Public Document Pack

SOUTHEND-ON-SEA BOROUGH COUNCIL

Health & Wellbeing Board

Date: Monday, 1st August, 2016
Time: 5.00 pm
Place: Johnson Room - Tickfield Centre
Contact: Robert Harris

Email: committeesection@southend.gov.uk

A G E N D A

1 **Apologies for Absence**

2 **Declarations of Interest**

3 **Minutes of the Meeting held on Thursday 7th April 2016** (Pages 1 - 4)

******** **For Information**

4 **Transforming Care Briefing** (Pages 5 - 10)
Report from Learning Disabilities Commissioning Manager attached

******** **For Discussion/Decision**

5 **Localities Approach for Southend-on-Sea** (Pages 11 - 78)
Joint report from the Associate Director of Integrated Care Commissioning and BCF Project Manager attached.

6 **Better Care Fund - Update and Section 75 Agreement (Deed of Variation)** (Pages 79 - 372)
Joint report of the Pooled Fund Manager and BCF Project Manager attached.

7 **Joint Adult Prevention Strategy** (Pages 373 - 410)
Report of the Head of Health Development attached.

8 **Summary of HWB Performance Indicator Report 1 Aug 2016** (Pages 411 - 418)
Report of the Health & Wellbeing Board advisor attached

9 **Forward Plan** (Pages 419 - 420)
Forward Plan attached

10 **A Better Start Programme Progress** (Pages 421 - 422)
Report attached

This page is intentionally left blank

SOUTHEND-ON-SEA BOROUGH COUNCIL

Meeting of Health & Wellbeing Board

Date: Thursday, 7th April, 2016
Place: Johnson Room - Tickfield Centre

3

Present: Councillor Moyies (Chair)
Dr Garcia-Lobera (Vice-Chair),
Councillors Evans, Lamb, Velmurugan, Betson,
Mr R Tinlin, Ms A Atherton, Ms A Semmence, Ms M Craig, Dr Chaturvedi, Mr N Leitch and Ms C Doorly, Mr M McCann* and Ms W Smith*

*Substitute in accordance with Council Procedure Rule 31.

In Attendance: Mr Walters, Ms E Hammans, Mr J O'Loughlin, Mr R Harris Mr B Martin and Mr J Lambert

Start/End Time: 5.00 - 6.15 pm

753 Apologies for Absence

Apologies for absence were received from Councillor Willis (no substitute), Mr A Pike/Mr A McIntyre (substitute: Ms W Smith), Ms S Morris (substitute: Mr M McCann), Mr S Leftley and Ms S Hardy.

754 Declarations of Interest

The following members declared interests as indicated below:-

(a) Councillor Salter – Agenda Item 7 (Essex Success Regime Briefing) – Non-pecuniary interest - husband is Business Unit Director at Southend Hospital for surgical services including oral surgery – urology;
(b) Dr J G Lobera – Agenda Item 7 (Essex Success Regime Briefing) – Non-pecuniary interest – practicing GP;
(c) Dr K Chaturvedi – Agenda Item 7 (Essex Success Regime Briefing) – Non-pecuniary interest – practicing GP;
(d) Councillor Velmurugan – Agenda Item 7 (Essex Success Regime Briefing) – Non-pecuniary interest – practicing GP.

755 Minutes of the meeting held on Tuesday 9th February 2016

Resolved:-

That the Minutes of the Meeting held on Tuesday 9th February 2016 be confirmed as a correct record and signed.

756 Childhood Obesity - update on Task & Finish Group

The Board considered a report of the Director of Public Health which provided an update on the work of the Childhood Obesity Task and Finish Group.

Resolved:

That the report and the proposals for taking forward action to tackle childhood obesity in Southend-on-Sea, be noted.

757 Children & Young Peoples Plan 2016-2017

The Board considered a report of the Head of Children's Services, Southend Borough Council, which presented the 2016-17 Children & Young People's Plan (CYPP) for consideration.

In response to a specific question regarding the delivery of the targets within the CYPP the Head of Children's Services advised that the targets are ambitious and deliverable within the resources available.

The Board commented on the delivery of targets in respect of the Health and Wellbeing strategic ambition 8 (housing) and noted that the targets concerning adequate affordable housing may need to be revisited in light of the Government's proposed changes to the planning regime.

Resolved:

That the 2016-17 Children & Young People's Plan be endorsed.

758 A Better Start Programme Briefing

The Board received a PowerPoint presentation from the Director of 'A Better Start' which provided an overview of the outcomes in the first year of operation and the challenges and opportunities for Year 2 of the 'A Better Start Southend.' The Board also considered the Executive Action Plan for 'A Better Start Southend' and was asked to comment on and provide feedback on the action plan.

The Board was reminded that it was the management and governance body responsible for overseeing the delivery of 'A Better Start Southend' and would at future meetings receive progress reports, etc against the action plan.

The Board asked a specific question regarding primary care and it was advised that work was taking place with the Southend CCG and the delivery of primary care will be locality based.

Resolved:

1. That the PowerPoint presentation on 'A Better Start Southend' be noted.

2. That the Executive Action Plan be approved.

759 Essex Success Regime Briefing

The Board considered a report of the Chief Officer, Southend CCG, which provided an update on the Mid and South Essex Success Regime, including current requirements for Sustainability and Transformation Plans (STPs) as part of the NHS Five Year Forward View.

The Board asked a number of questions relating to information sharing, the merger of hospitals and the sustainability of delivering the significant savings required. In response to these questions the Board noted the following:-

- Information/data sharing – The aim was to improve the sharing of patient information across health and social care and provide a full and complete shared care record of the patient. Nationally the Department of Health and NHS Policy was to move towards the provision of digitised records at the point of need and £1.3 billion had been designated nationally to facilitate digitised patient records across the health sector.
- Merger of Hospitals – Assurance was provided that the three hospitals in the region were not merging. A Joint Committee consisting of representatives of the three hospitals had been set-up to provide greater collaboration and does not replace the statutory responsibilities of the three hospitals.
- Provision of primary care – It was noted that there were two major workstreams in respect to primary care and there was a significant amount of work to do in this area which will be taken forward as one of the six areas for change identified under the Success Regime.
- Sustainability/Further Integration of CCGs – The Board was advised that there was not nationally an appetite for further integration of CCGs. It was noted that if the CCGs were merged there would not be the necessary clinical leadership and focus on local needs. However, it was recognised that there were areas that the CCGs could work more effectively together and one of the options being explored as part of the Success Regime was looking at how each CCG could take a lead on a specific issue.
- Investment in Prevention – This was a key area of focus and was included in the six areas of change to sustain local services and improve care as part of the Success Regime.
- Engagement and Consultation – The next steps and milestones were referred to. The options will be refined between end of May and early September 2016 with a view to consultation on service changes, etc between September to December 2016.

Resolved:

That the report and update on the Mid and South Essex Success Regime, including the requirements for STPs as part of the NHS Five Year Forward View, be noted.

760 Better Care Fund Plan 2016/17

The Board considered a report of the BCF Project Manager which outlined the requirements and planning process of the Better Care Fund (BCF) for 26/17; presented the draft BCF Plan for 2016/17 and sought agreement to delegate authority to the Corporate Director for People (SBC), the Chief Officer Southend CCG in consultation with the Chair and Vice-Chair of the Health & Wellbeing Board to make any minor amendments to the plan and enable any updates and the final BCF plan for 2016/17 to be submitted to NHS England by 25th April 2016.

Resolved:

1. That the planning requirements and process for the BCF 20-16/17 be noted.

2. That the draft BCF Plan for 2016/17 be noted.

3. That authority, to make any required minor amendments and sign off the final BCF Plan for 2016/17, be delegated to the Corporate Director for People (SBC), the Chief Officer Southend CCG in consultation with the Chair and Vice-Chair of the Health & Wellbeing Board.

761 Progress Report

The Board considered the following reports from the Health & Wellbeing Board Advisor:-

(a) Mental Health actions actions which would feed into the Mental Health Strategy;
(b) Progress report against the HWB Performance Indicators;
(c) The Health & Wellbeing Board Forward Plan for 2016/17.

The Board was also informed that the Community Recovery Pathway actions were feeding into the integrated care work and that a formal update would come to June's Board meeting.

Resolved:

That the reports covering the above matters be noted.

Chairman: _____

Southend Health & Wellbeing Board

Agenda Item No.

4

(Joint) Report of Simon Leftley, Director for People

……

to

Health & Wellbeing Board

on

15th June 2016

Report prepared by: Glyn Jones, Learning Disabilities Commissioning Manager, Integrated Commissioning Team, Southend-on-Sea.

For information only	X	For discussion		Approval required	

Transforming Care

Part 1 (Public Agenda Item) / Part 2

---

1. Purpose of Report

1.1. To update the Health and Wellbeing Board on Transforming Care

2. Recommendations

2.1. To note and approve the Transforming Care Partnership (Previously Pan Essex) Action Plan and the continuing work of partners.

3. Background & Context

3.1. Transforming Care is a national programme to improve people's lives in the wake of the events at Winterbourne View where people with learning disabilities and autism were badly treated and bullied. This was shown in a BBC Panorama episode. Many of these people demonstrated challenging behavior. These events took place in 2011. Winterbourne view was an independent hospital in Gloucestershire and many people were placed there, far from their own home and community.

3.2. A national programme with the objective of helping people stay within their own communities and not be sent to hospitals inappropriately then began. However

things did not improve and people were still being placed in such institutions. This is largely because systems were complicated and partners found it difficult to work together. This has led to a renewed effort in a National Programme called Transforming Care.

3.3. As part of this renewed programme, NHS England has facilitated the setting up of 46 local area partnerships. One of these partnership areas comprises: Southend-on-Sea; Essex; and Thurrock. This is the Pan Essex Transforming Care Partnership Board.

3.4. The Pan Essex Transforming Care Partnership Board includes Southend-on-Sea Borough Council; Thurrock Borough Council, and the 7 CCGs across Pan Essex, including Southend CCG. Simon Leftley is the Chair of this Partnership Board and Melanie Craig is the deputy. The Partnership Board will have a line of sight of local activities and will seek to influence improved services and community response for people with Learning Disabilities and Autism.

3.5. A programme team and consultation structure has been set up under that Board which comprises commissioners, professionals and people with Learning Disabilities and autism from those geographical areas. The approach to the development of services is one of co-production.

3.6. The Partnership Board is charged with developing a 3 year plan which: Seeks to prevent behavior that challenges; helps people to stay in their local communities; and reduces the need for often inappropriate inpatient beds. It also has a programme to discharge people from secure hospitals where their needs can be better met more locally and in the community. (There is planned reduction of Inpatient Beds across Pan Essex from 73 to 46).

3.7. The plan should show a vision and set of actions to achieve these goals. Much improvement is to take place in local communities/areas with better commissioning and provision, and where it makes sense to do so partners should work together across Pan Essex to commission specialist services. Commissioning is fragmented with commissioning for secure accommodation also being undertaken at the regional tier being undertaken by NHS England.

3.8. The Pan Essex Partnership Board submitted a draft plan in April 2016. This was the only plan in the East of England to achieve a green rag rating. This showed that the partners in the Pan Essex area had a clear vision and were on track. A draft version of the Pan Essex plan has come to a previous Health and Wellbeing Board. The plan in the Annex is an updated version of this plan for its July submission to point the direction for the next 3 years.

3.9. The key points of the plan and where commissioning is being undertaken are:

- The commissioning of enhanced local provision from local providers with better and more responsive crisis support that helps people to stay local and not demonstrate behavior that challenges. This includes more appropriate use of some inpatient services such as Assessment and Treatment Units.

- Improved integration in local areas of health and social care services. Services to be more seamless.

- The commissioning of a service for people who have offended or are at risk of offending. A pilot service is being commissioned to provide a service across Pan Essex.

- The commissioning of appropriate accommodation to meet people's needs

3.10. The Transforming Care Board is also seeking to influence Mental Health Commissioning and Provision on a Pan Essex and local basis to better meet the needs of people at risk of behavior that challenges. This about making sure that care is provided in a way that best suits individuals and for some people with Learning Disability and Autism this may well be in mainstream mental health services.

3.11. The scope of Transforming Care includes all people with Learning Disabilities and Autism and particularly those at risk of demonstrating behavior that challenges. Because this is about 'risk' and often in the community, the numbers are difficult to estimate. However, for Southend-on-Sea residents:

- There are less than 5 people who are being reviewed to find the most appropriate setting for them as part of 'Care and Treatment Reviews' (Discharge from hospital).
- There are no people requiring Forensic/Offending services that require Ministry of Justice Supervision in the Community.
- There are a few children in Tier 4 children and young people's secure facilities outside of Southend-on-Sea.

Across Health and Social Care within Southend-on-Sea we need a better understanding of individuals and a clear understanding of their needs for them to live as close to home as possible. This is about improving commissioning both within Southend-on-Sea and wider though joined up knowledge about people and services.

3.13 The next steps for the Pan Essex Programme Team include the:

- The development of specific pathways in designing the model
- The procurement of services
- The development of collaborative activity in relation to a number of areas, including training/workforce development and housing; improved discharge process both locally and pan Essex.
- Discussions around the pooling of budgets and areas for further collaboration including where efficiencies can be made.
- Better aligning approaches for Children and Young People which reduced later behavior that challenges. This includes the improved co-ordination of Transitions, as children and young people become adults.
- Development of specific autism streams of work.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- Nine HWB Strategy Ambitions (listed on final page)

Transforming Care contributes to some of the Strategy Ambition. In particular it contributes to 3, 5, 6 and 9.

- 3: Improving mental wellbeing
- 5: Living independently
- 6: Active and healthy ageing
- 9: Maximising opportunity

- Three HWB "Broad Impact Goals" which add value;
  a) Increased physical activity (prevention) *No direct impact.*
  b) Increased aspiration & opportunity (addressing inequality). *Helping people to stay in their communities and playing a part in that community.*
  c) Increased personal responsibility/participation (sustainability). *Enhancing opportunities for personal responsibility in the community balanced with effective support.*

5. Reasons for Recommendations

5.1. To approve the plan and the work of partners..

6. Financial / Resource Implications

6.1 Financial implications are being worked through in the context of a Finance work stream. Bids have been made as part of our submission/plan, including for Forensic/Offender service mentioned above. It is unlikely that all bids will be successful which will mean seeking efficiencies in service provision. More detailed work is being done on this by the Transforming Care Partnership Board in worksteams.

6.2 Across the whole Pan Essex system £101 million is spent per annum. Early analysis of cost pressures indicates that the short term cost pressure across Pan Essex is £9.2 million (Capital and Revenue) and for which bids have been made. Going forward beyond 18 months, there is an ongoing cost pressure of £3.5 Million per annum. (Reflecting the higher cost of packages in the community). This can be set against potential income from dowries (money following the patient from NHS England commissioned services), but which will not meet the full cost pressures.

7. Legal Implications

7.1. At present there are no specific legal implications.

8. Equality & Diversity

8.1. The developments promote equality and diversity. The intentions around Transforming Care are to develop appropriate person centred services and there are no discernible impacts on protected characteristics.

9. Appendices

9.1. The Pan Essex Transforming Care Plan is attached.

HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life a) Reduce need for children to be in care b) Narrow the education achievement gap c) Improve education provision for 16-19s d) Better support more young carers e) Promote children's mental wellbeing f) Reduce under-18 conception rates g) Support families with significant social challenges	**Ambition 2. Promoting healthy lifestyles** a) Reduce the use of tobacco b) Encourage use of green spaces and seafront c) Promote healthy weight d) Prevention and support for substance & alcohol misuse	**Ambition 3. Improving mental wellbeing** a) A holistic approach to mental and physical wellbeing b) Provide the right support and care at an early stage c) Reduce stigma of mental illness d) Work to prevent suicide and self-harm e) Support parents postnatal
Ambition 4. A safer population a) Safeguard children and vulnerable adults against neglect and abuse b) Support the Domestic Abuse Strategy Group in their work c) Work to prevent unintentional injuries among under 15s	**Ambition 5. Living independently** a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	**Ambition 6. Active and healthy ageing** a) oin up health & social care services b) educe isolation of older people c) hysical & mental wellbeing d) upport those with long term conditions e) mpower people to be more in control of their care
Ambition 7. Protecting health a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	**Ambition 8. Housing** a) Work together to; ○ Tackle homelessness ○ Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	**Ambition 9. Maximising opportunity** a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment

Agenda Item No. 5

Southend Health & Wellbeing Board

Joint Report of
Simon Leftley, Corporate Director for People, SBC
Melanie Craig, Chief Officer, Southend CCG

to
Health & Wellbeing Board
on
01 August 2016

Report prepared by:
Jacqui Lansley, Joint Associate Director of Integrated Care Commissioning
Nick Faint, BCF Project Manager

For discussion	X		For information only	X		Approval required

Locality Approach for Southend

Part 1 (Public Agenda Item)

1 Purpose of Report

The purpose of this report is to;

1.1 Provide Health & Wellbeing Board (HWB) with a briefing and update regarding the formation of commissioning Localities for health & social care in Southend on Sea; and

1.2 Demonstrate how an integrated complex care co-ordination service might fit with the Locality approach;

2 Recommendations

HWB are asked to;

2.1 Discuss and note the locality approach to be adopted and that it will be based on 4 Localities in Southend on Sea.

3 Background

3.1 The vision for the Locality approach is that a Locality is the central place where integrated health and social care interventions are delivered and co-ordinated, this represents a shift away from the hospital and into the community.

3.2 Each Locality will utilise existing (or new) NHS / Council estate to provide primary, community and social care services working in a multi-disciplinary team environment and a complex care service for a risk stratified cohort of

patients and carers. Further, the locality approach is aligned to the Essex Success Regime.

3.3 A complex care co-ordination service has been developed and is currently subject to approval. The service has been developed so that it is aligned to the Locality approach. It will support primary care and community services in ensuring patients receive the right care at the right time and in the right place.

3.4 The Locality approach and integrated services that exist within are aligned to the actions from the pre board discussion items held by HWB regarding Mental Health, Community Recovery Pathway and Integrated Childrens service.

3.5 During the course of quarter 1 2016 / 2017 the Joint Associate Director of Integrated Care Commissioning led an engagement process with the members of the Clinical Executive Committee SCCG to introduce the detail behind the Locality approach and the complex care service. The team has also engaged with system leaders from both commissioners (SCCG and the Council) and providers (SBC, SUHFT and SBC) in developing the Locality approach.

The proposed model

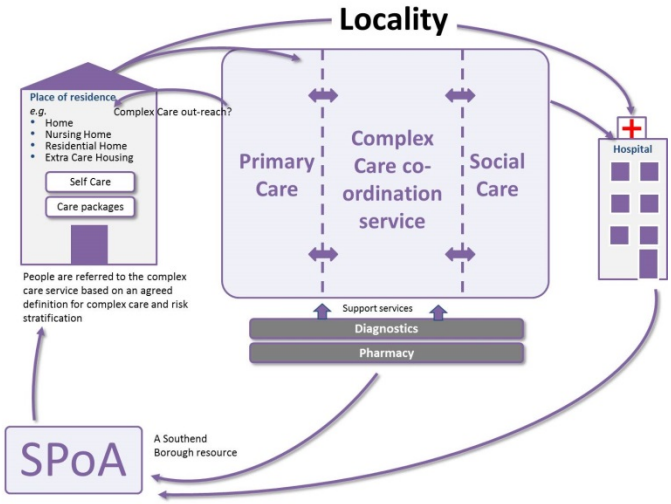
3.6 A number of factors have driven the move towards integrated care provision across Southend-on-Sea. Published in October 2014 by NHS England, The NHS five Year forward view (5YFV) sets out a positive vision for the future based around seven models of care.

3.7 To further help support the transition towards commissioning integrated care, it was agreed in May 2016 (see Appendix 1a & b) that the number of localities within Southend is 4 (four) which work around circa 50,000 residents or patients, as recognised as best practice by the Essex Success Regime.

3.8 Under this new care model outlined in the 5YFW, GP group practices will expand bringing nurses and community services, hospital specialists and others to provide integrated out-of-hospital care. These practices will shift a majority of outpatient consultations and ambulatory care to out-of-hospital settings. To support the 5YFV approach, most recently, the Essex Success Regime has highlighted the requirement for health and care economies to join-up and address problems systematically, rather than in isolation.

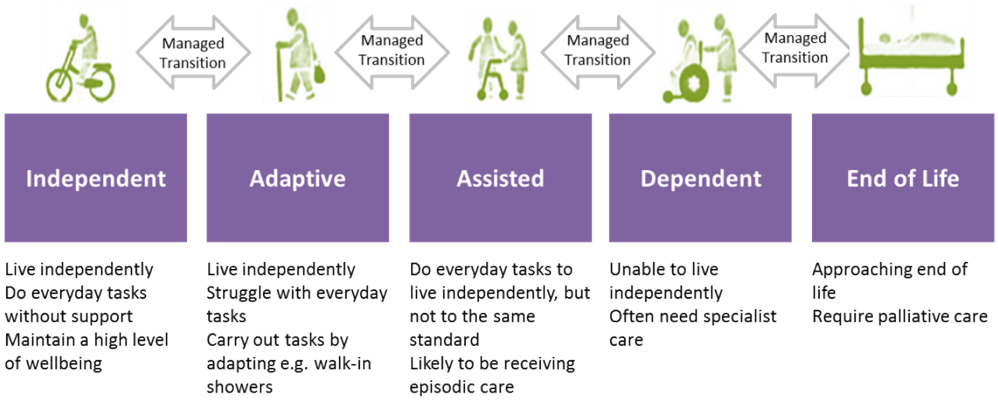
3.9 The drive for matrix working between health and care services has given rise to the opportunity to develop Localities (as demonstrated in the diagram below), where a combination of primary, community and social care can co-locate or integrate.

The Locality approach

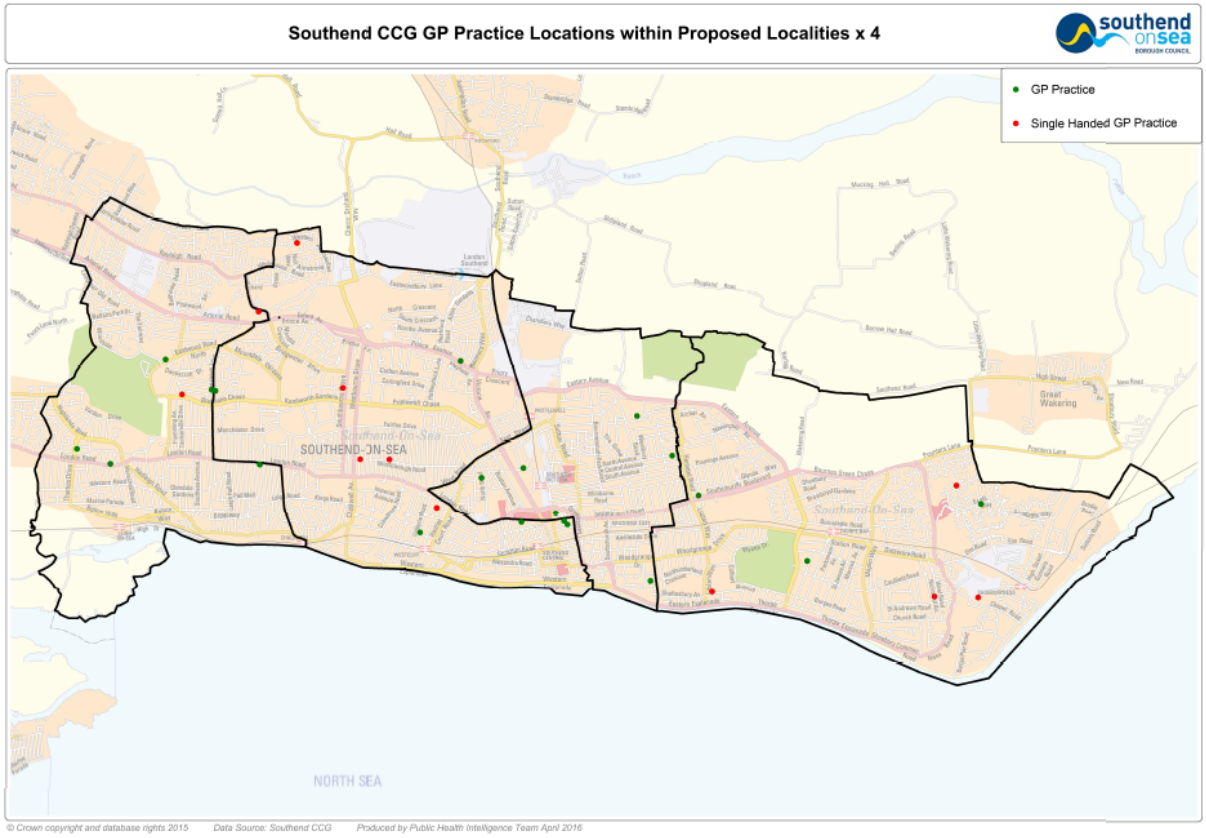


3.10 Closely aligned to a Locality approach is the transitional pathway through which patients will be assessed. Patients with complex care needs – measured through a combination of a frailty index and integrated health and social care data – are those with multiple long term conditions. The best place for the provision of health and social care to these patients should not be the hospital but through the Locality.

The transitional pathway



3.11 The 4 Localities for Southend are represented below;



Timeline for implementation

3.12 The agreed Locality approach will be implemented across Southend through a staged approach;

3.12.1 There will be a period of testing, which includes; the clustering of GP practices into a Locality framework; the further development of MDTs; the co-location of SPoR and the Access team; and locating a social care worker at a GP practice to embed the way in which health and social care work together.

3.12.2 Implementation of full locality approach, alignment with wider transformation programmes such as Adult Social Care redesign and community health services.

3.13 The four Localities are expected to be fully operational by April 2017.

Complex Care Co-ordination service

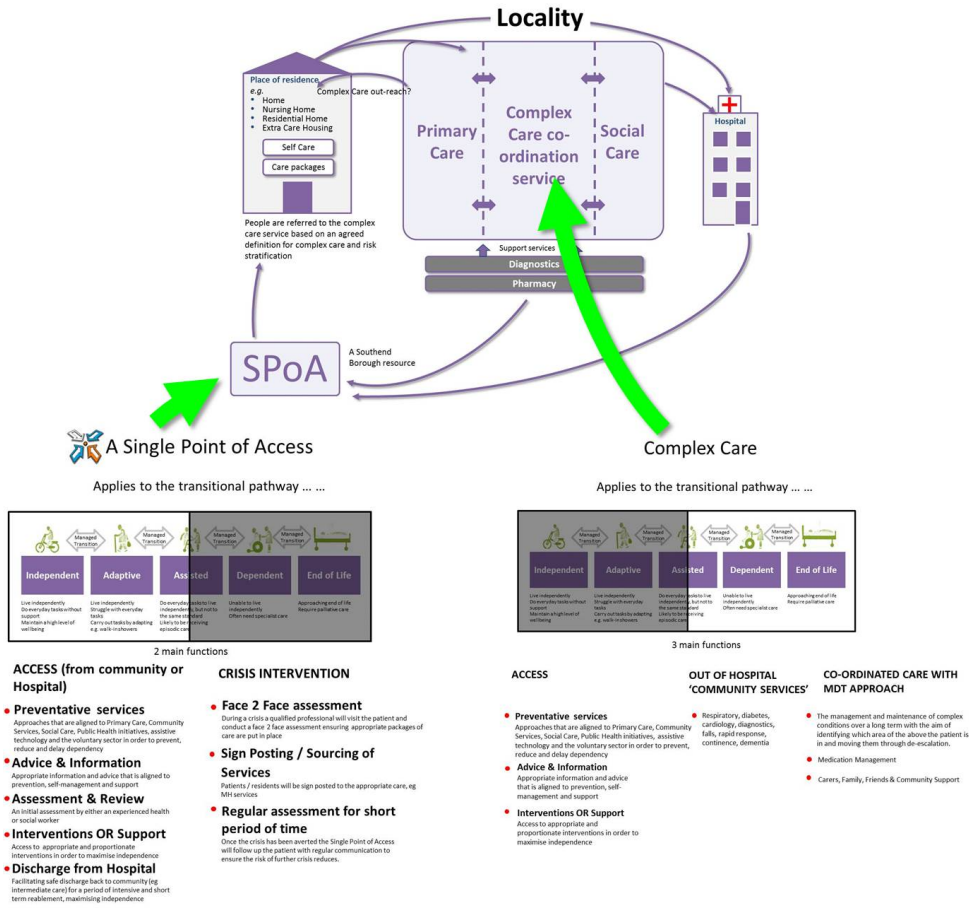
3.14 Within each locality there will be the provision of primary, community and social care. The complex care service will be delivered to support these services ensuring that 'complex care' patients have their care co-ordinated and delivered so as to avoid unnecessary interactions within the system.

3.15 The aim / vision of the complex care service is to provide those identified with complex care needs with a service that co-ordinates their health and social care provision based upon existing services and need. Their care is currently provided in an uncoordinated and inconsistent manner which is not tailored to

the specific needs of the patients nor is it most efficient use of resources. The aim of the service is to ensure care needs are assessed, care plans are co-designed through an established MDT approach and care is delivered in a co-ordinated way.

Alignment with the Locality Approach

3.16 The diagram below provides an over view of the complex care co-ordination service and how this interfaces with the Locality Approach and the transitional pathway.



3.17 A complex care co-ordination service will be in operation from 1st October 2016 across the borough of Southend to provide a co-ordination of existing health, social care and community services for an identified and risk stratified complex care cohort.

The next steps – transformation of Community Services

3.18 Following the implementation of the Locality approach we will undergo a process of consultation and engagement with commissioners, providers and patient groups to redesign community services so that they are fully aligned to the complex care co-ordination service and patient needs.

4 Health & Wellbeing Board Priorities / Added Value

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

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

4.2 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

4.3 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.

5 Reasons for Recommendations

5.1 As part of its governance role, HWB has oversight of the Locality approach.

6 Financial / Resource Implications

6.1 None at this stage

7 Legal Implications

7.1 None at this stage

8 Equality & Diversity

8.1 The Locality approach should result in more efficient and effective provision for vulnerable people of all ages.

9 Appendices

Appendix 1a & b – Options appraisal for Southend Locality approach	Appended separately

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

This page is intentionally left blank

Locality Approach for Southend

Report of

Sadie Parker (Associate Director Primary Care & Engagement, SCCG)
Jacqui Lansley (Joint Associate Director for Integrated Care Commissioning)

to

Locality Transformation Group

on

3rd May 2016

Report prepared by:
Paul Taylor, SBC
Andrea Bann, SCCG

For discussion	X	For information only		Approval / Action required	X

Date of the meeting	3rd May 2016
Sponsoring LTG Member	Jacqui Lansley
Purpose of Report	To approve the options appraisal and agree a number of localities for Southend
Recommendation	The Senior Officer Transformation Oversight Group is asked to Approve the recommendations
Previous LTG Dates	6th April 2016
Other committees / executive that this paper has gone to	n/a
Other committee / executives that this paper will go to	Clinical Executive 12th May 2016

1 Purpose of Report

The purpose of this report is as follows;

1.1 to provide LTG with an update to the development of the Locality Approach for Southend.

1.2 to provide LTG with an opportunity to discuss, feedback and agree the proposal for Locality Approach.

2 Recommendations

LTG are asked to;

2.1 sign off the recommendations; and

2.2 recommend that the paper (with any amendments) is presented to Clinical Executive Committee on 12th May 2016.

3 Background & Context

3.1 Introduction

This report is to provide the Senior Officer Transformation Oversight group with an options appraisal around how the commissioning localities will be formed for health & social care and a recommendation on the number of localities that would be suitable for Southend.

3.2 Background

The vision for the locality approach is that a locality is the central place where integrated health and social care interventions are co-ordinated, this represents a shift away from the hospital and into the community.

Each locality will utilise existing (or new) NHS / SBC estate to provide a complex care service for a risk stratified cohort of patients and carers. The locality (aligned to the redesign of adult social care) would also provide primary care services working in a multi-disciplinary team environment. Further, the locality approach is aligned to the Essex Success Regime.

In support of the work we are partnered as a system to deliver Better Start, a BIG Lottery funded programme working to enhance universal preventative services for Early Years and Early Years Public Health, to improve the life chances of Southend's children. A workstream within Better Start is focused on providing a 'family friendly' GP service based at practices. The service will look to build on existing and develop community relationships to provide integrated services in response to the health and care needs of the locality populations.

3.3 Report

A number of factors have driven the move towards integrated care provision across Southend-On-Sea. Published in October 2014 by NHS England, The NHS five Year forward view (5YFV) sets out a positive vision for the future based around seven models of care. One of these models outlines the need for multi-specialty community providers (MCPs). To further help support the transition towards commissioning integrated care,

this report is to identify the number of localities within Southend which work around 50,000 residents or patients.

Under this new care model outlined in the 5YFW, GP group practices will expand bringing nurses and community services, hospital specialists and others to provide integrated out-of-hospital care. These practices would shift a majority of outpatient consultations and ambulatory care out-of-hospital settings. To support the 5YFV approach, most recently, the Essex Success Regime has highlighted the requirement for health and care economies to join-up and address problems systematically, rather than in isolation. Monitor (2015) states:

The health economy faces quality, financial and operational challenges which put the sustainability of health and care services at risk. As well as the financial situation across the whole health and care economy, it will also look at governance and other issues. Across Essex in particular there are workforce challenges across primary and secondary care in the local health economy. The Success Regime will aim to produce a single strategic plan for the local health and care system, shared by all local stakeholders.

The drive for matrix working between health and care services has given rise to the opportunity to develop localities, where a combination of social work, primary and secondary care services can co-locate or integrate. Southend Clinical Commissioning Group (SCCG) have identified potential asset based sites across West, Central and East Southend. Clinical commissioning and Adult Social Care are currently undergoing transformational change and so it is now timely to consider the options for social work staff to be co-located or integrated with these sites, which will have the potential to:

- Increasing efficiencies across the health and care economies;
- Coordinate the commissioning of services to support the demographic changes, increased multi-morbidity, clusters of risk factors and the rising needs of frail older people;
- Facilitate the development of high standard out-of-hospital services;
- Improve outcomes for adults who use services;
- Support the prevention agenda with communities;
- Develop integrated assessment, care planning and joint approaches to health and social care practice;
- Align, where possible, to children services, schools and other health services *e.g.* mental health to drive towards a position of working with families and communities, rather than discrete sets of individuals.

Primary Care services in Southend are currently delivered by 35 GP practices spread over 30 locations; 38 Pharmacies, of which 7 open for extended hours; 22 dental practices and 22 Ophthalmologists. SCCG commissions community and Mental Health services (MH) from South Essex Partnership Trust (SEPT). These services include Adult Intermediate Care, Rapid Response Service, Continence Services, Podiatry Services, Occupational Therapy (OT), Mental Health (MH) and District Nursing (DN).

A number of Southend GP practices are based in converted residential properties. There are modern primary care centre facilities in North Road, Valkyrie Road and in Leigh, with additional investment from NHS England being used to develop two new primary care centres in Shoebury and St Luke's and to refurbish the Kent Elms Health Centre. These primary care centres will be a focus for our locality approach to integrated service provision in the borough.

The national average list size of a GP practice is around 7000 patients. In Southend, two thirds of our practices are smaller than this with 10 practices being operated by a single GP. Many of our GPs in these smaller practices are approaching or at retirement age and some operate with high ratios of patients, using locum GPs on a sessional basis to add capacity. This leads to concern about the stability and sustainability of local general practice and its ability to respond to changing policy for general practice, such as providing wider primary care at scale, moving more services into the community and providing services across seven days. The size of our practices range from Dr Velmurugan's surgery at 995 patients to the Queensway Medical Practice at 22,004 patients.

There is wide variety in the quality of and access to general practice in the local area. We look at referral rates, emergency admissions, A&E minors attendance, GP out of hours services usage, dementia diagnosis rates, prescribing and many other sources of information to triangulate data on practices. As we move to co-commissioning over the next few months, this data will inform our approach to monitoring GP practices and managing the implementation of our locality approach. One area we identified as a priority was the longstanding problems in accessing quality primary medical services for residents of care homes.

Southend on Sea has a higher than average density of care home provision and practices, particularly in the Westcliff area, and are struggling to provide the level of care needed by residents of care homes. We have procured and are currently mobilising a new pilot for a dedicated GP practice for residents of care homes across the borough. This practice will provide an enhanced level of coordinated and proactive care to its patients with a view to improving the quality of their care, reducing health crises through the implementation and regular monitoring of personal care plans, thus reducing the number of emergency admissions, A&E attendances and ambulance attendances for this group of patients.

There is currently some joined up practice with DN, OT (and other allied health professionals) and MH community services. Social workers are also attached to GP surgeries and attend Multi-Disciplinary Team (MDT) meetings once a month. However, there is more that can be done to prevent, reduce and delay the long term care needs.

Part of the solution could be the requirement to explicitly integrate community health services (GPs, DNs, MH and so on) rather than continue with a model which is largely fragmented and lacks the consistency of a health and social care approach.

Nationally, people with long-term conditions account for 50% of all GP appointments and 70% of hospital bed days, but there is mounting evidence that this heavy reliance on acute and long-term care is not the best way to manage patients with more complex need and is poor value for money. This is where social work can contribute: whereas historically the medical care model may have tended to arguably foster dependency, the social work model aims to promote independence. Early indications are that reductions of 15 – 20% of adults in residential/nursing home placements and 20 – 30% of patients in A&E attendance and hospital bed occupancy are achievable among people deemed to be at "high risk".

These figures are borne out by five case studies presented in the background papers of this joint report where GP-social worker partnerships have started to save money desperately needed elsewhere by listening to what outcomes people want.

There are three options highlighted below which identify the advantages and disadvantages to both the heath and care economies, taking into consideration the following factors:

- Demographics currently & projected
- Deprivation across each ward
- The current organization of children's teams within social care
- Current and likely future staffing numbers across East/West localities for social care
- Geographical size of each locality
- The potential rationalization of GP surgeries within each locality
- Number of residents attached to each GP surgery in each locality
- Adult social care activity data including number of assessments, safeguarding adults/children,
- SUHFT Hospital data (non-elective rates in each area/A&E attendance)
- Community Health services are co-hosted by Southend CCG and Castle Point and Rochford CCG.

There is potential to develop a commissioning model based on ward population as opposed to registered patient population. By aligning our clinical commissioning needs with the Southend Borough Council and other community providers we can work collaboratively to develop care models which will have a direct impact on the ward population taking into account the complexity of needs arising from poverty, housing and social care needs. This integrated approach will in turn help to facilitate the development of systemic change with other system stakeholders.

4 Options

4.1 Option 1: Remain the same

Adult social care is currently divided into two localities with a separate review team, hospital team and two entry points (Access & SPoR). Resultantly, there is limited preventative practice with most of social work time reacting to referrals with most time spent completing assessments, safeguarding enquiries, Mental Capacity Act (2005) assessments and Best Interest Assessments.

There are currently no primary care localities across Southend. All Primary Care providers operate in isolation of one another; this includes GP, Pharmacies, Dentist and Ophthalmologists, by way of independent contracts or NHS Regulations.

Advantages	Disadvantages
Continuity of care and outcomes will be supported in the short-term, minimizing change and distribution to the system currently in place.	The social care locality teams are largely reactive in nature which results in a lack of prevention, reduction in long-term care needs and an inability to forge close working relationships with health colleagues, communities and other assets in their area. The large size of the locality is also obstructive and presents a challenge to connect groups, GPs and other community provision and support.
Patients will remain registered with the same GP and continue to receive the perceived	Patients will continue to face issues accessing Primary Care and other local

same level of care.	community services
Care will continue to be delivered in the same way it always has been.	Systemic change cannot be achieved unless all stakeholders work together to realize the benefits of integrated working and the delivery of sustainable patient care.
Managing patients' needs geographically by locality will ensure you integrate services where they are needed the most.	GPs will continue to face issues in managing patients with complex care needs.

4.2 Option 2: 3 Localities (East, Central and West – Appendix 2)

Historically, South East Essex Primary Care Trust (SEE PCT) split GP provision into three localities. By reintroducing three localities based on the former SEE PCT boundaries it may be easier to win over 'hearts and minds' when working with the practices to support radical system change.

Ward population distribution across the three localities provides a slightly different picture. In terms of population the West locality is 1.7 times larger than the East locality, but the Central locality is just over 1.6 times larger than the East locality.

Locality	Registered Patients	Ward Count
West	62,000	70,000
Central	87,000	66,000
East	36,000	41,000

Areas of Multiple Deprivation Top 10%

Locality	Ward
West	2
Central	8
East	5

Advantages	Disadvantages
Greater economies of scale will allow greater numbers of social workers in each locality to provide the necessary cover (sickness, holiday), relative to option 3 which has more localities.	The central locality presents with high levels of multiple deprivation in comparison to East and West localities and twice the number of adults allocated to GPs (approx. 87,000 people vs. 62,000 and 36,000 people).
Practitioners will need to link more closely with various health clinicians and a variety of GPs because of the larger geographical	High levels of multiple deprivation within the central locality present a challenge to meeting the complexity of needs arising from poverty, housing, health and social care

area relative to option 3	needs and the competing demands from different GP practices.
Already aligns with Early Years teams which are based in 3 localities at present	The concentration on adult health and social care will have less of an advantage in the short-medium term.
By aligning health needs with the ward demographics and deprivation, there is greater opportunity to target the individual needs of the area e.g. respiratory issues, high rates of readmission, housing.	The social care data (appendix 5) highlights that there are 2274 adults open to adult social care teams in the proposed Central locality compared with 1499 (35% less than central) in West and 1164 in East (51% less than central).
	Does not support the development of self-sufficient communities / a community asset based approach.

4.3 Option 3: 4 Localities (Appendix 3a + 3b Locality 1, 2, 3 & 4) aligned with GP centres/surgeries

Locality	Registered Patients	Ward Count
West	53,500	38,500
Central West	52,000	40,000
Central East	55,500	34,000
East	36,000	41,500

Areas of Multiple Deprivation Top 10%

Locality	Wards
West	2
Central West	3
Central East	5
East	5

Advantages	Disadvantages
It will provide health and social workers with greater understanding of the localities, as there will be greater geographical clustering with the communities and services which will benefit patients.	Patients will need to adapt to the changing model of services.
There will also be more equality in terms of need between each of the localities so that patients can receive a more personalised	Aligning with GP surgeries may present as problematic as there will be a proportion of adults who are registered with the GP but

service, rather than having a central locality which is heavily in need of health and social care services and therefore resources will be spread more thinly.	who reside elsewhere in the Borough (figures unknown at present). Although this would be the case with any option
The West of Southend tends to have a high number of care homes, relative to the other parts of the Borough and so this model also supports a better distribution of locality teams.	Having four localities will create a need for an additional senior social worker compared with option 2 as there will be an additional locality.
Organizationally, having four localities is in some respects is easier to manage as each social care team manager would have one senior practitioner supporting one of the localities.	A reduction in numbers of staff per locality will dilute the diversity and specialist knowledge.
At the present time, adult social care is structurally misaligned to the needs of the local population and a lack of operational management across East and West localities are causing problems in managing and leading the service.	It will be more difficult to manage staff sickness/absenteeism although this can be mitigated by having a team manager above two localities so staff can move interchangeably between localities, depending on demand in each locality.

5 Conclusion / Recommendation

5.1 The recommendation is for option 3 (4 localities) based on the following reasons:

- The data analysis conducted on both health and social care needs supports the transformation into 4 localities, i.e. the services delivered to a patient through their journey support a 4 locality approach;
- The size of the localities highlighted in option 3, social workers will be able to develop stronger relationships with the community and will be able utilize the assets more effectively;
- There is a more even distribution of health, social care, educational and housing needs compared with option 2, which has a densely populated and deprived central locality with high levels of child protection and adult safeguarding issues; both health and social care will struggle to cope the level of demand in that locality.
- Since each area/ward and locality has their own individual challenges, interventions will be more targeted across the four localities – this advantage will be diluted with three localities; particularly a central locality with over 85,000 people registered with GPs. The data suggests the West often has high levels of Mental Capacity Act assessments (especially Chalkwell ward) due to the high numbers of residential/nursing care homes relative to the East of Southend.
- Greater distribution of demographic inequality across four localities is advantageous to option 3 since not all deprivation, poverty and complex need will be the responsibility of one locality to manage (i.e. the Central Locality).
- Physical accessibility will be improved for patients/adults using care services as there will be more locality teams and points of access to GP health centres (4 compared with 3) which will have a geographical advantage for Southend residents.
- Is aligned with the development required for SEPT community services.

The Senior Officer Transformation Oversight (SOTO) group reviews the three options outlined in this report and agree the preferred option.

5.2 Risks

Although option 3 will require one additional supervisory member of social care staff, it is acknowledged that this is needed due to the number of social care staff across all localities and the complexity of casework these teams will be managing. Any locality changes will require a system leadership approach which is developing in some areas of health and social care practice but still distant in others; this presents a challenge to develop enough trust across the systems for effective change.

NB: There are limitations on the quality of data on Carefirst (e.g. GP data on) and with CareTrak.

6 Appendices:

1. Option 1 map for current situation (2 localities);
2. Option 2 map for three localities;
3. Option 3 map for four localities
   3b – GP numbers for each of the 4 localities;
4. Indices of multiple deprivation across Southend-on-Sea (2015);
5. Option 2 data by GP registration:
   (a) Number of MCA2 completed across Southend-on-Sea
   (b) Number of Children known to Southend Borough Council
   (c) Number of open adult clients by area
   (d) Number of other agreements open to social care
   (e) Number of residential agreements by area
   (f) Number of Safeguarding Referrals
   (g) Number of adult clients with at least 3 assessments
6. Option 3 data by GP registration:
   (a) Number of Clients with at least 3 assessments by area
   (b) Number of Mental Capacity Act assessments by area
   (c) Number of children open to social care
   (d) Number of clients by area
   (e) Number of other agreements by area
   (f) Number of residential agreements by area
   (g) Number of adult safeguarding by area
7. Option 2 data by postcode:
   (a) Number of Mental Capacity Act assessments by postcode
   (b) Number of Children known to Southend Borough Council by postcode
   (c) Number of Clients open to adult social care by postcode
   (d) Number of other agreements by postcode
   (e) Number of residential agreements by postcode
   (f) Number of safeguarding referrals by postcode
   (g) Number of adult clients with at least 3 assessments
8. Option 2 data (non-elective admissions into secondary care):
   (a) Non elective admissions into hospital (2013-15) percentage increase;
   (b) Non elective admissions into hospital average
9. Option 3 data by postcode:

(a) Number of Clients with at least 3 assessments by area

(b) Number of Mental Capacity Act assessments by area

(c) Number of children open to social care

(d) Number of clients by area

(e) Number of other agreements by area

(f) Number of residential agreements by area

(g) Number of adult safeguarding by area

10. Option 3 data (non-elective admissions into secondary care):
    (a) Non elective admissions into hospital (2013-15) percentage increase;
    (b) Non elective admissions into hospital average

11. Percentage of people who had a limiting long-term illness/disability 2011 (Public Health)
12. Emergency Admissions into acute care from 2008 – 2013
13. Non-elective admissions, A&E attendances and emergency readmissions by patients MSOA
14. District Nurse allocations across Southend-on-Sea.

1. Background Papers

College of Social Work/Royal College of General Practitioners (2014) GPs and Social Workers: Partners for Better Care Delivering health and social care integration together: A report by The College of Social Work and the Royal College of General Practitioners.

Monitor (2015) *Essex to benefit from Success Regime* (Press Release) [online] Available at: https://www.gov.uk/government/news/essex-to-benefit-from-success-regime Accessed on: 15th January 2016.

This page is intentionally left blank

Appendices:

1. **Option 1 map for current situation (2 localities);**

2. **Option 2 map for three localities;**

3. **Option 3 map for four localities**
   3b – GP numbers for each of the 4 localities;

4. **Indices of multiple deprivation across Southend-on-Sea (2015);**

5. **Option 2 data by GP registration:**

   (a) Number of MCA2 completed across Southend-on-Sea
   (b) Number of Children known to Southend Borough Council
   (c) Number of open adult clients by area
   (d) Number of other Other agreements open to social care
   (e) Number of residential agreements by area
   (f) Number of Safeguarding Referrals
   (g) Number of adult clients with at least 3 assessments

6. **Option 3 data by GP registration:**

   (a) Number of Clients with at least 3 assessments by area
   (b) Number of Mental Capacity Act assessments by area
   (c) Number of children open to social care
   (d) Number of clients by area
   (e) Number of other agreements by area
   (f) Number of residential agreements by area
   (g) Number of adult safeguarding by area

7. **Option 2 data by postcode:**

   (a) Number of Mental Capacity Act assessments by postcode
   (b) Number of Children known to Southend Borough Council by postcode
   (c) Number of Clients open to adult social care by postcode
   (d) Number of other agreements by postcode
   (e) Number of residential agreements by postcode
   (f) Number of safeguarding referrals by postcode
   (g) Number of adult clients with at least 3 assessments

8. **Option 2 data (non-elective admissions into secondary care):**

   (a) Non elective admissions into hospital (2013-15) percentage increase;
   (b) Non elective admissions into hospital average

9. **Option 3 data by postcode:**

   (a) Number of Clients with at least 3 assessments by area
   (b) Number of Mental Capacity Act assessments by area
   (c) Number of children open to social care
   (d) Number of clients by area
   (e) Number of other agreements by area
   (f) Number of residential agreements by area

(g) Number of adult safeguarding by area

10. **Option 3 data (non-elective admissions into secondary care):**

    (a) Non elective admissions into hospital (2013-15) percentage increase;
    (b) Non elective admissions into hospital average

11. **Percentage of people who had a limiting long-term illness/disability 2011 (Public Health)**

12. **Emergency Admissions into acute care from 2008 – 2013**

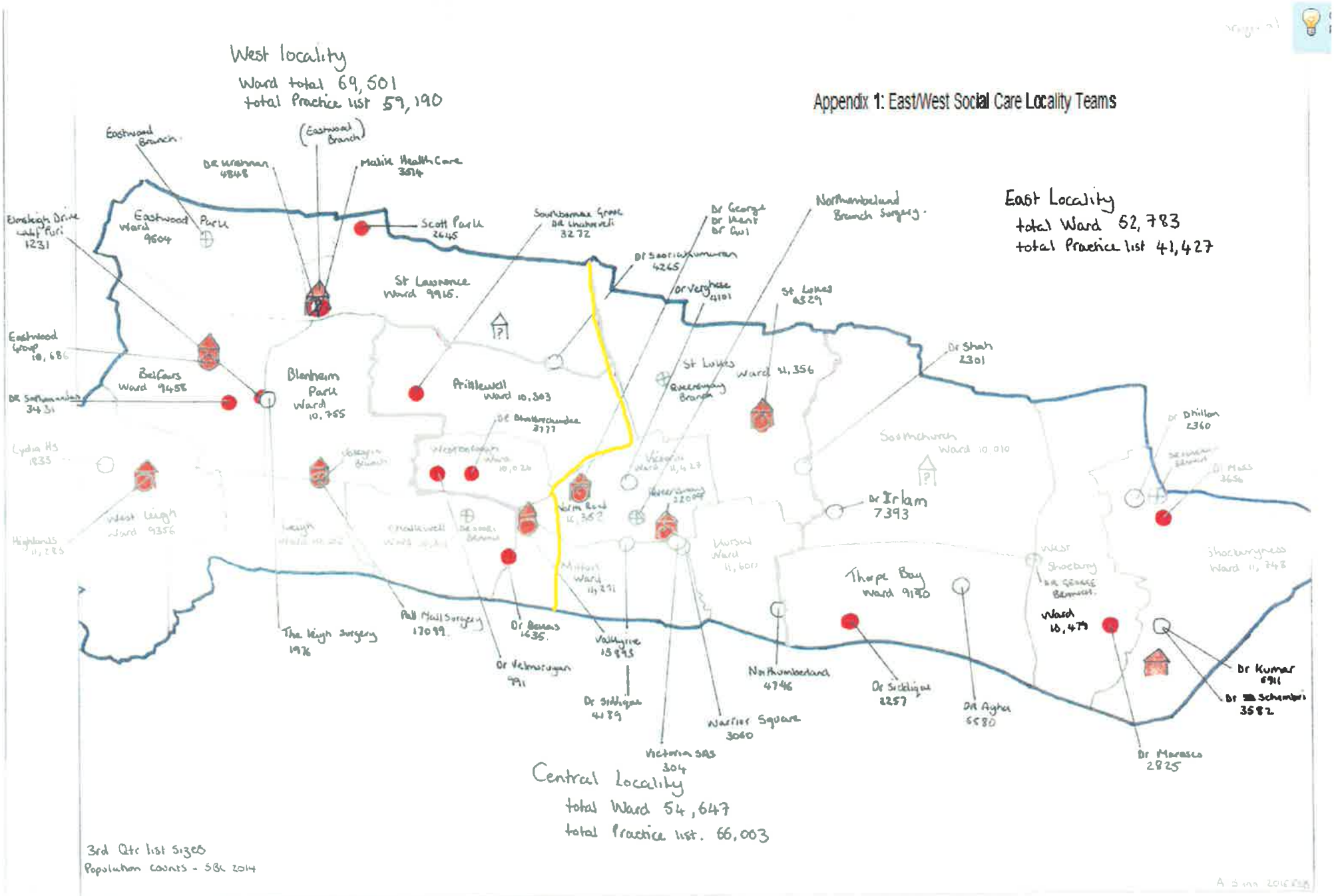
13. **Non-elective admissions, A&E attendances and emergency readmissions by patients MSOA**

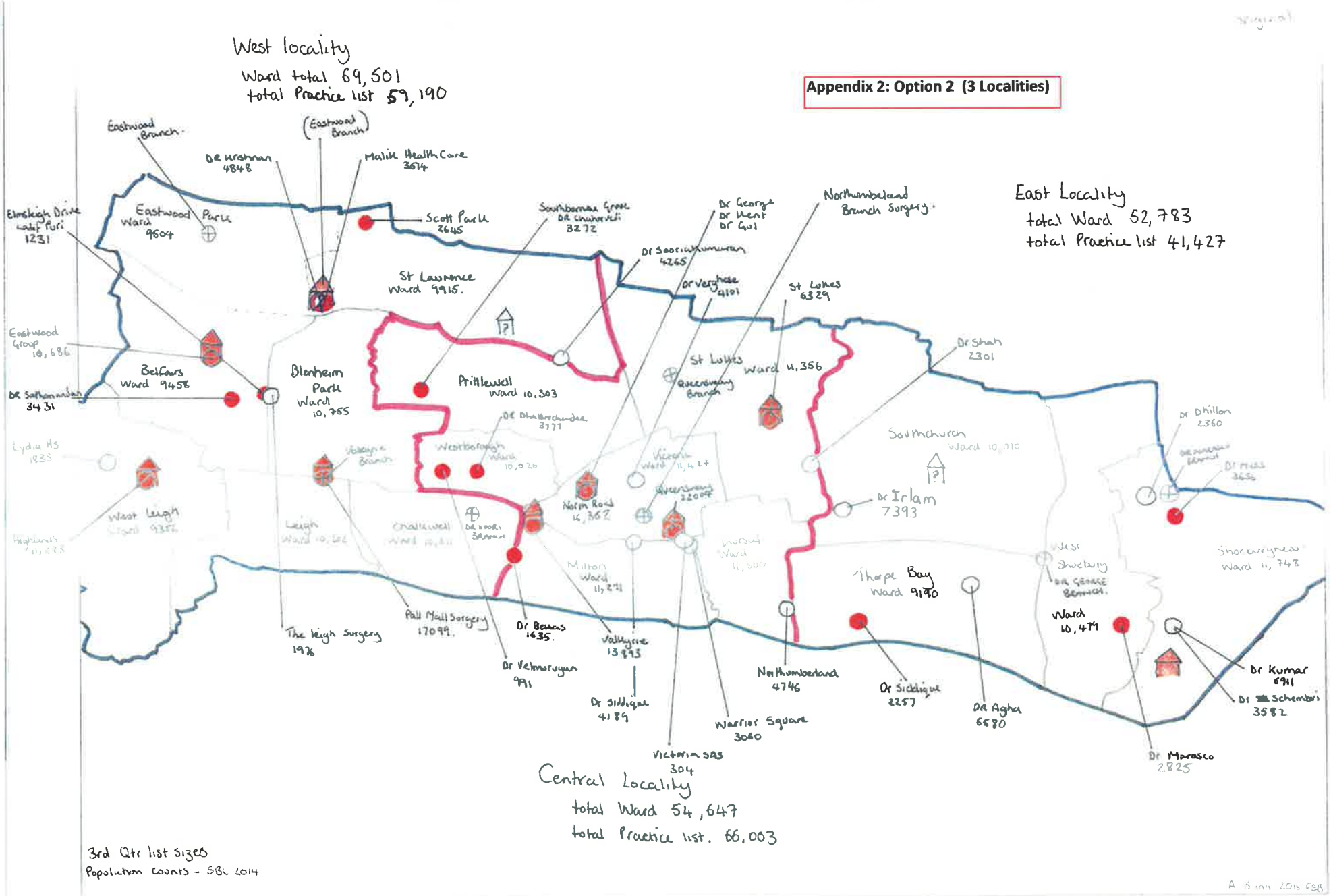
14. **District Nurse allocations across Southend-on-Sea.**

Background Papers:

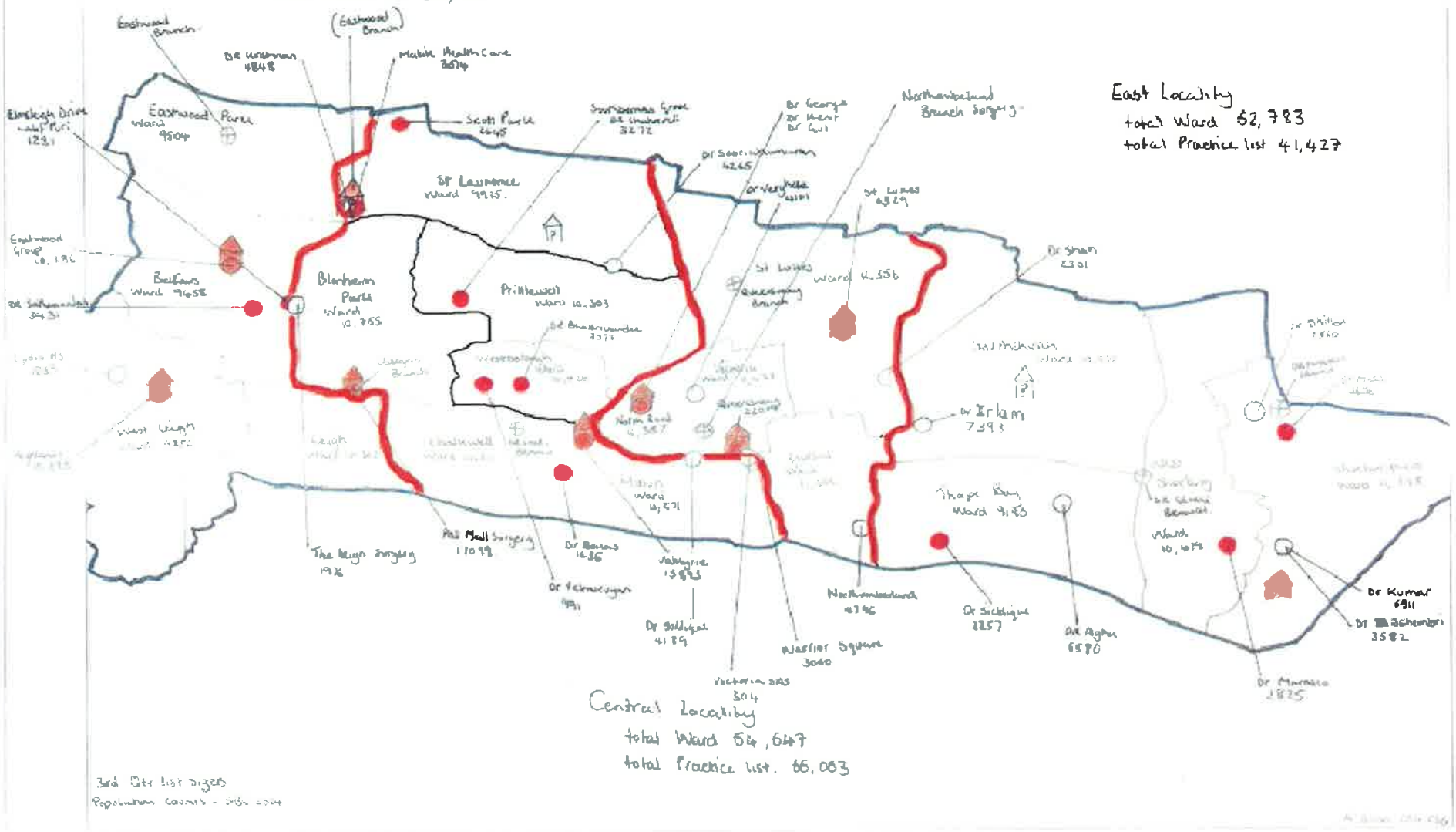
College of Social Work/Royal College of General Practitioners (2014) *GPs and Social Workers: Partners for Better Care Delivering health and social care integration together: A report by The College of Social Work and the Royal College of General Practitioners.*

Monitor (2015) *Essex to benefit from Success Regime* (Press Release) [online] Available at: https://www.gov.uk/government/news/essex-to-benefit-from-success-regime Accessed on: 15th January 2016.


