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Southend-on-Sea Borough Council

Department of the Chief Executive
John Williams - Director of Legal & Democratic Services

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Dear Board Member,

HEALTH & WELLBEING BOARD - WEDNESDAY, 21ST JUNE, 2017

Please find enclosed, for consideration at the next meeting of the Health & Wellbeing Board taking place on Wednesday, 21st June, 2017, the following report which was unavailable when the agenda was printed.

Agenda No Item

5 Better Care Fund (BCF) (Pages 1 - 128)

Report of the BCF Programme Manager attached

Robert Harris
Principal Democratic Services Officer
Legal & Democratic Services
Southend Borough Council

Southend Health & Wellbeing Board

Agend
Item No

5

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Ian Stidston, Interim Accountable Officer, Southend CCG

to

Health & Wellbeing Board

on

21 June 2017

Report prepared by:
Nick Faint BCF Programme Lead

For discussion		For information only		Approval required	X

Better Care Fund

2017/19

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is as follows;

1.1 To update members of the Health and Wellbeing Board (HWB) regarding;

1.1.1 The Better Care Fund (BCF) for 2017/19;

1.1.2 The improved BCF (iBCF) for 2017/18; and

1.2 To agree delegated authority to the Deputy Chief Executive (People) (Southend-on-Sea Borough Council 'SBC') and the Interim Accountable Officer (Southend Clinical Commissioning Group 'SCCG') in conjunction with the Chair and Vice Chair of HWB to agree the iBCF plan in accordance with the grant conditions as defined by the BCF policy framework (published March 2017), see appendix A.

2 Recommendations

HWB are asked to;

2.1 note the updates for BCF 2017/19 and the iBCF 2017/18;

2.2 agree priorities for setting the BCF 2017/19 plan, including the need to abide by the national BCF conditions;

2.3 agree delegated authority to the Deputy Chief Executive (People), SBC and the Interim Accountable Officer SCCG in conjunction with the Chair and Vice Chair of HWB to sign off the iBCF plan for 2017/18 on behalf of HWB; and

2.4 agree to the iBCF plan 2017/18 being consulted amongst HWB partners as outlined in section 5.

3 Background & Context

3.1 The BCF for 2016/17 was established between SCCG and SBC from 1 April 2016. It is underpinned by a legal Section 75 Agreement between the two organisations that sets out the proposed schemes to be funded, the required flows of income into the pooled budget and the distribution back to the scheme / organisational leads.

3.2 Throughout the course of 2016/17 HWB has reported quarterly BCF activity to NHS England. The most recent return made to NHS England (31 May 2017) continued the theme of reporting that the Southend system continues to operate in challenging financial and operational circumstances but that integrated mitigations and projects are beginning to have an impact, key issues being reported were;

3.2.1 Non-elective admissions are higher than the previous year but the trend is starting to decrease;

3.2.2 Admissions to residential care is stable and is being robustly managed within the context of transforming adult social care;

3.2.3 Delayed Transfers of Care (DToC) presents a significant challenge to both health and social care but is being robustly managed through a programme of DToC transformation; and

3.2.4 Reablement (those still at home 91 days after discharge) is on track and stable.

3.3 The four quarterly returns for 2016/17 are available at Appendix B

4 Southend BCF 2017/19

National

4.1 The Policy Framework was published in March 2017 (see Appendix A). Due to the General Election 2017 the publication of the technical planning guidance, which enables a BCF submission, has been delayed. The date for publication is unknown.

4.2 Attached at Appendix A is the BCF Policy Framework, published March 2017. Summary points are;

4.2.1 The planning cycle will move from annual to biennial (once every two years) to align with NHS planning requirements;

4.2.2 Local areas will be invited to graduate from BCF which will provide areas with greater autonomy;

4.2.3 National conditions will reduce from eight to four; (1) plans to be jointly agreed; (2) NHS contribution to adult social care is maintained in line with inflation ; (3) commissioning of out of hospital services; and (4) Managing Transfers of Care;

4.2.4 Metrics to measure performance will continue to focus on non-elective admissions; admissions to residential care homes; reablement; and DToC;

Local

4.3 At March 2017 HWB members approved a report (Appendix C) that requested HWB grant delegated powers to the Deputy Chief Executive (People) SBC, the Interim Accountable Officer SCCG and the Chair and Vice-Chair HWB to sign off the BCF plan 2017/19.

4.4 Since March 2017 SCCG and SBC have agreed the following principles that will be followed whilst setting the BCF 2017/19 plan, these are;

4.4.1 BCF fund is largely committed to existing community health and integrated social care activity;

4.4.2 The existing section 75 agreement will be amended to accommodate 2017/19 BCF plan and the iBCF element;

4.4.3 All national conditions will be met, consistent with approach 2016/17; and

4.4.4 Both SCCG and SBC will contribute the mandated funds to the BCF pool. This will be the same as 2016/17 with an anticipated uplift set and agreed by both DCLG and DoH.

5 Southend improved BCF 2017/18

5.1 The Planning Policy at Appendix A outlines the national conditions associated with BCF. One of these conditions is that local areas are responsible for managing transfers of care.

5.2 To enable local areas to manage transfers of care a new grant for adult social care (improved BCF 'iBCF') was announced as part of the Government's Spending Review 2015 and the Spring Budget 2017.

5.3 The iBCF will be paid direct to Local Authorities via a Section 31 grant from the Department for Communities and Local Government. Conditions attached to the grant are outlined below.

5.4 The grant conditions are;

5.4.1 Grant is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market.

5.5 A recipient local authority must:

5.5.1 pool the grant funding into the local Better Care Fund, unless the authority has written Ministerial exemption;

5.5.2 work with the relevant Clinical Commissioning Group(s) and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

5.5.3 provide quarterly reports as required by the Secretary of State.

5.6 The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care

systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

5.7 To support the planning for the allocation of iBCF the Government published a High Impact Change model which supports the requirements for meeting the national condition re 'Managing Transfers of Care'. The High Impact Change model (see Appendix D) outlines 8 step changes that should be considered and planned against to ensure local areas are able to manage more efficiently transfers of care. The step changes are listed below in paragraph 5.9.

5.8 The details for Southend re iBCF are as follows;

5.8.1 iBCF allocation for Southend are; 2017/18 - £3.99M; 2018/19 - £5.429M (indicative); and 2019/20 - £6.744M (indicative);

5.8.2 SBC and SCCG have, following a self-assessment exercise, agreed the priorities for allocating the iBCF as; discharge to assess; integrated discharge team; and trusted assessor

5.8.3 In support of the grant conditions the SBC and SCCG have agreed the introduction of step 9 which recognises the need for Southend to invest the iBCF to provide stability and extra capacity in the Southend care system;

5.9 Steps 1 – 9 are as follows;

5.9.1 **Step 1** – Early Discharge Planning – investment to support the development of the integrated discharge team

5.9.2 **Step 2** – Systems to monitor patient flow – investment in applications to predict and determine patient flow

5.9.3 **Step 3** – MDT, Voluntary Sector – investment to enhance MDT working, preventative activity and SPoA

5.9.4 **Step 4** – Home first – investment to support D2A model, Hospital 2 Home service and step-up facility

5.9.5 **Step 5** – Seven day – investment to support realignment of social care

5.9.6 **Step 6** – Trusted assessor – investment to support the development of a model

5.9.7 **Step 7** – Focus on Choice – investment to support asset based approach within MDT environment

5.9.8 **Step 8** – Enhancing Care in Care Homes – GSF investment and training for workforce development

5.9.9 **Step 9** – Investment to meet adult social care needs

Consultation and engagement

5.10 A grant condition for iBCF is that the iBCF is locally agreed.

5.11 To meet this grant condition for iBCF it is proposed that HWB are engaged and consulted with at a senior management level and virtually for Board members of the HWB, specifically;

5.11.1 via the Locality Transformation Group (LTG) the iBCF plan will be developed and the detail reviewed. LTG meets monthly and is attended by SBC, SCCG, SEPT and SUHFT. The group is chaired by the Director of Strategy, Commissioning & Procurement; and

5.11.2 Via virtual circulation of relevant documents, the HWB are distributed with the iBCF plan for review and comment;

6 Health & Wellbeing Board Priorities / Added Value

6.1 The BCF contributes to delivering HWB Strategy Ambitions in the following ways

6.2 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.

6.3 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

6.4 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

7 Reasons for Recommendations

7.1 As part of its governance role, HWB has oversight of the Southend BCF 2017/19.

8 Financial / Resource Implications

8.1 None at this stage

9 Legal Implications

9.1 None at this stage

10 Equality & Diversity

10.1 The BCF plan should result in more efficient and effective provision for vulnerable people of all ages.

11 Appendices

Appendix A – 2017 – 19 Integration and Better Care Fund (Policy Framework)	
Appendix B – Quarterly Returns	

Appendix C – HWB March 2017 report of BCF 2017 - 19	
Appendix D – High Impact Change Model	

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HWB Strategy Ambitions

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

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Department of Health

Department for Communities and Local Government

2017-19 Integration and Better Care Fund

Policy Framework

March 2017

Title: Integration and Better Care Fund Policy Framework 2017-19
Author: Social Care, Ageing and Disability / Integration, Local Devolution and Policy Improvement / 11120
Document Purpose: Policy
Publication date: 03/17
Target audience: This document is intended for use by those responsible for delivering the Better Care Fund at a local level (such as clinical commissioning groups, local authorities and health and wellbeing boards) and NHS England.
Contact details: Integration, Local Devolution and Policy Improvement Unit Richmond House Whitehall London SW1A 2NS Bettercarefund@dh.gsi.gov.uk

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www.gov.uk/dh

2017-19 Integration and Better Care Fund

Policy Framework

Prepared by the Department of Health and the Department for Communities and Local Government

Contents

Executive Summary

Why Integrate?

People need health, social care, housing and other public services to work seamlessly together to deliver better quality care. More joined up services help improve the health and care of local populations and may make more efficient use of available resources.

How is Integration being done?

There is no single way to integrate health and care. Some areas are looking to scale-up existing initiatives such as the New Care Models programme and the Integration Pioneers. Others are using local devolution or Sustainability and Transformation Plans as the impetus for their integration efforts.

One part of the solution – the Better Care Fund

The Better Care Fund is the only mandatory policy to facilitate integration. It brings together health and social care funding, with a major injection of social care money announced at Spring Budget 2017. This policy framework for the Fund covers two financial years to align with NHS planning timetables and to give areas the opportunity to plan more strategically. Details of the financial breakdown are below:

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)*	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

*Combined amounts announced at Spending Review 2015 and Spring Budget 2017

Many areas choose to pool more than is required. For 2017-19, there are four national conditions, rather than the previous eight:

1. **Plans to be jointly agreed**
2. **NHS contribution to adult social care is maintained in line with inflation**
3. **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care**

4. **Managing Transfers of Care** (a new condition to ensure people's care transfers smoothly between services and settings).

Beyond this, areas have flexibility in how the Fund is spent over health, care and housing schemes or services, but need to agree how this spending will improve performance in the following four metrics: **Delayed transfers of care; Non-elective admissions (General and Acute); Admissions to residential and care homes; and Effectiveness of reablement.**

Going beyond the Better Care Fund through Graduation

The Better Care Fund is intended to encourage further integration and 90% of areas say it has already had a positive impact on integration locally. For the most integrated areas, there will be benefits in graduating from the Fund to reduce the reporting and oversight to which they are subjected. We are planning to test the graduation process with a small number of advanced areas (6 to 10) in a 'first wave', in order to develop our criteria for graduation for all areas. We are therefore inviting 'Expressions of Interest' from areas that think they are exemplars of integration, by 28th April 2017.

Agreeing a local vision of integration

As part of Better Care Fund planning, we are asking areas to set out how they are going to achieve further integration by 2020. We would encourage areas to align their approach to health and care integration with Sustainability and Transformation Plan geographies, where appropriate. This may be an exact match (e.g. Greater Manchester) or it may be smaller units within Sustainability and Transformation Plans. The focus may also be on commissioning integration (e.g. North East Lincolnshire) or through Accountable Care Systems or Organisations that bring together provision (e.g. Northumberland). What matters is that there is locally agreed clarity on the approach and the geographical footprint which will be the focus for integration.

Measuring progress on integration

To help areas understand whether they are meeting our integration ambition, we are seeking to rapidly develop integration metrics for assessing progress, particularly at the interface where health and social care interact. These will combine outcome metrics, user experience and process measures. Following the development of the metrics and an assessment of local areas, we will ask the Care Quality Commission to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care.

Need more detail?

Further information on everything here can be found in the full Integration and Better Care Fund Policy Framework 2017-19.

Introduction

This document sets out the story of integration of health, social care and other public services. It provides an overview of related policy initiatives and legislation. It includes the policy framework for the implementation of the statutory Better Care Fund (BCF) in 2017-19, which was first announced in the Government's Spending Review of 2013 and established in the Care Act 2014. And it sets out our proposals for going beyond the BCF towards further integration by 2020. Whilst there will now be no separate process for integration plans, we will provide a set of resources, integration models and indicators for integration to help local areas towards our shared goal of person-centred, coordinated care.

