disabilities • Numerator: person days in denominator where there is a current crisis plan

Annex B Workforce Impact Assessment

BCT Work Stream: Learning Disability

Identifying Gap	Approach to Filling Gap	Actions / Owners / Time Line – Delivery Dates	Challenges / Risk / Mitigation
What is the workforce change required to delivery "redesigned service/new models of care/new setting of care"? The move to left-shift Learning Disability services into the community means a move from larger specialist providers, such as LPT, to a much more diverse and fragmented range of providers in the private and voluntary sector, as well as Personal Assistants and Domiciliary Care Providers. This workforce is less well paid, sometimes with poor English, and consequently more transient, much harder to quantify, assess and train. In additional there is heavy reliance on e-learning with fewer opportunities for supervision and synthesising new learning into practice, all of which mitigate against promoting independence and trying new approaches. There are a high number of prisons within LLR and it's known that nationally people with Autism and learning disabilities are over-represented and under-diagnosed in prisons, and there is no reason to assume LLR is different. LPT provide healthcare services in several prisons, drawing from the same pool of potential staff. Both Leicestershire County and Leicester City	**Are new roles required or changes to existing roles?** Services to people with Learning Disabilities and Autism would improve if all health care staff, including non-clinical staff, had a better understanding of how to communicate with people with LD. This is particularly the case in Primary Care **What, if any, is the educational intervention required to deliver the required future workforce?** BCT 'Challenging Behaviour Strategy' will help identify training for anyone involved in health and social care services to support access to universal health care services. Joint training between health and social care specialist LD staff would help improve their understanding of each other's services and ways of working. LPT and Leicestershire County Council have both found that newly qualified nurses/social workers are poor at communicating with people with Learning Disabilities (anecdotally some social work recruits were reluctant to attend an interview which involved a user panel). LPT	**Retraining & Recruitment** Shortage of LD nurses and social workers, both newly qualified and more experienced. **Balance of skills** Need for skills in specialist LD services but also importance of knowledge of LD/Autism among the whole health and social care workforce to ensure access to ordinary services. For example, a disproportionate number of people with LD die in UHL due to late diagnosis of cancer. This could be due to lack of screening, fragmented support staff, difficulties in describing the symptoms to health care staff, dismissal of symptoms by GPs, lack of support in accessing treatment etc. Many people with Autism struggle access services, often not getting through GP receptionists or Local Authority call centres: the LLR Autism Strategy aims to address this through training for all staff re basic awareness of Autism and some re-configuration of Local Authority systems. Within Leicester City CCG Autism awareness has been included in protected learning time for GPs	**Supply** Shortage of LD nurses and social workers, both newly qualified and more experienced. **Recruitment & Retention** Difficulties in recruiting staff who as general shortage of qualified staff, so applicants are often juggling several job offers, or fail to turn up for interview. **Education** The range of different service providers across LD means that it is very difficult to know what training they supply to staff and its quality e.g. does it follow NICE Guidance. See example in balance of skills section. **Experience (community v acute)** Balance between specialist / general services and arranging specialist services to be able to make links with general services while maintaining critical mass of expertise. **Modelling** Not discussed, though noted that LPT LD services functionally mapped eight of their

