Southend-on-Sea Borough Council
Legal & Democratic Services
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07 December 2021

HEALTH & WELLBEING BOARD - WEDNESDAY, 15TH DECEMBER, 2021
SUPPLEMENTARY APPENDICES TO BCF

Please find enclosed, for consideration at the next meeting of the Health & Wellbeing Board taking place on Wednesday, 15th December, 2021, the appendices to Agenda Item 5.

Agenda No **Item**

5. **Better Care Fund Appendices (Pages 1 - 56)**

Appendices attached

Robert Harris
Principal Democratic Services Officer

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Better Care Fund 2021-22 Template

1. Guidance

Overview

5

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

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

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your respective Better Care Manager)

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Southend-on-Sea
Completed by:	Taslima Qureshi
E-mail:	TaslimaQureshi@southend.gov.uk
Contact number:	01702 215550

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Councillor Lead Member
Name:	Councillor Cheryl Nevin

Has this plan been signed off by the HWB at the time of submission?	No
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Wed 15/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Cheryl	Nevin	cllrnevin@southend.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)	NHS Alliance Director	Tricia	D'Orsi	patricia.dorsi@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers	mid and south Essex CCGs	Anthony	McKeever	Anthony.McKeever@nhs.net
	Local Authority Chief Executive	Chief Executive	Andy	Lewis	andrewlewis@southend.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)	Executive Director,	Tandra	Forster	tandraforster@southend.gov.uk
	Better Care Fund Lead Official	Director of Commissionin	Benedict	Leigh	benedictleigh@southend.gov.uk
	LA Section 151 Officer	Executive Director	Joe	Chesterton	joechesterton@southend.gov.uk
Please add further area contacts that you would wish to be included in official correspondence -->					

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Template Completed

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	Yes
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Southend-on-Sea

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£1,721,065	£1,721,065	£0
Minimum CCG Contribution	£14,311,579	£14,311,579	£0
iBCF	£7,568,235	£7,568,235	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£23,600,879**	**£23,600,879**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£4,066,945
Planned spend	£7,539,116

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£6,772,463
Planned spend	£6,772,463

Scheme Types

Assistive Technologies and Equipment	£0	(0.0%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£150,210	(0.6%)
Community Based Schemes	£6,147,727	(26.0%)
DFG Related Schemes	£1,721,065	(7.3%)
Enablers for Integration	£85,000	(0.4%)
High Impact Change Model for Managing Transfer of	£4,421,318	(18.7%)
Home Care or Domiciliary Care	£1,649,832	(7.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£6,827,301	(28.9%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£0	(0.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£0	(0.0%)
Residential Placements	£2,036,821	(8.6%)
Other	£561,605	(2.4%)
Total	**£23,600,879**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	1,037.2	1,037.2

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SLIS data - available on the Better Care Exchange)	LOS 14+	8.4%	8.4%
	LOS 21+	3.9%	3.9%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SLIS data - available on the Better Care Exchange)	0.0%	93.1%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	480	550

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Southend-on-Sea

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Southend-on-Sea	£1,721,065
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£1,721,065**

iBCF Contribution	Contribution
Southend-on-Sea	£7,568,235
Total iBCF Contribution	**£7,568,235**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

CCG Minimum Contribution	Contribution
NHS Southend CCG	£14,311,579
Total Minimum CCG Contribution	**£14,311,579**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£14,311,579**	

	2021-22
Total BCF Pooled Budget	**£23,600,879**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Southend-on-Sea

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£1,721,065	£1,721,065	£0
Minimum CCG Contribution	£14,311,579	£14,311,579	£0
iBCF	£7,568,235	£7,568,235	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£23,600,879**	**£23,600,879**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£4,066,945	£7,539,116	£0
Adult Social Care services spend from the minimum CCG allocations	£6,772,463	£6,772,463	£0

Checklist

Column complete:

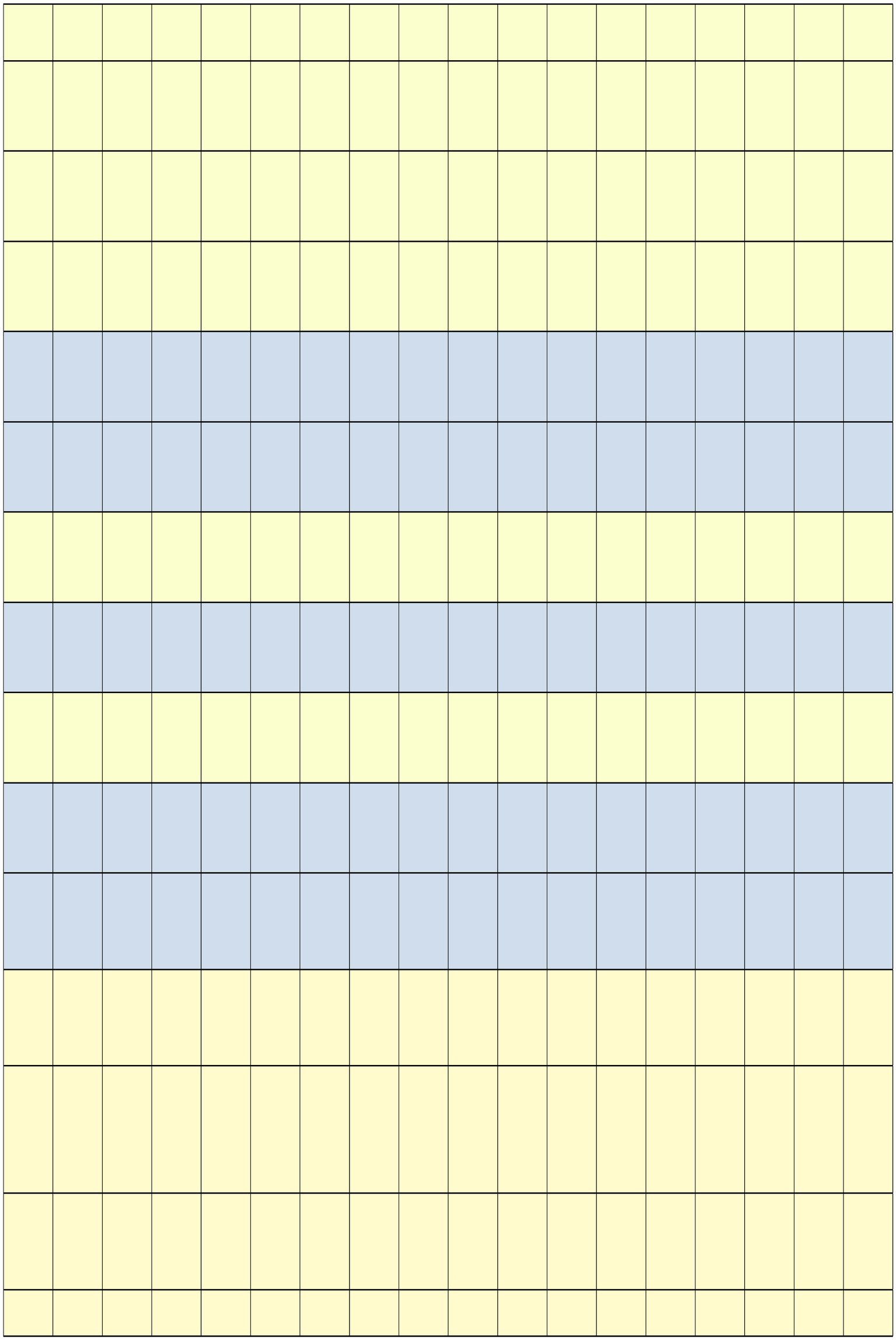
Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

