Integration and Better Care Fund

Narrative Plan Template 2017/19

Better Care Support Team

Area	**Southend on Sea**
Constituent Health and Wellbeing Boards	**Southend Health and Wellbeing Board**
Constituent CCGs	**Southend Clinical Commissioning Group**

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1 Introduction / Foreword

Introduction

Southend on Sea (Southend) is delighted to present our Better Care Fund (BCF) plan for 2017-19. The plan presented in this document builds on our approved plan for 2016-17 and aims to demonstrate and assure the national bodies that local partners have reviewed progress during the course of the last 2 years and used this information to develop the plan for 2017-19.

Our plan is complemented by the financial planning submission and the associated appendices which provide further evidence of our robust and proven planning process and ability to deliver.

Our plan has been developed and completed in accordance with the NHS Five Year Forward View1, the BCF Policy Framework2 and the BCF Technical Planning Guidance3.

Foreword from Cllr Lesley Salter, Chair HWB

I am pleased to present the Better Care Fund plan for 2017-19, which sets out how Southend's senior leaders in health and social care will continue to prioritise the health and wellbeing our local residents.

The opportunity to develop our priorities as part of a two-year planning cycle allows us to plan for the future with confidence. It provides both local service commissioners and providers a clear idea of the money that is available and the services we need.

The challenges in Southend are significant and demand for services continues to increase. We know there are still inequalities in health across the borough and we continue to face difficulties in recruiting and maintaining the diversely skilled workforce we need. Our local hospital services are also undergoing change through the Sustainability and Transformation Plan (STP) for mid and south Essex, and this process has meant residents are facing change on an unprecedented scale.

However, there are also many positives for Southend as we look to the future. The borough has an enviable and innovative track record in health and social care integration, through bringing services and a diverse range of professionals together we now have GPs, social workers and community-based health staff working as integrated teams, piloting new ways of working and learning from each other's experiences and successes.

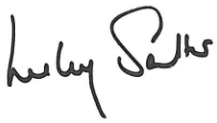
Our progress will be reflected in this plan and we will also set out our stall for the future. We will explain how we will continue the good work of recent years and demonstrate our local vision and model for the integration of health and social care. We will show just how far we have come.

You will see how we have jointly developed a coordinated and integrated plan of action to deliver our vision and that this meets with the national requirements for integrated health and social care services. The Health and Wellbeing Board (HWB) is aligned to this work and has an agreed approach to performance and risk management that includes local finances.

Our plan is a summary of all the excellent work that has been delivered and is underway in Southend. The plan has been submitted by the Health and Wellbeing Board by all partners,

[1] NHS Five Year Forward View
[2] 2017 / 19 Integration and Better Care Fund Policy Framework
[3] 2017 / 19 Integration and BCF planning requirement

including providers, commissioners and voluntary sector partners. In summary, I am delighted to submit the *Southend-on-Sea Better Care Fund Plan*.



Cllr Lesley Salter

Chair Health & Wellbeing Board

2 What is the local vision and approach for health and social care integration?

The local vision for health and social care services

*'To create a **health and social care economy** in which the population can access **optimal care** and enable **urgent care** to be delivered with maximum **efficiency and effectiveness'***

Health and Social Care economy; Southend will adopt a system wide view and understand impacts across all key constituents.

Optimal Care and Urgent Care; right care at the right time in the right setting to minimise need to use acute resources.

Efficiency and Effectiveness; a focus on both cost and quality of care, not one at the expense of the other. The current scope of focus and solutions should have positive impact on broader acute care setting and the overall health economy

Our vision is underpinned by focusing on the following areas:

- Risk stratification
- Joint commissioning
- Improvement of the community MDTs
- Improvement of the Single Point Of Referral
- Pilot seven day access to services
- Reducing admissions to acute care
- Integrated care records
- Acute Hospital sector challenges

Alignment of vision with national and regional requirements

2.1 The vision and Southend BCF plan for Southend is aligned to;

2.1.1 NHS England's 5 Year Forward View, in which greater engagement with patients, carers and citizens is encouraged so that there can be promotion of well-being and the prevention of ill-health;

2.1.2 The 2017-19 Integration and Better Care Fund Policy Framework and the 2017-19 Integration and BCF planning requirements. Our vision and BCF plan confirms the 4 national conditions set out in the BCF planning guidance;

2.1.3 Both regional and local initiatives, for example the STP (which is focused on acute reconfiguration and financial stability of acute service as well as all community physical and mental health services) and the transformation of Primary care;

2.2 Our BCF plan is aligned with the Joint Service Needs Assessment (JSNA) to ensure that our localities have access to equal, fair and speedy services. We work as a system between Southend Borough Council (SBC or 'the council'), Southend Clinical Commissioning Group (SCCG or 'the CCG') and Southend Public Health to achieve the priorities laid out in the JSNA.

2.3 Our BCF plan is aligned to our HWB strategy. The ambition for HWB in Southend is that everyone living in Southend has the best possible opportunity to live long, fulfilling, healthy lives.

2.4 Our BCF plan is aligned with our on-going challenges in Southend which enables the plan to focus on five “big ticket” priority areas. These are;

2.4.1 Mental Health

2.4.2 Complex Care

2.4.3 Integrated Children’s Services

2.4.4 Physical Activity levels

2.4.5 Primary Care Access

Engagement

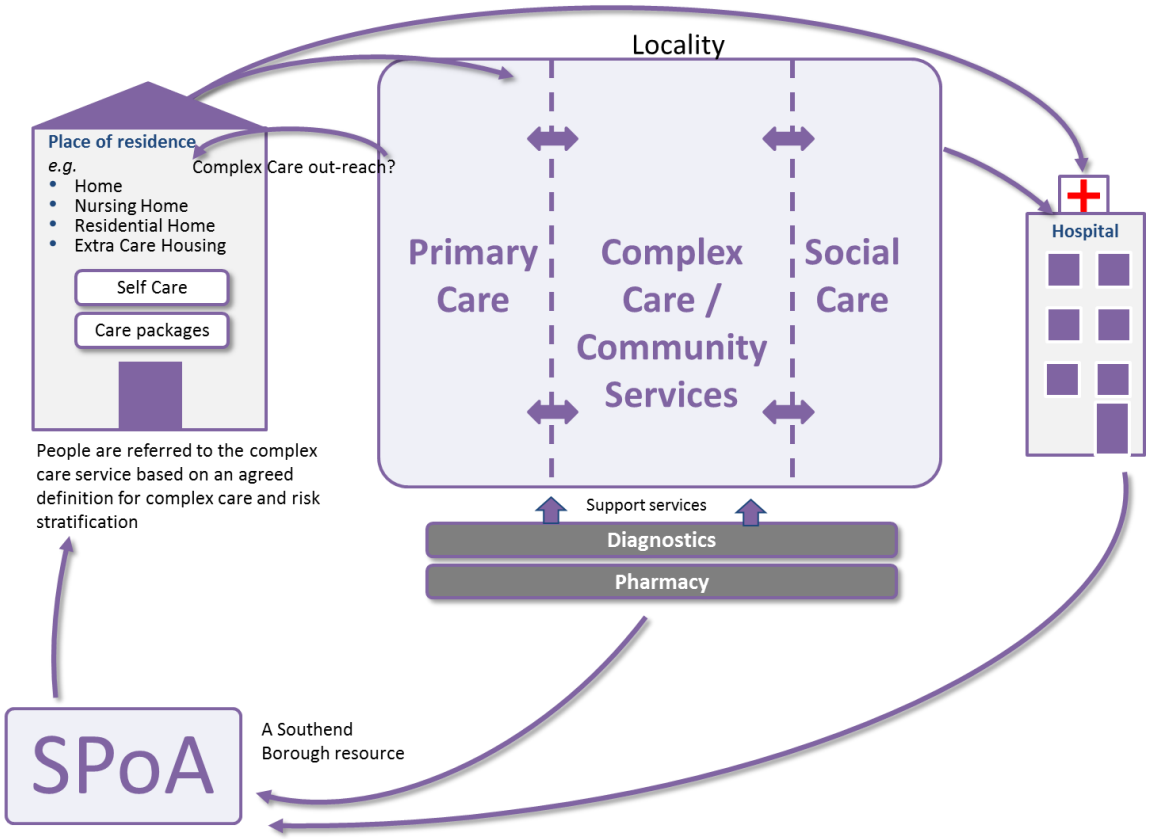
2.5 It is vital that our BCF plan is informed by a good understanding of patients’ experience of services and their expectations and perceptions of the health and social care services in the area.

