Integrated Care System
Nottingham & Nottinghamshire

2022/23 Better Care Fund Narrative Plan

Nottingham City HWB
Nottinghamshire County HWB

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Background

- Aim of the BCF
- Local approach to collaborative commissioning
- Reviewing the 21/22 plan
- Governance

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Aim of the Better Care Fund

The Better Care Fund (BCF) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care .

The ICS is committed to drive collaboration, innovation and integration through the BCF plans.

There are two joint plans: one agreed by Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottingham City Council; and one agreed by Nottingham and Nottinghamshire Integrated Care Board (ICB) and Nottinghamshire County Council. The plans are owned by the Health and Wellbeing Boards (HWBs) and governed by an agreement under section 75 of the NHS Act (2006).

The national conditions for the BCF 2022-23 are:

- Jointly agreed plan between local health and social care signed off by the health and wellbeing board.
- NHS contribution to adult social care to be maintained in line with the uplift to NHS minimum contribution
- Invest in NHS commissioned out-of-hospital services
- Implementing the BCF policy objectives:
    - Enable people to stay well, safe and independent at home for longer
    - Provide the right care in the right place at the right time.

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ICS approach to Collaborative Commissioning

A "Joint commissioning for Integrated Care" workstream with representatives from Nottingham City Council, Nottinghamshire County Council and Nottingham and Nottinghamshire ICB has been providing leadership to develop the role of Collaborative Commissioning as an enabler to deliver integrated care within the ICS.

A Framework has been agreed which sets out the principles for collaborative commissioning, based on an assessment of current ways of working, learning from other systems in England, and reflections from key policy documents.

The principles are now being confirmed through a number of test pieces in a "learning laboratory" approach that applies a consistent methodology to identify success factors for, and barriers to, successful collaborative commissioning. This learning will form the basis for scaling up our approach to collaborative commissioning.

A "Collaborative Commissioning Oversight Group" (CCOG) has been established to provide ongoing leadership for new ways of commissioning. As well as providing leadership and co-ordination for specific areas of collaborative commissioning, the group will inform system development priorities, including the development of integrated delivery approaches at Place.

CCOG will provide the strategic steer to the BCF Oversight Group, supporting the development of a 23-25 BCF Plan and ensuring this reflects changes to commissioned services and collective oversight of resources and outcomes.

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Our Collaborative Planning and Commissioning Framework

VISION

To deliver **Integrated Health and Care** within the ICS, joining up strategic leadership and the transformation of health and care to improve outcomes for our population, ensuring decision making is led and integrated at the appropriate population level, with an emphasis on subsidiarity.

PRINCIPLES

Why we are taking this approach

- We will deliver improved outcomes and reduce health inequalities, driven by an understanding of the needs of our population
- We will optimise the use of our collective resource by reducing duplication, moving away from services commissioned and delivered in silos, making it easier for people to access the right support or care to meet their needs
- We will enable providers to work collaboratively to deliver improved quality and efficiencies

What we will do together

- We will work with our population to ensure they are involved in decision making at all stages of planning and delivery
- We will work as health and care partners, considering the opportunities for person centred integrated delivery for every decision we make
- We will focus on early intervention and prevention to support people to avoid increasing levels of support / cost
- We will use the best available evidence to support our decision making

How we will work

- Our Place Based Partnerships will drive our integrated health and care approach, bring together the planning and delivery of integrated care
- We will have transparency in our decision making, sharing financial and outcomes information to reach a collective decision
- We will hold ourselves accountable for working to these principles and for the delivery of integrated health and care, recognising the statutory responsibilities of each partner

VALUES

- We will be open and honest with each other
- We will be respectful in working together
- We will be accountable, doing what we say we will do and following through on agreed actions

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2021/22 BCF Plan Review

A review of the Better Care Fund took place between May and August 2022. This was a joint review between Local Authorities and the ICB and is a key component to developing system-wide collaborative commissioning approaches.

The aim of the BCF review was to ensure all schemes are clearly defined with a shared understanding of their intended outcomes; ensure there is a clear alignment of all schemes to ICS plans; and develop a shared understanding of opportunities for greater collaborative commissioning and integrated service delivery plans.