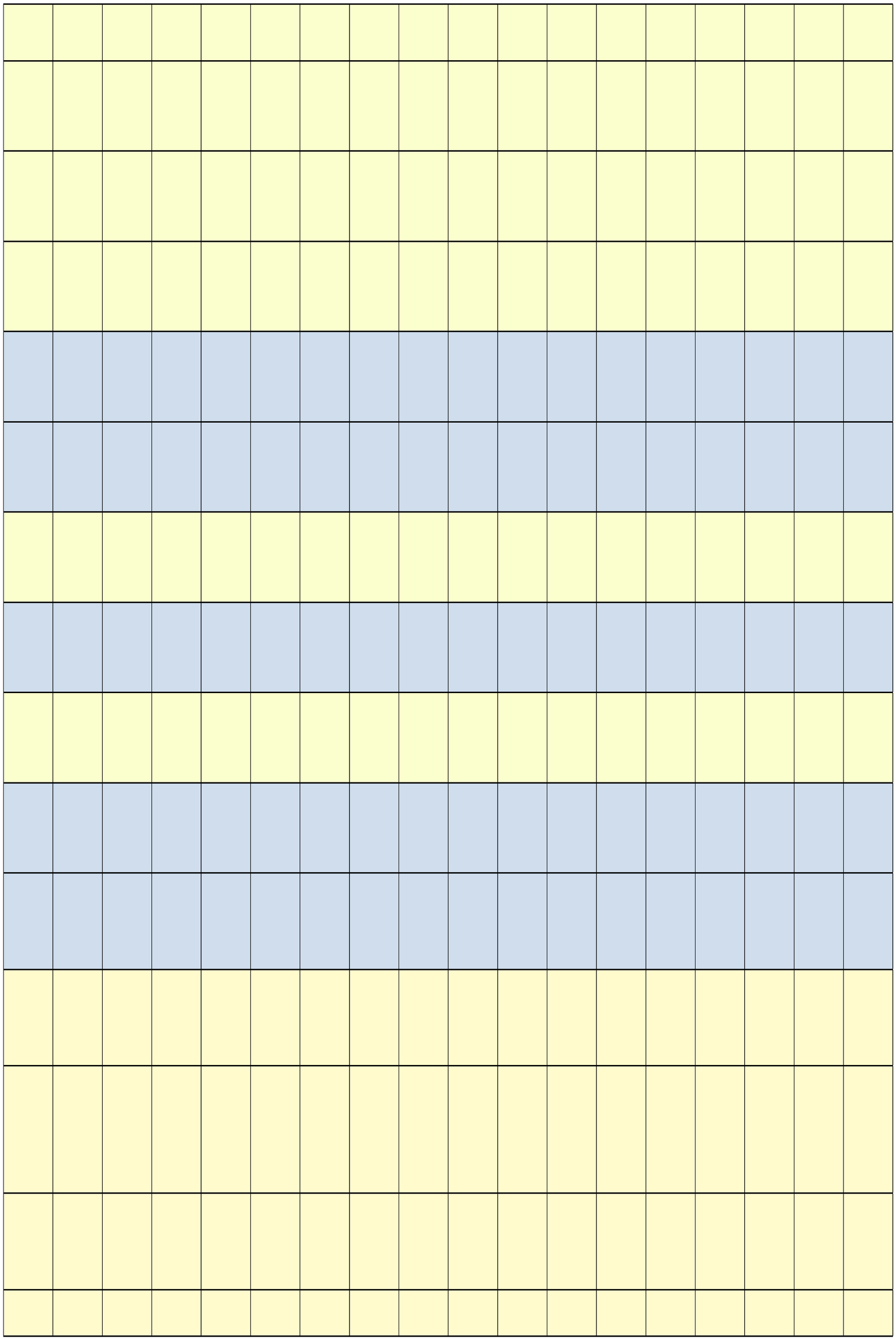
Sheet complete

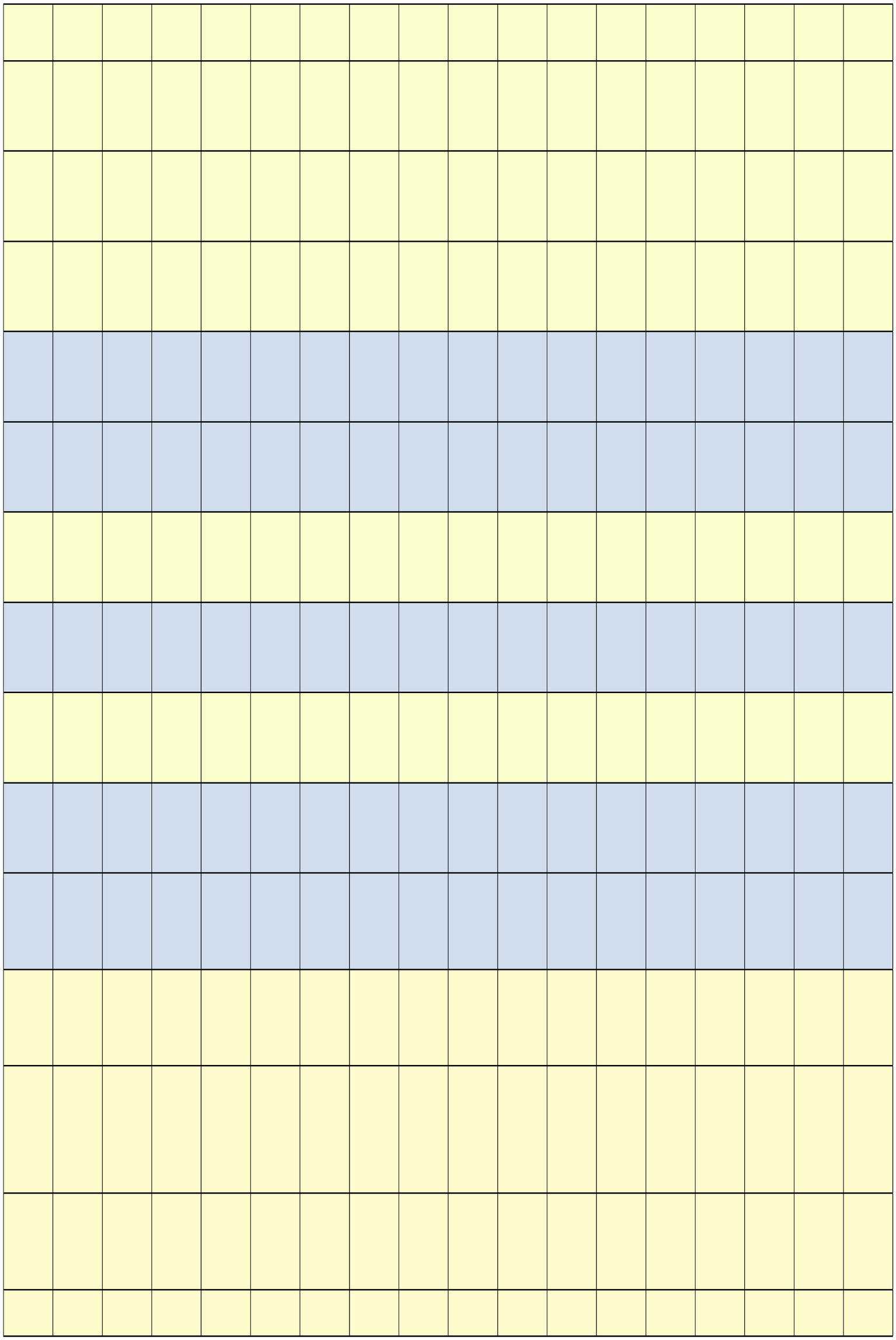
						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	DFG	Home Adaptations	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£1,721,065	Existing
2	High Impact Model	High Impact Change Model for Managing Transfer of Care	High Impact Change Model for Managing Transfer	Improved discharge to Care Homes		Social Care	System Investment	LA			Local Authority	iBCF	£1,670,508	Existing
3	iBCF Social Care	Sustaining the social care market and supporting the system to	Community Based Schemes	Low level support for simple hospital discharges		Social Care		LA			Local Authority	iBCF	£5,897,727	Existing
6	SCCG Community Services	The provision of community related health services	Integrated Care Planning and Navigation	Care navigation and planning		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£5,187,694	Existing