This Policy Framework has been developed by the Department of Health (DH), Department for Communities and Local Government (DCLG), Local Government Association (LGA), Association of Directors of Adult Social Services (ADASS), and NHS England.

The case for integrated health and care services

Today, people are living much longer, often with highly complex needs and multiple conditions. These needs require ongoing management from both health and care services, which combine both the medical and social models of care. As our population ages and the financial pressures on the health and care system increase, we need to be better at providing proactive, preventative care in community settings, so that people can be supported to live at home for longer and avoid the need for commissioned health and care services.

More joined up and sustainable services help improve the health and care of local populations and may make more efficient use of available resources (i.e. by reducing avoidable hospital admissions, facilitating timely discharge, and improving people's experiences of care). Integration needs to reflect the different strengths that the NHS and social care bring to an integrated response, including the role of social services of promoting and supporting independence, inclusion and rights as far as possible, invigorating wider community services and supporting informal carers.

People want services to work together to provide them with person-centred coordinated care. National Voices set out a narrative for person-centred care, which sums up what we are working to achieve: "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me."[1] This translates into positive interactions with health and care services, and better experiences for individuals as illustrated by Figure 1.

[1] http://www.nationalvoices.org.uk/publications/our-publications/narrative-person-centred-coordinated-care

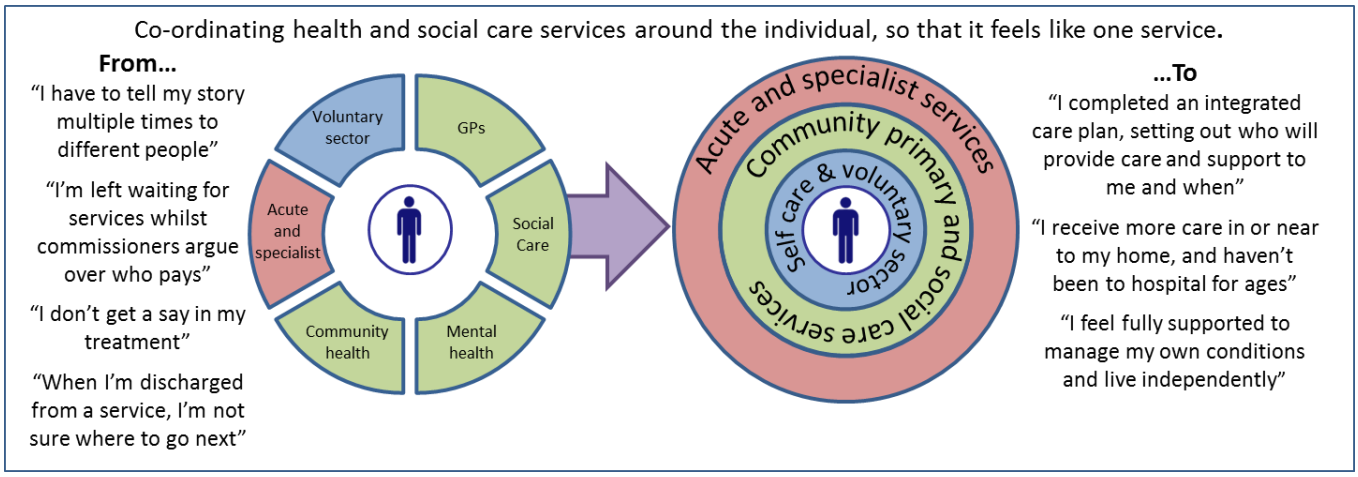


Figure 1: Co-ordinating health and care services around the individual

1. Integration to date

Integration is not a new goal and there have been initiatives over a number of years (see Figure 2).

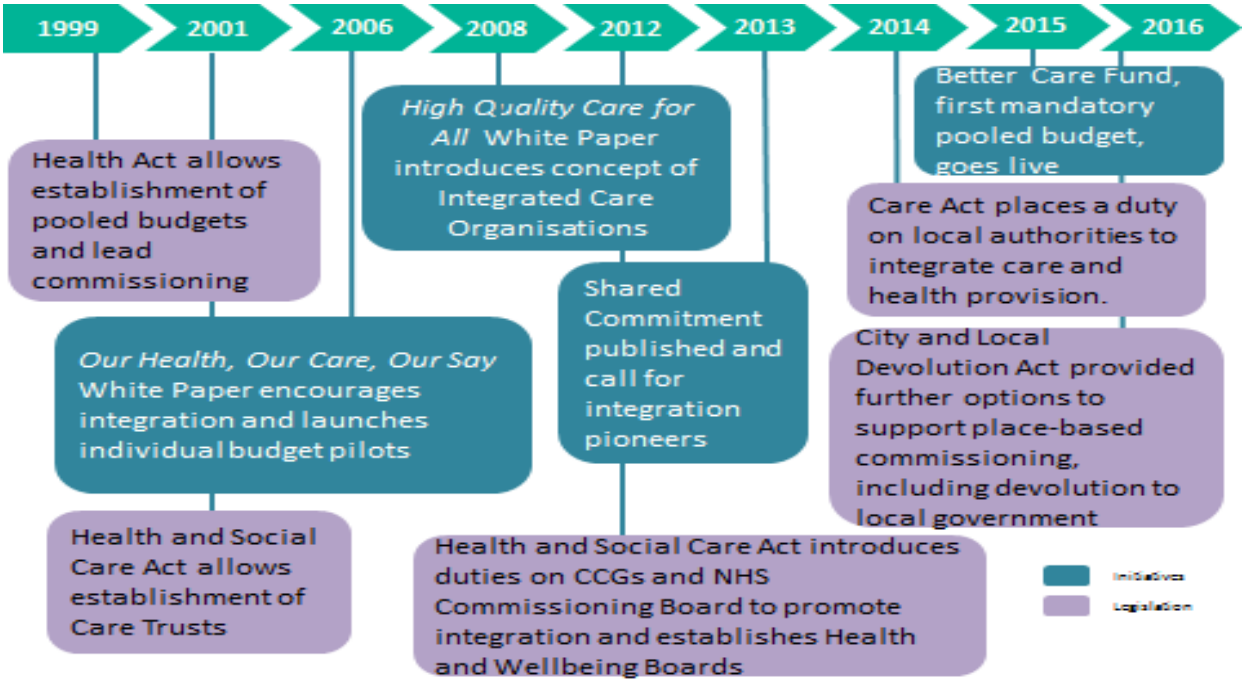


Figure 2: Key integration initiatives and enabling legislation

The Coalition Government and partners set out collective intentions on integration in Integrated Care and Support: Our Shared Commitment in 2013.[2] This showed how local areas can use existing structures such as **Health and Wellbeing Boards** to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

This collaboration with 12 national partners was backed by a call for areas wanting to lead the way to apply to become an 'Integrated Care Pioneer'. We identified excellent examples of joined-up care happening in different ways up and down the country and the **Integrated Care Pioneers Programme** was launched to learn from the most innovative areas and to encourage change from the bottom up. The second annual report[3] of the Pioneers summarises some of the recent learning and experiences, and the Pioneers' resource centre[4] contains a collection of tools, information and useful links.

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf
[3] https://www.england.nhs.uk/pioneers/wp-content/uploads/sites/30/2016/01/pioneer-programme-year2-report.pdf
[4] https://www.england.nhs.uk/pioneers/resource-centre/

More recently, the LGA, ADASS, NHS Confederation and NHS Clinical Commissioners have developed a shared vision document, Stepping up to the place[5] for a fully integrated system based on existing evidence. This framework describes the essential characteristics of an integrated system to improve the health and wellbeing of local populations, and paves the way for integration to happen faster and to go further, so that integrated, preventative, person-centred care becomes the norm.

There is also a growing recognition of the important contribution of housing to integration. A national Memorandum of Understanding to Support Joint Action on Improving Health through the Home[6] has been signed by a spectrum of organisations including: DH, DCLG, NHS England, ADASS and the LGA, along with members of the wider housing sector. The proposals set out in the Housing White Paper – Fixing our Broken Housing Market[7] – also underline the Government's commitment to do more to provide the homes we need for all in our society, including older people and those with care and support needs.

[5] http://www.nhsconfed.org/~/media/Confederation/Files/Publications/Documents/Stepping%20up%20to%20the%20place_Br1413_WEB.pdf
[6] https://www.adass.org.uk/media/3957/health-and-housing-mou-final-dec-14.pdf
[7] https://www.gov.uk/government/collections/housing-white-paper

2. Integration now and the wider policy context

Just as progress has already been made on integration, there are a number of current initiatives across the health and care system that contribute towards this goal.

Announced in June 2013, the **Better Care Fund (BCF)** brings together health and social care budgets to support more person-centred, coordinated care. In the first two years of the BCF, the total amount pooled has been £5.3bn in 2015-16 and £5.8bn in 2016-17.

The BCF offers a good opportunity to have shared conversations, and to consider issues from different perspectives, particularly how BCF plans can support the delivery of wider objectives and strategies around health and social care. In particular, every health and care system in England has produced a **Sustainability and Transformation Plan (STP),** providing the system-level framework within which organisations in local health and care economies can plan effectively and deliver a sustainable, transformed and integrated health and care service. Local areas should ensure the financial planning and overall direction of travel within BCF plans and the local STP(s) are fully aligned.

The **vanguards**, which are part of NHS England's new care models programme[8], have clear plans for managing demand more effectively across the local health and care system and reducing costs, at the same time as improving outcomes for patients and users. The vanguards programme has published two frameworks that cover population-based integrated models – the **Multi-speciality Community Providers (MCPs) and the Primary and Acute Care Systems (PACs)**.[9] Many of these two types of vanguards include social care as well as pursuing integration within health services. All areas are encouraged to take action against the core elements described in the models where these support local objectives around the integration of health and care services. Scaling up of PACS and MCPs in a small number of STP areas will create Accountable Care Organisations, with further details in the Next Steps on the NHS Five Year Forward View.

Local devolution deals can add impetus to all of these initiatives, offering local areas the opportunity to go beyond the integration of health and social care and drawing in other local government services such as housing, planning, skills, justice, and transport. This provides opportunities for local areas to further tailor public services around individual needs and also to tackle the wider determinants of health. Figure 3 shows how multiple integration initiatives interact, for example, within Greater Manchester.

[8] https://www.england.nhs.uk/wp-content/uploads/2015/11/new_care_models.pdf
[9] https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf and https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf

Figure 3 – Integration initiatives in Greater Manchester

There is a growing evidence base on the contribution that **housing** can make to good health and wellbeing. At a system level, poor housing costs the NHS at least £1.4bn per annum. And there are also costs to local government and social care. On an individual level, suitable housing can help people remain healthier, happier and independent for longer, and support them to perform the activities of daily living that are important to them – washing and dressing, preparing meals, staying in contact with friends and family.

The increase in funding for the **Disabled Facilities Grant (DFG)** – and the decision to move it into the BCF in 2015-16 – is recognised as an important step in the right direction. Further action to support people into more suitable accommodation, and to adapt existing stock, is also to be welcomed.

The Department of Health is also currently working with NHS England, Local Government and others to improve the support available to informal **carers**. Supporting informal carers also supports those they care for: improving outcomes for both parties, enabling people to live independently in the community for longer and reducing impact on commissioned services. All areas are therefore encouraged to consider how BCF plans can improve the support for carers. In doing so, they may wish to make use of *'An Integrated Approach to Identifying and Assessing Carer Health & Wellbeing'*[10], an NHS England resource that promotes and supports joint working between adult social care services, NHS commissioners and providers, and voluntary organisations.

Within an area, a number of initiatives can also contribute towards overall system integration. These are not sufficient to full integration of health and social care, but can offer important contributions to key cohorts of patients and service users. For example:

[10] https://www.england.nhs.uk/wp-content/uploads/2016/05/identifying-assessing-carer-hlth-wellbeing.pdf

- Some local areas are also taking action on **'Integrated Personal Commissioning'** (IPC), whereby individuals experience holistic, personalised care and support planning, and an option for them to commission their own care using a personal budget or direct payment arrangements that combine funding from health, social care and education. IPC is being progressed by nine demonstrator areas (covering 20 CCGs and 12 local authorities) that are leading the way in developing a practical operating framework to enable wider replication, with a further 10 early adopters set to join the programme by March 2017.[11]

  NHS England expects that IPC will become a mainstream model of care for around 5 per cent of the population, enabling the expansion of personal health budgets and integrated personal budgets at scale. IPC is expected to be operational in 50% of STP footprints by 2019. Some Demonstrator sites (i.e. Luton and Stockton on Tees) are incorporating their work on IPC into BCF plans, using personal health budgets and integrated personal budgets to create more stable, coordinated care at home and in the community for high risk groups. Others parts of the country are also encouraged to consider this approach.