Following the review:

- **We have a defined shared ambition** to drive integration, recognising the BCF as key tool to system oversight and integrated delivery at Place

- We have a **collective understanding** of the BCF plans and 'in-scope' services and revealed further opportunity in improving how services are collaboratively commissioned

- We have c**onfirmed that our BCF plan includes evidence based interventions (at a service level)** as outlined in the SCIE Logic Model for Integrated Care

We have started to develop a **shared BCF dashboard** to include population health information for ASC and performance narrative from project level reporting. A joint arrangement has been put in place to collate data from ICB and LA and upload to a single system data dashboard (by Q3 22/23).

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Recommendations from BCF Review

The 22/23 BCF Plan has been refreshed to reflect the outcome of the review in relation to the definition and labelling of BCF schemes. We now have aligned language in relation to our commissioned services. In order to maximise the opportunities of the BCF as a mechanism for integrated out of hospital services, a number of recommendations were made as detailed below.

Recommendation 1: Undertake a service review for the BCF priority areas to maximise opportunities for collaborative commissioning, pooled resources and the delivery of integrated services to improve outcomes for the population and achieve best value for money.
The reviews will be themed across the three areas that form the narrative plan:
1. **Prevention and early intervention services:** e.g. access, community workers, social prescribing
2. **Anticipatory Care Services** e.g. care co-ordination and navigation, crisis response, assistive technology,
3. **Discharge to assess services:** integrated discharge team, community beds, interim placements, reablement

Recommendation 2: Understand and scope the opportunities to use the BCF as a tool to achieve integrated delivery at Place Based Partnership level
During 22/23 Place Based Partnerships will continue to drive integrated delivery of BCF services/schemes. However, there is opportunity to co-ordinate and take a collective view across BCF scheme areas. The developing role of Place will maximise work with communities to understand local population needs and bring together partners, including providers, District Councils and voluntary sector. This provides an opportunity to tailor services to local population need and develop our local provider market. Place based approaches will be reflected in the 23-25 BCF Plan.

Recommendation 3: **Realise the full benefit of Health and Wellbeing Board oversight to ensure a focus on wider determinants and wellbeing and to maximise the input of all partners**.
The 22/23 BCF governance includes assurance and agreement to plans through the Health and Wellbeing Boards. As commissioning reviews progress and the role of Place matures, the relationship with the Health and Wellbeing Boards will develop. During 22/23 a number of papers and HWB workshops are planned which will ensure membership are fully informed, engaged and able to shape future plans.