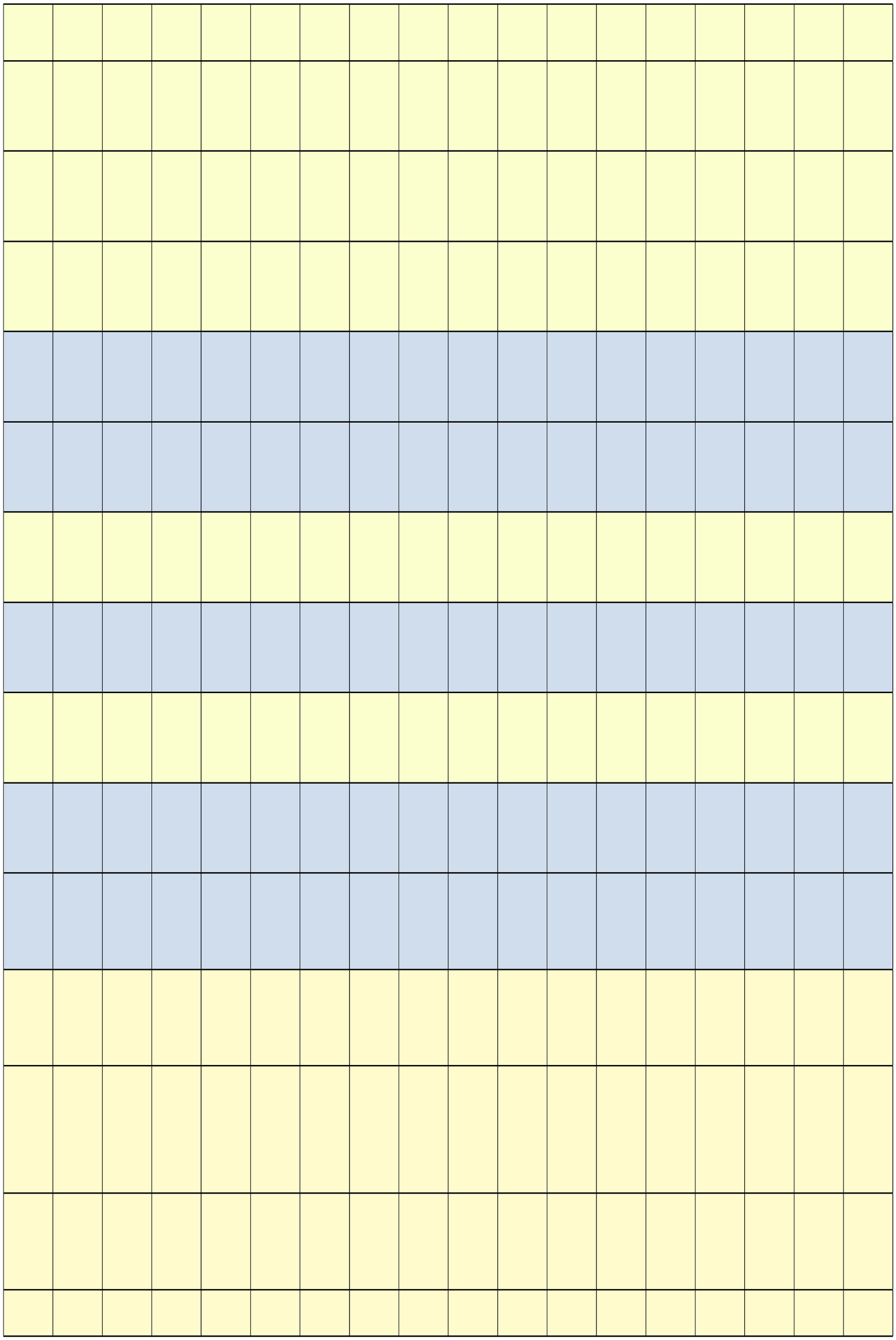
8	Carers Breaks	Carers Services	Carers Services	Other	Local investment	Other	Charity/Voluntary Sector	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£150,210	Existing
9	SCCG Havens Hospice	End of Life Services	Other		End of Life Care	Other	Charity/Voluntary Sector	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£561,605	Existing
16	SCCG Mental Health Services	The provision of community related health services	Integrated Care Planning and Navigation	Care navigation and planning		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,639,607	Existing
17	Dementia Support	A community-based dementia support offer to support those living	Community Based Schemes	Multidisciplinary teams that are supporting	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£100,000	New
18	Single Point of Access	Provision of a Single Point of Access to adult social care teams	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£474,250	New
19	Hospital Team	Provision of a dedicated team to support the Discharge to Assess	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£703,310	New
20	PCN & Locality Development	Aligned operational teams across adult social care and health co-	Enablers for Integration	Joint commissioning infrastructure	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£85,000	New
21	Residential Provision	Provision of residential care for those 65 and over	Residential Placements	Care home	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£2,036,821	New
22	Home Care	This scheme seeks to manage people being discharged from	Home Care or Domiciliary Care	Domiciliary care to support hospital discharge	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,649,832	New
23	Reablement	Re-ablement complements the work of intermediate care	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£357,750	New
24	Reablement	Re-ablement complements the work of intermediate care	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£965,500	New
25	Reablement	Re-ablement complements the work of intermediate care	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process	Narrative	Social Care		LA			Local Authority	Minimum CCG Contribution	£250,000	New