2.6 Over the past year our activities have been focused on implementing our new approaches to patient and public engagement and further developing the tools and channels that we will use.

2.7 We have attended dozens of events to engage face to face with members of the public across a range of different topics and issues. In May 2017 we held an engagement event to help develop the Locality approach for Southend. The event was a great success and attended by more than 150 people.

The Model

2.8 The agreed model that has been developed to deliver the Southend vision is known as the Locality approach and is demonstrated below.



The changes

2.9 The changes, as a result of implementing the agreed model, that we will continue to deliver for 2017–19 will build upon the successes from previous years and further develop the Southend vision for integrated health and social care. The changes that patients and residents will experience in terms of interacting with services will include;

2.9.1 **Locality model.** The completion of a 'Locality' approach where the locality is the central place that integrated health and social care interventions are co-ordinated. This change will represent a shift away from hospital into the community. The completion of the Locality approach will be aligned to the provision of both social care and primary care services working in a Multi-Disciplinary Team (MDT) environment. Appendix A provides a full description of the Locality model and the developing health and social care model.

2.9.2 **Complex Care.** The continued development of the complex care coordination service. In Jan 2017 the pilot service was commissioned. Through risk stratification we identify a cohort of patients with complex care needs. Once identified we design a service that co-ordinates their care needs and provides a holistic health and social care plan thus reducing demand on primary care and presentations at A&E. The service was commissioned as a pilot and will come to an end in March 2018. Our plan is to evaluate the service and commission on a permanent basis.

2.9.3 **End of Life pathway redesign.** Our emerging plans for the transformation of community services are forward looking and include the development of a pathway model focusing on complex care and frailty through from initial identification of risk and/or need to end of life. Through this model we will enhance advice, support and advocacy empowering people to take control and make choices.

2.9.4 **Adult Social Care (ASC) redesign.** ASC redesign is an important element to the locality approach and the delivery of integrated health and social care in Southend. ASC is currently leading a transformational project across the whole social care and health system which will turn around culture and mind-set, develop alternatives, develop engagement, communicate a compelling vision, and embed the narrative that supports this transformational change programme of work.

2.9.5 **Disabled Facilities Grant (DFG).** Through the BCF we aim to ensure the outcomes derived from the capital spend associated with the DFG are aligned and in support of those outcomes we derive from our integrated care commissioning activity for the cohort of patients identified with complex needs.

Alignment with Sustainability and Transformation Plan

2.10 NHS England's requirement for health and social care systems to draft a blueprint for the implementation of the five year forward view is otherwise known as Sustainability and Transformation Plans (STPs). The Southend system has agreed a local footprint for our STP and has aligned it with the Essex Success Regime (ESR).

2.11 The plans for the Mid & South Essex STP continue to develop with a focus on acute reconfiguration and financial stability for acute services. For the STP to succeed system leaders have agreed the need for the STP to be aligned with the plans to integrate health and social care within the community. The BCF plan will support the capacity for the acute services to be reconfigured.

2.12 To achieve the alignment close working relationships (between system leaders and organisations) have been formed alongside formal governance routes to ensure both the STP and BCF plans are working in partnership.

3 Background and context to the plan

Local Demographics and future challenges

3.1 In February 2017 Southend Public Health published an updated Joint Strategic Needs Assessment (JSNA) – Appendix B. The JSNA looks at the Borough of Southend and the demographics. It clearly articulates the challenges that our residents face from an early life through to older people. In Summary;

3.1.1 The population of Southend is in the region of 180,000. By 2021, this is expected to rise by a further 7%. Deprivation in Southend is higher than average and about 23.5% children live in poverty. Life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend. This is worse than the average for England.

3.1.2 The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity and alcohol have a negative impact on the health of the local population. There are also high levels of mental ill-health within Southend.

Current State of the health and adult social care market

3.2 The state of the social care market in Southend is improving. As a system we are continually looking for ways to invest and support the market but the specific challenges are around recruitment and retention and workforce development. We have over 100 care homes in Southend providing over 2,000 residential care beds. A significant proportion of residents are privately funded which provides challenges to the council to find care for state funded residents. The huge number of care homes provides challenges to the system in terms of consistency and quality of care.

3.3 During the course of the past year we have invested in domiciliary care by re-contracting with care providers and aligning the care being provided to the locality approach. We have also begun to invest in residential care homes (Gold Standard Framework) through supporting and training staff to improve quality of care.

3.4 Via the iBCF we also plan to enhance our investment in the voluntary sector which will help support and develop the social care provider market.

3.5 The Southend Local Account 2015-16 provides a comprehensive detailed account of the social care market in Southend. Please refer to Appendix C for the Local Account.

4 Progress to date

Summary

4.1 The progress made to integrate health and social care is significant. A recent report to HWB (Mar 2017), as evidenced in Appendix O and Oi, demonstrates the progress made at all levels of the system, which include leadership, operational and system leadership.

4.2 Described in detail at Appendix O and Oi our BCF plan for 2016-17 supported and drove our activities to integrate health and social care. As we now enter the planning phase for 2017-2019 our BCF plan will focus on further reductions in non-elective admissions, maintaining the performance for residential care admissions achieved in the previous 2 years against a backdrop of transformational change and continuing to deliver strong DToC performance.

4.3 To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the STP.

4.4 Southend HWB have recently commissioned an options appraisal to evaluate the 'what next' in terms of health and social care integration for Southend. This represents an exciting challenge for our system and one that our system partners are embracing.

4.5 Via the national BCF team support was sought though the LGA offer and a ‘what next’ report was commissioned. In June 2017 John Bewick OBE was commissioned to meet with both system and senior leaders of Southend. The report, at Appendix P, provides a very helpful independent analysis of our journey towards integration and provides very helpful areas to focus on for the period 2017-19. These area are due for ongoing discussion at both HWB and operational level and will be complete by Dec 2017.

