Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Southend Borough Council**
Clinical Commissioning Groups	**NHS Southend Clinical Commissioning Group**
Boundary Differences	Southend is largely coterminous. The most significant boundary considerations are with neighbouring Castle Point & Rochford CCG and Essex CC. The CCG Clinical Chief Officer is a member of the Joint Executive Group, so fully involved in strategic discussions and the Southend BCF. Essex CC are involved on a less formal basis via existing local authority networks
Date agreed at Health and Well-Being Board:	
Date submitted:	
Minimum required value of ITF pooled budget: 2014/15	£687,000.00
2015/16	£12,772,000.00
Total agreed value of pooled budget: 2014/15	£687,000.00
2015/16	£12,772,000.00

b) Authorisation and signoff

Signed on behalf of the Clinical	Southend Clinical Commissioning Group

Commissioning Group	
By Paul Husselbee	
Position Chief Accountable Officer	
Date.	

Signed on behalf of the Council	Southend-on-Sea Borough Council
By. Rob Tinlin	
Position. Chief Executive.	
Date.	

Signed on behalf of the Health and Wellbeing Board	Southend Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Salter
Date.	

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

All local providers contributed to the development of this plan either directly through its completion or through the development of planning and services which contribute to the overall plan.

The plan has been shared with all statutory health and social care providers.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

This plan is based upon the Southend System Leaders Integration Agreement and our successful Integrated Pioneer Bid which was subject to widespread consultation and agreement by the Health and Wellbeing Board before submission. The plan in part has been informed by our established joint strategies which have been fully consulted upon and patient and social care satisfaction surveys, and there have been two public events to further develop the plan. An initial open meeting was held following a CCG Governing Body meeting in public on 28th November 2013 around a 'Call to Action' where members of the public were able to contribute their views to help shape future planning.

A wider public event was held on the 28th January which was attended by over 100 members of the public specifically to look at the areas people have had highlighted as being important to them eg dementia services.

The 1st draft of the submitted plan was taken back to the 'Patient Involvement Group' on the 20th February following their earlier involvement.

The priorities identified through the extensive public engagement programme include dementia and falls both of which align to the priorities in the health and wellbeing strategy, Ambition 3 - Improving mental wellbeing and Ambition 6 - Active and healthy ageing.

e) Related documentation

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

Document or information title	Synopsis and links
1. Better Care Fund Plan on a Page	Please refer to appendix 1.e) 1
2. Plans jointly agreed	Southend system partners have a shared joint vision and are in the process of forming a strategic alliance with major stakeholders and a governance structure that reports directly to the Health and Wellbeing Board. Please refer to appendix 1.e)2
3. Seven Day working	Southend University Hospital Foundation Trust is an early implementer site for seven day working. Clinical and system engagement workshops have taken place and work streams identified. National team visit 3rd Feb early implementer bid embedded. Please refer to appendix 1.e)3
4. Data Sharing	Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs. The DH Informatics Support Team have recently spent two days working with Southend to seek a national solution relating to information governance that hampers the integration process, their final report is embedded Please refer to appendix 1.e)4
5. Protection of social care	The strategic alliance and governance framework referenced and embedded in section 2 of related documents 'Plans Jointly Agreed' will form the strategic oversight that ensures sustainability of social care. Please refer to appendix 1.e)2
6. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable	A successful track record of developing joint health and social care assessments underpinned Southend's successful bid to become one of 14 national Integrated Pioneer Pilots for integrating services. (see embedded bid). Please refer to appendix 1.e)2 & 6
7. Agreement on the consequential impacted changes in the acute sector	Southend system partners have commissioned a System wide capacity review which reported in February and will inform planning and future commissioning.

	System partners have also formed a strategic alliance that seeks to ensure the risk associated with radical service change to improve outcomes is managed collectively. Please refer to appendix 1.e)2 ‘ Plans Jointly Agreed’