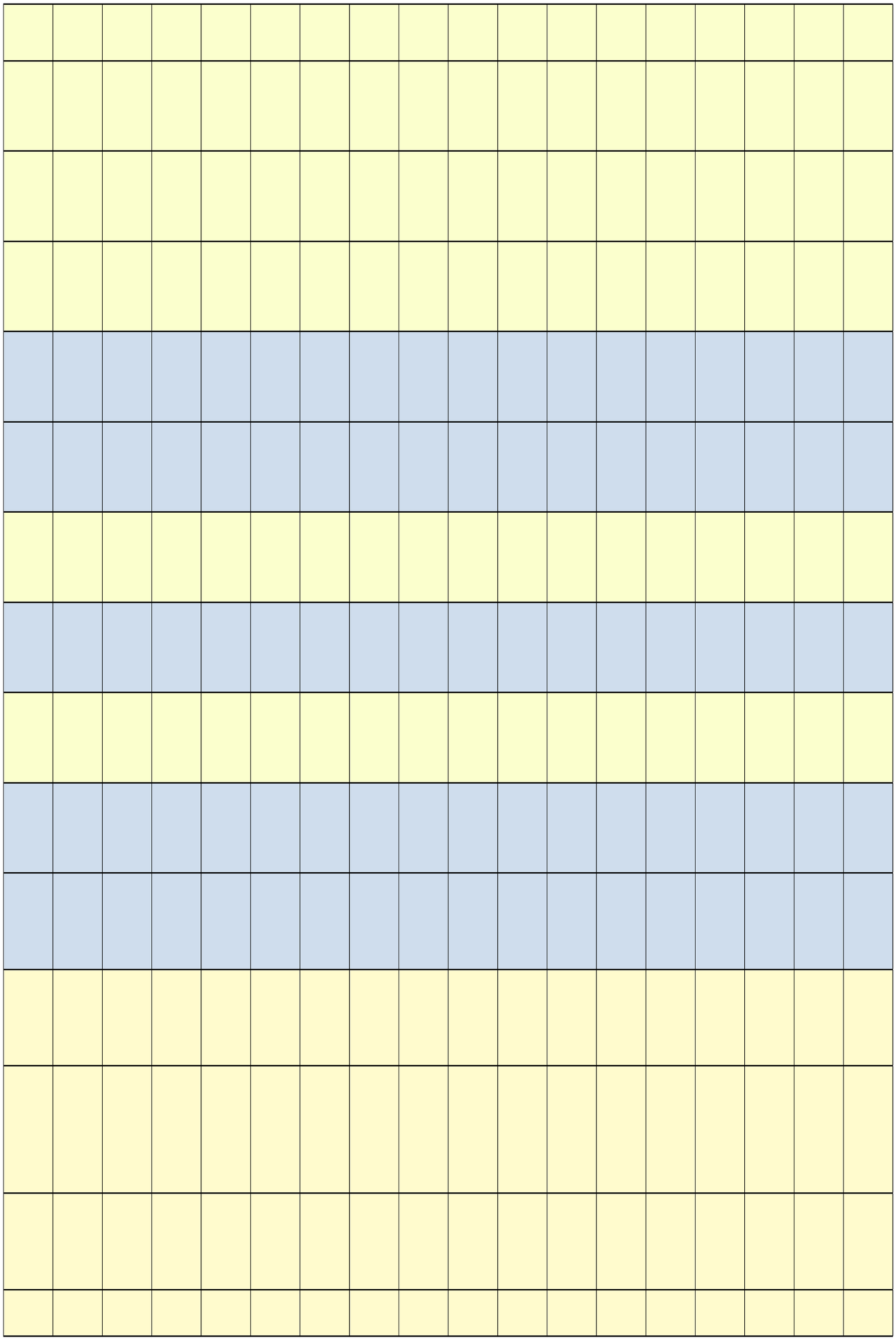
26	Children with Disabilities	Support for children with disabilities.	Community Based Schemes	Other	support young people aftercare discharge from	Social Care		LA			Local Authority	Minimum CCG Contribution	£100,000	New
27	Adoption Services	Support with adoption of children and young people.	Community Based Schemes	Other	support for enchanced health	Social Care		LA			Local Authority	Minimum CCG Contribution	£50,000	New

