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	**Coterminous**
Date agreed at Health and Well-Being Board:	**11/02/14**
Date submitted:	**14/02/14**
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	£14,132,762.00

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Southend Clinical Commissioning Group
By	
Position	
Date	30.01.2014

Signed on behalf of the Council	Southend-on-Sea Borough Council
By	

Position	
Date	30.01.2014

Signed on behalf of the Health and Wellbeing Board	Southend Health and Wellbeing Board
By Chair of Health and Wellbeing Board	
Date	30.01.2014

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 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 will be taken back to the next '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 andcare 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 will report in February and will inform planning and future commissioning. A full briefing document will be available for the final submission of the BCF plan. System partners have formed a strategic alliance that seeks to ensure the risk associated with radical service change to improve outcomes is managed collectively. See documents referenced & embedded in

	section 2 of related documents ‘ Plans Jointly Agreed’

2) VISION AND SCHEMES

a) Vision for health and care services

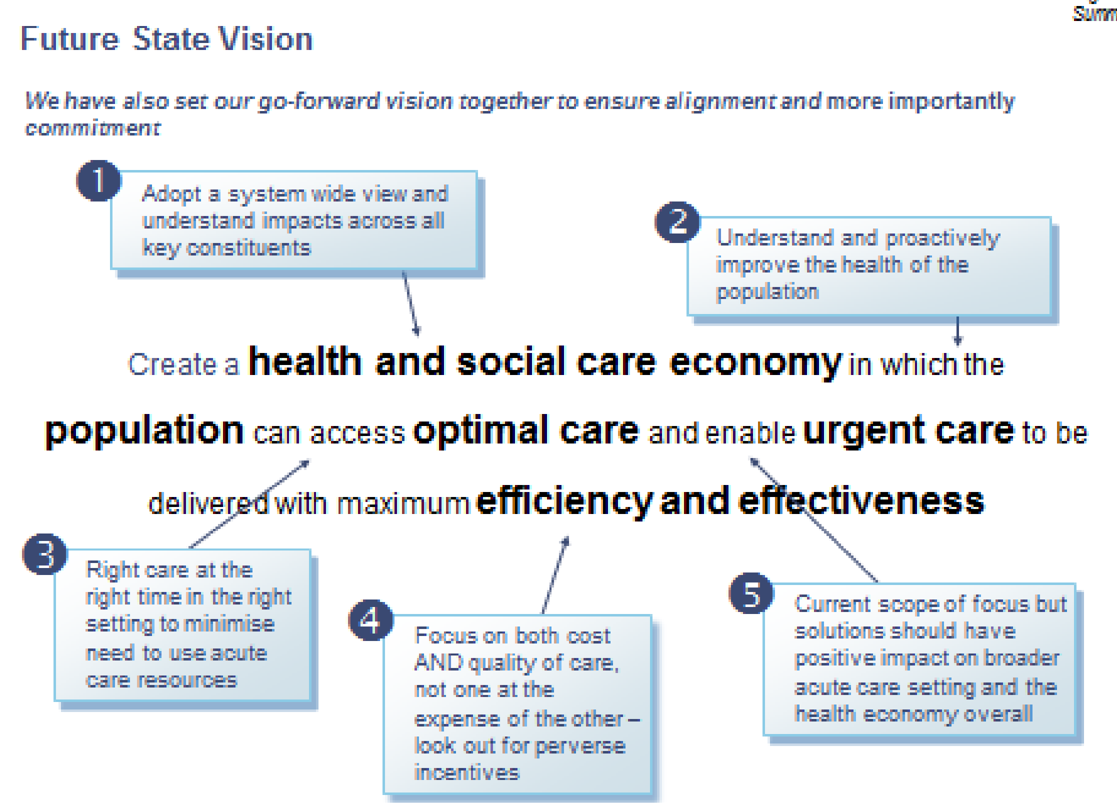
Please describe the vision for health and social care services for this community for 2018/19.

- 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 services. All the major stakeholders in the system are committed to work in partnership to achieve the 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 have many well established joint services which provide integrated care. Our challenge is to ensure that they work together efficiently and deliver across the whole system



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.

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 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 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

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

Our joint work programme is currently focusing on building on the successes of our existing work. This includes in summary

- Achieving further benefits from SPOR by further simplification of access and establishing a single route of referral
- Rolling out further multi-disciplinary teams – for example by developing practice level MDTs to all GP practices 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 an 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 more expensive forms of care such as 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.

Currently identified workstreams include:

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 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, 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.

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.

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

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.

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.

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.

NHS commissioners will be working closely with partners towards the savings quantified in Everybody Counts, namely 15% reductions in non-elective activity and 20% efficiency savings in planned care.

We are currently undertaking a system capacity review across health and social care which is due to report at the end of February. The outcome review will determine system capacity requirements across acute hospital settings, community and social care over the next 5 years and will underpin our future planning and areas for joint investment.

Our 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.

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.

Sustainability of Services

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 additional documentation number 2 Joint planning clearly articulates an agreement to manage risk collectively to ensure

sustainability of services.

e) Governance

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

Southend Health and Wellbeing Board will monitor high level progress.

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

We are taking a programme approach given the scale and complexity of change needed and the governance structure includes consideration and mitigation of risks to the project and as well as oversight to ensure rapid progress.

A programme manager has been appointed and the full programme management structure is in the process of being finalised.

ADD Diagram

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

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. A key aim is a significant reduction in permanent admissions to residential care to help achieve a financially sustainable social care system We are currently undertaking a system capacity review across health and social care which is due to report at the end of February. The outcome review will determine system capacity requirements across acute hospital settings, community and social care over the next 5 years and will underpin our future planning and areas for joint investment. There is recognition that in order to undertake radical change in services to achieve better outcomes requires support and commitment from all system partners to ensure services are protected and risk is managed collectively. Partners in Southend have formed a strategic alliance with a clear governance structure that reports directly to the Health and Wellbeing board. The alliance will be agreed through individual organisations internal governance structure with final sign off by the Health and Wellbeing board in March 2014.

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.

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 all health and care systems will use the NHS Number

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

N/A

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

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

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 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.

Almost all our GP practices hold regular multi-disciplinary team meetings to identify and discuss high risk patients and ensure a care plan is agreed by all agencies. Southend has historically used CareTrak to risk stratify patients although this has stopped under the new information governance legislation. As an Integrated Pioneer, the DH are working with Southend to enable us to restart and this is critical to successful delivery of our plan.

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
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.
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 JOG Structure and plan 05-12-13 DRAFT
1.e) 3	Seven Day Working	South East Essex expression of interest
1.e) 4	Data Sharing	Final ICP report.docx
1.e) 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	FINAL - Southend Health and Social Car
2.c)	Current schemes funded	