- Learning from the six **Enhanced Health in Care Homes** (EHCH) vanguard sites suggests that action to provide joined up primary, community and secondary health and social care to residents of care and nursing homes, as well as those living in the wider community, can have significant benefits. These include transforming the quality of care, reducing costs and activity levels, and supporting relationship-building at local level. Some parts of the country (i.e. East and North Hertfordshire and others) are already building in work around EHCH into their BCF plans and other parts of the country are encouraged to do the same. For more details, please see the 'Enhanced Health in Care Homes Framework'.[12]

[11] https://www.england.nhs.uk/commissioning/ipc/sites
[12] https://www.england.nhs.uk/wp-content/uploads/2016/09/ehch-framework-v2.pdf

3. Integration now and the Better Care Fund 2017-19

This Policy Framework for the Better Care Fund (BCF) covers two financial years (2017-19) to align with NHS planning timetables and to give areas the opportunity to plan more strategically. In 2017-18, the BCF will be increased to a mandated minimum of £5.128 billion and £5.617 billion in 2018-19.[13] The local flexibility to pool more than the mandatory amount will remain. Further details of the financial breakdown are set out in Table 1 below.

The main change to the Framework from last year is inclusion of significant amounts of local authority social care grant funding. Some of this was announced at the 2015 Spending Review, with an additional £2 billion over three years announced at Spring Budget 2017. There will be grant conditions on this new money to ensure it has the expected impact at the care front line.

In developing this framework, we have listened to feedback from local areas about the need to further streamline the processes around planning, assurance and performance reporting. There is also a halving of the number of national conditions that areas are required to meet through their BCF plans - reduced from eight to four. We have also set out more clearly, the requirements around the social care national condition.

The national conditions that areas will need to meet in their plans for 2017-18 and 2018-19 are: **plans to be jointly agreed; NHS contribution to adult social care is maintained in line with inflation; agreement to invest in NHS commissioned out of hospital services; and managing transfers of care**. The detailed requirements for each condition are set out in **Annex A**.

The removal of some national conditions from 2016-17 does not reflect a downgrading of the importance of these policies and we expect them to underpin local BCF plans. For example, all areas should be working to embed 7-day services across the health and care system. Shared information, interoperable IT and joint care assessments are critical enablers to deliver integrated services - therefore, we expect every area to continue taking action to build on the progress made in the last two years. In **Annex B** we have set out what you can do to keep up the momentum.

Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Clinical Commissioning Groups to pool the necessary funding.

[13] These are indicative figures only.

Better Care Fund in 2017-18

The Mandate to NHS England for 2017-18 requires NHS England to ring-fence £3.582 billion within its overall allocation to Clinical Commissioning Groups to establish the BCF in 2017-18. The Mandate was published on 20th March 2017.[14]

The remainder of the £5.128bn BCF in 2017-18 will be made up of the £431m Disabled Facilities Grant (DFG) and £1.115bn new grant allocation to local authorities to fund adult social care, as announced in the 2015 Spending Review and Spring Budget 2017. Both grants are paid directly from the Government to local authorities.

As in the previous two years, the NHS contribution to the BCF includes funding to support the implementation of the Care Act 2014. Funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) also remains in the NHS allocation.

Better Care Fund in 2018-19

The Mandate to NHS England for 2017-18 also denotes an indicative ring-fence of £3.65bn from allocations to Clinical Commissioning Groups for the establishment of the BCF in 2018-19. The actual amount will be confirmed via the Mandate for 2018-19, which will be published in winter 2017-18.

The remainder of the £5.617bn BCF in 2018-19 will be made up of the £468m DFG and an indicative amount of £1.499bn new grant allocation to local authorities to fund adult social care, both of which will be paid directly from the Government to local authorities.

As in 2017-18, funding previously earmarked for reablement (£300m) and for the provision of carers' breaks (£130m) remains in the NHS contribution.

Table 1: BCF funding contributions in 2017-19

Better Care Fund funding contribution (£bn)	2017-18	2018-19
Minimum NHS (clinical commissioning groups) contribution	£3.582	£3.65
Disabled Facilities Grant (capital funding for adaptations to houses)	£0.431	£0.468
New grant allocation for adult social care (Improved Better Care Fund)	£1.115	£1.499
Total	£5.128 billion	£5.617 billion

[14] https://www.gov.uk/government/publications/nhs-mandate-2017-to-2018

Conditions of access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the amount that is part of Clinical Commissioning Group allocations (as discussed earlier, these are £3.582bn in 17-18, and an indicative amount of £3.65bn in 18-19). These powers do not apply to the amounts paid directly from Government to local authorities.

For the DFG, the conditions of usage are set out in a Grant Determination Letter, due to be issued by DCLG in April. This references the statutory duty on local housing authorities to provide adaptations to those disabled people who qualify, and sets out other relevant conditions.

For the new grant allocation to local authorities to fund adult social care, the conditions of usage will also be set out in a Grant Determination Letter. This will also be issued by DCLG in April, though a draft version of the conditions has been shared in March, for information.

National Conditions for 2017-19

In 2017-19, NHS England will require that BCF plans demonstrate how the area will meet the following national conditions:

- **Plans to be jointly agreed;**
- **NHS contribution to adult social care is maintained in line with inflation;**
- **Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care; and**
- **Managing Transfers of Care**

The refreshed definitions of these national conditions are set out at **Annex A.**

NHS England will also set the following requirements, which local areas will need to meet to access the CCG elements of the funding:

- A requirement that the BCF is transferred into one or more pooled funds established under section 75 of the NHS Act 2006; and
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s).

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of CCG funding where conditions attached to the BCF are not met, except, as mentioned above, for those amounts paid directly to local government. The Act makes provision

at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2017-18 Mandate to NHS England confirms that NHS England will be required to consult the Department of Health and the Department for Communities and Local Government before using these powers.

Disabled Facilities Grant

In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans; as set out in the DFG Grant Determination Letter due to be issued by DCLG in April 2017.

New grant for adult social care (announced in the 2015 Spending Review and Spring Budget 2017 as 'Improved Better Care Fund' (iBCF) funding)

The Government's Spending Review in 2015 announced new money for the BCF of £105m for 2017-18, £825m for 2018-19 and £1.5bn for 2019-20. The Spring Budget 2017 subsequently increased this to £1.115bn for 2017-18, £1.499bn for 2018-19 and £1.837bn for 2019-20. The Government will require that this additional Improved Better Care Fund (iBCF) funding for adult social care in 2017-19 will be pooled into the local BCF. This funding does not replace, and must not be offset against the NHS minimum contribution to adult social care.

The new iBCF grant will be paid directly to local authorities via a Section 31 grant from the Department for Communities and Local Government. The Government will attach a set of conditions to the Section 31 grant, to ensure it is included in the BCF at local level and will be spent on adult social care. The final conditions will be issued in April. However, a draft has been shared with areas in March. The draft conditions of use of the Grant can be summarised as:

1. Grant paid to a local authority under this determination may be used only for the purposes of meeting adult social care needs; reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market is supported.

2. A recipient local authority must:

    a) pool the grant funding into the local BCF, unless an area has written Ministerial exemption;

    b) work with the relevant Clinical Commissioning Group and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and

c) provide quarterly reports as required by the Secretary of State.

3. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems. Local authorities are therefore able to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

In terms of the wider context, the funding is also intended to support councils to continue to focus on core services, including to help cover the costs of the National Living Wage, which is expected to benefit up to 900,000 care workers. This includes maintaining adult social care services, which could not otherwise be maintained, as well as investing in new services, such as those which support best practice in managing transfers of care.

Local authorities will be required to confirm that spending of the BCF money provided at Spending Review 2015 and Spring Budget 2017 will be additional to prior plans for social care spending, via a Section 151 Officer letter.

The assurance and approval of local Better Care Fund plans

As in 2016-17, plans will be developed locally in each Health and Wellbeing Board area by the relevant local authority and Clinical Commissioning Group(s). Plans will be assured and moderated regionally in line with the operational planning assurance process set out in the Integration and Better Care Fund Planning Requirements, published by NHS England and the Local Government Association.

Recommendations for approval of overall BCF plans will be made following moderation of regional assurance outcomes by NHS England and local government. Plans will be approved and permission to spend the CCG minimum contribution to the BCF will be given once NHS England and the Integration Partnership Board have agreed that the conditions attached to that funding have been met.

Local authorities are legally obliged to comply with grant conditions. The NHS Act 2006 (as amended by the Care Act 2014) allows NHS England to direct the use of the CCG elements of the fund where an area fails to meet one (or more) of the BCF conditions. This includes the requirement to develop an approved plan. If a local plan cannot be agreed or other National Conditions are not met, any proposal to direct use of the CCG elements of the Fund will be discussed with the Integration Partnership Board.

National performance metrics

As in 2015-16 and 2016-17, local areas are asked to agree and report metrics in the following four areas:

- Delayed transfers of care;
- Non-elective admissions (General and Acute);
- Admissions to residential and care homes; and
- Effectiveness of reablement

The detailed definitions of these metrics will be set out in the Integration and Better Care Fund Planning Requirements.

We are no longer requiring the national collection of a locally proposed metric.

Better Care Fund support offer in 2017-19

In implementing the BCF from 2017-18 to 2018-19, the joint Better Care Support team hosted by NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Build an intelligence base to understand the real impact of the BCF on delivering integration;
- Support local systems to enable the successful delivery of integrated care in 2017-19 by capturing and sharing learning, building and facilitating networks to identify solutions;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing delivery of the BCF – including quarterly reporting on national metrics and spending; and
- Support areas that are proposing to graduate or have graduated from the BCF.

4. Integration now - Graduating from the Better Care Fund

Overview

The Government's Spending Review 2015 set out that "areas will be able to graduate from the existing Better Care Fund (BCF) programme management once they can demonstrate that they have moved beyond its requirements, meeting the government's key criteria for devolution."

It is the Government's ambition that all areas will be able to work towards graduation from the BCF to be more fully integrated by 2020, with areas approved in waves as they demonstrate maturity and progress towards greater integration. The best areas are showing that greater levels of integration bring positive benefits in terms of improving people's health, wellbeing and experience of care, particularly in wrapping services around people's needs and shifting the focus to keeping people well and happy at home, with reduced demand for hospital and other health and care services.

These areas can apply for 'earned autonomy' from the BCF programme management. Graduation will mean that we will have a different relationship with these local areas; with reduced planning and reporting requirements and greater local freedoms to develop agreements appropriate to a more mature system of health and social care integration. This will include a bespoke support offer for areas that graduate, in addition to them no longer being required to submit BCF plans and quarterly reports.

We are planning to test the graduation process with a small number of areas (6 to 10) in the first instance. We are inviting areas that believe they can demonstrate that they meet the criteria for graduation now to put themselves forward prior to the deadline for submission of first plans, with a view to graduating from the BCF in this first wave.

Subsequent waves of areas will have the opportunity to graduate over the course of this spending review period. Departments, the LGA and NHS England will work with graduated areas to role-model how integration can support better outcomes for populations across health, social care and housing.

A "first wave" of Better Care Fund graduation

We have no set targets for the numbers of areas that graduate from the existing BCF programme management in each year. In the first round, we are planning to test graduation with a small number of areas (between 6 and 10), and will use this learning to refine the criteria and process going forward.

Graduation proposals should be made, at minimum, across an entire Health and Wellbeing Board geography, but could be aligned to Sustainability and Transformation Plan (STP)

footprints or devolution deal sites, as long as all relevant Health and Wellbeing Boards included in the proposal are supportive.

The eligibility criteria are set out below. Areas interested in participating in the first wave of graduates should benchmark themselves against these criteria and discuss their interest with their Better Care Manager.

The process of graduation will utilise sector-led improvement principles, supporting areas through peer review and development. This will culminate in a "graduation panel", which will provide face-to-face support and challenge to local areas to agree the conditions for graduation.

Eligibility criteria for Better Care Fund graduation

To keep the application process simple, all partners in an area wishing to apply for graduation will need to complete an Expression of Interest and demonstrate that they:

a) **Have in place a sufficiently mature system of health and social care with evidence of:**
    - Strong shared local political, professional, commissioner and community leadership;
    - An agreed system-wide strategy for improving health and wellbeing through health and social care integration to 2020. The government supports a range of models of health and social care integration, as set out in Chapter 5. You should reference your choice of model in your integration strategy or action plans and their links to wider health and local government strategies; and
    - A robust approach to managing risk, including adequate financial risk management arrangements proportionate to the level of risk in the system, for example, if any CCG is subject to financial directions, a clear appraisal of any additional risk and approach to managing it.

b) **Can demonstrate the application is approved by all signatories required by BCF planning**

c) **Provide evidence of improvement and/or approach to improving performance on BCF national performance metrics and how graduation will enable the area to accelerate improvement on these metrics. This should include current performance data and stretch targets.**

d) **Set out plans to pool an agreed amount greater than the minimum levels of the BCF or align the commissioning of an equivalent or greater scope of services. Set out plans to maintain joint investment in integrated services, including:**
    - Maintaining the NHS contribution to social care and NHS commissioned services in line with inflation;
    - Maintaining additional contributions from CCGs and local authorities to the pooled fund, in addition to the 'improved Better Care Fund' grant funding to local government; and

- Continuing to meet grant conditions attached to the newly allocated funding within the Improved Better Care Fund.

e) Are committed to a 'sector-led improvement' approach in which they are willing to act as peer leaders, working with national partners to support other areas looking to graduate.