West locality
Ward total 69,501
total Practice list 59,190
Appendix 1: East/West Social Care Locality Teams
East Locality
total Ward 62,783
total Practice list 41,427
Central Locality
total Ward 54,647
total Practice list. 66,003
Eastwood Branch
(Eastwood Branch)
Dr Uranmar 4848
Malik Health Care 3514
Scott Park 2645
Southbourne Grove Dr Chakravarti 3272
Dr George Dr Hunt Dr Gul
Northumberland Branch Surgery.
Dr Saarikkumaran 4265
Dr Varghese 4101
St Lukes 4329
Dr Shah 2301
Eastwood Park Ward 9604
Elmsleigh Drive Lady Park 1231
St Laurence Ward 9916.
Eastwood Group 10,686
Belfairs Ward 9458
Dr Sathyamurthy 3431
Blenheim Park Ward 10,755
Prittlewell Ward 10,303
Dr Bhattacharjee 2777
St Lukes Ward 11,356
Queensway Branch
Dr Dhillon 2360
Dr Moss 3656
Lydia HS 1833
West Leigh Ward 9356
Highlands 11,285
Leigh Ward 10,202
Chalkwell Ward 10,320
Victoria Ward 10,020
Victoria Ward 11,427
Queensway 32094
Kursaal Ward 11,605
Milton Ward 11,291
Southchurch Ward 10,010
Dr Irlam 7393
Thorpe Bay Ward 9180
West Shoebury Ward 10,479
Shoeburyness Ward 11,748
Dr George Bennett
Dr Kumar 6911
Dr Schembri 3582
Dr Marasco 2825
Dr Agha 6580
Dr Siddiqui 2257
Northumberland 4746
Warrior Square 3060
Victoria SRS 304
Dr Siddiqui 4189
Valkyrie 15895
Dr Bansal 1635
Dr Velmurugan 991
Pall Mall Surgery 17099
The Leigh Surgery 1976
Leigh Road 14,352
3rd Qtr list sizes
Population counts - SBC 2014


West locality
Ward total 69,501
total Practice list 59,190
Appendix 2: Option 2 (3 Localities)
East Locality
total Ward 52,783
total Practice list 41,427
Central Locality
total Ward 54,647
total Practice list. 66,003
Eastwood Branch.
(Eastwood Branch)
Dr Hrishnan 4848
Matrix Health Care 3514
Elmsleigh Drive Lead Pari 1231
Eastwood Park Ward 9504
Scott Park 2645
Southbourne Grove Dr Chakraverti 3272
Dr George Dr Hunt Dr Gul
Northumberland Branch Surgery.
Dr Soorichumuran 4265
Dr Verghese 4101
St Lukes 6329
St Lawrence Ward 9915.
Eastwood Group 10,686
Belfairs Ward 9458
Dr Sathanandan 3431
Blenheim Park Ward 10,755
Prittlewell Ward 10,303
St Lukes Queensway Branch
St Lukes Ward 11,356
Dr Shah 2301
Dr Bhattacharjee 3777
Southchurch Ward 10,910
Dr Dhillon 2360
Dr Irlam 7393
Lydia HS 1935
West Leigh 9356
Westborough Ward 10,026
Victoria Ward 11,427
Queensway 22004
Norm Road 16,352
Leigh Ward 10,662
Chalkwell Ward 10,811
Dr Woodall Johnson
Milton Ward 11,291
Horsea Ward 11,500
Thorpe Bay Ward 9190
West Shoebury Dr George Bennett.
Shoeburyness Ward 11,748
Ward 10,479
Dr Kumar 6911
Dr Schembri 3582
Dr Morasco 2825
Dr Agha 6580
Dr Siddique 2257
Northumberland 4746
Warrior Square 3060
Victoria SAS 304
Dr Siddiqui 4189
Dr Velmurugan 991
Valkyrie 13893
Dr Beevers 1635.
Pall Mall Surgery 17099.
The leigh surgery 1976
3rd Qtr list sizes
Population counts - SBC 2014

Appendix 3: Option 3 (4 Localities)



Appendix 3b Numbers of people in each locality (option 3)

LOCALITY 1	
13,108	Leigh
16710	West Leigh
8343	Eastwood
15324	Belfairs
53,485	TOTAL

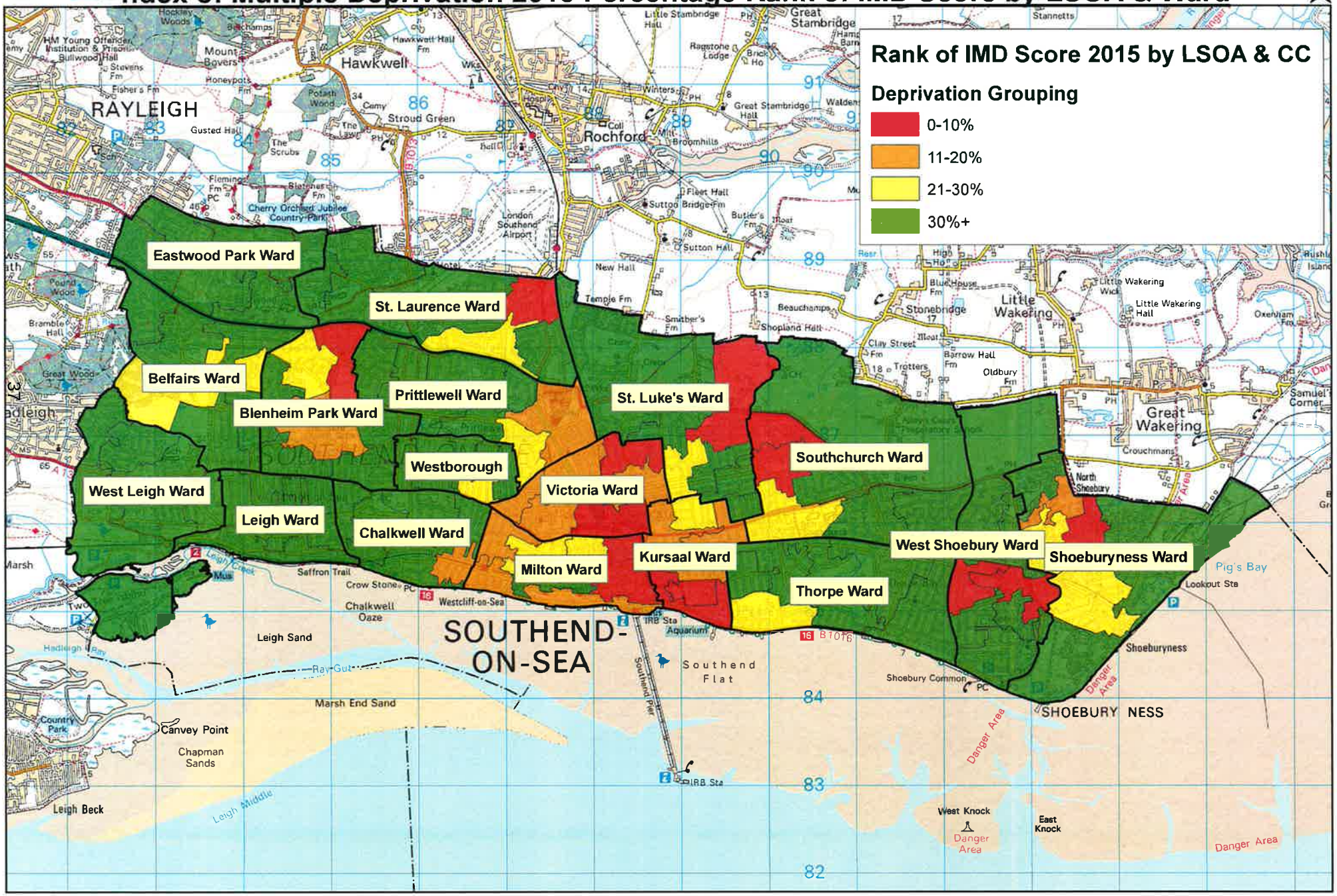
LOCALITY 2	
6927	St Laurence
3273	Prittlewell
4713	Westborough
1978	Blenheim
23000	Milton
0	Chalkwell
39891	TOTAL

LOCALITY 3	
4700	Kursaal
42000	Victoria
8631	St Lukes
55331	TOTAL

LOCALITY 4	
7391	Southchurch
8886	Thorpe Bay
2825	West Shoebury
16485	Shoeburyness
35587	TOTAL

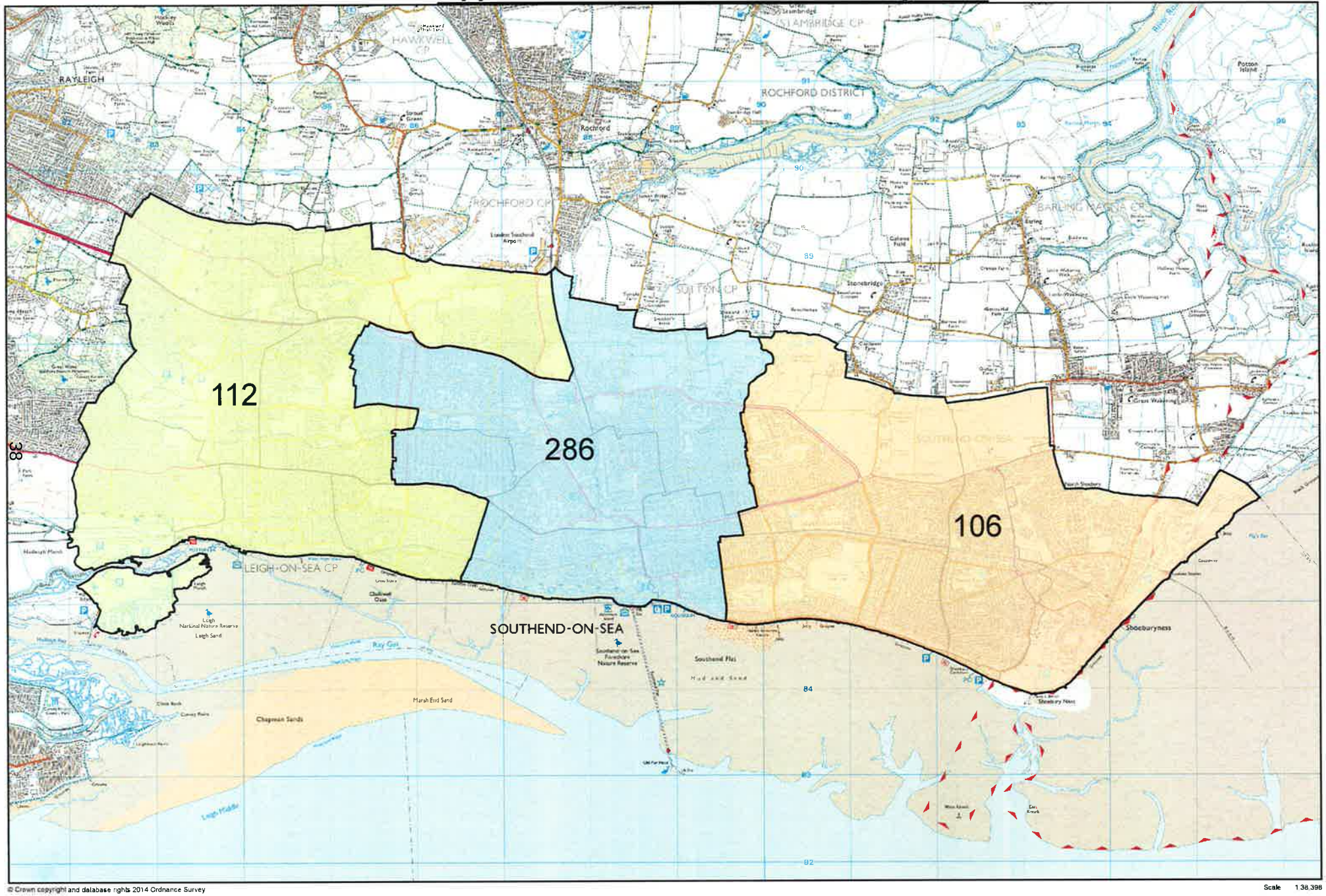
App 4: Areas of Multiple Areas of Deprivation in Southend-on-Sea