2) VISION AND SCHEMES

a) Vision for health and care services

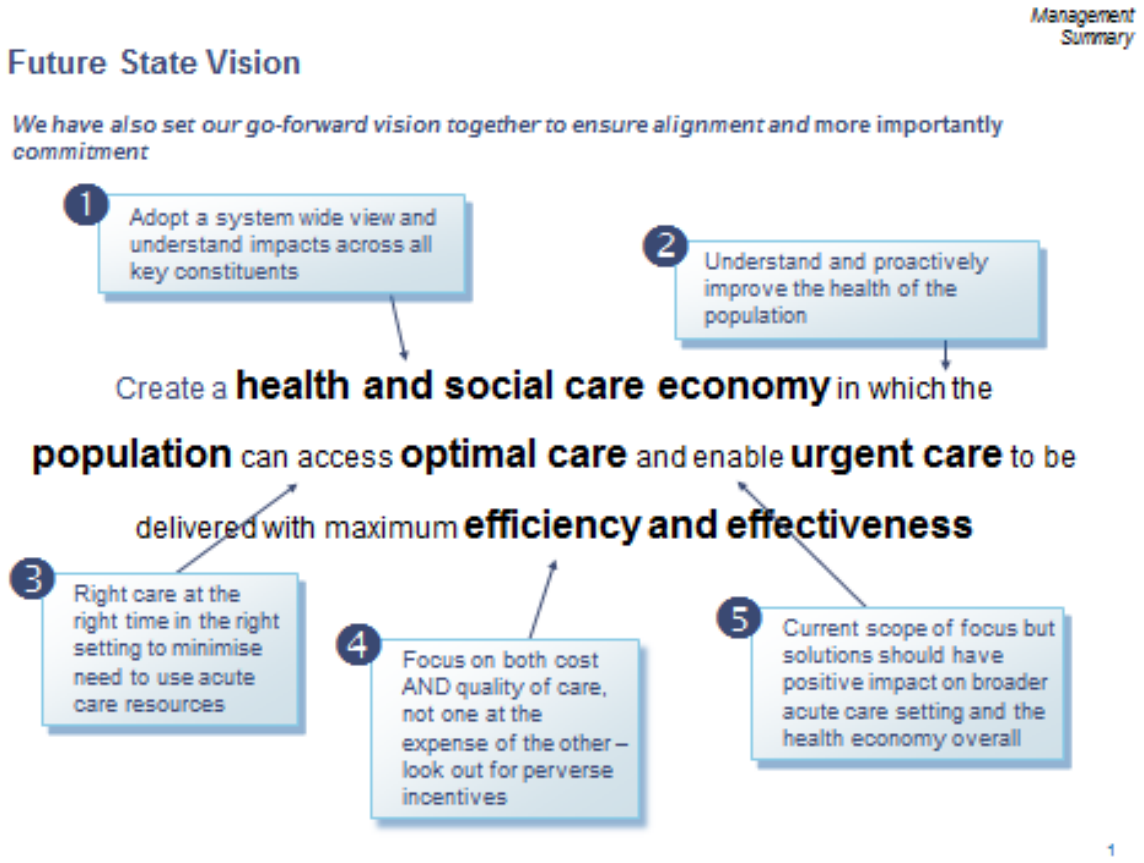
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

We believe the implementation of this plan represents an exciting opportunity to transform and improve health and social care services. All the major stakeholders in the system are committed to work in partnership to achieve our joint vision. Within this plan we will demonstrate a strong operational focus, understand what is required and have an effective governance and performance management model in place to drive delivery.

We need to move at pace but not at the expense of quality. Quality will be embedded in every step of the development process in line with the Francis Report and post Keogh recommendations

Our overarching vision is to create a sustainable health and social care system which delivers high quality care in the most appropriate setting, improve the health and wellbeing of our population and achieve value for money. Statutory and voluntary bodies in Southend have been working towards this for several years and we already have many well established joint services which provide integrated care. Our primary challenge is to ensure that they work together efficiently and deliver across the whole system



Our vision is underpinned by the Southend System Leaders Integration Agreement which includes the following focus 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
- Prevention/recovery in Mental Health

We want to build on our current successes in integrated care delivery to ensure that our prevention offer and self-management options are fully developed and optimised and where longer term care or support is needed it is provided around the service user/patient. We intend to build self-reliant confident communities to enable people to be in control of their care and self-manage. We will invest in preventative services to allow people to be in control and demand less on statutory services

We aim to improve the service user/patient experience through shared use of IT to support individual care planning as well as the use of CARETRAK to support mapping of local need, service planning and identifying more efficient ways of providing support across the system.

We will pilot pooled care budgets which follow the patient as a means of providing more integrated care and offering individuals more choice and control over how their services are delivered.

We will focus on promoting the use of personal health and social care budgets where appropriate and develop new joint contracting and commissioning models to support this.

Service users and patients will have more choice and control over how their health and social care is delivered.

People will experience health and social care as responsive and personalised to their needs and situations.

People will feel enabled to take responsibility for their own health and wellbeing with access to good quality and accessible advice and guidance.

The vision, focus and intentions described above will be delivered through six Better Care Fund Schemes:

- Independent living including reducing the reliance on residential care
- End Of life, palliative care and community services
- Prevention including intermediate care and reablement services
- Primary and community care
- Infrastructure to support Integrated working
- Transforming the emergency care pathway

We are clear about what we will be delivering in 2014/15, our plans for 2015/16 will be developed in the coming months. This allows us to build on what is working well and if our close monitoring of metrics shows we are not getting the shift in activity we expect we can amend our plans or move resources as required.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?

- What measures of health gain will you apply to your population?