Councils are re-organising their Care Manager teams into more specialist teams which will increase the level of knowledge re LD in these teams, and should create a more appropriate approach to managing contracts, where the provider has to take some responsibility for supporting the service-user when things become 'difficult' It's noted that the current arrangements for managing CHC – out-sourced to GEM – doesn't measure the right outcome to provide good services to people with LD. Five Year Forward View encourages the development of multi-speciality providers but in a neighbourhood /locality model there would not be enough expertise to provide a good service to people with Learning Disabilities. Instead LPT are re-designing their Community Services to work in three geographical areas: this should provide a more local service but retain a critical mass of LD expertise who can share information and forge stronger links with universal local providers. This will happen in this financial year, and will produce more detailed workforce information. Other developments which will impact of workforce ▪ Review of LPT Short Breaks service	Are working with DMU to address their concerns with the curriculum in LD nursing and SaLT and have also ensured that general nurses have some experience of LD services during their pre-registration training. There is a need for education and training across the whole LLR non LD workforce in ▪ Mental Capacity Act ▪ The 2014 Care Act ▪ Recognising and working with people with Autism. The LLR Autism Board (across health and social care) is currently auditing what training is available and how many health and social care staff have accessed it. **Managing Supply (International recruitment, redeployment, secondment, improved retention, return to practice, adaptation etc.)** It was noted that LD nursing commissions at DMU have increased in the last year, but some of this is to make up a shortfall from Nottingham University, and DMU will be seeking placements for these extra students north of LLR. LPT is struggling to recruit LD nurses at both newly qualified and experienced level, but finds it even more difficult to recruit RMNs.	The delivery of support to people with LD with additional physical health needs by a wider variety of providers will increase the demand for skills in specific health tasks such as peg-feeding. Unlike the tasks covered in the Health and Social care protocols these are often tasks required for life rather than a few weeks. LPT is the local organisation with the skills to supply this training but need to ensure that ▪ Providers are aware of the training and access it, across a changing staff team ▪ There are appropriate structures and protocols to ensure the training is effective in the place of care ▪ LPT is paid for this work Failure to address these issues will mean that these patients will become ill and become emergency admissions at UHL ED. **What further work is required?** Influencing GP training Finding ways to provide safe effective training re specific health care tasks to varied and changing support workforce employed in community and domestic settings. **Is further support required, and from whom?**	pathways in 2012-13. **7-Day Working** Not discussed

▪ Development of LPT enhanced outreach service for challenging behaviour which will support people in the community and reduce acute admissions. ▪ Development of Leicestershire County Council Step Up Step Down service supporting people to live in the community All of these initiatives will produce demand for a new/different workforce and these will be quantified over the next few months **What are the capacity gaps for this area/clinical pathway?** There is a need for really good communication skills including easy read documents, understanding non-verbal communications, positive behavioural support among both the specialist LD workforce but also in general health care workforce so that people with LD and Autism receive good access to ordinary health care through GP and other community services. This includes non-clinical staff such as receptionists. The BCT LD work-stream may develop a 'Challenging Behaviour Strategy' across LLR to support a consistent approach to clients/patients/service-users and prevent them being 'bounced' around the system.	Similarly both Local Authorities are finding it difficult to recruit Social Workers	Given the lack of knowledge re Learning Disability/Autism among GPs it would be useful to have some influence / input into GP training, but LPT has not yet found a way to achieve this.	

Mainstream Mental Health services use a 'Green Light' tool to assess if a person with mental health problems also has LD/Autism. With better networking and informal arrangements have improved services to people with LD/Autism in specialist mental health services and UHL but there is still room for improvement in both LPT Community Hospitals and General Practice. There is a particular problem in identifying people with LD who develop dementia, and this has been raised with the BCT dementia work stream. **Supply of workforce at what level? (e.g. Foundation, Generic, Enhanced, Specialist)** 228			

Transforming Care Partnership Plans

= Cells to be completed

GUIDANCE: Activity Data

As part of the CCG planning round TCPs will be required to submit 3 year trajectories of inpatient numbers for patients with LD or autistic spectrum disorder. The information collected in this template about inpatient numbers uses the same definitions and timeframes and should match what is submitted through the planning round.

Who is included in the inpatient trajectories?

The definition for inclusion is that used by the Assuring Transformation data collection (http://www.hscic.gov.uk/assuringtransformation). Include any person in an in-patient bed for mental and/or behavioural healthcare needs who has learning disabilities or autistic spectrum disorder (including Asperger's syndrome), of any age, ward security and status under the Mental Health Act.