ndex of Multiple Deprivation 2015 Percentage Rank of IMD Score by LSOA & Ward

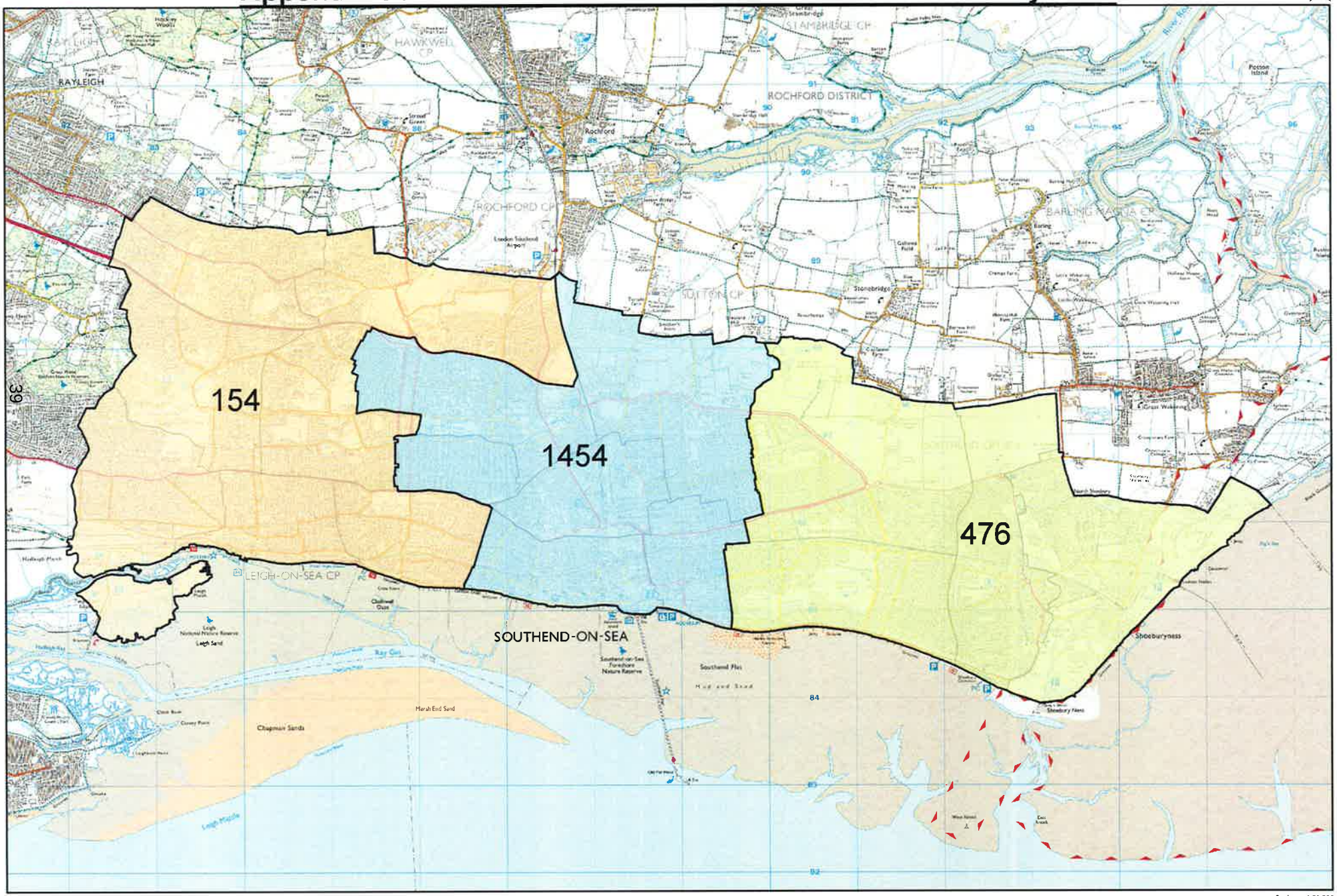


Scale 1:38,398

Appendix 5a - Number of MCA2s by Area

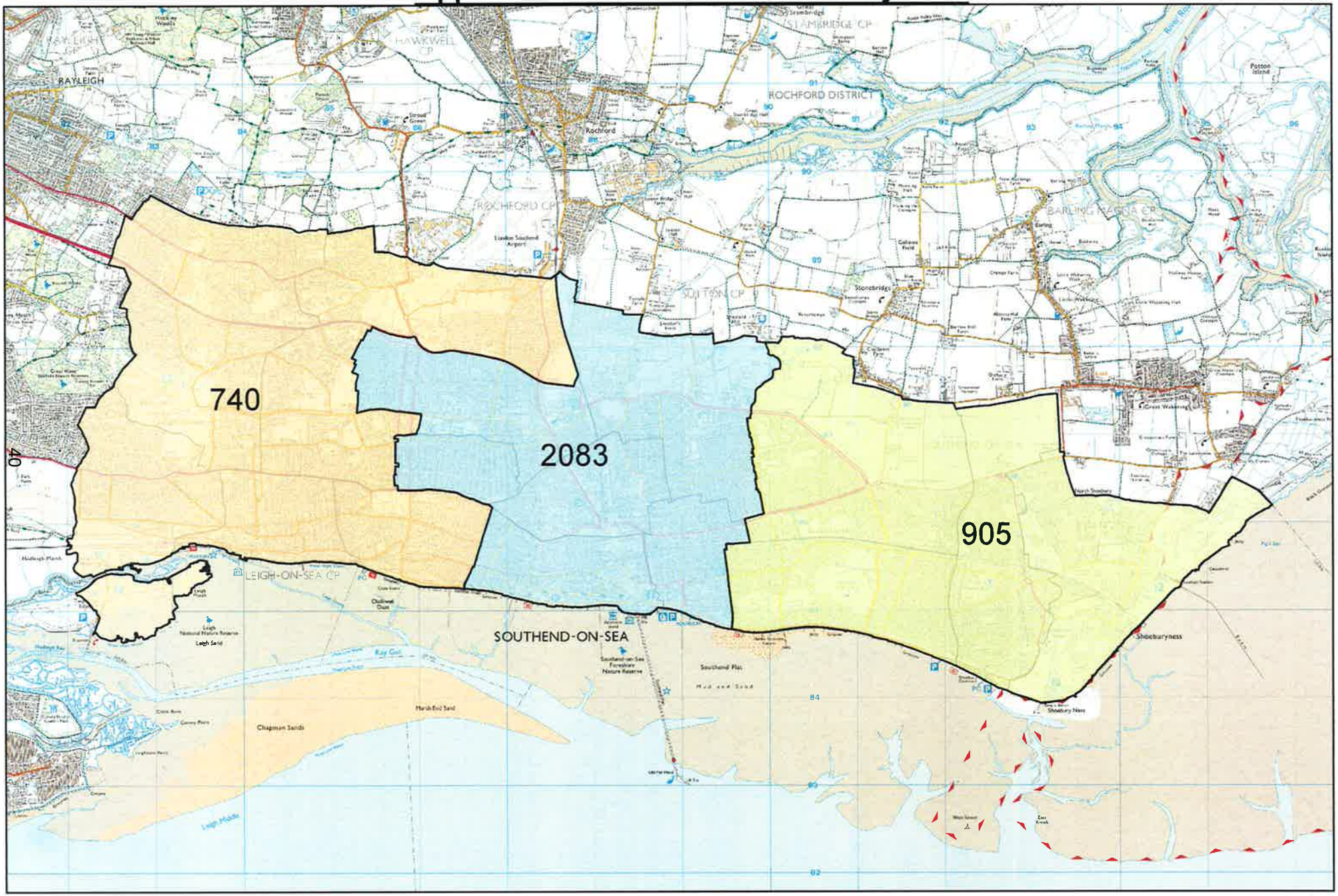


Appendix 5b - Number of Children Known to Social Care by Area



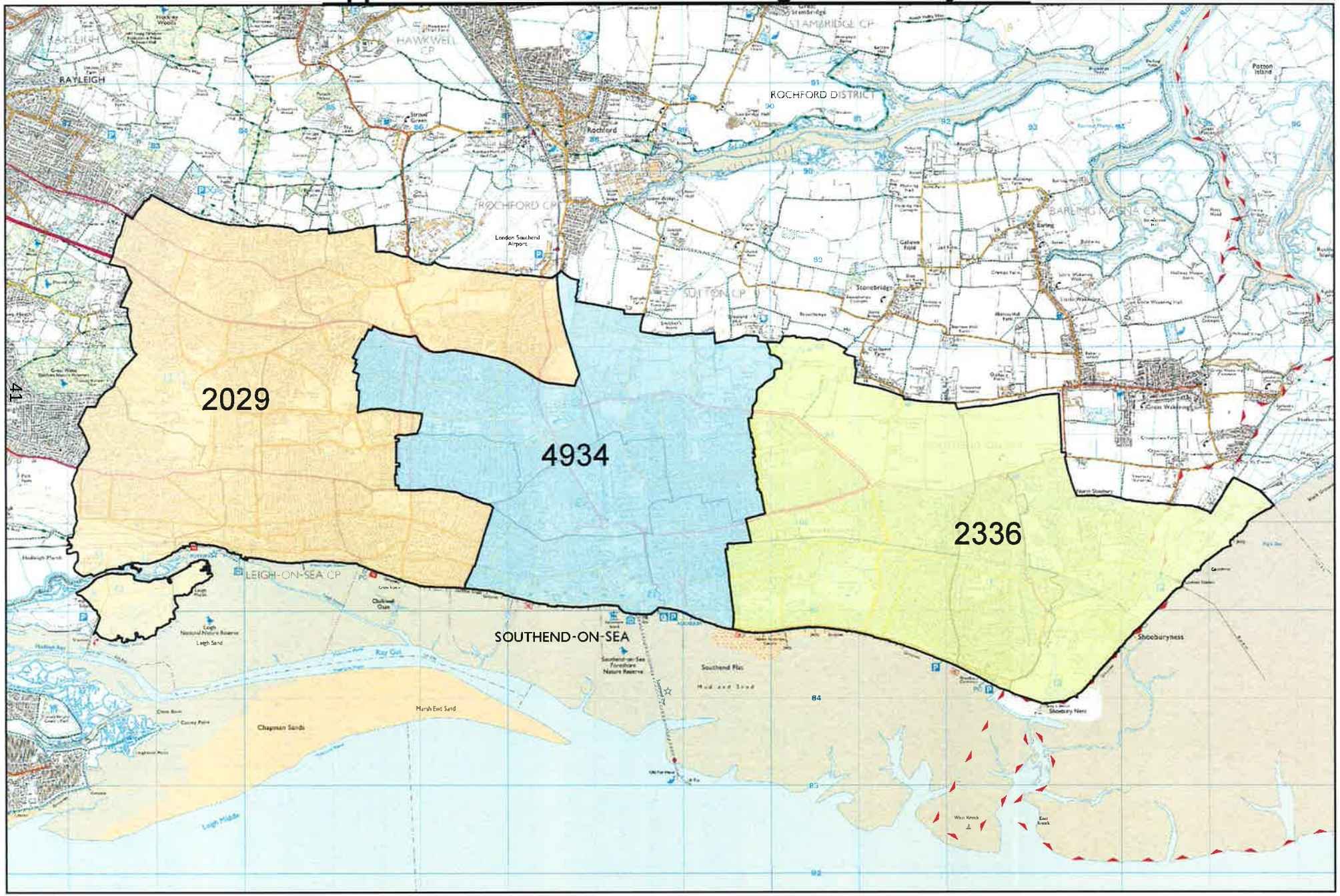
Scale 1:38,398

Appendix 5c - Number of Clients by Area



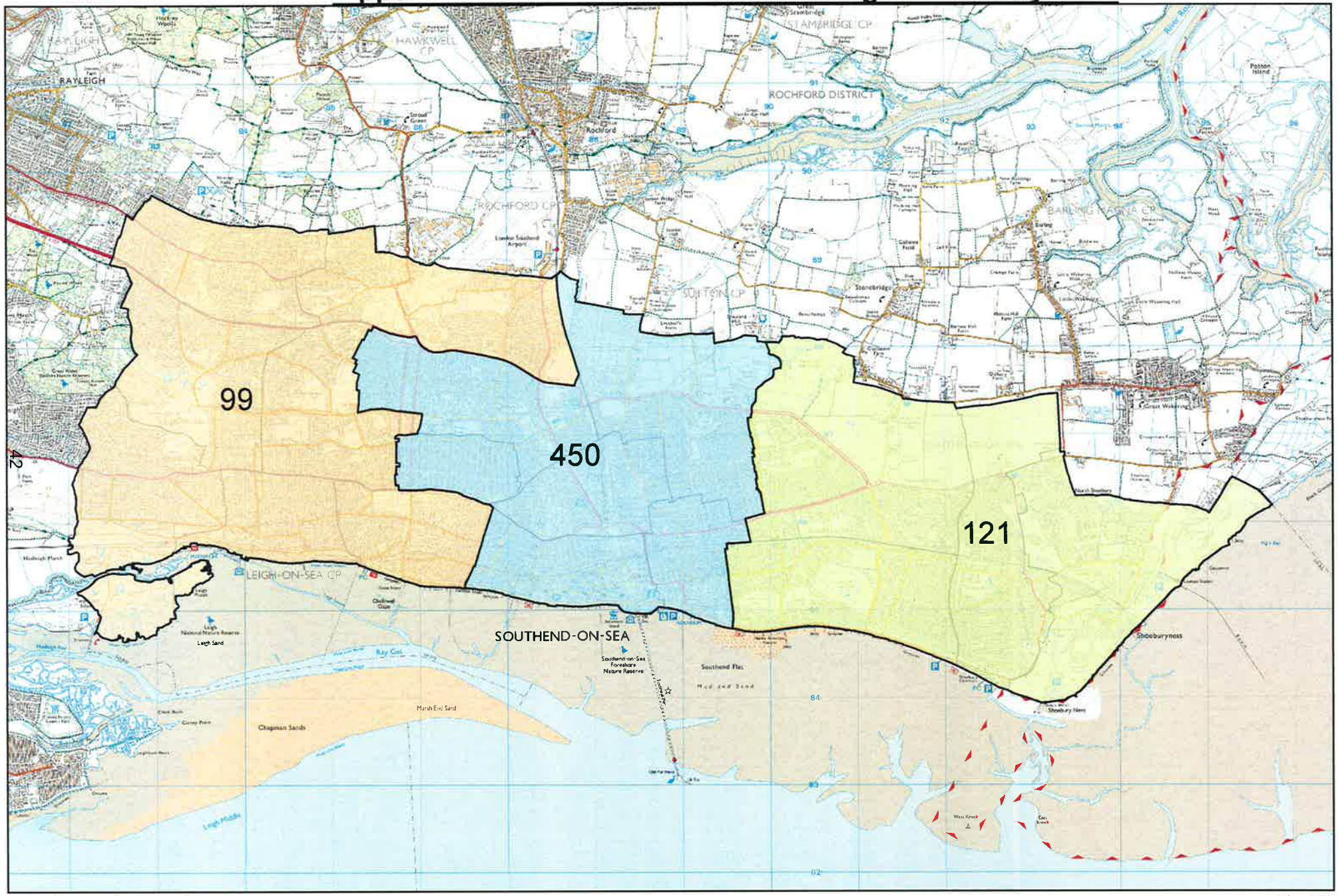
Scale 1:38,398

Appendix 5d - Number of Other Agreements by Area

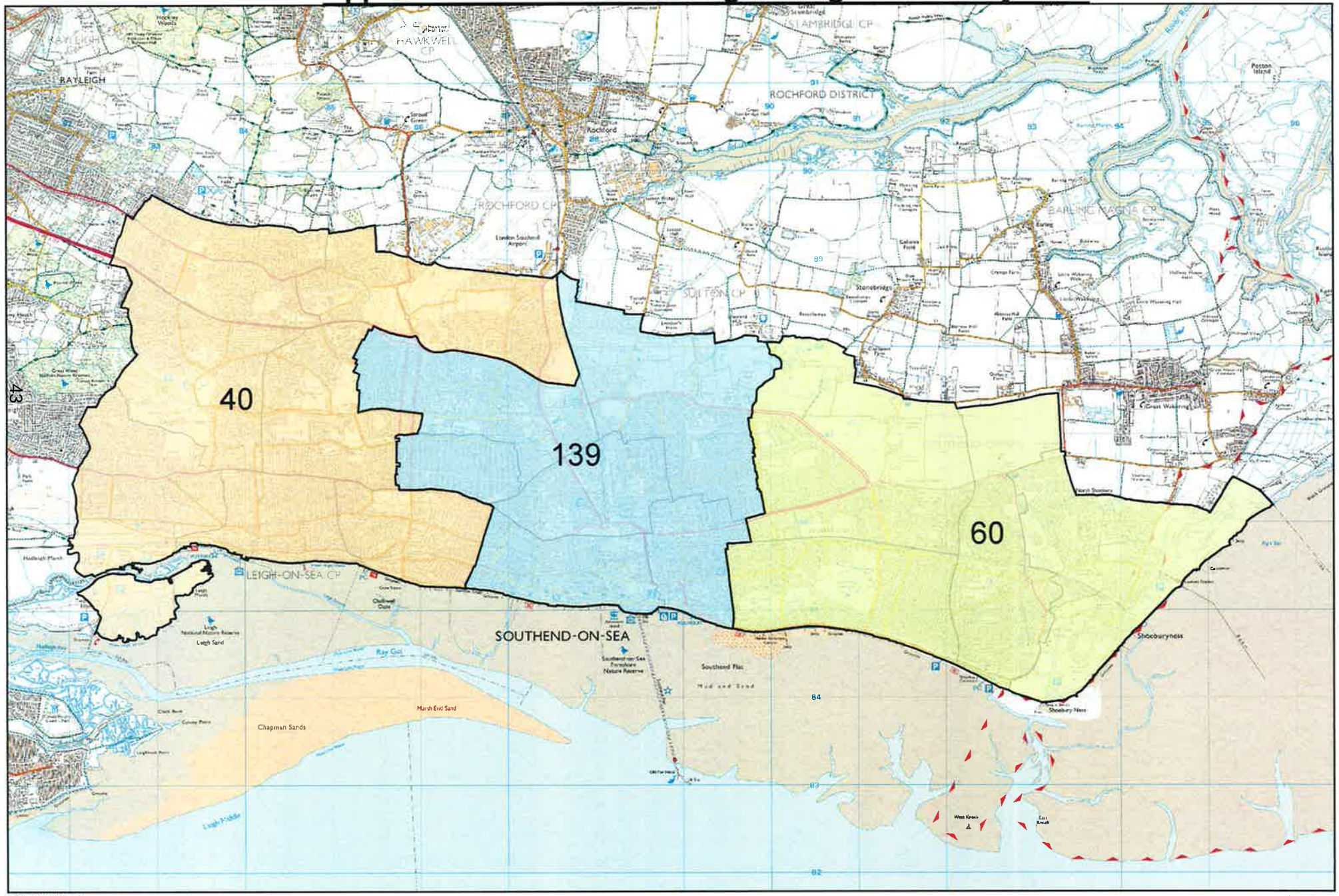


Scale 1:38,398

Appendix 5e - Number of Residential Agreements by Area

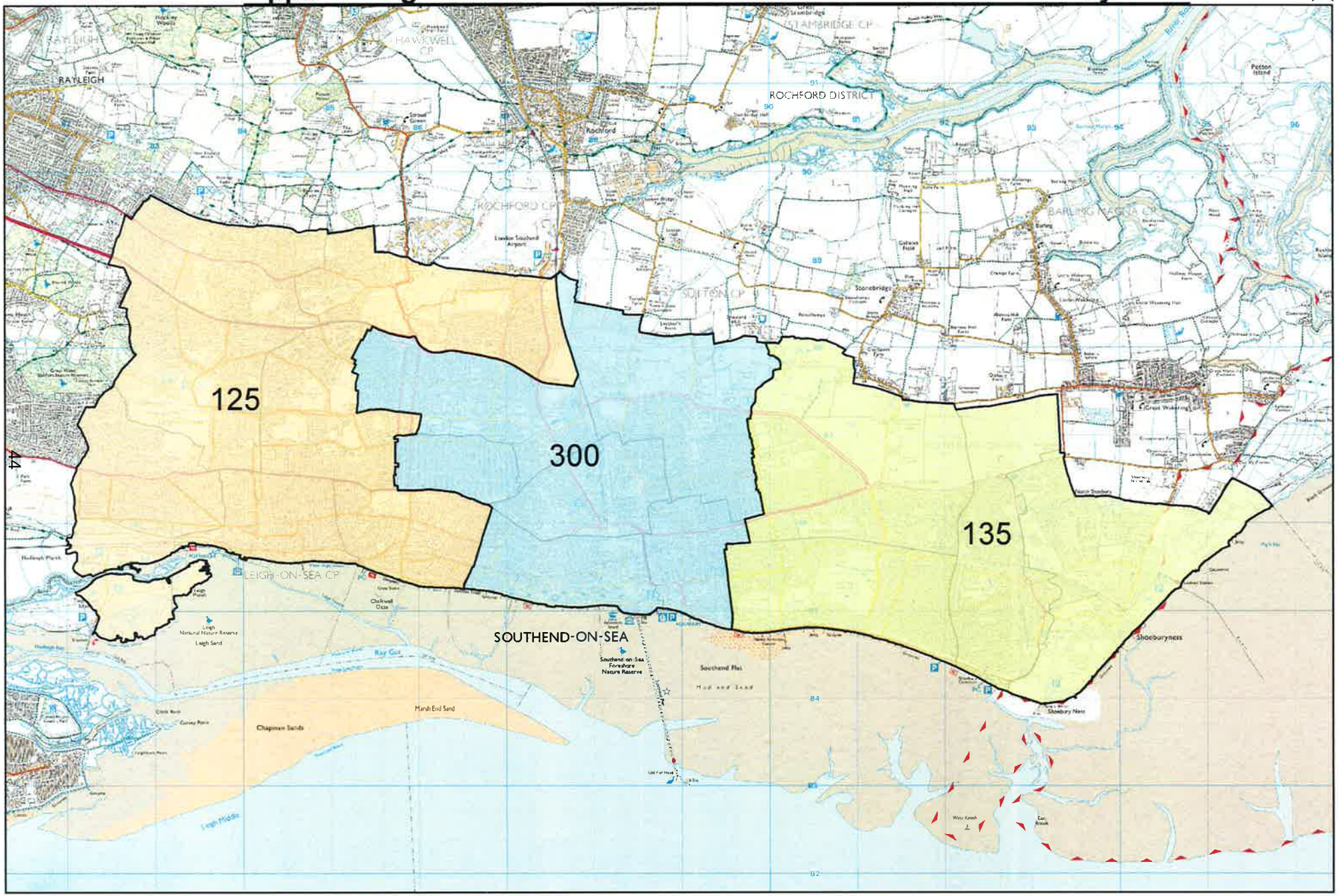


Appendix 5f - Number of Safeguarding Referrals by Area



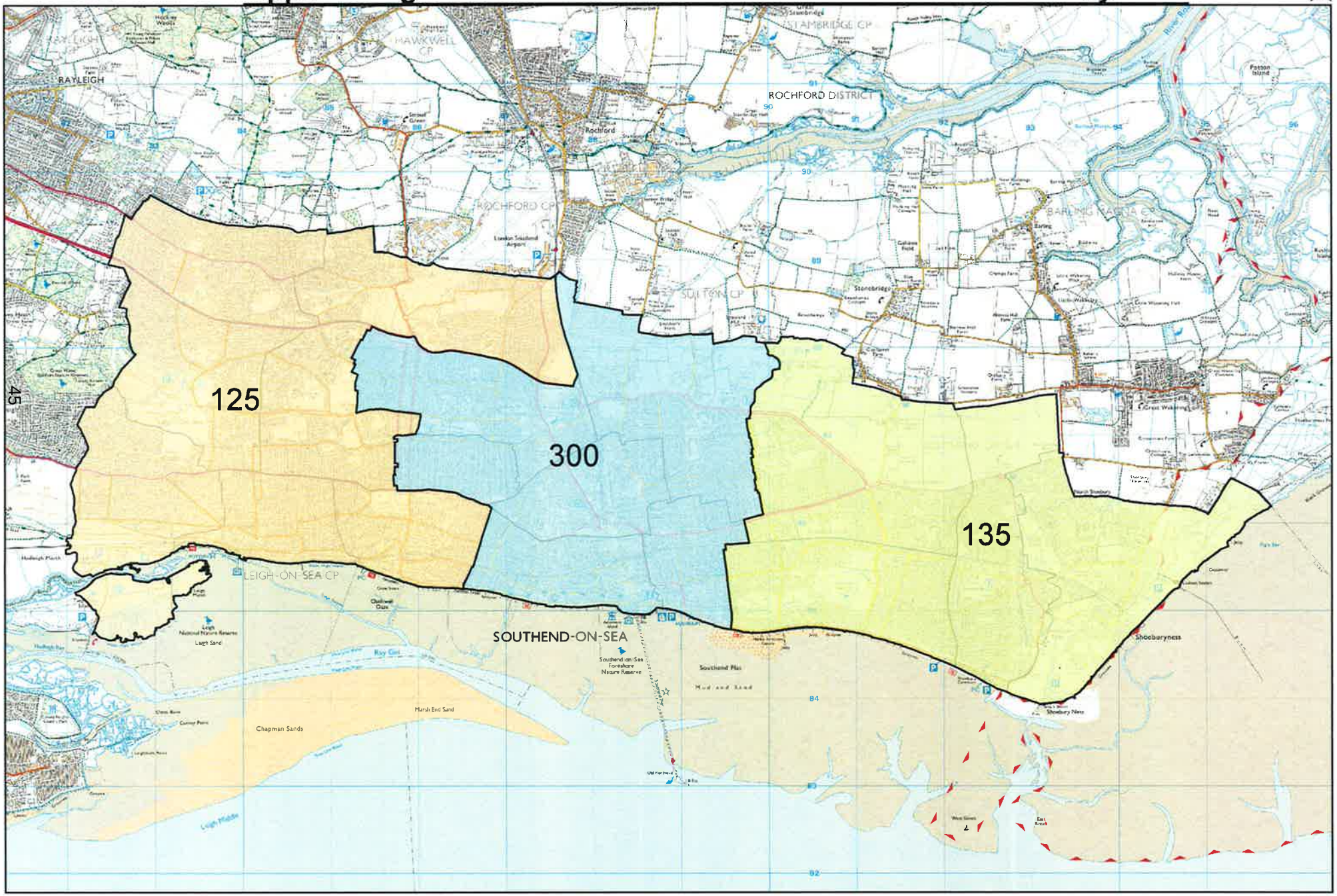
Scale 1:38,398

Appendix 5g - Number of Clients with at least 3 Assessments by Area



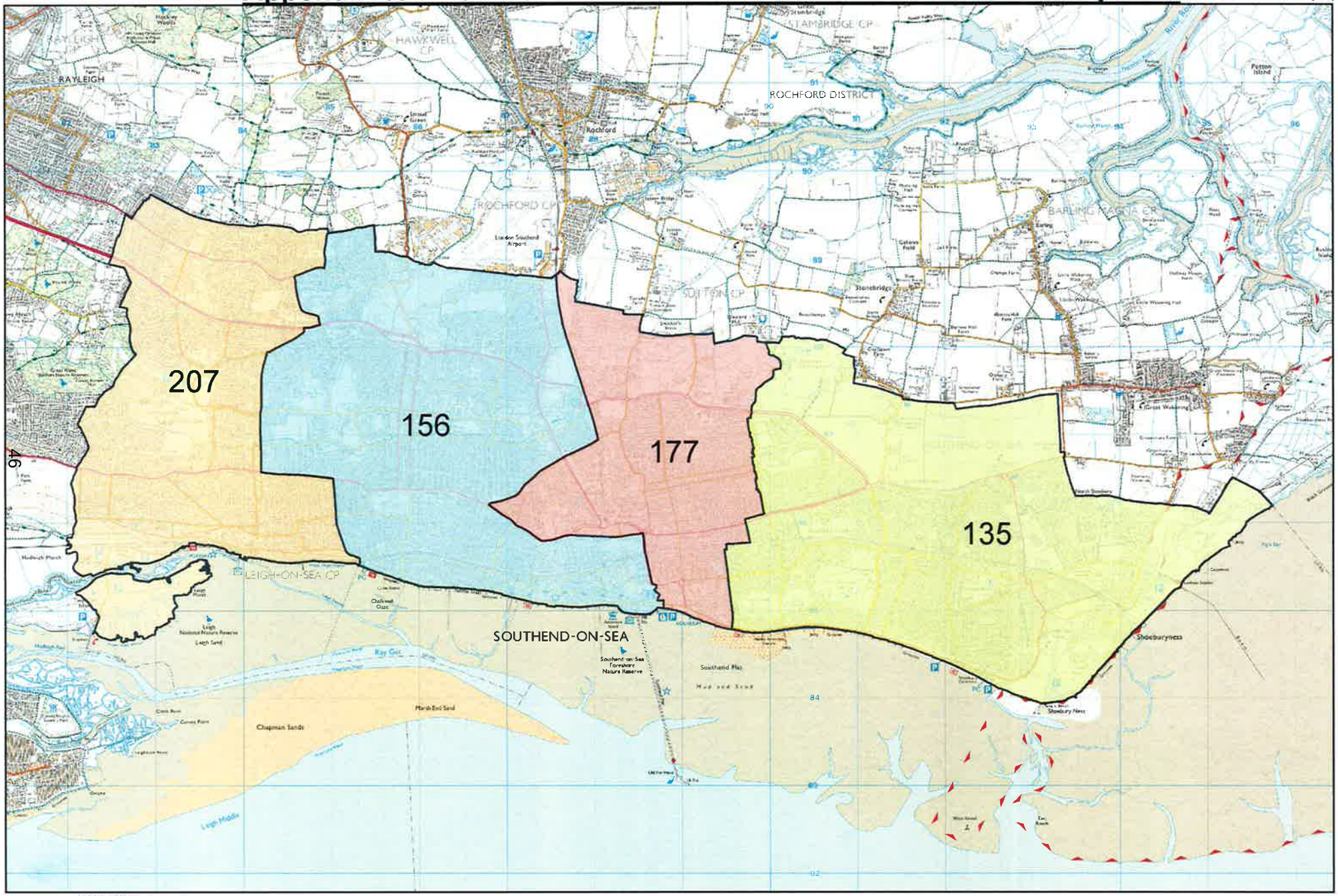
Scale 1:38,398

Appendix 5g - Number of Clients with at least 3 Assessments by Area



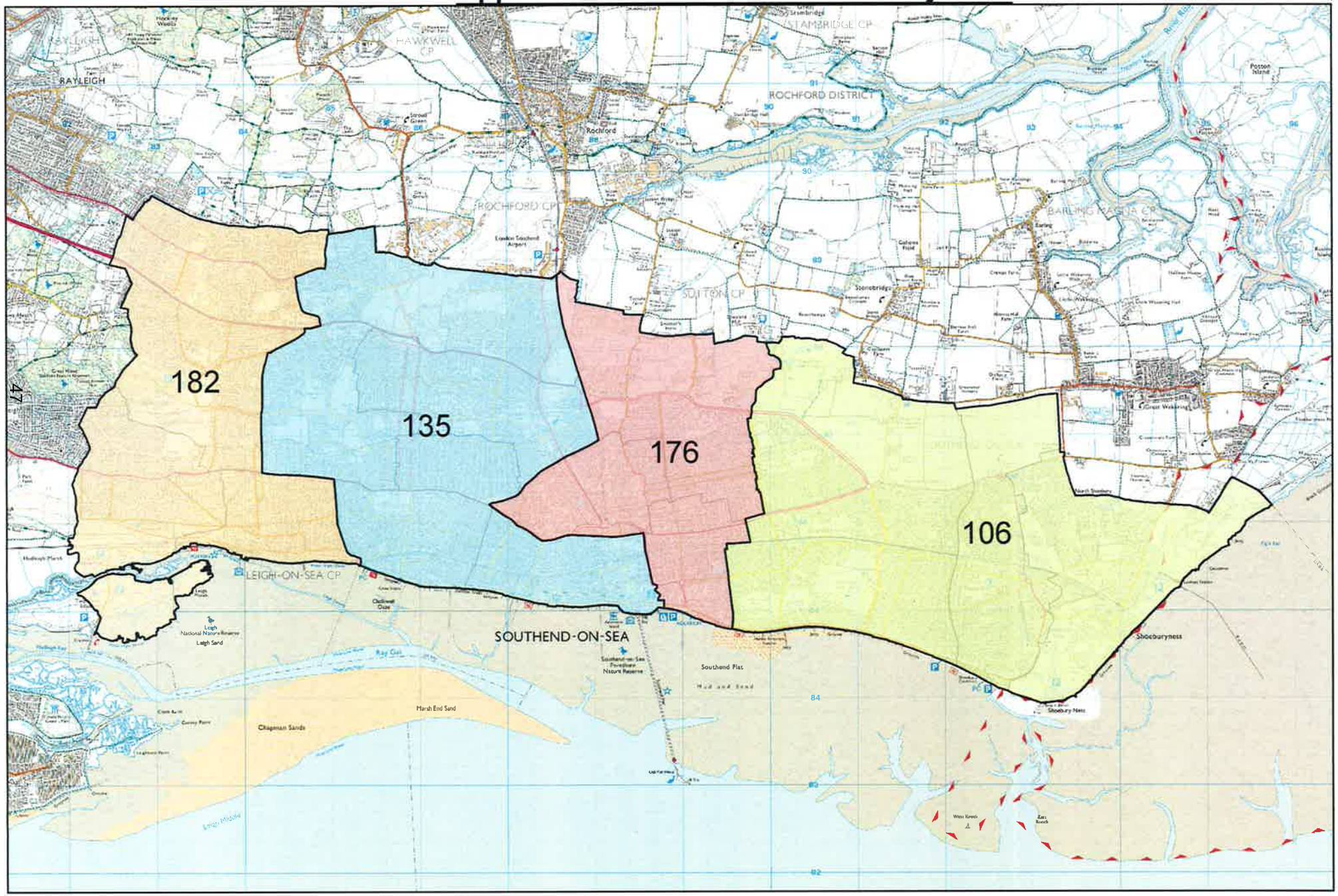
Scale 1:38,366

Appendix 6a - Number of Clients with at least 3 Assessments by Area

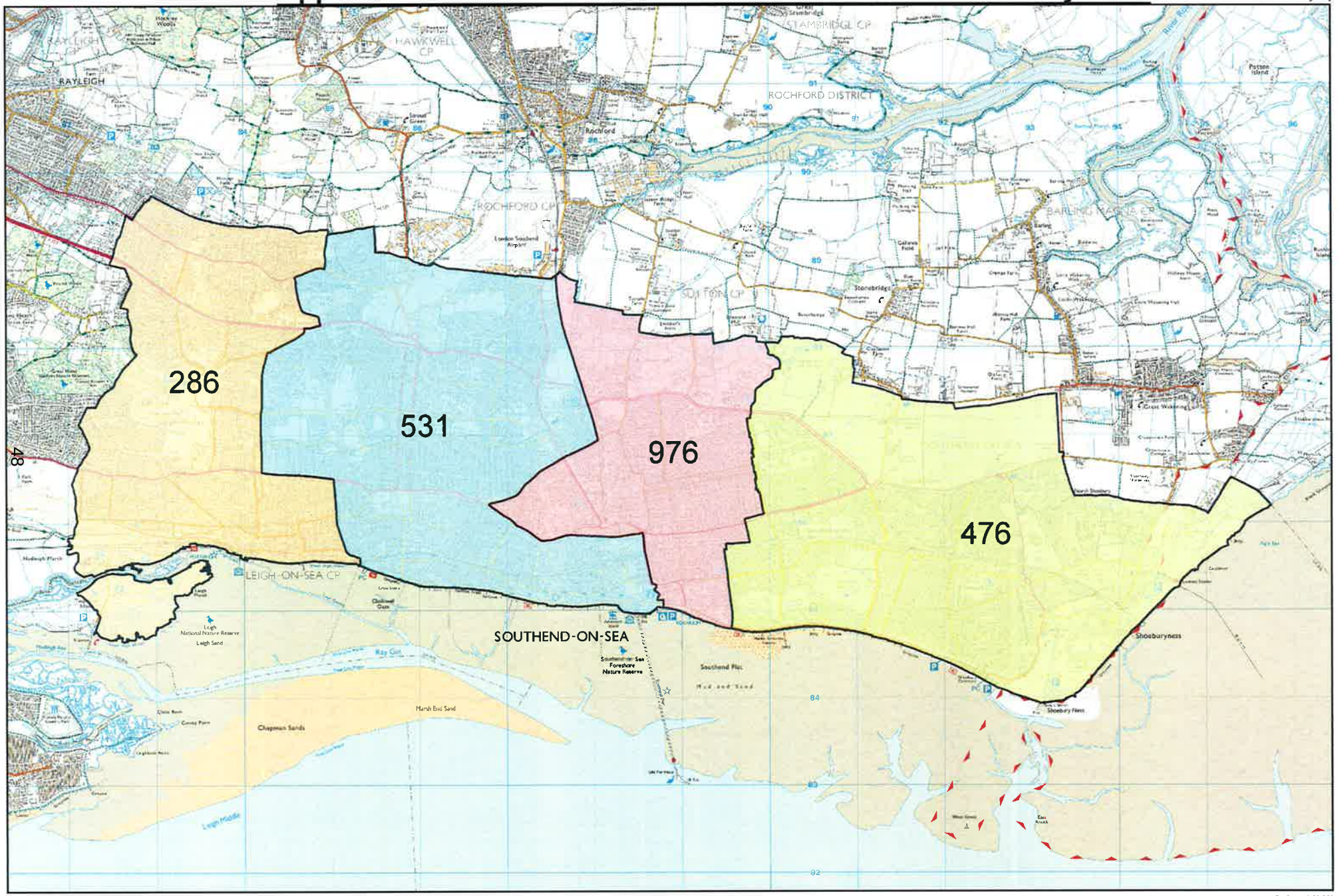


Scale 1:38,398

Appendix 6b - Number of MCA2s by Area

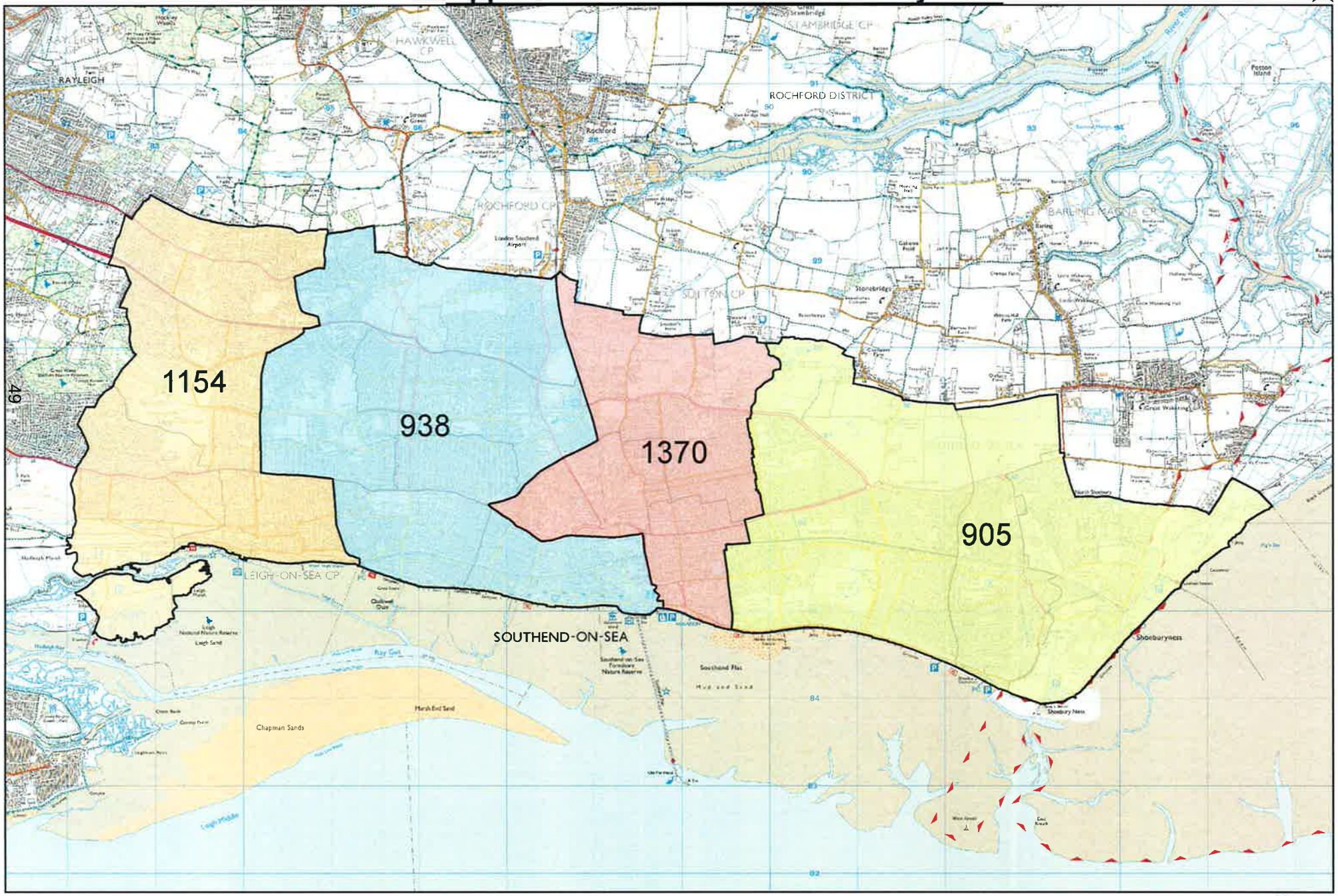


Appendix 6c - Number of Children Known to Social Care by Area



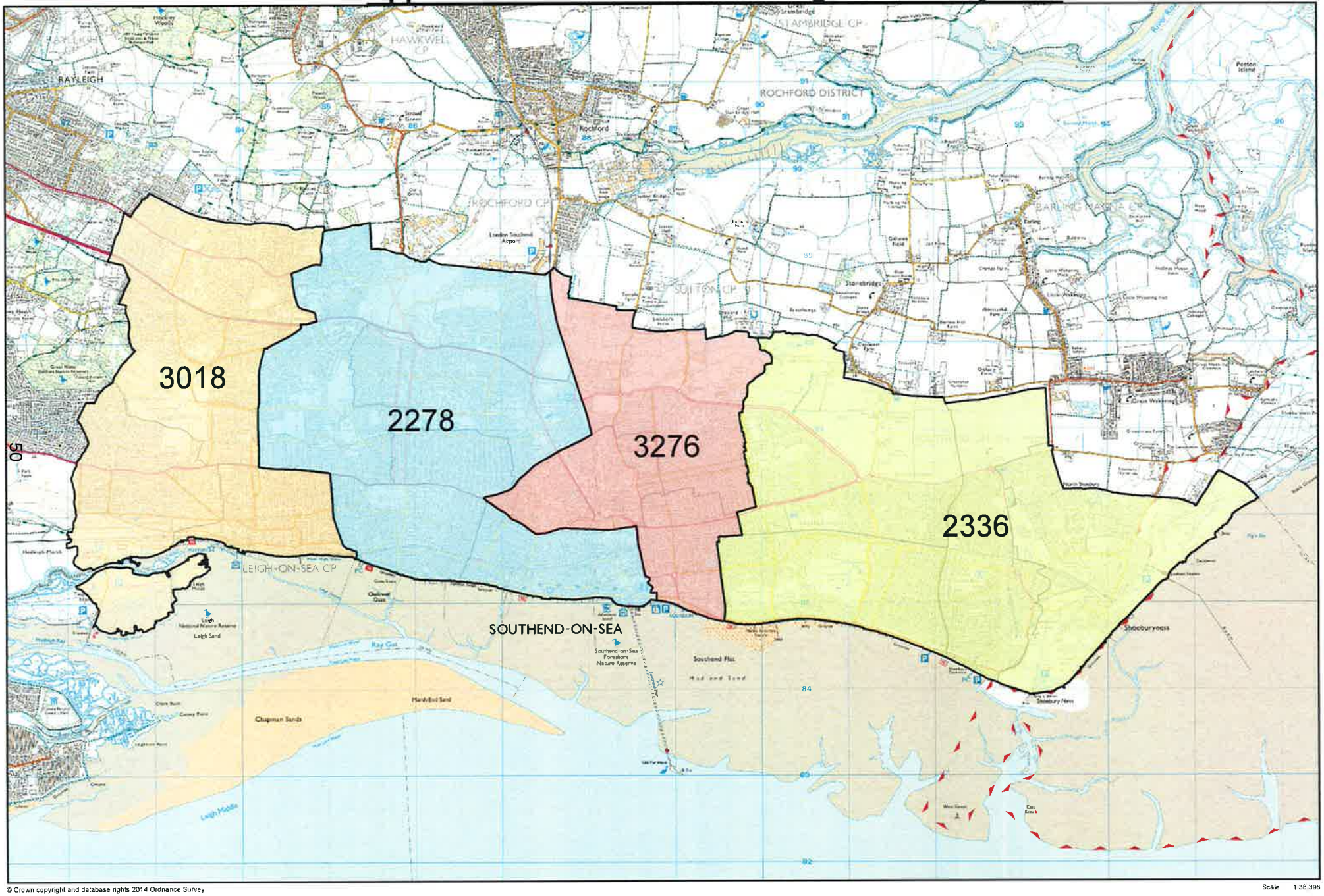
Scale 1:38,398

Appendix 6d - Number of Clients by Area



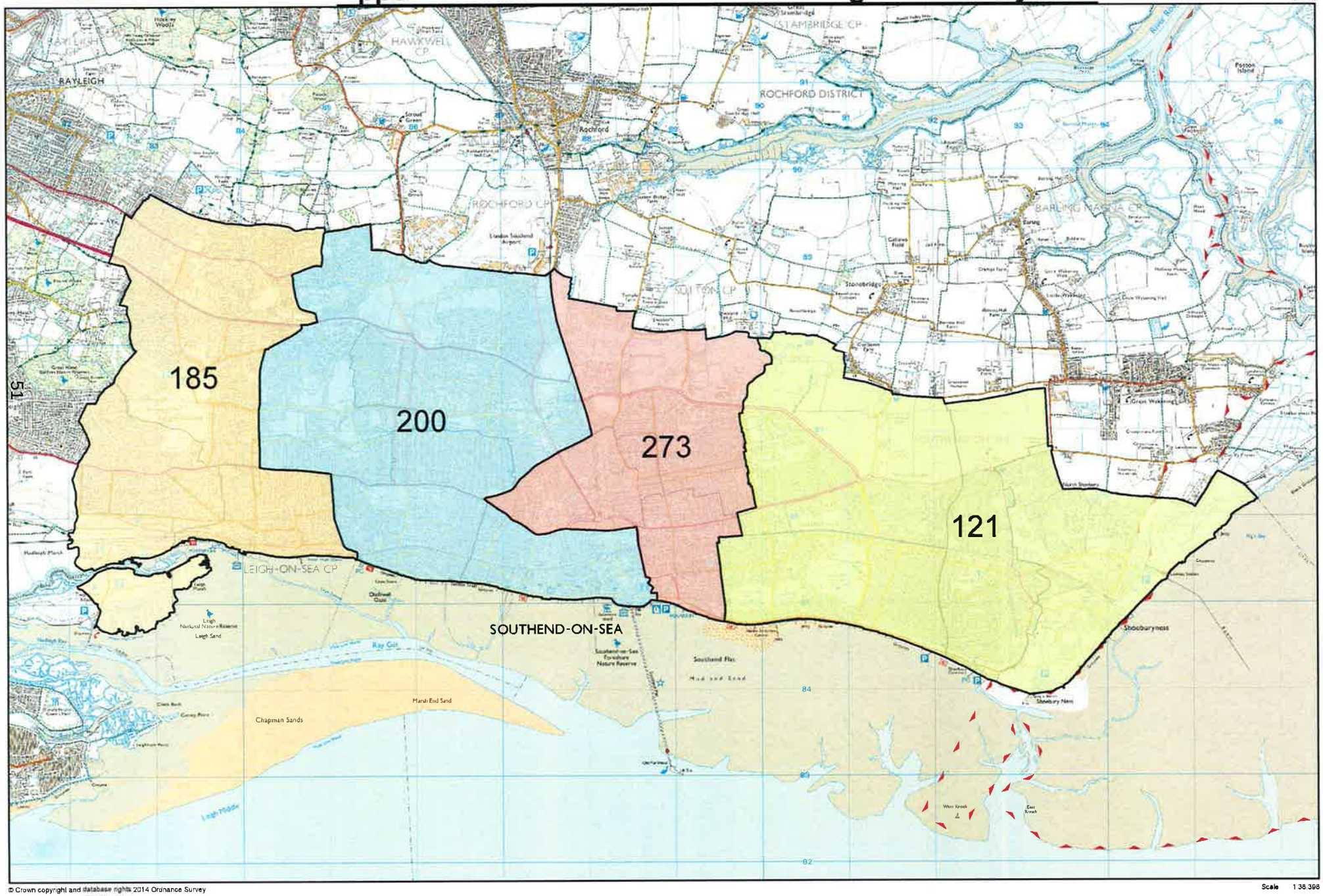
Scale 1:38,398

Appendix 6e - Number of Other Agreements by Area

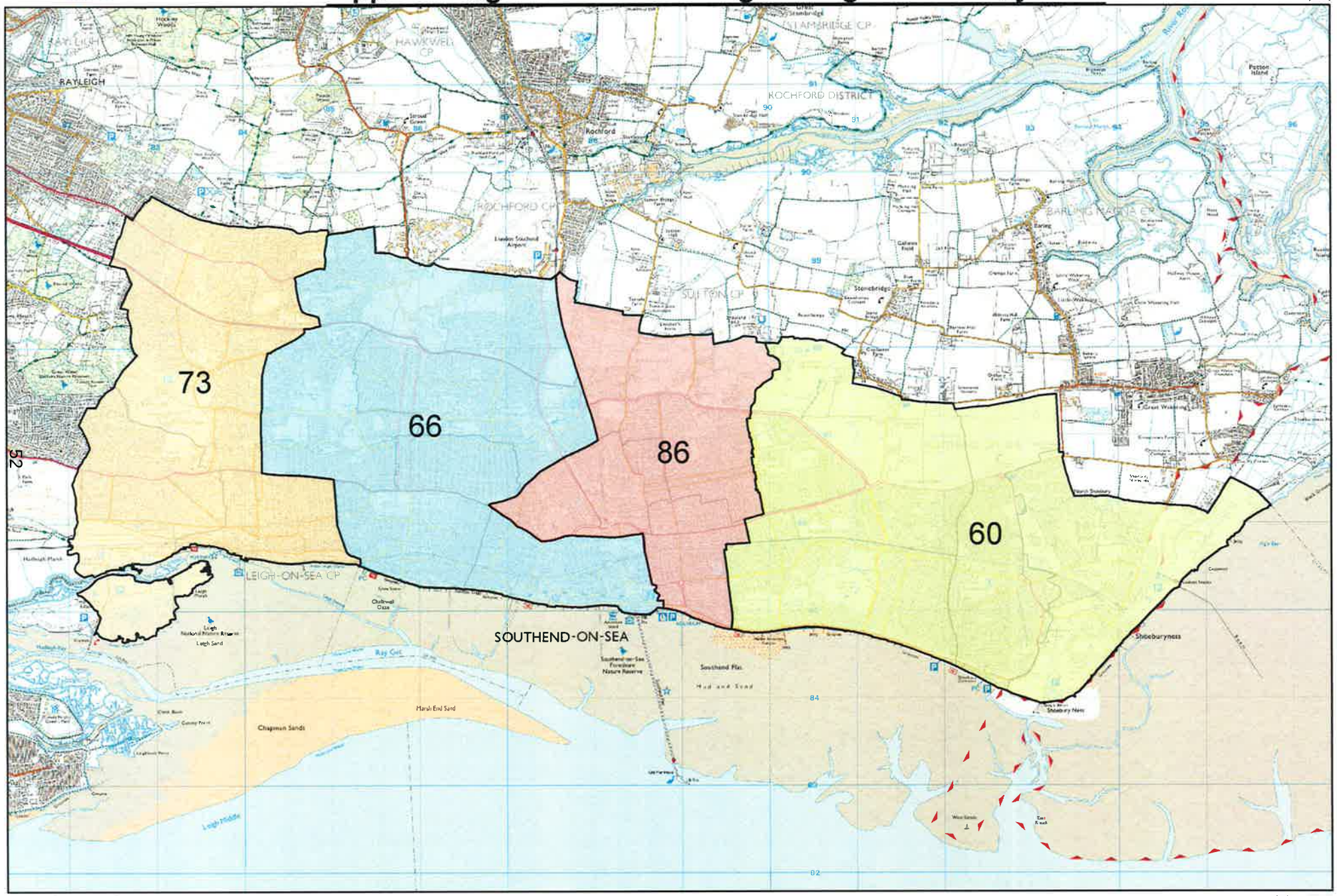


Scale 1:38,398

Appendix 6f - Number of Residential Agreements by Area

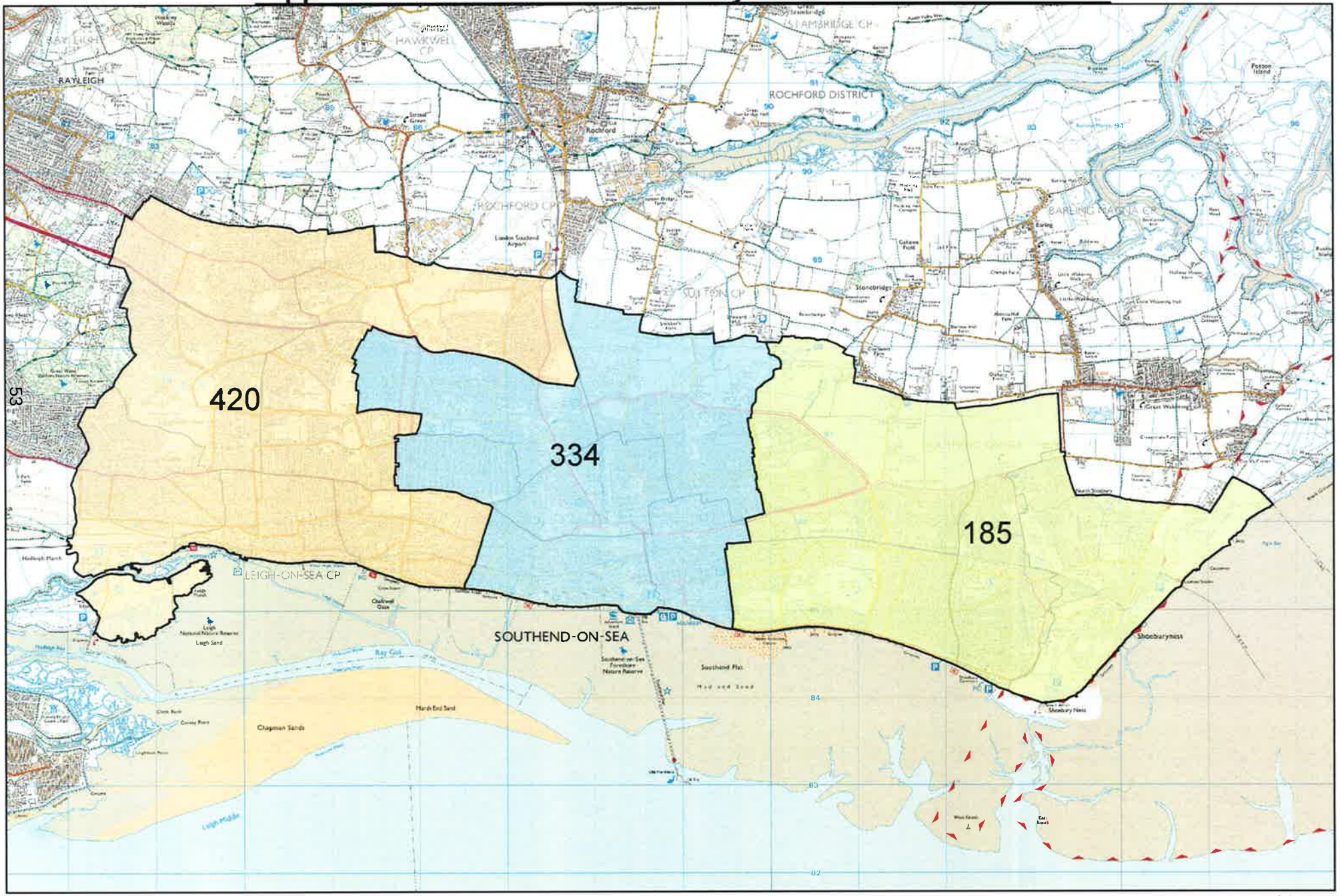


Appendix 6g - Number of Safeguarding Referrals by Area



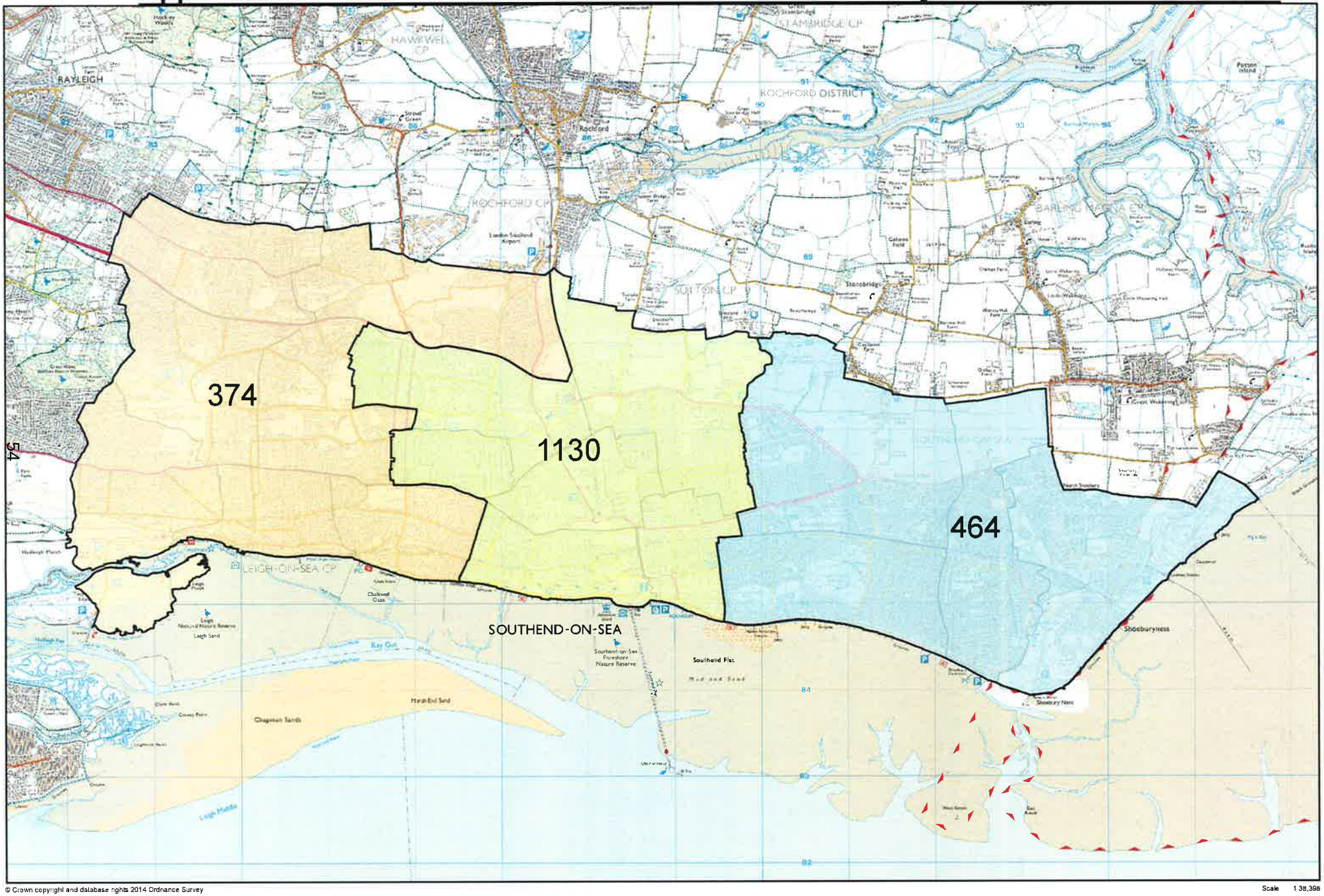
Scale 1:36,398

Appendix 7a - Number of MCA2s by Area - Resident Postcode



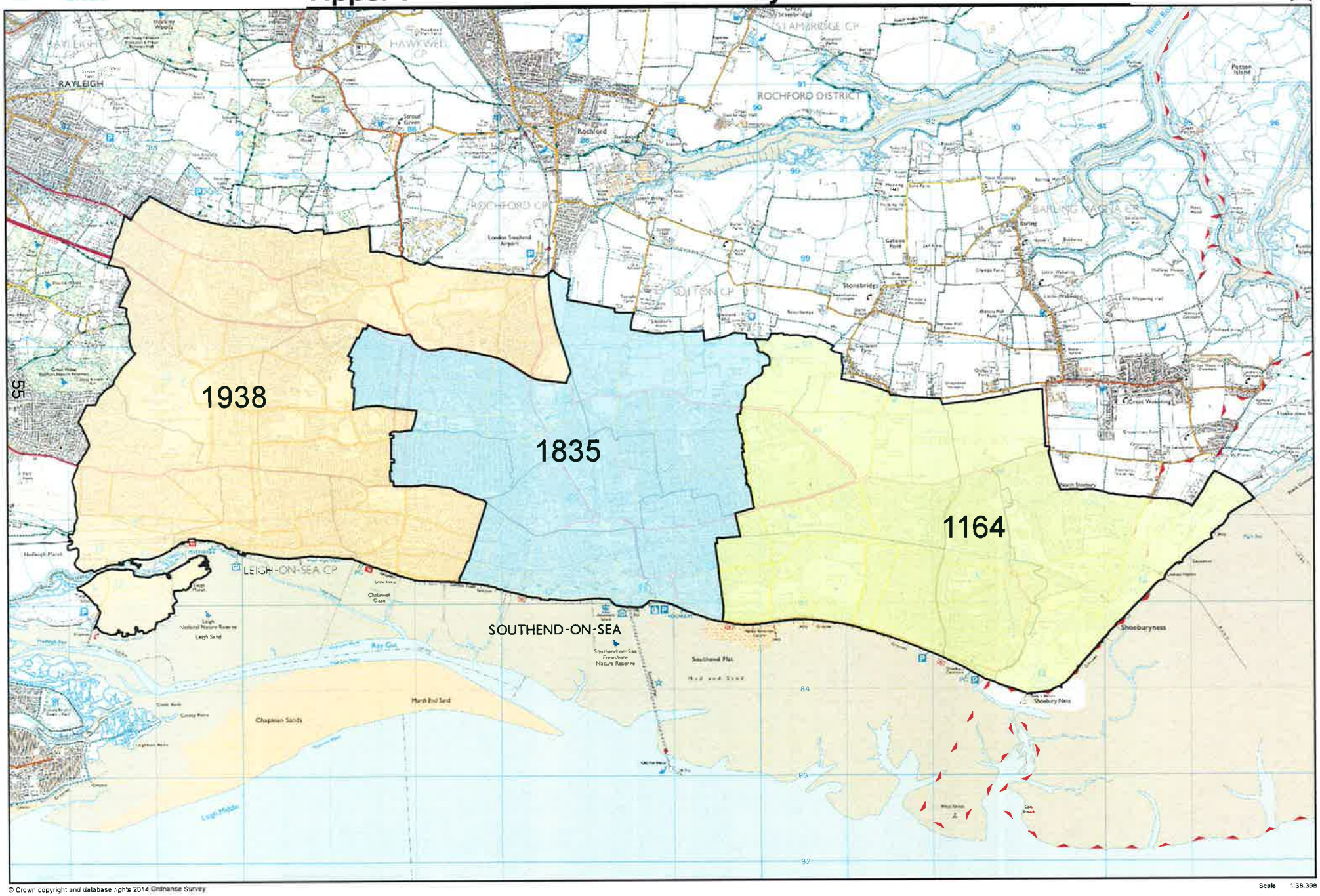
Scale 1:38,398

Appendix 7b - Number of Children Known to Social Care by Area - Resident Postcode



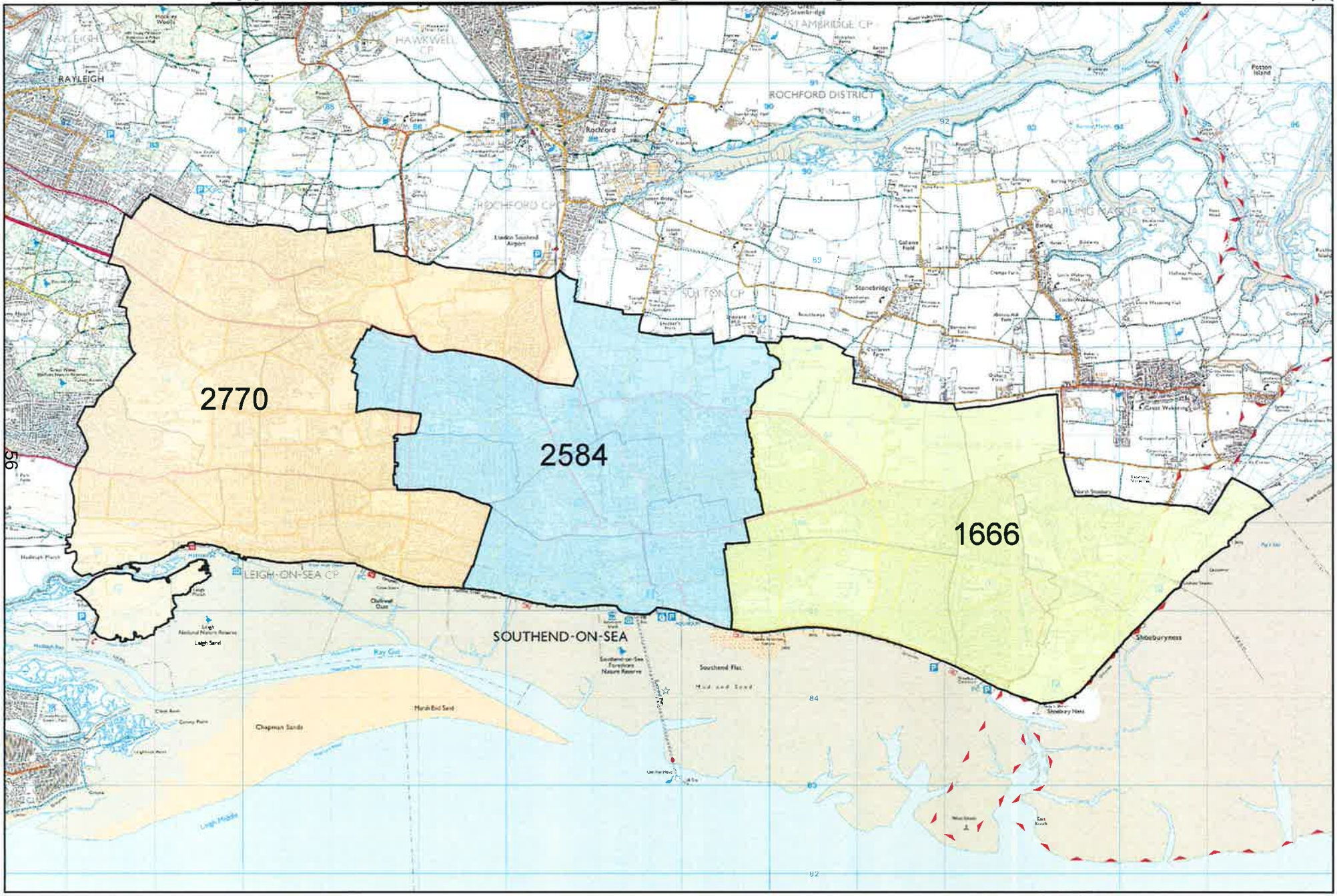
Scale 1:38,396

Appendix 7c - Number of Clients by Area - Resident Postcode



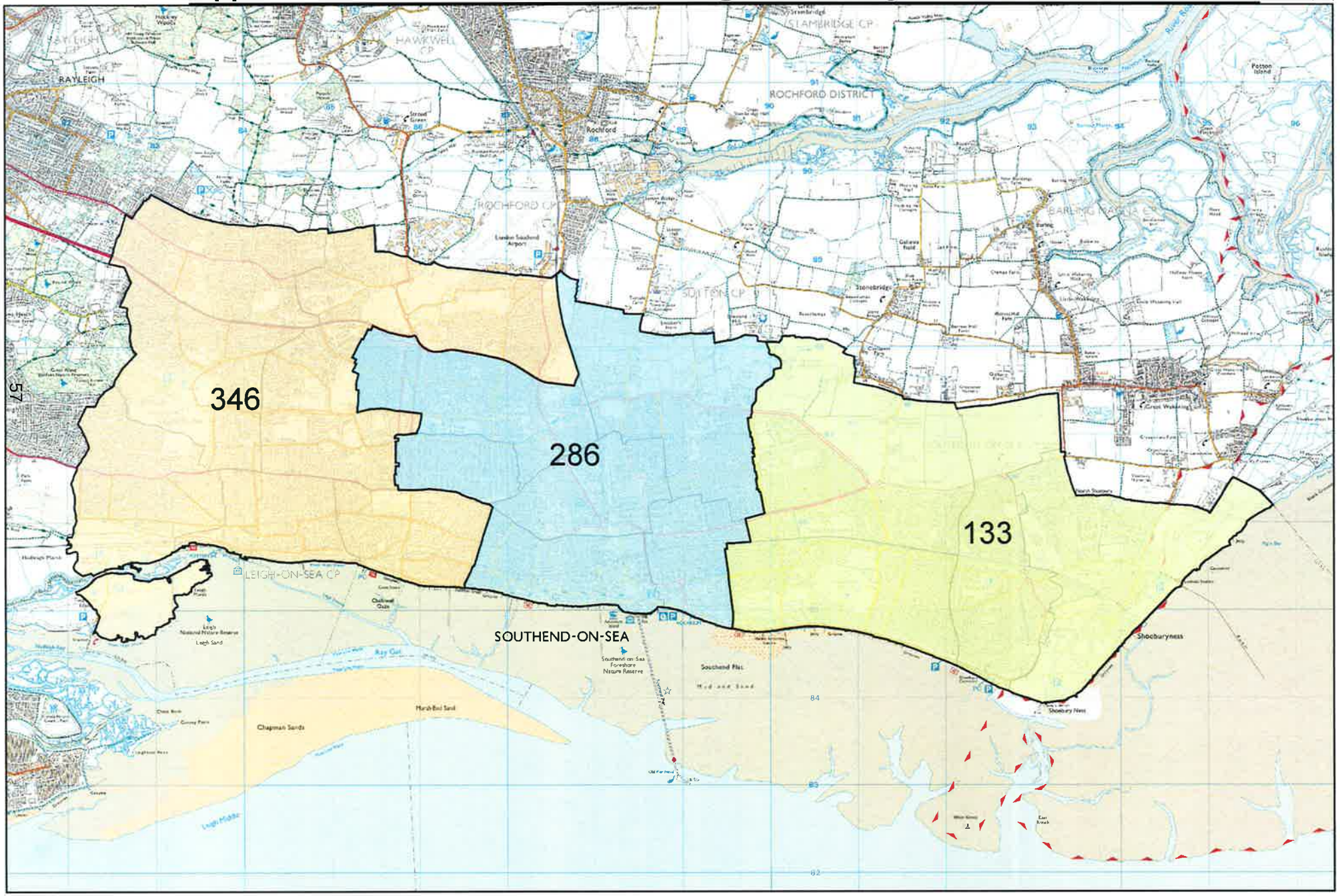
Scale 1:38,398

Appendix 7d - Number of Other Agreements by Area - Resident Postcode



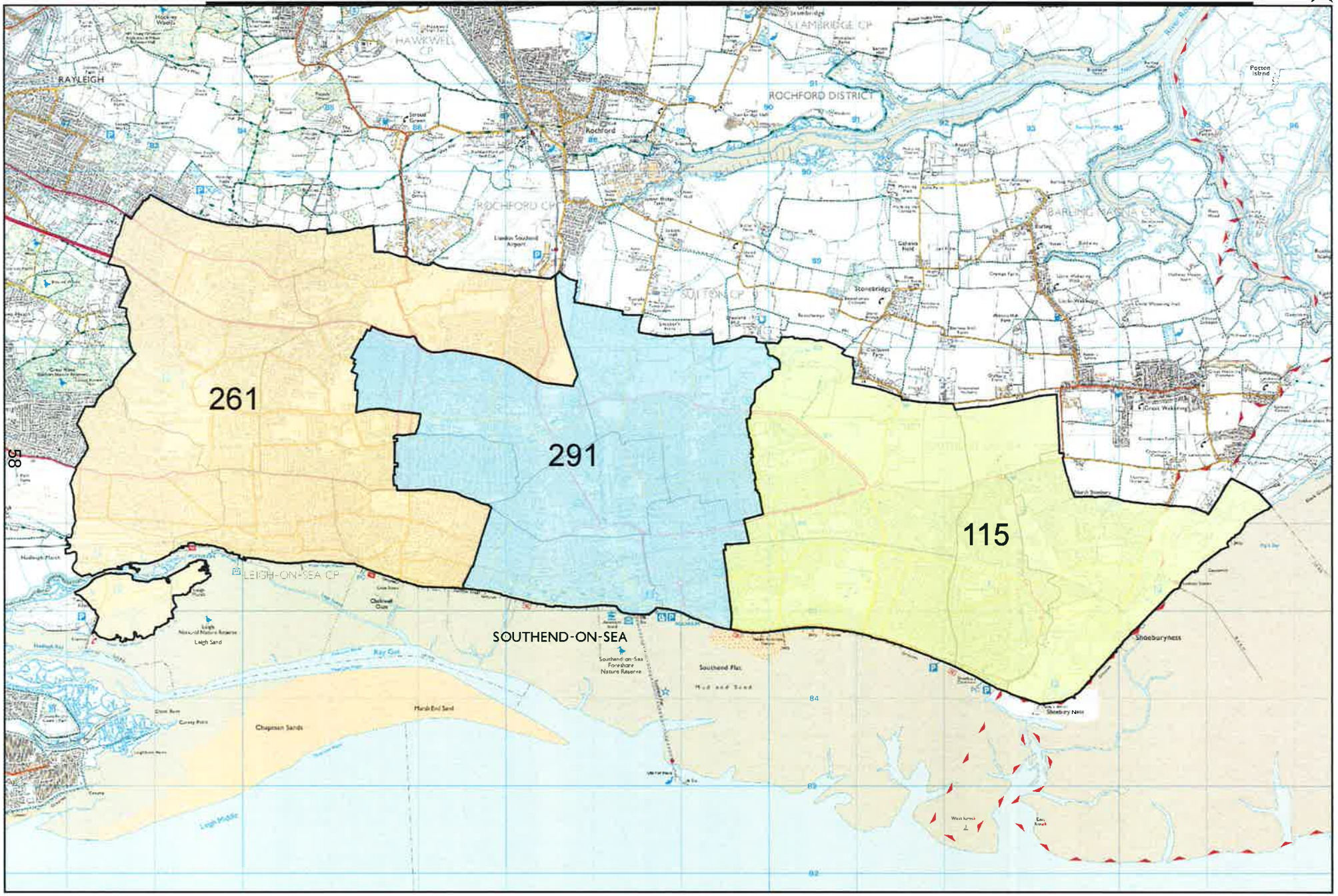
Scale 1:38,358

Appendix 7e - Number of Residential Agreements by Area - Resident Postcode



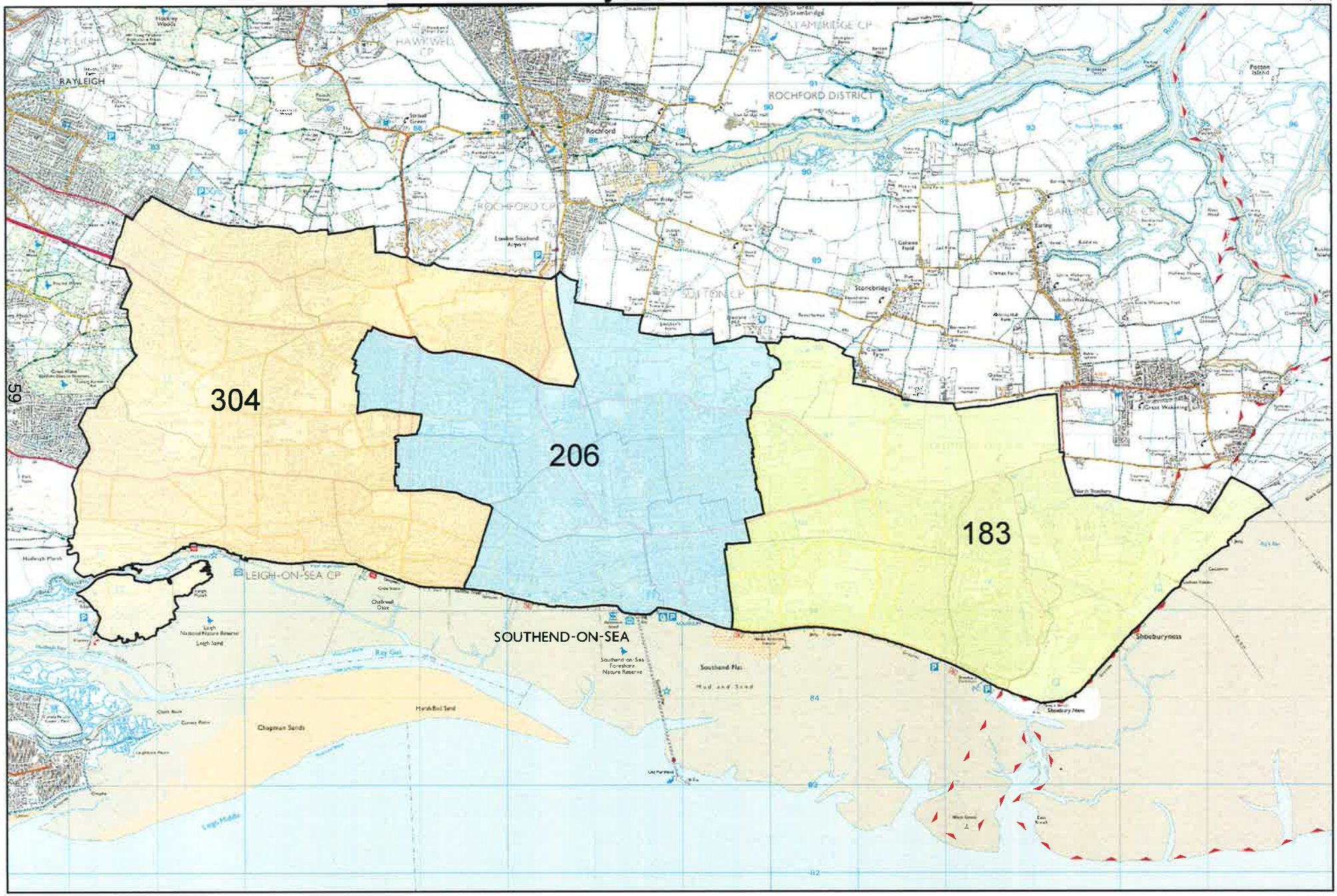
Scale 1:38,398

Appendix 7f - Number of Safeguarding Referrals by Area - Resident Postcodes



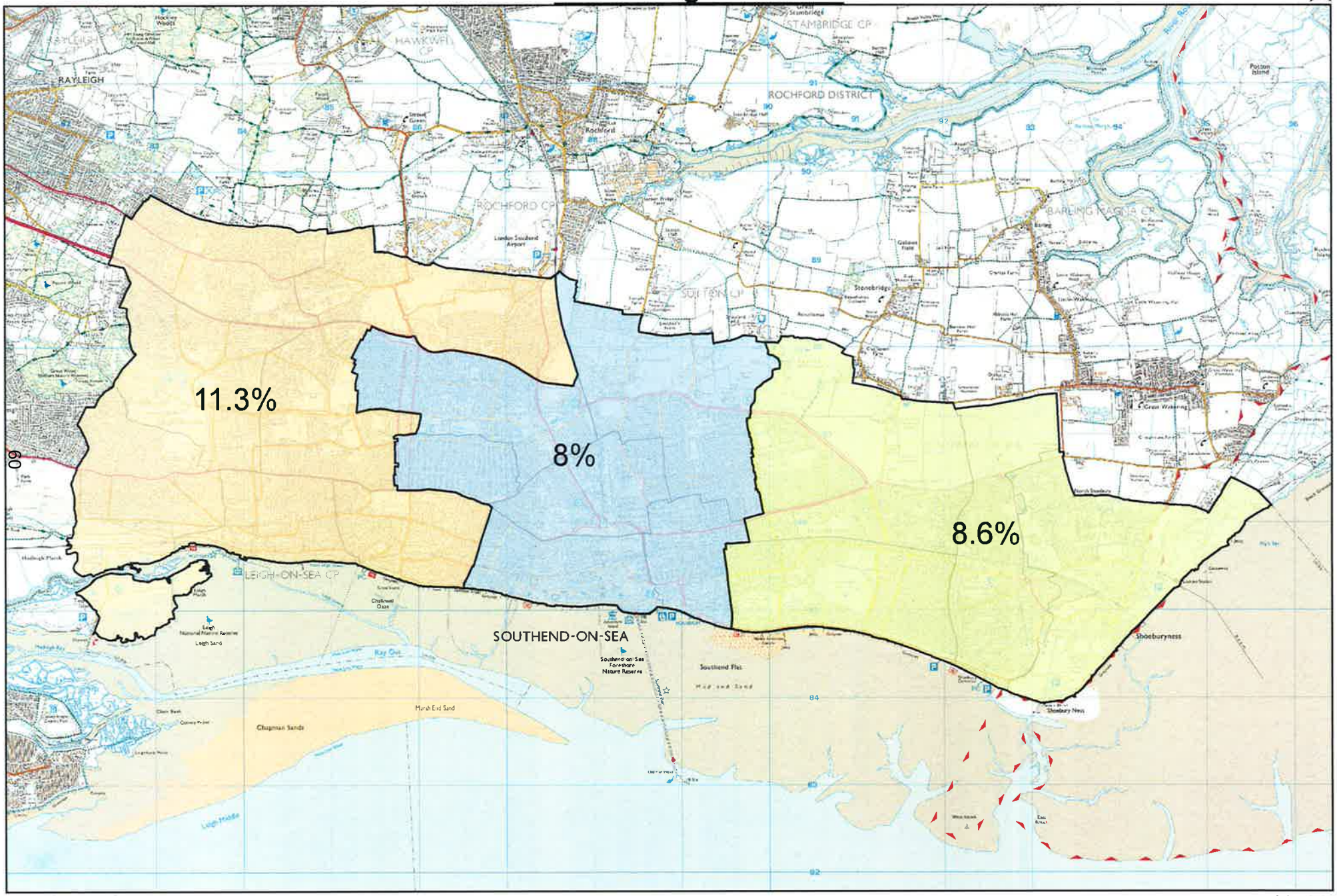
Scale 1:38,398

Append' 7g - Number of Clients with ' least 3 Assessments by Area - Resident Postcode



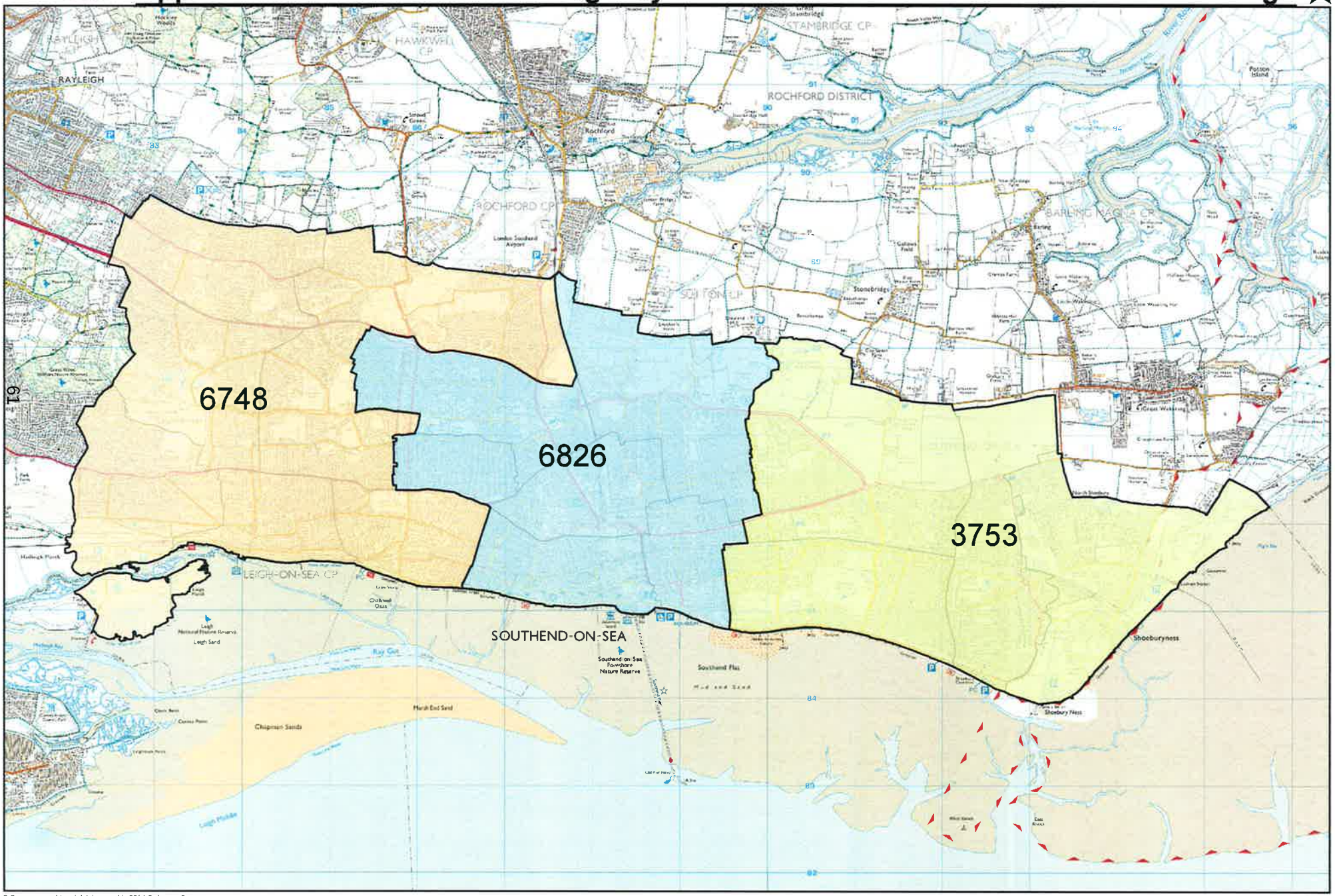
Scale 1:38,398

Appendix 8a - Non-Elective Emergency Admissions: 2013/14 - 2014/15
Percentage Increase



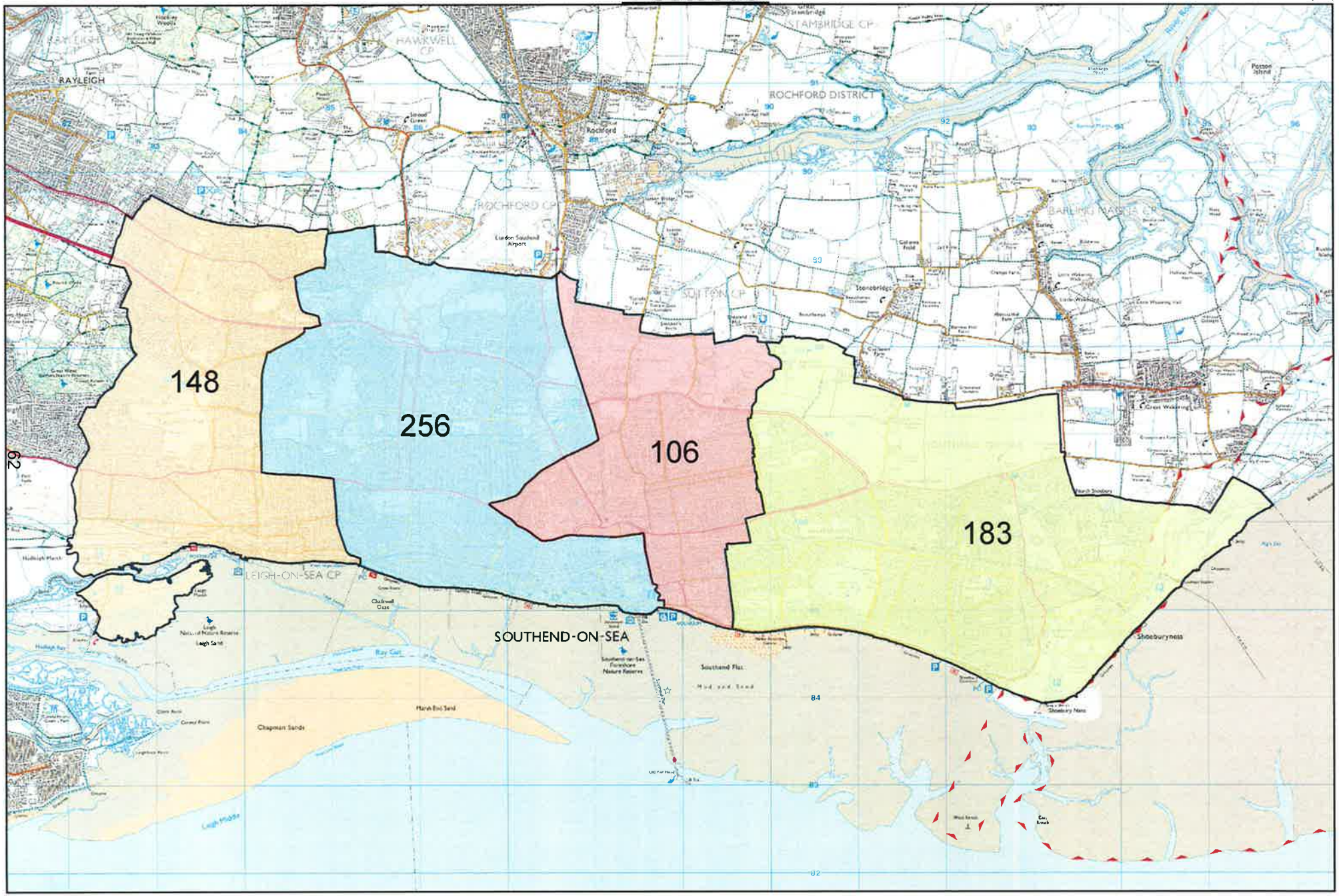
Scale 1:38,398

Appendix 8b - Non-Elective Emergency Admissions 2013/14 - 2014/15: 2 Year Average



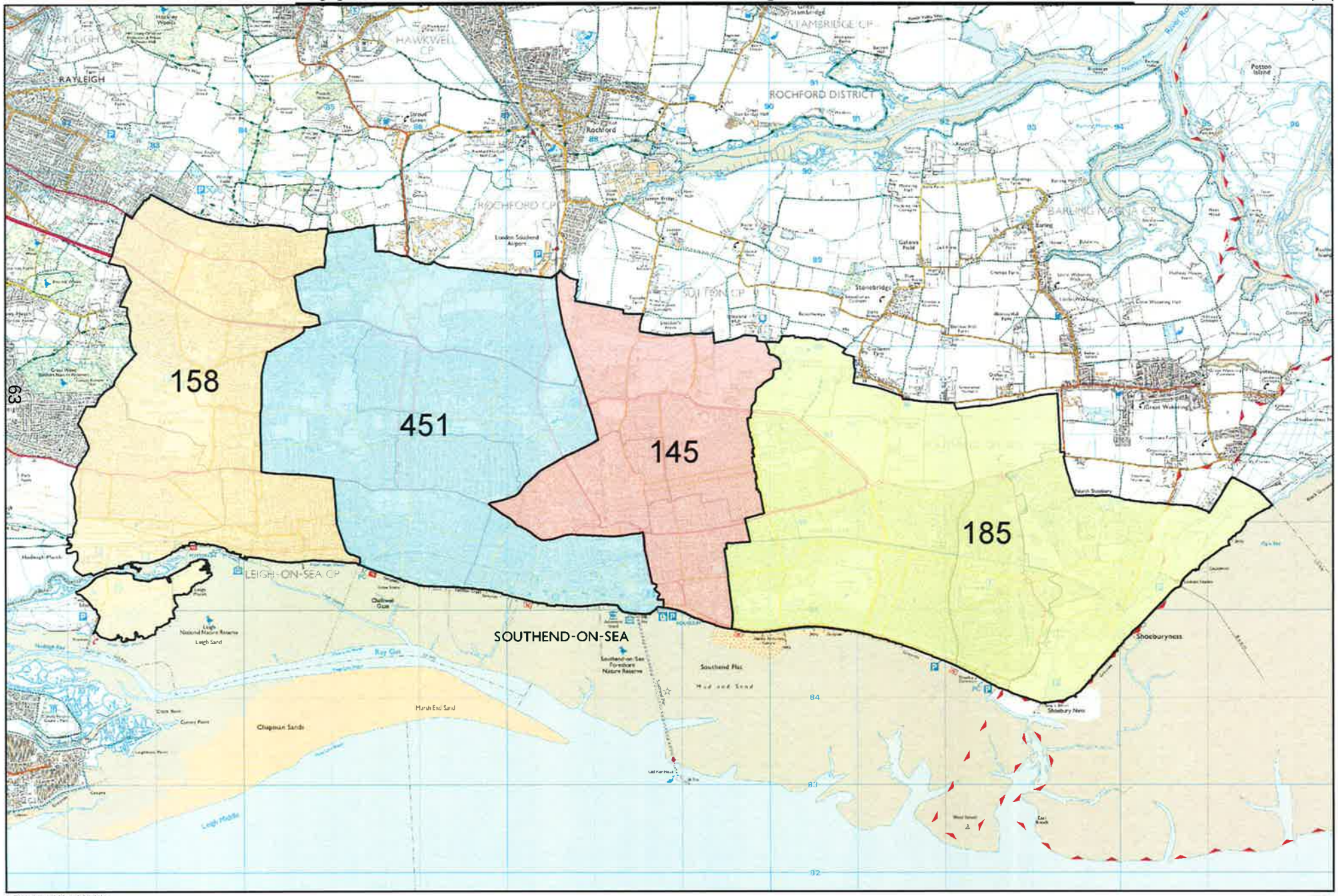
Scale 1:38,398

Appendix 9a - Number of Clients with at least 3 Assessments by Area - Resident Postcode