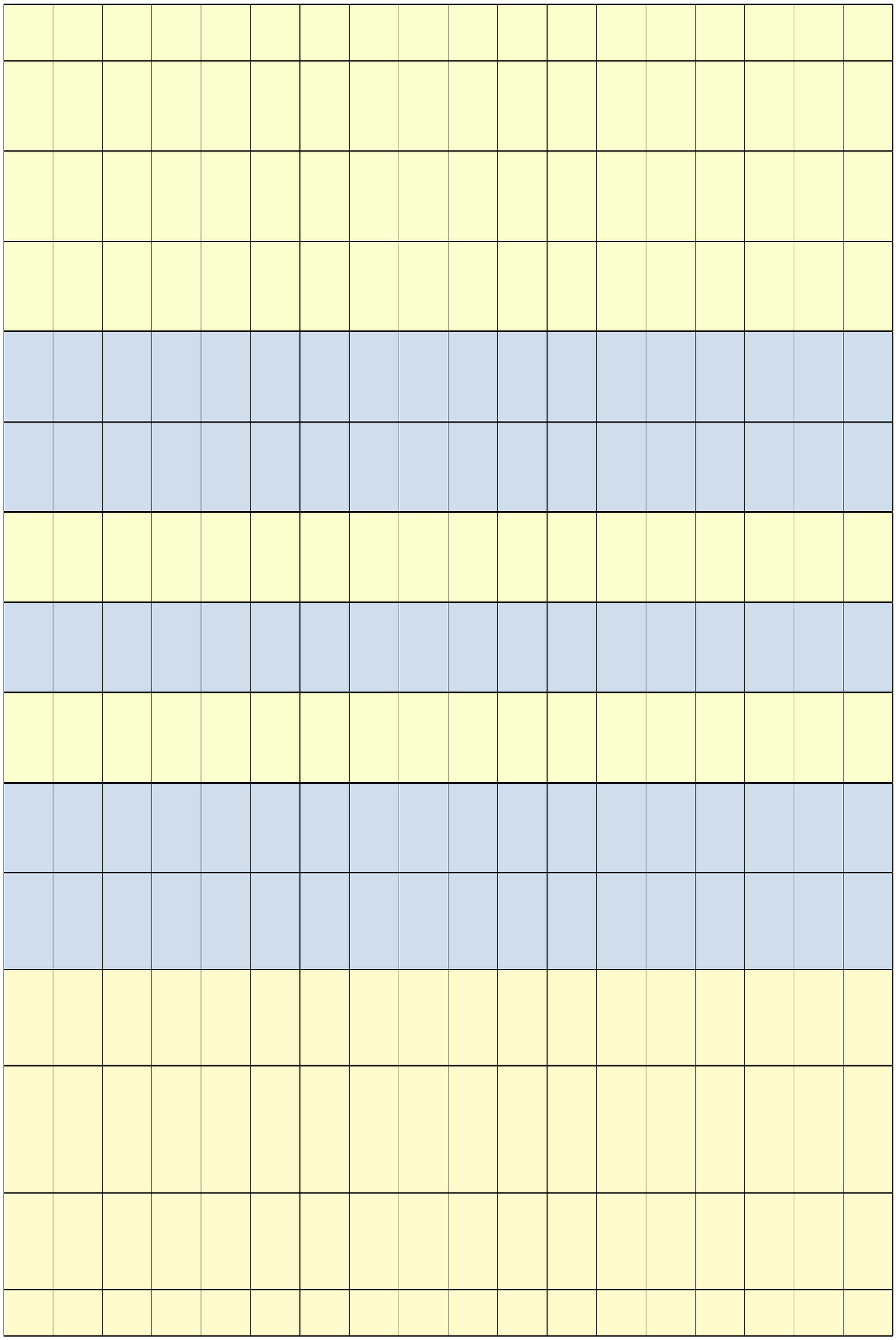


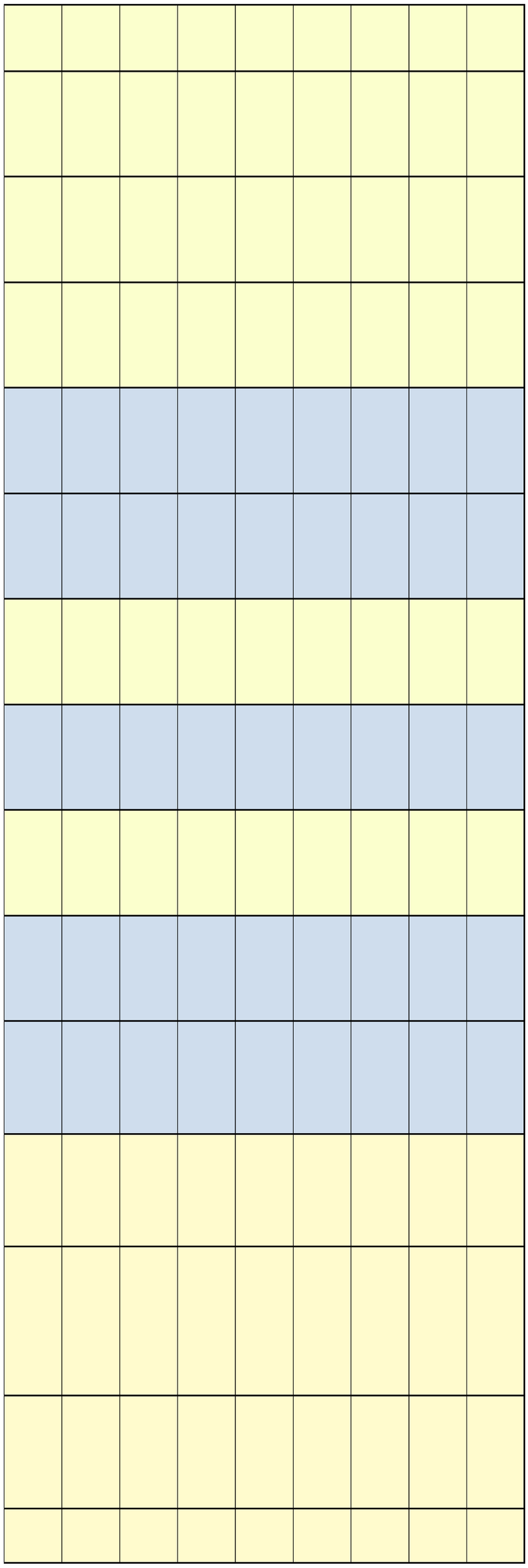












2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of ‘home ward’ for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.

Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Southend-on-Sea

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	1,037.2		1,037.2	As this is a new metric there will be limited scope to shift resources towards this in year. Consequently there is limited scope for managed change and the expectation is that this will be maintained at the previous level, with any change a consequence of the impact of COVID on the local system. However, a dedicated service focused on	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	8.4%	8.4%	Given current system pressures and the likelihood of increased pressure in the second half of this year, maintaining performance at the levels from Q1 and Q2 will represent a "stretch" target. These pressures include the ongoing impact of COVID; staffing issues in primary care, acute hospital and mental health services; and increasing levels of demand. MSEFT has confirmed that this is in line with their expectations, acknowledging that their own plans cover a wider geographic area than	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	3.9%	3.9%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	93.1%	The work undertaken with D2A home first model implementation to support clear discharge pathways, whereby assessments are made in the community and out of acute settings has taken significant traction. Although clear pathways are in place for our 'Home Again' and 'Bridge the Gap' bridging service, reablement,	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	659	556	480	550	target plan set for 21/22 is 550 per 100,00
	Numerator	238	198	171	200	
	Denominator	36,105	35,625	35,661	36,273	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	80.0%	81.5%	80.0%	target set at beginning of year 21/22 taking into account covid impact/position.
	Numerator	80	202	80	community-based reablement service will continue to work in partnership with other local services in Southend-on Sea. The service recognises national best practice,
	Denominator	100	248	100	guidance, and the needs of the individuals referred to it,

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Southend-on-Sea

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes			
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			

Southend on Sea Better Care Fund Narrative Plan 2021-22

Local Authority	**Southend on Sea Borough Council**
Clinical Commissioning Groups	**Southend Clinical Commissioning Group**
Boundary Differences	**Coterminous**
Date agreed at Health and Well-Being Board:	**Delegated sign off by Chair of HWB prior to final submission for full approval at 15th Nov 2021 HWB**
Date submitted:	**Draft 19th Oct 2021** **Deadline 16th November 2021**
Total agreed value of budget: 2021/22 Total CCG minimum contribution	**£14,311,579**

Southend BCF	**2020/21**	**2021/22**
	£000s	**£000s**
CCG Minimum Contribution	**13,575**	**£14,311**
DFG allocation	**1,516**	**1,721**

Signed on behalf of the Health and Wellbeing Board	**Southend on sea Health and Wellbeing Board**
Signature	
By Chair of Health and Wellbeing Board	**Councillor Cheryl Nevin**
Date	

Related document or information title	Documents
1. SE Essex Alliance, Mid & South Essex ICS, and Southend, Essex & Thurrock – links or attached documents • South East Essex Locality Strategy • Mid and South Essex Health and Care Partnership Five Year Strategy • Southend, Essex and Thurrock Dementia Strategy 2017-2021 • Southend, Essex and Thurrock Mental Health and Wellbeing Strategy 2017-2021 • MSE Quality strategy • SE Essex Alliance place plan • SE Essex Alliance terms of reference **to be added** • Alliance UEC delivery group TOR (**to be added**) **2. Southend on Sea - – links or attached documents** • Southend Health and Well-Being Strategy 2021-24 • Southend Joint Strategic Needs Assessment • Southend 2050 • Southend Local Plan • Adult Social Care Milestone Recovery Plans 2020-2022 • Ageing Well, Living Well and Caring Well strategies 2022-2027 • Southend Market Positioning Statement 2021 • Southend Joint Prevention Strategy 2016-2021 • Workforce Development Plan • LEPEL escalation • OPEL **to be added** • BCF management Group terms of Reference	South East Essex Locality Strategy MSE Quality Strategy SEE Place Plan SE%20Essex%20Alliance%20Terms%20o SBC 2021-Market Position Statement Workforce Development Plan LAPEL BCF Management Group Terms of Refer