Quarterly Trajectories over 3 Years (No. of Learning Disability Inpatients at the end of each quarter)

The trajectories are aiming to capture the total number of people with a learning disability and/or autism in inpatient care at the end of each quarter, in a specialist hospital bed (either MH or LD). The inpatient trajectories must be on a Transforming Care Partnership (TCP) basis. Trajectories are not based on who pays for care, but on the CCG/TCP of origin, i.e. where their home, or normal place of residence prior to hospital admission, is located, so patients whose care is commissioned by NHS England Specialised Commissioning Teams are reported against their TCP of origin. Figures presented in the TCP Joint Transformation plan through this annex should be consistent with the figures supplied through Unify as part of the CCG planning round.

Submitting CCG:	NHS East Leicestershire and Rutland
Submitting CCG Code	03W
Name of Transforming Care Partnership (TCP):	Leicester, Leicestershire and Rutland CCG

Select the CCGs within the Transforming Care Partnership (TCP)
NHS East Leicestershire and Rutland
NHS Leicester City
NHS West Leicestershire
If entry is red, you have selected a CCG twice, please re-select

GP Registered Population (18+) of Transforming Care Partnership:	853746

Transforming Care Partnership Learning Disability Inpatient Projections (including all patients originating from within the TCP, both NHS England- and CCG- commissioned)

	Year 0 (2015/16)	Year 1 (2016/17)				Year 2 (2017/18)				Year 3 (2018/19)			
	as at 31/03/16	as at 30/06/16	as at 30/09/16	as at 31/12/16	as at 31/03/17	as at 30/06/17	as at 30/09/17	as at 31/12/17	as at 31/03/18	as at 30/06/18	as at 30/09/18	as at 31/12/18	as at 31/03/19
NHS England commissioned inpatients	13	12	12	11	11	10	10	9	9	8	8	7	7
Inpatient Rate per Million GP Registered Population NHS England commissioned***	15.23	14.06	14.06	12.88	12.88	11.71	11.71	10.54	10.54	9.37	9.37	8.20	8.20
CCG commissioned inpatients	26	24	23	22	22	20	18	17	16	15	14	13	12
Inpatient Rate per Million GP Registered Population CCG commissioned***	30.45	28.11	26.94	25.77	25.77	23.43	21.08	19.91	18.74	17.57	16.40	15.23	14.06
Total No. of Inpatients with learning disabilities and/or autism* (TCP level; and by TCP of origin)**	39	36	35	33	33	30	28	26	25	23	22	20	19
Total Inpatient Rate per Million GP Registered Population ***	45.68	42.17	41.00	38.65	38.65	35.14	32.80	30.45	29.28	26.94	25.77	23.43	22.25

Important Notes

* People in an in-patient bed for mental and/or behavioural healthcare needs and has learning disabilities or autistic spectrum disorder (including Asperger's syndrome) of any age or security type.

** Quarterly projected figures are not on the basis of who pays, but on the basis of the Transforming Care Partnership the patient originates from, i.e. where their home, or normal place of residence prior to hospital admission, is located.

*** The national plan "Building the Right Support" published on 30 October 2015 sets out a planning assumption that each TCP will reduce reliance on inpatient care, and where they are currently above this level, will plan to reach an inpatient rate within the range 20-25 inpatients per million population for NHS England commissioned services and 10-15 inpatients per million for CCG commissioned services by March 2019.

Instructions

1. Please complete this template in relation to people **of all ages** originating within the area of your Transforming Care Partnership, regardless of who commissions the service or where it is currently delivered.
2. Please **complete the cells marked in yellow as a minimum**. = Cells to be completed
3. Please ignore / do not complete cells marked in grey = Cells to be ignored
4. Sections marked in light green are optional. Please provide the breakdown of inpatients by bed type if available, or if this assists with demonstrating or modelling the overall costs. If supplying optional bed type data, please ensure the totals match the yellow mandatory cells. = Completion is optional
5. Please complete any cell relating to costing in £s, e.g. one thousand pounds as £1000