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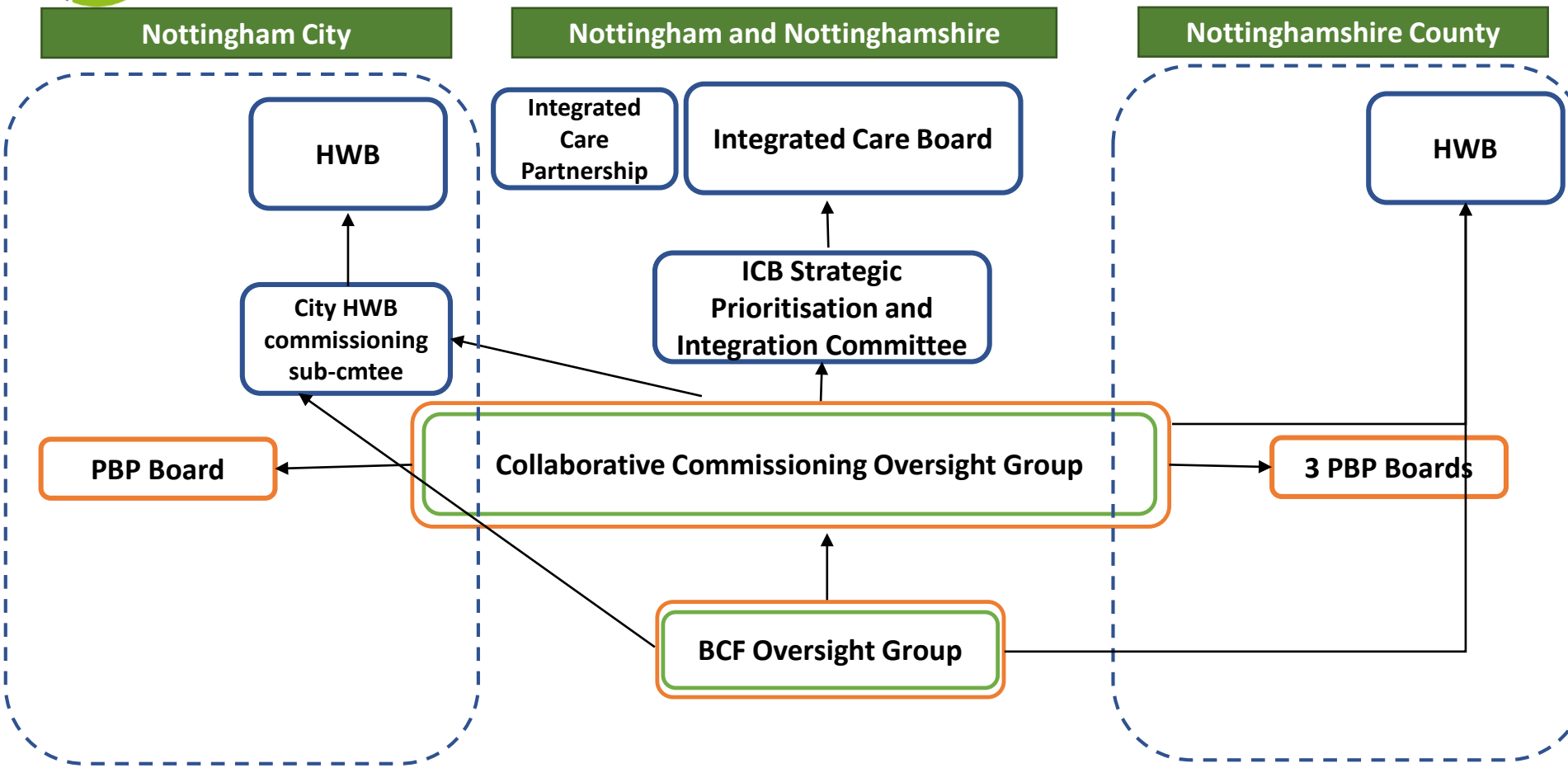
Collaborative Commissioning Governance

This slide shows the emerging governance and oversight which will align development of the integrated delivery at Place and strategic oversight to commissioning



Advisory | Statutory | Partnership | DRAFT

Governance of our 22/23 BCF plans

The City Health and Wellbeing Board has delegated responsibility for the BCF to the Health and Wellbeing Board Commissioning Sub-Committee. The Sub-Committee is jointly chaired by Nottingham City Council and Nottingham and Nottinghamshire ICB.

The Nottinghamshire County Health and Wellbeing Board is responsible for oversight of the BCF.

An ICS BCF Oversight Group meets quarterly to oversee planning and performance for the BCF. The group has representatives from commissioning, finance and transformation workstreams from the ICB and both local authorities. This group jointly plans and creates the BCF plan with input from wider commissioners and programmes. Expenditure and scheme level plans are produced at HWB level.

Wider partners including Providers, Local Authority service leads and the third sector are engaged in the plan at scheme level. Work will continue to develop collaborative commissioning approaches to Place Based Partnerships during 22/23 with the BCF as a key enabler to integration

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BCF Plans 22/23

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Developing our BCF plans for 22/23

The 22/23 BCF Plans provide an oversight of strategic commissioning and transformation plans. These cover a range of evidence based commissioned services, provisions and interventions (as per SCIE logic model Logic model for integrated care | SCIE). The range of services is focused under the following themes (note these headings are not those used in the BCF planning template):

- **Community based multidisciplinary teams** to provide proactive joint case management and to enable effective transfer of care from hospital
- **Personalised home care,** reablement and domiciliary packages
- **Navigation** and early help for people find appropriate services and support
- **Enablers** such as telecare, adaptations and equipment to support independence and self management

Our 22/23 plan also recognises that there is significant scope to fully embed key enablers and evidence based approaches to integrated delivery.

In 21/22 the ICS completed work to draft a Collaborative Commissioning and Planning Framework. This included a strategic review of local approaches to BCF, recognising BCF as a crucial tool to achieve integrated services and planning. By Q3 22/23 we will have established a focused programme of future collaborative commissioning, including agreeing a shared workplan and governance approach.