National Conditions

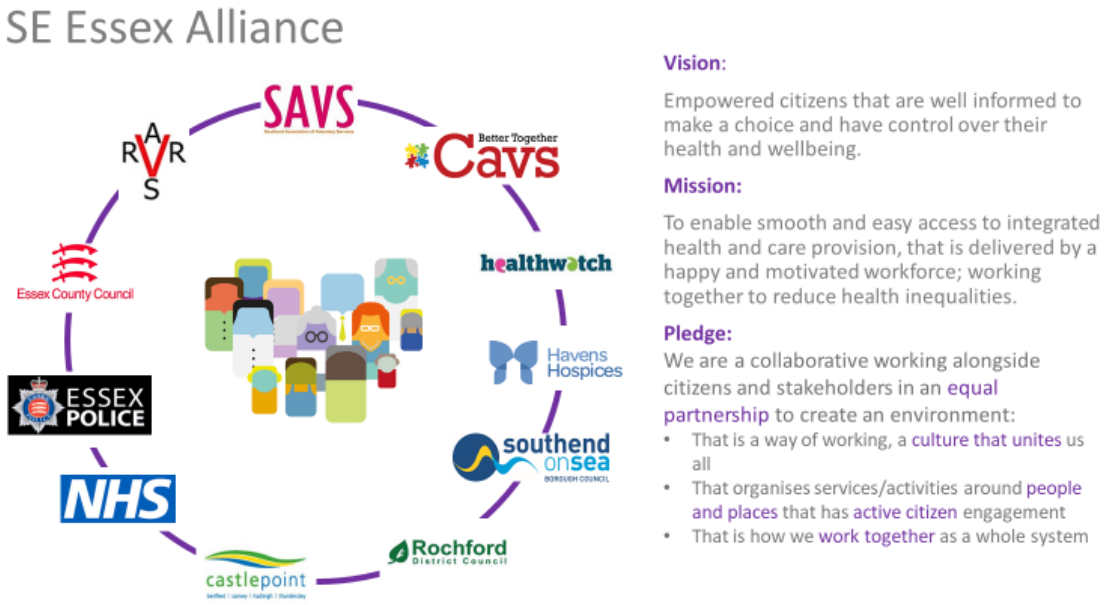
Executive Summary

Through consultation with a wide range of partners and stakeholders, our Health and Wellbeing Strategy 2021-23 and BCF Plan incorporates joint planning, ambitions and priorities on how we influence the wider determinants of health and wellbeing, which include the social, economic and environmental conditions that influence the health of individuals and populations. Within our strategy, we describe the challenges we face, but also describe some of the opportunities too, and know that our strong partnerships and commitment to working together means we are well placed to deliver sustainable, long-term improvements in the health and social care system to protect people and help them to live well and in good health.

National Condition 1: - Jointly Agreed Plan

Our Better Care Fund Plan builds upon the work previously undertaken in Southend through the South East Essex Locality Strategy, which brought together a partnership of local partners and stakeholders, including Providers, VCS and Housing who share an ambition to improve the wellbeing and lives of the people they serve. This strategy has been agreed by the SE Essex Alliance, the multi-agency forum that will have the lead responsibility for developing and implementing plans at a SE Essex place level to meet the needs identified by local Health and Wellbeing Boards. SE Essex, covering Southend, Castle Point and Rochford, will be the local “place” that will form part of the Mid and South Essex Integrated Care Partnership. Terms of reference for the SE Essex Alliance are attached.

Our plans are developing further through the development of the Mid and South Essex Integrated Care Partnership and SE Essex Place Plan, which has been subject to a significant level of consultation and engagement with stakeholders and partners with emphasis on a coherent strategic direction for the health and social care system across Southend. This includes how to deliver the best outcomes for local people, ensure future capacity, plan workforce requirements and scoping the implications for both local providers and the regulation of services across the system. The plan is grounded within our Health and Wellbeing Strategy, JSNA, Locality Strategy and plans of individual Alliance partner organisations.



We have also revised our BCF governance arrangements and established a BCF Management Group with key partners, (Terms of reference attached), planning priorities, reviewing key themes and activity across Southend, and having financial oversight of BCF governed through Section 75 Agreements agreed though the Health Wellbeing Board.

Our plan recognises both national and local challenges, particularly through COVID-19 response and recovery, including affordability challenges for social care and the NHS. It includes consideration of both iBCF and Social Care Grant with associated conditions to be met - including stabilisation of the home care and residential care markets, improving discharge arrangements and supporting the structural deficit in social care funding which would otherwise make such steps unsustainable.

It also acknowledges the growing pressures on community health services as a consequence of increasing demands in local acute hospital and primary care services. Levels of demand across primary care, acute hospitals, community health, mental health and VCSFE sectors are at unprecedented levels as a consequence of COVID. Through our BCF and other local collaborative planning processes, the local authority, CCG and other local partners will be working together for the remainder of 2021/22 and into 2022/23 to balance these unprecedented demands on existing services and consequent system pressures. We understand and acknowledge the need to focus any available growth funding from the BCF or other sources on measures that can help to reduce these pressures and improve performance.

National Condition 2: NHS contribution maintained in line with uplift to CCG minimum contribution

The CCG contribution for 2020/21 and 2021/22 are included within the planning template and reflect the required uplift increases. No additional funding increases have been agreed.

Protecting Social Care

Protecting adult social care services recognises that people's health and wellbeing are generally managed best where people live, with, where required, very occasional admissions to acute hospital settings. Without the full range of adult social care services being available, including those enabling services for people below the local authority's eligibility criteria for support, the local health system would quickly become unsustainable. Partners recognise that adult social care services are fundamental to the delivery of our ambition to deliver the right care and support, in the right place, at the right time. Protecting adult social care will allow the local health economy to deliver interventions that prevent an escalation of need.

BCF funding will be applied into the Councils' base budget which will better protect against services being stopped or reduced and, with Social Care Grant monies, support our shared Market Development and sustainability plans across Mid-South East Essex which will critically look at the broader market for care and support. The recent context has been one of demand growth for home care against available capacity, with increasing complexity of needs.

The extent to which core social care services underpin the effective working of the health and care system is in little doubt; the consequence of not supporting base budgets in this way is a risk that there will be a collapse of key elements of social care, which in turn would collapse the health system locally. Investment in social care supports whole system flow and while it may not be so visibly linked to the immediate needs of the acute sector, the effect of the absence of good social care is quickly evident. The Local Authorities are keen to ensure that additional funding from Government is used to deal first and foremost with structural social care deficits within their budgets – examples of particular areas of pressure are in reablement and improving market stability in the home care and residential care markets.