We aim to:

- Reduce urgent care demand in the hospital
- Reduce reliance on institutional care specifically residential care for the elderly
- Improve support to carers and prevent avoidable breakdowns in care
- Improve social capital and build community capacity
- Improve the health of our older population with a particular focus on falls and dementia.
- Enhance our prevention offer
- Provide a seamless, easy to access service
- Develop our advice and guidance approach

We will measure our progress by:

- Monitoring the number of unplanned admissions to hospital
- Monitoring admissions to residential and nursing care
- Monitoring falls and injuries in people aged 65 and over (and those with dementia)
- Monitoring the number of patients conveyed as a result of a fall
- Monitoring the number ant outcomes from reablement
- Monitoring the rate of admission into long term care of persons aged 65 and over, due to falls or the risk of falling
- Monitor, validate and cross reference dementia registers
- Monitoring single referral pathway for memory assessment
- Ensuring people with dementia on QoF receive annual reviews
- Monitor and evaluate new services for people with dementia and their carers
- Monitor the impact of our reablement offer and the need for longer term support
- Evaluate service user/patient satisfaction levels using a range of approaches.
- Monitor the numbers of carers supported to maintain a caring role
- We are investigating a measure for social isolation

Measures of health and social care gain to be applied include:

- Increase in detection rates of dementia at earlier stage. Reduction in waiting time for memory clinic
- Increase in the numbers of people with dementia supported at home
- Dementia pathway fully integrated into intermediate care pathway through single point of referral (SPOR)
- Reduction in the rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over (PHOF 2.24)
- Reduction in the rate of emergency hospital admissions for injuries due to falls in persons aged under 65 with dementia
- Reduction in the rate of emergency hospital admissions for fractured neck of femur in persons aged 65 and over (PHOF 4.14)
- Reduction in the number of patients conveyed as a result of a fall
- Reduction in the rate of admission into long term care of persons aged 65 and over, due to falls or the risk of falling
- To reduce the number of preventable re-admissions to hospital within 30 days of hospital readmissions (PHOF 4.11) and reduced social isolation (PHOF 1.18)
- Reduction in non-medical admissions of people with dementia into acute hospital beds
- Reduction in length of stay and delayed discharges from acute hospital settings
- Increase in the health related quality of life for older people

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The vision, focus and intentions described above will be delivered through the governance structure described in section e below and our six Better Care Fund Schemes:

- Independent living including reducing the reliance on residential care
- End Of life, palliative care and community services
- Prevention including intermediate care and reablement services
- Primary and community care
- Infrastructure to support Integrated working
- Transforming the emergency care pathway

Our joint work programme builds on the successes of our existing work and current intentions include:

- Achieving further benefits from SPOR by further simplification of access and establishing a single route of referral
- Rolling out further multi-disciplinary teams with an extended mix of professionals – for example by developing practice level MDTs to all GP practices, extended with additional professionals and targeting re-admissions
- Leveraging even more benefits from Caretrak by enhancing its strategic analysis functions
- Taking forward the Year of Care pilot work by focussing on two areas, the development of shadow currencies for a long term condition (LTC) Year of Care and the testing of a concept that considers post acute Recovery, Rehabilitation and Reablement. We will develop shadow and monitor a currency for patients with long-term conditions and develop a contracting and commissioning framework for local use in 2014/15. We will also test the RRR concept to establish whether funds can be liberated from within national tariffs (HRGs) to support rehabilitation and re-ablement services.
- Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.
- Developing further community based specialist services that avoid the need for a hospital referral or residential care.

However, we will also open up major new areas of exploration. These will include;

- Developing a broader ‘all ages approach’ to integration work, thereby engaging and mobilising a wider range of partners in our work. Key partners will include children’s services (particularly aspects of SEN, CAMHS and Troubled Families) and housing (particularly around home from hospital services, enhanced adaptations and home settings)
- Improving the engagement of the third sector in our integration work
- Deepening our understanding of individuals perspectives through use of ’I’ statements and truly effective engagement techniques.
- Additional work to ensure individuals feel empowered to take control of their own lives, treatment and care.

- Further, and more radical, collaborative commissioning for best value.
- Defining and delivering the new areas will be carried out through the Pioneer Programme and Joint Executive Group described in the governance section below. The Prevention, Commissioning and Operations Workstreams have recently been agreed and we are in the process of resourcing them.

Currently identified projects under way include:

1. Development of seven day services across the Acute Hospital Trust and in the community
Southend CCG, Southend University Hospital Foundation Trust (SUHFT), South Essex Partnership NHS Foundation Trust (SEPT) and Southend-on-Sea Borough Council (and Castle Point & Rochford CCG) are working together to enhance existing care pathways across seven days as well as developing new approaches. The hospital is a national pilot site for seven day services.

The Single Point of Referral, an integrated community team with a focus on hospital avoidance and discharge, will be piloting a seven day service from April 2014. This will be evaluated over six months to monitor the impact on hospital admissions and attendances at A&E. We will align our falls prevention pathways across the system to be in place by June 2014.

From June 2014 we will pilot A&E based social workers providing a seven day service with a focus on preventing unnecessary admission to hospital or residential care. The project will aim to enhance the prevention offer through advice, guidance and routine and screening, redirection to appropriate care pathways e.g. falls, reablement and prevent carer breakdown through early identification and intervention.