Selection criteria

As the first wave is testing the process, we will use the Expressions of Interest and other available information, including the following additional criteria, to select a small pool of 6-10 applicants, as follows:

a) The applicants commit and have the capacity to participate in the selection process which is set out below, participate in the pilot evaluation and share learning with peers and with national organisations supporting integration work.

b) The applicants have discussed their proposal with their local Better Care Manager.

c) The pilot cohort covers a range of different care model types as set out in Chapter 5.

d) The pilot cohort covers a spread of geographical locations and local authority type.

The selection process will include graduation workshops to help local leaders identify the steps necessary to graduate from the BCF and progress integration, in line with the 2015 Spending Review commitments. The workshops are based on the existing LGA sector-led improvement model, and will involve a half-day session for senior local health and local government leaders; these workshops will run in May and June, in order to complete the pilot in the agreed timeframe. The process will culminate in graduation panels (in early-to-mid July) with representatives from Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services, and will agree with local leaders, clear, measurable and transparent objectives and milestones for integration locally to 2020. We also intend to develop a dedicated package of support, building on the learning and experience of sites which have graduated from the pilot.

We are seeking areas which have made the most progress in moving beyond the requirements of the BCF. We recognise that the restricted number of pilot areas is likely to mean some areas are unsuccessful. We do understand that this will be disappointing for those areas not selected, but subsequent graduation waves will not be restricted in numbers in the same way. In addition those areas which are not selected for the pilot can continue to prepare for subsequent waves.

Expression of Interest process and timelines

- Applicants should submit to England.bettercaresupport@nhs.net an Expression of Interest, which demonstrates how local organisations meet the eligibility criteria a) to e) above by 5pm on 28th April 2017; this should include an indication of the discussion with their local Better Care Manager, which should take place before 19th April 2017.
- All applications will be assessed by the selection panel, with results communicated by 10th May 2017.
- Graduation workshops will run in May and June, with graduation panels taking place in early-to-mid July.

Guidance on submitting an Expression of Interest

The form should specifically address the eligibility criteria outlined in a) to e) above. Any submitted documents, including any covering letters, must not be longer than 6 pages, and have no embedded or attached appendices. Any attached or embedded documents will not be considered by the selection panel.

The Expressions of Interest will be assessed by a panel of representatives from the Department of Health, Department for Communities and Local Government, NHS England, Local Government Association, and Association of Directors of Adult Social Services. Its decision will be based on the evidence provided against eligibility criteria a) to e), with adjustments made to ensure a fair selection of pilots across geography, care model and local authority type in order to maximise the potential for learning from the pilots.

The support offer

We will put in place an ongoing support offer for areas, before, during and after the process of graduation. This will include:

- **Before –** Seminars, workshops or individual support for areas preparing for graduation (second and subsequent waves), including peer support from areas that have graduated;
- **During -** Advice and support for areas shortlisted for graduation to develop the core essential characteristics for integration including those required as evidence for graduation;
- **After -** Support for a peer network of graduated areas to share experience and evidence of what is working;

Once an area has been selected for graduation, we will aim to support them to achieve and/or maintain their integration vision. Areas that have 'graduated' from the BCF will continue to be subject to the normal local authority and CCG reporting requirements on finance and performance. We will develop with the first wave the format and process for providing a self-certifying annual report. In the unforeseen circumstances of serious financial or performance

issues or a breakdown in local partnership's ability to realise their integration plan, it may be necessary to reinstate some or all of the BCF programme management. This would be considered a last resort to support local leaders. Local areas would be given adequate advance notice, before any assurance or reporting requirements are reinstated.

BCF graduates will be at the forefront of demonstrating how integration of health and care is becoming a reality by 2020 and we expect that early graduates will work with national partners to share learning with others and provide leadership in delivering fuller integration by 2020.

5. Integration future - Integration to 2020

Overview

At the Spending Review 2015, the Government announced its ambition to integrate health and social care by 2020 so that it feels like one service. As noted by the Nuffield Trust there "is no one model of integrated care that is suited to all contexts, settings and circumstances".[15]

The ways local areas integrate will be different, and some parts of the country are already demonstrating different approaches, which reflect models the government supports. For example:

- **Greater Manchester –** a devolution area pooling health and social care budgets within 10 HWB localities. Where there are clear benefits, services will be commissioned across the footprint through the joint commissioning board (comprising the CCGs, local authorities and NHS England). Each locality has its own individual plan for integrating services which feeds into the overarching health and social care strategy.
- **North East Lincolnshire –** a lead commissioner model, in which the CCG exercises the Adult Social Care functions on behalf of the local authority;
- **Northumberland –** a single Accountable Care Organisation (ACO), taking on responsibility for general practice, primary care, hospital and community services, adult social care and mental health services.[16]

	Joint commissioning	Lead commissioning	Accountable Care Organisation (ACO)[17]
Characteristics	Some or all CCG/LA commissioning decisions made jointly. Budgets (and other resources) pooled or aligned in line with extent of joint commissioning.	One body exercises some or all functions of both the CCG and the LA, with the relevant resources delegated accordingly.	CCG and LA pay a set figure (possibly determined by capitation) to an Accountable Care Organisation to deliver an agreed set of outcomes for all health and care activity for the whole population, using a multi-year contract. The ACO decides what services to purchase to deliver those outcomes. MCPs and PACs are types of ACOs.

[15] Nuffield Trust, An overview of integrated care in the NHS. What is integrated care? (London: Nuffield Trust, 2011), 20.
[16] Northumberland is a PACs vanguard site, but the ACO goes well beyond simply combining primary and secondary acute care.
[17] M McClellan et al., Implementing Accountable Care to achieve Better Health at a Lower Cost, WISH 2016 http://www.wish-qatar.org/wish-2016/forum-reports

An integrated health and social care service should have full geographical coverage, with clear governance and accountability arrangements. As part of this, we would encourage areas to align their approach to health and care integration with STP geographies, where appropriate. This may be supplemented by initiatives for particular groups, such as Enhanced Health in Care Homes and Integrated Personal Commissioning.

The Government recognises the integration efforts that are already happening, including through the Better Care Fund (BCF), STPs and local devolution. There will be no separate process for integration plans. **Instead, we will simply require local areas to set out how they expect to progress to further integration by 2020 in their BCF 17-19 returns.**

Next Steps

To help areas understand whether they are meeting our integration ambition, we will develop integration metrics for assessing progress, particularly at the interface where health and social care interact. This will combine outcome metrics, user experience and process measures. The metrics will build on work already carried out on behalf of Government (see Annex C) and the Integration Standard tested on the Government's behalf by the Social Care Institute for Excellence (SCIE) found at Annex D. SCIE found that the standard identified helpful integration activities such as risk stratification and multi-disciplinary community teams, but was process-focussed and did not tell the whole integration story. We therefore want to bring elements of the standard into the wider integration scorecard. SCIE's full report is available here: www.scie.org.uk/integrated-health-social-care/integration-2020/research

Further work involving SCIE and key stakeholders will develop these integration metrics. If you have any thoughts on what to include in these, please email: Bettercarefund@dh.gsi.gov.uk

Following the development of the metrics we will ask the Care Quality Commission (CQC) to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care and will not cover wider council social care commissioning. This should lead to a tailored response to ensure those areas facing the greatest challenges can improve rapidly.

Other actions will include:

a) Consideration of Section 75 arrangements

The Department of Health, working with NHS England, is now considering what further changes could be made to secondary legislation to support more integrated, place-based approaches to health and social care, for example:

- The commissioning functions that can be included in scope
- The governance and partnership working arrangements that are permissible, for example Joint Committees

Before NHS England can make arrangements involving combined authorities and local authorities for example, regulations would need to be made prescribing those bodies for the purposes of such arrangements. The Department is also considering whether further amendments to the section 75 partnership regulations would support local areas to extend the benefits of partnership working as they take forward their integration vision.

b) Developing our evidence base on integration, through independent evaluation and sector-led engagement

We will build on our evidence base on what good integration looks like through:

- **The final report of the system-level evaluation of the Better Care Fund will be ready in winter 2017-18.** An interim report is expected in spring 2017, including a typology analysis of integration activities, initial findings from the comparative evaluation, and a BCF policy background paper (a documentary analysis of official BCF literature).

- **Learning from LGA's sector-led support using the Integration 'self-assessment' tool**[18] developed by LGA, ADASS, NHS Confederation and NHS Clinical Commissioners. The peer-led tool assesses local leaders' readiness, capacity and capability to integrate. We will build on this to facilitate graduation panels.

- **NHS England and NHS Improvement evaluation of the New Care Models Programme.** There is a wide range of national, local and independent evaluation of the NCM. Evaluations are progressing at pace.

- **DH and CQC testing the feasibility of a national survey of people's experience of integrated care.** This will be piloted in 2017-18 with a view to national roll out in the future.

Resources:

The LGA has developed a library of resources, signposting local areas to evidence, case studies, tools and resources which will support the development of integration ambitions locally.[19] The resource is organised around the essential integration characteristics, such as leadership, governance, prevention, housing and planning, co-production, care models and workforce. Organisations may also find the slides on Integration, produced by consulting firm Oliver Wyman, a useful resource.[20]

[18] http://www.local.gov.uk/documents/10180/7632544/1.10+Stepping+up+to+the+place+-+integration+self-assesment+tool+WEB.pdf/017681db-bec4-405d-b51d-4ff6f930227d
[19] http://www.local.gov.uk/integration-better-care-fund/-/journal_content/56/10180/8026967/ARTICLE
[20] http://www.oliverwyman.com/our-expertise/insights/2016/nov/global-health-strategy-hub.html

Annex A: Further information on the national conditions for 2017-19

NATIONAL CONDITION	DEFINITION
Condition 1: **Plans to be jointly agreed**	Local areas must ensure that their Better Care Fund (BCF) Plan covers the minimum of the pooled fund specified in the BCF allocations spreadsheet, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area. The plans should be signed off by the Health and Wellbeing Board itself, and by the constituent councils and Clinical Commissioning Groups. The Disabled Facilities Grant (DFG) will again be allocated through the BCF. As such, areas are required to involve local housing authority representatives in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing. In two-tier areas decisions around the use of the DFG funding will need to be made with the direct involvement of both tiers working jointly to support integration ambitions. DFG funding allocated by central government should be passed down by the county to the districts (in full, unless jointly agreed to do otherwise) to enable them to continue to meet their statutory duty to provide adaptations and in line with these plans. During these discussions, it will be important to continue to meet local needs for aids and adaptations, whilst also considering how adaptation delivery systems can help meet wider objectives around integration. For both single tier and two tier authorities, areas are required to set out in their plans how the DFG funding will be used over the two years. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people.
Condition 2: **NHS contribution to adult social care is maintained in line with inflation**	For 2017/18 and 2018/19, the minimum contribution to adult social care will be calculated using the assured figures from 2016/17 as a baseline. This will apply except where a Health and Wellbeing Board secures the agreement of the Integration Partnership Board to an alternative baseline. The NHS contribution to adult social care at a local level must be increased by 1.79% and 1.9% (in line with the increases applied to the money CCGs must pool) in 2017-18 and in 2018-19 respectively. Local areas can opt to frontload the 2018-19 uplift in 2017-18 and then carry over the same level of contribution in 2018-19 as in 2017-18. The funding must be used to contribute to the maintenance of adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition, the Department of Health wants to provide flexibility for local areas to determine how this investment in adult social care

	services is best used. The additional funding for adult social services paid directly to local authorities by the government in each year (please refer to page 17) does not replace, and cannot not be offset against, the NHS minimum contribution to adult social care.
Condition 3: **Agreement to invest in NHS commissioned out of hospital services, which may include 7 day services and adult social care**	Local areas should agree how they will use their share of the £1.018 billion in 2017/18 and £1.037 billion in 2018/19 that had previously been used to create the payment for performance fund (in the 2015-16 BCF). This should be achieved by funding NHS commissioned out-of-hospital services, which may include 7-day services and adult social care, as part of their agreed BCF plan. This can also include NHS investment in the high impact change model for managing transfers of care (linked to compliance with national condition 4), although CCGs can commission these services from funding outside of this ringfence. Local areas can choose to put an appropriate proportion of their share of the £1.018bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including 7-day services and adult social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2016-17). Further guidance to support local areas on deciding whether to hold back a proportion of funds as part of a risk share agreement will be provided in the Integration and Better Care Fund Planning Requirements.
Condition 4: **Managing Transfers of Care**	All areas should implement the High Impact Change Model for Managing Transfer of Care[21] to support system-wide improvements in transfers of care. Narrative plans should set out how local partners will work together to fund and implement this and the schemes and services commissioned will be assured through the planning template. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, ensuring that all partners are involved, including relevant Accident and Emergency Delivery Boards. Quarterly reports will be provided, as required by the Department of Health and the Department for Communities and Local Government.