1. INPATIENT PROVISION & UTILISATION

Inpatients originating from TCP population	2015/16 (current state)								2016/17 (Year 1)					2017/18 (Year 2)					2018/19 (Year 3)				
	Latest position (as at 31/12/2015)	Forecast at year end 2015/16 (as at 31/03/2016)			Costs				Number of inpatients	Costs				Number of inpatients	Costs				Number of inpatients	Costs			
	Total number of inpatients: 31/12/2015	Projected total number of inpatients: 31/03/2016 (from LD Patient Projections tab)	Number inpatient for **less** than 5 years as at 01/04/16	Number inpatient for **more** than 5 years as at 01/04/16	Average cost per bed day (£)	Estimated bed days during 2015/16 (calculated from inpatient figures)	Bed days during 2015/16 - Prefilled with estimated bed-days, please overwrite with best estimate	Annual cost (£)	Projected total number of inpatients: 31/03/2017 (from LD Patient Projections tab)	Average cost per bed day (£)	Estimated bed days during 2016/17 (calculated from inpatient figures)	Bed days during 2016/17 - Prefilled with estimated bed-days, please overwrite with best estimate	Annual cost (£)	Projected total number of inpatients: 31/03/2018 (from LD Patient Projections tab)	Average cost per bed day (£)	Estimated bed days during 2017/18 (calculated from inpatient figures)	Bed days during 2017/18 - Prefilled with estimated bed-days, please overwrite with best estimate	Annual cost (£)	Projected total number of inpatients: 31/03/2019 (from LD Patient Projections tab)	Average cost per bed day (£)	Estimated bed days during 2018/19 (calculated from inpatient figures)	Bed days during 2018/19 - Prefilled with estimated bed-days, please overwrite with best estimate	Annual cost (£)
CCG commissioned patients	**26**	**26**	**25**	**1**	**£793**	9490	9490	£7,525,570	**22**	**£867**	8760	8760	£7,594,920	**16**	**£952**	6935	6935	£6,604,478	**12**	**£928.11**	5110	5110	£4,742,628
CCG commissioned patients - total of bed types	26	26				9490	9490	£7,943,495	22		8760	8760	£7,309,673	16		6935	6935	£5,854,965	12		5110	5110	£4,742,628
Acute admission beds within specialised learning disability units	11	11			£1,452.00	4015	4015	£5,829,780	9	£1,452.00	3650	3650	£5,299,800	7	£1,452.00	2920	2920	£4,239,840	7	£1,452.00	2555	2555	£3,709,860
Acute admission beds within generic mental health settings	2	2			£286.00	730	730	£208,780	1	£286.00	548	548	£156,585	1	£286.00	365	365	£104,390	0	£286.00	183	183	£52,195
Forensic rehabilitation beds						0	0	£0			0	0	£0			0	0	£0			0	0	£0
Complex continuing care and rehabilitation beds	3	3			£283.00	1095	1095	£309,885	2	£283.00	913	913	£258,238	1	£283.00	548	548	£154,943	1	£283.00	365	365	£103,295
Other beds	10	10			£437.00	3650	3650	£1,595,050	10	£437.00	3650	3650	£1,595,050	7	£437.00	3103	3103	£1,355,793	4	£437.00	2008	2008	£877,278
NHS England Specialised Commissioned patients	**13**	**13**	**7**	**6**	**£577**	4745	4745	£2,737,865	**11**	**£577**	4380	4380	£2,527,260	**9**	**£577**	3650	3650	£2,106,050	**7**	**£577**	2920	2920	£1,684,840
NHS England commissioned patients - total of bed types	13	13				4745	4745	£2,503,900	11		4380	4380	£0	9		3650	3650	£0	7		2920	2920	£0
High secure forensic beds	0	0			£604.00	0	0	£0	0		0	0	£0	0		0	0	£0	0		0	0	£0
Medium secure forensic beds	4	4			£525.00	1460	1460	£766,500	3		1278	1278	£0	3		1095	1095	£0	2		913	913	£0
Low secure forensic beds	7	7			£480.00	2555	2555	£1,226,400	6		2373	2373	£0	4		1825	1825	£0	3		1278	1278	£0
CAMHS	2	2			£700.00	730	730	£511,000	2		730	730	£0	2		730	730	£0	2		730	730	£0
Other NHS England commissioned beds	0	0			£0.00	0	0	£0	0		0	0	£0	0		0	0	£0	0		0	0	£0
All inpatients originating from TCP population (CCG or NHS England commissioned)	**39**	**39**	**32**	**7**				**£ 10,263,435**	**33**				**£ 10,122,180**	**25**				**£ 8,710,528**	**19**				**£ 6,427,468**