Successes in Southend

4.6 There are many examples that evidence the success of integration of health and social care in Southend. Since the inception of our BCF planning some of these successes include;

4.6.1 Data sharing. It is well recognised in Southend that accurate commissioning, case finding and risk stratification for integrated health and social care services forms the platform for an integrated service provision. During the early history of the Pioneer programme Southend led a work stream to ensure that data across health and social care could be linked and shared.

4.6.2 Transforming Care Partnership. A pan Essex partnership has been formed to develop a plan that will change local services in a way that will make a real difference to the lives of children, young people and adults with a learning disability and / or autism who display challenging behaviour, including those with a mental health condition. Our plans will include things like improving community services so that people can live near their family and friends, and making sure that the right staff with the right skills are in place to support and care for people with a learning disability. Our plans will be a 'living' document which will continue to be developed in partnership with the service users, their friends, family and carers as well as charities and other groups.

4.6.3 Integrated commissioning team. In April 2015 an integrated commissioning team was formed from resource from both SBC and SCCG. The team are responsible for health and social care services in Southend for adults, the elderly and frail, mental health, dementia and children's. Commissioned services include Child and Adolescent Mental Health Services (CAMHS) and a complex care co-ordination service.

4.6.4 Locality approach. In May 2016 it was jointly agreed that 4 localities would be formed across Southend and that the locality would be the central place where integrated health and social care interventions are delivered and co-ordinated.

4.6.5 Single Point of Referral (SPoR) co-location with Southend Access. In July 2016 the SPoR and the Access team co-located at SBC to ensure that professionals who were referring patients into a health and social care system had the opportunity to refer through a single front door. Phase 1 of the project included co-locating two well established health and social care teams into one team. Working in partnership with our providers Phase 2 includes a review of activity and a redesign of service specification.

4.6.6 Complex Care co-ordination service. In January 2017 a complex care service commenced operations which would co-ordinate existing community based health and social care services around an individual with complex needs. New resource has begun to work with patients in Southend to ensure that the support and care patients receive is integrated and seamless.

4.6.7 Mental Health strategy and dementia services. Mental Health services face significant demand in Southend which is forecast to increase. An Essex wide (including Southend and Thurrock) Mental Health strategy has recently been agreed, this strategy provides the direction for mental health services and the challenge to develop a Southend specific implementation plan will now be addressed. Strategically, dementia services for Southend have recently been remodelled following a period of staff and community engagement and will now incorporate an enhanced service that is fully integrated within existing health, social care and community assets. From a performance perspective SCCG is historically and continues to be top of the league for East of England CCGs when diagnosing dementia.

4.7 Serious Illness Conversation. From November 2016 until May 2017 Southend were part of an NHS England pilot to support primary care in having 'serious illness conversations' with patients who were considered to be at 'End of Life'. The pilot was led by Clatterbridge Cancer Care NHS Trust and involved 18 Southend GPs in the initial stages. Over the course of 6 months over 200 conversations were had across the pilot. The pilot is currently at evaluation stage with a view to rolling out the training across community health providers and primary care.

4.7.1 Other examples include DToC performance, jointly commissioned services, GP home visits in each West Central locality and re contracting with domiciliary care providers on a locality basis

5 Evidence base and local priorities to support plan for integration

Evidence base supporting the case for change

5.1 Data and information derived from the Director of Public Health for Southend's Annual Public Health Report 2015 (Appendix D) and additional sources including the Health and Wellbeing Strategy (Appendix E) and current JSNA (Appendix C) highlight the key health and social care challenges facing the system of Southend. The above reference appendices also provide the detailed evidence base that underpins our BCF plan. Paragraph 5.2 provides the high level evidence base;

5.2 The local priorities for Southend, as evidenced through the above referenced documents are;

5.3 **Primary Care.** Through joint partnership arrangements SCCG and the council have worked with NHS England to identify gaps and variation in primary care services. Locally, there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years.

5.4 **Ageing population.** Southend has an ageing population. We know the incidence and prevalence of ill health and disease increases with age and have identified a number of conditions, population groups and specific interventions where we believe more effective collaboration and coordination between partners will improve outcomes for local people and reduce costs to the health and social care economy. The key issues identified are:

5.4.1 **Older people**; residents at risk of falls and / or at risk of social isolation are included in this cohort. Southend has an ageing population, many of whom do not have family or a local network to support them as they age. These issues are similar for those ageing people who are living with long-term conditions, in particular; cardio vascular disease, respiratory and asthma.

5.4.2 **Older people with mental health and / or dementia**; mental health and dementia amongst older people increasing in parallel with national indicators. Our services to treat this cohort of patients require transformation to ensure the services are much more community based and integrated with primary care, community health services and social care.

6 Better Care Fund plan

Disabled Facilities Grant

6.1 Southend BCF will allocate £1.299M (2017-18) and £1.405M (2018-19) in capital to the council for use under the DFG guidance.

6.2 The services funded under the DFG are currently operated from in-house resource following the cessation of our contract with our private sector provider and the recommendation of an independent review.

6.3 The transition of private sector provider to in-house provider will be complemented with review the outcomes we are currently achieving with the use of the DFG. The aim of which will be to align the DFG spend to influence outcomes associated with families and those residents with complex care needs.

Commissioning, maintaining and transforming community services

6.4 Southend BCF will allocate £6.401M (2017-18) and £6.522M (2018-19) in revenue to SCCG for use to commission, maintain and transform community services.

6.5 During 2017-18 we will maintain the existing community services with our providers which will include services such as our SPoR, tissue viability, leg ulcers, the community element of stroke services, continence, intensive dementia support and occupational therapy. For a list of these services please refer to Appendix F.

6.6 During 2018-19 our plan is to design transformation programme which will change our existing service delivery model to a locality approach which is aligned to the health and social care delivery models outlined in the Five Year Forward view. The Locality approach is outlined below;

Locality approach

6.7 SCCG's approach within the BCF for 2017-19 to transforming community services for the benefit of Southend residents is through an integrated 'locality approach'. A locality will provide comprehensive integrated out of hospital care for provision, co-ordination and signposting ensuring that the shift is taken away from the hospital. This locality approach may not necessarily be a physical location but will use existing council and health estate and provide services in a range of different ways.

6.8 The approach will be to recognise the locality and not the hospital as the main location where health and social care takes place. The new model will establish the 'home' accessing services with the locality as a more efficient location for quality and value focused health and social care.

6.9 There will be a focus on retraining the workforce to enhance their roles in delivering whole person care that enhances self-management and independence.

6.10 The locality approach will also enhance retention and recruitment of clinical staff particularly district nurses, practice managers and GPs.

6.11 Through adopting the locality approach residents of Southend will see a benefit through improved outcomes as follows;

6.11.1 The integrated health and care system designed to ensure proactive prevention and early intervention, breaking the cycle of reactive care provision;

6.11.2 To family carers and the health and social care workforce;

6.11.3 Robust predictive modelling and risk stratification identifying patients at risk of decline for enrolment into the complex care service before their health deteriorates.