[21] Including arrangements for a Trusted Assessor model, as per the following link: http://www.local.gov.uk/documents/10180/7058797/Impact+change+model+managing+transfers+of+care/3213644f-f382-4143-94c7-2dc5cd6e3c1a

Annex B: Maintaining progress on the 2016-17 national conditions

We have made changes to the national conditions and reduced the number of conditions to reflect wider changes in the policy and delivery landscape.

For the policy areas that are no longer national conditions of the Better Care Fund (BCF) in 17-19 (see table below), we encourage areas to continue taking action through their BCF plans or other local agreements to ensure these policy priorities and critical enablers for integration continue to feature in local planning and delivery.

National condition	Update for 2017-19 Better Care Fund planning
1. Plans to be jointly agreed	This is a condition for 2017-19 (see Annex A)
2. NHS contribution to adult social care is maintained in line with inflation.	This is a condition for 2017-19 (see Annex A)
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admission to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Improving services through the implementation of the 7-day service clinical standards remains an important priority.[22] All areas should be working to make progress on implementing the 4 priority clinical standards, supported by NHS England and NHS Improvement, so that by April 2018, 50% of patients have access to these standards of care every day of the week with this rising to everyone by 2020. Sustainability and Transformation Plans are providing an opportunity for areas to come together to consider the delivery of 7-day services across geographical areas. Although not a requirement for accessing BCF funding in 2017-19, BCF areas should continue to make progress locally, building on the action taken in 2016-17, on implementing standard 9 of the 7- day hospital service clinical standards which concerns the transfer of patients to community, primary and social care. Standard 9 sets out that: 'Support services, both in the hospital and in primary, community and mental health settings must be available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken, 'Academy of Medical

[22] https://www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/the-clinical-case/

	Royal Colleges (2012): Seven day consultant present care'. Without the timely transfer of patients across settings of care there can be detriment to both existing hospital patients and newly-arriving patients. All BCF areas should work together to avoid unnecessary delays in patient pathways, including taking the actions to reduce delayed transfers of care set out in the section on DTOC below.
Better data sharing between health and social care, based on the NHS number	Data sharing is no longer a condition of the BCF but it remains an important enabler to delivery of BCF or wider integration commitments. To enable effective information sharing for direct care, Parliament introduced the Safety and Quality Act in 2015 which now makes it a legal requirement to share information where it is likely to facilitate the provision of health or care services and is in the individuals' best interests. The Safety and Quality Act also now makes it a legal requirement to use a consistent identifier (such as the NHS number) to support local information sharing. There are examples of where leadership commitment is enabling information sharing at a local level. In addition, through Local Digital Roadmaps, local areas are outlining ambitions for the use of information sharing and technology to support the delivery of care. There are existing examples across the country of where local areas are joining up local systems to give a single health and care record to support the delivery of direct care. These approaches will enable improved coordination of care and support information sharing across health and care settings. The National Data Guardian has also published a review of data security, consent and opt outs across health and care. The report proposed a set of ten data security standards for the health and care system and made a series of recommendations to support information sharing. This includes a commitment to refresh the current Information Governance Toolkit, so that it becomes a portal to support organisations across health and social care to demonstrate increasing resilience and compliance with the standards. Local areas should consider how best to implement these recommendations in conjunction with national policy and services such as CareCERT. The review builds on the previous two Caldicott reports to emphasise the

	importance of building public trust in data security and information sharing, and encouraging public bodies to ensure they engage with citizens regarding how their information is shared.
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 professional	This is no longer a condition of the BCF; however, BCF plans should have embedded within them, an integrated and proactive approach to planning and managing care with other health and care professionals.
Agreement on the consequential impact of changes on the providers that are predicted to be substantially affected by the plans	This is no longer a condition of the BCF but areas should engage with groups likely to be affected by the use of the fund (including health and social care providers) in order to achieve the best outcomes for local people (as set out in condition 1 for 2017-19)
3. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	This is a condition for 2017-19 (see Annex A)
Agreement on local action plans to reduce delayed transfers of care (DTOC)	There is an improved condition around Managing Transfers of Care (National Condition 4), which requires areas to implement the High Impact Change Model for Managing Transfers of Care. Areas should agree a joint approach to funding, implementing and monitoring the impact of these changes, including setting out the intended impact on reducing delayed transfers of care. This will also support the target of a reduction in total delayed transfers of care to 3.5% by September 2017 (recognising existing variation between areas), which is referenced in the Mandate to NHS England for 2017-18.

Annex C: Draft Interface Metrics

Proposed scorecard for measuring effectiveness of social and healthcare interfaces

A Main performance indicators

A1 NEL admissions (65+) per 1,000 65+

A2 NEL admissions (65+) with length of stay >30 days per 1,000 65+

A3 Emergency readmission (65+) per 1,000 emergency admissions 65+

A4 Institutionalisation bed days (65+) per 1,000 65+

A5 DTOC – overall and due to social care placement or package per 1,000 65+

B Supporting overarching indicator

B1 Index of 'User reported quality of life' and 'Proportion of people feeling supported to manage their LTC'

C Contextual indicator

C1 Index of multiple deprivation (IMD)

Additional contextual indicators to collect in the future:
- Public health and social care spend per capita for 65+
- Proportion of 65+ with shared care records in place which are accessible by all care manage teams

Annex D: Integration Standard

	Objective	Improvement to person's experience	System change needed to deliver this objective
1	**Digital inter-operability**	"I have access to a Digital Integrated Care Record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data)"	• Areas reach **digital maturity**, including universal use of the NHS number as the primary identifier and fully interoperable IT across providers and commissioners.
2	**Resource targeted at key cohorts to prevent crises and maintain wellbeing**	"If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital." "If it would benefit me, I will be able to access a personal budget, giving me greater control over money spent on my care."	• Areas use health and social care data to **risk stratify** their populations, identifying those most at risk of unplanned admissions and allocating resources according to need. • Areas will allow greater access to **Integrated Personal Commissioning**, for identified groups who could benefit. • Areas use **capitated budgets** where appropriate
3	**Value for money**	"I receive the best possible level of care from the NHS and my Local Authority."	• Areas deliver against a **clear plan for making efficiencies** across health and care, through integration.
4	**Single assessment and care plans**	"If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care."	• Areas use **multi-disciplinary integrated teams** and make use of professional networks to ensure high-quality joined-up care is delivered in the most appropriate place seven days a week.
5	**Integrated community care**	"My GP and my social worker or carer work with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it."	
6	**Timely and safe discharges**	"If I go into hospital, health and social care professionals work together to make sure I'm not there for any longer than I need to be."	
7	**Social care embedded in urgent and emergency care**	"If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them".	

Better Care Fund Template Q1 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Have funds been pooled via a S.75 pooled budget? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Plan	Yes	Yes	Yes
	Forecast	Yes	Yes	Yes
	Actual	Yes		
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

	Please provide an update on indicative progress against the metric?	Commentary on progress
NEA	Yes	Yes
DTOC	Yes	Yes
Local performance metric	Yes	Yes
If no metric, please specify	Please provide an update on indicative progress against the metric?	Commentary on progress
Patient experience metric	Yes	Yes
Admissions to residential care	Yes	Yes
Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?
Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes

Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there 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 professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes
Yes

Yes
Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q1 2016/17	
Health and Well Being Board	**Southend-on-Sea**
completed by:	nick faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Clr Lesley Salter, Chair HWB

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	2
3. National Conditions	36
4. I&E	21
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes		
2) Maintain provision of social care services	Yes		
3) In respect of 7 Day Services - please confirm:			
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes		
4) In respect of Data Sharing - please confirm:			
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes		
7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number

The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

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

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					
Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast							

Expenditure

Q1 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Total BCF pooled budget for 2016-17 (Rounded)
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					
Please comment if one of the following applies: - There is a difference between the planned / forecasted annual totals and the pooled fund - The Q1 actual differs from the Q1 plan and / or Q1 forecast							

Commentary on progress against financial plan:	n/a

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB and has been rounded to the nearest whole number.

National and locally defined metrics

Selected Health and Well Being Board:	Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Pressure within the hospital continues. Our plans to reduce non-elective admissions continue to gather momentum through the introduction of the Locality approach, Complex Care Co-ordination service, End of Life pathway redesign and our engagement with the Essex Success Regime.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to excalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the demanding agreed DToC rates and that the

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2016 and into 2017. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our current performance for Q1 16/17 is 91.2% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2016)	180,589

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Q4 15/16 population figures onwards have been updated to the mid-year 2016 estimates as we have moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Southend-on-Sea

Remaining Characters	31,872

Please provide a brief narrative on overall progress, reflecting on performance in Q1 16/17. Please also make reference to performance across any other relevant areas that are not directly reported on within this template.
Non Elective, residential admissions and DToC We are delighted that our BCF plan for 2016/17 was approved by NHS England at the end of June 2016. Our plans for 2015/16 were delivered and surpassed as previously submitted in our quarterly returns. For 2016/17 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in 15/16 against a backdrop of transofrmational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the Essex Success Regime. Our robust governance structure assures the system that plans are on track and that all partners are engaged. Income & Expenditure Income & Expenditure has remained on plan.

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 25th November 2016

The BCF Q1 Data Collection

This Excel data collection template for Q2 2016-17 focuses on budget arrangements, the national conditions, income and expenditure to and from the fund, and performance on BCF metrics.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an overview of progress with your BCF plan, the wider integration of health and social care services, and a consideration of any variances against planned performance trajectories or milestones.

Cell Colour Key

Data needs inputting in the cell
Pre-populated cells
Question not relevant to you

Throughout this template cells requiring a numerical input are restricted to values between 0 and 100,000,000.

Content

The data collection template consists of 8 sheets:

Checklist - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements - this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the BCF Policy Framework 16-17 and BCF planning guidance.
4) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
5) Supporting Metrics - this tracks performance against the two national metrics, a DTOC metric, a Non-Elective Admissions metric, locally set metric and locally defined patient experience metric in BCF plans.

6) Additional Measures - additional questions on new metrics that are being developed to measure progress in developing integrated, cooridnated, and person centred care.
7) Narrative - this allows space for the description of overall progress on BCF plan delivery and performance against key indicators.

Checklist

This sheet contains all the validations for each question in the relevant sections.

All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:

The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board

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 7 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This section requires the Health & Wellbeing Board to confirm if funds have been pooled via a Section 75 agreement. Please answer as at the time of completion.

If it had not been previously stated that the funds had been pooled can you now confirm that they have now?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Policy Framework 16/17 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) and Better Care Fund Planning Guidance 16/17 (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/) have been met through the delivery of your plan. Please answer as at the time of completion.

It sets out the eight conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' or 'No - In Progress' that these have been met. Should 'No' or 'No - In Progress' be selected, please provide an estimated date when condition will be met, an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed.

Full details of the conditions are detailed at the bottom of the page.

4) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:

Forecasted income into the pooled fund for each quarter of the 2016-17 financial year
Actual income into the pooled fund in Q1 & Q2 2016-17
Forecasted expenditure from the pooled fund for each quarter of the 2016-17 financial year
Actual expenditure from the pooled fund in Q1 & Q2 2016-17

Figures should reflect the position by the end of each quarter. It is expected that the total planned income and planned expenditure figures for 2016-17 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan or amendments to forecasts made since the previous quarter.

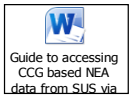
5) Supporting Metrics

This tab tracks performance against the two national supporting metrics, a Delayed Transfers of Care metric, a Non-Elective Admissions metric, the locally set metric, and the locally defined patient experience metric submitted in approved BCF plans. In all cases the metrics are set out as defined in the approved plan for the HWB and the following information is required for each metric:

An update on indicative progress against the six metrics for Q2 2016-17
Commentary on progress against each metric

If the information is not available to provide an indication of performance on a measure at this point in time then there is a drop-down option to indicate this. Should a patient experience metric not have been provided in the original BCF plan or previous data returns there is an opportunity to state the metric that you are now using.

Guidance on accessing CCG based NEA numerator data from SUS via the 'Activity and Planning Report' has been circulated in tandem with this report in order to enable areas to perform their own in year monitoring of NEA data. This guidance document can also be accessed via the embeded object below.



NEA denominator population (All ages) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Please note that the Non-Elective Admissions per 100,000 population (All ages) population projections are based on a calendar year.