2. COMMUNITY PROVISION

Individual packages of support	2015/16 (current state)					2016/17 (Year 1)					2017/18 (Year 2)					2018/19 (Year 3)				
	Number of packages	Average annual cost per package to CCGs (£)	Average annual cost per package to local govt (£)	Total annual cost to CCGs (£)	Total annual cost to local govt (£)	Number of packages	Average annual cost per package to CCGs (£)	Average annual cost per package to local govt (£)	Total annual cost to CCGs (£)	Total annual cost to local govt (£)	Number of packages	Average annual cost per package to CCGs (£)	Average annual cost per package to local govt (£)	Total annual cost to CCGs (£)	Total annual cost to local govt (£)	Number of packages	Average annual cost per package to CCGs (£)	Average annual cost per package to local govt (£)	Total annual cost to CCGs (£)	Total annual cost to local govt (£)
NHS-funded packages of support (e.g. S117/CHC) in community settings for former inpatients	8	£106,082.00		£848,656		10	£106,082.00		£1,060,820		12	£106,082		£1,272,984		13	£106,082.00		£1,379,066	
Local authority-funded packages of support in community settings for former inpatients (Former inpatients on this template should include those discharged after 1st April 2009).	21		£34,812.00		£731,052	22		£34,812.00		£765,864	23		£34,812.00		£800,676	24		£34,812.00		£835,488
Joint NHS/local government funded packages of support in community settings for former inpatients	7	£33,441.00	£24,371.00	£234,087	£170,597	10	£33,441.00	£24,371.00	£334,410	£243,710	13	£33,441.00	£24,371.00	£434,733	£316,823	15	£33,441.00	£24,371.00	£501,615	£365,565
NHS-funded packages of support in community settings for other people at risk of admission	2	£68,035.00		£136,070					£0					£0					£0	
Local authority-funded packages of support in community settings for other people at risk of admission	2		£84,027.00		£168,054					£0					£0					£0
Joint NHS/local government funded packages of support in community settings for other people at risk of admission	1		£103,828.00	£0	£103,828				£0	£0				£0	£0				£0	£0
NHS-funded packages of support in community settings for children and young people				£0					£0					£0					£0	
Local authority-funded packages of support in community settings for children and young people					£0					£0					£0					£0
Joint NHS/local government funded packages of support in community settings for children and young people				£0	£0				£0	£0				£0	£0				£0	£0