6.11.4 Each complex care patient has a care plan tailored to their individual needs, with different programmes designed for different needs e.g. diabetic programme, chronic heart failure programme;

6.11.5 Care takes place at convenient locations for the patient, with significant locality based care with support for transportation to ensure high levels of compliance with treatment programmes

6.11.6 Breaking down barriers between organisations and removing silo working will deliver improvements in the care patients receive, increasing quality and patient experience

6.11.7 Full authority over care decisions, and full clinical and financial accountability to ensure incentives are aligned to drive better outcomes for patients

6.11.8 By delivering enhanced quality outcomes for patients by ensuring that those delivering care have the appropriate skills and competency to do so.

6.11.9 Reduced unplanned attendances at Accident and Emergency

6.11.10 Decreased inpatient admissions and re-admissions and specialist utilisation (including reduced outpatient appointments)

6.11.11 Shortened inpatient length of stay (enhanced recuperation and rehabilitation care in appropriate settings

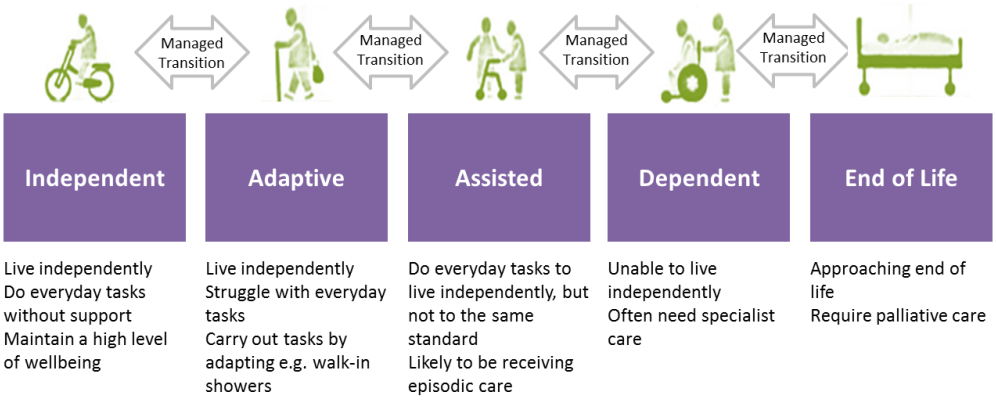
6.11.12 Reduced proportion of deaths in hospital (and increased provision of end-of-life care at home/ in hospices, aligned with patient choice)

6.11.13 Release of GP time to address other patient groups

6.12 Following a detailed analysis of demand, demographics and workforce it has been agreed that four localities are appropriate for Southend. A map of Southend shown in Localities can be found at Appendix A.

6.13 Residents will be risk stratified according to the 'transition pathway' outlined below. Patients with complex care needs – measured through a combination of a frailty index and integrated health and social care data – will most likely be those with multiple long term conditions. The best place for the provision of health and social care to these patients should not be the hospital but through the locality. Co-production and self-management, facilitated by technology, needs to be the location for higher acuity health and social care.

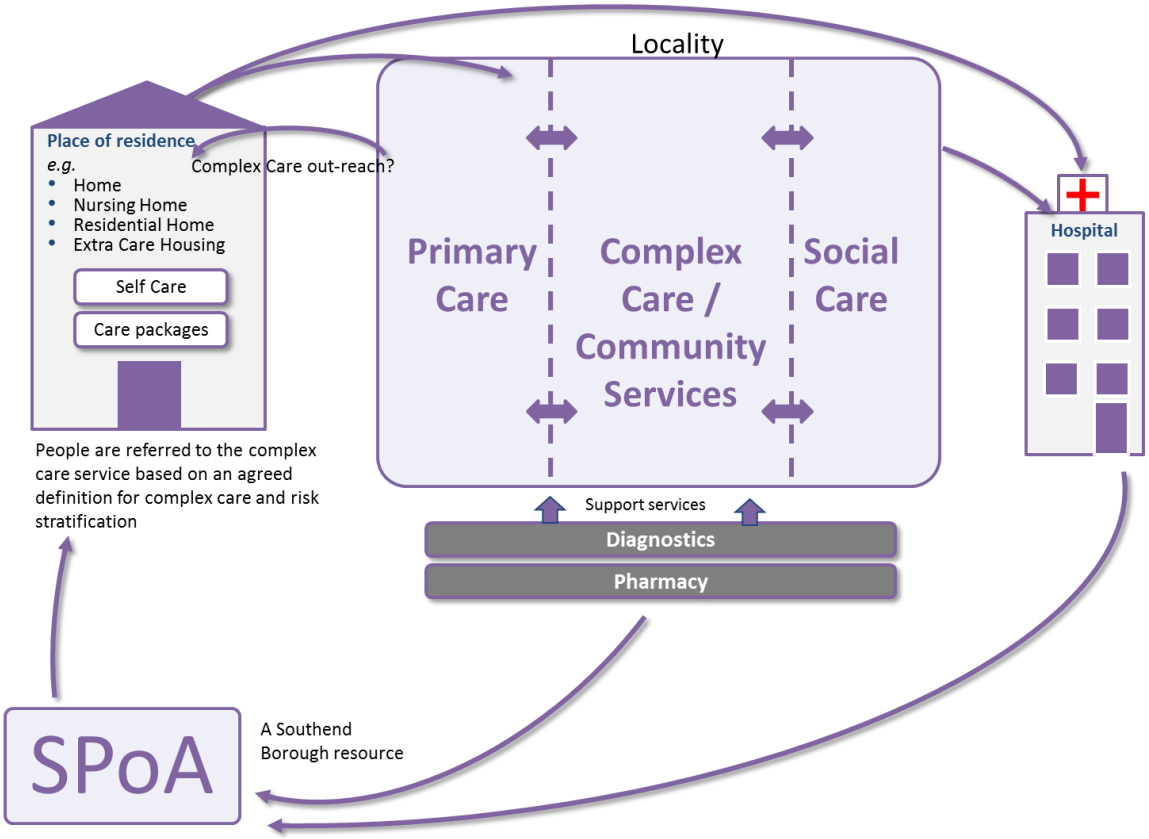
The transitional pathway



6.14 Led by our integrated commissioning team and by working in partnership with Primary Care providers, community service provision, our hospital provider, social care providers we have designed a model that is based on a locality approach and will deliver complex care services from within each locality.

6.15 Through working with adult social services we have designed a robust front door for both health professionals and residents to access health and social care information advice and a crisis service.