Plans are forming to develop a GP Federation across Southend which will give greater resilience to practices and enable them to deliver a wider range of services and enable greater access outside core hours. Options and feasibility will be developed over 2014/15.

2. Development of pooled budgets which follow the patient across health and social care delivery.
This opportunity has emerged from the Year of Care work and we are planning virtual pooled budgets from April 2014. We will to evaluate throughout the year with a target of initiating actual budgets from financial year 2015/16.

3. Reduction in emergency readmissions within 30 days of discharge.
The Home from Hospital service is being commissioned from April 2014 to help ensure that older people do not remain in hospital longer than they need once clinical requirements have been met. It has been identified, that due to social isolation, many older adults need some support and assistance in the home to regain their confidence, strength and reconnection with the community in the early days after discharge from hospital. The 'Home from Hospital' scheme will provide support and other practical assistance for a short term period of up to six weeks. The service will be coherent with current and future provision. This will assist us in achieving our aim for no person to enter permanent residential care directly from hospital.

4. Development of the Falls Prevention Pathway.
Work is underway to further develop the falls pathway following a recent evaluation. We will be taking an integrated approach to a falls pathway with additional investment which will enhance the delivery of community assessment and provide additional equipment e.g. tilt table etc.

The Falls Service will support provision of Falls Prevention training delivered to Health and Social Care Staff, and a Falls Prevention and Bone Health Strategy - with a focus on early screening.

5. Development of dementia pathways.
We are in Year 2 of our Dementia Plan and developing options for the redesign of existing sheltered housing into dementia specialist extra care housing.

To ensure early diagnosis assessment and support pathways for people with challenging behaviour. This work is being undertaken by SEPT, Southend CCG and Southend-on-Sea Borough Council.

Review of existing assessment pathways is complete and consultation on proposed changes is planned for April 2014.

6. Acute mental health
Mental health is a key priority for Southend CCG and we are fully committed to delivering parity of esteem. The CCG has made significant progress in a number of areas in 2013/14 and intend to build on this over the next 2 years. The joint mental health commissioning strategy has driven key changes within Southend, namely, the development of a GP crisis line, improving dementia intensive support services, piloting psychological therapies in long term conditions, developing shared care protocols and reducing mental health delayed discharges.

As part of our strategy we will implement the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services.

The south Essex mental health commissioning economy is complex and one of our first tasks is to agree which aspects of the strategy are best delivered on a system perspective and which are best delivered within the CCG organisational boundary.

The CCG are focussing on a number of areas:

- Focus on improving service delivery through developments such as the single point of access and the community transformation programme
- Focus on early intervention and self-management through developments such as mental health personal budgets and recovery colleges
- Focus on improving access and developing the crisis pathway through developments such as adopting the national crisis concordat
- Focus on training and integration through improving skills within primary and community care.
- Focus on improving experience through developing mental health specific friends and family tests
- Focus on approach to prevention by ensuring that there are linkages between the mental health strategy and public health and wellbeing strategies.

d) Implications for the acute sector
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

We are currently undertaking a system capacity review across health and social care. The outcome review will determine system capacity requirements and the financial impact across acute hospital settings, community and social care over the next 5 years and will underpin our future planning and areas for joint investment.

Furthermore, the review of acute services which is planned across Essex is expected to lead to changes in hospital services. Locally, we will ensure through the JEG,that proposed changes are supported by a corresponding change in community and social care as necessary.

Within our local system, NHS commissioners are working with the hospital and community services to deliver the savings quantified in Everybody Counts, namely 15% reductions in non-elective activity and 20% efficiency savings in planned care. Detailed modelling and planning is taking place to apply these national values to local services. A Joint Improvement Plan is being developed by the hospital and commissioners which requires action on the parts of the hospital and commissioners. It is imperative that as activity reduces within the hospital, the organisation is able to extract costs at the same time and that safety and quality is maintained or improved.

Our BCF plan intends to strengthen the quality and capacity of social, primary and community care services. The services must be better placed to respond to patients' needs and prevent emergency admissions. The plan also intends to better integrate services between social and community care, but also to strengthen integration across acute and community care pathways. To ensure consistency in approach to BCF schemes we have worked with our neighbouring organisations to align pathway changes that impact on a single hospital provider. In addition the schemes within our plans have been developed with system partners to ensure a consistent approach to planning & the impact of the plans to minimise the risk of duplication.

By delivering the plan, savings will be realised through avoided emergency admissions and supporting people in their home before institutional care. At present our emergency admissions are high compared to national benchmarked data. Year to date emergency admissions have increased by 3% based on 2012/13 and the admission conversion rate of 4% is above both the regional and national average.