Delayed Transfers Of Care numerator data for actual performance has been sourced from the monthly DTOC return found here:
http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

DTOC denominator population (18+) projections are based on Subnational Population Projections, Interim 2014-based (published May 2016) found here:
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1

Please note that the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+) population projections are based on a calendar year.

Actual and baseline data on Re-ablement and Residential Admissions can be sourced from the annual ASCOF return found here:
http://content.digital.nhs.uk/searchcatalogue?productid=22085&q=ascof
Please note these are annual measures and the latest data for 2015/16 data was published 05/10/2016. Plan data for these metrics in 2016/17 were submitted by HWBs within Submission 4 planning returns and final figures are displayed within the 'Remaining Metrics Enquiry' tab of the Submission 4 report.

6) Additional Measures

This tab includes a handful of new metrics designed with the intention of gathering some detailed intelligence on local progress against some key elements of person-centred, co-ordinated care. Following feedback from colleagues across the system these questions have been modified from those that appeared in last years BCF Quarterly Data Collection Template (Q2/Q3/Q4 2015-16). Nonetheless, they are still in draft form, and the Department of Health are keen to receive feedback on how they could be improved / any complications caused by the way that they have been posed.

For the question on progress towards instillation of Open APIs, if an Open API is installed and live in a given setting, please state 'Live' in the 'Projected 'go-live' date field.
For the question on use and prevalence of Multi-Disciplinary/Integrated Care Teams please choose your answers based on the proportion of your localities within which Multi-Disciplinary/Integrated Care Teams are in use.

For the PHB metric, areas should include all age groups, as well as those PHBs that form part of a jointly-funded package of care which may be administered by the NHS or by a partner organisation on behalf of the NHS (e.g. local authority). Any jointly funded personal budgets that include NHS funding are automatically counted as a personal health budget. We have expanded this definition following feedback received during the Q3 reporting process, and to align with other existing PHB data collections.

7) Narrative

In this tab HWBs are asked to provide a brief narrative on overall progress, reflecting on performance in Q2 16/17.
A recommendation would be to offer a narrative around the stocktake themes as below:
Highlights and successes
What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?
Challenges and concerns
Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?
Potential actions and support
What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Better Care Fund Template Q2 2016/17

Data Collection Question Completion Checklist

1. Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

2. Budget Arrangements

Funds pooled via a S.75 pooled budget? If not previously stated that the funds had been pooled can you confirm that they have now? If no, date provided?
Yes

3. National Conditions

			7 day services		
	1) Are the plans still jointly agreed?	2) Maintain provision of social care services	3i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	3ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	4i) Is the NHS Number being used as the consistent identifier for health and social care services?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter (in-line with signed off plan) and how this is being addressed?	Yes	Yes	Yes	Yes	Yes

4. I&E (2 parts)

		Q1 2016/17	Q2 2016/17	Q3 2016/17
Income to	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Expenditure From	Forecast	Yes	Yes	Yes
	Actual	Yes	Yes	
	Please comment if there is a difference between the annual totals and the pooled fund	Yes		
Commentary on progress against financial plan:		Yes		

5. Supporting Metrics

		Please provide an update on indicative progress against the metric?	Commentary on progress
	NEA	Yes	Yes
	DTOC	Yes	Yes
	Local performance metric	Yes	Yes
	If no metric, please specify	Yes	Yes
Patient experience metric	Yes	Yes	Yes
	Admissions to residential care	Yes	Yes
	Reablement	Yes	Yes

6. Additional Measures

	GP	Hospital	Social Care	Community	Mental health
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	Yes
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes

	To GP	To Hospital	To Social Care	To Community	To Mental health
From GP	Yes	Yes	Yes	Yes	Yes
From Hospital	Yes	Yes	Yes	Yes	Yes
From Social Care	Yes	Yes	Yes	Yes	Yes
From Community	Yes	Yes	Yes	Yes	Yes
From Mental Health	Yes	Yes	Yes	Yes	Yes
From Specialised Palliative	Yes	Yes	Yes	Yes	Yes

	GP	Hospital	Social Care	Community	Mental health
Progress status	Yes	Yes	Yes	Yes	Yes
Projected 'go-live' date (mm/yy)	Yes	Yes	Yes	Yes	Yes

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Yes

Total number of PHBs in place at the end of the quarter	Yes
Number of new PHBs put in place during the quarter	Yes
Number of existing PHBs stopped during the quarter	Yes
Of all residents using PHBs at the end of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	Yes

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes

7. Narrative

Brief Narrative	Yes

Data sharing			
4ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	4iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	4iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	5) Is there 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 professional
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes
Yes	Yes	Yes	Yes

Q4 2016/17
Yes

Yes

Specialised palliative
Yes
Yes

To Specialised palliative
Yes
Yes
Yes
Yes
Yes
Yes

Specialised palliative
Yes
Yes

Cover

Q2 2016/17	
Health and Well Being Board	**Southend-on-Sea**
completed by:	Nick Faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Chair of HWB

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	15
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes		
3) In respect of 7 Day Services - please confirm:				
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes	Yes		
4) In respect of Data Sharing - please confirm:				
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissionin

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Car will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services
Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

- To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
- To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made agains Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of informati also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
- confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
- confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
- ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
- ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated he social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)
Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (de days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763					

Q2 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q2 actual differs from the Q2 plan and / or Q2 forecast	

Commentary on progress against financial plan:	no comment

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan, Forecast and Q1 Actual figures are sourced from the Q1 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Pressure within the hospital and the system continues. Our plans to reduce non-elective admissions continue to build through the introduction of the Locality approach, Complex Care Co-ordination service, End of Life pathway redesign and our engagement with the Essex Success Regime.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to excalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the demanding agreed DToC rates and that the

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2016 and into 2017. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our current performance for Q1 16/17 is 93% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

4. Proposed Measure: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13.3

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2016)	180,589

5. Proposed Measure: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Southend-on-Sea

Remaining Characters	31,872

Please provide a brief narrative on overall progress, reflecting on performance in Q2 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Non Elective, residential admissions and DToC

We are delighted that our BCF plan for 2016/17 was approved by NHS England at the end of June 2016. Our plans for 2015/16 were delivered and surpassed as previously submitted in our quarterly returns. For 2016/17 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in 15/16 against a backdrop of transofrmational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the Essex Success Regime.

Our robust governance structure assures the system that plans are on track and that all partners are engaged.

Income & Expenditure

Income & Expenditure has remained on plan.

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Cover

Q3 2016/17	
Health and Well Being Board	**Southend-on-Sea**
Completed by:	Nick Faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Lesley Salter

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	36
4. I&E	17
5. Supporting Metrics	13
6. Additional Measures	67
7. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within this quarter (in-line with signed off plan) and how this is being addressed?

Condition (please refer to the detailed definition below)	Q1 Submission Response	Q2 Submission Response	Please Select ('Yes', 'No' or 'No - In Progress')	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	If the answer is "No" or "No - In Progress" please provide an explanation as to why the condition was not met within the quarter and how this is being addressed:
1) Plans to be jointly agreed	Yes	Yes	Yes		
2) Maintain provision of social care services	Yes	Yes	Yes		
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes		
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be taken (Standard 9)?	Yes	Yes	Yes		
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes		
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes		
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes		
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes		
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes		
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes		
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes		
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes		

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissionin

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequenc Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services
Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.
Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made agains standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of informati right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated he services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.

This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas sho as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

8) Agreement on local action plan to reduce delayed transfers of care (DTOC)
Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (de population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

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Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762				

Q3 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762			

Please comment if one of the following applies: - There is a difference between the forecasted annual total and the pooled fund - The Q3 actual differs from the Q3 plan and / or Q3 forecast	

Commentary on progress against financial plan:	nil comment

Footnotes:

*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB. Pre-populated Plan figures are sourced from the Q1 16/17 collection whilst Forecast, Q1 and Q2 Actual figures are sourced from the Q2 16/17 return previously submitted by the HWB.

National and locally defined metrics

Selected Health and Well Being Board:	Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Pressure within the hospital and the system continues and whilst non-elective admissions (inline with national trends) are higher than 15/16 the trend for 16/17 is declining. This is an indication that our system based plans and commissioned activity are beginning to have an impact and reduce non-elective admissions. We expect for the trend to continue into Q4 16/17.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to escalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the demanding agreed

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2017 and beyond. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our performance for Q3 16/17 is 92.5% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

Improving Data Sharing: (Measures 1-3)

1. Proposed Measure: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Measure: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Measure: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

Other Measures: Measures (4-5)

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Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13.3

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2016)	180,589

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Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **non-acute** setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the **acute** setting?	Yes - throughout the Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2016 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Southend-on-Sea

Remaining Characters	31,593

Please provide a brief narrative on overall progress, reflecting on performance in Q3 16/17. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Non Elective, residential admissions and DToC

We are delighted that our BCF plan for 2016/17 continues to support and drive our activities to integrate health and social care. Our plans for 2016/17 continues to deliver. As we now enter the planning phase fro 2017 - 2019 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in the previous 2 years against a backdrop of transofrmational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the Essex Success Regime.

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

Our robust governance structure assures the system that plans are on track and that all partners are engaged.

Income & Expenditure

Income & Expenditure has remained on plan.

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Cover

Q4 2016/17	
Health and Well Being Board	**Southend-on-Sea**
completed by:	Nick Faint
E-Mail:	nickfaint@southend.gov.uk
Contact Number:	01702 212 113
Who has signed off the report on behalf of the Health and Well Being Board:	Cllr Lesley Salter

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. I&E	19
5. Supporting Metrics	13
6. Year End Feedback	13
7. Additional Measures	67
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:	Southend-on-Sea

Have the funds been pooled via a s.75 pooled budget?	Yes
If it had not been previously stated that the funds had been pooled can you now confirm that they have now?	
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question, which is pre-populated, the data is from a previous quarterly collection returned by the HWB.

National Conditions

Selected Health and Well Being Board: Southend-on-Sea

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these have been met, as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?

Condition	Q1 Submission Response	Q2 Submission Response	Q3 Submission Response	Please Select (Yes or No)	If the answer is 'No', please provide an explanation as to why the condition was not met within the year (in-line with signed off plan) and how this is being addressed?
1) Plans to be jointly agreed	Yes	Yes	Yes	Yes	
2) Maintain provision of social care services	Yes	Yes	Yes	Yes	
3) In respect of 7 Day Services - please confirm:					
i) Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate	Yes	Yes	Yes	Yes	
ii) Are support services, both in the hospital and in primary, community and mental health settings available seven days a week to ensure that the next steps in the patient's care pathway, as determined by the daily consultant-led review, can be	Yes	Yes	Yes	Yes	
4) In respect of Data Sharing - please confirm:					
i) Is the NHS Number being used as the consistent identifier for health and social care services?	Yes	Yes	Yes	Yes	
ii) Are you pursuing Open APIs (ie system that speak to each other)?	Yes	Yes	Yes	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott Principles and guidance?	Yes	Yes	Yes	Yes	
iv) Have you ensured that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights?	Yes	Yes	Yes	Yes	
5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Yes	Yes	Yes	Yes	
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	Yes	Yes	Yes	Yes	
7) Agreement to invest in NHS commissioned out-of-hospital services	Yes	Yes	Yes	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	Yes	Yes	Yes	

National conditions - detailed definitions

The BCF policy framework for 2016-17 and BCF planning guidance sets out eight national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.

2) Maintain provision of social care services

Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2016-17.

The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund.

In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process.

It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) Agreement for the delivery of 7-day services across health and social care to

Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order:

• To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week;
• To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why.

The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf).
By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.

4) Better data sharing between health and social care, based on the NHS number
The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.

Local areas should:
• confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place.
• ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review.

The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga

5) Ensure a joint approach to assessments and care planning and ensure that,
Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.

6) Agreement on the consequential impact of the changes on the providers that are

The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations.

There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.

7) Agreement to invest in NHS commissioned out of hospital services, which may
Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund.
This should be achieved in one of the following ways:

- To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better Care Fund plan; or

- Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16);

This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.

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

Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue.

As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target.

All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month.

As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising.

In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue.

We would expect plans to:

• Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring;
• Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and best practice with regards to reducing DTOC from LGA and ADASS;
• Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance;
• Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity;
• Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies;
• Demonstrate engagement with the independent and voluntary sector providers.

Footnotes:
Source: For each of the condition questions which are pre-populated, the data is from the quarterly data collections previously returned by the HWB.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Southend-on-Sea

Income

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	nil comment

Expenditure

Previously returned data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762			

Q4 2016/17 Amended Data:

		Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Annual Total	Pooled Fund
Please provide, plan, forecast and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	£13,131,049
	Forecast	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	
	Actual*	£3,282,763	£3,282,762	£3,282,762	£3,282,762	£13,131,049	

Please comment if there is a difference between the forecasted / actual annual totals and the pooled fund	nil comment

Commentary on progress against financial plan:	nil comment

Footnotes:
*Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a quarterly collection previously filled in by the HWB.