The proposed model

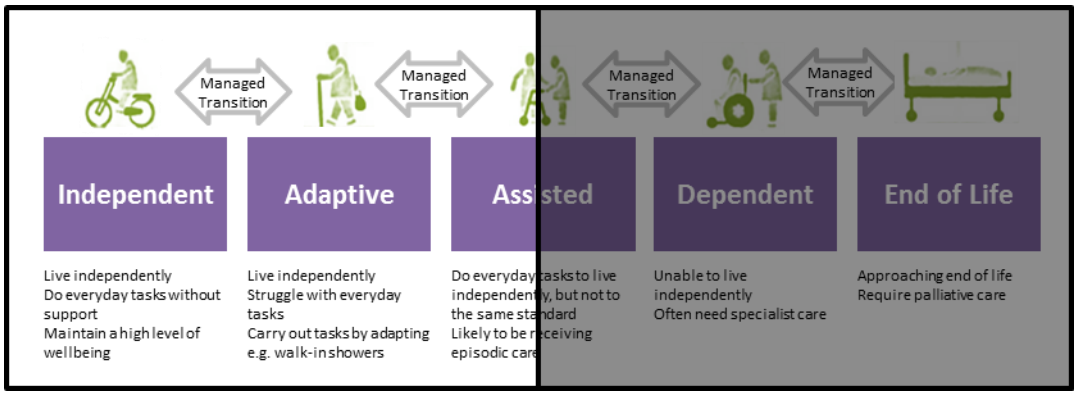


6.16 The SPoA focuses on;

6.16.1 Access to services; focused on preventative measures, advice and information; assessment and review; interventions or support; and discharge from hospital;

6.16.2 Crisis intervention; focused on face 2 face assessment, sign posting and the regular assessment for a short period of time following a period of care.

6.17 The SPoA targets those individuals who sit within the transitional pathway as outlined below;



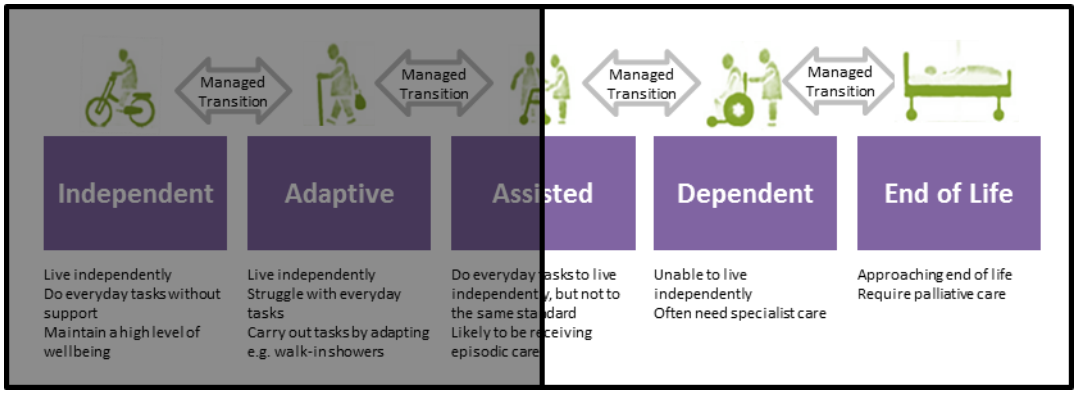
6.18 Complex Care / community services works in an MDT environment co-locating teams of professionals which will include GPs, community nurses, care co-ordinators, therapies, social workers, pharmacists, voluntary sector, mental health practitioners, dieticians and Long Term Condition nurses, facilitated through an integrated IT solution and delivering care according to standardised pathways and a task orientated approach. The main focus for the complex care element is;

6.18.1 Access to services; focused on preventative measures, advice and information or support;

6.18.2 Out of hospital community services focused on moderate frailty; respiratory, diabetes, cardiology, diagnostics, falls, rapid response, continence and dementia; and

6.18.3 Co-ordinated care with an MDT approach; focused on the management and maintenance of complex conditions over a long term with the aim of identifying which area of the transition pathway the patient is in and moving them through de-escalation; medication management; and carers, family, friends and community support.

6.19 The complex care service targets those individuals who sit within the transitional pathway as outlined below;



Outcomes

6.20 The provision of community services and transformation to a locality approach is measured through the following performance metrics;

6.20.1 Non elective hospital admissions;

6.20.2 Delayed Transfers of Care; and

6.20.3 Reablement;

6.21 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

The Locality approach – progress to date

6.22 The process to implement the Locality approach is a complex and lengthy journey which challenges the relationship between commissioner and provider and also challenges the workforce to think and act differently. Progress to date has been encouraging but it is recognised that there is still much to do. The following list are all achievements in implementing the locality approach;

- **Feb 2016.** HWB (informal session) discussed Health and Social Care integration and the model for implementation; Community Recovery Pathway;
- **May 2016**. Southend agreed 4 Localities in Southend; West; West Central; East Central; and East;
- **June 2016**. STP assigns East Central as the STP pilot locality for 'urban deprived';
- **June 2016.** Co-location of SPoR and Access team;
- **July 2016.** Senior stakeholders and executives meet to discuss integrated locality teams;
- **Aug 2016 – Dec 2016.** Nominated integrated locality team meetings to design and build and also develop relationships for East Central;
- **Sep 2016.** Essex Partnership University NHS Trust (EPUT) commit resource to lead Locality approach
- **Jan 2017 - present** (some of the activity)
    - Moderate needs MDT commences in East Central, currently running on a weekly basis
    - Social Care conduct community asset mapping for Southend
    - Check-in with senior stakeholders and executives to sponsor work
    - Social Workers aligned to Localities and GPs
    - Community nursing teams aligned to Localities and GPs
    - Re tendering and contracting with Domiciliary Care providers on a Locality basis

- Complex Care 'go live' – additional resource in system to support Locality approach
- Transformation of primary care led to development of a business case to support extended access and triaging
- Commenced West Central to be next Locality for development of integrated team

Provide, maintaining and redesign social care

6.23 Southend BCF will allocate £4.274M for (2017-18) and £4.355M for (2018-19) in revenue to the council for use to provide, maintain and redesign social care.

6.24 During 2017-19 we will maintain social care services which will include services such as our SPoR, community social work assessments, a discharge to assess model, dementia services and the Falls service. A full list of services can be found at Appendix G.

6.25 Whilst we maintain services we will develop a plan which will redesign our existing service delivery model (as outlined below) and be aligned to the locality approach and the Southend health and social care integrated vision, outlined above;

Redesign of Adult Social Care (ASC)

6.26 ASC redesign is an important element to the redesign and delivery of integrated health and social care in Southend. ASC is currently leading a transformational programme across social care and health system which is turning around culture and mind-set, developing alternatives, developing engagement, communicating a compelling vision, and developing and embedding the narrative that supports this transformational programme of work.

6.27 The redesign of social care is changing the approach to adults, families, carers and the community. Using strengths-based assessments and care planning, Social Care is focusing on individual abilities and community assets, rather than an approach that overly focuses on deficits and services to meet need. The approach is empowering and is facilitating the adult to take control of their own live rather than being told what is best for them.

6.28 Social workers are learning to take a preventative approach, as part of a Multi-Disciplinary Team (MDT), to their practice in community settings. The vision is for social workers, alongside their health colleagues, to have a strong understanding of their local community and engage wholly with Southend residents to maximise independence, inclusion and reduce marginalisation.

6.29 By adopting a collaborative and preventative approach to our practice we are minimising admissions into long term residential care, admissions into hospital and minimising the need for large domiciliary care packages. Social Care is creating a robust multi-disciplinary front-end adult social care team where advice, information and signposting to the wider community and universal services can minimise the long term dependency on health and social care services.