Services catering to many individuals (e.g. Community Learning Disability Team, crisis support team)	2015/16 (current state)			2016/17 (Year 1)			2017/18 (Year 2)			2018/19 (Year 3)		
	Annual cost to CCG(s) in 15/16 (£)	Annual cost to NHS England spec com in 15/16 (£)	Annual cost to local govt in 15/16 (£)	Annual cost to CCG(s) in 16/17 (£)	Annual cost to NHS England spec com in 16/17 (£)	Annual cost to local govt in 16/17 (£)	Annual cost to CCG(s) in 17/18 (£)	Annual cost to NHS England spec com in 17/18 (£)	Annual cost to local govt in 17/18 (£)	Annual cost to CCG(s) in 18/19(£)	Annual cost to NHS England spec com in 18/19 (£)	Annual cost to local govt in 18/19 (£)
LD Outreach Team	£715,000			£919,865			£919,865			£919,865		
LD Community Teams	£2,260,000			£2,284,860			£2,284,860			£2,284,860		
LD Occupational Therapists	£495,000			£500,445			£500,445			£500,445		
LD Physiotherapists	£630,000			£636,930			£636,930			£636,930		
LD Psychologists	£305,000			£308,355			£308,355			£308,355		
LD Speech and language Therapists	£615,000			£621,765			£621,765			£621,765		
LD Short Breaks	£2,056,000			£2,078,616			£2,078,616			£2,078,616		
LD Outpatients	£1,318,000			£1,332,498			£1,332,498			£1,332,498		
Local Authority Commissioned LD Services (City) for breakdown see below			£27,664,000			£30,292,080			£32,866,907			£35,660,594
Local Authority In-house Day Services (City)			£3,562,000			£3,900,390			£4,231,923			£4,591,637
Local Authority LD Voluntary Sector funded services (City)			£476,000			£521,220			£565,524			£613,593
Local Authority Commissioned LD Services (Rutland)			£1,431,770									
Local Authority Commissioned LD Services (Leicestershire County)			£44,904,000			£44,500,000			£45,123,000			£46,657,000

If you have additional services, please use the additional information cell at the bottom of the form

3. TOTAL REVENUE COSTS

	2015/16 (current state)				2016/17 (Year 1)				2017/18 (Year 2)				2018/19 (Year 3)			
	Cost to CCGs (£)	Cost to NHS England (£)	Cost to local govt (£)	Total (£)	Cost to CCGs (£)	Cost to NHS England (£)	Cost to local govt (£)	Total (£)	Cost to CCGs (£)	Cost to NHS England (£)	Cost to local govt (£)	Total (£)	Cost to CCGs (£)	Cost to NHS England (£)	Cost to local govt (£)	Total (£)
Forecast annual cost of inpatient provision used by TCP population	£7,525,570	£2,737,865		£10,263,435	£7,594,920	£2,527,260		£10,122,180	£6,604,478	£2,106,050		£8,710,528	£4,742,628	£1,684,840		£6,427,468
Forecast annual cost of individual community support packages for former inpatients/those at risk of admission	£1,218,813		£1,173,531	£2,392,344	£1,395,230		£1,009,574	£2,404,804	£1,707,717		£1,117,499	£2,825,216	£1,880,681		£1,201,053	£3,081,734
Forecast annual cost of community services	£8,394,000	£0	£78,037,770	£86,431,770	£8,683,334	£0	£79,213,690	£87,897,024	£8,683,334	£0	£82,787,354	£91,470,688	£8,683,334	£0	£87,522,824	£96,206,158
Total	**£17,138,383**	**£2,737,865**	**£79,211,301**	**£99,087,549**	**£17,673,484**	**£2,527,260**	**£80,223,264**	**£100,424,008**	**£16,995,529**	**£2,106,050**	**£83,904,853**	**£103,006,432**	**£15,306,643**	**£1,684,840**	**£88,723,877**	**£105,715,359**

4. CAPITAL INVESTMENT/RECEIPTS

	2015/16 (current state)	2016/17 (Year 1)	2017/18 (Year 2)	2018/19 (Year 3)
	2015/16	2016/17	2017/18	2018/19
Forecast capital investment required to support discharges to year end (£)				
Forecast capital receipts from any estate sales (under legal charge) to year end (£)				