National and locally defined metrics

Selected Health and Well Being Board: Southend-on-Sea

Non-Elective Admissions	Reduction in non-elective admissions
Please provide an update on indicative progress against the metric?	No improvement in performance
Commentary on progress:	Pressure within the hospital and the system continues and whilst non-elective admissions (inline with national trends) are higher than 15/16 the trend for 16/17 is declining. This is an indication that our system based plans and commissioned activity are beginning to have an impact and reduce non-elective admissions. We expect for the trend to continue into 2017/18.

Delayed Transfers of Care	Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+)
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	We have a System agreed plan re DToC that will continue our historically strong performance in managing our system DToC rates. The delivery of the DToC plan is both monitored and managed at a System level. Operational management has an agreed process to escalate. The management teams within both health and social care continue to ensure operational resources are in place to deliver the

Local performance metric as described in your approved BCF plan	People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend
Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our BCF activity is focused on providing an integrated health and social care service for patients with complex care needs. We are planning the configuration of these services and expect for the work to have an impact on this performance metric through 2017 and beyond. Data for this metric for period July 16 - March 17 will not be available until Sep 17.

Local defined patient experience metric as described in your approved BCF plan	Friends and Family Net promoter score - SUFHT In Patient wards
If no local defined patient experience metric has been specified, please give details of the local defined patient experience metric now being used.	

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Our performance for Q4 16/17 is 90% against a target of 91.7%.

Admissions to residential care	Rate of permanent admissions to residential care per 100,000 population (65+)

Please provide an update on indicative progress against the metric?	On track to meet target
Commentary on progress:	Southend is operating in the context of budget reductions that are set to continue well into 2018. To address these reduced budgets and deliver a more integrated service for our residents Southend on Sea Borough Council is in the process of transforming Adult Social Care. We are, therefore, anticipating, that our residential care admissions will stay at the same levels for 16/17 as they were for 15/16.

Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Please provide an update on indicative progress against the metric?	On track for improved performance, but not to meet full target
Commentary on progress:	Our current performance is circa 75% against a target of 86%. The commissioning of a new Domiciliary Care contract is anticipated to have a positive impact on the reablement performance. Additionally we are undertaking a review of the access pathway for reablement services.

Footnotes:

For the local performance metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB.
For the local defined patient experience metric (which is pre-populated), the data is from submission 4 planning returns previously submitted by the HWB, except in cases where HWBs provided a definition of the metric for the first time within the Q1 16-17 template.

Year End Feedback on the Better Care Fund in 2016-17

Selected Health and Well Being Board:	Southend-on-Sea

Part 1: Delivery of the Better Care Fund
Please use the below form to indicate what extent you agree with the following statements and then detail any further supporting information in the corresponding comment boxes.

Statement:	Response:	Comments: Please detail any further supporting information for each response
1. The overall delivery of the BCF has improved joint working between health and social care in our locality	Agree	
2. Our BCF schemes were implemented as planned in 2016/17	Agree	
3. The delivery of our BCF plan in 2016/17 had a positive impact on the integration of health and social care in our locality	Agree	
4. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Non-Elective Admissions	Agree	
5. The delivery of our BCF plan in 2016/17 has contributed positively to managing the levels of Delayed Transfers of Care	Agree	
6. The delivery of our BCF plan in 2016/17 has contributed positively to managing the proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	Agree	
7. The delivery of our BCF plan in 2016/17 has contributed positively to managing the rate of residential and nursing care home admissions for older people (aged 65 and over)	Agree	

Part 2: Successes and Challenges
Please use the below forms to detail up to 3 of your greatest successes, up to 3 of your greatest challenges and then categorise each success/challenge appropriately

8. What have been your greatest successes in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **successes**	Response category:
Success 1	the commissioning of a complex care co-ordination service	3. Collaborative working relationships
Success 2	the development of a Locality approach	1. Shared vision and commitment
Success 3	the introdcution of a moderate needs MDT	3. Collaborative working relationships

9. What have been your greatest challenges in delivering your BCF plan for 2016-17?	Response - Please detail your greatest **challenges**	Response category:
Challenge 1	data sharing	7. Digital interoperability and sharing data
Challenge 2	governance	10. Managing change
Challenge 3	finance	6. Delivering services across interfaces

Footnotes:

Question 11 and 12 are free text responses, but should be assigned to one of the following categories (as used for previous BCF surveys):

1. Shared vision and commitment
2. Shared leadership and governance
3. Collaborative working relationships
4. Integrated workforce planning
5. Evidencing impact and measuring success
6. Delivering services across interfaces
7. Digital interoperability and sharing data
8. Joint contracts and payment mechanisms
9. Sharing risks and benefits
10. Managing change

Other

Additional Measures

Selected Health and Well Being Board: Southend-on-Sea

1. Proposed Metric: Use of NHS number as primary identifier across care settings

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
NHS Number is used as the consistent identifier on all relevant correspondence relating to the provision of health and care services to an individual	Yes	Yes	Yes	Yes	No	No
Staff in this setting can retrieve relevant information about a service user's care from their local system using the NHS Number	Yes	Yes	Yes	Yes	Yes	Yes

2. Proposed Metric: Availability of Open APIs across care settings

Please indicate across which settings relevant service-user information is currently being shared digitally (via Open APIs or interim solutions)

	To GP	To Hospital	To Social Care	To Community	To Mental health	To Specialised palliative
From GP	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Hospital	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Social Care	Not currently shared digitally	Not currently shared digitally	Shared via Open API	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally
From Community	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Mental Health	Shared via Open API	Shared via Open API	Not currently shared digitally	Shared via Open API	Shared via Open API	Not currently shared digitally
From Specialised Palliative	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Not currently shared digitally	Shared via Open API

In each of the following settings, please indicate progress towards instillation of Open APIs to enable information to be shared with other organisations

	GP	Hospital	Social Care	Community	Mental health	Specialised palliative
Progress status	In development	In development	In development	In development	In development	In development
Projected 'go-live' date (dd/mm/yy)	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17	31/03/17

3. Proposed Metric: Is there a Digital Integrated Care Record pilot currently underway?

Is there a Digital Integrated Care Record pilot currently underway in your Health and Wellbeing Board area?	Pilot being scoped

4. Proposed Metric: Number of Personal Health Budgets per 100,000 population

Total number of PHBs in place at the end of the quarter	24
Rate per 100,000 population	13

Number of new PHBs put in place during the quarter	7
Number of existing PHBs stopped during the quarter	17
Of **all** residents using PHBs at the **end** of the quarter, what proportion are in receipt of NHS Continuing Healthcare (%)	94%

Population (Mid 2017)	182,046

5. Proposed Metric: Use and prevalence of Multi-Disciplinary/Integrated Care Teams

Are integrated care teams (any team comprising both health and social care staff) in place and operating in the non-acute setting?	Yes - in some parts of Health and Wellbeing Board area
Are integrated care teams (any team comprising both health and social care staff) in place and operating in the acute setting?	Yes - in some parts of Health and Wellbeing Board area

Footnotes:

Population projections are based on Subnational Population Projections, Interim 2014-based (published May 2016).
http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandz1
Population figures were updated to the mid-year 2017 estimates as we moved into the new calendar year.

Narrative

Selected Health and Well Being Board:	Southend-on-Sea

Remaining Characters	31,605

Please provide a brief narrative on overall progress, reflecting on performance in Q4 16/17 and the year as a whole. A recommendation would be to offer a narrative around the stocktake themes as below:

Highlights and successes

What would you consider to be your most significant area of success, or development since the last quarter? What has contributed to this improvement?

Challenges and concerns

Does the information on National Conditions and Supporting metrics point to any issues or areas of improvement? Are there any new anticipated challenges for the coming quarter?

Potential actions and support

What actions could be taken and what support could be offered to address performance challenges and capitalise on successes for subsequent quarters?

Non Elective, residential admissions and DToC

We are delighted that our BCF plan for 2016/17 continues to support and drive our activities to integrate health and social care. Our plans for 2016/17 have continued to deliver. As we now enter the planning phase fro 2017 - 2019 our BCF plan will focus on further reductions in Non Elective admissions, maintaining the performance for residential care admissions achieved in the previous 2 years against a backdrop of transformational change and continuing to deliver strong DToC performance. To achieve these objectives our plans to transform existing services include implementing a Locality approach, commissioning a complex care co-ordination service and engagement with the STP.

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

Our robust governance structure assures the system that plans are on track and that all partners are engaged.

Income & Expenditure

Income & Expenditure has remained on plan.

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APPENDIX C

Southend Health & Wellbeing Board

Agenda Item No.

Joint Report of
Simon Leftley, Deputy Chief Executive (People), Southend Borough Council;
Ian Stidston, Interim Accountable Officer, Southend CCG

to

Health & Wellbeing Board

on

22 March 2017

Report prepared by:
Nick Faint BCF Programme Lead

For discussion		For information only		Approval required	X

Better Care Fund

2017/19 Plan

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is as follows;

1.1 To update members of the Health and Wellbeing Board (HWB) regarding the Better Care Fund (BCF) planning process for 2017/19; and

1.2 To agree delegated authority to the Deputy Chief Executive (People) (Southend-on-Sea Borough Council 'SBC') and the Interim Accountable Officer (Southend Clinical Commissioning Group 'SCCG') in conjunction with the Chair and Vice Chair of HWB to agree the BCF plan and to enable a submission to be made to NHS England in accordance with the planning guidance (not yet published).

2 Recommendations

HWB are asked to;

2.1 note the update for BCF 201/19;

2.2 agree delegated authority to the Deputy Chief Executive (People), SBC and the Interim Accountable Officer SCCG in conjunction with the Chair and Vice Chair of HWB to sign off the final BCF plan for 2017/19 on behalf of HWB; and

2.3 agree to the BCF plan 2017/19 being consulted amongst HWB partners as outlined in section 4.5 – 4.8.

3 Background & Context

3.1 The BCF for 2016/17 was established between SCCG and SBC from 1 April 2016. It is underpinned by a legal Section 75 Agreement between the two organisations that sets out the proposed schemes to be funded, the required flows of income into the pooled budget and the distribution back to the scheme / organisational leads.

3.2 Throughout the course of 2016/17 HWB has reported quarterly BCF activity to NHS England. The most recent return made to NHS England (3 March 2017) continued the theme of reporting that the Southend system continues to operate in challenging financial and operational circumstances but that integrated mitigations and projects are beginning to have an impact, key issues being reported were;

3.2.1 Non-elective admissions are higher than the previous years quarter but the trend is starting to decrease;

3.2.2 Admissions to residential care is stable and is being robustly managed within the context of transforming adult social care;

3.2.3 Delayed Transfers of Care (DToC) presents a significant challenge to both health and social care but is being robustly managed through a programme of DToC transformation; and

3.2.4 Reablement (those still at home 91 days after discharge) is on track and stable.

3.3 The three quarterly returns for 2016/17 are available at Appendix A

4 Southend BCF 2017/19

National

4.1 The policy and technical planning guidance and detailed direction to enable local areas to draft the BCF plans for 2017/19 is not yet published, the date for publication is currently unknown.

4.2 Attached at Appendix B is the most recent published guidance (Dec 2016). Summary points are;

4.2.1 The planning cycle will move from annual to biennial (once every two years) to align with NHS planning requirements;

4.2.2 Local areas will be invited to graduate from BCF which will provide areas with greater autonomy;

4.2.3 National conditions will reduce from eight to three; (1) plans jointly agree; (2) protection of social care; and (3) commissioning of out of hospital services;

4.2.4 Metrics to measure performance will continue to focus on non-elective admissions; admissions to residential care homes; reablement; and DToC;

Local

4.3 Whilst it is difficult to currently plan for BCF 2017/19 without national policy guidance an assurance process has already commenced between SBC and SCCG to review the impact and effectiveness of spend on current integrated services. The outcome of this process will help inform the BCF plan for 2017/19 once guidance has been published.

Timeline

4.4 The timeline is currently unknown.

Consultation and engagement

4.5 A national requirement for the BCF is that HWBs sign off, agree and are engaged in the planning process.

4.6 It is anticipated that following March 2017 HWB planning guidance will be published by NHS England and final / signed of plans will be required to be submitted prior to June 2017 HWB.

4.7 To meet the national requirement outlined in para 4.5 it is proposed that HWB are engaged and consulted with at a senior management level and virtually for Board members of the HWB, specifically;

4.7.1 Via the Locality Transformation Group (LTG) the BCF plan will be developed and the detail reviewed. LTG meets monthly and is attended by SBC, SCCG, SEPT and SUHFT. The group is chaired by the Director of Strategy, Commissioning & Procurement; and

4.7.2 Via virtual circulation of relevant documents, the HWB are distributed with the various planned submissions for review and comment;

4.8 The agreed plan and Section 75 agreement will be brought to the next appropriate HWB following March 2017.

5 Health & Wellbeing Board Priorities / Added Value

5.1 The BCF contributes to delivering HWB Strategy Ambitions in the following ways

5.2 Ambition 5 – Living Independently; through the promotion of prevention and engagement with residents, patients and staff the BCF will actively support individuals living independently.