6.30 The plan is for social care to ensure that individuals are regularly reviewed to ensure that their needs are being met in the most empowering way. These teams will be developed into a highly skilled and adaptable workforce, which can respond to the changing needs of individuals and the communities, so adults and their carers can receive support and guidance at the right time and in the right way.

Outcomes

6.31 This project will be measured through the following performance metrics;

6.31.1 Residential care admissions;

6.31.2 Delayed Transfers of Care; and

6.31.3 Reablement.

6.32 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

The Redesign of social care – progress to date

6.33 At Appendix Gi there are three of the most recent transforming adult social care newsletters, these provide a detailed sense of the progress to date in transforming adult social care.

Reablement & Care Act

6.34 Southend BCF will allocate £1.475M (for 2017-18) and £1.503M (for 2018-19) in revenue to the council for use to provide, reablement services and continue with the requirements of the Care Act.

6.35 During 2017-19 we will continue to commission reablement services which will include services such as our Single Point of Referral (SPoR), Stroke early supported discharge pathway, discharge to assess and home again services.

6.36 The strategic objective of this scheme is to maintain social care and reduce hospital admissions through funding reablement services with the aim of improving social care discharge management and admission avoidance including developing existing reablement services.

6.37 The funding will be used to facilitate seamless care for patients on discharge from hospital, to promote ongoing recovery and independence and to prevent avoidable hospital admissions.

6.38 Reablement complements the work of intermediate care services and aims to provide a short term, time limited service to support people to retain or regain their independence at times of change and transition. It is intended to promote the health, wellbeing, independence, dignity and social inclusion of the people who use the service.

6.39 The service provider works in partnership with the service users, their families and carers in assessing problems and needs, goal setting, planning and implementing reablement programmes. In order to meet the objectives, reablement requires service providers to develop and skill their workers to be able to motivate and encourage service users and in some cases to take risks.

6.40 Patients who have had a hospital stay and are assessed as benefitting from a period of reablement to assist them in gaining as much independence as possible. Also people who remain within the community, requiring support to live at home and have not ‘gone near’ a hospital or long-term care placement. It is anticipated that referrals of individuals living in the community will contribute towards a reduction in the number of individuals being admitted to hospital.

Outcomes

6.41 This project will be measured through the following performance metrics;

6.41.1 A reduction in avoidable admissions to hospital

6.41.2 Facilitate timely hospital discharges

6.41.3 Prevention and maximising independence

6.41.4 Recovery and enablement services.

6.41.5 Community rehabilitation and reablement.

6.41.6 Processes to minimise delayed discharge

Improved Better Care Fund (iBCF)

6.42 Southend BCF will allocate £3.988M (for 2017-18) and £5.428M (for 2018-19) in revenue to the council for use in accordance with the grant conditions as set out in the BCF planning guidance.

6.43 The plan for 2017-18 (see Appendix H) and agreed by NHS England on 3rd August 2017 (see Appendix I) was developed in accordance with the high impact change model and each element of the step change model is underdevelopment. It is our ambition that each of the planned investments will have been made by the end of Q3 2017-18.

6.44 Some of the investments are being considered and developed, a timeline for the implementation of the high impact change model has been developed and is available at Appendix Hi. The timeline notes that each step change is at various different levels of development, for example the integrated discharge pathway is being piloted at Southend Hospital. Please refer to Appendix K for an outline to the project and Appendix L for an update as at Aug 2017.

6.45 Other projects are at a similar level of development whilst others required further scoping. For example, the Trusted Assessor requires a partnership approach to be developed between Essex County Council, a neighbouring CCG, our local CCG and the council.

6.46 Investment, aligned to the grant conditions for iBCF, will be in social care. These investments will be made to support a whole system transformational change approach which will include community groups, health and social care. Using a strength-based approach we will focus on individual abilities and family and community assets, rather than an approach that overly focuses on deficits and services to meet need. Our model is empowering and facilitates the individual in taking control of their own lives rather than being told what is best for them. Health, social care and partners will take a preventative approach to practice in a community setting. This investment will include (but will not be limited to) supporting training, enhancing capacity, capital investment and technology to support prevention.

6.47 The plan for 2018-19 will build upon the successes evaluated from 2017-18 and will continue to invest in areas that are identified as challenging to the Southend system. The plan for 2018-19 will also be in accordance with any published guidance from either NHS England or the Local Government Association (LGA).

6.48 At this point in time we expect for our iBCF plan for 2018-19 to be focused on delivering the locality approach, supporting the social care market and relieving system pressures.

7 Risk

7.1 The RAID log for Southend BCF (Appendix N) provides a detailed analysis of the key risks identified for 2017-19. It has been developed in conjunction with the Council's Corporate Risk Officer and the CCG's Head of Corporate Governance and agreed with key partners via the Locality Transformation Group (LTG). The risks are reviewed on a monthly basis by the BCF Pooled Fund Manager with oversight by the LTG on a bi-monthly basis.

7.2 The majority of services within the BCF Plan are currently operational, and risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the HWB on the recommendation of the LTG. These plans will include robust programme plans for each project, including key milestones, impacts and risks.

7.3 To deliver the vision in Southend's BCF plan, under the direction of the HWB, the council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which determines the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment has been undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks.

7.4 The total value of the BCF in Southend is £17.439M (for 2017-18) and £19.216M (for 2018-19), which includes iBCF contribution, and for both years (2017-19) no amount of the BCF is described as 'at risk'.

7.5 The council and the CCG, working with its providers Southend University Hospital NHS Foundation Trust (SUHFT) and Essex Partnership University NHS Foundation Trust (EPUT), have agreed to assume strategic responsibility for the whole health and social care system economy. They accept collective responsibility for overspends, working together, and with providers, to pre-empt or minimise their occurrence.

7.6 The HWB has specifically considered performance against the total emergency admissions target set locally for 2017-19 and determined that in the light of the solid performance in the last year, together with the close working with the STP in the context of agreeing a new contract with SUHFT, no "at risk" contingency is required in 2017-19. Accordingly, the whole BCF funding will in 2017-19 be invested in NHS out of hospital services.

7.7 The HWB remains closely involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. Section 75 performance reports for each BCF scheme will continue to be provided to the Locality Transformation Group and to the HWB.

7.8 The issue of treatment of overspends in the BCF schemes has also been agreed and the HWB have agreed that the BCF for 2017-18 should again be fixed at the agreed value of the Pooled Fund. A decision is to be taken for 2018-19. The effect of this is that any expenditure over and above the value of the fund will fall to the Council or the CGG depending on whether the expenditure is incurred on the social care functions or health care related functions.

7.9 The Section 75 Agreement stipulates that Financial Contributions in each Financial Year will be paid to the fund monthly in advance receivable on the first day of the month.

7.10 In terms of management arrangements, the Section 75 agreement stipulates that, if during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the LTG within 21 days. The LTG, where appropriate in consultation with the HWB, will then consider whether it needs to agree the action plan in order to reduce expenditure.

8 National Conditions

Plans jointly agreed

8.1 This plan, submitted on 11th September 2017, has been signed off on behalf of the HWB by both the Chair, the Vice Chair, the Director Adult Social Care (DASS), SBC and the Accountable Officer (AO), SCCG. Operationally, commissioners and providers have signed off this plan.