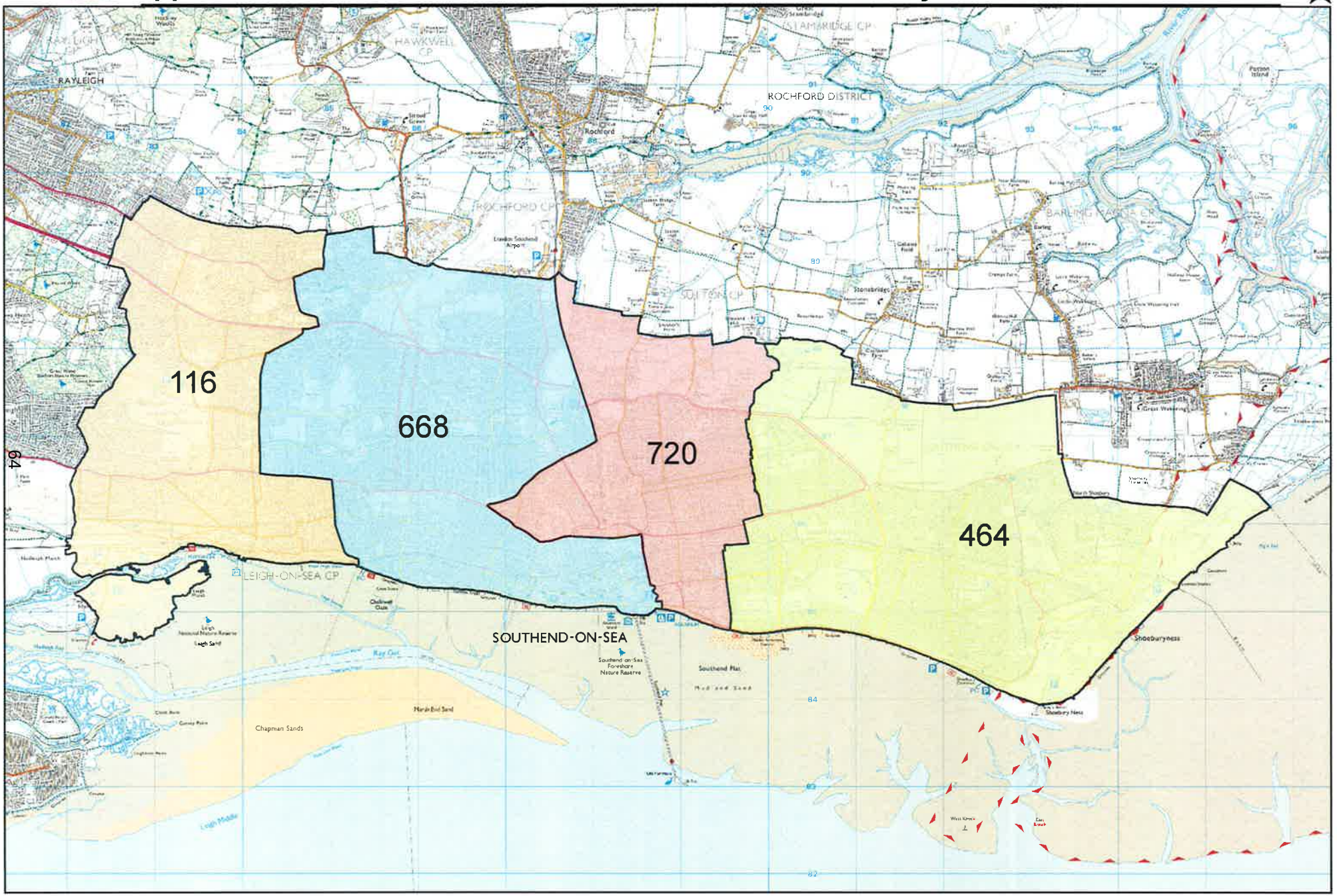
Scale 1:38,398

Appendix 9b - Number of MCA2s by Area - Resident Postcode



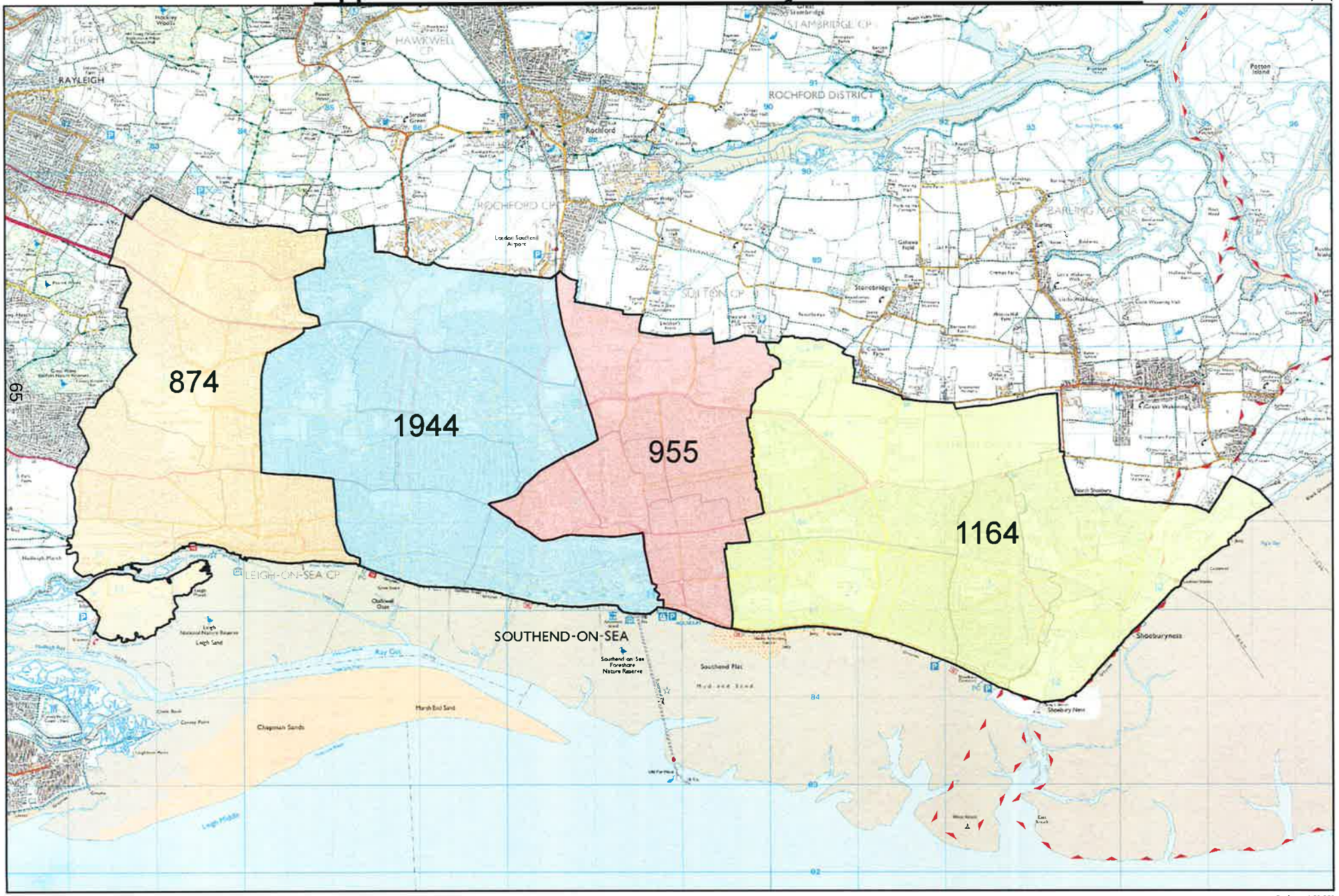
Scale 1:38,398

Appendix 9c - Number of Children Known to Social Care by Area - Resident Postcode

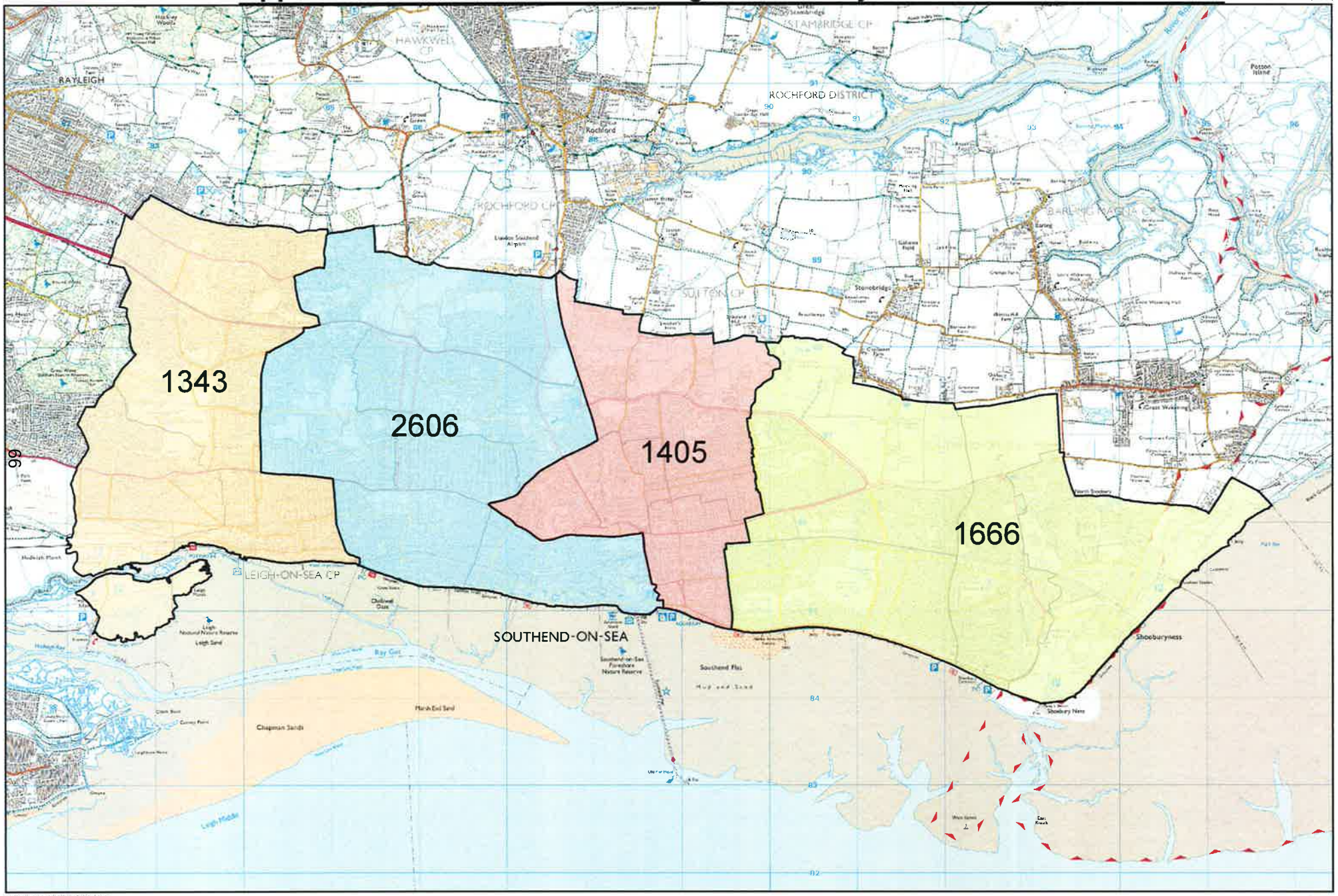


Scale 1:39,398

Appendix 9d - Number of Clients by Area - Resident Postcode

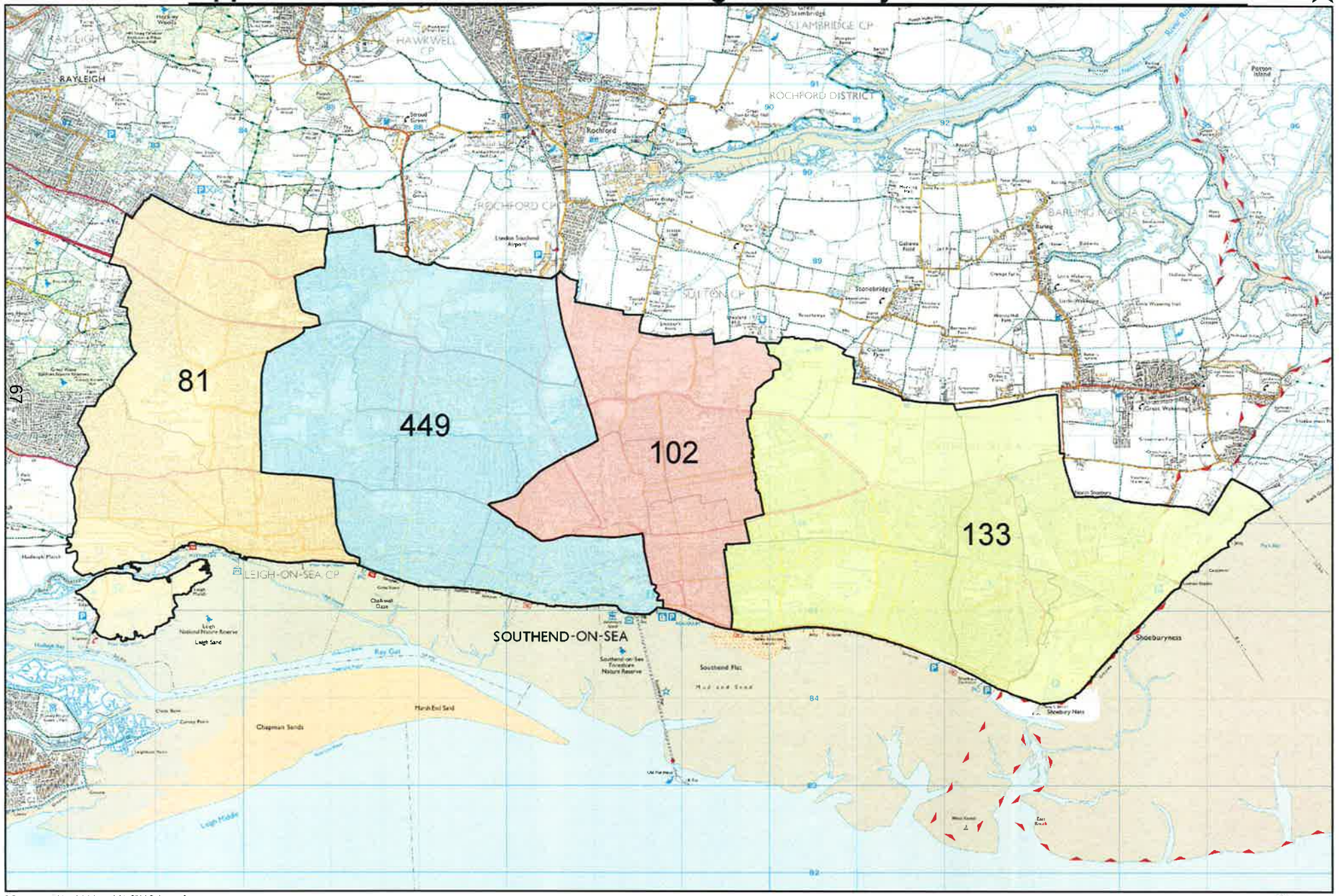


Appendix 9e - Number of Other Agreements by Area - Resident Postcode



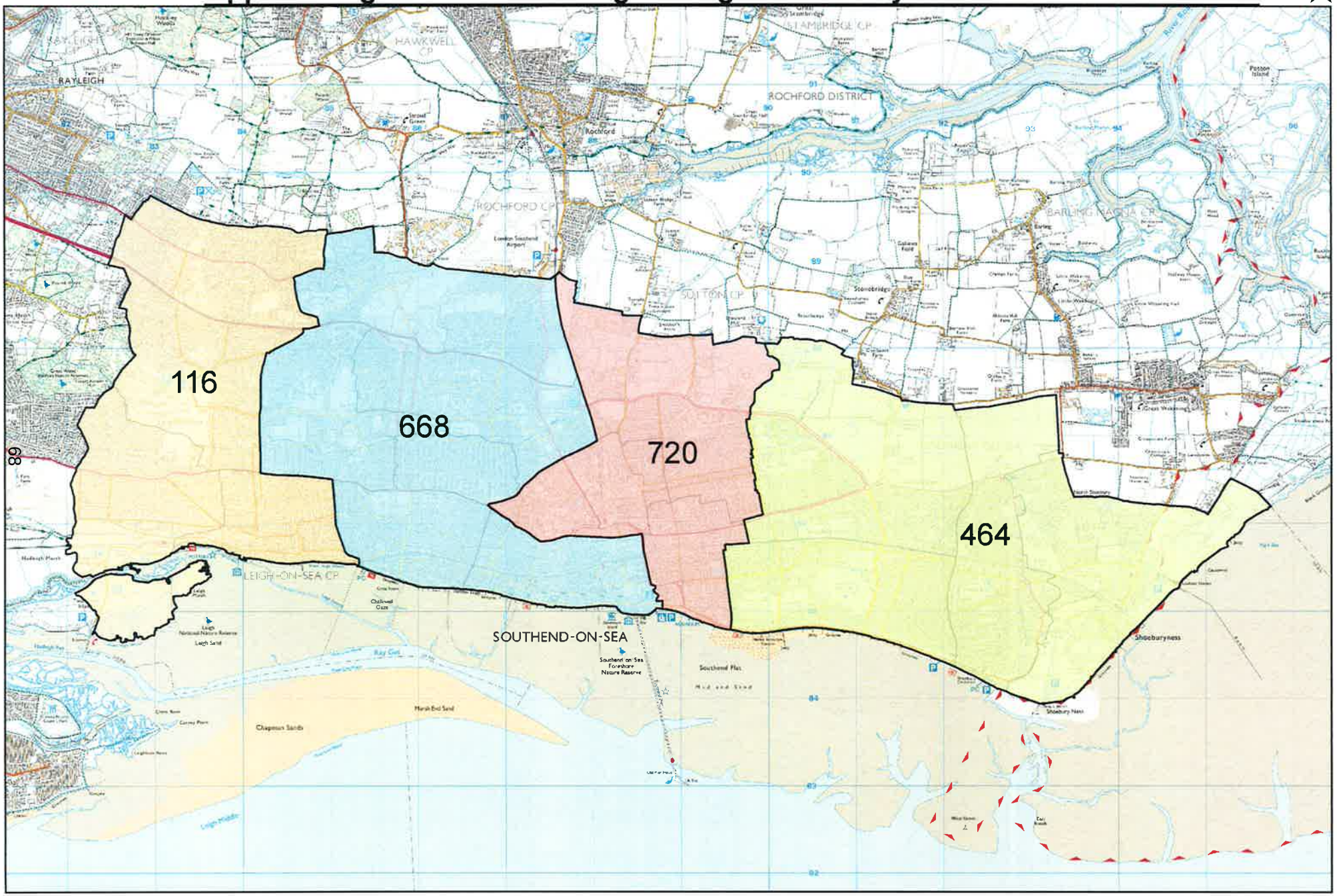
Scale 1:36,366

Appendix 9f - Number of Residential Agreements by Area - Resident Postcode



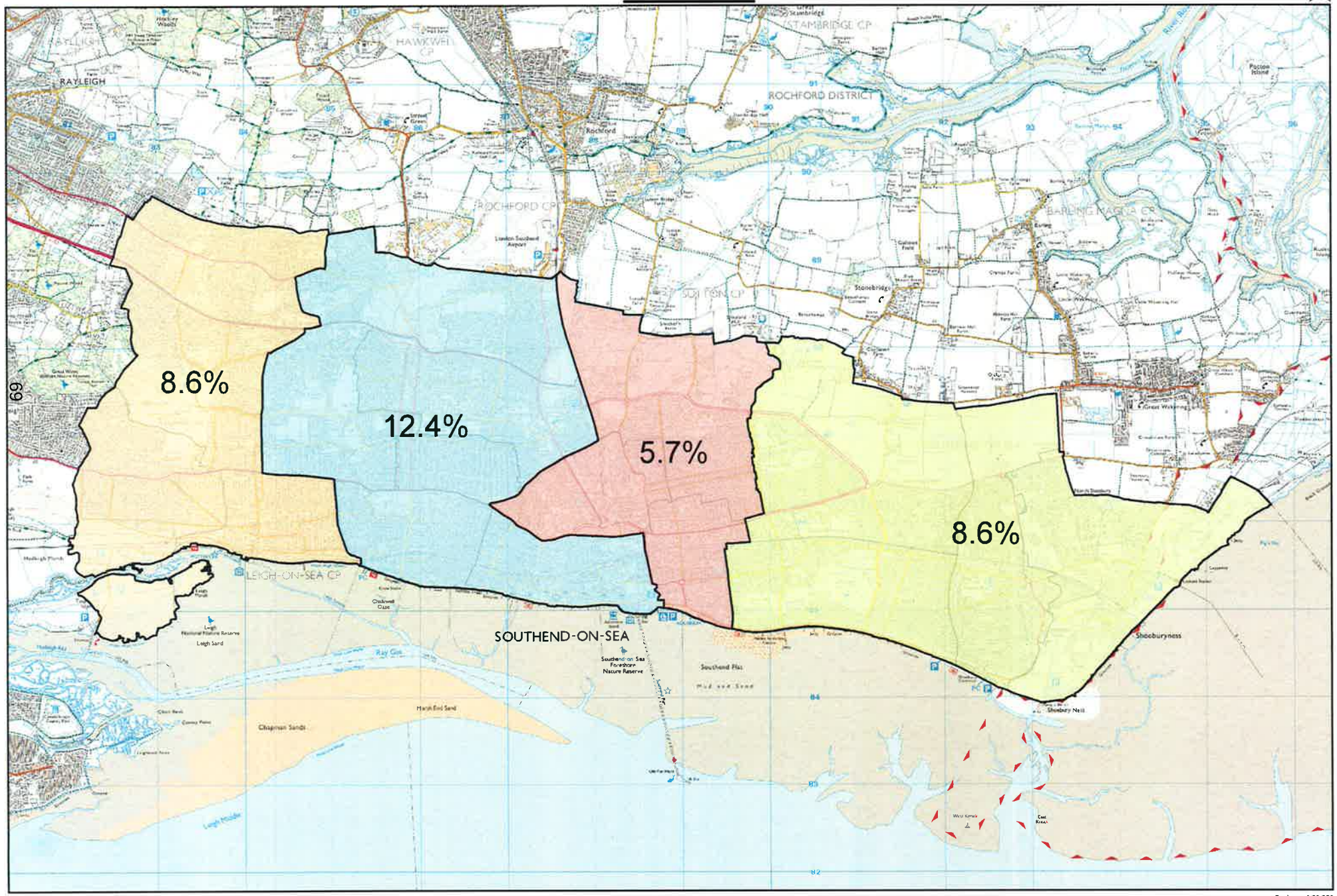
Scale 1:38,398

Appendix 9g - Number of Safeguarding Referrals by Area - Resident Postcode



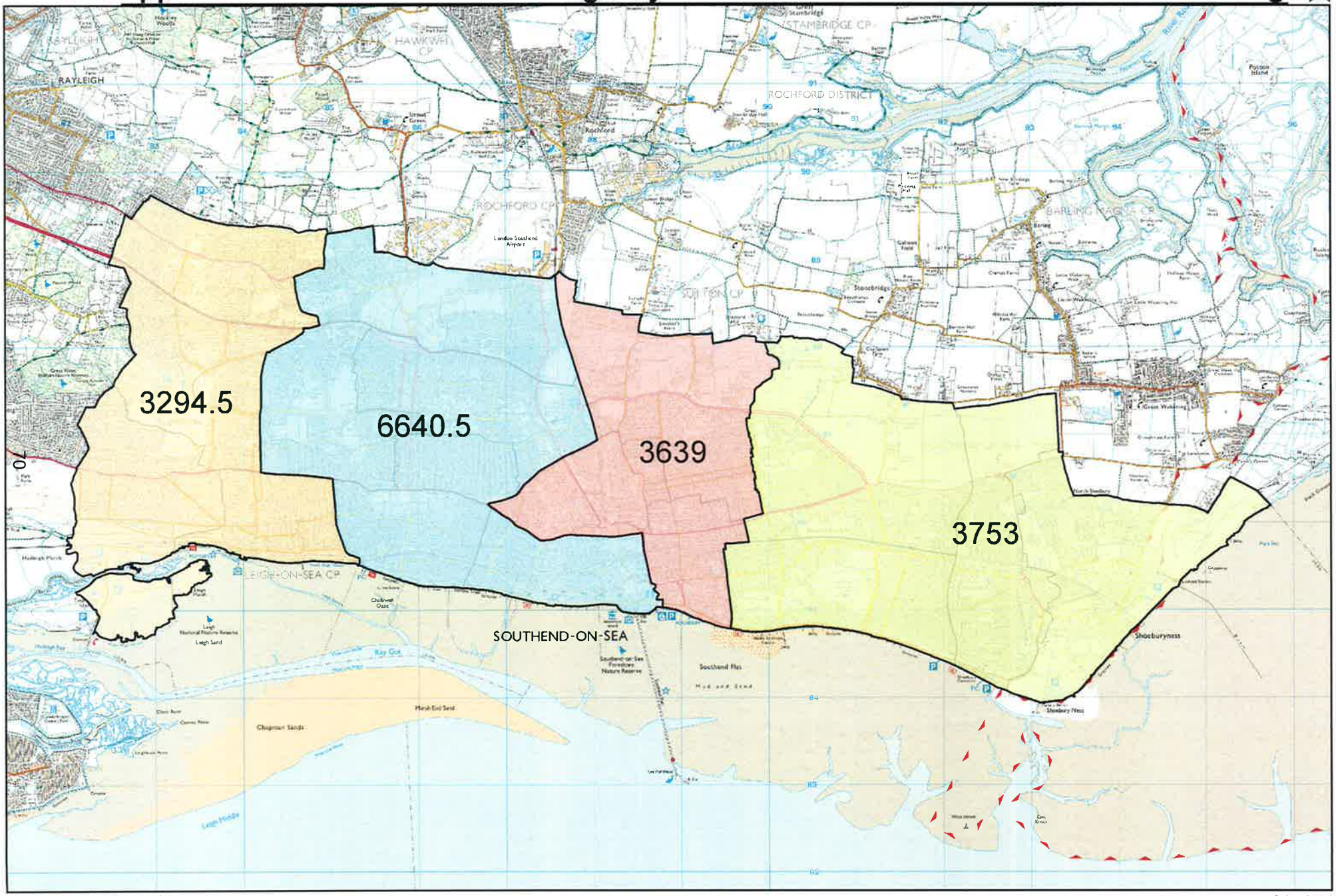
Scale 1:38,398

Appendix 10a - Non-Elective Emergency Admissions: 2013/14 - 2014/15 Percentage Increase



Scale 1:38,398

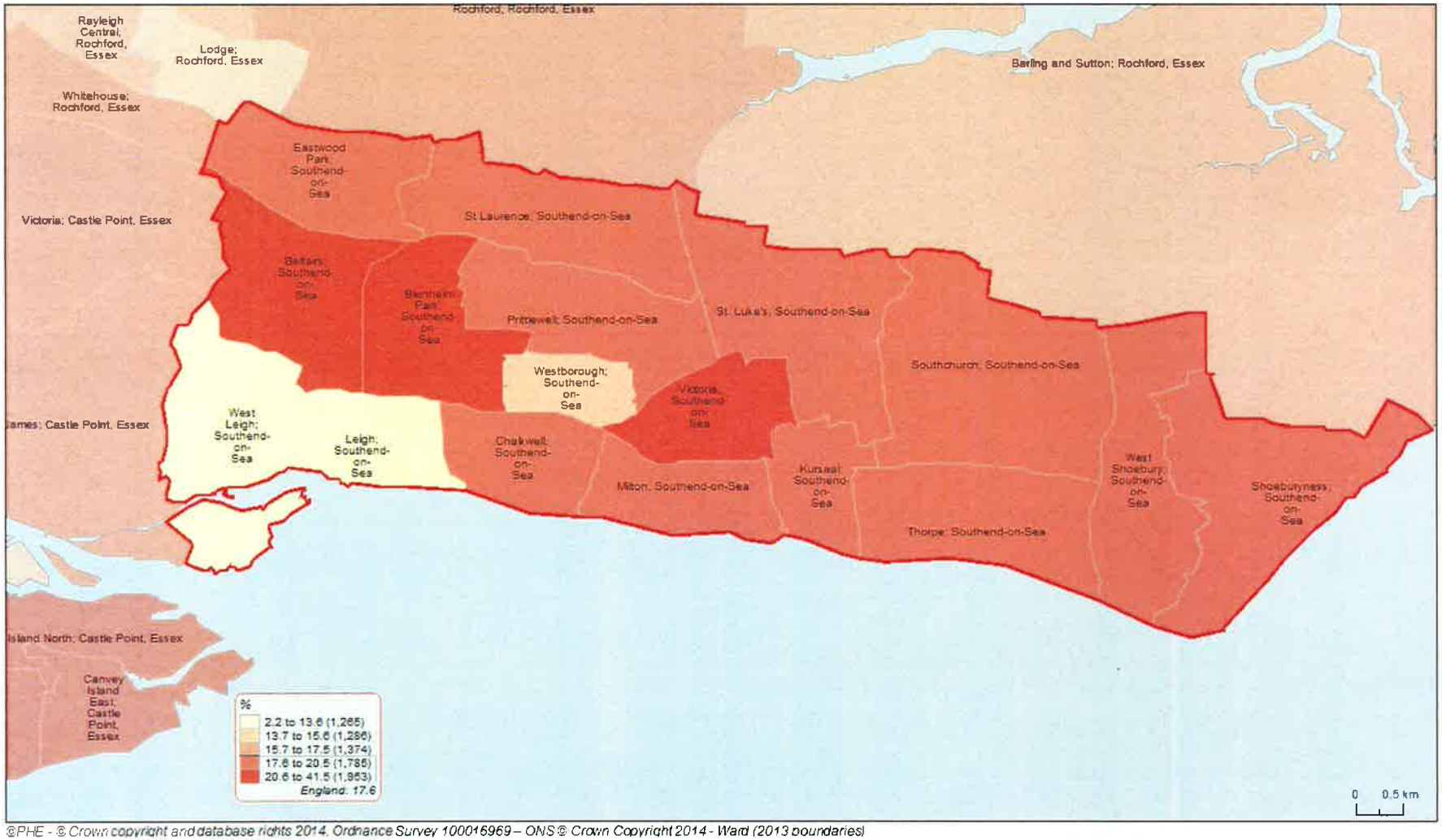
Appendix 10b - Non-Elective Emergency Admissions 2013/14 - 2014/15 : 2 Year Average



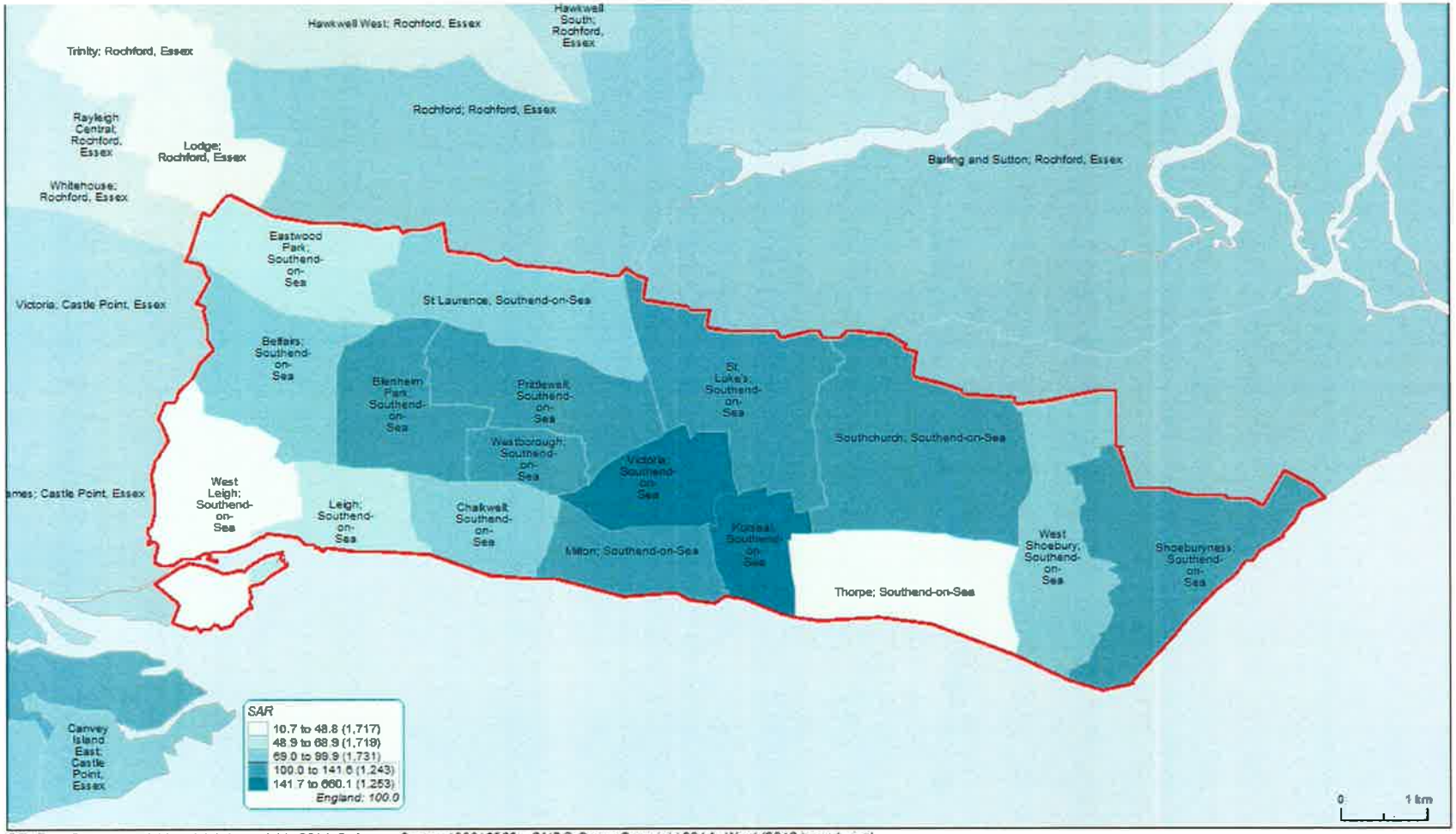
Scale 1:38,396

Appendix 11: Percentage of people who had a limiting long-term illness/disability – 2011 (Public Health)

% of people who had a limiting long-term illness or disability, 2011 - *source: ONS Census*



Appendix 12: Emergency Admissions into acute care from 2008 - 2013



Appendix 13 – Non-elective admissions, A&E attendance and emergency readmissions by patients MSOA both through postcode and GP registration

Non-Elective Admissions by patients MSOA, 2015/16, Registered Patients

Non-Elective Admissions by patients MSOA, 2015/16, Resident Patients

Appendix 13 – Non-elective admissions, A&E attendance and emergency readmissions by patients MSOA both through postcode and GP registration

Accident and Emergency Attendances by patients MSOA, 2015/16, Registered Patients

Accident and Emergency Attendances by Patients MSOA, 2015/16 Resident Population

Appendix 13 – Non-elective admissions, A&E attendance and emergency readmissions by patients MSOA both through postcode and GP registration

Emergency Readmissions by Patients MSOA, 2015/16 Registered Population

Emergency Readmissions by Patients MSOA, 2015/16 Resident Population

Appendix 14: District Nurse allocation across Southend-on-Sea

Practice	Registered patients	DN wte	RN wte	HCA wte	Total 'DN'
Jayatilaka, Elmsleigh	1976	1(1)	2.13(3)	1(1)	Vacancy to be added when recruited 1.0 RN
Puri, Elmsleigh	1225				
Sathanandan, Blenheim Chase	3424				
Zaidi, Eastwood Road	10683				
Current caseload: 165	**17308**	**1.00**	**2.13**	**1.00**	**4.13**
Nagle Pall Mall	17094	0.8(1)	2.6(3)	1.0 (1)	HCA 1.00
Sooriakumaran, Leigh Road	4251				
Current caseload: 203	**21345**	**0.80**	**2.60**	**1.00**	**4.40**
Houston, Highlands	11243	1(1)	1.6(2)	1.8(2)	
Jack, Lydia House	1831				
Current caseload: 249	**13074**	**1.00**	**1.60**	**1.80**	**4.40**
Chaturvedi Southbourne Grove	3281	1(1)	2.33(3)	1.24(2)	
Krishnan, Kent Elms HC	4851				
Malik, KEHC	3524				
Ng	2650				
Current caseload: 177	**14306**	**1.00**	**2.33**	**1.24**	**4.57**
Ziadi Rayleigh Road		1(1)	1.6(2)	1(1)	1.69 RN
Zaidi,Kent Elms	10683				
Krishnan, Kent Elms HC	4851				
Malik, KEHC	3524				
Current caseload: 194	**19058**	**1.00**	**1.60**	**1.00**	**3.60**

Total	**74989**	**4.80**	**10.26**	**6.04**	**21.10**
			Plus vacancies		**3.69**

Check
What does
this chart
say

Is it where they
are located?

Care Home allocation

Care Home	Beds
Avondale	19
Cavell Lodge	38
St Ediths Court	39
Brambles	22
Adalah	29
Admirals Court	42
Catherine Miller House	29
Rose Martha Court	67
Memory House	39
Legra	17
Grandville Lodge	19
Fairview House	52
Brooklands	45
Havengore	22
Total WTE Leigh	479

This page is intentionally left blank

Agenda Item No. 6

Southend Health & Wellbeing Board

Joint Report of
Simon Leftley, Corporate Director for People, SBC
Melanie Craig, Chief Officer, Southend CCG

to
Health & Wellbeing Board
on
01 August 2016

Report prepared by:
Ian Ambrose, BCF Pooled Fund Manager, Southend Borough Council
Nick Faint, BCF Project Manager

For discussion		For information only		Approval required	X

Better Care Fund – Update and Section 75 Agreement (Deed of Variation)

Part 1 (Public Agenda Item)

1 Purpose of Report

1.1 The purpose of this report is to inform Health & Wellbeing Board (HWB) regarding the current status of the Southend Better Care Fund (BCF) 16/17 plan; and to request that HWB note the Section 75 agreement deed of variation.

2 Recommendations

2.1 HWB are asked to **NOTE** the approved status of the Southend BCF plan 16/17 and **NOTE** the Section 75 agreement deed of variation;

3 Background

3.1 The BCF for 2015/16 was established between Southend Clinical Commissioning Group (SCCG) and Southend on Sea Borough Council (SBC) from 1st April 2015. It is underpinned by a legal Section 75 (s75) 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 leads.

3.2 Throughout the course of 2015/16 HWB has reported quarterly BCF activity to NHS England. A return was submitted for Q4 2014/15, Q1, Q2, Q3 & Q4 2015/16.

3.3 In January 2016 a Policy Framework (at Appendix 1) was published by the Department of Health (DoH) and the Department for Communities and Local

Government (DCLG) which provides direction for HWBs in formulating BCF plans for 2016/17. Sections 3.6 – 3.8 provide a summary of the Policy Framework.

3.4 The technical planning guidance and detailed direction to enable local areas to draft the BCF plans for 2016/17 was published on 23rd February. The technical planning guidance is at Appendix 2.

BCF performance for 2015/16

3.5 On 27th May 2016 a Q4 2015/16 report was submitted to NHS England. The report contained the accumulative performance for period from beginning of Q4 2014/15 to end Q4 2015/16; an activity period spanning five quarters. Key points from this report are;

3.5.1 Non-Elective admissions reduced by 5.0%. The agreed target was 3.5%.

3.5.2 Admissions to residential care reduced by 18%. The agreed target was 11.5%.

3.5.3 The current performance of the Southend BCF allows for the recovery of a proportional amount of Pay 4 Performance money that was placed at risk through the BCF. The full amount has now been recovered from a pot totalling £1,047m.

BCF National Policy Framework for 2016/17

3.6 The BCF National Policy Framework was published in January 2016 and is attached at Appendix 1 to this paper. A summary of the key points noted in the Policy Framework are;

3.7 For 2016/17 HWBs are required to meet the following conditions to access the BCF ring fenced funding;

3.7.1 that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006;

3.7.2 HWBs jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s);

3.7.3 that plans are approved by NHS England in consultation with DoH and DCLG; and

3.7.4 that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including health and social care.

3.8 Further, NHS England will also require that BCF plans demonstrate how the following conditions will be met;

3.8.1 plans to be jointly agreed; the BCF plan is to be signed off by the HWB, the Local Authority and the CCG.

3.8.2 maintain provision of social care services; social care services are to be supported consistent with 2015/16. As a minimum, it should maintain the level of protection provided through BCF 2015/16.

3.8.3 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.

3.8.4 better data sharing between health and social care, based on the NHS number; confirm that the NHS number is being used, confirm Application Programming Interfaces (APIs) – systems that speak to each other – are being used, confirm appropriate Information Governance is in place, ensure local residents are informed that data is being shared.

3.8.5 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;

3.8.6 agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

3.8.7 agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care; local areas are to agree how their share of the £1bn (for Southend circa £1m) that had previously been used to create the pay for performance will be allocated. This is to fund NHS commissioned out of hospital services, which may include a range of services including social care.

3.8.8 agreement on a local action plan to reduce delayed transfers of care (DToC). Each area is to agree a local action plan to address DToC with a locally agreed target.

Finances

3.9 The full technical planning guidance of the BCF fund for 2016/17 is at Appendix 2. SCCGs minimum contribution to the BCF is £11.938m which represents an increase of £0.338m from 2015/16. The LA contribution is £1.153m which is the Disabled Facilities Grant (DFG).

3.10 Within the £11.938m contribution from SCCG a minimum of £3,842m is to be transferred through to SBC to maintain the provision of social care services, which represents an inflationary increase from £3,777m for 2015/16.

4 The BCF plan for 2016/17

General

4.1 The Southend BCF plan for 2016/17 was submitted on 3rd May 2016 and was approved on 5 July 2016 by NHS England (see Appendix 3).

4.2 The Southend BCF plan (at Appendix 4a & b) for 2016/17 is based on the following;

4.2.1 conformance to the national conditions,

4.2.2 building on the successes and lessons learnt from 2015/16;

4.2.3 aligned with wider transformation activity; and

4.2.4 a plan to further integrate our health and social care system.

Response to national conditions

4.3 **S75;** this national condition existed as a national condition in 2015/16. The Southend BCF plan for 2016/17 will be formalised through a deed of variation (Appendix 5) to our existing s75 agreement (Appendix 6) (established 1st April 2015). SCCG and SBC commissioned Bevan Brittan to draft the deed of variation in accordance with our agreed commercial direction.

4.4 **Health and Wellbeing Boards jointly agree the plan;** HWB agreed the BCF (submitted to NHS England of 21st March 2016) on 7th April 2016. HWB further agreed delegated powers to the Chair of HWB, Vice Chair of HWB Chief Officer SCCG and Corporate Director for People SBC to sign off any amendments to the plan. The final plan was submitted on 3rd May 2016, (see Appendix 4a & b).

4.5 **that plans are approved by NHS England in consultation with DoH and DCLG;** a regional assurance process has been developed by the East of England BCF regional manager which will facilitate both approval and moderation of the plans;

4.6 **that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services;** Sufficient funding, aligned with national guidance, have been committed to funding out of hospital / community services for 2016/17.

Making the broader connections

Essex Success Regime (ESR)

4.7 ESR is part of the NHS Five Year Forward View and with a scope that includes mid and South Essex is targeted to;

4.7.1 reduce the clinical and financial disadvantages for our local hospitals;

4.7.2 accelerate plans for changes in urgent and emergency care;

4.7.3 join up services in primary, community and social care;

4.7.4 simplify commissioning, reduce workload and duplication;

4.7.5 develop a more flexible workforce; and

4.7.6 share data between health and social care.

4.8 Many of the priorities for ESR are aligned to the BCF National Policy Framework 2016/17 and the Southend BCF plan for 2016/17. Through the existing governance structure we will ensure the plans for each of the programmes are understood and accounted for.

Adult Social Care (ASC) redesign

4.9 ASC redesign is an important element to the redesign and delivery of integrated health and social care in Southend. ASC is currently leading a transformational project across the whole social care and health system which will turn around culture and mindset, develop alternatives, develop engagement, communicate a compelling vision, and develop and embed the narrative that supports this transformational change programme of work.

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

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

4.12 Adopting a collaborative and preventative approach to our practice will minimise admissions into long term residential care, admission into hospital and minimise the need for large domiciliary care packages. Social Care will create a robust multi-disciplinary front-end adult social care team where advice, information and signposting to the wider community and universal services can minimise the long term dependency on health and social care services.

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

5 Section 75 Agreement – Deed of Variation

5.1 Bevan Brittan have drafted a deed of variation to the 2015/16 s75 agreement. The deed of variation is at Appendix 5 and the s75 agreement is at Appendix 6.

5.2 SCCG Governing Body (GB) signed off the Deed of Variation on 2nd June 2016. There is no legal requirement for SBC Cabinet to sign off the Deed of Variation to the s75 agreement as the s75 agreement is not new and is a variation to an existing contract.

5.3 The deed of variation accounts for the revised BCF plan for 2016/17. A summary of the changes are listed below;

5.3.1 Accounts for the revised governance structures now in place;

5.3.2 Accounts for the Southend system to change direction following any future direction from the Essex Success Regime; and

5.3.3 Allows for the CCG and SBC to agree any future funding in addition to the minimum BCF contributions.

6 Health & Wellbeing Board Priorities / Added Value

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

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

6.2 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

6.3 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 BCF.

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 Locality approach should result in more efficient and effective provision for vulnerable people of all ages.

11 Appendices

Appendix 1 – BCF Policy Framework 2016/17	Appended separately
Appendix 2 – Technical Planning Guidance 2016/17	Appended separately
Appendix 3 – NHS England Southend approval letter	Appended separately
Appendix 4 (a & b) – Southend BCF plan	Appended separately
Appendix 5 – s75 Deed of Variation	Appended Separately
Appendix 6 – s75 Agreement 15/16	Appended Separately

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

This page is intentionally left blank

Department of Health

Department for Communities and Local Government

2016/17 Better Care Fund

Policy Framework

January 2016

Title: Better Care Fund, Policy Framework 2016/17
Author: SCLGCP/ SCP/ Integrated Care Policy / 11120
Document Purpose: Policy
Publication date: **01/2016**
Target audience: This document is intended for use by NHS England and those responsible for delivering the Better Care Fund at a local level (such as, clinical commissioning groups, local authorities and health and wellbeing boards).
Contact details: Edward Scully Richmond House Whitehall London SW1A 2NS Edward.scully@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

www.gov.uk/dh

2016/17 Better Care Fund

Policy Framework

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

Contents

Background

The Better Care Fund 2016/17 Policy Framework

The Better Care Fund is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation. In 2015-16, the Government committed £3.8 billion to the Better Care Fund with many local areas contributing an additional £1.5 billion, taking the total spending power of the Better Care Fund to £5.3 billion.

Current health and care approaches have evolved to respond reactively to changes in an individual's health or ability to look after themselves, and they often do not meet people's expectations for person-centred co-ordinated care. Greater integration is seen as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and facilitating early discharge.

We recognise that local areas are at different points in their integration journey and in supporting them to achieve their ambitions for integrated care, we will need to prioritise progress on known barriers to change to ensure the key factors associated with successful integration are embedded and shared across the system. The Better Care Fund and other drivers of integrated care such as New Care Models pave the way for greater integration of health and social care services.

In 2016-17, the Better Care Fund will be increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. The local flexibility to pool more than the mandatory amount will remain. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund. In looking ahead to 2016-17, it is important that Better Care Fund plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

This document sets out the policy framework for the implementation of the fund in 2016-17, as agreed across the Department of Health, Department for Communities and Local Government, Local Government Association, Association of Directors of Adult Social Services, and NHS England. In developing this policy framework, the strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund has been taken on board, and we have streamlined and simplified the planning and assurance of the Better Care Fund in 2016-17, including removing the £1 billion payment for performance framework.

In place of the performance fund are two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system, and to

ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

Further detailed guidance will be issued by NHS England, working with the partners above, on developing Better Care Fund plans for 2016-17. The guidance will form the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England's website. Local areas are asked to refer to and follow this guidance.

Beyond the 2016-17 Better Care Fund

The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements. Further details will be set out shortly in guidance.

1. The 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 Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

Under the mandate to NHS England for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

Of the £3.519 billion Better Care Fund allocation to Clinical Commissioning Groups, £2.519 billion of that allocation will be available upfront to Health and Wellbeing Boards to be spent in accordance with the local Better Care Fund plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to a new national condition.

NHS England and the Government will allocate the Better Care Fund to local areas based on a framework agreed with Ministers. For 2016-17, the allocation will be based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

Within the Better Care Fund allocation to Clinical Commissioning Groups is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in the Better Care Fund Planning Requirements.

Individual allocations of the Better Care Fund for 2016-17 to local areas and the detailed formulae used will be published on NHS England's website in early January.

2. Conditions of Access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. In 2016-17, NHS England will set the following conditions, which local areas will need to meet to access the funding:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- 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)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (as set out in section 3 below)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

NHS England will also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- 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;
- Better data sharing between health and social care, based on the NHS number;
- 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;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

Detailed definitions of these national conditions are set out at Annex A.

Conditions of Access to the Better Care Fund

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of funding where conditions attached to the Better Care Fund are not met. 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 2016-17 mandate to NHS England confirms that NHS England will be required to consult Ministers before using these powers.

NHS England's power to set conditions on the Better Care Fund applies to the £3.519bn that is part of Clinical Commissioning Group allocations. For the £394m paid directly to local government, the Government will attach appropriate conditions to the funding to ensure it is included in the Better Care Fund at local level. As set out in Better Care Fund technical guidance, for 2016-17 authorities in two-tier areas will have to allocate Disabled Facilities Grant funding to their respective housing authorities from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people.

3. The Assurance and Approval of the Local Better Care Fund Plans

Local Better Care Fund plans will be developed in line with the agreed guidance, templates and support materials issued by NHS England and the Local Government Association. For 2016-17, we have set out a more streamlined process that is better integrated into the business-as-usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities.

The first stage of the overall assurance of plans will be local sign-off by the relevant Health and Wellbeing Board, local authority and Clinical Commissioning Group(s). In line with the NHS operational planning assurance process, plans will then be subject to regional moderation and assurance. The key aspects of the process for the planning, assurance and approval of Better Care Fund plans are:

- Brief narrative plans will be developed locally and submitted to regional teams through a short high level template, setting out the overall aims of the plan and how it will meet the national conditions
- A reduced amount of finance and activity information relating to local Better Care Fund plans will be collected alongside Clinical Commissioning Group operational planning returns to submitted to NHS England, to ensure consistency and alignment
- Better Care Managers will work with NHS England Directors of Commissioning Operations teams to ensure they have the knowledge and capacity required to review and assure Better Care Fund plans. To support this local government regional leads for the Better Care Fund (LGA lead CEOs and ADASS chairs) or their representatives will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation)
- There may be flexibility permitted for devolution sites to submit plans over a larger footprint if appropriate
- An assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor and local government
- These judgements on ‘plan quality’ and ‘risks to delivery’ will contribute to the placing of plans into three categories – ‘Approved’, ‘Approved with support’, ‘Not approved’.

A diagram of the above assurance and approval process is included in Annex B. The full details will be set out in the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England’s website.

The Assurance and Approval of the Local Better Care Fund Plans

Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an area's plan being proportionate to the perceived level of risk in a system. Recommendations of approval for Better Care Fund plans for high risk areas will be made by the regional moderation process but those decisions will be quality assured by the Integration Partnership Board (which is a senior programme leadership board comprising DH, DCLG, NHS England, Local Government Association and the Association of Directors of Adult Social Services). Final decisions on approval will be made by NHS England, based on the advice of the moderation and assurance process, in accordance with the legal framework set out in section 223 GA of the NHS Act 2006.

Where plans are not initially approved, or are approved with support, NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

NHS England has the ability to direct use of the fund where an area fails to meet one of the Better Care Fund conditions. This includes the requirement to develop a plan approved by NHS England and Ministers. If a local plan cannot be agreed, any proposal to direct use of the fund will be subject to consultation with DH and DCLG (as required under the 2016-17 mandate to NHS England).

4. National Performance Metrics

Under the 2015-16 Better Care Fund policy framework, local areas were asked to set targets against the following five key metrics:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient / service user experience
- A locally-proposed metric

In the interests of stability and consistency, areas will be expected to maintain the progress made in 2015-16. The detailed definitions of these metrics are set out in the Better Care Fund section of the NHS technical planning guidance.

5. Implementation 2016-17

The implementation of local Better Care Fund plans will formally begin from 1 April 2016. As part of its wider planning process, NHS England will require local areas to produce a multi-year strategic plan, showing how local services will get from where they are now to where the Five Year Forward View requires them to be by 2020. This will set out the actions and specific deliverables that NHS England will take forward to deliver the objectives set out in the multi-year mandate to NHS England – including those relating to the integration of health and social care and the continuation of the Better Care Fund.

In implementing the Better Care Fund in 2016-17, NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Work with partners to identify and remove barriers to service integration;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing success of the Better Care Fund – including delivery against key national performance metrics;
- Prepare as necessary for the continuation of the Better Care Fund over the next Parliament.

Annex A: Detailed Definitions of National Conditions

CONDITION	DEFINITION
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.
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/attac

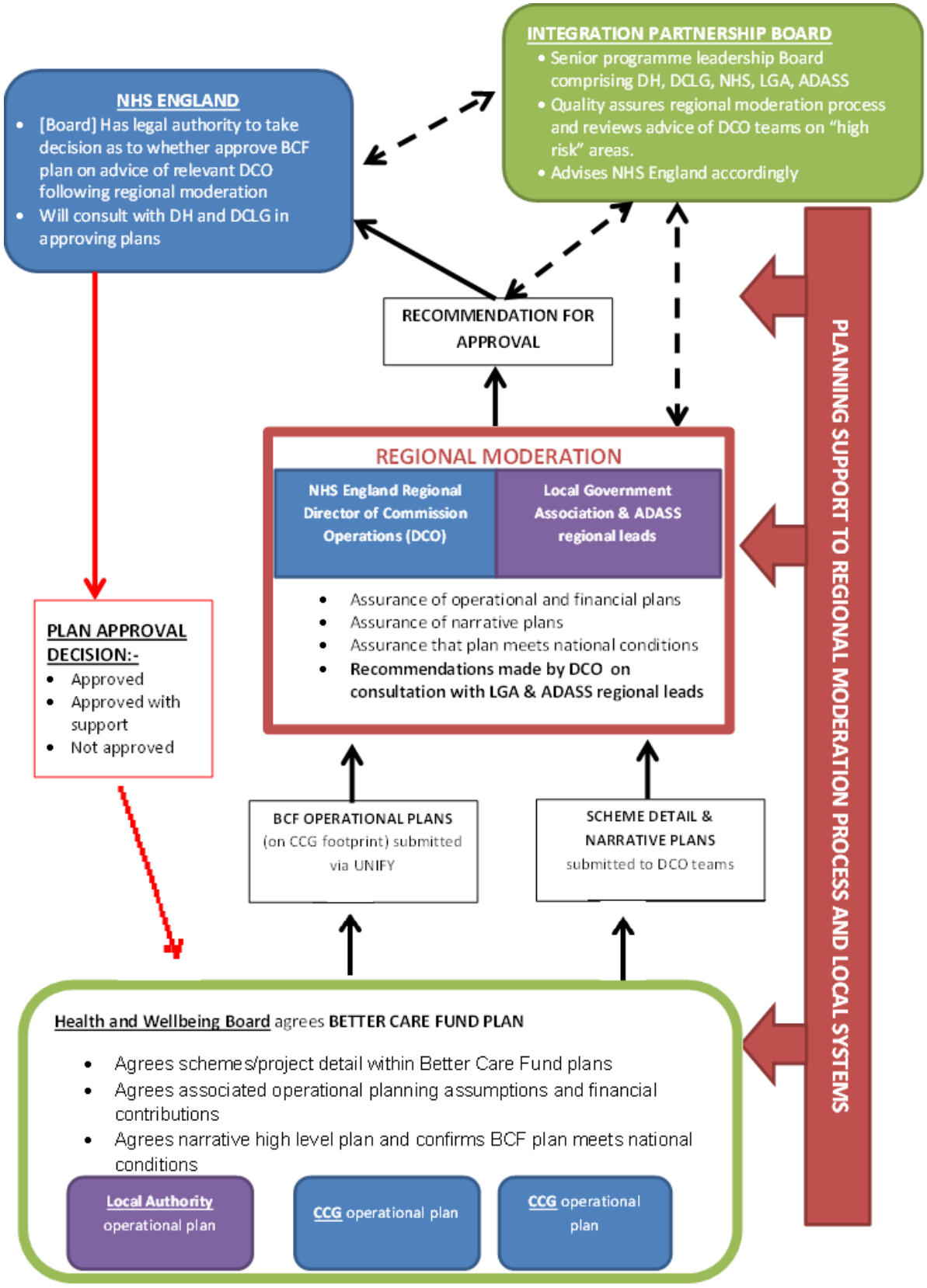
	hment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf"
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings 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.
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
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.
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.
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.
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.

Annex B: Assurance and Approval of Better Care Fund Plans



This page is intentionally left blank

Technical Guidance Annex 4:

Better Care Fund Planning Requirements for 2016-17

February 2016

NHS England Publications Gateway Reference 04437

CONTENTS

INTRODUCTION

1. The Department of Health (DH) and the Department for Communities and Local Government (DCLG) have published a detailed policy framework[1] for the implementation of the Better Care Fund in 2016-17, developed in partnership with the Local Government Association, Association of Directors of Adult Social Services and NHS England. This forms part of the NHS Mandate for 2016-17 to 2017-18. It requires NHS England to issue further detailed guidance to local areas on developing Better Care Fund (BCF) plans for 2016-17.

2. For 2016-17 it has been agreed that the BCF planning and assurance process should be integrated as fully as possible with the core NHS operational planning and assurance process. This guidance, which has been developed in conjunction with the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), is therefore included here as an annex to the core NHS planning guidance for 2016-17. This does not diminish the requirement for plans to be jointly developed with local government partners, and approved by Health and Wellbeing Boards. This guidance is also being disseminated directly to local authorities via the Local Government Association.

3. The policy framework signals the need for stability in 2016-17, and a reduction in the overall planning and assurance requirements on local areas. This includes a shorter narrative plan requirement, reduced detailed requirements on the scheme level data, and for plan assurance to be owned by NHS England and local government regional teams, rather than through the national assurance and resubmission process that existed for 2015-16.

4. Whilst the policy framework remains broadly stable in 2016-17, local areas should be mindful in developing their plans about the linkages with NHS sustainability and transformation plans which NHS partners will be required to produce in 2016, and the Government's Spending Review requirement to produce a whole system integration plan for 2017. Both planning requirements will require a whole system approach from 2017-20.

POLICY REQUIREMENTS

5. The legal framework for the Fund derives from the amended NHS Act 2006, which requires that in each area the Fund is transferred into one or more pooled budgets, established under Section 75, and that plans are approved by NHS England in consultation with DH and DCLG. The Act also gives NHS England powers to attach additional conditions to the payment of the Better Care Fund to ensure that the policy framework is delivered through local plans. In 2016-17, NHS England will set eight conditions, which local areas will need to meet through the planning process in order to access the funding. The conditions require:

    i. That a BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, should be signed off by the HWB itself, and by the constituent Councils and CCGs;

[1] https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

ii. A demonstration of how the area will meet the national condition to maintain provision of social care services in 2016-17.

iii. Confirmation of agreement on how plans will support progress on meeting the 2020 standards for seven-day services, to prevent unnecessary non-elective admissions and support timely discharge;

iv. Better data sharing between health and social care, based on the NHS number;

v. 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;

vi. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;

vii. That a proportion of the area's allocation is invested in NHS commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

viii. Agreement on a local action plan to reduce delayed transfers of care.