Realisation of NHS Savings
National planning guidance sees the BCF as having the potential to improve sustainability, raise quality and reduce emergency admissions; the latter will have to reduce by around 15%. Within Southend, there is a joint vision and a collective commitment to radical change. Unlike programmes which are funded from 'new' money, the BCF cannot operate in isolation. It has touch points with our main strategic work streams, for example, the older people's programme. It will also form a part of the CCG five year strategic plan. The Better Care Fund is one of the essential elements of this wider strategic programme and we need to ensure that it supports our wider vision.

In terms of process, we are at the initial stage of preparing the BCF plan and, as a result of our engagement activities, we have received a large number of proposals for transformation from a wide range of stakeholders. Having grouped those proposals into key themes, our next task is to evaluate the proposals in detail, in order to assess the potential scale and scope of NHS savings which could be realised as a result of their implementation.

Risk of Savings not being realised
Southend system partners recognise the risks attached to system transformation and the potential impact on services if planned schemes do not achieve their anticipated outcomes. The Strategic Alliance of system partners referenced and embedded in appendix 1e) 2 clearly articulates an agreement to manage risk collectively to ensure sustainability of services.

We are aware of the risk that the required savings may not be realised, despite having implemented a wide range of transformational schemes. In the risk section of this template, we have described several areas of risk and, in particular, the risk of failing to protect acute services. We are working jointly to conduct a risk assessment which will be informed by the evaluation of the proposals mentioned in the section above.

We also recognise that the BCF schemes alone will not fully address the financial challenges we

currently face across the health and social care economy, we will therefore be undertaking further planning work over the next few months to address this.

e) Governance

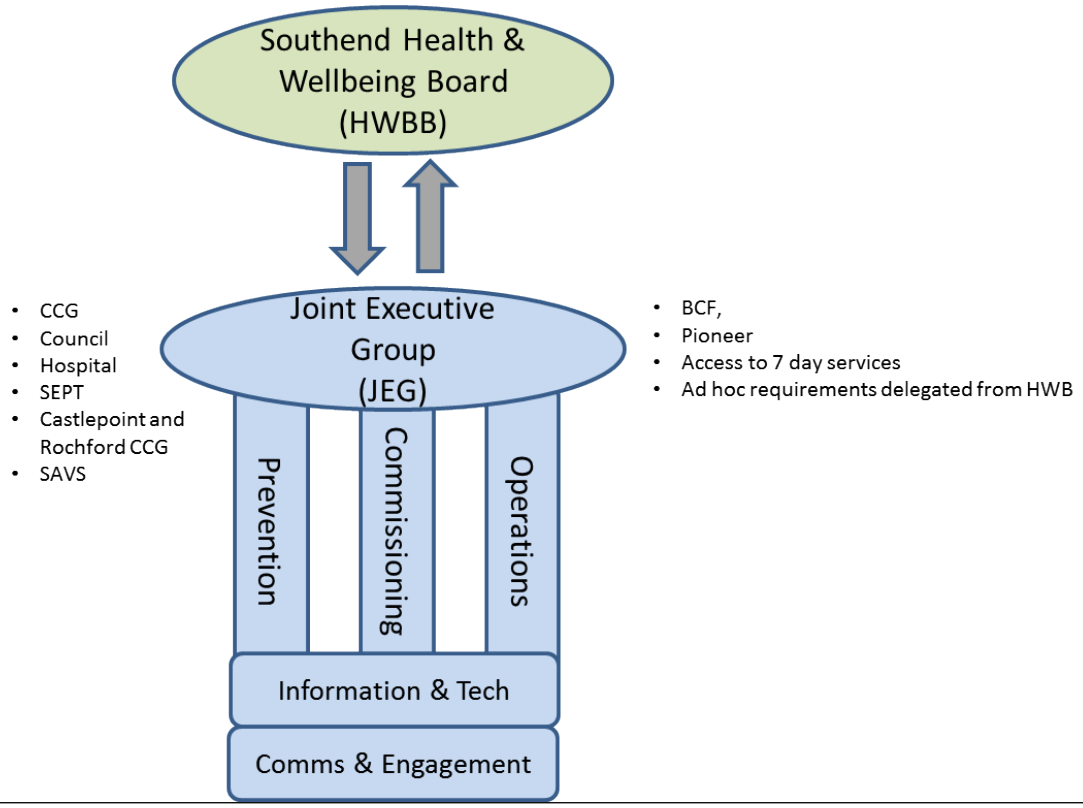
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The Southend Health and Wellbeing Board will be the primary governance point and will monitor high level progress.

The Joint Executive Group, (JEG), a Chief Officers group has responsibility for overseeing integration related activity and driving through change at pace. Additionally, Chief Officers are members of the Urgent Care Working Group (UCWG) which develops urgent care strategy and oversees system-wide operational delivery.

We are taking an MSP and PRINCE 2 based programme approach given the scale and complexity of change needed. The governance structure will be supported by processes for decision making, risk mitigation, issue management and progress reporting to ensure oversight and rapid progress.