8.2 HWB will formally receive this BCF plan on 20th September 2017.

8.3 Our iBCF plan (Appendix H) for 2017-18 was formally approved on 3rd August 2017, see Appendix I for the approval letter.

8.4 Through the governance process outlined in Section 10 we have engaged with health and social care providers to fully understand the impact of the fund. We continue to work proactively with our providers which includes Southend's voluntary sector to mitigate any negative impacts and build on positive impacts.

8.5 Our Director for Adult Operations and Housing is part of the BCF delivery group and is also responsible for the DFG. We have, therefore, ensured housing authority representatives have been involved in the development of the BCF plan.

8.6 Through the BCF we aim to ensure the outcomes derived from the capital spend associated with the DFG are aligned and in support of those outcomes we derive from our integrated care commissioning activity for the cohort of patients identified with complex needs.

8.7 We continue to invest in our workforce to understand the cultural and workforce impact of the changes our BCF plans to implement. We have engaged a system facilitator to work with an appointed Leadership 4 Change team to address the workforce on two fronts.

8.7.1 Firstly, our Leadership 4 Change team have attended residential courses which are enabling a cohesive approach to system leadership. This team is then responsible for integrating the learning into our workforce.

8.7.2 Secondly, with the support of our system facilitator we are conducting a gap analysis of our workforce needs which will then support the design of a transformation programme.

Maintain provision of social service

8.8 The total amount from the BCF allocated for supporting adult social care services, and agreed locally, is £4.274M (2017-18) and £4.355M (2018-19). This budget will be allocated to maintain and support the provision of social care services. This agreed approach is aligned with the BCF Policy Framework 2017-19 and consistent with the DoH guidance to NHS England on the funding transfer from NHS to social care in 2013/14.Full details, which include a comparison of approach and spend, are provided in Section 6.

8.9 The total amount from the BCF allocated for supporting adult social care services has been maintained in real terms compared to 2016-17. In 2016-17 a total of £4.199M was allocated and in 2017-18 a total of £4.274M, 2018-19 £4.355M has been allocated, this represents an increase of 1.79% (2017-18) and 1.89% (2018-19). The

increase in spend will not destabilise but help support and maintain services provided throughout 2017/19.

8.10 The Department of Health (DoH) and LGA recently published the local apportionment of the £138m set aside for Care Act Duties. The apportionment to Southend is consistent with national directive and planning guidance and this plan confirms both its identification and allocation within the BCF.

8.11 We are currently waiting for the apportionment of the carer specific funding. We can confirm that our plan will be aligned with the BCF national conditions and await further national guidance.

8.12 We are committed to extending our support to carers in recognition of the vital role they play in the cared for person's well-being and in line with the duties under the Care Act. We have used the national models available to estimate the number of carers not currently known to the council and we are using this information to establish what the increase in carers' assessments is likely to be. We are committed to:

8.12.1 Identifying the carers who are not currently known to the council

8.12.2 Increasing and developing the workforce in response to the increasing demand.

8.12.3 Investing in staff training of both health and social care staff to ensure that the staff have the skills to recognise the impact of the caring role on the carer as well as ensuring the carer has a self-directed service.

8.12.4 Ensuring that there is accessible advice and information available to carers to support them in their caring role

8.12.5 Increasing the availability of respite provision to enable carers to have a break from their caring role.

8.13 We will allocate an agreed amount to carer specific services.

Agreement to invest in NHS commissioned out of hospital services

8.14 For 2017-19 and aligned with national conditions and the SCCG operational plan Southend BCF plans to deliver a reduction in non-elective admissions. At end of Q4 2016-17 non elective YTD admissions had reduced by 1.2% (from Q1 to Q4 2016-17).

8.15 Our HWB have decided to not pool any funding at risk and that the BCF plan would commit funding for out of hospital community services upfront.

Agreement on local action plan to reduce delayed transfers of care (DToC)

8.16 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 9.2 delayed days per day per 100,000 population between Feb 2017 and Apr 2017[4]; by comparison the national target is approx. 9.4 delayed days per day for every 100k of population.

[4] NHS Social Care interface dashboard published 4th July 2017

8.17 A target for DToC has been agreed and submitted to NHS England (see appendix J). The process was led by both SCCG and the council and engaged providers who have an impact on DToC. We recognise that whilst our DToC performance is extremely good there are always areas for improvement. Subsequently, the agreed targets will support either sustaining our excellent performance or a further decrease in DToC.

8.18 The plan (see Appendix H) was developed in accordance with the high impact change model and each element of the step change model is underdevelopment. It is our ambition that each of the planned investments will have been made by the end of Q3 2017-18.

8.19 Some of the investments have been made, for example the integrated discharge pathway is being piloted at Southend Hospital. Please refer to Appendix K for an outline to the project and Appendix L for an update as at Aug 2017.

8.20 Other projects are at a similar level of development whilst others required further scoping. For example, the Trusted Assessor requires a partnership approach to be developed between Essex County Council, a neighbouring CCG, our local CCG and the council.

9 Overview of funding contributions

Minimum funding contributions met

9.1 Southend can confirm that the minimum funding requirements for the BCF plan are as per below. These include the following;

		2017-18	2018-19
9.1.1	SCCG contribution	£12.151M	£12.382M
9.1.2	Disabled Facilities Grant	£1.299M	£1.405M
9.1.3	Care Act 2014 and reablement	£1.475M	£1.503M
9.1.4	Carers Break funding	£0.200M	£TBCM
9.1.5	Protection of social services	£4.274M	£4.355M
9.1.6	iBCF	£3.998M	£5.428M

9.2 Section 6 to this plan demonstrates how each element of the funding contributions will be used.

Additional funding contributions

9.3 No funding has been allocated from either the council or SCCG, in addition to the minimal funding requirements.

Local Agreement on funding arrangements

9.4 Both the BCF planning return and this plan have been signed off by the Chair and Vice Chair of HWB, the DASS at SBC, and the AO SCCG.

9.5 SCCG Clinical Executive Committee (CEC) have requested to review the BCF plan. A meeting is planned for 14th September 2017, after which any comments will be noted and fed into the plan.

9.6 There are 4 key changes to the funding contributions, these are;

9.6.1 CCG contribution. This has changed from £11.937M (2016-17) to £12.151M (2017-18) and £12.382M (2018-19).

9.6.2 DFG. This has changed from £1.193M (2016-17) to £1.299M (2017-18) and £1.405M (2018-19). The additional capital resource funding requirement has been agreed by both the council and SCCG.

9.6.3 Care Act 2014 and reablement. This has changed from £1.450M (2016-17) to £1.475M (2017-18) and £1.503M (2018-19).

9.6.4 Protecting social services. This has changed from £4.199M (2016-17) to £4.274M (2017-18) and £4.355M (2018-19). The additional funding is consistent with the Department for Health guidance to NHS England on the funding transfer from NHS to social care.