In Q1 22/23 the BCF Strategic review has provided a collective agreement of a forward plan to transform BCF planning. This will realise the potential for BCF to support effective integrated service delivery at Place and neighbourhood level, supported by system oversight.

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Accelerating our Health Inequalities Approach

The ICS Health Inequalities Strategy sets out how the Nottingham and Nottinghamshire health and care system plans to work together to addresses significant gaps in health life expectancy. https://healthandcarenotts.co.uk/wp-content/uploads/2020/10/Notts-ICS-HI-strategy-06-October-v1.8.pdf The strategy recognises that reducing health inequalities is about more than access and quality of health and care services given that wider determinants contribute 80% towards health outcomes. A joint approach to address health, wellbeing but also employment, education, living situation and relationships is crucial. Our BCF plans are part of our approach to reducing health inequalities and this will continue to evolve as new approaches to delivery of care and support are developed.

Our approach to addressing health inequalities is embedded through a number of system approaches and across our BCF schemes.

- **The equality impact assessment** is applied whenever we change or introduce service provision. 22/23 will see work to review processes with a view to develop a system wide approach that supports partnership assessment and monitoring. Most recently, this has been applied to Carers support services, Discharge to Assess and Transfer of Care Hub work. The outputs of these assessments is to include work to monitor protected characteristics across models of care and assessed the need to target increased resource for pathway 1 patients to areas of higher deprivation.
- **PCN Health Inequalities Plans** include needs assessment and adjustments to care for people who experiencing health inequalities. Priority areas include management of long term conditions, identification of carers and improve health assessments of people with serious mental illness. This will be supported by alignment of a Prevention strategy and priorities at Place level, maximising joint efforts to enable community focused responses. This will support Development of care provision that is able to deliver in a culturally responsive way and assessing the needs for cultural specific care.
- **Anticipatory Care Model** will align with the population focus of the CORE20plus5. During 22/23 the programme will scope use population health approaches and data to identify those are at risk of poorer outcomes and build delivery approaches that are able to scale and flex interventions to meet their needs.
- During 22/23 the introduction of multi-disciplinary assessment, coordination and case management of health, care and housing for people experiencing **Severe Multiple Disadvantage** (interplay of homelessness, substance misuse, mental health and criminal justice) will support a multi-agency approach to cohort often at higher risk of hospital admission. This includes mobilisation of additional investment to support effective hospital discharge form people experiencing **homelessness**.
- **Carers services –** a joint EQIA process supported the review of existing provision and has led to strengthened outcome metrics relating to protected characteristics and commissioning of services in 22/23 with an emphasis on the ability to deliver in a personalised and strength based way, this will include focus on delivery culturally responsive provision.

How the 22/23 BCF supports delivery of our ICS Vision

ICS Vision

Our neighbourhoods, places and system will seamlessly integrate to provide joined up care. Every citizen will enjoy their best possible health and wellbeing

BCF objective

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

Priority work areas

- **Ageing Well** Anticipatory Care Model
- **Living Well** Prevention, maximising independence and 'early help'
- **Urgent Care** Discharge to Assess and Transfer of Care Hubs

Enabling System programmes

- **Community Transformation**
- **System development**
- **Data insight and interoperability**

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Our BCF priorities

We work with our people and communities to support people to live as independently as possible. We will offer support and rehabilitation to people at risk of hospital admission or who have been in hospital. We will ensure that people transfer from hospital to the community in a timely way and prevent unnecessary admission to hospitals and residential care

1. Living Well

Prevention and Early Intervention

- Wellbeing, independence and healthy lifestyle
- Single point of access for advice and information about range of care needs
- Wider determinants e.g. social prescribing

2. Ageing Well

Anticipatory Care

- **ICB 'out of hospital community services'**
  - **Care co-ordination and navigation** (risk stratification, planning MDT case management)
  - Urgent care/**crisis response** nursing
  - **Community nursing** (housebound) and **Long term conditions**
  - **Rehabilitation**
  - **ED 'Front door'** streaming
- **ASC** assessment, homecare (extended hours/day working, crisis)
- Assistive technology, telehealth and adaptations
- Support to **unpaid Carers (**Carers Assessments)
- **Council reablement services, maximising independence/ supported living**
- **Primary Care Enhanced Services -** case management for risk of admission, improving access for asylum seekers, SMD, safeguarding
- **Disabled Facilities Grant** (home adaptations)