A programme manager has been appointed and the programme management structure is in the process of being finalised. The intention is that the JEG will be supported by five workstreams as shown in the diagram below. Workstream Leads are being appointed whose first task will be to complete a workstream definition that will include clear deliverable and milestones.



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services

The current eligibility criteria for adult social care will remain at critical and substantial. It is not envisaged that this will change over the next five years.

Our local definition of protecting social care services is, “ensuring eligibility criteria and investment remains at required levels with a focus on prevention and ensuring that health services are available earlier and in better co-ordinated ways to reduce demand on social care”

Please explain how local social care services will be protected within your plans

Promoting independence and reablement, supporting carers and offering alternatives to longer term reliance on residential care are key elements of the Southend approach to protecting social care services. Funding currently agreed via the NHS transfers monies has enabled the local authority to maintain current eligibility criteria, keep delayed transfers of care to a minimum and offer timely assessment and longer term support to people with eligible needs. This will need to be sustained if not increased, within the funding allocations for 14/15 and beyond to maintain and develop further the current offer. In particular the Care Bill is likely to impact on the numbers of assessments required with larger numbers of people needing an assessment who would previously have not had contact with Social Care. This also raises the opportunity to engage in preventative approaches with a wider range of Southend residents and strengthens the importance of a joint approach.

Southend CCG and Southend-on-Sea Borough Council will work together to agree levels of investment with a focus on achievement of agreed joint objectives. Investment in social care reablement and prevention services will reduce hospital admissions and admissions to residential care. This will support the achievement of a financially sustainable social care system.

There is recognition that in order to undertake radical change in services to achieve better outcomes requires support and commitment from all system partners. This ensures services are protected and risk is managed collectively. System leaders in Southend have formed a strategic alliance with a clear governance structure that reports directly to the Health and Wellbeing board.

We are beginning to scope opportunities for joint commissioning across health and social care to achieve value for money and increased efficiencies and have identified the need for a wide ranging prevention strategy to support a shift in resources and manage demand. We will use the BCF to:

- Develop our prevention offer with a focus on increased utilisation of third sector opportunities
- Review our commissioning approaches with a view to developing joint commissioning where this can achieve better outcomes and value for money.
- Focus on integrated service delivery to improve efficiency and reduce duplication
- Support market development to broaden the range of alternatives to residential care.

The Care Bill offers opportunities to review our approach to assessment and we will explore options for increased use of self assessment and review options for the delivery of front end assessment with an increased focus on self management and use of universal services. The Care Bill is the catalyst for further developing our information, advice and guidance pathways and we will use the BCF to scope out opportunities for a joint IAG approach. Within our BCF schemes we have allocated £626k to support implementation of the Care Bill.

b) 7 day services to support discharge

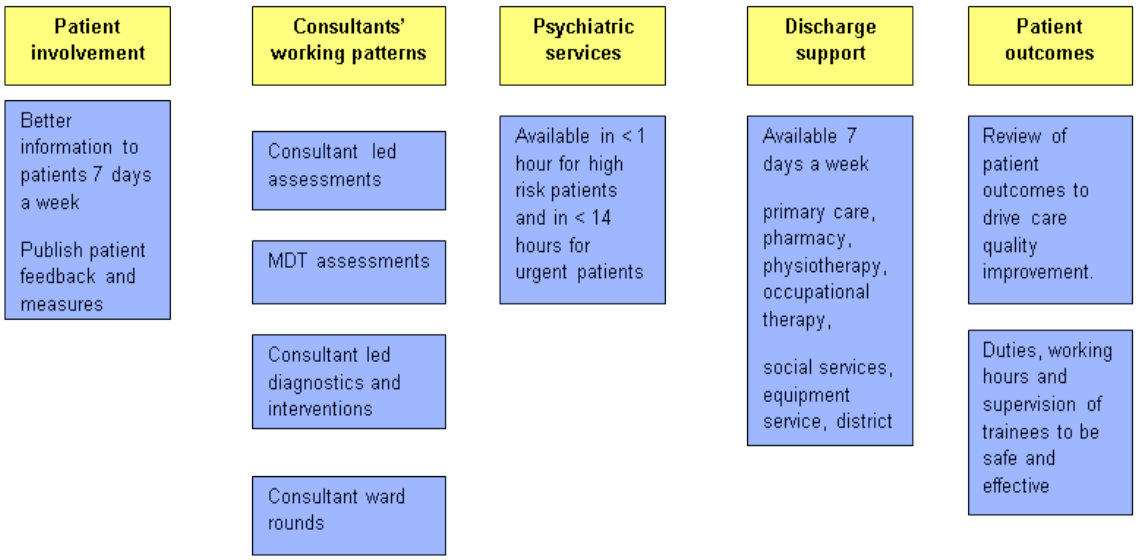
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Southend Borough Council, Southend CCG and Southend Hospital Trust have been successful in gaining early adopter status for seven day services. The bid to become an early adopter was fully supported by Health and Social Care leaders and partners across Southend.