National Condition 3: invest in Out-of-hospital Services

Our local plans have significant focus on out of hospital services and their key importance in ensuring that services are designed around and respond to, the needs of local people, delivering care in community settings where possible to ensure future sustainability. Through the BCF Management Group and the Alliance, we plan to further develop out of hospital services that are integrated and responsive. Part of this model involves the development of integrated teams in localities, bringing together staff from primary care, social care, community health and VCFSE organisations so that they can work better, together, to meet the needs of both individuals and the local community.

This will include a specific focus on reducing the numbers of admissions and readmissions that can be avoided through providing more intensive and focused support for people in the community. Work is underway on developing a "virtual ward" model in SS9 PCN, with an aspiration that this will be in place by Q4 this year. In addition, a dedicated team and new multi-agency care planning process has been introduced for high intensity service users in Southend. This has had a significant impact, both in reducing demands across multiple

Alliance partner agencies, but also in improving outcomes, experience and quality of life for individuals supported through this approach. Further work on implementing a shared multi-agency care plan for individuals on primary care frailty and dementia registers is also underway, with a specific goal of facilitating earlier intervention and preventing escalation.

Partnership flexibility

Southend Local Authority and the CCG currently work together to commission services in one or more of the following commissioning mechanisms

- Lead Commissioning Arrangements
- Integrated Commissioning
- Joint (Aligned) Commissioning
- the establishment of one or more Pooled Funds

The following Individual Schemes with Lead Commissioning with Council as Lead Partner:

Scheme	**Service/Scheme Description**
Dementia Support	A community-based dementia support offer to support those living with dementia and their carers to live well and as independently as possible in the community.
Single Point of Access	Provision of a Single Point of Access to adult social care teams.
Hospital Team	Provision of a dedicated team to support the Discharge to Assess Policy and guidance
PCN and locality development	Aligned operational teams across adult social care and health co-located in Localities of Southend and geographically aligned with the Primary Care Networks (PCNs) in Southend.
Residential provision	Provision of residential care for those 65 and over.
Home Care	This scheme seeks to manage people being discharged from Southend hospital in the most appropriate way, maximising the use of community-based provision, reablement and minimising the use of long-term residential settings. This scheme will follow the locally agreed D2A protocols and the Home First approach.
Reablement	Re-ablement 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.
Children with Disabilities (Section 117)	Support for children with disabilities.
Adoption Services	Support with adoption of children and young people.

The following Individual Schemes with Lead Commissioning with CCG as Lead Partner:

Community Schemes	**Service Description**
Integrated Wound Care Services	The community wound care service exists to manage patients presenting with acute and chronic wounds including leg ulcers and clinical advice on tissue viability.
Stroke (Community Service) ESD	Stroke rehabilitation service to support Early Supportive Discharge (ESD team) which includes OT, Physio, SLT, Psychology and specialist nurses.
Pressure Relieving Equipment	Equipment designed to keep people well in a bed-based setting or where mobility is limited. Support to the wound management services with pressure relieving aids.
Continence Advisory Service	The Continence Advisory Service (Adult) provides a community-based nurse-led continence promotion and treatment of incontinence service, across SEE.
Wheelchair Services	The South East Essex Wheelchair Service provides wheelchairs to people meeting national criteria for wheelchairs.
Occupational Therapy	The Occupational Therapy Team exists for adults (18+) who are unable to live independently at home by maximising their independence in performing activities of daily living, promoting dignity and preventing unnecessary admissions to hospital and support discharges.
Urgent Community Resource Team	A core aim of the Urgent Community Response Team is to reduce the number of avoidable attendances to A&E and admissions to hospital, and support early discharges from hospital, providing more effective crisis care pathways closer to home in the community.
Community Nursing Service (CNS)	The CNS provides anticipatory case management of health and social care needs in supporting independence in partnership with the individual and their carer(s) or family to deliver personalised care in their place of choice, and only attend hospital when it is unavoidable.
Integrated Palliative Care Service (IPC)	The IPC service provides community palliative care and End of Life (EOL) service through the management of Palliative Care Support Register (PCSR) and provision of domiciliary Specialist Palliative Nursing and EOL Care.
Community Coordination Centre	The CCC consists of a multidisciplinary team providing a professional facing referral management and assessment function allowing easy access to a range of intermediate care

	services and onward referral to the wider health and social care system to avoid unnecessary hospital/care home admission and the facilitation of hospital discharge.
Collaborative Care Team	The collaborative Care Team is a community-based rehabilitation service, providing evidence-based care to service users following an acute incident in the community or a hospital admission that requires a period of rehabilitation following a stroke, neurological event or an unstable fracture.
Care Coordination Service	The Care Co-ordination Service exists to significantly improve the co-ordination of health and social care services required to support those who are most vulnerable, living with frailty or multiple and complex needs to maintain their optimum level of independence and wellbeing, through the provision of effective and coordinated services reducing the need for hospital admission.

Mental Health Schemes	**Service Description**
Older People Community Mental Health Teams (inc. Assessment Service)	OPCMH delivers clinical assessment, social care assessment, capacity assessment, care planning, contingency and crisis planning, review, treatment and professional to professional advice and liaison.
Dementia Intensive Support Team	Wrap around, intensive support, professional to professional liaison, expert in- reach and multi-disciplinary case management for people diagnose with dementia and those with possible dementia.
Older People Day Care (Mental Health)	Older people's day services (occupational therapy), Mental Health in reach to older people's mental health day care facilities.
Reablement Beds	Discharge to assess and step-down beds

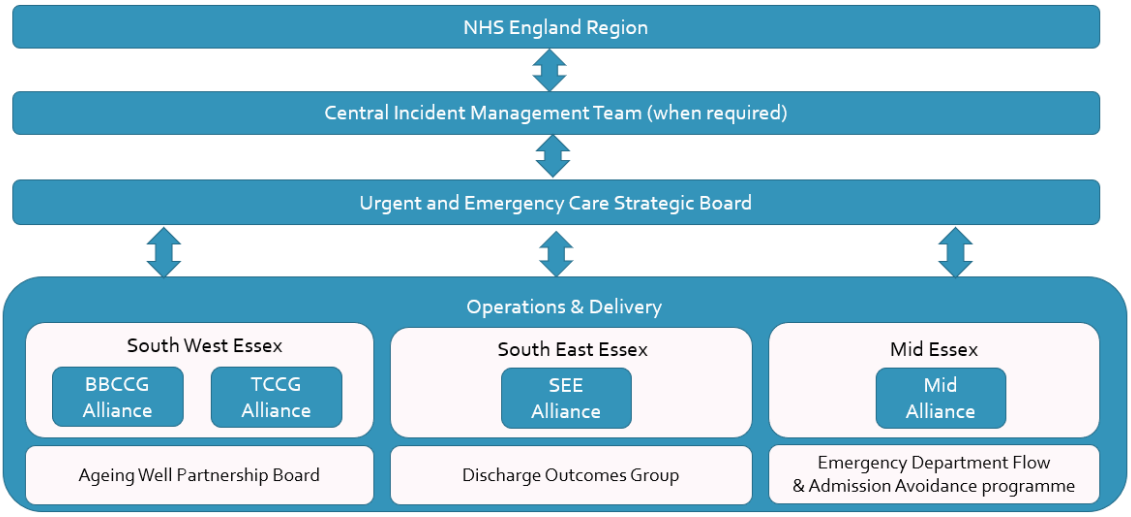
<u>National Condition 4:</u> Plan for improving outcomes for people being discharged from hospital