9.6.5 The impact of these changes on services has been assessed and no impact is envisaged.

10 Programme Governance

Governance

10.1 We regularly review the BCF governance structure to ensure that it is robust and able to cope with the demands of health and social care integration. Prior to February 2016 the BCF governance structure was as per diagram 1 below. Following a detailed review of the structure to ensure it was aligned with our revised BCF plan for 2016-17 and wider transformational activity (for example STP) the governance structure was amended as per diagram 2. Additionally, we took the opportunity to appoint a transformation lead who will ensure the BCF activity for 2016-17 and going forward is aligned with wider transformation and makes the broader connections.

10.2 A governance review was recently undertaken with the objective of ensuring that our current governance structure (outlined in diagram 2) was robust and able to deliver the BCF plan for 2017-19. The outcome of the review was that our current arrangements were sufficient and more than able to meet the requirements of our transformational activity.

Diagram 1 (Governance structure pre Feb 2016)

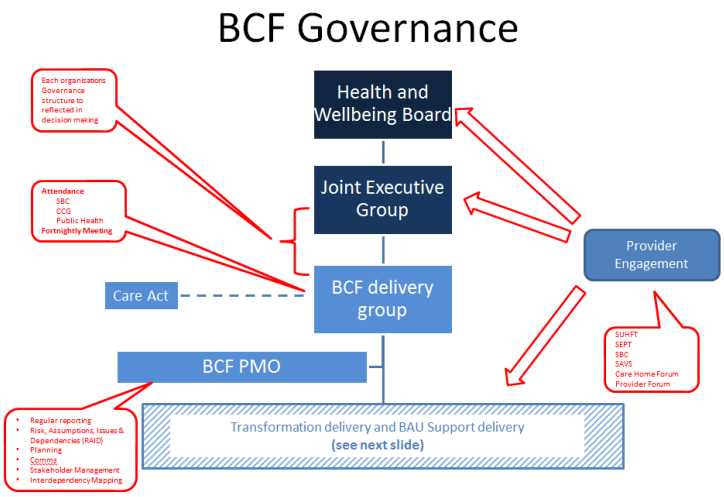
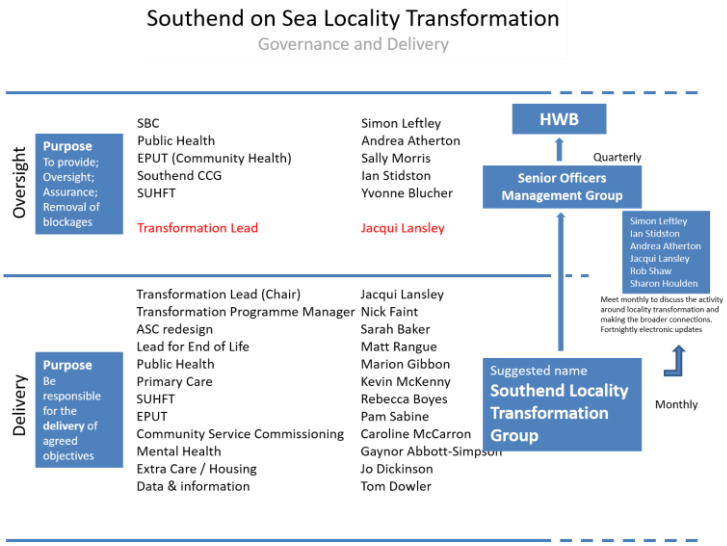


Diagram 2 (Governance structure post Feb 2016)



10.3 Responsible for the BCF delivery is HWB. With multi organisational representation the HWB receives regular reports from the BCF programme to assure financial and operational performance. HWB meet 5 times per annum.

10.4 Responsible for the operational delivery of BCF is the Southend Locality Transformation Group (SLTG). With multi organisational representation the LTG meets monthly. The LTG reports to HWB.

10.5 To work through the day to day delivery of BCF we have appointed a Transformational Lead who is supported by a BCF programme team. The BCF programme team is responsible for developing, managing and monitoring performance, risk, plan and finances. The BCF programme team report directly to LTG.

10.6 A detailed BCF programme plan has been developed (see Appendix M) alongside a BCF RAID log (see Appendix N).

11 National Metrics

11.1 The agreed targets for non-elective admissions, residential care home admissions, reablement, Delayed Transfers of Care and patient engagement is detailed in the BCF planning template submitted in support of the narrative plan.

11.2 Our agreed targets will be delivered through the following activities, each aligned with individual BCF projects;

11.2.1 transforming community services to a locality;

11.2.2 redesigning social care;

11.2.3 discharge to assess service;

11.2.4 overnight support service;

11.2.5 reablement services;

11.2.6 working closer with care homes;

11.2.7 a complex care co-ordination service;

11.2.8 redesigning our end of life pathway;

11.3 We are confident that our track record of delivery (outlined below), delivery and governance structure provides the appropriate assurance that our planning for 2017-19 has been undertaken and undergone a rigorous planning process;

11.3.1 Delivered a reduction in non-elective admissions. Detailed analysis has been undertaken regarding our performance for 2016-17 and our success has been assigned to the commissioning of a number of services that are aligned to delivering services within the community. Our plan for 2017-19 is a continuation of our plan for 2016-17.

11.3.2 Delivered a reduction in residential care admissions. Detailed analysis has been undertaken regarding our performance for 2016-17 and our success has been assigned to a revised approach to panel review, the implementation of a discharge to assess model and closer management of the discharge pathway.

11.3.3 Delivered a reablement metric that shows that a significant percentage of those (over the age of 65) discharged from hospital are still at home 91 days after discharge. Detailed analysis has been undertaken regarding our performance for 2016-17 and our success has been assigned to closer management of the reablement services, the implementation of a discharge to assess model and closer management of the discharge pathway.

11.4 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 9.2 delayed days per day for every 100k of population (Feb 2017 – Apr 2017); by comparison the national target is approx. 9.4 delayed days per day for every 100k of population.

11.5 A target for DToC has been agreed and submitted to NHS England.

Measuring the successful development of each Locality

11.6 The locality approach in Southend has been designed according to a number of factors which include demand, demographics and workforce. Each locality are, therefore, different. For example, the issues that face East Central differ from those that face West; East Central have predominantly deprived areas with large differences for health inequalities, there are huge mental health issues which have led to high rates of substance misuse and challenges for healthy lifestyles. West have a mixture between a predominantly ageing and frail population and an affluent population who commute to London and work in the financial sector.

11.7 The challenge to measure the successful development of each locality is significant. A locality dashboard for each locality will be developed with a mixture of KPIs and outcomes. Each dashboard will specifically measure the success of pilots such as the moderate needs MDT and the complex care service. Early indications show that the complex care service is having a positive impact on A&E attendances and admissions whilst from a qualitative perspective narratives reflecting patient's stories have been developed.

11.8 The plans to measure the effectiveness of our moderate needs MDTs are also in development; we have recently engaged with University of Essex to begin the process of formally evaluating our MDTs.

11.9 Whilst the challenge to measure patient outcomes is significant the challenge to monitor workforce, recruitment and retention will be tougher. Workforce issues in Southend are well publicised but via the HWB a strategy is being developed to ensure a system approach is adopted to ensure we fully address. The locality dashboard will be developed to measure this aspect.