5.3 Ambition 6 – Active and healthy ageing; through engaging and integrating health and social services within the community the services will be aligned to assisting individuals to age healthily and actively; and

5.4 Ambition 9 – Maximising opportunity; Overarching BCF; Southend is the drive to improve and integrate health and social services. Through initiatives within the BCF we will empower staff to personalize the integrated care individuals receive and residents to have a say in the care they receive.

6 Reasons for Recommendations

6.1 As part of its governance role, HWB has oversight of the Southend BCF 2017/19.

7 Financial / Resource Implications

7.1 None at this stage

8 Legal Implications

8.1 None at this stage

9 Equality & Diversity

9.1 The BCF plan should result in more efficient and effective provision for vulnerable people of all ages.

10 Appendices

Appendix A – Quarterly Returns	
Appendix B – Current planning guidance	

HWB Strategy Ambitions

Ambition 1. A positive start in life A. Children in care | B. Education- Narrow the gap | C. Young carers | D. Children's mental wellbeing | E. Teen pregnancy | F. Troubled families	**Ambition 2. Promoting healthy lifestyles** A. Tobacco – reducing use | B. Healthy weight | C. Substance & Alcohol misuse	**Ambition 3. Improving mental wellbeing** A. Holistic: Mental/physical | B. Early intervention | C. Suicide prevention/self-harm | D. Support parents/postnatal
Ambition 4. A safer population A. Safeguarding children and vulnerable adults | B. Domestic abuse | C. Tackling Unintentional injuries among under 15s	**Ambition 5. Living independently** A. Personalised budgets | B. Enabling community living |C. Appropriate accommodation | D. Personal involvement in care | E. Reablement | F. Supported to live independently for longer	**Ambition 6. Active and healthy ageing** A. Integrated health & social care services | B. Reducing isolation | C. Physical & mental wellbeing | D. Long Term conditions– support | E. Personalisation/ Empowerment
Ambition 7. Protecting health A. Increased screening | B. Increased immunisations | C. Infection control | D. Severe weather plans in place | E. Improving food hygiene	**Ambition 8. Housing** A. Partnership approach to; Tackle homelessness | B. Deliver health, care & housing in a more joined up way | C. Adequate affordable housing | D. Adequate specialist housing | E. Strategic understanding of stock and distribution	**Ambition 9. Maximising opportunity** A. Population vs. Organisational based provision | B. Joint commissioning and Integration | C. Tackling health inequality (improved access to services) | D. Opportunities to thrive; Education, Employment

Local Government Association

High impact change model

Managing transfers of care between hospital and home

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A self-assessment tool for local health and care systems

Contents

1.Introduction

This model was developed by strategic system partners including the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), NHS England, the Department of Health (DH), the Emergency Care Improvement Programme (ECIP), Monitor and the Trust Development Authority (now NHSi) during 2015.

It builds on lessons learnt from practice and promotes a new approach to system resilience, moving away from a focus solely on winter pressures to a year-round approach to supporting timely hospital discharge. Whilst acknowledging that there is no simple solution to creating an effective and efficient care and health system, this model signals a commitment to work together to identify what can be done to improve current ways of working. The model was endorsed in a joint meeting between local government leaders and secretaries of state for health and for communities and local government in October 2015.

2. Purpose of the model

This high impact change model aims to focus support on helping local system partners minimise unnecessary hospital stays and to encourage them to consider new interventions for future winters.

It offers a practical approach to supporting local health and care systems to manage patient flow and discharge and can be used to self-assess how local care and health systems are working now, and to reflect on, and plan for, action they can take to reduce delays throughout the year.

The model identifies eight system changes which will have the greatest impact on reducing delayed discharge:

- early discharge planning
- systems to monitor patient flow
- multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector
- home first/discharge to assess
- seven-day services
- trusted assessors
- focus on choice
- enhancing health in care homes.

3. Principles

This model is not designed to be a performance management tool. Instead, it takes as its starting point a recognition that even the best performing systems will be experiencing challenges in relation to hospital discharge.

The model is underpinned by a sector-led improvement approach which emphasises the importance of triangulating both hard and soft types of data to tease out local stories within a culture of openness and trust. This model supports genuine, honest reflection and discussion between trusted colleagues within local health and care systems and includes a suggested action plan so that decisions arising from conversations using the model can be implemented across the year.

4. The model

Change 1

Early discharge planning. In elective care, planning should begin before admission. In emergency/ unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

Change 2

Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand) and to plan services around the individual.

Change 3

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols and on shared and agreed responsibilities, promotes effective discharge and positive outcomes for patients.

Change 4

Home first/discharge to access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.

Change 5

Seven-day service. Effective joint 24/7 working improves the flow of people through the system and across the interface between health and social care meaning that services are more responsive to people's needs.

Change 6

Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Change 7

Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options. The voluntary and community sector can be a real help to patients in supporting them to explore their choices and reach decisions about their future care.

Change 8

Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

4. The model

High impact changes that support delayed transfers of care between hospital and home

Change 1

Early discharge planning. In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected date of discharge to be set within 48 hours.

Not yet established	Plans in place	Established	Mature	Exemplary
Early discharge planning in the community for elective admissions is not yet in place [119]	Change to clinical commissioning group (CCG) and change to adult social care (ASC) commissioners are discussing how community and primary care coordinate early discharge planning	Joint pre-admission discharge planning is in place in primary care	GPs and District Nurses lead the discussions about early discharge planning for elective admissions	Early discharge planning occurs for all planned admissions by an integrated community health and social care team
Discharge planning does not start in A&E	Plans are in place to develop discharge planning in A&E for emergency admissions	Emergency admissions have a provisional discharge date set in within 48 hours	Emergency admissions have discharge dates set which whole hospital are committed to delivering	Evidence shows X per cent patients go home on date agreed on admission

4. The model

Change 2

Systems to monitor patient flow. Robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.

Not yet established	Plans in place	Established	Mature	Exemplary
No relationship between demand and capacity in care pathways	Analysis of demand underway to calculate capacity needed for each care pathway	Policy agreed and plan in place to match capacity to care pathway demand	Capacity usually matches demand along the care pathway	Capacity always matches demand along the whole care pathway
Capacity available not related to current demand	Analysis of demand variations underway to identify current variations	Analysis completed and practice change rolled out across trust and in community	Capacity usually matches demand 24/7 to match real variation	Capacity always matches demand 24/7 reflecting real variations
Bottlenecks occur regularly in the trust and in the community	Analysis of causes of bottlenecks underway and practice changes being designed	Analysis completed and practice changes being put in place and evaluated	Bottlenecks rarely occur and are quickly tackled when they do	There are no bottlenecks caused by process or supply failure
There is no ability to increase capacity when admissions increase – tipping point reached quickly	Analysis of admissions variation ongoing with capacity increase plans being developed	Staff understand the need to increase capacity when admissions increase	Capacity is usually automatically increased when admissions increase	Capacity is always automatically increased when admissions increase
Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Staff training in place to ensure understanding of the need to increase senior clinical capacity	Staff understand the need to increase senior clinical support when necessary	Senior clinical decision making support is usually available and increased when necessary	Senior clinical decision making support available and increased automatically when necessary to carry out assessment and reviews 24/7

4. The model

Change 3

Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector. Coordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.

Not yet established	Plans in place	Established	Mature	Exemplary
Separate discharge planning processes in place	Discussion ongoing to create integrated health and ASC discharge teams	Joint NHS and ASC discharge team in place	Joint teams trust each other's assessments and discharge plans	Integrated teams using single assessment and discharge process
No daily multidisciplinary team meeting in place [121]	Discussion to introduce MDTs on all wards with trust and community health and ASC	Daily MDT attended by ASC, voluntary sector and community health	Integrated teams cover all MDTs including community health provision to pull patients out	Integrated service supports MDTs using joint assessment and discharge processes
Continuing Health Care assessments carried out in hospital and taking "too" long	Discussion between CCG and trust to establish discharge to assess arrangements	Discharge to assess arrangements in place with care sector and community health providers	CHC and complex assessments done outside hospital in people's homes/extra care or reablement beds	Fully integrated discharge to assess arrangements in place for all complex discharges

4. The model

Change 4

Home first/discharge to access. Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow

Not yet established	Plans in place	Established	Mature	Exemplary
People are still assessed for care on an acute hospital ward	Nursing capacity in community being created to do complex assessments in the community	People usually return home with reablement support for assessment	People return home with reablement support from integrated team	All patients return home for assessment and reablement after being declared fit for discharge
People enter residential /nursing care too early in their care career	Systems analysing which people can go home instead of into care – plans for self funder advice	People usually only enter a care/nursing home when their needs cannot be met through care at home	Most people return home for assessment before making a decision about future care	People always return home whenever possible supported by integrated health and social care support
People wait in hospital to be assessed by care home staff	Work being done to identify homes less responsive to assess people quickly	Care homes assess people usually within 48 hours	Care homes usually assess people in hospital within 24 hours	Care homes accept previous residents trusting trust /ASC staff assessment and always carry out new assessments within 24 hours

4. The model

Change 5

Seven-day service. Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.

Not yet established	Plans in place	Established	Mature	Exemplary
Discharge and social care teams assess and organise care during office hours five days a week	Plan to move to seven day working being drawn up	Health and social care teams working to new seven day working patterns	Health and social care teams providing seven day working	Seamless provision of care regardless of time of day or week
OOHs emergency teams provide non office hours and weekend support	New contracts and rotas for health and social care staff being drawn up and negotiated	New contracts agreed and in place	New staffing rotas and contracts in place across all disciplines	New staffing rotas and contracts in place and working seamlessly
Care services only assess and start new care Monday to Friday	Negotiations with care providers to assess and restart care at weekends	Staff ask and expect care providers to assess at weekends	Most care providers assess and restart care at weekends	All care providers assess and restart care 24/7
Diagnostics, pharmacy and patient transport only available Monday to Friday	Hospital departments have plans in place to open in the evenings and at weekends	Hospital departments open 24/7 whenever possible	Whole system commitment usually enabling care to restart within 24 hours, seven days a week	Whole system commitment enabling care always to restart within 24 hours, seven days a week

4. The model

Change 6

Trusted assessors. Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.

Not yet established	Plans in place	Established	Mature	Exemplary
Assessments done separately by health and social care	Plan for training of health and social care staff	Assessments done by different organisations accepted and resources committed	Discharge and social care teams assessing on behalf of health and social care	Integrated assessment teams committing joint pooled resources
Multiple assessments requested from different professionals	One assessment form/ system being discussed	One assessment format agreed between organisations /professions	Single assessment in place	Resources from pooled budget accessed by single assessment without separate organisational sign off
Care providers insist on assessing for the service or home	Care providers discussing joint approach of assessing on each other's behalf	Care providers share responsibility of assessment	Some care providers assess on each other's behalf and commit to care provision	Single assessment for care accepted and done by all care providers in system

4. The model

Change 7

Focus on choice. Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.

Not yet established	Plans in place	Established	Mature	Exemplary
No advice or information available at admission	Draft pre-admission leaflet and information being prepared	Admission advice and information leaflets in place and being used	Patients and relatives aware that they need to decide about discharge quickly	Patients and relatives planning for discharge from point of admission
No choice protocol in place	Choice protocol being written or updated to reduce seven days	New choice protocol implemented and understood by staff	Choice protocol used proactively to challenge people	All staff understand choice and can discuss discharge proactively
No voluntary sector provision in place to support self-funders	Health and social care commissioners co-designing contracts with voluntary sectors	Voluntary sector provision in place in the trust proving advice and information	Voluntary sector provision integrated in discharge teams to support people home from hospital	Voluntary sector fully integrated as part of health and social care team both in the trust and the community

4. The model

Change 8

Enhancing health in care homes. Offering people joined-up, coordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

Not yet established	Plans in place	Established	Mature	Exemplary
Care homes unsupported by local community and primary care	CCG and ASC commissioners working with care providers to identify need	Community and primary care support provided to care homes on request	Care homes manage the increased acuity in the care home	Care homes integrated into the whole health and social care community and primary care support
High numbers of referrals to A&E from care homes especially in evenings and at weekends	Specific high referring care homes identified and plans in place to address	Dedicated intensive support to high referring homes in place	No unnecessary admissions from care homes at weekends	No variation in the flow of people from care homes into hospital during the week
Evidence of poor health indicators in Care Quality Commission (CQC) inspections	Analysis of poor care identifies homes where extra support and training needed	Quality and safeguarding plans in place to support care homes	Community health and social care teams working proactively to improve quality in care homes	Care home CQC ratings reflect high quality care

4. The model

Action planning template

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				
Systems to monitor patient flow				
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)				
Home First Discharge to Assess				
Seven-day services				
Trusted assessors				
Focus on choice				
Enhancing health in care homes				

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