We currently provide a seven day week hospital social work service and will be expanding this to provide an A&E attached social worker to focus on admission avoidance. We are working towards enhancing our seven day reablement/prevention offer. This involves community nursing, OTs and social workers providing a seven day assessment capacity for patients in the community to prevent hospital admission as well as to facilitate safe hospital discharge.

The CCG will be applying a CQUIN to enhance 7day working across the Hospital Trust.

Delivery of services across seven days is a core strand of our integration programme and the implementation plan will be structured around the five workstreams below.



The clinical standards below will apply seven days a week and 24 hours a day.

	Standard	Approach	Measure
1	Patient involvement and	Shared decision making	Patient feedback on

	information	with clear information	weekday/weekend service comparison displayed in public (Audit)
2	Emergency admissions assessed < 14 hours	Consultant led. High risk patients in < 1 hour. Early Warning Scores for all patients.	% of emergency admissions assessed in < 14 hours. % of patients with EWS (Record on PAS)
3	MDT assessment in < 14 hours for emergency inpatients	Integrated management plan with estimated discharge date	% of emergency inpatients with MDT assessment in < 14 hours (record on PAS)
4	Standardised shift handovers	Multi-professional, twice a day, electronic, governed by policy	% of shift changes compliant with policy (Audit)
5	Inpatient access to consultant-directed diagnostic services	< 1 hour for critical < 12 hours for urgent < 24 hours for routine	Quarterly audit of provision by each service
6	Inpatient 24 hour access to consultant-directed interventions	e.g. Critical care, Radiology, Endoscopy, Surgery, etc	Quarterly audit of provision by each service
7	Psychiatric assessment for acute admissions	In < 1 hour for emergency patients and in < 14 hours for urgent	% of assessments within timescales (record on PAS)
8	Consultant led ward rounds	Twice daily for acute wards and once daily for other wards	Quarterly audit of provision by each service
9	Support for discharge	All support services available 7 days a week, social services, equipment, transport, etc	Quarterly audit of provision by each service
10	Patient outcome reviews and training	All involved to participate in reviews. Hours, duties and supervision of trainees to be safe.	Number of outcomes per months completed. Quarterly audit of arrangements for trainees.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Yes our health and care systems will use the NHS Number. One of our BCF schemes is ”Infrastructure to support integrated working” which aims to improve the service user/patient experience through initiatives which will include integrated care records, shared use of IT to support individual care planning, the use of CARETRAK to support mapping of local need, service planning and identifying more efficient ways of providing support across the system

Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs.

The DH Informatics Support Team have recently spent two days working with Southend to seek a national solution relating to information governance that hampers the integration process, their final report is embedded. Please refer to appendix 1.e)4

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

We are committed to using NHS numbers as the primary identifier in all our work. We include the NHS number in all our dealings between health and social care around information sharing. Over the last three years the availability of NHS Numbers in Social Care has improved from 15% availability to over 90%. The intention is to use the NHS Number in all customer correspondence from August this year.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Yes all health and care systems will use the NHS Number. The CCG and SBC are committed to adopting systems that are based upon Open APIs and Open Standards, wherever possible, and encouraging existing suppliers to adopt Open APIs and Open Standards in future releases of software.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practise and in particular requirements set out in Caldicott 2.

Yes we are fully committed and have a Health and Adult Social Care Services - Information Sharing Protocol (April 2013) with 4-5 more detailed sharing agreements that sit below this e.g. Caretrak, Major Adaptations. We also submit the NHS IG Toolkit each year and we're due to submit our application for next year by 31st March 2014.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The CCG is developing a clear programme with a specialist CCG delivery team and clinical champion to support practices in being accountable for co-ordinating patient-centred care for older people and those with complex needs. The CCG are providing additional resource for practices by way of the £5/head population set out in 'Everyone Counts'. With 19 small or single handed practices in Southend, there are greater challenges to deliver this requirement. We have taken positive and bold steps to develop a GP Federation for Southend. We have formed a steering group and have a business model to develop the Federation. This will be crucial in ensuring the smaller practices particularly are able to deliver this requirement with a more robust infrastructure.

Over the next year, the CCG will support all practices to hold monthly MDTs with an extended range of professional where possible. While the majority of practices hold regular MDTs at present, this is a key enabler to ensure GPs can coordinate the care for older people and those with complex needs. We are piloting an extended MDT in our largest practice in Q1 2014/15 and bringing in a wider mix of therapy and social care staff. Through the extended MDTs we will ensure people with dementia are well care for.

The MDTs have been supported by CareTrak to risk stratify patients. This has had to be stopped under the new information governance legislation, however, as an Integration Pioneer, the DH are working with Southend to enable us to restart and this is critical to the successful

delivery of our plan.

Southend has over 150 care homes. During 2014/15 we will extend our Single Point of Referral (SPOR) to care homes to ensure maximum benefit of community and social care services are delivered to care home residents including those with dementia. During 2013/14 we piloted a new service with GP practices to improve quality of care for patients in care homes. In 2014/15 we will evaluate and extend this service (with appropriate modifications) and link the service to MDts, and the accountable GP model.