6. Conditions i - vi, above are based on policy set out in the 2013 Spending Review and were included in the 2015-16 BCF framework. They have been updated to reflect further policy developments and the 2015 Spending Review.

7. New condition vii replaces the national payment-for-performance element of the Fund, linked to delivering a reduction in non-elective activity that was a condition in 2015-16. We expect a similar local performance element will be deployed other than in those local areas that delivered their emergency admission reductions in 2015-16 and are confident that this can be repeated in 2016-17.Condition viii is also a new national condition for 2016-17. The details of each of the conditions are set out in the new policy framework.

PLANNING REQUIREMENTS

8. Local partners will need to develop a joint spending plan that is approved by NHS England as a condition of the NHS contribution to the Fund being released into pooled budgets. The process for developing plans will be simplified from the approach used for 2015-16 plans and will be aligned to the timetable for developing CCG operational plans. All national partners have agreed to minimise the amount of information that is collected and assured nationally as part of this process. In developing BCF plans for 2016-17 local partners will be required to develop, and agree, through the relevant Health and Wellbeing Board (HWB):

i. A short, jointly agreed narrative plan including details of how they are addressing the national conditions;

ii. Confirmed funding contributions from each partner organisation including arrangements in relation to funding within the BCF for specific purposes;

iii. A scheme level spending plan demonstrating how the fund will be spent;

iv. Quarterly plan figures for the national metrics.

9. The below table sets out where the information to fulfil the above planning requirements will be collected and how it will be assured:

Requirement	Collection method	Assurance approach
Narrative plans	Submitted to NHS England regional / local Directors of Commissioning Operations (DCO) teams in an agreed format	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Confirmation of funding contributions	Submitted through CCG Finance Template and through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Conditions	Detail submitted to NHS England regional / DCO teams through narrative plans (as above), with further confirmations submitted through a nationally developed high level BCF planning return (spreadsheet)	Assured by DCO teams, with regional moderation involving the LGA and ADASS
Scheme level spending plan	Submitted to NHS England regional / DCO teams through a nationally developed high level BCF planning return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process
National Metrics	Submitted through UNIFY and through a nationally developed high level BCF template return (spreadsheet)	Collated and analysed nationally, with feedback provided to DCO teams for regional moderation and assurance process

These will be the only planning requirements for the Better Care Fund in 2016-17.

NARRATIVE PLANS

10. There will not be a 'Nationally Consistent Assurance Review' of BCF plans for 2016-17 and therefore no national assessment of narrative plans. Local partners are still required to have in place a shared HWB level plan for integrating health and social care services through the BCF. This should build on approved plans for 2015-16 and demonstrate that local partners have reviewed progress in the first year of the BCF as the basis for developing plans for 2016-17. High level narrative plans produced for 2016-17 will therefore be expected to demonstrate incremental changes to 2015-16 plans reflecting this review of progress. As part of its assurance of CCG plans, NHS England will review BCF plans to ensure the appropriate use of risk management arrangements in the context of the BCF Condition 7.

11. In building on current BCF plans, the high level narrative plans that will need to be produced will also need to demonstrate that local partners have collectively agreed the following:

i. The local vision for health and social care services – showing how services will be transformed to implement the vision of the Five Year Forward View and moving towards integrated health and social care services by 2020, and the role the BCF plan in 2016-17 plays in that context;

ii. An evidence base supporting the case for change;

iii. A coordinated and integrated plan of action for delivering that change;

iv. A clear articulation of how they plan to meet each national condition; and

v. An agreed approach to financial risk sharing and contingency.

12. In all cases these elements can be demonstrated and referenced from existing plans or initiatives, including refreshed 2015-16 BCF plans. There will not be a need to restate information that is already satisfactorily provided in existing plans. This does not diminish the need for local areas to develop plans together and publish them in line with the requirements of their respective organisations.

13. In addition to the national condition relating to improving data sharing (see below), narrative plans are expected to demonstrate how digital or information technology is being established as an instrumental enabler to the delivery of integration, with reference to the Five Year Forward View and Personalised Health and Care 2020[2]. 90 communities have so far come together to create local digital roadmaps, with CCGs and local authorities included in each one. Where these are in place they should be referenced within BCF plans; where they are not it is expected that BCF plans will include a reference to their development. This recognises that integrated planning and delivery of the enabling information technology (including access to integrated digital records) is a vital part of the infrastructure to support improved operational performance on a number of areas that are a core focus of the BCF. These include reducing unnecessary non-elective admissions, seven day-a-week out-of-hospital services, and timely discharge.

CONFIRMATION OF FUNDING CONTRIBUTION

14. NHS England has published individual HWB level allocations of the BCF for 2016-17, and the detailed formulae used, on its website.[3] This builds upon confirmation of each CCG's contributions to the BCF in 2016-17 which is included in the core CCG allocations, also published on the NHS England website.[4]

15. All local partners will need to confirm mandatory and additional funding contributions to all plans to which they are a partner. This will include confirming that individual elements of the funding have been used in accordance with their purpose as set out in the policy framework and below. This will be collected nationally through a high level BCF Planning Return. Detailed instructions on completing this are included in the guidance section of the return template. Local

[2] https://www.england.nhs.uk/ourwork/futurenhs/nhs-five-year-forward-view-web-version/ and https://www.gov.uk/government/publications/personalised-health-and-care-2020
[3] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
[4] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

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.

Disabled Facilities Grant

16. Following the approach taken in 2015-16, the Disabled Facilities Grant (DFG) will again be allocated through the BCF. This is to encourage areas to think strategically about the use of home adaptations, use of technologies to support people in their own homes, and to take a joined-up approach to improving outcomes across health, social care and housing. In 2016-17, the housing element has been strengthened through the National Conditions, which require local housing authority representatives to be involved in developing and agreeing BCF plans. Again, following the approach taken in 2015-16, the DFG will be paid to upper-tier authorities in 2016-17. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to its respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

Care Act 2014 Monies

17. As described in the Policy Framework, the BCF allocation to CCGs includes £138m to support the implementation of the Care Act 2014 and other policies. BCF plans should set out how informal family carers will be supported by local authorities and the NHS. This funding is not new but has been uplifted from the £135m made available through the BCF in 2015-16 for a broader set of duties around the Care Act – this has been simplified to focus mainly on carer support. Further guidance and details of the exact breakdown will be set out in the Local Authority Social Services Letter, which will be sent by the Department of Health to the Directors of Adult Social Services in due course.

Former Carers' Break Funding

18. The BCF also includes, as in 2015-16, £130m of funds previously earmarked for NHS replacement care so that carers can have a break. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care).

Reablement Funding

19. The Better Care Fund also includes, as in 2015-16, £300m of NHS funding to maintain current reablement capacity in councils, community health services, the independent and voluntary sectors to help people regain their independence and reduce the need for ongoing care.

NATIONAL CONDITIONS

20. Local partners will be required to articulate a plan for meeting each national condition, as set out in the BCF policy framework and operationalised by the guidance contained in this document, through their BCF narrative plan. This

should include clear links to other relevant programmes or streams of work in place locally to deliver on these priorities. It is expected that local areas will want to provide more detailed plans for the new conditions in 2016-17. There will also be a requirement to confirm whether plans are in place to meet the conditions as part of the BCF planning return.

21. The two new national conditions and the conditions on 'Better data sharing between health and social care, based on the NHS number' and 'Maintain provision of social care services' should be read in conjunction with the additional guidance as set out in paragraphs 23 –34 below.

22. Confirmation that BCF plans meet the eight national conditions will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

FURTHER GUIDANCE ON NATIONAL CONDITIONS

Maintain provision of social care services

23. Local areas must include an explanation within their plans of how the use of BCF resources will meet the national condition to maintain provision of social care services.

24. In setting the level of protection for social care localities should 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 NHS England's regional assurance process.

25. 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"

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

26. At the present time the HSCIC is not extending the NHS Number batch service to additional local authorities. We understand that for some local authorities this will be causing difficulties in meeting the condition set out in the BCF to use the NHS Number as an identifier across the health and care system. We are working closely together to resolve the issue at a national level. If a locality is currently unable to obtain the NHS Number from the HSCIC then this should be noted in the BCF plan and it will be taken into account when assessing the plan.

Agreement to invest in NHS commissioned out-of-hospital services

27. The BCF Policy Framework establishes that £1 billion of the CCG contribution to the Fund required to deliver investment to the NHS and previously linked to the performance framework will continue to be ring-fenced to deliver investment or equivalent savings to the NHS, whilst supporting local integration aims. Each

CCG's share of this funding will be set out in allocations and will need to be spent as set out in the new national condition.

28. Local areas should agree how they will use their share of the £1 billion that had previously been used to create the national payment for performance element of the fund. This should be achieved in one of the following ways:

    - To fund NHS commissioned out-of-hospital services, that demonstrably lead to off-setting reductions in other NHS costs against the 2014-15 baseline; or

    - Local areas that did not meet their 2015-16 emergency admission reduction goals are expected to consider putting an appropriate proportion of their share of the ring-fenced £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess emergency hospital activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 2015-16).

29. Specifically, where local areas successfully delivered their agreed 2015-16 emergency admission reductions and all partners are confident that the 2016-17 BCF plan can meet its objectives then they can choose to invest the full element of the £1bn linked to NHS-commissioned out-of-hospital services upfront. This could include a wide range of services, to be determined locally. CCGs and Councils should include a breakdown of planned expenditure, including the amount they identify as NHS-commissioned spend, within the scheme level spending plan.

30. However, where the local partners recognise a significant degree of risk associated with the delivery of their 2016-17 BCF plan, for example where emergency admission reductions targets were consistently not met in 2015-16, we expect them to consider using a local risk sharing agreement, given that 'the same pound cannot be spent twice' – on emergency admissions *and* on NHS-commissioned out-of-hospital activity at the same time.

31. Where local partners agree to use a risk share agreement the default approach should be to base this on the 2015-16 approach, as set out at **Appendix 2**. However, we are open to other local approaches that demonstrably achieve the same objective. The key point is that BCF investment does not cause a CCG to over extend itself in financial terms and hence put the financial balance of the health economy at risk.

32. As part of BCF planning returns, local areas will need to demonstrate that they are using their share of the NHS-ring-fenced £1 billion fund in the way described above. The template includes confirmation of the local share, and calculates the amount invested in NHS Commissioned out-of-hospital services from the spending plan. There is also an opportunity to confirm the value of additional funds that are part of appropriate risk sharing arrangements. Further details on this are set out in the guidance section of the return template.

Agreement on a local action plan to reduce delayed transfers of care (DTOC) and improve patient flow

33. In planning to meet this condition all areas should consider their performance in relation to DTOC (and patient flow) and work together to develop a proportionate plan to improve their position. The key elements that local areas should include in their action plan are set out below. These are drawn from existing best practice approaches and available mechanisms for managing effective transfers and delays, rather than introducing new ones.

- **Situation Analysis**
  In order to ensure that the plan developed is proportionate to address the local situation partners should review their current performance and assess the level of opportunity within the system for reducing delays and improving transfers. This should include:
    - Detailed analysis of current performance levels (including trend analysis) and the causes of delays;
    - An assessment of current schemes in place to reduce delays and improve transfers of care and how effective these are;
    - A gap analysis comparing local measures to the best practice interventions (see below);
    - A consideration of whether additional measures are required where rates of delay are very high, including whether a risk sharing arrangement may be appropriate.

- **Target and Action Plan**
  In developing their plan, local partners are expected to agree a target for reducing DTOC that is realistic but ambitious. There should be a clear articulation of how the target has been set, with reference to the situation analysis. The DTOC target and CCG planning assumption should be in alignment and include a trajectory for reducing the number of delays. The target should be underpinned by a set of clear actions to deliver improvement that builds both on successful local initiatives and on the nationally agreed best practice interventions. In addition, areas may also want to consider other metrics which monitor patient flow (such as average length of stay) at a local level. There are a number of metrics being used locally by the Emergency Care Improvement Programme (ECIP) which can be shared.

  Information about the best practice interventions can be found on the Local Government Association's website at http://www.local.gov.uk/adult-social-care/-/journal_content/56/10180/5516287/ARTICLE#impact-change or on the Better Care Exchange at https://bettercare.tibbr.com/tibbr/

- **Accountability Arrangements**
  All actions need to be clearly owned, so the plan should set out lines of responsibility and accountability for delivering each element of the plan, as well as an agreed process for local assurance and escalation where any issue cannot readily be resolved.

- **Using Local Capacity**
  Local partners are encouraged to include an analysis of their local capacity and requirements in their plans and to set out how that capacity can best be used across health and social care to minimise delays and meet evolving

need. A joint commissioning approach between health and care is encouraged. In capacity mapping and planning, local areas will need to consider the long-term sustainability of the market for both health and social care.

Many areas already recognise the role that the voluntary and community sector can play in supporting patients to remain in their own home or return there more quickly following a period in hospital. Local plans can consider explicitly how this sector can contribute to reductions in DTOC. Areas should consider whether other local stakeholders, such as housing providers, have a role to play in efforts to reduce delays.

- **Additional measures**
  As set out above, areas should consider as part of the situation analysis and the development of an action plan, what measures are proportionate to address local levels of performance. Where DTOC are high and rising, or there are significant issues with patient flow across the health and care system, local areas should demonstrate how they have considered all options for addressing this, including the potential use of risk sharing arrangements and broader incentives within the system.

  A local CQUIN has also been included in the NHS contract for 2016-17 which provides a mechanism for local areas to reward improvement in the proportion of patients discharged to their usual place of residence within 7 days of admission.

  If there is local agreement that a risk sharing arrangement for DTOC is appropriate then local areas should consider the use of existing mechanisms. At a national level, the Care Act 2014 sets out a discretionary system whereby the NHS can seek reimbursement from a local authority (LA) if the LA does not meet its statutory duties to assess and, where appropriate, put in place care and support arrangements to allow a patient to be discharged from acute care. These arrangements are explained in the Care and Support Statutory Guidance and reiterated in NHS England's Monthly Delayed Transfers of Care Situation Reports: Definitions and Guidance[5].

  Local areas may decide that they want to use wider mechanisms as part of a risk sharing mechanism and have the flexibility to do so. In doing so, local areas should ensure that their approach takes into account the legal framework on payments set out in the Care Act and that they are content that they are not acting in any way which goes against current legislation.[6]

  In considering the use of reimbursement under the Care Act and wider risk sharing mechanisms, local areas should agree collectively on the approach and assure themselves that it will lead to resources being spent in the best interest of the local population and with a positive impact on the performance of the local health and care system.

[5] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315993/Care-Act-Guidance.pdf and https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

[6] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted/data.htm and http://www.legislation.gov.uk/allTheCareandSupportDischargeofHospitalPatientsRegulations2014

SCHEME LEVEL SPENDING PLAN

34. A scheme level spending plan will be required to account for the use of the full value of the budgets pooled through the BCF. These plans will need to include:
    - Area of spend
    - Scheme type
    - Commissioner type
    - Provider type
    - Funding source
    - Total 15-16 investment (if existing scheme)
    - Total 16-17 investment.

35. Detail on scheme-level spending plans will be collected nationally through a high level BCF Planning Return and detailed instructions on completing this are included in the guidance section of the template.

NATIONAL METRICS

36. The BCF Policy Framework establishes that the national metrics for measuring progress of integration through the BCF will continue as they were set out for 2015-16, with only minor amendments to reflect changes to the definition of individual metrics. In summary these are:

    a. Non-elective admissions (General and Acute);
    b. Admissions to residential and care homes[7];
    c. Effectiveness of reablement;
    d. Delayed transfers of care.

37. The detailed definition of the non-elective admissions (NEA) metric is set out in the Planning Round Technical Definitions[8]. BCF plans will need to establish a HWB-level NEA activity plan. This will initially be established by mapping agreed CCG level activity plans to the HWB footprint using the mapping formula provided in the planning return template. Figures submitted in first draft CCG operating plan returns have been pre-populated into the template centrally and mapped accordingly. HWBs will be expected to agree CCG level activity plans for NEAs as part of the operational planning process and through the BCF to ensure broader system ownership of the non-elective admission plan as part of a whole system integrated care approach.

38. The level of non-elective activity which BCF plans seek to avoid, in addition to reductions already included within the calculation of CCG operating plan figures, should be clearly identified in the BCF planning return. This reduction should be set at a level which the CCG and local system feel can be achieved, and, in any case, the emergency admissions baseline for 2016-17 must not be set any higher than the BCF stretch ambitions used in 2015-16. This is because 'the same pound cannot be spent twice', so if emergency admissions were not prevented in 2015-16 then the funding will have had to be used to reimburse

[7] The ASCOF definition of this metric has changed. The revised definition is now used in the full specification of metric at the end of this annex.
[8] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

hospitals for their emergency admissions.

39. The detailed definitions of the other three metrics are set out at the end of this document. HWBs will be required to set ambitious plans in relation to each metric. The national condition on DToC sets out further requirements in relation to setting targets for that metric.

40. Information on all four metrics will continue to be collected nationally. The below table sets out a summary of the information required and where this will be collected:

Metric	Collection method	Data required
Non-elective admissions (General and Acute)	• Collected nationally through UNIFY at CCG level • HWB level figures confirmed through BCF Planning Return	Quarterly HWB level activity plan figures for 2016-17, mapped directly from CCG operating plan figures, using mapping provided, against the original 2014-15 baseline and 2015-16 targets.
Admissions to residential and care homes;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Effectiveness of reablement;	• Collected through nationally developed high level BCF Planning Return	Annual target for 2016-17
Delayed transfers of care;	• Collected through nationally developed high level BCF Planning Return	Quarterly target for 2016-17

Further information on the data to be provided for each metric can be found in the guidance section of the BCF planning return template.

41. In addition the requirement for BCF plans to include a locally determined metric and a locally determined patient experience metric is again included within the requirements of the BCF planning return. It is expected that local areas will continue to use measures that allow them to effectively track the implementation of integrated care locally.

42. Work to establish a set of new integration metrics continues to be led by the Department of Health. Information collected on a number of potential new measures through the BCF quarter 2 reporting return will help inform that process. The new measures will not be used as part of the BCF framework for 2016-17. Work will continue through 2016-17 to develop them further.

LOCAL PLAN DEVELOPMENT, SIGN OFF AND ASSURANCE

43. Local partners are expected to continue working together to develop a joint, HWB level plan for integrating health and social care services. These should continue to build on plans delivered in 2015-16, and also look forward to longer

term strategic plans. There may be flexibility for devolution sites to submit plans over a larger footprint if appropriate.

44. The Better Care Support Team will provide a range of resources to help local areas develop their plans, including signposting to existing support and advice available on integrated care, technical support on the BCF planning requirements, and continuing to share examples of good practice. Information on planning support requirements collected through the BCF Q2 quarterly returns will also be used to develop further planning specific support. A self-assessment process is also being conducted as part of the main NHS planning approach to identify areas which feel they need more targeted support.

45. The first stage of the overall assurance of plans will be local sign-off by the relevant local authority and CCG(s). In line with the NHS operational planning assurance process, plans will then be subject to regional assurance and moderation. Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an areas plan being proportionate to the perceived level of risk in a system.

46. BCF plans will be submitted and assured through the following steps:-

- The first submission will be of the high level BCF Planning Return only, detailing the technical elements of the planning requirements, including funding contributions, a scheme level spending plan, national metric plans, and any local risk sharing agreement.
- Then brief narrative plans will be submitted to regional teams from HWBs, setting out how the plan will meet the national conditions and the other planning requirements.
- At the same point HWB partners will be required to submit a second version of the completed BCF Planning Return.
- CCGs will also be submitting further versions of their operational planning returns during this period, using central UNIFY and Finance return templates. This will include some of the same data – including funding contributions and NEA figures. There will be a national reconciliation process to ensure the data provided matches in all cases.
- The assurance process, including reconciling any data issues, will happen within NHS England's Directors of Commissioning Operations' (DCO) teams, in alignment with the process for reviewing CCG operating plans. Better Care Managers will work with these teams to ensure they have the knowledge and capacity required to review and assure BCF plans. A set of consistent 'Key Lines Of Enquiry (KLOE) will be produced to support the assurance process and will be available to local areas as a guide in developing plans.
- The assurance process will check specifically that the requirements of Condition 7 have been satisfied, i.e. that planned investment in the Better Care Fund is affordable to CCGs, and contains adequate performance/risk management schemes in respect of emergency hospital admissions.

- To support this, local government regional leads for the BCF (LGA lead CEOs and ADASS chairs) will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation) and will be consulted by DCO teams when making recommendations about plan approval;
- As part of that regional moderation process an assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Authority, Monitor and local government;
- These judgements on 'plan development' and 'risks to delivery' will help inform the placing of plans by NHS England into three categories – 'Approved', 'Approved with support', 'Not approved'. The next steps for a HWB whose plan is placed within each category are set out below:
    - Approved – proceed with implementation in line with plans;
    - Approved with support – proceed with implementation with some ongoing support from regional teams to address specific issues relating to 'plan development' and / or 'risks to delivery';
    - Not Approved – do not proceed with implementation. Work with the NHS England DCO team, Better Care Manager and LGA / ADASS representatives to put in place steps for achieving plan approval (and / or meet relevant conditions) ahead of April 2016.

47. The overall assurance process is illustrated in the schematic at **Appendix 3**.

NATIONAL ASSURANCE AND PLAN APPROVAL

48. There will be no national assurance process for BCF Plans for 2016-17. Instead regional teams will work with the Better Care Support Team to provide assurance to the national Integration Partnership Board (jointly chaired by DH and DCLG whose membership includes NHS England, LGA and ADASS) that the above process has been implemented to ensure that high quality plans are in place which meet national policy requirements and have robust risk-sharing agreements where appropriate. This will include offering assurance that appropriate support and assurance arrangements are in place for high risk areas.

49. In accordance with the legal framework set out in section 223GA of the NHS Act 2006, final decisions on approval will be made by NHS England in consultation with DH and DCLG. These decisions will be based on the advice of the moderation and assurance process set out above. Where plans are not initially approved NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

50. NHS England has the ability to direct use of the CCG contribution to a local fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that can be approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and / or impose a spending plan on a local area, and the content of any imposed plan, will be

subject to consultation with DH and DCLG (as required under the 2016-17 NHS Mandate), with the decision then taken by NHS England.

HIGH LEVEL TIMETABLE

51. The submission and assurance process will follow the following timetable:

NHS Planning Guidance for 2016-17 issued	22 December 2015
Technical Annexes to the planning guidance issued,	19 January 2016
BCF Planning Requirements; Planning Return template, BCF Allocations published	February 2016
First BCF submission (following CCG Operating Plan submission on 8 Feb), agreed by CCGs and local authorities, to consist of: • BCF planning return only All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net .	2 March 2016
Assurance of CCG Operating Plans and BCF plans	March 2016
Second submission following assurance and feedback, to consist of: • Revised BCF planning return • High level narrative plan All submissions will need to be sent to DCO teams and copied to england.bettercaresupport@nhs.net	21 March 2016
Assurance status of draft plans confirmed	By 8 April
Final BCF plans submitted, having been signed off by Health and Wellbeing Boards	25 April 2016
All Section 75 agreements to be signed and in place	30 June 2016

52. This timetable should be read alongside the timetable of page 16 of the NHS shared planning guidance.[9]

STATUTORY FRAMEWORK AND ALLOCATIONS[10]

53. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the NHS Mandate to include specific requirements relating to the establishment and use of an integration fund.

54. Under the NHS Mandate for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to CCGs to establish the BCF. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

[9] https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/
[10] As set out in the policy framework for the BCF in 2016-17: https://www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017

55. Of the £3.519 billion BCF allocation to CCGs, £2.519 billion will be available upfront to HWBs to be spent in accordance with the local BCF plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to the requirement of the new national condition vii set out in paras 27 to 32 above.

56. Within the BCF allocation to CCGs is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in paragraphs 14-19 above.

57. For 2016-17, the allocations have been based on a mixture of the CCG allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund. Full HWB level allocations have been published on the NHS England website.[11]

[11] https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

APPENDIX 1- SPECIFICATION OF BETTER CARE FUND METRICS

Metric 1: Non-Elective Admissions (General and Acute)

The baseline for measurement continues to be 2014-15, as incorporated into the local 2015-16 targets.

The definition of this metric is published as part of the technical definitions for NHS planning in 2016-17, which can be found here:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Metric 2: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

Outcome sought	Reducing inappropriate admissions of older people (65+) in to residential care
Rationale	Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.
Definition	**Description**: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes. **Numerator**: The sum of the number of council-supported older people (aged 65 and over) whose long-term support needs were met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care). This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator**: Size of the older people population in area (aged 65 and over). This should be the appropriate ONS mid-year population estimate or projection.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Annual (collected Apr-March) Timing: Final data for 2014-15 was published in October 2015 Baseline: This will be 2014-15 data as published by the HSCIC (note that for the published data the 2014, not the 2015 ONS population estimate has been used for the population denominator)

Historic	Data first collected 2014-15 following a change to the data source. The transition from ASC-CAR to SALT resulted in a change to which admissions were captured by this measure, and a change to the measure definition. Previously, the measure was defined as "Permanent admissions of older adults to residential and nursing care homes, per 100,000 population". With the introduction of SALT, the measure was re-defined as "Long-term support needs of older adults met by admission to residential and nursing care homes, per 100,000 population."

Metric 3: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcome sought	Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
Rationale	Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
Definition	The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. **Numerator:** Number of older people discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. This should only include the outcome for those cases referred to in the denominator. The numerator will be collected from 1 January to 31 March during the 91-day follow-up period for each case included in the denominator. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC **Denominator:** Number of older people discharged from acute or community hospitals from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting). The collection of the denominator will be between 1 October and 31 December. This data is taken from Short- and Long-Term Support (SALT) collected by HSCIC Alongside this measure is the requirement that there is **no decrease** in the proportion of people (aged 65 and over) offered rehabilitation services following discharge from acute or community hospital.
Source	Adult Social Care Outcomes Framework: (HSCIC - SALT: http://www.hscic.gov.uk/socialcarecollections2016)

Reporting schedule for data source	Frequency: Annual (although based on 2x3 months data – see definition above) Timing: Final data for 2014-15 was published in October 2015 Baseline: This should be 2014-15 data as published by the HSCIC.
Historic	Data first collected 2011-12 (currently four years data final available (2011-12, 2012-13, 2013-14 and 2014-15)

Metric 4: Delayed transfers of care from hospital per 100,000 population

Outcome sought	Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
Rationale	This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.
Definition	Total number of delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both)* A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer. **Numerator:** The total number of delayed days (for patients aged 18 and over) for all months of baseline/payment period* **Denominator:** ONS mid-year population estimate (mid-year projection for 18+ population) *Note: this is different to ASCOF Delayed Transfer of Care publication which uses 'patient snapshot' collected for one day each month.
Source	Delayed Transfers of Care (NHS England http://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/) Population statistics (Office for National Statistics, http://www.ons.gov.uk/ons/rel/pop-estimate/population-estimates-for-england-and-wales/index.html)
Reporting schedule for data source	Frequency: Numerator collected monthly (aggregated to quarters for monitoring). (Denominator annual) Timing: 2 month lag. Baseline: 2014/15 quarterly rates
Historic	Data first collected Aug 2010

APPENDIX 2 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. Paragraph 30 sets out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2016-17. Where this is the case the arrangements should be described within narrative plans in line with the requirements set out in paragraph 31 to include an agreed approach to financial risk sharing and contingency.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. Further guidance on how to complete this is included within the guidance tab of the template itself.

3. As a minimum, a risk sharing arrangement that is put in place in this way should:

    a) Create a maximum risk share fund which is equal to the value of non-elective admissions that original BCF plans aimed to avoid.

    The reference point below which reductions can be credited to the BCF is the LOWER of the 14/15 outturn used as the baseline for 15-16 BCF plans, or the activity levels included in CCG Operating Plans for 16-17 after accounting for efficiency measures to reduce non-elective admissions (but before adjusting for the impact of actions taken in the context of 16-17 BCF plans). This is how the BCF risk fund meets the principle that "the money follows the patient" and "the same pound can't be spent twice" – on the emergency admission not avoided, and on other services.

    b) Ensure the value of this fund is withheld by CCGs from their BCF allocation which is paid into the pooled budget at the beginning of the year (recognising that CCG allocations have been set to take account of a number of efficiency measures to reduce non elective admissions which will need to be taken account of when setting the baseline against which the impact of BCF initiatives will be measured);

    c) Make payments into the pooled fund on a quarterly basis equivalent to the value of admissions avoided, up to the maximum risk share fund;

    d) Ensure that unreleased funds are retained by the CCG to cover the cost of additional non-elective activity.

4. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.

5. In addition to this specific guidance, the assurance of overall risk sharing arrangements and contingency plans will look at the management of risk in each plan, with reference to key metrics. This will be consistent with the approach set out in guidance for 2015-16, focusing on whether each plan includes:

a) A quantified pooled funding amount that is ‘at risk’;

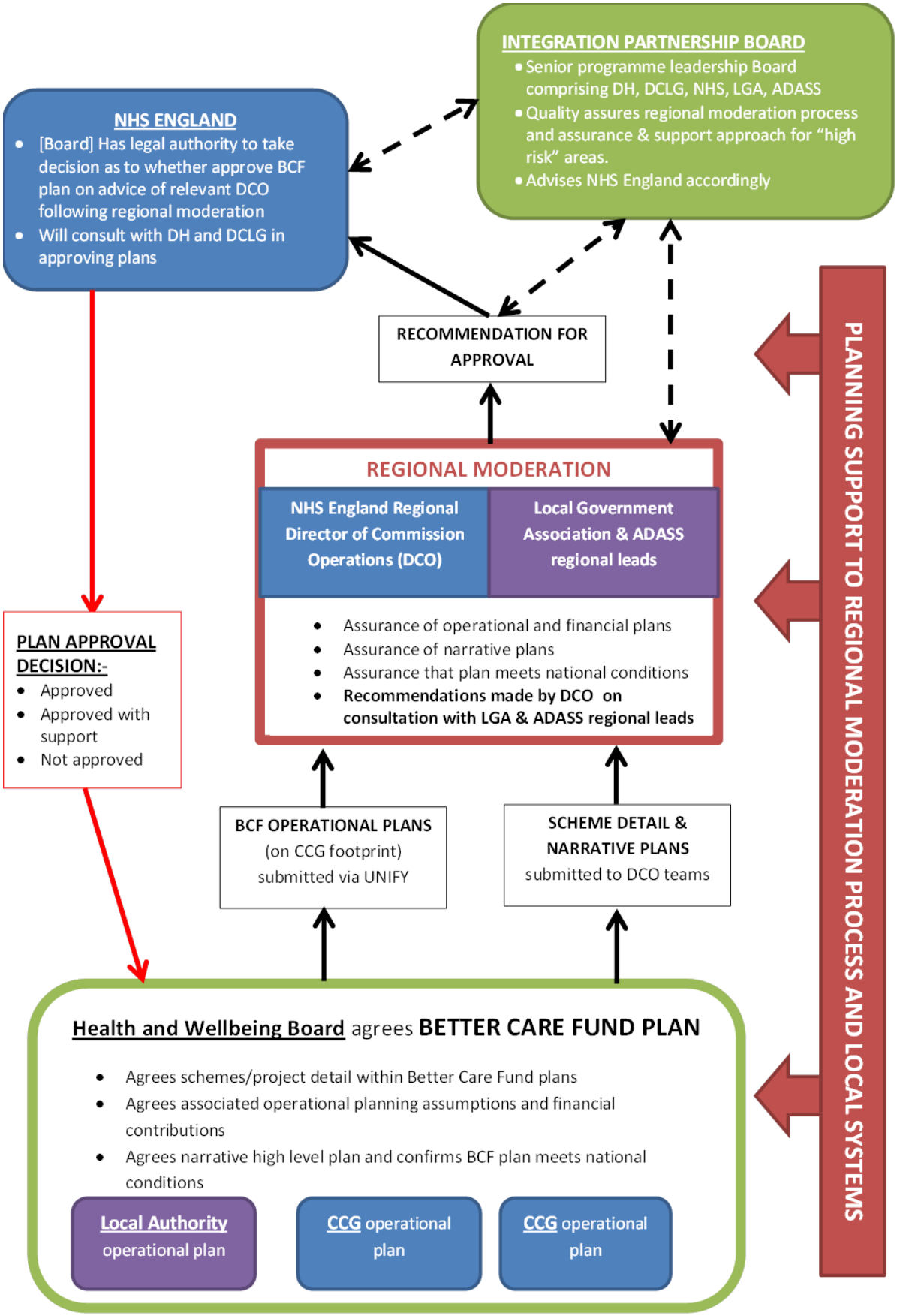
b) Demonstration that this has been calculated using clear analytics and modelling;

c) An articulation of any other risks associated with not meeting BCF targets Non-Elective Admissions and Delayed Transfers Of Care in 2016-17;

d) An articulation of the risk sharing arrangements in place across the health and care system, and how these are reflected in contracting and payment arrangements;

e) An articulation of the proportion of the financial risk will be borne by each party, and how these are reflected in contracting and payment arrangements.

APPENDIX 3 - ASSURANCE DIAGRAM



This page is intentionally left blank

NHS England
Skipton House
80 London Road
London,
SE1 6LH
E-mail: Andrew.ridley1@nhs.net

To: *(by email)*
Councillor Lesley Salter, Chair of Southend On Sea Health & Wellbeing Board
Rob Tinlin, Chief Executive, Southend On Sea Council
Dr Jose Garcia, Accountable Officer, Southend On Sea Clinical Commissioning Group

5 July 2016

Dear colleagues

BETTER CARE FUND 2016-17

Thank you for submitting your Better Care Fund (BCF) plan for regional assurance. We know that the BCF has again presented challenges in preparing plans at pace and we are grateful for your commitment in providing your agreed plan. As you will be aware the Spending Review in November 2015, reaffirmed the Government's commitment to the integration of health and social care and the continuation of the BCF itself.

I am delighted to let you know that, following the regional assurance process, your plan has been classified as '**Approved**'. Essentially, your plan meets all requirements and the focus should now be on delivery.

Your BCF funding can therefore now be released subject to the funding being used in accordance with your final approved plan, which has demonstrated compliance with the conditions set out in the BCF policy framework for 2016-17 and the BCF planning guidance for 2016-17, and which include the funding being transferred into pooled funds under a section 75 agreement.

These conditions have been imposed through NHS England's powers under sections 223G and 223GA of the NHS Act 2006 (as amended by the Care Act 2014). These sections allow NHS England to make payment of the BCF funding subject to conditions. If the conditions are not complied with, NHS England is able to withhold or recover funding, or direct the CCG in your Health and Wellbeing Board area as to the use of the funding.
You should now progress with your plans for implementation. Ongoing support

and oversight with your BCF plan will be led by your local Better Care Manager.

Once again, thank you for your work and best wishes with implementation and delivery.

Yours sincerely,

Andrew Ridley
Regional Director, South of England, and SRO for the Better Care Fund

NHS England

Copy (by email) to:
Attu Assan, Director of Strategic Delivery, NHS England – Midlands & East (East)
Anthony Kealy, Programme Director, Better Care Support Team

SOUTHEND ON SEA
BETTER CARE FUND PLAN

2016/17

STAGE 3 SUBMISSION

3RD MAY 2016

Change Control		
Summary	**approved with support**	
Overview	The plan is well structured and targeted. Vision, values and alignment to wider agenda articulated well. There is a real focus on prevention, providing community solutions, ensuring a good integrated pathway and improving outcomes, building on 15/16 achievements. Data sharing arrangements are in place. Governance structures were well explained. Financial commitments were described with no major gaps	
Key Issues to be addressed		
Programme		
Partners	It would be helpful to identify in one section BCF plan partners and providers including mental health	Section 1.4
Plan and Risk Log	Please provide detailed version of plan and risk log	Section 2.34 and Appendix 1 & 2
Expenditure Plan	Please provide scheme level expenditure for the expenditure plan [Tab 4 in BCF Template] to support the high level numbers provided	Section 4.4, 4.23 and 4.34 and Appendix 3 & 4
Provider Engagement	Please include implications of the BCF plan for local providers and additional information on how providers have been engaged and how engagement will be managed in 16/17. Please also provide confirmation of provider agreement with the plan, how providers will be engaged in implementation and how they are represented e.g. on Health and Wellbeing Board or on project teams. Please confirm that HWB is sighted on implications for local providers	Section 2.7 – 2.9
Work-stream Issues		
Workforce Planning	Please give additional supporting information and milestones on the development and implementation of workforce plan	Section 3.5.2
Maintain Provision of Adult Social Care	Please confirm funding for carer specific support	Section 1.1.4 and 3.9
7 Day Working	Please provide additional information to support the implementation of the 7 day services plan including milestones and provider engagement including mental health services and how the plan is aligned to the Essex Success Regime Strategy	Section 3.12 andAppendix 2 and 5.
Data sharing	Significant progress has been made in developing data sharing. Please provide additional information including milestones for further development and implementation in 16/17	Appendix 2

	The plan points to the use of Care Track in developing risk stratification as a key element in the 16/17 plan. Please provide additional information on plan development and milestones for the improvement of primary and secondary care prevention identified in the plan	
DTOC	DTOC targets are still to be agreed between SCCG, the Council, Southend Hospital and Community Service Provider Please provide a schedule for the agreement of DTOC targets and alignment with CCG operating plans. Please also detail how monitoring and accountability by partner organisations will be managed and how risk planning and mitigation will be managed	Section 3.37 and Appendix 6
Risk Share	Risk share has been considered and rejected based on successful meeting of last year's emergency targets. Please provide additional information on risks considered to continue to meet these targets and what mitigation is being considered? Please confirm how providers have been involved in the risk share and mitigation planning.	Section 2.40 and Appendix 1
Mental Health	Please provide additional information on the engagement of Mental Health Trust in the BCF plan and the provision of dementia services Dementia services are referenced effectively throughout the plan Please provide further information on dementia services; milestones identify strategic partners and milestones to meet the plan target to improve dementia services; processes for joint assessment and care management for people with dementia	Section 4.11 and Appendix 7
Consultation	Please provide further details on public engagement and consultation on the development of the BCF programme and on consultation on the 16/17 Plan itself	Section 2.16
Essex Success Regime	Please provide additional information to identify the contribution that BCF makes to the Essex Success Regime and how providers are engaged with the BCF programme	Section 2.10 – 2.12 and Appendix 8
Plan Metrics and Objectives	Please provide supporting information for the 16/17 targets e.g. for reablement; people with long term conditions feeling supported; patient experience Please give supporting documentation on how metrics have been arrived at and their management.	Section 5.6, 5.7 and 5.8.
Further amendments		
CCG minimum contributions	Southend CCG confirms the allocation of the minimum funding contribution as required by the BCF national conditions.	Section 1
Reablement	Section updated.	Section 4.37
Locality approach	Section updated to demonstrate that SBC and SCCG are actively considering a joint approach to	Section 4.14

	'invest to save'.	
Childrens commissioning	Plan updated re integrated children commissioning and that the CCG and SBC will be jointly discussing an approach to commission children services from one integrated budget	Section 2.18 – 2.19

TABLE OF CONTENTS

1 Confirmation of funding contributions

Minimum funding contributions met

1.1 Southend on Sea (Southend) can confirm that the minimum funding requirements for the Better Care Fund (BCF) plan are as per below. These include the following;

1.1.1	Southend CCG (SCCG) contribution	-	£11.937M
1.1.2	Disabled Facilities Grant	-	£1.193M
1.1.3	Care Act 2014 Monies	-	£0.474M
1.1.4	Former Carers Break funding	-	£0.421M
1.1.5	Reablement funding	-	£0.976M
1.1.6	Protection of social services	-	£4.199M

1.2 Section 4 to this plan demonstrates how each element of the funding contributions will be used.

Additional funding contributions

1.3 No additional funding has been allocated from either the Southend on Sea Borough Council (Council) or Southend CCG (SCCG)

Partners and providers

1.4 Partners and providers who have contributed to the delivery of BCF 2015/16 and continue to be engaged in BCF for 2016/17 include all partners and providers represented at HWB, these include;

1.4.1 Southend on Sea Borough Council;

1.4.2 Southend Clinical Commissioning Group;

1.4.3 Southend University Hospital NHS Foundation Trust;

1.4.4 South Essex Partnership University NHS Foundation Trust (community and mental health provider);

1.4.5 Southend Association of Voluntary Services; and

1.4.6 NHS England

Local Agreement on funding arrangements

1.5 Both the BCF planning return and this plan have been signed off by the Health & Wellbeing Board (HWB) on 7th April 2016.

1.6 A full overview of funding contributions for 2016/17 are provided in section 1.1 and worksheet #3 (HWB funding sources) of the BCF planning template.

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

1.7.1 SCCG contribution. This has changed from £11.619M (2015/16) to £11.937M (2016/17).

1.7.2 DFG. This has changed from £0.694M (2015/16) to £1.193M (2016/17). The additional capital resource funding requirement has been agreed by both the Council and SCCG.

1.7.3 Care Act 2014 Monies. This has changed from £0.455M (2015/16) to £0.474M (2016/17).

1.7.4 Protecting social services. This has changed from £4.087M (2015/16) to £4.199M (2016/17). The additional funding is consistent with the Department for Health guidance to NHS England on the funding transfer from NHS to social care.

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

2 Narrative plan

The local vision for health and social care services

2.1 Our vision is;

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

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

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

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

Our vision is underpinned by focusing on the following areas:

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

Alignment of vision with national and regional requirements

2.2 The vision for Southend is not only aligned to NHS England's 5 Year Forward View, in which greater engagement with patients, carers and citizens is encouraged so that there can be promotion of well-being and the prevention of ill-health but is also aligned to both regional and local initiatives. The Essex Success Regime (ESR) is focused on Acute financial stability, Primary care and integration. The Southend BCF is aligned with all three.

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

2.4 Our BCF plan is aligned to our HWB strategy. The ambition for HWB in Southend (outlined in Section 2.1) is that everyone living in Southend has the best possible opportunity to live long, fulfilling, healthy lives.

2.5 Aligned with on-going challenges and the BCF plan, Southend HWB will closely focus on achieving five new "big ticket" priority areas for 2016/17. These are;

2.5.1 Mental Health

2.5.2 Complex Care

2.5.3 Integrated Children's Services

2.5.4 Physical Activity levels

2.5.5 Primary Care Access

2.6 NHS England recently published a requirement for health and social care systems to draft a blueprint for the implementation of the five year forward view, these will be known as Sustainability Transformation Plans (STPs). The Southend system has agreed a local footprint for our STP and have aligned it with the ESR. In doing so we have ensured that appropriate governance is in place to assure system leaders that there will be a 'southend' local element to the ESR STP.

Alignment of BCF plan with providers

2.7 The implications for providers (noted above in section 1) have been discussed through a number of processes through which providers are engaged. These include various operational level project group meetings, senior officer engagement, HWB, SCCG operational planning for 2016/17 and project meetings with the ESR structure.

2.8 Implications for providers will continue to be managed in proactive and robust environment with operational leads discussing the detail at project group meetings and HWB taking overall responsibility.

2.9 The development of the BCF 16/17 plan has fully engaged providers with the plan being signed off through HWB on 7th April 2016.

Alignment of BCF plan with ESR

2.10 The ESR is split into two components; (1) transformation focusing on services within the 3 acute hospitals; and (2) transformation focusing on local health and care.

2.11 Each of the projects with the Southend BCF for 16/17 are aligned to supporting the system and designing services which span both the hospital and the community. For example the development of our locality approach (section 4) will focus on developing localities around primary care in Southend with the aim of reducing the demand on the hospital and resourcing the community services to deliver services to both the community and a complex care cohort.

2.12 At Appendix 8 is the latest newsletter from the ESR (component 2) which recognises the support needed from local areas to deliver the required outcomes.

Engagement

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

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

2.15 We have attended dozens of events to engage face to face with members of the public across a range of different topics and issues. In May 2015 we held an engagement event to help develop the HWB strategy for Southend. The event was a great success and attended by more than 150 people.

2.16 NHS and Council staff regularly attend meetings of both Southend's PPGF (Patient Participation Group Forum) and PPEISG (Patient & Public Engagement & Involvement Steering Group) to discuss health topics and gain insight from service

users. The groups are able to offer valuable input into discussions about planned commissioning intentions, service changes or new initiatives ensuring patient experience is at the forefront of service design and delivery.

The changes

2.17 The changes that will commence delivery through the BCF for 2016/17 include;

2.17.1 **Locality model.** The initiation of a 'Locality' approach where the locality is the central place that integrated health and social care interventions are co-ordinated which will represent a shift away from hospital into the community. Each locality will utilise existing (or new) NHS or Council estate to provide a complex care service for a risk stratified cohort of patients and their carers. The Locality approach will be aligned to the provision of both social care and primary care services working in a Multi-Disciplinary Team (MDT) environment.

2.17.2 **Complex Care.** Through risk stratification we will identify a cohort of patients with complex care needs. Once identified we will design a service that co-ordinates their care needs and provides a holistic health and social care plan. This will reduce demand on primary care, presentations at A&E and increase the support available for carers.

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

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

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

2.17.6 **Data Sharing.** We are the first system nationally to receive approval from the Secretary of State for Health for its application to amend section 251 of the Health and Social Care Act. This amendment is enabling us to share data across health and social care for the purposes of commissioning and risk stratification. We began implementing the technology required to enable data sharing in July 2015 and plan to explore further the opportunities we are now presented with following extensive testing and refining.

Future opportunities for BCF

2.18 The partners of Southend BCF have identified an opportunity to enhance and develop the BCF plan. Discussions are taking place to integrate childrens health commissioning within the Council function, on the basis that the Council could then deliver integrated services and potential savings. This proposal is aligned with a jointly held and shared holistic view of children's services, and particularly aligns

itself with the work being undertaken through A Better Start, a BIG Lottery funded programme working to enhance universal preventative services for Early Years and Early Years Public Health, to improve the life chances of Southend's children.

2.19 Realistically implementation would take a minimum of 6 months given the need for consultation and full transparent due diligence to be undertaken into the finances and contractual / mandated commitments. Inevitably savings would take time to flow given the need to re-commission the services so the proposal is being aligned towards our integrated planning for 2017/18 and beyond.

Evidence base supporting the case for change

2.20 Data and information derived from the Director of Public Health for Southend's Annual Public Health Report, the latest Southend Health Profile and additional sources including the Health and Wellbeing Strategy and current JSNA, cardiovascular risk profile and other sources highlight the key health and social care challenges facing the system of Southend.

2.21 Key commissioners, specifically the Council and SCCG, use CareTrack, a computer based care and support tool. CareTrack enables the partnership to undertake risk stratification of local citizens in receipt of health or social care support. Through using this tool we have been able to identify whether needs could be better met through collaborative/ integrated service delivery. As an integrated health pioneer local partners have also undertaken a number of complex mapping exercises including an epidemiological analysis of hospital attendances and admissions. This data has been used to complement the CareTrack information and identify issues and interventions where integrated service delivery would improve outcomes for local people and make service delivery more efficient and cost effective.

2.22 Through joint partnership arrangements SCCG and the Council have worked with NHS England to identify gaps and variation in primary care services. Locally, there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years. Current plans are that SCCG and Council will be enabled to co-commission primary care and community based services in new innovative ways to improve primary and secondary prevention interventions provided to vulnerable or hard to reach people who are currently accessing services in a way that is neither efficient nor cost effective.

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

2.24 The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity and alcohol have a negative impact on the health of the local population. There are also high levels of mental ill-health within Southend. This means we need to take action to address the links between the social determinates such as worklessness and mental ill-health and demand for health or social care services in specific areas of disadvantage in Southend.

2.25 We are currently undertaking a community development programme to address the impact of disadvantage and poor health outcomes in specific localities. We need to integrate local health and social care interventions better in these areas and we will use the resources of the BCF to support this through the schemes outlined.

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

2.26.1 older people (falling, social isolation)

2.26.2 people living with long term conditions (Cardiovascular disease, diabetes, respiratory disease, asthma)

2.26.3 people living with dementia

2.27 There are a number opportunities to improve the support provided to local people through more effective collaboration and integration. For example, strategic partners are currently working to develop more effective local approaches to support people living with dementia. By doing this we hope to reduce the significant gap and variation between the number of people currently diagnosed with dementia and those known to be living with the condition.

2.28 Living longer does not always mean a better life. Locally we have looked the impact of long term chronic conditions on the health of local people. currently the prevalence of LTC within Southend.

2.29 Tackling long term conditions through joining up pathways and commissioning services across health and social care that enable people to be supported to self-manage existing conditions is a key focus for local partners.

A co-ordinated and integrated plan of action for delivering change

Governance

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

Diagram 1 (Governance structure pre Feb 2016)

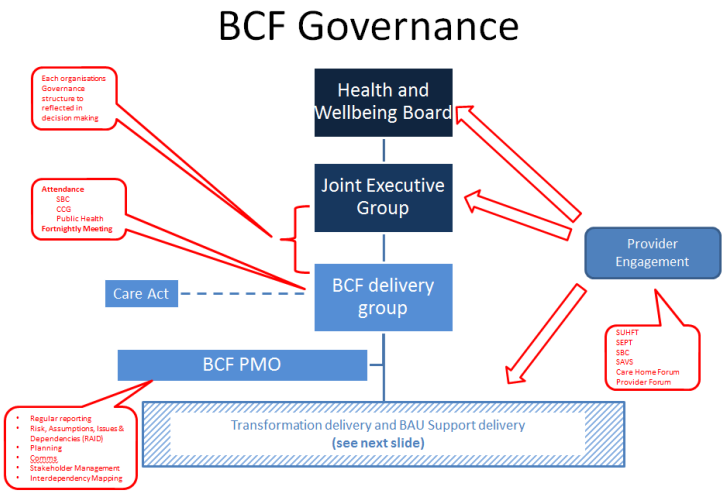
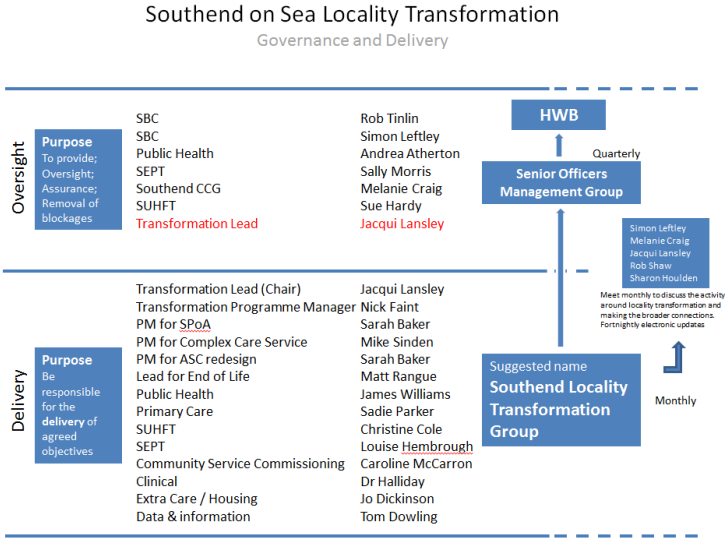


Diagram 2 (Governance structure post Feb 2016)

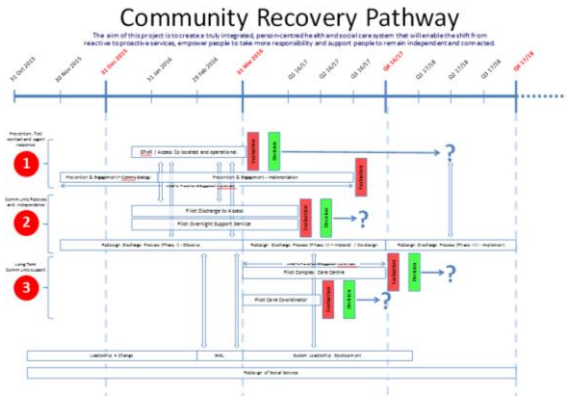


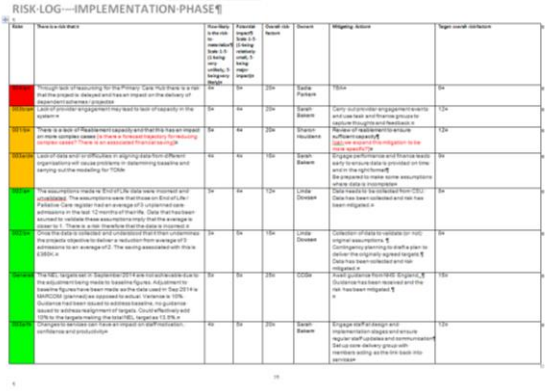
2.31 Responsible for the BCF delivery is HWB. With multi organisational representation the HWB receives regular reports from the BCF programme to assure financial and operational performance. HWB meet 5 times per annum.

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

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

2.34 A detailed BCF programme plan has been developed and a high level timeline is shown below, alongside a snapshot of the BCF risk log. Both documents are at Appendix 1 and 2.





A clear articulation of how we plan to meet each national condition

2.35 Please refer to Section 3.

An agreed approach to financial risk sharing and contingency

Risk Sharing

2.36 Section 29 of the Better Care Fund Planning Requirements for 2016/17 (Technical Guidance Annex 4) published in February 2016 outlines that where local areas have successfully delivered their agreed 2015/16 emergency admission reduction and all partners are confident that the 2016/17 BCF plan can meet its objectives they can choose to invest the full element of the risk money associated with commissioning out of hospital services upfront.

2.37 For 2015/16 and aligned with national conditions Southend BCF planned to deliver a 3.5% reduction in non elective admissions. At end of Q3 2015/16 non elective YTD admissions had reduced by 5.7%.

2.38 Aligned with section 2.37 above our HWB have decided to not pool any funding at risk and that the BCF plan would commit funding for out of hospital community services upfront.

2.39 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Subsequently, no risk sharing is planned regarding DToC.

2.40 The risk associated with Southend taking the approach outlined above is fully recognised within both the operational and governance structure of delivery. Risks are managed proactively and through the RAID log at Appendix 1.

Additional Risk

2.41 The HWB has recognised that there is significant financial challenge across both commissioners and providers. The BCF plan is aligned with SCCG's operational plan, Council budget setting and the ESR (which has the challenge of reconfiguring finances in the acute sector). Our HWB further recognise that organisations are proactively managing their respective financial circumstances and continue to monitor the risk status.

3 Narrative plan – national conditions

Plans jointly agreed

3.1 This plan, submitted on 3rd May 2016, has been signed off by the HWB. Operationally SCCG and the Council have signed off this plan.

3.2 HWB formally signed off the BCF plan on 7th April 2016.

3.3 Through the governance process outlined in Section 2 we have engaged with health and social care providers to fully understand the impact of the fund. We continue to work proactively with our providers to mitigate any negative impacts and build on positive impacts.

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

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

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

3.5.2 Secondly, with the support of our system facilitator we are conducting a gap analysis of our workforce needs which will then support the design of a transformation programme. The programme will be developed by end Q2 2016/17 with HWB taking responsibility for sign off.

Maintain provision of social service

3.6 The total amount from the BCF allocated for supporting adult social care services, and agreed locally, is £4.199M. This budget will be allocated to maintain and support the provision of social care services. This agreed approach is aligned with the BCF Policy Framework 16/17 and consistent with the DoH guidance to NHS England on the funding transfer from NHS to social care in 2013/14. Full details, which include a comparison of approach and spend, are provided in Section 4.

3.7 The total amount from the BCF allocated for supporting adult social care services has been maintained in real terms compared to 2015/16. In 2015/16 a total of £4.087M was allocated in 2016/17 a total of £4.199M has been allocated, this represents an increase of 2.7%. The increase in spend will not destabilise but help support and maintain services provided throughout 2016/17.

3.8 The Department of Health (DoH) and Local Government Association (LGA) recently published the local apportionment of the £138m set aside for Care Act Duties. The apportionment to Southend is £0.474M and this plan confirms both its identification and allocation within the BCF.

3.9 We are currently waiting for the apportionment of the carer specific funding. In the interim we have allocated £0.421M to the provision of Carers Break. Our plan is therefore aligned with BCF national conditions.

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

3.10.1 Identifying the carers who are not currently known to the Council

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

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

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

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

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

Agreement for the delivery of 7 day services

3.12 The work to introduce 7 day services commenced mid 2014 and was sponsored by an Exec Lead from SUHFT, which demonstrates provider engagement. A gap analysis and reports were produced and discussed through various governance structure (See Appendix 5). A plan to implement 7 day services was developed which focused on hospital activity and activity in the community. Please refer to Appendix 2 for a milestone / plan re activity in the community.

3.13 Through the development of community services (see section 4) we are developing a plan to provide appropriate 7 day services across the community, primary, mental health and social care.