3. Discharge to Assess

- **Integrated Discharge Team** at hospital (including LA funded roles and in-reach from community health services)
- ICB commissioned **community beds**
- **Housing schemes** e.g. ASSIST, Housing to Health
- LA **interim placements**, urgent/discharge homecare, reablement

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1. Living Well – Prevention and Early Intervention Schemes

Prevention, as defined in the Care Act Statutory Guidance (2016), is about **the care and support system actively promoting independence and wellbeing**. This means intervening early to support individuals, helping people retain their skills and confidence, and preventing need or delaying deterioration wherever possible

During 22/23 our review of Prevention strategies in partnership across the ICS will aim to align language, priorities and collaborative commissioning approaches. We'll look to maximise opportunities to support strength based and personalised approaches across health and social care to support independence, wellbeing and to prevent ill health.

Our 22/23 areas of focus within the BCF plan are support to unpaid Carers, early intervention, access to advice, information and coordinated support. This recognises the benefit brought by the Health and Wellbeing Board strategy to focus on the wider determinants on improving health and wellbeing through community focused approaches.

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1. Living Well - Prevention & Early Intervention: Our Support to Unpaid Carers

During 22/23, a priority area of collaborative commissioning is to increase early intervention and improve services for unpaid carers.

This will be underpinned by the key system achievement in 22/23 of the completion of the **ICS Carers Strategy**
The ICS Carers strategy has been jointly developed between Nottingham City and Nottinghamshire Councils, ICB and co-produced with Carers. Carers voices and experiences are directly shaping the future of services and support, which are important to them. The strategy sets out what we will do together to improve the health and wellbeing of carers.

'Our vision is to support and work in true and active partnership with carers and their families for them to achieve healthy, balanced lives, to give them the confidence that they will be supported in a fair, respected and honest way by all the agencies they come into contact with.'

Scope of Services to Support Unpaid Carers
Carers Hub – a single point of access for information and advice. This will include assessment and support planning
- Education, training and engagement with schools, employers and health and care professionals
Carers respite- to provide breaks from caring with a flexible offer to include home based breaks and residential breaks.
Young Carers Service- information, advice, support and activities.

The strategy will provide guidance and structure to review existing BCF Carers Schemes and collaborative commissioning of high quality carers services during 22/23. This will lead to improved outcomes for carers, increased return on investment and opportunities to increase early intervention and integration across health and care.

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1. Living Well – Prevention and Early Intervention Schemes

Nottingham City	
Early Intervention	*Scheme ID 2 Care Navigation and Planning* *Scheme ID 13 Carers, Advice and support, respite service* *Plus embedded early intervention and prevention approaches across delivery of adult social care schemes (note some scheme/spend shown in 2- Ageing Well – anticipatory care model)* *Integration of community connections, Primary Care Networks and support roles e.g. social prescribing*

Nottinghamshire County	
Early Intervention	*Scheme ID 12 Carers Short Breaks* *Scheme ID 19 Carers respite* *Scheme ID 21 Carer Advice and Support* *Scheme ID 22 'Supporting People'* *Scheme ID 27 Enabling Care Act statutory responsibilities* *Plus embedded early intervention and prevention approaches across delivery of adult social care schemes (note some scheme/spend shown in 2- Ageing Well – anticipatory care model)* *Integration of community connections, Primary Care Networks and support roles e.g. social prescribing*

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2. Ageing Well - Our Anticipatory Care model

Our priority for 22/23 is to shape effective anticipatory care models based on well embedded 'building blocks', including the **Primary Care practice level MDTs**, which focus on admission avoidance and frailty in particular. Whilst these are well embedded there are some gaps e.g. consistent attendance from social care and the VCS. We will be raising the profile of what anticipatory care means and the role it plays in the system.

During 22/23 we will be working across ICB, Local Authority, Provider and VCS partners to outline our implementation plan for submission to NHSEI by Q4 22/23. This will include scoping and **co-producing our approach with people with lived experience** to ensure we deliver this agenda in a personalised way.