Additional information

Line 19 - CCG Commissioned inpatient bed trajectory is based on the patient turnover looking at discharges and length of inpatient stays over the past 18 months in conjunction with new admission avoidance processes and enhanced LD Outreach Team.
Line 28 - specialised commissioning inpatient trajectory was provided by NHSE Leicestershire and Lincolnshire Area Team
Line 44 - CCGs hold detailed information regarding former inpatients with LD and/or Autism which goes back to 07/2014 - this has enabled us to identify which of these people are in receipt of NHS funded CHC or S117 packages of care. To get details for patients prior to this date would require a large-scale paper-file exercise as the electronic system used by LLR's Commissioning Support Unit does not list LD and/or Autism as a separate code.
Line 45 - as above the details of former inpatients since 07/2014 have been used to identify the costs of local authority packages.
Line 46 - as line 45 above.
Lines 44046 – for future years predicted costs are based on the numbers of people who will coming out of an inpatient setting using our CCG inpatient trajectory figures.
Lines 47-49 - LLR 'At Risk' register processes are still being set up. The majority of people on the current lists have been previous inpatients, so the costs of their packages would have been included in lines 44-46 above. An online system is being implemented and training will be rolled out to local authorities, so larger number of people will be expected on this register in the coming months and more accurate information on care packages will be known.
Lines 50-52 – The CCGs can identify the number of children who receive NHS funding but these cases are classified as "complex care" and further work is needed to identify whether they have LD and/or Autism. Information from local authorities is varied and classification of LD is not clear and often relates to 'learning difficulties' or SEND, further work on this will need to be done.
Lines 63-65 - a total figure has been given for each local authority, this includes all LD services; residential & nursing, direct payments, home care, supported living, shared lives, day services, transport and LD voluntary sector funded services. We are still awaiting future costs for Rutland County Council for years 16/17, 17/18 and 18/19.

Describe estimated requirement for Transformation Funding

Please describe and prioritise transformation funding requirements. Please provide as much detail as possible, explaining your requirements in the text of your plan.

Item	Costing assumptions	Item Cost (£)
Cost item 1 (please describe in this cell)	NHS Band 8a Project Manager for Transforming Care Plan (PMO Office)	£60,000
Cost item 2 (please describe in this cell)	NHS Band 7 Transforming Care - Care Coordinator (host TBC)	£52,000
Cost item 3 (please describe in this cell)	Specialist Positive Behavioural Support Planning Resource for LD and Autism (all age)	£50,000
Cost item 4 (please describe in this cell)	Workforce development (training packages on meeting the needs of people with LD and/or autism - communication) 3	£20,000
Cost item 5 (please describe in this cell)	Independent advocacy services to support discharge and admissions avoidance	£50,000
Cost item 6 (please describe in this cell)	Piloting personalised and flexible short breaks provision with young people going through transition	£200,000
Cost item 7 (please describe in this cell)	Commissioning voluntary sector to support health promotion	£50,000
Cost item 8 (please describe in this cell)	Additional SALT provision within LD Outreach Team	£25,000
Cost item 9 (please describe in this cell)	Piloting Crisis Intervention Service/Facility	£200,000
Cost item 10 (please describe in this cell)	Total Revenue Funding	£707,000
Cost item 11 (please describe in this cell)		
Cost item 12 (please describe in this cell)	Developing Step down and Step through housing provision (Capital Funding)	£700,000
Cost item 13 (please describe in this cell)		
Cost item 14 (please describe in this cell)		
Cost item 15 (please describe in this cell)		
Cost item 16 (please describe in this cell)		
Cost item 17 (please describe in this cell)		
Cost item 18 (please describe in this cell)		
Cost item 19 (please describe in this cell)		
Cost item 20 (please describe in this cell)		
	Total	**£1,407,000**

Please describe match funding here. Please provide as much detail as possible, breaking down contributions by source and financial year (2016/17, 2017/18 or 2018/19)

*Enhancement of the LD Outreach Team - £398,000 from 2016/17 onwards.
* LD Implementation Manager , with a role to support TCP, working across the 3 CCGs -£40,500 annually .
* Recruitment of an LD Support Officer for Assuring Transformation Data Collection and CTR/Blue Light Meeting Coordination-£27,000 annually.
* Commissioning of a post-diagnostic support service for people with Aspergers without an intellectual disability - £174,000