3.14 The high level ambition of our plan is to prevent unnecessary non-elective admissions through provision of an agreed level of infrastructure across out of hospital services 7 days per week which will support the timely discharge of patients from acute physical and mental health settings, on every day of the week helping to avoid unnecessary delayed discharges.

3.15 We are currently developing a delivery plan to support the transformation to 7 day services as it is part of our wider transformation work we need to ensure it is aligned with both the ESR and our Primary Care strategy.

3.16 In April 2015 the Secretary of State for Health approved the sharing of data for the purposes of commissioning and risk stratification in Southend. Since April 2015 we have been working proactively to build on this progress.

3.17 As a system we are committed to sharing data across health and social care. Both providers and commissioners agree that data sharing across organisations is the key to making services more appropriate to individual needs and efficiency savings.

3.18 Our senior leaders sponsor the data sharing activity to ensure appropriate governance is in place and any risks and issues are appropriately scoped and mitigated.

3.19 Our health and care systems, in the majority of areas use the NHS Number as the consistent identifier for health and social care services.

3.20 SCCG and SBC are committed to adopting systems that are based upon Open APIs and Open Standards (in line with NHS contractual guidance), wherever possible, and encouraging existing suppliers to adopt Open APIs and Open Standards in future releases of software. This would be specifically addressed within the information schedules and / or the data quality improvement plans of each of the contracts with providers.

3.21 We confirm that there are appropriate Information Governance (IG) processes in place and that our agreements are in line with the revised Caldicott principles.

3.22 An agreed condition, as part of the Secretary of State approval in April 2015, was that residents and patients have clarity about how data about them is used, who has access and how they can exercise their legal rights. We undertook a detailed programme of engagement with our residents between April 2015 and July 2015 ensuring that residents were engaged with through multi channels and with various formats of communication.

3.23 In support of our data sharing work we have developed a local digital roadmap, aligned with national requirements that will support progress.

3.24 We anticipate for the steps outlined above to have a positive impact on both service users and patients.

Ensure a joint approach to assessments and care planning

3.25 Since September 2012 SCCG and the Council has commissioned a Single Point of Referral Service (SPoR), which acts as the key contact point for health care professionals both in primary care and acute discharge services, to the integrated teams which provides a multi-disciplinary response to urgent issues or needs of patients within the community who would otherwise attended A&E and experienced a 0-1 day length of stay.

3.26 At present the threshold has yet to be established with regard to the number of referrals that can be made into the service upon full implementation although the numbers of referrals have increased year on year since the commencement of the service.

Agreement on the consequential impact on providers

3.27 Southend GPs and member practices have been engaged at various levels. The GPs elected to SCCG's Governing Body and appointed to the clinical executive have been directly involved in the development of this plan, and key elements of the BCF schemes have been supported by GP colleagues working as clinical project leads (as part of our overall QIPP and Transformation Programme). In addition SCCG has appointed a GP as clinical lead for integration, who works with SCCG one day a week.

3.28 The broader membership of SCCG has been engaged through our GP members forum and kept updated through the weekly inbox bulletin. All practices have been key to shaping some of our key schemes.

3.29 The overall impact of SCCG allocations and BCF and QIPP requirements over the 2016/17 period is modeled within the operational planning submissions currently being finalised by SCCG for the 2016/17 planning round. Commissioner plans

outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. SCCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Southend University Hospital NHS Foundation Trusts' financial sustainability, the ESR and the STP.

3.30 We have attended dozens of events to engage face to face with members of the public across a range of different topics and issues. In May 2015 we held our annual public event which was a great success and attended by more than 150 people.

3.31 Southend Association of Voluntary Services (SAVS) is a key member of our integration work and attends HWB.

Agreement to invest in NHS commissioned out of hospital services

3.32 Section 29 of the Better Care Fund Planning Requirements for 2016/17 (Technical Guidance Annex 4) published in February 2016 outlines that where local areas have successfully delivered their agreed 2015/16 emergency admission reduction and all partners are confident that the 2016/17 BCF plan can meet its objectives they can choose to invest the full element of the risk money associated with commissioning out of hospital services upfront.

3.33 For 2015/16 and aligned with national conditions Southend BCF planned to deliver a 3.5% reduction in non elective admissions. At end of Q3 2015/16 non elective YTD admissions had reduced by 5.7%.

3.34 Aligned with section 2.33 above our HWB have decided to not pool any funding at risk and that the BCF plan would commit funding for out of hospital community services upfront.

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

3.35 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Subsequently, no risk sharing is planned regarding DToC.

3.36 A target for DToC is in the process of being agreed. The process is led by both SCCG and the Council and engages providers who have an impact on DToC. We recognise that whilst our DToC performance is extremely good there are always areas for improvement. Subsequently, the agreed targets will support a further decrease in DToC. The agreement will be made between SCCG, the Council, Southend Hospital and our community service provider.

3.37 We are also in the process of agreeing a structure and action plan to further improve our consistent low levels of DToC in support of the targets. Details for the action plan, including issues to focus on and historic performance can be found at Appendix 6.

3.38 The plan is currently being aligned between our transformation activity and the priorities set by the System Resilience Group.

3.39 The targets will be reflected in both CCGs (Southend and neighbouring CCG) operational plans.

3.40 A discharge summit is planned for Q1 2016/17 which will consider the further development of responsibility, accountability and monitoring. The summit will also consider the high impact interventions recommended by ECIP.

4 Scheme level spending plan

Disabled Facilities Grant

4.1 Southend BCF will allocate £1.193M in capital to the Council for use under the DFG guidance.

4.2 During 2016/17 the provision of services funded under the DFG will be brought in-house within the Council. This action will be taken following the cessation of our contract with our private sector provider and the recommendation of an independent review.

4.3 The transition of private sector provider to in-house will also review the outcomes we are currently achieving with the use of the DFG with the aim of aligning the spend to influence outcomes associated with those residents with complex care needs.

Commissioning. maintaining and transforming community services

4.4 Southend BCF will allocate £6.288M in revenue to SCCG for use to commission, maintain and transform community services. A detailed draft expenditure plan is at Appendix 3.

4.5 During 2016/17 we will maintain the existing community services with our providers which will include services such as our Single Point of Referral (SPoR), tissue viability, leg ulcers, the community element of stroke services, continence, intensive dementia support and occupational therapy.

4.6 Whilst we maintain services we will develop a transformation plan which will change our existing service delivery model to a locality approach, as outlined below;

Locality approach

4.7 SCCG's approach within the BCF for 2016/17 to transforming community services for the benefit of Southend residents is through an integrated 'locality approach'. A locality will provide comprehensive integrated out of hospital care for provision, co-ordination and signposting ensuring that the shift is taken away from the hospital. This locality approach may not necessarily be a physical location but will use existing Council and health estate and provide services in a range of different ways.

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

4.9 There will be a focus on retraining the workforce to play their role in delivering whole person care that enhances self-management.

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

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

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

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

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

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

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

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

4.10.8 Reduced unplanned attendances at Accident and Emergency

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

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

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

4.10.12 Release of GP time to address other patient groups

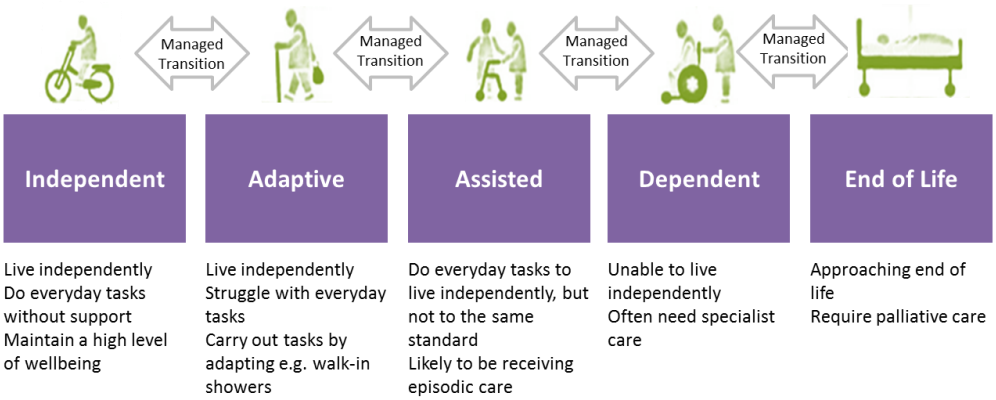
4.11 We recognise that a significant proportion of the cohort will be those with dementia and in need of dementia services. Further, we recognise the need to continually develop our dementia services. The providers are key to developing our services and through our Dementia Support Group (DSG) we have developed an action plan which has been jointly developed between commissioners and providers and is aligned to enhancing our existing services. The action plan for the DSG can be found at Appendix 7.

4.12 Our early analysis suggests that, based on resident need, location of primary care provision and the social care redesign, either three or four localities are appropriate for Southend.

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

4.14 To support the implementation of the locality approach SBC and SCCG have agreed to jointly review opportunities for SBC to invest in SCCGs 'invest to save' programme. For example Support to Care Homes, Community Geriatrician and End of Life. The identification of the schemes will form part of the initial journey which will also identify the investment required and the savings available.

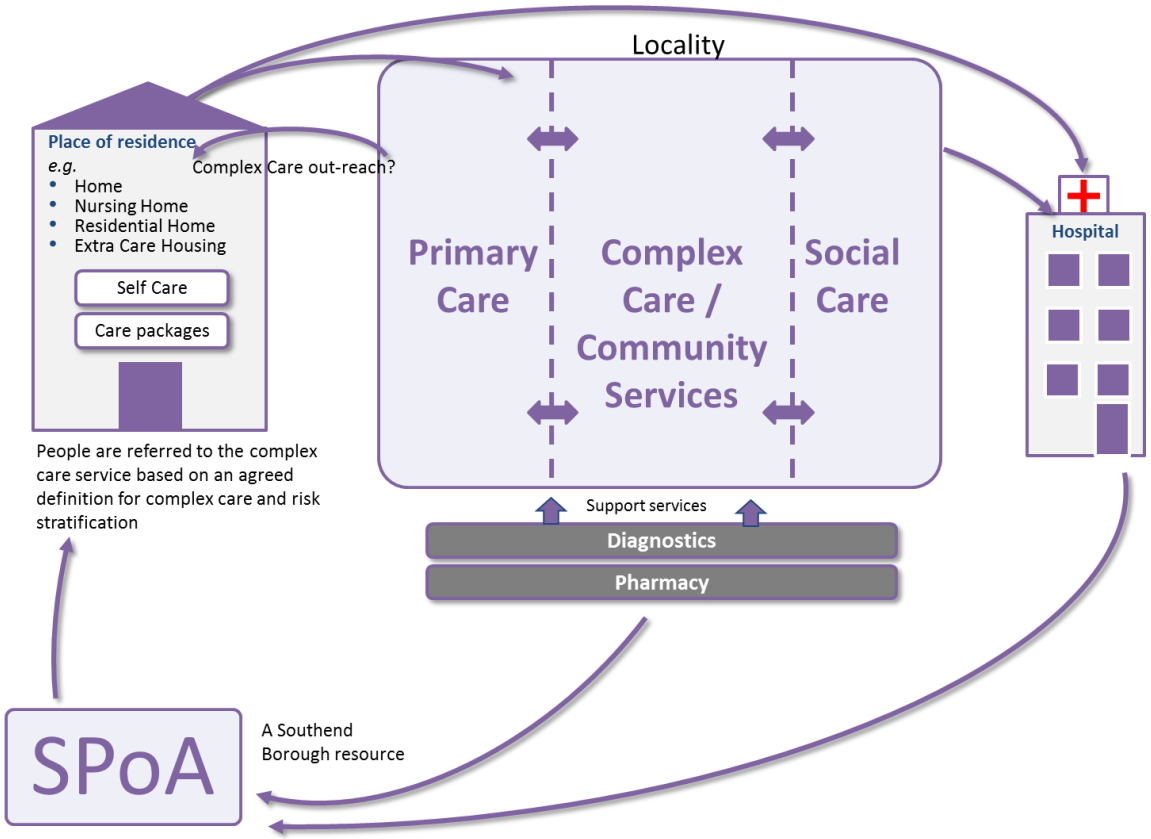
The transitional pathway



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

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

The proposed model

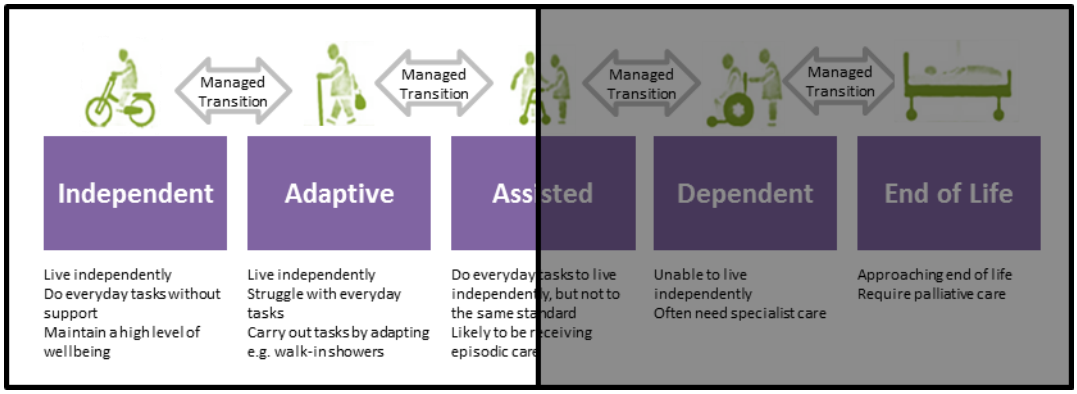


4.17 The Single Point of Access (SPoA) will be redesigned to focus on;

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

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

4.18 The SPoA will target those individuals who sit within the transitional pathway as outlined below;



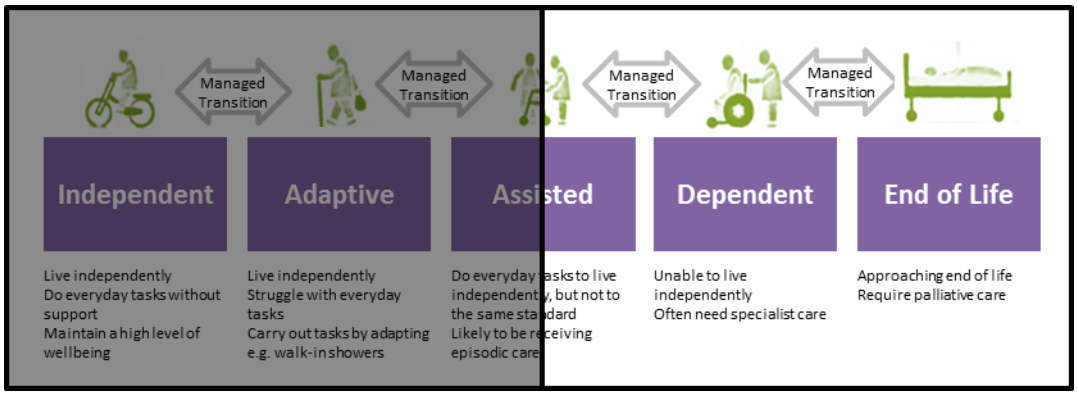
4.19 Complex Care / community services will work in an MDT environment co-locating teams of professionals which will include GPs, community nurses, care co-ordinators, therapies, social workers, pharmacists, voluntary sector, mental health practitioners, dieticians and Long Term Condition nurses, facilitated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

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

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

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

4.20 The complex care service will target those individuals who sit within the transitional pathway as outlined below;



Outcomes

4.21 The provision of community services and transformation to a locality approach will be measured through the following performance metrics;

4.21.1 non elective hospital admissions;

4.21.2 Delayed Transfers of Care;

4.21.3 reablement;

4.21.4 friends and family (in patient) test; and

4.21.5 those with a Long Term Condition feeling supported

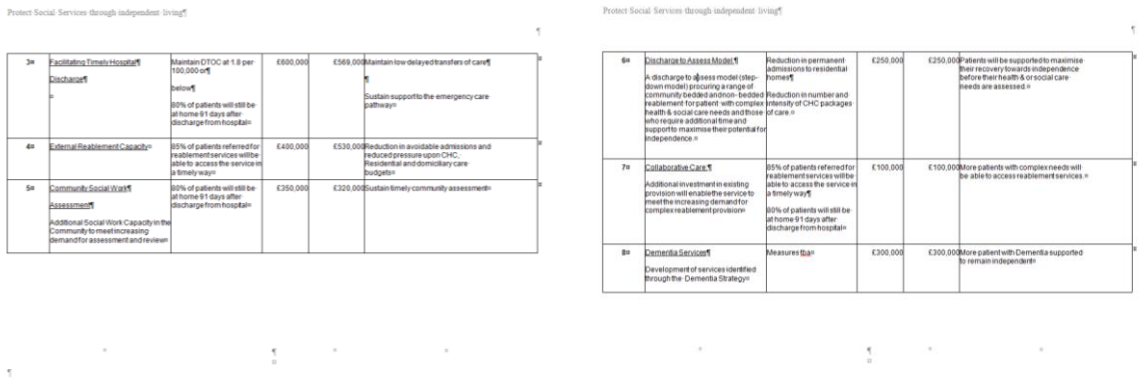
4.22 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

Provide, maintaining and redesign social care

4.23 Southend BCF will allocate £4.199M in revenue to the Council for use to provide, maintain and redesign social care. A detailed draft expenditure plan is at Appendix 4a.

4.24 During 2016/17 we will maintain social care services which will include services such as our Single Point of Referral (SPoR), community social work assessments, a discharge to assess model, dementia services and the Falls service.

4.25 A detailed analysis has been undertaken which compares planned spend with 2015/16 and has supported a review process which aligned outcomes with spend. A snapshot of this review is available below;



Protect Social Services through independent living

3	Facilitating Timely Hospital Discharge	Maintain DTOC at 1.8 per 100,000 or below 93% of patients will still be at home 91 days after discharge from hospital	£600,000	£569,000	Maintain low delayed transfers of care Sustain support to the emergency care pathway
4	External Reablement Capacity	85% of patients referred for reablement services will be able to access the service in a timely way	£400,000	£530,000	Reduction in avoidable admissions and reduced pressure upon CHC; Residential and domiciliary care budgets
5	Community Social Work Assessment Additional Social Work Capacity in the Community to meet increasing demand for assessment and review	93% of patients will still be at home 91 days after discharge from hospital	£350,000	£320,000	Sustain timely community assessment

Protect Social Services through independent living

6	Discharge to Assess Model A discharge to assess model (step-down model) procuring a range of community bedded and non- bedded reablement for patient with complex health & social care needs and those who require additional time and support to maximise their potential for independence	Reduction in permanent admissions to residential homes Reduction in number and intensity of CHC packages of care	£250,000	£250,000	Patients will be supported to maximise their recovery towards independence before their health & or social care needs are assessed
7	Collaborative Care Additional investment in existing provision will enable the service to meet the increasing demand for complex reablement provision	85% of patients referred for reablement services will be able to access the service in a timely way 80% of patients will still be at home 91 days after discharge from hospital	£100,000	£100,000	More patients with complex needs will be able to access reablement services.
8	Dementia Services Development of services identified through the Dementia Strategy	Measures tba	£300,000	£300,000	More patient with Dementia supported to remain independent

4.26 Whilst we maintain services we will develop a plan which will redesign our existing service delivery model (as outlined below) and be aligned to the locality approach, outlined above;

Redesign of Adult Social Care (ASC)

4.27 ASC redesign is an important element to the redesign and delivery of integrated health and social care in Southend. ASC is currently leading a transformational project across the whole social care and health system which will turn around culture and mindset, develop alternatives, develop engagement, communicate a compelling vision, and develop and embed the narrative that supports this transformational change programme of work.

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

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

4.30 Adopting a collaborative and preventative approach to our practice will minimise admissions into long term residential care, admission into hospital and minimise the need for large domiciliary care packages. Social Care will create a robust multi-disciplinary front-end adult social care team where advice, information and signposting to the wider community and universal services can minimise the long term dependency on health and social care services.

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

Outcomes

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

4.32.1 Residential care admissions;

4.32.2 Delayed Transfers of Care; and

4.32.3 Reablement.

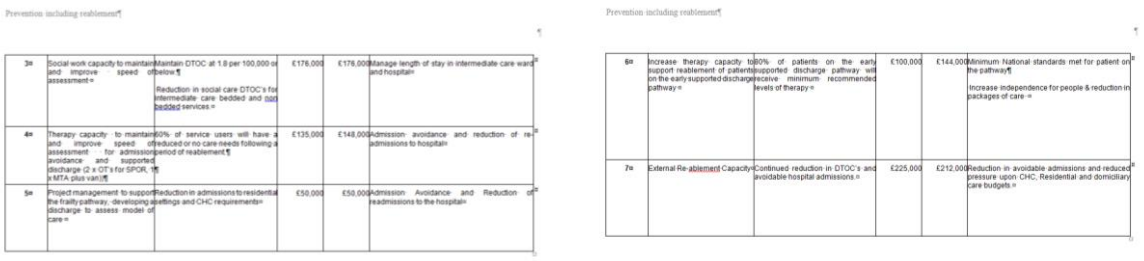
4.33 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

Reablement & Care Act

4.34 Southend BCF will allocate £1.450M in revenue to the Council for use to provide, reablement services and continue with the implementation of the Care Act. A detailed draft expenditure plan is at Appendix 4b.

4.35 During 2016/17 we will commission reablement services which will include services such as our Single Point of Referral (SPoR), Stroke early supported discharge pathway, discharge to assess and home again services.

4.36 A detailed analysis has been undertaken which compares planned spend with 2015/16 and has supported a review process which aligned outcomes with spend. A snapshot of this review is available below;



3¤	Social work capacity to maintain and improve speed of assessment ¤	Maintain DTOC at 1.8 per 100,000 or below.¶ Reduction in social care DTOC's for intermediate care bedded and non bedded services ¤	£176,000	£176,000	Manage length of stay in intermediate care ward and hospital¤
4¤	Therapy capacity to maintain and improve speed of assessment for admission avoidance and supported discharge (2 x OT's for SPOR, 1¶ x MTA plus van)¶	20% of service users will have a reduced or no care needs following a period of reablement.¶	£135,000	£148,000	Admission avoidance and reduction of re-admissions to hospital¤
5¤	Project management to support the frailty pathway developing a discharge to assess model of care ¤	Reduction in admissions to residential settings and CHC requirements¤	£50,000	£50,000	Admission Avoidance and Reduction of readmissions to the hospital¤

6¤	Increase therapy capacity to support reablement of patients on the early supported discharge pathway ¤	80% of patients on the early supported discharge pathway will receive minimum recommended levels of therapy ¤	£100,000	£144,000	Minimum National standards met for patient on the pathway¶ Increase independence for people & reduction in packages of care ¤
7¤	External Re-ablement Capacity¤	Continued reduction in DTOC's and avoidable hospital admissions ¤	£225,000	£212,000	Reduction in avoidable admissions and reduced pressure upon CHC, Residential and domiciliary care budgets ¤

4.37 The joint evaluation of spend on reablement will achieve greater focus and/or resource on particular areas initially looking at improving effectiveness of the service and intermediate care aligned to preventing hospitalisation and institutional care and re-admissions. The exec leads for this evaluation will initially focus on the review of reablement and intermediate care needs including financial savings.

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

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

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

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

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

Outcomes

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

4.43.1 A reduction in avoidable admissions to hospital

4.43.2 Facilitate timely hospital discharges

4.43.3 Prevention and maximising independence

4.43.4 Recovery and enablement services.

4.43.5 Community rehabilitation and re-ablement.

4.43.6 Processes to minimise delayed discharge

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

5 National metrics

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

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

5.2.1 transforming community services to a locality;

5.2.2 redesigning social care;

5.2.3 discharge to Assess service;

5.2.4 overnight support service;

5.2.5 reablement services;

5.2.6 working closer with care homes;

5.2.7 engagement of a Community Geriatrician;

5.2.8 designing a co-ordination service for those with complex care needs;

5.2.9 redesigning our end of life pathway;

5.2.10 implementation of a Falls service;

5.3 We are confident that our track record of delivery (outlined below), delivery and governance structure provides the appropriate assurance that our planning for 2016/17 has been undertaken and undergone a rigorous planning process. Our BCF plan for 2015/16 has as at end Q3 2015/16;

5.3.1 delivered a reduction in non-elective admissions of 5.7%. Our target was 3.5%. Detailed analysis has been undertaken regarding our performance for 2015/16 and our success has been assigned to the commissioning of a number of services that are aligned to delivering services within the community. Our plan for 2016/17 is a continuation of our plan for 2015/16.

5.3.2 delivered a reduction in residential care admissions of 11.5%. Our target was 11.5%. Detailed analysis has been undertaken regarding our performance for 2015/16 and our success has been assigned to a revised approach to panel review, the implementation of a discharge to assess model and closer management of the discharge pathway.

5.3.3 delivered a reablement metric that shows 81.4% of those (over the age of 65) discharged from hospital are still at home 91 days after discharge. Detailed analysis has been undertaken regarding our performance for 2015/16 and our success has been assigned to closer management of the reablement services, the implementation of a discharge to assess model and closer management of the discharge pathway.

5.4 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Subsequently, no risk sharing is planned regarding DToC.

5.5 A target for DToC is in the process of being agreed. The process is led by both SCCG and the Council and engages providers who have an impact on DToC. We recognise that whilst our DToC performance is extremely good there are always areas for improvement. Subsequently, the agreed targets will support a further decrease in DToC. The agreement will be made between SCCG, the Council, Southend Hospital and our community service provider.

Development of 2016/17 targets

5.6 Reablement. The trajectory of those still at home 91 days after discharge from hospital into a reablement service has steadily improved from an historic review. Our vision is to continue this improvement and we are mindful of the challenges we face in achieving this. The target for 2016/17 demonstrates this vision and the actions we are taken and discussed in this plan acknowledge the challenge we face. For example, we have recently commissioned a Discharge 2 Assess service with the aim of easing flow through hospital and also increasing the proportion of population still at home 91 days after discharge. Service commenced mid February 2016.

5.7 Long term conditions. Our BCF plan for 2016/17 is focused on the cohort of patients with long term conditions and complex care needs, for example the locality approach. We are confident that the actions we are and plan to take will continue to increase those at home, with a long term condition, and feeling supported to manage it themselves. For example we plan to introduce a complex care co-ordination service which will support a complex care cohort in navigating their way through our system.

5.8 Patient experience. The friends and family score of our hospital in patients is recognised as a particular challenge for our system. Through contract negotiations for 2016/17 we will be requesting an action plan from the hospital to improve the score. We have, therefore, agreed to target a maintenance of 2015/16 performance.

Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: Guidance

Overview

The purpose of this template is to collect information from CCGs, local authorities, and Health and Wellbeing Boards (HWBs) in relation to Better Care Fund (BCF) plans for 2016-17. The focus of the collection is on finance and activity information, as well as the national conditions. The template represents the minimum collection required to provide assurance that plans meet the requirements of the Better Care Fund policy framework set out by the Department of Health and the Department of Communities and Local Government (www.gov.uk/government/publications/better-care-fund-how-it-will-work-in-2016-to-2017). This information will be used during the regionally led assurance process in order to ensure that BCF plans being recommended for sign-off meet technical requirements of the fund.

The information collected within this template is therefore not intended to function as a 'plan' but rather as a submission of data relating to a plan. A narrative plan will also need to be provided separately to regional teams, but there will be no centrally submitted template for 2016-17. CCGs, local authorities, and HWBs will want to consider additional finance and activity information that they may wish to include within their own BCF plans that is not captured here.

This tab provides an overview of the information that needs to be completed in each of the other tabs of the template. This should be read in conjunction with Annex 4 of the NHS Shared Planning Guidance for 2016-17; Better Care Fund Planning Requirements for 2016-17', which is published here: www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/

Timetable

The submission and assurance process will follow the following timetable:

• NHS Planning Guidance for 2016-17 released – 22 December 2015
• BCF Allocations published following release of CCG allocations – 09 February 2016
• Annex 4 - BCF Planning Requirements 2016-17 released - 22 February 2016
• BCF Planning Return template, released – 24 February 2016
• First BCF submission by 2pm on 02 March 2016, agreed by CCGs and local authorities, to consist of:
  o BCF planning return template
All submissions will need to be sent to DCO teams and copied to the National Team (england.bettercaresupport@nhs.net)
• First stage assurance of planning return template and initial feedback to local areas - 02 to 16 March 2016
• Second version of the BCF Planning Return template, released (with updated NEA plans) – 9th March
• Second submission following assurance and feedback by 2pm on 21 March 2016, to consist of:
  o High level narrative plan
  o Updated BCF planning return template
• Second stage assurance of full plans and feedback to local areas - 21 March to 13 April 2016
• **BCF plans finalised and signed off by Health and Wellbeing Boards and submitted by 2pm on 03 May 2016**
This should be read alongside the timetable on page of page 15 of Annex 4 - BCF Planning Requirements.

Introduction

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

Data needs inputting in the cell
Pre-populated cell

To note - all cells in this template requiring a numerical input are restricted to values between 0 and 1,000,000,000.

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

Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.
The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'.
The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B7) will change to 'Complete Template'.

Please ensure that all boxes on the checklist tab are green before submission.

1. Cover

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

All data that has been pre-populated in the yellow cells has been taken from submission 2 templates submitted by Health and Well-Being Boards, where a submission 2 template was not received the submission 1 data has been used instead."

On the cover sheet please **enter the following information:**
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area.

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

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please **enter the following information:**
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition.

The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.

On this tab please **enter the following information:**
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure.

- Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below.

- Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

4. HWB Expenditure plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please **enter the following information:**
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme)

This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

On this tab please **enter the following information:**
- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)
- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

- Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure.

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

5b. HWB Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the “Technical Definitions” and the “Supplementary Technical Definitions” at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion.

On this tab please **enter the following information:**
- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

CCG - HWB Mapping

The final tab provides details of the CCG to HWB mapping used to calculate contributions to Health and Wellbeing Board level non-elective activity plans.

Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: Checklist

This is a checklist in relation to cells that need data inputting in the each of the sheets within this file. It is sectioned out by sheet name and contains the question, cell reference (hyperlinked) for the question and two separate checks
- the 'tick-box' column (D) is populated by the user for their own reference (not mandatory), and
- the 'checker' column (E) which updates as questions within each sheet are completed.The checker column has been coloured so that if a value is missing from the sheet it refers to, the cell will be Red and contain the word 'No' - once completed the cell will change to Green and contain the word 'Yes'. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (B7) will change to 'Complete Template'.Please ensure that all boxes on the checklist tab are green before submission.

Complete Template

1. Cover

	Cell Reference	Complete?	Checker
Health and Well Being Board	C10	☐	Yes
completed by:	C13	☐	Yes
e-mail:	C15	☐	Yes
contact number:	C17	☐	Yes
Who has signed off the report on behalf of the Health and Well Being Board:	C19	☐	Yes

Sheet Completed:	Yes

2. Summary and confirmations

	Cell Reference	Complete?	Checker
Summary of BCF Expenditure : Please confirm the amount allocated for the protection of adult social care : Expenditure (£000's)	E37	☐	Yes
Summary of BCF Expenditure : If the figure in cell D29 differs to the figure in cell C29, please indicate please indicate the reason for the variance.	F37	☐	Yes
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	F47	☐	Yes

Sheet Completed:	Yes

3. HWB Funding Sources

	Cell Reference	Complete?	Checker
Local authority Social Services: <Please Select Local Authority>	B16 : B25	☐	Yes
Gross Contribution: £000's	C16 : C25	☐	Yes
Comments (if required)	E16 : E25	☐	N/A
Are any additional CCG Contributions being made? If yes please detail below;	C42	☐	Yes
Additional CCG Contribution: <Please Select CCG>	B45 : B54	☐	Yes
Gross Contribution: £000's	C45 : C54	☐	Yes
Comments (if required)	E45 : E54	☐	N/A
Funding Sources Narrative	B61	☐	N/A
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	C70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	C71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	C72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	C73	☐	Yes
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority? Comments	D70	☐	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified? Comments	D71	☐	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool? Comments	D72	☐	Yes
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used? Comments	D73	☐	Yes

Sheet Completed:	Yes

4. HWB Expenditure Plan

	Cell Reference	Complete?	Checker
Scheme Name	B17 : B266	☐	Yes
Scheme Type (see table below for descriptions)	C17 : C266	☐	Yes
Please specify if 'Scheme Type' is 'other'	D17 : D266	☐	Yes
Area of Spend	E17 : E266	☐	Yes
Please specify if 'Area of Spend' is 'other'	F17 : F266	☐	Yes
Commissioner	G17 : G266	☐	Yes
if Joint % NHS	H17 : H266	☐	Yes
if Joint % LA	I17 : I266	☐	Yes
Provider	J17 : J266	☐	Yes
Source of Funding	K17 : K266	☐	Yes
2016/17 (£000's)	L17 : L266	☐	Yes
New or Existing Scheme	M17 : M266	☐	Yes
Total 15-16 Expenditure (£) (if existing scheme)	N17 : N266	☐	Yes

Sheet Completed:	Yes

5. HWB Metrics

	Cell Reference	Complete?	Checker
5.1 - Are you planning on any additional quarterly reductions?	E43	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q1	G45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q2	I45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q3	K45	☐	Yes
5.1 - HWB Quarterly Additional Reduction Figure - Q4	M45	☐	Yes
5.1 - Are you putting in place a local risk sharing agreement on NEA?	E49	☐	Yes
5.1 - Cost of NEA	E54	☐	Yes
5.1 - Comments (if required)	F54	☐	Yes
5.2 - Residential Admissions : Numerator : Forecast 15/16	G69	☐	Yes
5.2 - Residential Admissions : Numerator : Planned 16/17	H69	☐	Yes
5.2 - Comments (if required)	I68	☐	N/A
5.3 - Reablement : Numerator : Forecast 15/16	G82	☐	Yes
5.3 - Reablement : Denominator : Forecast 15/16	G83	☐	Yes
5.3 - Reablement : Numerator : Planned 16/17	H82	☐	Yes
5.3 - Reablement : Denominator : Planned 16/17	H83	☐	Yes
5.3 - Comments (if required)	I81	☐	N/A
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q3	K94	☐	Yes
5.4 - Delayed Transfers of Care : 15/16 Forecast : Q4	L94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q1	M94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q2	N94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q3	O94	☐	Yes
5.4 - Delayed Transfers of Care : 16/17 Plans : Q4	P94	☐	Yes
5.4 - Comments (if required)	Q93	☐	N/A
5.5 - Local Performance Metric	C105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Metric Value	E105	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Numerator	E106	☐	Yes
5.5 - Local Performance Metric : Planned 15/16 : Denominator	E107	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Metric Value	F105	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Numerator	F106	☐	Yes
5.5 - Local Performance Metric : Planned 16/17 : Denominator	F107	☐	Yes
5.5 - Comments (if required)	G105	☐	N/A
5.6 - Local defined patient experience metric	C117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Metric Value	E117	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Numerator	E118	☐	Yes
5.6 - Local defined patient experience metric : Planned 15/16 : Denominator	E119	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Metric Value	F117	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Numerator	F118	☐	Yes
5.6 - Local defined patient experience metric : Planned 16/17 : Denominator	F119	☐	Yes
5.6 - Comments (if required)	G117	☐	N/A

Sheet Completed:	Yes

6. National Conditions

	Cell Reference	Complete?	Checker
1) Plans to be jointly agreed	C14	☐	Yes
2) Maintain provision of social care services (not spending)	C15	☐	Yes
3) 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	C16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number	C17	☐	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	C18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	C19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services	C20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	C21	☐	Yes
1) Plans to be jointly agreed, Comments	D14	☐	Yes
2) Maintain provision of social care services (not spending), Comments	D15	☐	Yes
3) 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, Comments	D16	☐	Yes
4) Better data sharing between health and social care, based on the NHS number, Comments	D17	☐	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, Comments	D18	☐	Yes
6) Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans, Comments	D19	☐	Yes
7) Agreement to invest in NHS commissioned out-of-hospital services, Comments	D20	☐	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan, Comments	D21	☐	Yes

Sheet Completed:	Yes

Template for BCF submission 3: due on 03 May 2016

Submission 3 Template Changes - Updates from Submission 2 template

Change	Tabs Impacted	
Data from the Newcastle and Gateshead late submission Q2 templates included.	All tabs	
Footnotes to describe how the expenditure plan summary figures have been calculated.	2. Summary and confirmations	
The NEA activity values have been updated following the third '16/17 Shared NHS Planning' submission. Please review the impact and amend the additional quarterly reduction value, if required.	5. HWB Metrics	5b. HWB Metrics Tool
Updated SUS 15/16 Actual and FOT figures (mapped from CCG data) provided as support to the third '16/17 Shared NHS Planning' submission.	5b. HWB Metrics Tool	
Locally reported actual Q3 15/16 NEA data is now included.	5b. HWB Metrics Tool	
Residential Admissions Planned 15/16 rate has been amended for 6 HWBs to show the rate as calculated by using the numerator and denominator shown in the table.	5. HWB Metrics	5b. HWB Metrics Tool

Template for BCF submission 3: due on 03 May 2016

Better Care Fund 2016-17 Planning Template

Sheet: 1. Cover Sheet

The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. The selection of your Health and Wellbeing Board (HWB) on this sheet also then ensures that the correct data is prepopulated through the rest of the template.

All data that has been pre-populated in the yellow cells has been taken from submission 2 templates submitted by Health and Well-Being Boards, where a submission 2 template was not received the submission 1 data has been used instead."

On the cover sheet please enter the following information:
- The Health and Wellbeing Board;
- The name of the lead contact who has completed the report, with their email address and contact number for use in resolving any queries regarding the return;
- The name of the lead officer who has signed off the report on behalf of the CCGs and Local Authority in the HWB area. 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 6 cells are green should the template be sent to england.bettercaresupport@nhs.net

You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided.

It presents a summary of the first BCF submission and a mapped summary of the NEA activity plans received in the second iteration of the "CCG NHS Shared Planning Process".

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 James Moyies

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. Summary and confirmations	3
3. HWB Funding Sources	13
4. HWB Expenditure Plan	13
5. HWB Metrics	34
6. National Conditions	16

Template for BCF submission 3: due on 03 May 2016

Sheet: 2. Summary of Health and Well-Being Board 2016/17 Planning Template

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2016/17

2. Summary and confirmations

This sheet summarises information provided on sheets 2 to 6, and allows for confirmation of the amount of funding identified for supporting social care and any funds ring-fenced as part of risk sharing arrangement. To do this, there are 2 cells where data can be input.

On this tab please enter the following information:
- In cell E37 ,please confirm the amount allocated for ongoing support for adult social care. This may differ from the summary of HWB expenditure on social care which has been calculated from information provided in the 'HWB Expenditure Plan' tab. If this is the case then cell F37 will turn yellow. Please use this to indicate the reason for any variance;
- In cell F47 please indicate the total value of funding held as a contingency as part of local risk share, if one is being put in place. For guidance on instances when this may be appropriate please consult the full BCF Planning Requirements document. Cell F44 shows the HWB share of the national £1bn that is to be used as set out in national condition vii. Cell F45 shows the value of investment in NHS Commissioned Out of Hospital Services, as calculated from the 'HWB Expenditure Plan' tab. Cell F49 will show any potential shortfall in meeting the financial requirements of the condition. The rest of this tab will be populated from the information provided elsewhere within the template, and provides a useful printable summary of the return.

3. HWB Funding Sources

	Gross Contribution
Total Local Authority Contribution	£1,193,374
Total Minimum CCG Contribution	£11,937,675
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£13,131,049**

Specific funding requirements for 2016-17	Select a response to the questions in column B
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes

4. HWB Expenditure Plan

Summary of BCF Expenditure (*)

	Expenditure
Acute	£0
Mental Health	£0
Community Health	£6,288,581
Continuing Care	£0
Primary Care	£0
Social Care	£6,842,468
Other	£0
Total	**£13,131,049**

Please confirm the amount allocated for the protection of adult social care	If the figure in cell E37 differs to the figure in cell C37, please indicate the reason for the variance.
Expenditure	
£6,842,468	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool (**)

	Expenditure
Mental Health	£0
Community Health	£6,288,581
Continuing Care	£0
Primary Care	£0
Social Care	£0
Other	£0
Total	**£6,288,581**

BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share

	Fund
Local share of ring-fenced funding	£3,392,349
Total value of NHS commissioned out of hospital services spend from minimum pool	£6,288,581
Total value of funding held as contingency as part of local risk share to ensure value to the NHS	£0
Balance (+/-)	**£2,896,232**

5. HWB Metrics

5.1 HWB NEA Activity Plan

	Q1	Q2	Q3	Q4	Total
Total HWB Planned Non-Elective Admissions	5,042	5,098	5,098	4,987	20,225
HWB Quarterly Additional Reduction Figure	0	0	0	0	0
HWB NEA Plan (after reduction)	5,042	5,098	5,098	4,987	20,225
Additional NEA reduction delivered through the BCF					£0

5.2 Residential Admissions

		Planned 16/17
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	696.5

5.3 Reablement

		Planned 16/17
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Annual %	86.0%

5.4 Delayed Transfers of Care

		Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	485.8	429.2	551.5	526.1

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend	60.2

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

	Metric Value Planned 16/17
Friends and Family Net promoter score - SUFHT In Patient wards	91.70230967

6. National Conditions

National Conditions For The Better Care Fund 2016-17	Please Select (Yes, No or No - plan in place)
1) Plans to be jointly agreed	Yes
2) Maintain provision of social care services (not spending)	Yes
3) 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
4) Better data sharing between health and social care, based on the NHS number	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	Yes
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes

Footnotes

* **Summary of BCF Expenditure** is the sum of the self-reported HWB amounts allocated to the 7 different 'areas of spend' that have been provided by HWBs in their plans (from the HWB Expenditure Plan tab), where:
Area of Spend = Acute, Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other

** **Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool** is the sum of the amounts allocated to the 6 individual out of hospital 'areas of spend' that have been provided in tab 4. HWB Expenditure Plan, where;
Area of Spend = Mental Health, Community Health, Continuing Care, Primary Care, Social Care & Other (everything other than Acute)
Commissioner = CCG, NHS England or Joint (if joint we use the NHS% of the value)
Source of Funding = CCG Minimum Contribution

Template for BCF submission 3: due on 03 May 2016

Sheet: 3. Health and Well-Being Board Funding Sources

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2016/17

3. HWB Funding Sources

This sheet should be used to set out all funding contributions to the Health and Wellbeing Board's Better Care Fund plan and pooled budget for 2016-17. It will be pre-populated with the minimum CCG contributions to the Fund in 2016/17, as confirmed within the BCF Allocations spreadsheet. https://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan

These cannot be changed. The sheet also requests a number of confirmations in regard to the funding that is made available through the BCF for specific purposes.
On this tab please enter the following information:
- Please use rows 16-25 to detail Local Authority funding contributions by selecting the relevant authorities and then entering the values of the contributions in column C. This should include all mandatory transfers made via local authorities, as set out in the BCF Allocations spreadsheet, and any additional local authority contributions. There is a comment box in column E to detail how contributions are made up or to allow contributions from an LA to split by funding source or purpose if helpful. Please note, only contributions assigned to a Local Authority will be included in the 'Total Local Authority Contribution' figure.
- Please use cell C42 to indicate whether any additional CCG contributions are being made. If 'Yes' is selected then rows 45 to 54 will turn yellow and can be used to detail all additional CCG contributions to the fund by selecting the CCG from the drop down boxes in column B and enter the values of the contributions in column C. There is a comment box in column E to detail how contributions are made up or any other useful information relating to the contribution. Please note, only contributions assigned to an additional CCG will be included in the 'Total Additional CCG Contribution' figure. - Cell C57 then calculates the total funding for the Health and Wellbeing Board, with a comparison to the 2015-16 funding levels set out below. - Please use the comment box in cell B61 to add any further narrative around your funding contributions for 2016-17, for example to set out the driver behind any change in the amount being pooled.The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Local Authority Contribution(s)	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
Southend-on-Sea	£1,193,374	Disabled Facilities Grant
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
<Please Select Local Authority>		
Total Local Authority Contribution	**£1,193,374**	

CCG Minimum Contribution	Gross Contribution
NHS Southend CCG	£11,937,675
Total Minimum CCG Contribution	**£11,937,675**

Are any additional CCG Contributions being made? If yes please detail below;	No

Additional CCG Contribution	Gross Contribution	Comments - please use this box clarify any specific uses or sources of funding
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**£0**	

Total BCF pooled budget for 2016-17	**£13,131,049**

Funding Contributions Narrative

The final section on this sheet then sets out four specific funding requirements and requests confirmation as to the progress made in agreeing how these are being met locally - by selecting either 'Yes', 'No' or 'No - in development' in response to each question. 'Yes' should be used when the funding requirement has been met. 'No - in development' should be used when the requirement is not currently agreed but a plan is in development to meet this through the development of your BCF plan for 2016-17. 'No' should be used to indicate that there is currently no agreement in place for meeting this funding requirement and this is unlikely to be agreed before the plan is finalised.
- Please use column C to respond to the question from the dropdown options;
- Please detail in the comments box in row D issues and/or actions that are being taken to meet the funding requirement, or any other relevant information.

Specific funding requirements for 2016-17	Select a response to the questions in column B	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1. Is there agreement about the use of the Disabled Facilities Grant, and arrangements in place for the transfer of funds to the local housing authority?	Yes	
2. Is there agreement that at least the local proportion of the £138m for the implementation of the new Care Act duties has been identified?	Yes	
3. Is there agreement on the amount of funding that will be dedicated to carer-specific support from within the BCF pool?	No - in development	We are waiting for the national guidance re the local proportion. Once received we will be in a position to locally agree.
4. Is there agreement on how funding for reablement included within the CCG contribution to the fund is being used?	Yes	

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

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

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

						Expenditure						
Scheme Name	Scheme Type (see table below for descriptions)	Please specify if 'Scheme Type' is 'other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	if Joint % NHS	if Joint % LA	Provider	Source of Funding	2016/17 Expenditure (£)	New or Existing Scheme	Total 15-16 Expenditure (£) (if existing scheme)
Protecting Social Services	Personalised support/ care at home		Social Care		Local Authority			Local Authority	CCG Minimum Contribution	£4,199,094	Existing	£4,087,000
Reablement including supporting the Care Act	Reablement services		Social Care		Local Authority			Private Sector	CCG Minimum Contribution	£1,450,000	Existing	£1,431,000
Integrated community services (inlc provision of complex care and End o	Personalised support/ care at home		Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	£6,286,581	New	
Adaptions at homes for disabled	Personalised support/ care at home		Social Care		Local Authority			Private Sector	Local Authority Social Services	£1,193,374	Existing	£694,000

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

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

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

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

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Template for BCF submission 3: due on 03 May 2016

Sheet: 4. Health and Well-Being Board Expenditure Plan

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

Data Submission Period:
2016/17

4. HWB Expenditure Plan

This sheet should be used to set out the full BCF scheme level spending plan. The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing, which is required to demonstrate how the national policy framework is being achieved. Where a scheme has multiple funding sources this can be indicated and split out, but there may still be instances when several lines need to be completed in order to fully describe a single scheme. In this case please use the scheme name column to indicate this.

On this tab please enter the following information:
- Enter a scheme name in column B;
- Select the scheme type in column C from the dropdown menu (descriptions of each are located in cells B270 - C278); if the scheme type is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column D;
- Select the area of spending the scheme is directed at using from the dropdown menu in column E; if the area of spending is not adequately described by one of the dropdown options please choose 'other' and give further explanation in column F;
- Select the commissioner and provider for the scheme using the dropdown menu in columns G and J, noting that if a scheme has more than one provider or commissioner, you should complete one row for each. For example, if both the CCG and the local authority will contract with a third party to provide a joint service, there would be two lines for the scheme: one for the CCG commissioning from the third party and one for the local authority commissioning from the third party;
- In Column K please state where the expenditure is being funded from. If this falls across multiple funding streams please enter the scheme across multiple lines;
- Complete column L to give the planned spending on the scheme in 2016/17;
- Please use column M to indicate whether this is a new or existing scheme.
- Please use column N to state the total 15-16 expenditure (if existing scheme) This is the only detailed information on BCF schemes being collected centrally for 2016-17 but it is expected that detailed scheme level plans will continue to be developed locally.

Scheme Type	Description
Reablement services	The development of support networks to maintain the patient at home independently or through appropriate interventions delivered in the community setting. Improved independence, avoids admissions, reduces need for home care packages.
Personalised support/ care at home	Schemes specifically designed to ensure that the patient can be supported at home instead of admission to hospital or to a care home. May promote self management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term. Admission avoidance, re-admission avoidance.
Intermediate care services	Community based services 24x7. Step-up and step-down. Requirement for more advanced nursing care. Admissions avoidance, early discharge.
Integrated care teams	Improving outcomes for patients by developing multi-disciplinary health and social care teams based in the community. Co-ordinated and proactive management of individual cases. Improved independence, reduction in hospital admissions.
Improving healthcare services to care homes	Improve the quality of primary and community health services delivered to care home residents. To improve the consistency and quality of healthcare outcomes for care home residents. Support Care Home workers to improve the delivery of non essential healthcare skills. Admission avoidance, re-admission avoidance.
Support for carers	Supporting people so they can continue in their roles as carers and avoiding hospital admissions. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. Admission avoidance
7 day working	Seven day working across health and/or social care settings. Reablement and avoids admissions
Assistive Technologies	Supportive technologies for self management and telehealth. Admission avoidance and improves quality of care

Template for BCF submission 3: due on 03 May 2016

Sheet: 5. Health and Well-Being Board Better Care Fund Metrics

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

Data Submission Period:
2016/17

5. HWB Metrics

This sheet should be used to set out the Health and Wellbeing Board's performance plans for each of the Better Care Fund metrics in 2016-17. This should build on planned and actual performance on these metrics in 2015-16. The BCF requires plans to be set for 4 nationally defined metrics and 2 locally defined metrics. The non-elective admissions metric section is pre-populated with activity data from CCG Operating Plan submissions for all contributing CCGs, which has then been mapped to the HWB footprint to provide a default HWB level NEA activity plan for 2016-17. There is then the option to adjust this by indicating how many admissions can be avoided through the BCF plan, which are not already built into CCG operating plan assumptions. Where it is decided to plan for an additional reduction in NEA activity through the BCF the option is also provided within the template to set out an associated risk sharing arrangement. Once CCG have made their second operating plan activity uploads via Unify this data will be populated into a second version of this template by the national team and sent back in time for the second BCF submission. At this point Health and Wellbeing Boards will be able to amend, confirm, and comment on non-elective admission targets again based on the new data. The full specification and details around each of the six metrics is included in the BCF Planning Requirements document. Comments and instructions in the sheet should provide the information required to complete the sheet.

Further information on how when reductions in Non-Elective Activity and associated risk sharing arrangements should be considered is set out within the BCF Planning Requirements document.

5.1 HWB NEA Activity Plan

- Please use cell E43 to confirm if you are planning on any additional quarterly reductions (Yes/No)
- If you have answered Yes in cell E43 then in cells G45, I45, K45 and M45 please enter the quarterly additional reduction figures for Q1 to Q4.
- In cell E49 please confirm whether you are putting in place a local risk sharing agreement (Yes/No)
- In cell E54 please confirm or amend the cost of a non elective admission. This is used to calculate a risk share fund, using the quarterly additional reduction figures.
- Please use cell F54 to provide a reason for any adjustments to the cost of NEA for 16/17 (if necessary)

	% CCG registered population that has resident population in Southend-on-Sea	% Southend-on-Sea resident population that is in CCG registered population	Quarter 1		Quarter 2		Quarter 3		Quarter 4		Total (Q1 - Q4)	
Contributing CCGs			CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**	CCG Total Non-Elective Admission Plan*	HWB Non-Elective Admission Plan**
NHS Castle Point and Rochford CCG	4.6%	4.5%	4,486	206	4,535	208	4,535	208	4,436	203	17,992	824
NHS Southend CCG	96.6%	95.5%	5,005	4,837	5,060	4,890	5,060	4,890	4,950	4,784	20,075	19,401
Totals		**100%**	**9,491**	**5,042**	**9,595**	**5,098**	**9,595**	**5,098**	**9,386**	**4,987**	**38,067**	**20,225**

Are you planning on any additional quarterly reductions?	No							
If yes, please complete HWB Quarterly Additional Reduction Figures								
HWB Quarterly Additional Reduction Figure								
HWB NEA Plan (after reduction)								
HWB Quarterly Plan Reduction %								

Are you putting in place a local risk sharing agreement on NEA?	No	
BCF revenue funding from CCGs ring-fenced for NHS out of hospital commissioned services/risk share ***	£3,392,349	
Cost of NEA as used during 15/16 ****	£1,490	Please add the reason, for any adjustments to the cost of NEA for 16/17 in the cell below.
Cost of NEA for 16/17 ****		

Additional NEA reduction delivered through the BCF								
HWB Plan Reduction %								

* This is taken from the latest CCG NEA plan figures included in the Unify2 planning template, aggregated to quarterly level, extracted on 12th April 2016.

** This is calculated as the % contribution of each CCG to the HWB level plan, based on the CCG-HWB mapping (see CCG - HWB Mapping tab)

*** Within the sum subject to the condition on NHS out of hospital commissioned services/risk share, for any local area putting in place a risk share for 2016/17 as part of its BCF planning, we would expect the value of the risk share to be equal to the cost of the non-elective activity that the BCF plan seeks to avoid. Source of data: https://www.england.nhs.uk/wp-content/uploads/2016/02/bcf-allocations-1617.xlsx

**** Please use the following document and amend the cost if necessary in cell E54. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/477919/2014-15_Reference_costs_publication.pdf

5.2 Residential Admissions

- In cell G69 please enter your forecasted level of residential admissions for 2015-16. In cell H69 please enter your planned level of residential admissions for 2016-17. The actual rate for 14-15 and the planned rate for 15-16 are provided for comparison. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

		Actual 14/15*****	Planned 15/16*****	Forecast 15/16	Planned 16/17	Comments
Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual rate	831.0	521.4	706.9	696.5	As noted in Southend's Q2 15/16 quarterly return the planned residential care admissions (for 15/16) changed in line with the baseline re-alignment. Our target was 11.5% reduction from a total 279 admissions. Forecast 15/16 is based on a pro rata approach to YTD performance at Mo10 15/16 (184). The planned 16/17 metric is based on forecast for 15/16 and subject to further due diligence.
	Numerator	279	177	240	240	
	Denominator	33,575	33,950	33,950	34,458	

*****Actual 14/15 & Planned 15/16 collected using the following definition - 'Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population'. Any numerator less than 6 has been supressed in the published data and is therefore showing blank in the numerator and annual rate cells above. These cells will also be blank if an estimate has been used in the published data. Planned 15/16 rate has been amended for 6 HWBs to show the rate as calculated by using the numerator and denominator shown in the table.

5.3 Reablement

- Please use cells G82-83 (forecast for 15-16) and H82-83 (planned 16-17) to set out the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. By entering the denominator figure in cell G83/H83 (the planned total number of older people (65 and over) discharged from hospital into reablement / rehabilitation services) and the numerator figure in cell G82/H82 (the number from within that group still at home after 91 days) the proportion will be calculated for you in cell G81/H81. Please add a commentary in column I to provide any useful information in relation to how you have agreed this figure.

Actual 14/15*****	Planned 15/16	Forecast 15/16	Planned 16/17	Comments

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual %	77.4%	80.0%	81.5%	86.0%	Forecast 15/16 is based on YTD (mo10 15/16) performance. Planned 16/17 is based on Q3 16/17 performance (discharges). Data will be available for this metric on 31st March 2017. Proxy indicators will be provided in quarterly submissions throughout FY 16/17.
	Numerator	105	112	233	86	
	Denominator	135	140	286	100	

*****Any numerator or denominator less than 6 has been supressed in the published data and is therefore showing blank in the cells above. These cells will also be blank if an estimate has been used in the published data.

5.4 Delayed Transfers of Care

- Please use rows 93-95 (column L for Q4 15-16 forecasts and columns M-P for 16-17 plans) to set out the Delayed Transfers Of Care (delayed days) from hospital per 100,000 population (aged 18+). The denominator figure in row 95 is pre-populated (population - aged 18+). The numerator figures in cells L94-P94 (the Delayed Transfers Of Care (delayed days) from hospital) needs entering. The rate will be calculated for you in cells L93-P93. Please add a commentary in column Q to provide any useful information in relation to how you have agreed this figure.