We have clear Place based MDT model which requires us to risk stratify the population and at a place/neighbourhood level, work across health, social care, VCS, social prescribers etc. to proactively engage people and work with them to co-produce solutions in our target areas. We are going to be tracking data to evidence whether or not these interventions make a difference on the amount of social care/health input these people need over time.

Our priority areas are:
- Frailty
- Health inequalities (priorities linked to the CORE 20 plus 5)
- High frequency service users of UEC services (ambulance/ED)

We have a system wide approach to addressing health inequalities and a **really strong foundation of data through our Strategic Analytics and Information Unit** which is operational across the ICB. We can demonstrate that we know where each of our PHM target cohorts reside, the risk factors and link with touchpoints for NHS services. We are working hard as a system to expand this out into social care data too. The introduction of anticipatory care will also seek to engage with those in the most 20% deprived areas of the ICS, frailty and people with long term conditions utilising UEC services to manage their conditions.

This work will be supported by the **Community transformation work during 22/23**– increase integration between health and care services at Primary Care Network level, this programme is enabling strong partnerships and improved relationships by connecting commissioned delivery with local communities and joint delivery models with VCS organisations to enable joined up care that is connected to local communities.

The Ageing Well Anticipatory Care framework will be operational by 1st April 2023,

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2. Ageing Well - Disabled Facilities Grant

Disabled Facilities Grants support independence through minor adaptations to a person's own home. Assistive Technology supports people to live independently.

There are a number of offers in place including telecare services and the dispersed alarm service. The provision supports both our Prevention & Early Intervention and Anticipatory Care priorities

Nottinghamshire County Council approach to DFGs is to transfer the apportioned budget to District Councils to administrate and arrange.

Alongside DFGs work is taking place across both BCF footprints to understand priorities and alignment of housing representatives to support system priority areas.

The Nottinghamshire County ASSIST scheme and Nottingham City Hospital to Home scheme enables health and social care providers to work in partnership to assess and support people to move into more suitable properties in a timely manner, enabling recovery and reablement at home, which reduces risk of admission to hospital and supports effective discharge from hospital. 22/23 will provide opportunity to review these as part of the Transfer of Care Hub development.

Focused areas of need

- Neurodiversity and dementia, e.g. sensory needs
- Promoting and developing independence e.g. preparing for independent living; adjusting after a major change; managing long term deteriorating conditions
- Short term housing support e.g. planned, crisis response, for assessment, for step up and step down.
- Housing related support – e.g. tenancy support and sustainment; money management, hoarding

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2. Ageing Well – Our Anticipatory Care Schemes

(note historic scheme labelling means that City and County expenditure can not be compared on a scheme by scheme basis)

Nottingham City	
Care Coordination and Navigation	*Scheme ID 1 – CityCare 'Out of Hospital Contract' MDT, LTC case management, specialist nurses and NCGPA Social Prescribing*
Primary Care Enhanced Services	*Scheme ID 7- GP Practice enhanced services for case management, MDT and coordination with specialist teams*
Urgent Care/2 hr Crisis	*Scheme ID 3 – CityCare 'Out of Hospital Contract' 2hour response service*
Housing & Tech	*Scheme ID 10,11,12- Assistive Technology – telehealth, dispersed alarms, equipment* *Scheme ID 14 – Housing Health – Hospital to Home, supporting prevention and D2A* *Scheme ID 15- Disabled Facilities Grant*
Nottinghamshire County	
Care Coordination and Navigation	*Scheme ID 5 and 8 NHT South Notts/Mid Notts case management, MDTs and specialist nursing)*
Primary Care Enhanced Services	*Scheme ID 4 – GP Practice enhanced services for case management, MDT and coordination with specialist teams* *Scheme ID 20 Care Home Quality*
Urgent Care	*Scheme ID 6 British red cross 2 hour response* *Scheme ID 7 South Notts NHT 2 hour response* *Scheme ID 11 Evening and night nursing* *Scheme ID 13 ED Front Door and streaming (SFHT acute)*
Housing & Tech	*Scheme ID 26 – Disabled Facilities Grant* *Scheme ID 24- Supported accommodation younger adults* *Scheme ID 25 Direct Payments for older and younger adults*

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3. Our Discharge to Assess model

Plans for improving discharge and ensuring that people get the right care in the right place:

A system D2A self assessment of 'What Good Looks Like in line with the High Impact Change Model' took place via a system workshop on the 21st July 2022, this was led by both the Local Government Association and ECIST. A feedback and next steps workshop took place on the 8th September 2022, the outputs will be incorporated to the system (ICB, LA and Provider) Discharge to Assess Operational Steering Group's system plan.