The work undertaken with MSE NHS Foundation Trust (Southend, Basildon and Broomfield acute hospitals) to improve patient flow has taken significant traction together with D2A home first model implementation to support clear discharge pathways, whereby assessments are made in the community and out of acute settings. Although clear pathways are in place for our 'Home Again' and 'Bridge the Gap' bridging service, reablement, intermediate care and Home Care, we recognise the challenges in the local

system particularly in home care market capacity and sustainability. We have winter planning short term mitigations in place locally and enacting long terms workforce plans and price reviews to increase the hourly rate for home care sector. Albeit the care market capacity issue will remain a significant risk to the system of any further unexpected upsurge. (See attached LAPEL – Local Authority management of market pressures escalation level)

There has been a substantial focus on hospital readmission rates at both SE Essex place and wider Mid and South Essex system levels. The MSE Clinical Care and Outcomes Review Group has oversight and leads on work on readmissions for the ICP. At a local level, this system level work and plans links with the SE Essex Alliance Urgent and Emergency Care Delivery Group A dedicated team for high intensity service users has been introduced in SE Essex and this has had a positive impact in terms of both service utilisation and patient wellbeing. Detailed analysis to identify root causes and contributory factors to readmissions will be undertaken over the remainder of 2021/22. This will inform future work that will be co-ordinated across the Alliance and the BCF management group.

Regional winter planning Governance



The work is highly interrelated and will need to be managed and coordinated through the Discharge to Assess Working Group. The plan is to ensure that there is strong correlation to the UEC Programme of the acute services to ensure consistency of approach to patient flow and discharge.

High Impact Change Model plans

Self-assessment against high impact change model:

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?

Early discharge planning	Plans are in place	Rollout Red to Green EDDs set in a timely manner Set expectation on admission	ongoing-2022/23	LOS will reduce Improved patient flow Patients informed regarding plans/ treatment options Increased No. of green days
Systems to monitor patient flow	Plans are in place	Consistent systems within Trust that provide accurate info/ patient status in real time	On going 2021/22	Easy identification of barriers to discharge
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Planned	Hospital discharge team. Full implementation of home first approach	TBC	Improved patient flow and experience Increase of patients returning home Reduction in placements
Home First Discharge to Assess	Established	Improve internal discharge processes, patient flow, market capacity	ongoing-2022/23	Improved patient flow and experience Increase of patients returning home Reduction in placements
Seven-day services	Plans in place	Whole system to operate at this level Clinical cover/ decision making over weekends for discharge	TBC	Consistent discharge picture through the week
Trusted assessors	Plans are in place	Plans to use Therapy reports to commission home care services	TBC	Minimise duplication Improved patient flow and experience
Focus on choice	Established	Protocol and processes in place to be understood and followed	TBC	Choice issued at correct time Reduction of choice delays Patients aware of discharge expectation on admission
Enhancing health in care homes	Plans are in place	Care home staff and primary care to manage patients in community	TBC	Reduction in admission from care homes

Disabled Facilities Grant

Statutory Disabled Facility Grants (DFG) will continue to be delivered via the Better Care Fund which significantly contributes towards helping older and vulnerable homeowners remain in their properties; this meets one of the key aims of the BCF to prevent people from being admitted into hospital or residential care.

The Adaptations Team are still working with the effects of both COVID and Brexit with impact on supply chain of materials being available. They continued to work with contractors to support the service and have received firm commitments from 2/3 contractors for the next few months to support the service. However, the nationwide shortage of materials and labour will continue to impacted Social Housing Adaptations creating some delays.

The Council have a significant population of 182,463 (Feb 2020) and as such have seen a steady increase in the demand for disabled facility grants. Traditionally disabled facility grants pay for a range of adaptations to people homes, including Level Access Showers, Ramps, Stairlifts and extensions to provide ground floor bedrooms and bathrooms. However, since the incorporation of the DFG within the Better Care Fund this has encouraged the Council and CCG to think strategically about the use of home aids/adaptations and the use of technologies to support people in their own homes and there are plans to use DFG capital for Extra Care housing provision.

Since Cabinet approval of the “new” DFG Policy in June 2021 we have been able to utilise discretionary funds to support larger adaptations. We have enabled larger works to be approve by offering a deferred loan which will be repaid to SBC when the property is sold. Many residents who may have been assessed as having a large contribution towards the work, are happy to consider this option as they desperately require major adaptations to enable them to remain living in their own home by supporting their health and wellbeing.

Our dedicated DFG lead is the Adaptations Team Manager within Adults & Communities Department who reports both finance and activity to the BCF Management Board (terms of reference attached) of which hold oversight and governance responsibility of DFG spend.

Equalities

Our BCF draws together a range of strategies and policies which have, in their development been subject to an assessment of their impact upon key groups within our population. In addition BCF is driven by national policy, designed to positively impact upon both the health and social care system and importantly, upon individuals improved health, self-care and wellbeing, seeking to address inequalities and improve outcomes informed by our Joint Strategic Needs Assessments.

Our independent public health report for 2020/21 reflects on our local health inequalities which have been further exacerbated during the past 15 months by the impact of COVID-19. We have seen enormous pressure placed on and across all public sector and

community services. Many of our citizens have been impacted through COVID-related ill-health and mortality. Some of these have been disproportionate and the task of vaccinating all adults has progressed well but there remain some inequalities and hesitancy.

COVID-19 has impacted significantly on mental wellbeing, from people dealing with the illness and bereavement, the consequences of living with restrictions, the closure of schools and workplaces and businesses. We will both prioritise and ensure our local programmes can support the mental wellbeing recovery and support people to continue living with COVID.

A number of other areas highly impacted by COVID where we need to refocus our collective approach and refresh our thinking including obesity and the food environment, drug and alcohol misuse, loneliness and self-care, the wellbeing of some our more vulnerable groups, such as people who are classed as unpaid carers, people living with autism and those who are affected by homelessness.

The report provides a brief outline of the challenges that these groups face in our communities and how we are addressing some of these concerns whilst highlighting what more we can drive forward to improve their health outcomes. It is also an opportunity to consider how to deploy our efforts to review our investment approach in related services, optimise our collaboration with the community sector and continue to enable our communities to play a more active role in both designing services and empowering their self-determination.

In considering the development of our aligned BCF plan, it is recognised that it is both complex and multi-faceted and, it is for this reason, that Equalities Impact Assessments are managed at a scheme level. In principle, there are no expected implications for any one section of the community, but inevitably when any process or access route to services changes, there may be an impact that is unintended. Therefore, all changes will be subject to ongoing review to consider the EIA implications.

As a collection of initiatives, there will also be a review to ensure that the cumulative effect of changes has not or does not unduly affect any one cohort of people.

END