The Single Point of Referral offers integrated assessment followed by identification of a lead professional for individuals. Locality teams in the Adult Social Care work with GP clusters and attend MDTs to identify individuals at risk of hospital admission and care planned with a lead professional. Our plan will expand the SPOR across seven days and bring in more services under this umbrella. Building on the work of the SPOR we will develop a formal joint process for risk assessment and care planning which will be rolled out across services during 15/16. As part of this we plan to develop recording protocols to measure the numbers of people who are subject to a joint risk assessment and/or care plans.

GPs will undertake the accountable lead professional role for patients over the age of 75 years through the national contractual arrangements (the Directed Enhanced Service). The CCG is supporting practices develop enhanced services including:

- services for elderly patients at high risk of admission including those in care homes,
- provide same day telephone access for both high risk patients and the professionals caring for them,
- supporting practices to improve access to patients and to extend access to cover the 7-day period.

These developments will be enabled by the additional funding CCGs are required to make available to practices.

RISKS

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

Risk	Risk rating	Mitigating Actions
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs	High	• Appropriate governance structures Provision of regular, timely and accurate information to support monitoring of services
Failure to reduce acute activity causing financial pressure	High	• System planning is focused on a range of community interventions in a move away from hospital admission. • Regular joint monitoring of progress against identified deliverables and early identification of emerging risks will ensure that potential problems are spotted quickly and mitigation action taken . • Closely monitor demand for acute services and ensure that contingency plans are in place for diversion of funding if necessary • Development of the BCF plan across partnerships to explore sharing of risk and rewards
The transition to new models of working lead to risks to quality and safety.	High	• Clear lines of accountability up and including the HWBB. • Ensure clear mobilisation transition plan is

		developed and overseen by JEG • A robust performance and quality outcomes framework needs to be developed to monitor and quality and safety.
The transition to new models of working lead to risks to quality and safety.	High	• Clear lines of accountability up to and including the HWBB. • Ensure a clear mobilisation transition plan is developed and overseen by JEG • A robust performance and quality outcomes framework needs to be developed to monitor quality and safety.
The scale and pace of the change required with risk of increase in number of SUIs and safeguarding referrals across the partnership	High	• Review of quality and Safeguarding arrangements in place to respond to and learn from any issues that arise • Accountability to H&WB board as well as internal governance boards • Review of existing resource capacity to deal with SUIs and safeguarding referrals
Staff within partnership organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery	High	• Workforce strategies across partners need to take into account change requirements
We are unable to engage care homes sufficiently	High	• Training and incentive programme in development for care homes
We are not able to share data across organisations	High	• Liaison with national team to use Caretrak as a model of best practice and pilot to remove barriers.
Despite intention and plans social care services are not protected	Medium	• Closely monitor demand for social care arising from demographic change and the new statutory duties under the Care and Support Bill • Robust governance process will ensure that risks are quickly identified.
Re investment and a changed commissioning focus may create viability problems for providers.	Medium	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of savings plans on providers • Impact of plans on quality of service delivery monitored • Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered
There is a risk that the local authority and CCG are unable to agree actions to re direct resources to meet the requirement soon	Medium	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan • Further development of integrated service delivery projects with robust evidence base to measure success
There is a risk that demand for	Medium	• Early and broad engagement with community

crisis services (residential/ hospital services) will not reduce because of insufficient quality of Community & primary services.		and primary care providers on the CCG and Council quality agenda.
There is a risk that the acute services review in Essex will be out of sync with BCF implementation	Medium	• Close engagement with Monitor and the TDA as well as other local and national partners on emerging findings. • Use of CCG and Council plans to influence the outcome of the review. • Joint agreement on adaptions required to BCF planning for alignment with the wider strategic review
Lack of engagement and support from Providers	Medium	• Use the JEG to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for transformation and use these to inform on-going discussions • Use provider clinical forums to keep clinicians aware and engaged. • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business. Develop a communication strategy for both internal and external stakeholders.
Staff are not fully aware of and engaged with the changes set out in the Better Care Fund plan	Medium	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' comms channels to promote better understanding and flag examples of excellent performance and innovation
GP practices do not take up and fully implement the DES	Medium	• GP clinical leaders are working with practices to encourage sign up

APPENDICES

Ref	Document Title	Document
1.e) 1	Better Care Fund on a Page	BCF plan on a page_final2.pptx
1.e) 2	Plans Jointly Agreed	Integration Concordat.doc
1.e) 3	Seven Day Working	South East Essex expression of interes
1.e) 4	Data Sharing	Final ICP report.docx

1.e) 5	Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable	 FINAL - Southend Health and Social Car
1.e) 6	South Essex Mental Health Plan Checklist	 BCF Plan Appendix 6, South Essex Menta