Integrated Delivery of **Transfer of Care Hub** models will go live in Q3 22/23 across all ICS Hospital Trusts. Preparation during 22/23has included system mapping of D2A pathways, reflecting issues, blockages and best practice implementation. This has included the development of a single transfer of care data set agreed to enable smoother and consistent communication across D2A pathways and Providers. During 22/23 improved relationships and pathways have been made with housing and specialist services such as homelessness and substance misuse to better support discharges for people with complex social needs.Q4 22/23 will ensure that projects and services to support specific cohort needs are linked into the developing Transfer of Care Hubs.

Collaborative Commissioning Progress: A collaborative commissioning review has resulted in a system wide agreement to a pooled funding investment for additional capacity across services to support improve delivery of the 'Pathway 1' integrated business case. This additional resource will be supported by a joint service specification, shared data monitoring and performance oversight. This is being supported by the ICS System Analytic Insight Unit and creation of a single Urgent Care dashboard.

Q3 22/23 will agree the approach to reflecting the additional resource in the BCF plan and BCF section 75 arrangements. There will also be a commitment to the intelligence information necessary to monitor performance across reablement, rehabilitation and homecare services. A partnership agreement will produce collective outcome framework and KPIs to monitor 'pathway 1' performance. This monitoring and oversight will align with the BCF metrics dashboard and feed into the Urgent Emergency Care Board and the Ageing Well Board.

Completion of the Intermediate Care Demand and Capacity modelling template has supported focus on alignment between programmes to address discharge and programmes for anticipatory care. There is significant challenge locally in balancing resource that meets the demands of hospital discharge with the intention to resource prevention and anticipatory interventions.

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3. Our Discharge to Assess schemes

(note historic scheme labelling means that City and County expenditure can not be compared on a scheme by scheme basis)

Nottingham City	
Integrated Discharge Team	*Scheme ID 4, 8,9- Facilitating Discharge, integrated enablement teams and supporting D2A. Mental Health integrated discharge*
Rehab/reablement	*Scheme ID 4, 6- reablement, rehabilitation and homecare provision.*
Community beds	*Scheme ID 4 City Care 'out of hospital' contract community beds*
Housing	*Scheme ID 15 Hospital to Home – housing advice to D2A, minor adaptations and 'handyperson' type support.*

Nottinghamshire County	
Integrated Discharge Team	*Scheme ID 3 Support to Integrated Discharge planning* *Scheme ID 15 Bassetlaw Mental health discharge roles* *Scheme ID 16,17, 18 Bassetlaw Discharge and assessment teams (across acute, mental health and community)*
Rehab/reablement	*Scheme ID 1- Short term rehab (NHT lot 10 South Notts)* *Scheme ID 9 and 10- Falls Prevention (NHT Mid Notts Community Rehab falls and South Notts East Bridgford Falls Rehab)*
Community beds	*Scheme ID 2- Community beds (NHT Lot 8- South Notts Lingsbar and Mid Notts Fernwood)* *Scheme ID 23- Nursing and dementia interim placement*
Housing	*Housing support to D2A 'ASSIST' under review*

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Summary of Changes to 22/23 Plans

22/23 Change to Nottinghamshire County HWB BCF Plan

As an output of the BCF review there was collective agreement to refresh the labelling of schemes in the Nottinghamshire County BCF Plan

The 22/23 Nottinghamshire County BCF Planning template will more clearly align with current commissioning arrangements for BCF services

This will provide improved clarity across schemes and consistency in labelling in readiness for more in-depth collaborative commissioning reviews of BCF services ahead of 23-25 plans.

22/23 Changes to Nottingham City HWB BCF Plan

The Nottingham City BCF scheme labelling did not require significant change
The review has led to Scheme ID 10 being removed. This line related to Programme Support costs, which are now considered 'core' workforce delivery.
Updated labelling of scheme ID 16 and 21 from 'other' to 'personalised budgeting and commissioning'