		15-16 plans				15-16 actual (Q1, Q2 & Q3) and forecast (Q4) figures				16-17 plans				
		Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)	Q1 (Apr 16 - Jun 16)	Q2 (Jul 16 - Sep 16)	Q3 (Oct 16 - Dec 16)	Q4 (Jan 17 - Mar 17)	Comments
Delayed Transfers of Care (delayed days) from hospital per 100,000 population (aged 18+).	Quarterly rate	510.9	183.8	299.3	524.7	489.5	432.5	618.5	530.3	485.8	429.2	551.5	526.1	We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Reduced levels of DToC are increasingly of high significance and are one of the key targets within the BCF, DToC has also been identified as a major focus of the Essex Success Regime. Through our
	Numerator	717	258	420	742	687	607	868	750	687	607	780	750	
	Denominator	140,337	140,337	140,337	141,428	140,337	140,337	140,337	141,428	141,428	141,428	141,428	142,550	

5.5 Local performance metric (as described in your BCF 16/17 planning submission 2 return)

- Please use rows 105-107 to update information relating to your locally selected performance metric. The local performance metric set out in cell C105 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
People with a LTC feeling supported to manage their condition. Numerator and Denominators are not available for Southend	Metric Value	59.2	60.2	Data derived from HSCIC, Domain 2.2. Data for FY 15/16 not published until Sep 2016 and measured period July 15 - March 16. Data for FY 16/17 not published until Sep 2017 and measured period July 16 - March 17.
	Numerator	630.0	602.0	
	Denominator	1,002.0	1,000.0	

5.6 Local defined patient experience metric (as described in your BCF 16/17 planning submission 2 return)

- You may also use rows 117-119 to update information relating to your locally selected patient experience metric. The local patient experience metric set out in cell C117 has been taken from your BCF 16-17 planning submission 2 template - these local metrics can be amended, as required.

		Planned 15/16	Planned 16/17	Comments
Friends and Family Net promoter score - SUFHT In Patient wards	Metric Value	91.7	91.7	Data derived from HSCIC Domain 4 (21.1 - inpatient). Planned for 15/16 represents YTD performance at Dec 2015. Planned performance for 16/17 is subject to final contract negotiations between the CCG and SUHFT. We are working with the trust to improve response rates and proposals include increasing the number of volunteers handing out FFT postcards and targeting the areas with lower response rates. This will be closely monitored to ensure continued improvement. All staff on wards and in clinic will hand out surveys to patients, particularly on discharge. As work continues into 2016/17, new FFT posters will be put up across the Trust to raise awareness and the trust will promote positive comments on the
	Numerator	1,072.0	1,072.0	
	Denominator	1,169.0	1,169.0	

Template for BCF submission 3: due on 03 May 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.1 HWB NEA Activity

Southend-on-Sea Data Source Used - 15/16	MAR				
	Q1	Q2	Q3	Q4	Total
Southend-on-Sea 14/15 Baseline (outturn)	5,029	5,006	5,132	4,885	20,052
Southend-on-Sea 15/16 Plan	4,863	4,827	4,956	4,885	19,531
Southend-on-Sea 15/16 Actual	4,684	4,546	4,760		13,990

14/15 baseline and plan data has been taken from the "Better Care Fund Revised Non-Elective targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection" returned by HWB's in July 2015. The Q1 15/16 actual performance has been taken from the "Q1 Better Care Fund data collection" returned by HWB's in August 2015. The Q2 actual performance 15/16 and the Q4 15/16 plan figure have been taken from the "Q2 Better Care Fund data collection" returned by HWB's in November 2015. The Q3 15/16 actual performance has been taken from the "Q3 Better Care Fund data collection" returned by HWB's in February 2016. Actual Q4 data is not available at the point of this template being released.

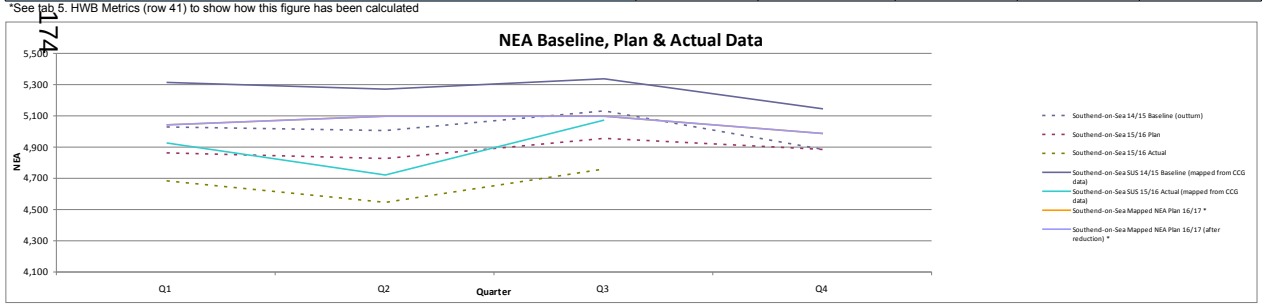
Southend-on-Sea SUS 14/15 Baseline (mapped from CCG data)	**5,314**	**5,271**	**5,337**	**5,145**	**21,067**
Southend-on-Sea SUS 15/16 Actual (mapped from CCG data)	4,926	4,721	5,073		14,721
Southend-on-Sea SUS 15/16 FOT (mapped from CCG data)					19,773

SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures were mapped from the baseline data supplied to assist the CCGs with the 16/17 shared planning round.

Over the last year the monitoring of non-elective admission (NEA) activity has shifted away from the use of the Monthly Activity Return (MAR) towards the use of Secondary Users Service data (SUS). This has been reflected in the latest planning round where NHS England, Monitor and TDA have worked with CCGs and providers to create a consistent methodology to enable the creation of consistent NEA plans. The SUS CCG mapped data included here has been derived using this methodology. More details on the methodology used to define NEA can be found in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

Southend-on-Sea Mapped NEA Plan 16/17 *	**5,042**	**5,098**	**5,098**	**4,987**	**20,225**
Southend-on-Sea Mapped NEA Plan 16/17 (after reduction) *	**5,042**	**5,098**	**5,098**	**4,987**	**20,225**

*See tab 5. HWB Metrics (row 41) to show how this figure has been calculated



Template for BCF submission 3: due on 03 May 2016

Sheet: 5b. Health and Well-Being Board Better Care Fund NEA and DTOC Tool

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2016/17

Metrics Tool

There is no data required to be completed on this tab. The tab is instead designed to provide assistance in setting your 16/17 plan figures for NEA and DTOC. Baseline 14/15, plan 15/16 and actual 15/16 data has been provided as a reference. The 16/17 plan figures are taken from those given in tab 5. HWB Metrics.

For NEAs we have also provided SUS 14/15 Baseline, SUS 15/16 Actual and SUS 15/16 FOT (Forecast Outturn) figures, mapped from the baseline data supplied to assist CCGs with the 16/17 shared planning round. This has been provided as a reference to support the new requirement for BCF NEA targets to be set in line with the revised definition set out in the "Technical Definitions" and the "Supplementary Technical Definitions" at the foot of the following webpage:

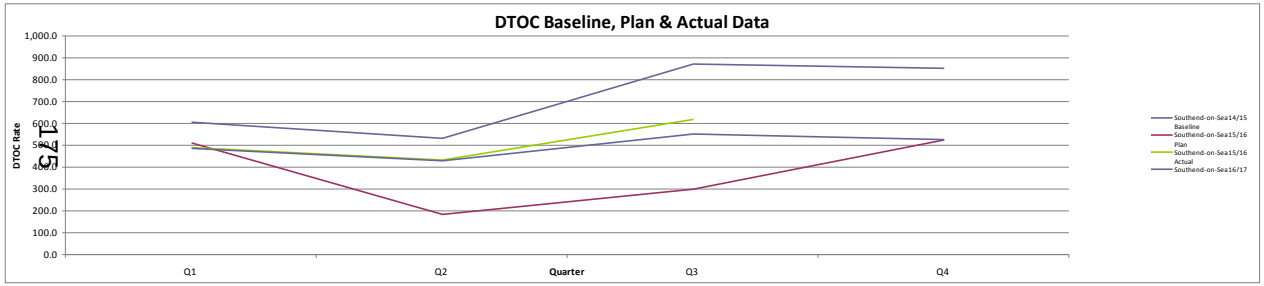
https://www.england.nhs.uk/ourwork/futurenhs/deliver-forward-view/

5.4 Delayed Transfers of Care

	Q1	Q2	Q3	Q4
Southend-on-Sea 14/15 Baseline	605.5	531.8	871.8	852.2
Southend-on-Sea 15/16 Plan	510.9	183.8	299.3	524.7
Southend-on-Sea 15/16 Actual	489.5	432.5	618.5	

Delayed Transfers Of Care numerator data for baseline and 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/. Actual Q4 data is not available at the point of this template being released.

Southend-on-Sea 16/17 Plans	**485.8**	**429.2**	**551.5**	**526.1**



Template for BCF submission 3: due on 03 May 2016

Sheet: 6. National Conditions

Selected Health and Well Being Board:

Southend-on-Sea

Data Submission Period:

2016/17

6. National Conditions

This sheet requires the Health & Wellbeing Board to confirm whether the eight national conditions detailed in the Better Care Fund Planning Guidance are on track to be met through the delivery of your plan in 2016-17. The conditions are set out in full in the BCF Policy Framework and further guidance is provided in the BCF Planning Requirements document. Please answer as at the time of completion. On this tab please enter the following information:

- For each national condition please use column C to indicate whether the condition is being met. The sheet sets out the eight conditions and requires the Health & Wellbeing Board to confirm either 'Yes', 'No' or 'No - in development' for each one. 'Yes' should be used when the condition is already being fully met. 'No - in development' should be used when a condition is not currently being met but a plan is in development to meet this through the delivery of your BCF plan in 2016-17. 'No' should be used to indicate that there is currently no plan agreed for meeting this condition by 31st March 2017.
- Please use column C to indicate when it is expected that the condition will be met / agreed if it is not being currently.
- Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.

National Conditions For The Better Care Fund 2016-17	Does your BCF plan for 2016-17 set out a clear plan to meet this condition?	Please detail in the comments box issues and/or actions that are being taken to meet the condition, or any other relevant information.
1) Plans to be jointly agreed	Yes	
2) Maintain provision of social care services (not spending)	Yes	
3) 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	
4) Better data sharing between health and social care, based on the NHS number	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	Yes	
8) Agreement on a local target for Delayed Transfers of Care (DTOC) and develop a joint local action plan	Yes	

CCG to Health and Well-Being Board Mapping

HWB Code	LA Name	CCG Code	CCG Name	% CCG in HWB	% HWB in CCG
E09000002	Barking and Dagenham	07L	NHS Barking and Dagenham CCG	89.7%	88.4%
E09000002	Barking and Dagenham	08F	NHS Havering CCG	6.8%	8.3%
E09000002	Barking and Dagenham	08M	NHS Newham CCG	0.2%	0.4%
E09000002	Barking and Dagenham	08N	NHS Redbridge CCG	2.1%	2.9%
E09000003	Barnet	07M	NHS Barnet CCG	91.1%	92.9%
E09000003	Barnet	07P	NHS Brent CCG	2.0%	1.8%
E09000003	Barnet	07R	NHS Camden CCG	0.8%	0.5%
E09000003	Barnet	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000003	Barnet	07X	NHS Enfield CCG	2.9%	2.4%
E09000003	Barnet	08D	NHS Haringey CCG	2.1%	1.6%
E09000003	Barnet	08E	NHS Harrow CCG	1.2%	0.8%
E09000003	Barnet	08H	NHS Islington CCG	0.1%	0.0%
E09000003	Barnet	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.0%
E08000016	Barnsley	02P	NHS Barnsley CCG	94.4%	98.2%
E08000016	Barnsley	02X	NHS Doncaster CCG	0.3%	0.3%
E08000016	Barnsley	03A	NHS Greater Huddersfield CCG	0.2%	0.2%
E08000016	Barnsley	03L	NHS Rotherham CCG	0.3%	0.3%
E08000016	Barnsley	03N	NHS Sheffield CCG	0.2%	0.4%
E08000016	Barnsley	03R	NHS Wakefield CCG	0.4%	0.6%
E06000022	Bath and North East Somerset	11E	NHS Bath and North East Somerset CCG	94.0%	98.3%
E06000022	Bath and North East Somerset	11H	NHS Bristol CCG	0.3%	0.8%
E06000022	Bath and North East Somerset	11X	NHS Somerset CCG	0.2%	0.5%
E06000022	Bath and North East Somerset	12A	NHS South Gloucestershire CCG	0.0%	0.1%
E06000022	Bath and North East Somerset	99N	NHS Wiltshire CCG	0.1%	0.3%
E06000055	Bedford	06F	NHS Bedfordshire CCG	37.5%	97.4%
E06000055	Bedford	06H	NHS Cambridgeshire and Peterborough CCG	0.4%	1.9%
E06000055	Bedford	04G	NHS Nene CCG	0.2%	0.7%
E09000004	Bexley	07N	NHS Bexley CCG	93.6%	89.4%
E09000004	Bexley	07Q	NHS Bromley CCG	0.0%	0.1%
E09000004	Bexley	09J	NHS Dartford, Gravesham and Swanley CCG	1.5%	1.6%
E09000004	Bexley	08A	NHS Greenwich CCG	7.7%	8.9%
E08000025	Birmingham	13P	NHS Birmingham Crosscity CCG	92.0%	57.3%
E08000025	Birmingham	04X	NHS Birmingham South and Central CCG	96.9%	20.5%
E08000025	Birmingham	05C	NHS Dudley CCG	0.2%	0.0%
E08000025	Birmingham	05J	NHS Redditch and Bromsgrove CCG	2.9%	0.4%
E08000025	Birmingham	05L	NHS Sandwell and West Birmingham CCG	40.1%	18.6%
E08000025	Birmingham	05P	NHS Solihull CCG	15.0%	3.0%
E08000025	Birmingham	05Y	NHS Walsall CCG	0.5%	0.1%
E06000008	Blackburn with Darwen	00Q	NHS Blackburn with Darwen CCG	89.0%	95.8%
E06000008	Blackburn with Darwen	00T	NHS Bolton CCG	1.2%	2.3%
E06000008	Blackburn with Darwen	00V	NHS Bury CCG	0.2%	0.2%
E06000008	Blackburn with Darwen	01A	NHS East Lancashire CCG	0.7%	1.6%
E06000009	Blackpool	00R	NHS Blackpool CCG	87.0%	97.5%
E06000009	Blackpool	02M	NHS Fylde & Wyre CCG	2.6%	2.5%
E08000001	Bolton	00T	NHS Bolton CCG	97.3%	97.6%
E08000001	Bolton	00V	NHS Bury CCG	1.3%	0.9%
E08000001	Bolton	00X	NHS Chorley and South Ribble CCG	0.2%	0.1%
E08000001	Bolton	01G	NHS Salford CCG	0.6%	0.5%
E08000001	Bolton	02H	NHS Wigan Borough CCG	0.8%	0.9%
E06000028 & E06000029	Bournemouth & Poole	11J	NHS Dorset CCG	45.7%	100.0%
E06000036	Bracknell Forest	10G	NHS Bracknell and Ascot CCG	82.1%	94.8%
E06000036	Bracknell Forest	99M	NHS North East Hampshire and Farnham CCG	0.6%	1.1%
E06000036	Bracknell Forest	10C	NHS Surrey Heath CCG	0.1%	0.1%
E06000036	Bracknell Forest	11C	NHS Windsor, Ascot and Maidenhead CCG	1.8%	2.2%
E06000036	Bracknell Forest	11D	NHS Wokingham CCG	1.4%	1.8%
E08000032	Bradford	02N	NHS Airedale, Wharfdale and Craven CCG	67.4%	18.7%
E08000032	Bradford	02W	NHS Bradford City CCG	99.4%	21.5%
E08000032	Bradford	02R	NHS Bradford Districts CCG	97.8%	58.4%
E08000032	Bradford	02T	NHS Calderdale CCG	0.1%	0.0%
E08000032	Bradford	02V	NHS Leeds North CCG	0.6%	0.2%
E08000032	Bradford	03C	NHS Leeds West CCG	1.7%	1.1%
E08000032	Bradford	03J	NHS North Kirklees CCG	0.1%	0.0%
E09000005	Brent	07M	NHS Barnet CCG	2.0%	2.1%
E09000005	Brent	07P	NHS Brent CCG	89.6%	87.2%
E09000005	Brent	07R	NHS Camden CCG	4.0%	2.7%
E09000005	Brent	09A	NHS Central London (Westminster) CCG	1.2%	0.6%
E09000005	Brent	07W	NHS Ealing CCG	0.5%	0.6%
E09000005	Brent	08C	NHS Hammersmith and Fulham CCG	0.2%	0.1%
E09000005	Brent	08E	NHS Harrow CCG	5.7%	3.9%
E09000005	Brent	08Y	NHS West London (K&C & QPP) CCG	4.4%	2.8%
E06000043	Brighton and Hove	09D	NHS Brighton and Hove CCG	97.8%	99.7%
E06000043	Brighton and Hove	09G	NHS Coastal West Sussex CCG	0.1%	0.2%
E06000043	Brighton and Hove	99K	NHS High Weald Lewes Havens CCG	0.3%	0.2%
E06000023	Bristol, City of	11H	NHS Bristol CCG	94.7%	97.9%
E06000023	Bristol, City of	12A	NHS South Gloucestershire CCG	3.8%	2.1%
E09000006	Bromley	07N	NHS Bexley CCG	0.2%	0.1%
E09000006	Bromley	07Q	NHS Bromley CCG	94.9%	95.3%
E09000006	Bromley	07V	NHS Croydon CCG	1.1%	1.3%
E09000006	Bromley	08A	NHS Greenwich CCG	1.5%	1.2%
E09000006	Bromley	08K	NHS Lambeth CCG	0.0%	0.1%
E09000006	Bromley	08L	NHS Lewisham CCG	2.0%	1.8%
E09000006	Bromley	99J	NHS West Kent CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Y	NHS Aylesbury Vale CCG	91.2%	35.0%
E10000002	Buckinghamshire	06F	NHS Bedfordshire CCG	0.6%	0.5%
E10000002	Buckinghamshire	10H	NHS Chiltern CCG	96.1%	59.9%
E10000002	Buckinghamshire	06N	NHS Herts Valleys CCG	1.2%	1.4%
E10000002	Buckinghamshire	08G	NHS Hillingdon CCG	0.8%	0.5%
E10000002	Buckinghamshire	04F	NHS Milton Keynes CCG	1.2%	0.6%
E10000002	Buckinghamshire	04G	NHS Nene CCG	0.1%	0.2%
E10000002	Buckinghamshire	10Q	NHS Oxfordshire CCG	0.6%	0.8%
E10000002	Buckinghamshire	10T	NHS Slough CCG	2.8%	0.8%

E10000002	Buckinghamshire	11C	NHS Windsor, Ascot and Maidenhead CCG	1.3%	0.4%
E08000002	Bury	00T	NHS Bolton CCG	0.8%	1.2%
E08000002	Bury	00V	NHS Bury CCG	94.3%	94.3%
E08000002	Bury	01A	NHS East Lancashire CCG	0.1%	0.2%
E08000002	Bury	01D	NHS Heywood, Middleton and Rochdale CCG	0.4%	0.5%
E08000002	Bury	01M	NHS North Manchester CCG	2.0%	2.0%
E08000002	Bury	01G	NHS Salford CCG	1.4%	1.8%
E08000033	Calderdale	02R	NHS Bradford Districts CCG	0.4%	0.7%
E08000033	Calderdale	02T	NHS Calderdale CCG	98.6%	98.8%
E08000033	Calderdale	03A	NHS Greater Huddersfield CCG	0.4%	0.4%
E08000033	Calderdale	01D	NHS Heywood, Middleton and Rochdale CCG	0.1%	0.1%
E10000003	Cambridgeshire	06F	NHS Bedfordshire CCG	1.1%	0.8%
E10000003	Cambridgeshire	06H	NHS Cambridgeshire and Peterborough CCG	72.1%	96.6%
E10000003	Cambridgeshire	06K	NHS East and North Hertfordshire CCG	0.9%	0.7%
E10000003	Cambridgeshire	99D	NHS South Lincolnshire CCG	0.4%	0.0%
E10000003	Cambridgeshire	07H	NHS West Essex CCG	0.2%	0.1%
E10000003	Cambridgeshire	07J	NHS West Norfolk CCG	1.5%	0.4%
E10000003	Cambridgeshire	07K	NHS West Suffolk CCG	4.0%	1.4%
E09000007	Camden	07M	NHS Barnet CCG	0.1%	0.2%
E09000007	Camden	07P	NHS Brent CCG	1.5%	2.2%
E09000007	Camden	07R	NHS Camden CCG	84.6%	88.4%
E09000007	Camden	09A	NHS Central London (Westminster) CCG	6.0%	5.1%
E09000007	Camden	08D	NHS Haringey CCG	0.5%	0.6%
E09000007	Camden	08H	NHS Islington CCG	3.4%	3.2%
E09000007	Camden	08Y	NHS West London (K&C & QPP) CCG	0.2%	0.2%
E06000056	Central Bedfordshire	10Y	NHS Aylesbury Vale CCG	2.1%	1.5%
E06000056	Central Bedfordshire	06F	NHS Bedfordshire CCG	56.8%	95.1%
E06000056	Central Bedfordshire	06K	NHS East and North Hertfordshire CCG	0.2%	0.5%
E06000056	Central Bedfordshire	06N	NHS Herts Valleys CCG	0.4%	0.8%
E06000056	Central Bedfordshire	06P	NHS Luton CCG	2.4%	2.0%
E06000049	Cheshire East	01C	NHS Eastern Cheshire CCG	96.3%	50.6%
E06000049	Cheshire East	04J	NHS North Derbyshire CCG	0.4%	0.3%
E06000049	Cheshire East	05G	NHS North Staffordshire CCG	1.1%	0.6%
E06000049	Cheshire East	05N	NHS Shropshire CCG	0.1%	0.0%
E06000049	Cheshire East	01R	NHS South Cheshire CCG	98.6%	45.3%
E06000049	Cheshire East	01W	NHS Stockport CCG	1.6%	1.3%
E06000049	Cheshire East	02A	NHS Trafford CCG	0.2%	0.1%
E06000049	Cheshire East	02D	NHS Vale Royal CCG	0.7%	0.2%
E06000049	Cheshire East	02E	NHS Warrington CCG	0.7%	0.4%
E06000049	Cheshire East	02F	NHS West Cheshire CCG	2.0%	1.3%
E06000050	Cheshire West and Chester	01C	NHS Eastern Cheshire CCG	1.1%	0.7%
E06000050	Cheshire West and Chester	01F	NHS Halton CCG	0.2%	0.0%
E06000050	Cheshire West and Chester	01R	NHS South Cheshire CCG	0.5%	0.2%
E06000050	Cheshire West and Chester	02D	NHS Vale Royal CCG	99.3%	29.3%
E06000050	Cheshire West and Chester	02E	NHS Warrington CCG	0.4%	0.3%
E06000050	Cheshire West and Chester	02F	NHS West Cheshire CCG	96.8%	69.4%
E06000050	Cheshire West and Chester	12F	NHS Wirral CCG	0.3%	0.2%
E09000001	City of London	07R	NHS Camden CCG	0.2%	6.0%
E09000001	City of London	09A	NHS Central London (Westminster) CCG	0.0%	0.8%
E09000001	City of London	07T	NHS City and Hackney CCG	1.9%	74.1%
E09000001	City of London	08H	NHS Islington CCG	0.1%	3.1%
E09000001	City of London	08Q	NHS Southwark CCG	0.0%	0.1%
E09000001	City of London	08V	NHS Tower Hamlets CCG	0.4%	15.8%
E06000052	Cornwall & Scilly	11N	NHS Kernow CCG	99.7%	99.4%
E06000052	Cornwall & Scilly	99P	NHS North, East, West Devon CCG	0.4%	0.6%
E06000047	County Durham	00D	NHS Durham Dales, Easington and Sedgefield CCG	97.4%	53.0%
E06000047	County Durham	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.1%	0.0%
E06000047	County Durham	13T	NHS Newcastle Gateshead CCG	0.7%	0.7%
E06000047	County Durham	00J	NHS North Durham CCG	96.6%	45.7%
E06000047	County Durham	00P	NHS Sunderland CCG	1.2%	0.6%
E08000026	Coventry	05A	NHS Coventry and Rugby CCG	74.0%	99.9%
E08000026	Coventry	05H	NHS Warwickshire North CCG	0.3%	0.1%
E09000008	Croydon	07Q	NHS Bromley CCG	1.5%	1.3%
E09000008	Croydon	07V	NHS Croydon CCG	95.6%	93.7%
E09000008	Croydon	09L	NHS East Surrey CCG	3.0%	1.3%
E09000008	Croydon	08K	NHS Lambeth CCG	2.7%	2.6%
E09000008	Croydon	08R	NHS Merton CCG	0.8%	0.4%
E09000008	Croydon	08T	NHS Sutton CCG	0.8%	0.4%
E09000008	Croydon	08X	NHS Wandsworth CCG	0.4%	0.4%
E10000006	Cumbria	01H	NHS Cumbria CCG	97.4%	100.0%
E10000006	Cumbria	01K	NHS Lancashire North CCG	0.2%	0.0%
E06000005	Darlington	00C	NHS Darlington CCG	98.2%	96.3%
E06000005	Darlington	00D	NHS Durham Dales, Easington and Sedgefield CCG	1.2%	3.1%
E06000005	Darlington	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.0%	0.1%
E06000005	Darlington	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.5%
E06000015	Derby	04R	NHS Southern Derbyshire CCG	50.1%	100.0%
E10000007	Derbyshire	02Q	NHS Bassetlaw CCG	0.2%	0.0%
E10000007	Derbyshire	05D	NHS East Staffordshire CCG	8.1%	1.4%
E10000007	Derbyshire	01C	NHS Eastern Cheshire CCG	0.3%	0.0%
E10000007	Derbyshire	03X	NHS Erewash CCG	92.2%	11.3%
E10000007	Derbyshire	03Y	NHS Hardwick CCG	94.6%	12.2%
E10000007	Derbyshire	04E	NHS Mansfield and Ashfield CCG	1.9%	0.5%
E10000007	Derbyshire	04J	NHS North Derbyshire CCG	98.3%	36.0%
E10000007	Derbyshire	04L	NHS Nottingham North and East CCG	0.2%	0.0%
E10000007	Derbyshire	04M	NHS Nottingham West CCG	5.0%	0.6%
E10000007	Derbyshire	03N	NHS Sheffield CCG	0.5%	0.4%
E10000007	Derbyshire	04R	NHS Southern Derbyshire CCG	48.2%	33.0%
E10000007	Derbyshire	01W	NHS Stockport CCG	0.1%	0.0%
E10000007	Derbyshire	01Y	NHS Tameside and Glossop CCG	14.1%	4.3%
E10000007	Derbyshire	04V	NHS West Leicestershire CCG	0.5%	0.2%
E10000008	Devon	11J	NHS Dorset CCG	0.3%	0.3%
E10000008	Devon	11N	NHS Kernow CCG	0.3%	0.2%
E10000008	Devon	99P	NHS North, East, West Devon CCG	70.0%	80.5%
E10000008	Devon	11X	NHS Somerset CCG	0.4%	0.3%
E10000008	Devon	99Q	NHS South Devon and Torbay CCG	51.1%	18.7%
E08000017	Doncaster	02P	NHS Barnsley CCG	0.4%	0.3%

E08000017	Doncaster	02Q	NHS Bassetlaw CCG	1.2%	0.5%
E08000017	Doncaster	02X	NHS Doncaster CCG	96.7%	97.8%
E08000017	Doncaster	03L	NHS Rotherham CCG	1.5%	1.3%
E08000017	Doncaster	03R	NHS Wakefield CCG	0.1%	0.1%
E10000009	Dorset	11J	NHS Dorset CCG	52.7%	95.9%
E10000009	Dorset	11X	NHS Somerset CCG	0.6%	0.7%
E10000009	Dorset	11A	NHS West Hampshire CCG	2.0%	2.5%
E10000009	Dorset	99N	NHS Wiltshire CCG	0.8%	0.9%
E08000027	Dudley	13P	NHS Birmingham Crosscity CCG	0.2%	0.5%
E08000027	Dudley	05C	NHS Dudley CCG	93.2%	90.9%
E08000027	Dudley	05L	NHS Sandwell and West Birmingham CCG	4.0%	6.9%
E08000027	Dudley	06A	NHS Wolverhampton CCG	1.8%	1.5%
E08000027	Dudley	06D	NHS Wyre Forest CCG	0.6%	0.2%
E09000009	Ealing	07P	NHS Brent CCG	1.7%	1.5%
E09000009	Ealing	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000009	Ealing	07W	NHS Ealing CCG	86.7%	90.8%
E09000009	Ealing	08C	NHS Hammersmith and Fulham CCG	5.7%	2.9%
E09000009	Ealing	08E	NHS Harrow CCG	0.3%	0.2%
E09000009	Ealing	08G	NHS Hillingdon CCG	0.6%	0.5%
E09000009	Ealing	07Y	NHS Hounslow CCG	5.0%	3.7%
E09000009	Ealing	08Y	NHS West London (K&C & QPP) CCG	0.6%	0.4%
E06000011	East Riding of Yorkshire	02Y	NHS East Riding of Yorkshire CCG	97.4%	85.2%
E06000011	East Riding of Yorkshire	03F	NHS Hull CCG	9.4%	8.0%
E06000011	East Riding of Yorkshire	03M	NHS Scarborough and Ryedale CCG	0.7%	0.2%
E06000011	East Riding of Yorkshire	03Q	NHS Vale of York CCG	6.4%	6.6%
E10000011	East Sussex	09D	NHS Brighton and Hove CCG	1.0%	0.6%
E10000011	East Sussex	09F	NHS Eastbourne, Hailsham and Seaford CCG	100.0%	34.5%
E10000011	East Sussex	09P	NHS Hastings and Rother CCG	99.7%	33.3%
E10000011	East Sussex	99K	NHS High Weald Lewes Havens CCG	98.1%	29.7%
E10000011	East Sussex	09X	NHS Horsham and Mid Sussex CCG	2.9%	1.2%
E10000011	East Sussex	99J	NHS West Kent CCG	0.8%	0.7%
E09000010	Enfield	07M	NHS Barnet CCG	1.1%	1.3%
E09000010	Enfield	07T	NHS City and Hackney CCG	0.1%	0.1%
E09000010	Enfield	06K	NHS East and North Hertfordshire CCG	0.3%	0.6%
E09000010	Enfield	07X	NHS Enfield CCG	95.5%	90.7%
E09000010	Enfield	08D	NHS Haringey CCG	7.8%	6.9%
E09000010	Enfield	06N	NHS Herts Valleys CCG	0.1%	0.2%
E09000010	Enfield	08H	NHS Islington CCG	0.2%	0.1%
E10000012	Essex	07L	NHS Barking and Dagenham CCG	0.1%	0.0%
E10000012	Essex	99E	NHS Basildon and Brentwood CCG	99.8%	18.3%
E10000012	Essex	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.0%
E10000012	Essex	99F	NHS Castle Point and Rochford CCG	95.4%	11.7%
E10000012	Essex	06K	NHS East and North Hertfordshire CCG	1.8%	0.7%
E10000012	Essex	08F	NHS Havering CCG	0.2%	0.0%
E10000012	Essex	06L	NHS Ipswich and East Suffolk CCG	0.2%	0.0%
E10000012	Essex	06Q	NHS Mid Essex CCG	100.0%	25.4%
E10000012	Essex	06T	NHS North East Essex CCG	98.7%	22.4%
E10000012	Essex	08N	NHS Redbridge CCG	3.2%	0.6%
E10000012	Essex	99G	NHS Southend CCG	3.4%	0.4%
E10000012	Essex	07G	NHS Thurrock CCG	1.5%	0.2%
E10000012	Essex	08W	NHS Waltham Forest CCG	0.5%	0.1%
E10000012	Essex	07H	NHS West Essex CCG	97.3%	19.7%
E10000012	Essex	07K	NHS West Suffolk CCG	2.3%	0.4%
E08000037	Gateshead	13T	NHS Newcastle Gateshead CCG	39.6%	98.0%
E08000037	Gateshead	00J	NHS North Durham CCG	0.9%	1.1%
E08000037	Gateshead	00L	NHS Northumberland CCG	0.5%	0.7%
E08000037	Gateshead	00N	NHS South Tyneside CCG	0.3%	0.2%
E10000013	Gloucestershire	11M	NHS Gloucestershire CCG	97.6%	98.6%
E10000013	Gloucestershire	05F	NHS Herefordshire CCG	0.5%	0.1%
E10000013	Gloucestershire	10Q	NHS Oxfordshire CCG	0.2%	0.2%
E10000013	Gloucestershire	12A	NHS South Gloucestershire CCG	0.3%	0.1%
E10000013	Gloucestershire	05R	NHS South Warwickshire CCG	0.5%	0.2%
E10000013	Gloucestershire	05T	NHS South Worcestershire CCG	1.1%	0.5%
E10000013	Gloucestershire	99N	NHS Wiltshire CCG	0.2%	0.2%
E09000011	Greenwich	07N	NHS Bexley CCG	5.2%	4.3%
E09000011	Greenwich	07Q	NHS Bromley CCG	1.1%	1.3%
E09000011	Greenwich	08A	NHS Greenwich CCG	88.6%	89.9%
E09000011	Greenwich	08L	NHS Lewisham CCG	4.1%	4.5%
E09000012	Hackney	07R	NHS Camden CCG	0.8%	0.7%
E09000012	Hackney	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000012	Hackney	07T	NHS City and Hackney CCG	90.6%	94.6%
E09000012	Hackney	08D	NHS Haringey CCG	0.6%	0.7%
E09000012	Hackney	08H	NHS Islington CCG	4.1%	3.4%
E09000012	Hackney	08V	NHS Tower Hamlets CCG	0.5%	0.5%
E06000006	Halton	01F	NHS Halton CCG	98.2%	96.7%
E06000006	Halton	01J	NHS Knowsley CCG	0.1%	0.2%
E06000006	Halton	99A	NHS Liverpool CCG	0.3%	1.1%
E06000006	Halton	02E	NHS Warrington CCG	0.6%	0.9%
E06000006	Halton	02F	NHS West Cheshire CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	07P	NHS Brent CCG	0.3%	0.5%
E09000013	Hammersmith and Fulham	07R	NHS Camden CCG	0.0%	0.1%
E09000013	Hammersmith and Fulham	09A	NHS Central London (Westminster) CCG	2.4%	2.3%
E09000013	Hammersmith and Fulham	07W	NHS Ealing CCG	0.6%	1.2%
E09000013	Hammersmith and Fulham	08C	NHS Hammersmith and Fulham CCG	90.9%	88.0%
E09000013	Hammersmith and Fulham	07Y	NHS Hounslow CCG	0.5%	0.8%
E09000013	Hammersmith and Fulham	08Y	NHS West London (K&C & QPP) CCG	6.4%	7.2%
E10000014	Hampshire	10G	NHS Bracknell and Ascot CCG	0.6%	0.0%
E10000014	Hampshire	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000014	Hampshire	11J	NHS Dorset CCG	0.5%	0.3%
E10000014	Hampshire	10K	NHS Fareham and Gosport CCG	98.6%	14.5%
E10000014	Hampshire	09N	NHS Guildford and Waverley CCG	2.9%	0.5%
E10000014	Hampshire	10M	NHS Newbury and District CCG	5.9%	0.5%
E10000014	Hampshire	10N	NHS North & West Reading CCG	0.9%	0.0%
E10000014	Hampshire	99M	NHS North East Hampshire and Farnham CCG	76.4%	12.4%
E10000014	Hampshire	10J	NHS North Hampshire CCG	99.2%	15.9%
E10000014	Hampshire	10R	NHS Portsmouth CCG	4.5%	0.7%

E10000014	Hampshire	10V	NHS South Eastern Hampshire CCG	95.4%	14.6%
E10000014	Hampshire	10X	NHS Southampton CCG	5.5%	1.1%
E10000014	Hampshire	10C	NHS Surrey Heath CCG	0.7%	0.0%
E10000014	Hampshire	11A	NHS West Hampshire CCG	97.7%	39.0%
E10000014	Hampshire	99N	NHS Wiltshire CCG	1.3%	0.5%
E10000014	Hampshire	11D	NHS Wokingham CCG	0.6%	0.0%
E09000014	Haringey	07M	NHS Barnet CCG	1.1%	1.6%
E09000014	Haringey	07R	NHS Camden CCG	0.5%	0.5%
E09000014	Haringey	07T	NHS City and Hackney CCG	3.0%	3.1%
E09000014	Haringey	07X	NHS Enfield CCG	1.3%	1.4%
E09000014	Haringey	08D	NHS Haringey CCG	87.7%	91.6%
E09000014	Haringey	08H	NHS Islington CCG	2.3%	1.9%
E09000015	Harrow	07M	NHS Barnet CCG	4.3%	6.3%
E09000015	Harrow	07P	NHS Brent CCG	3.7%	5.0%
E09000015	Harrow	07W	NHS Ealing CCG	1.3%	1.9%
E09000015	Harrow	08E	NHS Harrow CCG	90.0%	84.3%
E09000015	Harrow	06N	NHS Herts Valleys CCG	0.2%	0.4%
E09000015	Harrow	08G	NHS Hillingdon CCG	1.7%	1.9%
E09000015	Harrow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000001	Hartlepool	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.1%	0.4%
E06000001	Hartlepool	00K	NHS Hartlepool and Stockton-On-Tees CCG	32.6%	99.6%
E09000016	Havering	07L	NHS Barking and Dagenham CCG	4.0%	3.3%
E09000016	Havering	08F	NHS Havering CCG	92.0%	95.9%
E09000016	Havering	08M	NHS Newham CCG	0.0%	0.1%
E09000016	Havering	08N	NHS Redbridge CCG	0.5%	0.6%
E09000016	Havering	07G	NHS Thurrock CCG	0.1%	0.1%
E06000019	Herefordshire, County of	11M	NHS Gloucestershire CCG	0.3%	0.9%
E06000019	Herefordshire, County of	05F	NHS Herefordshire CCG	98.1%	97.3%
E06000019	Herefordshire, County of	05N	NHS Shropshire CCG	0.3%	0.5%
E06000019	Herefordshire, County of	05T	NHS South Worcestershire CCG	0.8%	1.3%
E10000015	Hertfordshire	10Y	NHS Aylesbury Vale CCG	0.4%	0.0%
E10000015	Hertfordshire	07M	NHS Barnet CCG	0.2%	0.0%
E10000015	Hertfordshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000015	Hertfordshire	06H	NHS Cambridgeshire and Peterborough CCG	2.1%	1.6%
E10000015	Hertfordshire	10H	NHS Chiltern CCG	0.1%	0.0%
E10000015	Hertfordshire	06K	NHS East and North Hertfordshire CCG	96.8%	46.6%
E10000015	Hertfordshire	07X	NHS Enfield CCG	0.3%	0.0%
E10000015	Hertfordshire	08E	NHS Harrow CCG	0.5%	0.1%
E10000015	Hertfordshire	06N	NHS Herts Valleys CCG	98.1%	50.9%
E10000015	Hertfordshire	08G	NHS Hillingdon CCG	2.3%	0.6%
E10000015	Hertfordshire	06P	NHS Luton CCG	0.4%	0.0%
E10000015	Hertfordshire	07H	NHS West Essex CCG	0.7%	0.2%
E09000017	Hillingdon	10H	NHS Chiltern CCG	0.1%	0.1%
E09000017	Hillingdon	07W	NHS Ealing CCG	5.2%	6.9%
E09000017	Hillingdon	08C	NHS Hammersmith and Fulham CCG	0.5%	0.3%
E09000017	Hillingdon	08E	NHS Harrow CCG	2.2%	1.8%
E09000017	Hillingdon	08G	NHS Hillingdon CCG	94.3%	90.0%
E09000017	Hillingdon	07Y	NHS Hounslow CCG	1.0%	0.9%
E09000018	Hounslow	07W	NHS Ealing CCG	5.8%	8.0%
E09000018	Hounslow	08C	NHS Hammersmith and Fulham CCG	1.0%	0.6%
E09000018	Hounslow	08G	NHS Hillingdon CCG	0.2%	0.2%
E09000018	Hounslow	07Y	NHS Hounslow CCG	88.0%	87.1%
E09000018	Hounslow	09Y	NHS North West Surrey CCG	0.3%	0.4%
E09000018	Hounslow	08P	NHS Richmond CCG	5.3%	3.6%
E09000018	Hounslow	08Y	NHS West London (K&C & QPP) CCG	0.1%	0.1%
E06000046	Isle of Wight	10L	NHS Isle of Wight CCG	100.0%	100.0%
E09000019	Islington	07R	NHS Camden CCG	4.4%	4.9%
E09000019	Islington	09A	NHS Central London (Westminster) CCG	0.4%	0.4%
E09000019	Islington	07T	NHS City and Hackney CCG	3.2%	4.1%
E09000019	Islington	08D	NHS Haringey CCG	1.3%	1.7%
E09000019	Islington	08H	NHS Islington CCG	89.8%	89.0%
E09000020	Kensington and Chelsea	07P	NHS Brent CCG	0.0%	0.1%
E09000020	Kensington and Chelsea	07R	NHS Camden CCG	0.2%	0.4%
E09000020	Kensington and Chelsea	09A	NHS Central London (Westminster) CCG	4.1%	5.1%
E09000020	Kensington and Chelsea	08C	NHS Hammersmith and Fulham CCG	0.9%	1.2%
E09000020	Kensington and Chelsea	08Y	NHS West London (K&C & QPP) CCG	64.1%	93.2%
E10000016	Kent	09C	NHS Ashford CCG	100.0%	8.3%
E10000016	Kent	07N	NHS Bexley CCG	1.1%	0.2%
E10000016	Kent	07Q	NHS Bromley CCG	0.8%	0.2%
E10000016	Kent	09E	NHS Canterbury and Coastal CCG	100.0%	14.1%
E10000016	Kent	09J	NHS Dartford, Gravesham and Swanley CCG	98.3%	16.5%
E10000016	Kent	09L	NHS East Surrey CCG	0.1%	0.0%
E10000016	Kent	08A	NHS Greenwich CCG	0.1%	0.0%
E10000016	Kent	09P	NHS Hastings and Rother CCG	0.3%	0.0%
E10000016	Kent	99K	NHS High Weald Lewes Havens CCG	0.6%	0.0%
E10000016	Kent	09W	NHS Medway CCG	6.0%	1.1%
E10000016	Kent	10A	NHS South Kent Coast CCG	100.0%	13.0%
E10000016	Kent	10D	NHS Swale CCG	99.9%	7.1%
E10000016	Kent	10E	NHS Thanet CCG	100.0%	9.3%
E10000016	Kent	99J	NHS West Kent CCG	98.7%	30.4%
E06000010	Kingston upon Hull, City of	02Y	NHS East Riding of Yorkshire CCG	1.3%	1.5%
E06000010	Kingston upon Hull, City of	03F	NHS Hull CCG	90.6%	98.5%
E09000021	Kingston upon Thames	08J	NHS Kingston CCG	87.1%	95.8%
E09000021	Kingston upon Thames	08R	NHS Merton CCG	1.0%	1.2%
E09000021	Kingston upon Thames	08P	NHS Richmond CCG	0.7%	0.8%
E09000021	Kingston upon Thames	99H	NHS Surrey Downs CCG	0.9%	1.5%
E09000021	Kingston upon Thames	08T	NHS Sutton CCG	0.1%	0.1%
E09000021	Kingston upon Thames	08X	NHS Wandsworth CCG	0.3%	0.5%
E08000034	Kirklees	02P	NHS Barnsley CCG	0.1%	0.0%
E08000034	Kirklees	02R	NHS Bradford Districts CCG	1.0%	0.8%
E08000034	Kirklees	02T	NHS Calderdale CCG	1.3%	0.6%
E08000034	Kirklees	03A	NHS Greater Huddersfield CCG	99.5%	54.8%
E08000034	Kirklees	03C	NHS Leeds West CCG	0.3%	0.2%
E08000034	Kirklees	03J	NHS North Kirklees CCG	99.0%	42.4%
E08000034	Kirklees	03R	NHS Wakefield CCG	1.5%	1.2%
E08000011	Knowsley	01F	NHS Halton CCG	1.1%	0.9%

E08000011	Knowsley	01J	NHS Knowsley CCG	86.9%	88.2%
E08000011	Knowsley	99A	NHS Liverpool CCG	2.5%	8.0%
E08000011	Knowsley	01T	NHS South Sefton CCG	0.2%	0.1%
E08000011	Knowsley	01X	NHS St Helens CCG	2.3%	2.9%
E09000022	Lambeth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000022	Lambeth	07V	NHS Croydon CCG	0.7%	0.8%
E09000022	Lambeth	08K	NHS Lambeth CCG	86.8%	92.7%
E09000022	Lambeth	08R	NHS Merton CCG	1.2%	0.7%
E09000022	Lambeth	08Q	NHS Southwark CCG	1.8%	1.6%
E09000022	Lambeth	08X	NHS Wandsworth CCG	3.6%	3.8%
E10000017	Lancashire	02N	NHS Airedale, Wharfdale and Craven CCG	0.2%	0.0%
E10000017	Lancashire	00Q	NHS Blackburn with Darwen CCG	11.0%	1.5%
E10000017	Lancashire	00R	NHS Blackpool CCG	13.0%	1.8%
E10000017	Lancashire	00T	NHS Bolton CCG	0.3%	0.0%
E10000017	Lancashire	00V	NHS Bury CCG	1.4%	0.2%
E10000017	Lancashire	00X	NHS Chorley and South Ribble CCG	99.8%	14.5%
E10000017	Lancashire	01H	NHS Cumbria CCG	1.4%	0.6%
E10000017	Lancashire	01A	NHS East Lancashire CCG	98.9%	30.0%
E10000017	Lancashire	02M	NHS Fylde & Wyre CCG	97.4%	11.9%
E10000017	Lancashire	01E	NHS Greater Preston CCG	100.0%	17.1%
E10000017	Lancashire	01D	NHS Heywood, Middleton and Rochdale CCG	0.9%	0.2%
E10000017	Lancashire	01J	NHS Knowsley CCG	0.1%	0.0%
E10000017	Lancashire	01K	NHS Lancashire North CCG	99.8%	12.8%
E10000017	Lancashire	01T	NHS South Sefton CCG	0.5%	0.0%
E10000017	Lancashire	01V	NHS Southport and Formby CCG	3.0%	0.3%
E10000017	Lancashire	01X	NHS St Helens CCG	0.5%	0.0%
E10000017	Lancashire	02G	NHS West Lancashire CCG	97.1%	8.8%
E10000017	Lancashire	02H	NHS Wigan Borough CCG	0.8%	0.2%
E08000035	Leeds	02W	NHS Bradford City CCG	0.6%	0.0%
E08000035	Leeds	02R	NHS Bradford Districts CCG	0.7%	0.3%
E08000035	Leeds	02V	NHS Leeds North CCG	96.4%	24.3%
E08000035	Leeds	03G	NHS Leeds South and East CCG	98.5%	31.9%
E08000035	Leeds	03C	NHS Leeds West CCG	97.9%	42.7%
E08000035	Leeds	03J	NHS North Kirklees CCG	0.3%	0.0%
E08000035	Leeds	03Q	NHS Vale of York CCG	0.6%	0.2%
E08000035	Leeds	03R	NHS Wakefield CCG	1.5%	0.6%
E06000016	Leicester	03W	NHS East Leicestershire and Rutland CCG	2.5%	2.2%
E06000016	Leicester	04C	NHS Leicester City CCG	92.5%	95.2%
E06000016	Leicester	04V	NHS West Leicestershire CCG	2.6%	2.6%
E10000018	Leicestershire	03V	NHS Corby CCG	0.6%	0.0%
E10000018	Leicestershire	03W	NHS East Leicestershire and Rutland CCG	85.3%	40.1%
E10000018	Leicestershire	04C	NHS Leicester City CCG	7.5%	4.2%
E10000018	Leicestershire	04N	NHS Rushcliffe CCG	5.4%	1.0%
E10000018	Leicestershire	04Q	NHS South West Lincolnshire CCG	5.7%	1.1%
E10000018	Leicestershire	04R	NHS Southern Derbyshire CCG	0.6%	0.5%
E10000018	Leicestershire	05H	NHS Warwickshire North CCG	1.6%	0.4%
E10000018	Leicestershire	04V	NHS West Leicestershire CCG	96.2%	52.7%
E09000023	Lewisham	07Q	NHS Bromley CCG	1.3%	1.5%
E09000023	Lewisham	09A	NHS Central London (Westminster) CCG	0.1%	0.1%
E09000023	Lewisham	08A	NHS Greenwich CCG	2.2%	2.0%
E09000023	Lewisham	08K	NHS Lambeth CCG	0.2%	0.3%
E09000023	Lewisham	08L	NHS Lewisham CCG	92.1%	92.5%
E09000023	Lewisham	08Q	NHS Southwark CCG	3.7%	3.7%
E10000019	Lincolnshire	06H	NHS Cambridgeshire and Peterborough CCG	0.2%	0.2%
E10000019	Lincolnshire	03W	NHS East Leicestershire and Rutland CCG	0.2%	0.0%
E10000019	Lincolnshire	03T	NHS Lincolnshire East CCG	99.2%	32.1%
E10000019	Lincolnshire	04D	NHS Lincolnshire West CCG	98.5%	30.4%
E10000019	Lincolnshire	04H	NHS Newark & Sherwood CCG	2.4%	0.4%
E10000019	Lincolnshire	03H	NHS North East Lincolnshire CCG	2.7%	0.6%
E10000019	Lincolnshire	03K	NHS North Lincolnshire CCG	2.6%	0.6%
E10000019	Lincolnshire	99D	NHS South Lincolnshire CCG	90.6%	19.5%
E10000019	Lincolnshire	04Q	NHS South West Lincolnshire CCG	93.2%	16.2%
E08000012	Liverpool	01J	NHS Knowsley CCG	8.5%	2.8%
E08000012	Liverpool	99A	NHS Liverpool CCG	94.3%	96.2%
E08000012	Liverpool	01T	NHS South Sefton CCG	3.3%	1.0%
E06000032	Luton	06F	NHS Bedfordshire CCG	2.3%	4.5%
E06000032	Luton	06P	NHS Luton CCG	97.2%	95.5%
E08000003	Manchester	00V	NHS Bury CCG	0.3%	0.1%
E08000003	Manchester	00W	NHS Central Manchester CCG	93.7%	36.9%
E08000003	Manchester	01D	NHS Heywood, Middleton and Rochdale CCG	0.5%	0.2%
E08000003	Manchester	01M	NHS North Manchester CCG	85.1%	30.3%
E08000003	Manchester	00Y	NHS Oldham CCG	0.9%	0.4%
E08000003	Manchester	01G	NHS Salford CCG	2.5%	1.1%
E08000003	Manchester	01N	NHS South Manchester CCG	93.9%	28.2%
E08000003	Manchester	01W	NHS Stockport CCG	1.5%	0.8%
E08000003	Manchester	01Y	NHS Tameside and Glossop CCG	0.4%	0.2%
E08000003	Manchester	02A	NHS Trafford CCG	4.3%	1.8%
E06000035	Medway	09J	NHS Dartford, Gravesham and Swanley CCG	0.2%	0.2%
E06000035	Medway	09W	NHS Medway CCG	94.0%	99.5%
E06000035	Medway	10D	NHS Swale CCG	0.1%	0.0%
E06000035	Medway	99J	NHS West Kent CCG	0.2%	0.3%
E09000024	Merton	07V	NHS Croydon CCG	0.5%	0.8%
E09000024	Merton	08J	NHS Kingston CCG	3.5%	3.0%
E09000024	Merton	08K	NHS Lambeth CCG	0.9%	1.4%
E09000024	Merton	08R	NHS Merton CCG	87.7%	81.5%
E09000024	Merton	08T	NHS Sutton CCG	3.4%	2.7%
E09000024	Merton	08X	NHS Wandsworth CCG	6.5%	10.5%
E06000002	Middlesbrough	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.2%	0.2%
E06000002	Middlesbrough	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.3%
E06000002	Middlesbrough	00M	NHS South Tees CCG	52.0%	99.5%
E06000042	Milton Keynes	06F	NHS Bedfordshire CCG	1.5%	2.5%
E06000042	Milton Keynes	04F	NHS Milton Keynes CCG	95.5%	96.1%
E06000042	Milton Keynes	04G	NHS Nene CCG	0.6%	1.4%
E08000021	Newcastle upon Tyne	13T	NHS Newcastle Gateshead CCG	58.0%	95.0%
E08000021	Newcastle upon Tyne	99C	NHS North Tyneside CCG	6.0%	4.2%
E08000021	Newcastle upon Tyne	00L	NHS Northumberland CCG	0.8%	0.8%

E09000025	Newham	07L	NHS Barking and Dagenham CCG	0.5%	0.3%
E09000025	Newham	09A	NHS Central London (Westminster) CCG	0.1%	0.0%
E09000025	Newham	07T	NHS City and Hackney CCG	0.1%	0.0%
E09000025	Newham	08M	NHS Newham CCG	96.9%	97.9%
E09000025	Newham	08N	NHS Redbridge CCG	0.2%	0.2%
E09000025	Newham	08V	NHS Tower Hamlets CCG	0.2%	0.2%
E09000025	Newham	08W	NHS Waltham Forest CCG	1.7%	1.4%
E10000020	Norfolk	06H	NHS Cambridgeshire and Peterborough CCG	0.7%	0.7%
E10000020	Norfolk	06M	NHS Great Yarmouth and Waveney CCG	47.5%	12.3%
E10000020	Norfolk	06L	NHS Ipswich and East Suffolk CCG	0.1%	0.0%
E10000020	Norfolk	06V	NHS North Norfolk CCG	100.0%	18.8%
E10000020	Norfolk	06W	NHS Norwich CCG	100.0%	23.7%
E10000020	Norfolk	99D	NHS South Lincolnshire CCG	0.2%	0.0%
E10000020	Norfolk	06Y	NHS South Norfolk CCG	98.8%	25.3%
E10000020	Norfolk	07J	NHS West Norfolk CCG	98.5%	18.5%
E10000020	Norfolk	07K	NHS West Suffolk CCG	2.6%	0.7%
E06000012	North East Lincolnshire	03T	NHS Lincolnshire East CCG	0.8%	1.2%
E06000012	North East Lincolnshire	03H	NHS North East Lincolnshire CCG	95.9%	98.7%
E06000012	North East Lincolnshire	03K	NHS North Lincolnshire CCG	0.1%	0.2%
E06000013	North Lincolnshire	02Q	NHS Bassetlaw CCG	0.2%	0.1%
E06000013	North Lincolnshire	02X	NHS Doncaster CCG	0.0%	0.1%
E06000013	North Lincolnshire	02Y	NHS East Riding of Yorkshire CCG	0.0%	0.1%
E06000013	North Lincolnshire	04D	NHS Lincolnshire West CCG	1.0%	1.4%
E06000013	North Lincolnshire	03H	NHS North East Lincolnshire CCG	1.4%	1.4%
E06000013	North Lincolnshire	03K	NHS North Lincolnshire CCG	97.2%	96.8%
E06000024	North Somerset	11E	NHS Bath and North East Somerset CCG	1.7%	1.6%
E06000024	North Somerset	11H	NHS Bristol CCG	0.3%	0.6%
E06000024	North Somerset	11T	NHS North Somerset CCG	99.1%	97.7%
E06000024	North Somerset	11X	NHS Somerset CCG	0.0%	0.2%
E08000022	North Tyneside	13T	NHS Newcastle Gateshead CCG	1.0%	2.5%
E08000022	North Tyneside	99C	NHS North Tyneside CCG	93.1%	96.4%
E08000022	North Tyneside	00L	NHS Northumberland CCG	0.7%	1.1%
E10000023	North Yorkshire	02N	NHS Airedale, Wharfdale and Craven CCG	32.4%	8.3%
E10000023	North Yorkshire	01H	NHS Cumbria CCG	1.2%	1.0%
E10000023	North Yorkshire	00C	NHS Darlington CCG	1.3%	0.2%
E10000023	North Yorkshire	02X	NHS Doncaster CCG	0.2%	0.1%
E10000023	North Yorkshire	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.2%	0.1%
E10000023	North Yorkshire	01A	NHS East Lancashire CCG	0.1%	0.0%
E10000023	North Yorkshire	02Y	NHS East Riding of Yorkshire CCG	1.3%	0.7%
E10000023	North Yorkshire	03D	NHS Hambleton, Richmondshire and Whitby CCG	98.7%	22.9%
E10000023	North Yorkshire	03E	NHS Harrogate and Rural District CCG	99.9%	26.3%
E10000023	North Yorkshire	00K	NHS Hartlepool and Stockton-On-Tees CCG	0.2%	0.0%
E10000023	North Yorkshire	02V	NHS Leeds North CCG	3.0%	1.0%
E10000023	North Yorkshire	03G	NHS Leeds South and East CCG	0.5%	0.2%
E10000023	North Yorkshire	03M	NHS Scarborough and Ryedale CCG	99.3%	19.2%
E10000023	North Yorkshire	03Q	NHS Vale of York CCG	32.6%	18.7%
E10000023	North Yorkshire	03R	NHS Wakefield CCG	2.0%	1.2%
E10000021	Northamptonshire	10Y	NHS Aylesbury Vale CCG	0.1%	0.0%
E10000021	Northamptonshire	06F	NHS Bedfordshire CCG	0.1%	0.0%
E10000021	Northamptonshire	06H	NHS Cambridgeshire and Peterborough CCG	1.6%	1.9%
E10000021	Northamptonshire	03V	NHS Corby CCG	99.1%	9.6%
E10000021	Northamptonshire	05A	NHS Coventry and Rugby CCG	0.3%	0.2%
E10000021	Northamptonshire	03W	NHS East Leicestershire and Rutland CCG	1.9%	0.8%
E10000021	Northamptonshire	04F	NHS Milton Keynes CCG	3.2%	1.2%
E10000021	Northamptonshire	04G	NHS Nene CCG	98.8%	85.0%
E10000021	Northamptonshire	10Q	NHS Oxfordshire CCG	1.2%	1.1%
E10000021	Northamptonshire	99D	NHS South Lincolnshire CCG	0.9%	0.2%
E06000057	Northumberland	01H	NHS Cumbria CCG	0.0%	0.1%
E06000057	Northumberland	13T	NHS Newcastle Gateshead CCG	0.3%	0.4%
E06000057	Northumberland	00J	NHS North Durham CCG	0.2%	0.2%
E06000057	Northumberland	99C	NHS North Tyneside CCG	0.9%	0.6%
E06000057	Northumberland	00L	NHS Northumberland CCG	98.0%	98.7%
E06000018	Nottingham	04K	NHS Nottingham City CCG	89.7%	94.8%
E06000018	Nottingham	04L	NHS Nottingham North and East CCG	4.7%	2.1%
E06000018	Nottingham	04M	NHS Nottingham West CCG	5.7%	1.6%
E06000018	Nottingham	04N	NHS Rushcliffe CCG	4.1%	1.5%
E10000024	Nottinghamshire	02Q	NHS Bassetlaw CCG	97.5%	13.5%
E10000024	Nottinghamshire	02X	NHS Doncaster CCG	1.7%	0.6%
E10000024	Nottinghamshire	03W	NHS East Leicestershire and Rutland CCG	0.3%	0.1%
E10000024	Nottinghamshire	03X	NHS Erewash CCG	7.8%	0.9%
E10000024	Nottinghamshire	03Y	NHS Hardwick CCG	5.1%	0.6%
E10000024	Nottinghamshire	04D	NHS Lincolnshire West CCG	0.4%	0.1%
E10000024	Nottinghamshire	04E	NHS Mansfield and Ashfield CCG	98.1%	22.5%
E10000024	Nottinghamshire	04H	NHS Newark & Sherwood CCG	97.6%	15.5%
E10000024	Nottinghamshire	04K	NHS Nottingham City CCG	10.3%	4.4%
E10000024	Nottinghamshire	04L	NHS Nottingham North and East CCG	95.0%	17.3%
E10000024	Nottinghamshire	04M	NHS Nottingham West CCG	89.3%	10.2%
E10000024	Nottinghamshire	04N	NHS Rushcliffe CCG	90.5%	13.6%
E10000024	Nottinghamshire	04Q	NHS South West Lincolnshire CCG	0.7%	0.1%
E10000024	Nottinghamshire	04R	NHS Southern Derbyshire CCG	0.6%	0.4%
E10000024	Nottinghamshire	04V	NHS West Leicestershire CCG	0.1%	0.0%
E08000004	Oldham	01D	NHS Heywood, Middleton and Rochdale CCG	1.4%	1.3%
E08000004	Oldham	01M	NHS North Manchester CCG	2.6%	2.1%
E08000004	Oldham	00Y	NHS Oldham CCG	94.7%	96.3%
E08000004	Oldham	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E10000025	Oxfordshire	10Y	NHS Aylesbury Vale CCG	6.2%	1.8%
E10000025	Oxfordshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000025	Oxfordshire	04G	NHS Nene CCG	0.1%	0.1%
E10000025	Oxfordshire	10M	NHS Newbury and District CCG	0.1%	0.0%
E10000025	Oxfordshire	10N	NHS North & West Reading CCG	2.0%	0.3%
E10000025	Oxfordshire	10Q	NHS Oxfordshire CCG	97.3%	96.6%
E10000025	Oxfordshire	05R	NHS South Warwickshire CCG	0.7%	0.3%
E10000025	Oxfordshire	12D	NHS Swindon CCG	2.6%	0.8%
E06000031	Peterborough	06H	NHS Cambridgeshire and Peterborough CCG	22.6%	96.1%
E06000031	Peterborough	99D	NHS South Lincolnshire CCG	5.2%	3.9%
E06000026	Plymouth	99P	NHS North, East, West Devon CCG	29.3%	100.0%

E06000044	Portsmouth	10K	NHS Fareham and Gosport CCG	1.4%	1.3%
E06000044	Portsmouth	10R	NHS Portsmouth CCG	95.5%	98.4%
E06000044	Portsmouth	10V	NHS South Eastern Hampshire CCG	0.3%	0.3%
E06000038	Reading	10N	NHS North & West Reading CCG	61.2%	36.6%
E06000038	Reading	10Q	NHS Oxfordshire CCG	0.2%	0.6%
E06000038	Reading	10W	NHS South Reading CCG	79.9%	60.1%
E06000038	Reading	11D	NHS Wokingham CCG	3.1%	2.7%
E09000026	Redbridge	07L	NHS Barking and Dagenham CCG	5.6%	3.8%
E09000026	Redbridge	08F	NHS Havering CCG	0.9%	0.8%
E09000026	Redbridge	08M	NHS Newham CCG	1.5%	1.8%
E09000026	Redbridge	08N	NHS Redbridge CCG	92.6%	88.7%
E09000026	Redbridge	08W	NHS Waltham Forest CCG	3.4%	3.2%
E09000026	Redbridge	07H	NHS West Essex CCG	1.8%	1.7%
E06000003	Redcar and Cleveland	03D	NHS Hambleton, Richmondshire and Whitby CCG	1.0%	1.0%
E06000003	Redcar and Cleveland	00M	NHS South Tees CCG	47.7%	99.0%
E09000027	Richmond upon Thames	08C	NHS Hammersmith and Fulham CCG	0.4%	0.4%
E09000027	Richmond upon Thames	07Y	NHS Hounslow CCG	5.0%	7.1%
E09000027	Richmond upon Thames	08J	NHS Kingston CCG	1.6%	1.5%
E09000027	Richmond upon Thames	08P	NHS Richmond CCG	92.2%	90.3%
E09000027	Richmond upon Thames	99H	NHS Surrey Downs CCG	0.0%	0.1%
E09000027	Richmond upon Thames	08X	NHS Wandsworth CCG	0.3%	0.6%
E08000005	Rochdale	00V	NHS Bury CCG	0.6%	0.5%
E08000005	Rochdale	01A	NHS East Lancashire CCG	0.2%	0.3%
E08000005	Rochdale	01D	NHS Heywood, Middleton and Rochdale CCG	96.6%	96.6%
E08000005	Rochdale	01M	NHS North Manchester CCG	1.8%	1.6%
E08000005	Rochdale	00Y	NHS Oldham CCG	0.8%	0.9%
E08000018	Rotherham	02P	NHS Barnsley CCG	3.4%	3.2%
E08000018	Rotherham	02Q	NHS Bassetlaw CCG	0.9%	0.4%
E08000018	Rotherham	02X	NHS Doncaster CCG	1.1%	1.3%
E08000018	Rotherham	03L	NHS Rotherham CCG	97.9%	93.5%
E08000018	Rotherham	03N	NHS Sheffield CCG	0.7%	1.6%
E06000017	Rutland	06H	NHS Cambridgeshire and Peterborough CCG	0.0%	0.3%
E06000017	Rutland	03V	NHS Corby CCG	0.3%	0.6%
E06000017	Rutland	03W	NHS East Leicestershire and Rutland CCG	9.8%	85.6%
E06000017	Rutland	99D	NHS South Lincolnshire CCG	2.7%	12.0%
E06000017	Rutland	04Q	NHS South West Lincolnshire CCG	0.4%	1.5%
E08000006	Salford	00T	NHS Bolton CCG	0.2%	0.3%
E08000006	Salford	00V	NHS Bury CCG	1.8%	1.4%
E08000006	Salford	00W	NHS Central Manchester CCG	0.3%	0.3%
E08000006	Salford	01M	NHS North Manchester CCG	2.1%	1.7%
E08000006	Salford	01G	NHS Salford CCG	93.9%	95.1%
E08000006	Salford	02A	NHS Trafford CCG	0.2%	0.1%
E08000006	Salford	02H	NHS Wigan Borough CCG	0.9%	1.2%
E08000028	Sandwell	13P	NHS Birmingham Crosscity CCG	2.8%	6.2%
E08000028	Sandwell	04X	NHS Birmingham South and Central CCG	0.2%	0.2%
E08000028	Sandwell	05C	NHS Dudley CCG	3.0%	2.8%
E08000028	Sandwell	05L	NHS Sandwell and West Birmingham CCG	54.3%	89.2%
E08000028	Sandwell	05Y	NHS Walsall CCG	1.6%	1.3%
E08000028	Sandwell	06A	NHS Wolverhampton CCG	0.3%	0.3%
E08000014	Sefton	01J	NHS Knowsley CCG	1.8%	1.0%
E08000014	Sefton	99A	NHS Liverpool CCG	2.9%	5.2%
E08000014	Sefton	01T	NHS South Sefton CCG	96.1%	51.9%
E08000014	Sefton	01V	NHS Southport and Formby CCG	97.0%	41.9%
E08000014	Sefton	02G	NHS West Lancashire CCG	0.3%	0.1%
E08000019	Sheffield	02P	NHS Barnsley CCG	0.8%	0.4%
E08000019	Sheffield	03Y	NHS Hardwick CCG	0.4%	0.0%
E08000019	Sheffield	04J	NHS North Derbyshire CCG	0.7%	0.3%
E08000019	Sheffield	03L	NHS Rotherham CCG	0.3%	0.1%
E08000019	Sheffield	03N	NHS Sheffield CCG	98.6%	99.2%
E06000051	Shropshire	05F	NHS Herefordshire CCG	0.5%	0.3%
E06000051	Shropshire	05G	NHS North Staffordshire CCG	0.4%	0.3%
E06000051	Shropshire	05N	NHS Shropshire CCG	96.5%	95.4%
E06000051	Shropshire	01R	NHS South Cheshire CCG	0.5%	0.3%
E06000051	Shropshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.2%	0.9%
E06000051	Shropshire	05T	NHS South Worcestershire CCG	1.0%	1.0%
E06000051	Shropshire	05X	NHS Telford and Wrekin CCG	2.4%	1.4%
E06000051	Shropshire	02F	NHS West Cheshire CCG	0.2%	0.1%
E06000051	Shropshire	06D	NHS Wyre Forest CCG	0.7%	0.3%
E06000039	Slough	10H	NHS Chiltern CCG	3.2%	6.7%
E06000039	Slough	10T	NHS Slough CCG	96.6%	92.9%
E06000039	Slough	11C	NHS Windsor, Ascot and Maidenhead CCG	0.4%	0.4%
E08000029	Solihull	13P	NHS Birmingham Crosscity CCG	2.0%	6.8%
E08000029	Solihull	04X	NHS Birmingham South and Central CCG	0.3%	0.3%
E08000029	Solihull	05A	NHS Coventry and Rugby CCG	0.0%	0.1%
E08000029	Solihull	05J	NHS Redditch and Bromsgrove CCG	0.4%	0.3%
E08000029	Solihull	05P	NHS Solihull CCG	83.8%	91.7%
E08000029	Solihull	05R	NHS South Warwickshire CCG	0.4%	0.5%
E08000029	Solihull	05H	NHS Warwickshire North CCG	0.2%	0.2%
E10000027	Somerset	11E	NHS Bath and North East Somerset CCG	3.1%	1.1%
E10000027	Somerset	11J	NHS Dorset CCG	0.5%	0.7%
E10000027	Somerset	11T	NHS North Somerset CCG	0.9%	0.3%
E10000027	Somerset	99P	NHS North, East, West Devon CCG	0.3%	0.5%
E10000027	Somerset	11X	NHS Somerset CCG	98.5%	97.3%
E10000027	Somerset	99N	NHS Wiltshire CCG	0.1%	0.0%
E06000025	South Gloucestershire	11E	NHS Bath and North East Somerset CCG	0.6%	0.4%
E06000025	South Gloucestershire	11H	NHS Bristol CCG	4.7%	8.2%
E06000025	South Gloucestershire	11M	NHS Gloucestershire CCG	0.8%	1.8%
E06000025	South Gloucestershire	12A	NHS South Gloucestershire CCG	95.0%	89.4%
E06000025	South Gloucestershire	99N	NHS Wiltshire CCG	0.0%	0.1%
E08000023	South Tyneside	13T	NHS Newcastle Gateshead CCG	0.0%	0.1%
E08000023	South Tyneside	00N	NHS South Tyneside CCG	99.3%	99.2%
E08000023	South Tyneside	00P	NHS Sunderland CCG	0.3%	0.6%
E06000045	Southampton	10X	NHS Southampton CCG	94.5%	99.6%
E06000045	Southampton	11A	NHS West Hampshire CCG	0.2%	0.4%
E06000033	Southend-on-Sea	99F	NHS Castle Point and Rochford CCG	4.6%	4.5%
E06000033	Southend-on-Sea	99G	NHS Southend CCG	96.6%	95.5%

E09000028	Southwark	07R	NHS Camden CCG	0.5%	0.4%
E09000028	Southwark	09A	NHS Central London (Westminster) CCG	2.0%	1.3%
E09000028	Southwark	08K	NHS Lambeth CCG	6.6%	7.6%
E09000028	Southwark	08L	NHS Lewisham CCG	1.9%	1.8%
E09000028	Southwark	08Q	NHS Southwark CCG	94.5%	88.9%
E09000028	Southwark	08X	NHS Wandsworth CCG	0.0%	0.1%
E08000013	St. Helens	01F	NHS Halton CCG	0.2%	0.1%
E08000013	St. Helens	01J	NHS Knowsley CCG	2.6%	2.3%
E08000013	St. Helens	01X	NHS St Helens CCG	91.1%	96.5%
E08000013	St. Helens	02H	NHS Wigan Borough CCG	0.6%	1.1%
E10000028	Staffordshire	13P	NHS Birmingham Crosscity CCG	0.5%	0.4%
E10000028	Staffordshire	04Y	NHS Cannock Chase CCG	99.3%	14.9%
E10000028	Staffordshire	05C	NHS Dudley CCG	1.4%	0.5%
E10000028	Staffordshire	05D	NHS East Staffordshire CCG	91.9%	14.5%
E10000028	Staffordshire	01C	NHS Eastern Cheshire CCG	0.6%	0.1%
E10000028	Staffordshire	04J	NHS North Derbyshire CCG	0.7%	0.2%
E10000028	Staffordshire	05G	NHS North Staffordshire CCG	95.1%	23.5%
E10000028	Staffordshire	05N	NHS Shropshire CCG	1.1%	0.4%
E10000028	Staffordshire	01R	NHS South Cheshire CCG	0.5%	0.1%
E10000028	Staffordshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	96.2%	23.7%
E10000028	Staffordshire	04R	NHS Southern Derbyshire CCG	0.5%	0.3%
E10000028	Staffordshire	05V	NHS Stafford and Surrounds CCG	99.5%	16.6%
E10000028	Staffordshire	05W	NHS Stoke on Trent CCG	8.9%	2.9%
E10000028	Staffordshire	05X	NHS Telford and Wrekin CCG	1.0%	0.2%
E10000028	Staffordshire	05Y	NHS Walsall CCG	1.6%	0.5%
E10000028	Staffordshire	05H	NHS Warwickshire North CCG	1.2%	0.2%
E10000028	Staffordshire	06A	NHS Wolverhampton CCG	2.8%	0.9%
E10000028	Staffordshire	06D	NHS Wyre Forest CCG	0.2%	0.0%
E08000007	Stockport	00W	NHS Central Manchester CCG	0.7%	0.6%
E08000007	Stockport	01C	NHS Eastern Cheshire CCG	1.6%	1.1%
E08000007	Stockport	01N	NHS South Manchester CCG	2.9%	1.7%
E08000007	Stockport	01W	NHS Stockport CCG	95.2%	96.5%
E08000007	Stockport	01Y	NHS Tameside and Glossop CCG	0.2%	0.2%
E06000004	Stockton-on-Tees	00C	NHS Darlington CCG	0.4%	0.2%
E06000004	Stockton-on-Tees	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.3%	0.5%
E06000004	Stockton-on-Tees	03D	NHS Hambleton, Richmondshire and Whitby CCG	0.1%	0.1%
E06000004	Stockton-on-Tees	00K	NHS Hartlepool and Stockton-On-Tees CCG	66.8%	98.7%
E06000004	Stockton-on-Tees	00M	NHS South Tees CCG	0.3%	0.5%
E06000021	Stoke-on-Trent	05G	NHS North Staffordshire CCG	3.4%	2.7%
E06000021	Stoke-on-Trent	05V	NHS Stafford and Surrounds CCG	0.5%	0.3%
E06000021	Stoke-on-Trent	05W	NHS Stoke on Trent CCG	91.1%	97.0%
E10000029	Suffolk	06H	NHS Cambridgeshire and Peterborough CCG	0.1%	0.2%
E10000029	Suffolk	06M	NHS Great Yarmouth and Waveney CCG	52.5%	16.5%
E10000029	Suffolk	06L	NHS Ipswich and East Suffolk CCG	99.6%	52.8%
E10000029	Suffolk	06T	NHS North East Essex CCG	1.3%	0.6%
E10000029	Suffolk	06Y	NHS South Norfolk CCG	1.2%	0.4%
E10000029	Suffolk	07K	NHS West Suffolk CCG	91.0%	29.6%
E08000024	Sunderland	00D	NHS Durham Dales, Easington and Sedgefield CCG	0.7%	0.7%
E08000024	Sunderland	13T	NHS Newcastle Gateshead CCG	0.5%	0.8%
E08000024	Sunderland	00J	NHS North Durham CCG	2.3%	2.0%
E08000024	Sunderland	00N	NHS South Tyneside CCG	0.4%	0.2%
E08000024	Sunderland	00P	NHS Sunderland CCG	98.5%	96.2%
E10000030	Surrey	10G	NHS Bracknell and Ascot CCG	1.7%	0.2%
E10000030	Surrey	07Q	NHS Bromley CCG	0.4%	0.1%
E10000030	Surrey	09G	NHS Coastal West Sussex CCG	0.2%	0.0%
E10000030	Surrey	09H	NHS Crawley CCG	6.6%	0.7%
E10000030	Surrey	07V	NHS Croydon CCG	1.2%	0.4%
E10000030	Surrey	09L	NHS East Surrey CCG	96.6%	14.1%
E10000030	Surrey	09N	NHS Guildford and Waverley CCG	94.0%	16.9%
E10000030	Surrey	09X	NHS Horsham and Mid Sussex CCG	1.6%	0.3%
E10000030	Surrey	07Y	NHS Hounslow CCG	0.5%	0.1%
E10000030	Surrey	08J	NHS Kingston CCG	4.4%	0.7%
E10000030	Surrey	08R	NHS Merton CCG	0.2%	0.0%
E10000030	Surrey	99M	NHS North East Hampshire and Farnham CCG	23.0%	4.2%
E10000030	Surrey	10J	NHS North Hampshire CCG	0.1%	0.0%
E10000030	Surrey	09Y	NHS North West Surrey CCG	99.5%	29.6%
E10000030	Surrey	08P	NHS Richmond CCG	0.5%	0.0%
E10000030	Surrey	10V	NHS South Eastern Hampshire CCG	0.1%	0.0%
E10000030	Surrey	99H	NHS Surrey Downs CCG	97.1%	23.9%
E10000030	Surrey	10C	NHS Surrey Heath CCG	99.0%	7.6%
E10000030	Surrey	08T	NHS Sutton CCG	1.2%	0.2%
E10000030	Surrey	99J	NHS West Kent CCG	0.2%	0.0%
E10000030	Surrey	11C	NHS Windsor, Ascot and Maidenhead CCG	7.7%	1.0%
E09000029	Sutton	07V	NHS Croydon CCG	1.0%	1.9%
E09000029	Sutton	08J	NHS Kingston CCG	3.3%	3.2%
E09000029	Sutton	08K	NHS Lambeth CCG	0.1%	0.2%
E09000029	Sutton	08R	NHS Merton CCG	6.2%	6.5%
E09000029	Sutton	99H	NHS Surrey Downs CCG	1.4%	2.0%
E09000029	Sutton	08T	NHS Sutton CCG	94.5%	86.0%
E09000029	Sutton	08X	NHS Wandsworth CCG	0.1%	0.2%
E06000030	Swindon	11M	NHS Gloucestershire CCG	0.0%	0.2%
E06000030	Swindon	12D	NHS Swindon CCG	96.3%	98.4%
E06000030	Swindon	99N	NHS Wiltshire CCG	0.6%	1.4%
E08000008	Tameside	00W	NHS Central Manchester CCG	0.5%	0.5%
E08000008	Tameside	01M	NHS North Manchester CCG	6.4%	5.5%
E08000008	Tameside	00Y	NHS Oldham CCG	3.6%	3.8%
E08000008	Tameside	01W	NHS Stockport CCG	1.6%	2.1%
E08000008	Tameside	01Y	NHS Tameside and Glossop CCG	85.1%	88.1%
E06000020	Telford and Wrekin	05N	NHS Shropshire CCG	1.8%	3.0%
E06000020	Telford and Wrekin	05X	NHS Telford and Wrekin CCG	96.7%	97.0%
E06000034	Thurrock	07L	NHS Barking and Dagenham CCG	0.2%	0.2%
E06000034	Thurrock	99E	NHS Basildon and Brentwood CCG	0.2%	0.2%
E06000034	Thurrock	08F	NHS Havering CCG	0.1%	0.2%
E06000034	Thurrock	07G	NHS Thurrock CCG	98.4%	99.3%
E06000027	Torbay	99Q	NHS South Devon and Torbay CCG	48.9%	100.0%
E09000030	Tower Hamlets	07R	NHS Camden CCG	1.1%	0.9%

E09000030	Tower Hamlets	09A	NHS Central London (Westminster) CCG	0.3%	0.2%
E09000030	Tower Hamlets	07T	NHS City and Hackney CCG	0.8%	0.8%
E09000030	Tower Hamlets	08M	NHS Newham CCG	0.2%	0.3%
E09000030	Tower Hamlets	08V	NHS Tower Hamlets CCG	98.9%	97.7%
E08000009	Trafford	00W	NHS Central Manchester CCG	4.7%	4.3%
E08000009	Trafford	01G	NHS Salford CCG	0.1%	0.1%
E08000009	Trafford	01N	NHS South Manchester CCG	3.2%	2.2%
E08000009	Trafford	02A	NHS Trafford CCG	95.3%	93.2%
E08000009	Trafford	02E	NHS Warrington CCG	0.1%	0.1%
E08000036	Wakefield	02P	NHS Barnsley CCG	0.8%	0.6%
E08000036	Wakefield	03G	NHS Leeds South and East CCG	1.0%	0.8%
E08000036	Wakefield	03C	NHS Leeds West CCG	0.1%	0.2%
E08000036	Wakefield	03J	NHS North Kirklees CCG	0.6%	0.3%
E08000036	Wakefield	03R	NHS Wakefield CCG	94.6%	98.1%
E08000030	Walsall	13P	NHS Birmingham Crosscity CCG	1.8%	4.7%
E08000030	Walsall	04Y	NHS Cannock Chase CCG	0.7%	0.3%
E08000030	Walsall	05L	NHS Sandwell and West Birmingham CCG	1.6%	3.1%
E08000030	Walsall	05Y	NHS Walsall CCG	92.4%	90.7%
E08000030	Walsall	06A	NHS Wolverhampton CCG	1.3%	1.2%
E09000031	Waltham Forest	07T	NHS City and Hackney CCG	0.3%	0.3%
E09000031	Waltham Forest	08M	NHS Newham CCG	1.1%	1.5%
E09000031	Waltham Forest	08N	NHS Redbridge CCG	1.4%	1.4%
E09000031	Waltham Forest	08W	NHS Waltham Forest CCG	94.3%	96.8%

E09000032	Wandsworth	09A	NHS Central London (Westminster) CCG	0.7%	0.4%
E09000032	Wandsworth	08C	NHS Hammersmith and Fulham CCG	0.3%	0.2%
E09000032	Wandsworth	08J	NHS Kingston CCG	0.1%	0.0%
E09000032	Wandsworth	08K	NHS Lambeth CCG	2.7%	2.9%
E09000032	Wandsworth	08R	NHS Merton CCG	3.0%	1.8%
E09000032	Wandsworth	08P	NHS Richmond CCG	1.3%	0.7%
E09000032	Wandsworth	08X	NHS Wandsworth CCG	88.8%	93.6%
E09000032	Wandsworth	08Y	NHS West London (K&C & QPP) CCG	0.5%	0.3%
E06000007	Warrington	01F	NHS Halton CCG	0.3%	0.2%
E06000007	Warrington	01G	NHS Salford CCG	0.5%	0.6%
E06000007	Warrington	01X	NHS St Helens CCG	2.2%	2.0%
E06000007	Warrington	02E	NHS Warrington CCG	97.8%	97.0%
E06000007	Warrington	02H	NHS Wigan Borough CCG	0.2%	0.2%
E10000031	Warwickshire	13P	NHS Birmingham Crosscity CCG	0.1%	0.2%
E10000031	Warwickshire	05A	NHS Coventry and Rugby CCG	25.6%	21.4%
E10000031	Warwickshire	11M	NHS Gloucestershire CCG	0.2%	0.2%
E10000031	Warwickshire	04G	NHS Nene CCG	0.2%	0.2%
E10000031	Warwickshire	10Q	NHS Oxfordshire CCG	0.3%	0.3%
E10000031	Warwickshire	05J	NHS Redditch and Bromsgrove CCG	0.8%	0.2%
E10000031	Warwickshire	05P	NHS Solihull CCG	0.6%	0.3%
E10000031	Warwickshire	05Q	NHS South East Staffs and Seisdon Peninsular CCG	0.8%	0.3%
E10000031	Warwickshire	05R	NHS South Warwickshire CCG	96.1%	45.6%
E10000031	Warwickshire	05H	NHS Warwickshire North CCG	96.8%	30.9%
E10000031	Warwickshire	04V	NHS West Leicestershire CCG	0.5%	0.3%
E06000037	West Berkshire	10M	NHS Newbury and District CCG	93.1%	66.2%
E06000037	West Berkshire	10N	NHS North & West Reading CCG	35.7%	23.7%
E06000037	West Berkshire	10J	NHS North Hampshire CCG	0.7%	0.9%
E06000037	West Berkshire	10Q	NHS Oxfordshire CCG	0.2%	1.1%
E06000037	West Berkshire	10W	NHS South Reading CCG	9.1%	7.6%
E06000037	West Berkshire	99N	NHS Wiltshire CCG	0.1%	0.4%
E06000037	West Berkshire	11D	NHS Wokingham CCG	0.1%	0.1%
E10000032	West Sussex	09D	NHS Brighton and Hove CCG	1.2%	0.4%
E10000032	West Sussex	09G	NHS Coastal West Sussex CCG	99.5%	57.7%
E10000032	West Sussex	09H	NHS Crawley CCG	93.4%	13.9%
E10000032	West Sussex	09L	NHS East Surrey CCG	0.3%	0.0%
E10000032	West Sussex	09N	NHS Guildford and Waverley CCG	3.1%	0.8%
E10000032	West Sussex	99K	NHS High Weald Lewes Havens CCG	1.0%	0.2%
E10000032	West Sussex	09X	NHS Horsham and Mid Sussex CCG	95.6%	25.8%
E10000032	West Sussex	10V	NHS South Eastern Hampshire CCG	4.2%	1.0%
E10000032	West Sussex	99H	NHS Surrey Downs CCG	0.5%	0.2%
E09000033	Westminster	07P	NHS Brent CCG	1.3%	2.0%
E09000033	Westminster	07R	NHS Camden CCG	2.9%	3.1%
E09000033	Westminster	09A	NHS Central London (Westminster) CCG	81.6%	71.1%
E09000033	Westminster	08C	NHS Hammersmith and Fulham CCG	0.1%	0.0%
E09000033	Westminster	08Y	NHS West London (K&C & QPP) CCG	23.5%	23.7%
E08000010	Wigan	00T	NHS Bolton CCG	0.1%	0.1%
E08000010	Wigan	01G	NHS Salford CCG	1.1%	0.8%
E08000010	Wigan	01X	NHS St Helens CCG	3.9%	2.3%
E08000010	Wigan	02E	NHS Warrington CCG	0.4%	0.2%
E08000010	Wigan	02G	NHS West Lancashire CCG	2.7%	0.9%
E08000010	Wigan	02H	NHS Wigan Borough CCG	96.7%	95.6%
E06000054	Wiltshire	11E	NHS Bath and North East Somerset CCG	0.7%	0.3%
E06000054	Wiltshire	11J	NHS Dorset CCG	0.3%	0.5%
E06000054	Wiltshire	11M	NHS Gloucestershire CCG	0.4%	0.6%
E06000054	Wiltshire	10M	NHS Newbury and District CCG	0.9%	0.2%
E06000054	Wiltshire	11X	NHS Somerset CCG	0.3%	0.4%
E06000054	Wiltshire	12A	NHS South Gloucestershire CCG	0.9%	0.5%
E06000054	Wiltshire	12D	NHS Swindon CCG	1.0%	0.5%
E06000054	Wiltshire	11A	NHS West Hampshire CCG	0.1%	0.1%
E06000054	Wiltshire	99N	NHS Wiltshire CCG	96.7%	97.0%
E06000040	Windsor and Maidenhead	10G	NHS Bracknell and Ascot CCG	12.3%	10.9%
E06000040	Windsor and Maidenhead	10H	NHS Chiltern CCG	0.6%	1.2%
E06000040	Windsor and Maidenhead	09Y	NHS North West Surrey CCG	0.2%	0.5%
E06000040	Windsor and Maidenhead	10Q	NHS Oxfordshire CCG	0.0%	0.2%
E06000040	Windsor and Maidenhead	10T	NHS Slough CCG	0.6%	0.5%
E06000040	Windsor and Maidenhead	10C	NHS Surrey Heath CCG	0.1%	0.0%
E06000040	Windsor and Maidenhead	11C	NHS Windsor, Ascot and Maidenhead CCG	88.9%	85.5%
E06000040	Windsor and Maidenhead	11D	NHS Wokingham CCG	1.2%	1.2%
E08000015	Wirral	02F	NHS West Cheshire CCG	0.4%	0.3%
E08000015	Wirral	12F	NHS Wirral CCG	99.7%	99.7%
E06000041	Wokingham	10G	NHS Bracknell and Ascot CCG	3.2%	2.7%
E06000041	Wokingham	10N	NHS North & West Reading CCG	0.1%	0.0%
E06000041	Wokingham	10Q	NHS Oxfordshire CCG	0.1%	0.5%
E06000041	Wokingham	10W	NHS South Reading CCG	11.1%	9.0%
E06000041	Wokingham	11D	NHS Wokingham CCG	93.5%	87.9%
E08000031	Wolverhampton	05C	NHS Dudley CCG	1.4%	1.7%
E08000031	Wolverhampton	05L	NHS Sandwell and West Birmingham CCG	0.1%	0.3%
E08000031	Wolverhampton	05Q	NHS South East Staffs and Seisdon Peninsular CCG	1.7%	1.4%
E08000031	Wolverhampton	05Y	NHS Walsall CCG	3.9%	4.0%
E08000031	Wolverhampton	06A	NHS Wolverhampton CCG	93.7%	92.7%
E10000034	Worcestershire	13P	NHS Birmingham Crosscity CCG	0.5%	0.6%
E10000034	Worcestershire	04X	NHS Birmingham South and Central CCG	2.6%	1.1%
E10000034	Worcestershire	05C	NHS Dudley CCG	0.8%	0.4%
E10000034	Worcestershire	11M	NHS Gloucestershire CCG	0.5%	0.6%
E10000034	Worcestershire	05F	NHS Herefordshire CCG	1.0%	0.3%
E10000034	Worcestershire	05J	NHS Redditch and Bromsgrove CCG	95.9%	27.9%
E10000034	Worcestershire	05N	NHS Shropshire CCG	0.3%	0.1%
E10000034	Worcestershire	05P	NHS Solihull CCG	0.5%	0.2%
E10000034	Worcestershire	05R	NHS South Warwickshire CCG	2.3%	1.1%
E10000034	Worcestershire	05T	NHS South Worcestershire CCG	97.1%	48.8%
E10000034	Worcestershire	06D	NHS Wyre Forest CCG	98.5%	18.8%
E06000014	York	03E	NHS Harrogate and Rural District CCG	0.1%	0.1%
E06000014	York	03Q	NHS Vale of York CCG	60.4%	99.9%

Dated **2016**

SOUTHEND-ON-SEA BOROUGH COUNCIL

and

NHS SOUTHEND CLINICAL COMMISSIONING GROUP

VARIATION TO FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES FOR 2016- 2017

Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

Kings Orchard | 1 Queen Street | Bristol BS2 0HQ
T 0870 194 1000 F 0870 194 1001

Interchange Place | Edmund Street | Birmingham B3 2TA
T 0870 194 1000 F 0870 194 5001

www.bevanbrittan.com

Contents

THIS VARIATION AGREEMENT is made on day of 2016

PARTIES

(1) **SOUTHEND-ON-SEA BOROUGH COUNCIL** of Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER (the **"Council"**); and

(2) **NHS SOUTHEND CLINICAL COMMISSIONING GROUP** of Harcourt House, 5-15 Harcourt Avenue, Southend on Sea, SS2 6HE (the "**CCG"**)

(together "**the Partners**")

BACKGROUND

(A) The Partners entered into a Framework Partnership Agreement relating to the commissioning of health and social care services on 31st March 2015 in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable ("the Partnership Agreement").

(B) The Partners acknowledge that in accordance with the Better Care Fund Plan 2016/2017 the Essex Success Regime is still emerging and aligned with the Better Care Fund and any change required would be the subject of a separate agreement between the Partners.

(C) The Parties further acknowledge that the admission reduction targets provided for in the Partnership Agreement for 2015/2016 have been achieved and therefore no specific provisions regarding risk share are included in this Variation Agreement.

(D) Pursuant to Clause 30 of the Partnership Agreement, the Partners have agreed to vary the terms of the Partnership Agreement as set out in this Variation Agreement with effect from the date of this Variation Agreement in relation to the financial year commencing 1st April 2016 and ending 31st March 2017.

AGREED TERMS

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, expressions defined in the Partnership Agreement and used in this Agreement have the meaning set out in the Partnership Agreement.

1.2 Subject to Clause 1.1 in this Agreement the following words and expressions shall have the following meanings:

Agreement means this Variation Agreement including any schedules and appendices.

1.3 The rules of interpretation set out in the Partnership Agreement apply to this Agreement.

2 VARIATION

2.1 The Partners acknowledge agree and confirm that in accordance with Clause 30 of the Partnership Agreement (which provides that any variation shall be recorded in writing and signed for and on behalf of each of the Partners) that the Partnership Agreement shall be amended as follows:

Clause or Schedule of the Partnership Agreement	Variation agreed	New Schedule in Partnership Agreement (as applicable)
Clause 1 – Defined Terms and Interpretation	The term **Joint Executive Group** shall be deleted and replaced with the following term and meaning: **Locality Transformation Group** means the Locality Transformation Group responsible for the review of performance and oversight of this Agreement as set out in Schedule 2. The terms **Payment for Performance Framework; Payment for Performance Fund; Payment for Performance Shortfall** shall be deleted as no longer used in the Partnership Agreement.	
Clause 2.2	The reference in Clause 2.2 to "**Clause 21**" shall be deleted and replaced with the correct clause reference "**Clause 22**"	
New Clause 10A	**"Investment Schemes** means schemes developed by either of the Partners which the other Partners has agreed to invest in using the powers under Section 75 and upon such terms as agreed between the Partners in accordance with Clause 10A;" **"10A INVESTMENT SCHEMES** **10A.1** Where either of the Partners has agreed to support the other Partner in relation to an Investment Scheme the following principles shall apply to each Investment Scheme: 10A.1.1. Any Investment Scheme shall be considered by the Partner investing in an Investment Scheme following the submission by the of a business case: 10A.1.2 A written agreement shall document any Investment Scheme which the Partners have agreed to proceed with; 10A.1.2 Such written agreement will state the purpose of	

	the Investment Scheme; the amount to be invested; the length of the investment; the expected return on the investment; and, when any reviews which are to be carried out."	
Clause 12.1	Clause 12.1 shall be deleted and replaced as follows: 12.1 In relation to the schemes set out in Schedule 1 part 2, and subject to this clause the commissioner responsible for the individual schemes as set out in that part of Schedule 1 shall carry the risk of any overspend in relation to that scheme. In the event that any underspend arises in relation to any scheme, they shall be applied: 12.1.1 First, to be used to meet any overspend in any other scheme managed by the same Partner. 12.1.2 Secondly by being released to the Partner responsible for managing the scheme which has underspent, subject always to that Partner retaining the discretion to make payments for the purpose of health and social care either within or outside the Better care schemes to the other party.	
All Clause and Schedules (as applicable)	Any reference to **Joint Executive Group** shall be deleted and replaced with **Locality Transformation Group**	
Schedule 1 – Scheme Specification and appendices	The existing Scheme Specification only but not the Scheme Description appendices as set out in Schedule 1 to the Partnership Agreement shall be deleted and replaced with the new Scheme Specification to this Agreement as set out in Schedule 1 to this Agreement and the existing appendices shall be read in accordance with paragraph 2 of	Schedule 1

	the new Scheme Specification.	
Schedule 2 - Governance	The existing Terms of Reference for the Joint Executive Group as set out in Schedule 2 to the Partnership Agreement shall be deleted and replaced with the new Terms of Reference for the Locality Transformation Group as set out in Schedule 2 to this Agreement.	Schedule 2
Schedule 6 – Better Care Fund Plan	The existing Better Care Fund Plan and appendices as set out in Schedule 6 to the Partnership Agreement shall be deleted and replaced with the new Better Care Fund Plan 2016 – 2017 and appendices as set out in Schedule 3 to this Agreement.	Schedule 6

2.2 Except as amended by this Agreement and as set out in Clause 2.1 above and Schedules 1, 2 and 3 of this Agreement, the Partnership Agreement shall continue in full force and effect and this Agreement shall not release or lessen any accrued rights, obligations or liability of any of the Partners under the Partnership Agreement.

3 GENERAL

3.1 The provisions of the following clauses of the Partnership Agreement shall apply, mutatis mutandis, to this Agreement: Clause 15 (Audit and Access Rights),Clause 23 (Dispute Resolution Procedure), Clause 25 (Confidentiality) Clause (Freedom of Information and Environmental Protection Regulations) Clause 29 (Notices) and Clause 34 (Assignment and Sub- Contracting).

4 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

5 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

6 ENTIRE AGREEMENT

6.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

6.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the Partners.

7 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

8 GOVERNING LAW AND JURISDICTION

8.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

8.2 Subject to Clause 23 (Dispute Resolution) of the Partnership Agreement, the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

SCHEDULE 1– SCHEME SPECIFICATION

AGREED SCHEME SPECIFICATIONS

The schemes set out in appendices 1- 4 comprise the Better Care Fund schemes for the financial year 2016/17. These schemes shall be funded through a single pooled fund hosted by the Council and managed as set out below

1 FINANCE

1.1 Pooled fund contributions for 2016/17:-

1.1.1 The Council £1,193,374 payable in twelve equal monthly instalments

1.1.2 The CCG £11,937,675 payable in twelve equal monthly instalments

1.2 The pooled fund shall be divided into sub funds to reflect the four schemes as set out below

	Scheme	**Lead Partner**	**Amount**
BCF001	Protecting Social Services	Council	£4,199,094
BCF002	Reablement, including support the Care Act	Council	£1,450,000
BCF003	Integrated Community Services	CCG	£6,288,581
BCF004	Disabled Facilities Grants	Council	£1,193,374
Total			£13,131,049

1.3 Payments from the pooled fund shall be made to each partner for their respective schemes in accordance with the table below

Partner	**Total**
Council	£6,842,468
CCG	£6,288,581
Total	£13,131,049

1.4 The core amount will be paid to the Partners by 12 equal monthly instalments.

1.5 The Council shall host the pooled fund, and appoint the pooled fund manager.

1.6 The pooled Fund Manager shall be Ian Ambrose, Group Manager – Financial Management.

1.7 Payments from the pooled fund shall be to the lead authority for the purpose of payments due under contracts or by way of grant in accordance with the individual schemes only.

2 SCHEME DESCRIPTIONS

2.1 The Scheme Descriptions set out in the appendices to the deleted Schedule 1 in the Partnership Agreement shall be supplemented by and read in the context of the relevant annexes to the new Better Care Plan set out at Schedule 6

3 REPORTING

3.1 The Council and the CCG shall ensure that the individual scheme leads report back to the Programme Transformation Board, the Locality Transformation Group and the Health and Wellbeing Board as required under this agreement, and any BCF Guidance, to provide

accountability and transparency as to the use of the money, and the effectiveness of its use in accordance with the timetable and format to be agreed by between the Partners.

SCHEDULE 2 – LOCALITY TRANSFORMATION GROUP TERMS OF REFERENCE

1 BACKGROUND & CONTEXT

1.1 The creation of the Locality Transformation Group (LTG) was approved by the senior officers of SCCG and SBC. Specifically, the LTG was delegated the responsibility to manage the delivery of the locality approach, Better Care Fund and Pioneer Programme.

2 PURPOSE

2.1 Manage the delivery of the locality approach, Better Care Fund and Pioneer Programme on behalf of the HWB.

3 MEMBERSHIP

- Transformation Lead
- Project Manager for SPoA / Access transformation;
- Project Manager for Complex Care Service;
- Project Manager for Adult Social Care redesign;
- Exec Lead for End of Life;
- Head of Health Development, Public Health;
- Associate Director, Primary Care and Engagement, SCCG;
- Assistant Director; Emergency Department, SUHFT;
- Director of Integrated Services for Adults and Older People, SEPT
- Head of Integrated Care Commissioning, SCCG;
- Clinical Lead (TBC)
- Strategy and Commissioning Manager Mental Health and Dementia;
- Data, Performance & Information Manager

In attendance

3.1 Transformation Programme Manager;

Other colleagues will be invited to attend specific items as agreed in advance by the Chair.

Chair

3.2 The LTG will be chaired by the Transformation Lead. Vice Chair will be Head of Integrated Care Commissioning.

Substitutions

3.3 Substitutions for annual leave or short term sickness absence are required and subject to the Chair's agreement.

Quorum

3.4 The quorum shall be 6 Members including as a minimum the following representatives:

- Chair or vice chair
- Member of Southend Borough Council
- 1 Member from Southend CCG
- 1 Member from Public Health
- 1 Member from SEPT
- 1 Member from SUHFT

4 RESPONSIBILITIES

4.1 initiating the commencement of new activity as approved by HWB or Senior Officer Management Group;

4.2 assigning resource to approved roles and responsibilities;

4.3 developing definition documents including PID, business cases, benefits plans, project plans etc

4.4 Monitoring programme and project delivery;

4.5 Monitoring programme finances;

4.6 Ensuring progress against significant milestones & strategic objectives

4.7 Monitor and manage a Risk, Assumption, Issue and Dependency process

4.8 delivery of assurance roles;

4.9 recommending to HWB or Senior Officers Management Group scope extensions to existing activities

4.10 To act as escalation point for any issues that cannot be resolved at the project or work stream level;

4.11 Approve, implement and manage a change process to project documentation

4.12 To agree communications

4.13 Reviewing project closure and benefit reports

5 MANAGEMENT

Frequency

5.1 LTG will convene once monthly.

Recording

5.2 All LTG meetings will be minuted through agreed actions and timescales.

Papers

5.3 In normal circumstances, papers will be made available to all attendees at least 3 working days in advance Papers are to be no more than 4 pages and in the appropriate template. Papers will only be 'tabled on the day' with the agreement of the Chair.

Reporting

5.4 Reporting will be carried out using LTG agreed templates.

6 REVIEW

6.1 These Terms of Reference will be reviewed on a 6 monthly basis.

SOUTHEND ON SEA
BETTER CARE FUND PLAN

2016/17

STAGE 3 SUBMISSION

3RD MAY 2016

Change Control		
Summary	**approved with support**	
Overview	The plan is well structured and targeted. Vision, values and alignment to wider agenda articulated well. There is a real focus on prevention, providing community solutions, ensuring a good integrated pathway and improving outcomes, building on 15/16 achievements. Data sharing arrangements are in place. Governance structures were well explained. Financial commitments were described with no major gaps	
Key Issues to be addressed		
Programme		
Partners	It would be helpful to identify in one section BCF plan partners and providers including mental health	Section 1.4
Plan and Risk Log	Please provide detailed version of plan and risk log	Section 2.34 and Appendix 1 & 2
Expenditure Plan	Please provide scheme level expenditure for the expenditure plan [Tab 4 in BCF Template] to support the high level numbers provided	Section 4.4, 4.23 and 4.34 and Appendix 3 & 4
Provider Engagement	Please include implications of the BCF plan for local providers and additional information on how providers have been engaged and how engagement will be managed in 16/17. Please also provide confirmation of provider agreement with the plan, how providers will be engaged in implementation and how they are represented e.g. on Health and Wellbeing Board or on project teams. Please confirm that HWB is sighted on implications for local providers	Section 2.7 – 2.9
Work-stream Issues		
Workforce Planning	Please give additional supporting information and milestones on the development and implementation of workforce plan	Section 3.5.2
Maintain Provision of Adult Social Care	Please confirm funding for carer specific support	Section 1.1.4 and 3.9
7 Day Working	Please provide additional information to support the implementation of the 7 day services plan including milestones and provider engagement including mental health services and how the plan is aligned	Section 3.12 and Appendix 2 and 5.

	to the Essex Success Regime Strategy	
Data sharing	Significant progress has been made in developing data sharing. Please provide additional information including milestones for further development and implementation in 16/17 The plan points to the use of Care Track in developing risk stratification as a key element in the 16/17 plan. Please provide additional information on plan development and milestones for the improvement of primary and secondary care prevention identified in the plan	Appendix 2
DTOC	DTOC targets are still to be agreed between SCCG, the Council, Southend Hospital and Community Service Provider Please provide a schedule for the agreement of DTOC targets and alignment with CCG operating plans. Please also detail how monitoring and accountability by partner organisations will be managed and how risk planning and mitigation will be managed	Section 3.37 and Appendix 6
Risk Share	Risk share has been considered and rejected based on successful meeting of last year's emergency targets. Please provide additional information on risks considered to continue to meet these targets and what mitigation is being considered? Please confirm how providers have been involved in the risk share and mitigation planning.	Section 2.40 and Appendix 1
Mental Health	Please provide additional information on the engagement of Mental Health Trust in the BCF plan and the provision of dementia services Dementia services are referenced effectively throughout the plan Please provide further information on dementia services; milestones identify strategic partners and milestones to meet the plan target to improve dementia services; processes for joint assessment and care management for people with dementia	Section 4.11 and Appendix 7
Consultation	Please provide further details on public engagement and consultation on the development of the BCF programme and on consultation on the 16/17 Plan itself	Section 2.16
Essex Success Regime	Please provide additional information to identify the contribution that BCF makes to the Essex Success Regime and how providers are engaged with the BCF programme	Section 2.10 – 2.12 and Appendix 8
Plan Metrics and Objectives	Please provide supporting information for the 16/17 targets e.g. for reablement; people with long term conditions feeling supported; patient experience Please give supporting documentation on how metrics have been arrived at and their management.	Section 5.6, 5.7 and 5.8.
Further amendments		
CCG minimum	Southend CCG confirms the allocation of the	Section 1

contributions	minimum funding contribution as required by the BCF national conditions.	
Reablement	Section updated.	Section 4.37
Locality approach	Section updated to demonstrate that SBC and SCCG are actively considering a joint approach to 'invest to save'.	Section 4.14
Childrens commissioning	Plan updated re integrated children commissioning and that the CCG and SBC will be jointly discussing an approach to commission children services from one integrated budget	Section 2.18 – 2.19

TABLE OF CONTENTS

1 Confirmation of funding contributions

Minimum funding contributions met

1.1 Southend on Sea (Southend) can confirm that the minimum funding requirements for the Better Care Fund (BCF) plan are as per below. These include the following;

1.1.1 Southend CCG (SCCG) contribution - £11.937M

1.1.2 Disabled Facilities Grant - £1.193M

1.1.3 Care Act 2014 Monies - £0.474M

1.1.4 Former Carers Break funding - £0.421M

1.1.5 Reablement funding - £0.976M

1.1.6 Protection of social services - £4.199M

1.2 Section 4 to this plan demonstrates how each element of the funding contributions will be used.

Additional funding contributions

1.3 No additional funding has been allocated from either the Southend on Sea Borough Council (Council) or Southend CCG (SCCG)

Partners and providers

1.4 Partners and providers who have contributed to the delivery of BCF 2015/16 and continue to be engaged in BCF for 2016/17 include all partners and providers represented at HWB, these include;

1.4.1 Southend on Sea Borough Council;

1.4.2 Southend Clinical Commissioning Group;

1.4.3 Southend University Hospital NHS Foundation Trust;

1.4.4 South Essex Partnership University NHS Foundation Trust (community and mental health provider);

1.4.5 Southend Association of Voluntary Services; and

1.4.6 NHS England

Local Agreement on funding arrangements

1.5 Both the BCF planning return and this plan have been signed off by the Health & Wellbeing Board (HWB) on 7th April 2016.

1.6 A full overview of funding contributions for 2016/17 are provided in section 1.1 and worksheet #3 (HWB funding sources) of the BCF planning template.

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

1.7.1 SCCG contribution. This has changed from £11.619M (2015/16) to £11.937M (2016/17).

1.7.2 DFG. This has changed from £0.694M (2015/16) to £1.193M (2016/17). The additional capital resource funding requirement has been agreed by both the Council and SCCG.

1.7.3 Care Act 2014 Monies. This has changed from £0.455M (2015/16) to £0.474M (2016/17).

1.7.4 Protecting social services. This has changed from £4.087M (2015/16) to £4.199M (2016/17). The additional funding is consistent with the Department for Health guidance to NHS England on the funding transfer from NHS to social care.

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

2 Narrative plan

The local vision for health and social care services

2.1 Our vision is;

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

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

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

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

Our vision is underpinned by focusing on the following areas:

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

Alignment of vision with national and regional requirements

2.2 The vision for Southend is not only aligned to NHS England's 5 Year Forward View, in which greater engagement with patients, carers and citizens is encouraged so that there can be promotion of well-being and the prevention of ill-health but is also aligned to both regional and local initiatives. The Essex Success Regime (ESR) is focused on Acute financial stability, Primary care and integration. The Southend BCF is aligned with all three.

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

2.4 Our BCF plan is aligned to our HWB strategy. The ambition for HWB in Southend (outlined in Section 2.1) is that everyone living in Southend has the best possible opportunity to live long, fulfilling, healthy lives.

2.5 Aligned with on-going challenges and the BCF plan, Southend HWB will closely focus on achieving five new "big ticket" priority areas for 2016/17. These are;

2.5.1 Mental Health

2.5.2 Complex Care

2.5.3 Integrated Children's Services

2.5.4 Physical Activity levels

2.5.5 Primary Care Access

2.6 NHS England recently published a requirement for health and social care systems to draft a blueprint for the implementation of the five year forward view, these will be known as Sustainability Transformation Plans (STPs). The Southend system has agreed a local footprint for our STP and have aligned it with the ESR. In doing so we have ensured that appropriate governance is in place to assure system leaders that there will be a 'southend' local element to the ESR STP.

Alignment of BCF plan with providers

2.7 The implications for providers (noted above in section 1) have been discussed through a number of processes through which providers are engaged. These include various operational level project group meetings, senior officer engagement, HWB, SCCG operational planning for 2016/17 and project meetings with the ESR structure.

2.8 Implications for providers will continue to be managed in proactive and robust environment with operational leads discussing the detail at project group meetings and HWB taking overall responsibility.

2.9 The development of the BCF 16/17 plan has fully engaged providers with the plan being signed off through HWB on 7th April 2016.

Alignment of BCF plan with ESR

2.10 The ESR is split into two components; (1) transformation focusing on services within the 3 acute hospitals; and (2) transformation focusing on local health and care.

2.11 Each of the projects with the Southend BCF for 16/17 are aligned to supporting the system and designing services which span both the hospital and the community. For example the development of our locality approach (section 4) will focus on developing localities around primary care in Southend with the aim of reducing the demand on the hospital and resourcing the community services to deliver services to both the community and a complex care cohort.

2.12 At Appendix 8 is the latest newsletter from the ESR (component 2) which recognises the support needed from local areas to deliver the required outcomes.

Engagement

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

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

2.15 We have attended dozens of events to engage face to face with members of the public across a range of different topics and issues. In May 2015 we held an engagement event to help develop the HWB strategy for Southend. The event was a great success and attended by more than 150 people.

2.16 NHS and Council staff regularly attend meetings of both Southend's PPGF (Patient Participation Group Forum) and PPEISG (Patient & Public Engagement & Involvement Steering Group) to discuss health topics and gain insight from service users. The groups are able to offer valuable input into discussions about planned commissioning intentions, service changes or new initiatives ensuring patient experience is at the forefront of service design and delivery.

The changes

2.17 The changes that will commence delivery through the BCF for 2016/17 include;

2.17.1 **Locality model.** The initiation of a 'Locality' approach where the locality is the central place that integrated health and social care interventions are co-ordinated which will represent a shift away from hospital into the community. Each locality will utilise existing (or new) NHS or Council estate to provide a complex care service for a risk stratified cohort of patients and their carers. The Locality approach will be aligned to the provision of both social care and primary care services working in a Multi-Disciplinary Team (MDT) environment.

2.17.2 **Complex Care.** Through risk stratification we will identify a cohort of patients with complex care needs. Once identified we will design a service that co-ordinates their care needs and provides a holistic health and social care plan. This will reduce demand on primary care, presentations at A&E and increase the support available for carers.

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

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

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

2.17.6 **Data Sharing.** We are the first system nationally to receive approval from the Secretary of State for Health for its application to amend section 251 of the Health and Social Care Act. This amendment is enabling us to share data across health and social care for the purposes of commissioning and risk stratification. We began implementing the technology required to enable data sharing in July 2015 and plan to explore further the opportunities we are now presented with following extensive testing and refining.

Future opportunities for BCF

2.18 The partners of Southend BCF have identified an opportunity to enhance and develop the BCF plan. Discussions are taking place to integrate childrens health commissioning within the Council function, on the basis that the Council could then deliver integrated services and potential savings. This proposal is aligned with a jointly held and shared holistic view of children's services, and particularly aligns itself with the work being undertaken through A Better Start, a BIG Lottery funded programme working to enhance universal preventative services for Early Years and Early Years Public Health, to improve the life chances of Southend's children.

2.19 Realistically implementation would take a minimum of 6 months given the need for consultation and full transparent due diligence to be undertaken into the finances and contractual / mandated commitments. Inevitably savings would take time to flow given the need to re-commission the services so the proposal is being aligned towards our integrated planning for 2017/18 and beyond.

Evidence base supporting the case for change

2.20 Data and information derived from the Director of Public Health for Southend's Annual Public Health Report, the latest Southend Health Profile and additional sources including the Health and Wellbeing Strategy and current JSNA, cardiovascular risk profile and other sources highlight the key health and social care challenges facing the system of Southend.

2.21 Key commissioners, specifically the Council and SCCG, use CareTrack, a computer based care and support tool. CareTrack enables the partnership to undertake risk stratification of local citizens in receipt of health or social care support. Through using this tool we have been able to identify whether needs could be better met through collaborative/ integrated service delivery. As an integrated health pioneer local partners have also undertaken a number of complex mapping exercises including an epidemiological analysis of hospital attendances and admissions. This data has been used to complement the CareTrack information and identify issues and interventions where integrated service delivery would improve outcomes for local people and make service delivery more efficient and cost effective.

2.22 Through joint partnership arrangements SCCG and the Council have worked with NHS England to identify gaps and variation in primary care services. Locally, there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years. Current plans are that SCCG and Council will be enabled to co-commission primary care and community based services in new innovative ways to improve primary and secondary prevention interventions provided to vulnerable or hard to reach people who are currently accessing services in a way that is neither efficient nor cost effective.

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

2.24 The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity and alcohol have a negative impact on the health of the local population. There are also high levels of mental ill-health within Southend. This means we need to take action to address the links between the social determinates such as worklessness and mental ill-health and demand for health or social care services in specific areas of disadvantage in Southend.

2.25 We are currently undertaking a community development programme to address the impact of disadvantage and poor health outcomes in specific localities. We need to integrate local health and social care interventions better in these areas and we will use the resources of the BCF to support this through the schemes outlined.

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

2.26.1 older people (falling, social isolation)

2.26.2 people living with long term conditions (Cardiovascular disease, diabetes, respiratory disease, asthma)

2.26.3 people living with dementia

2.27 There are a number opportunities to improve the support provided to local people through more effective collaboration and integration. For example, strategic partners are currently working to develop more effective local approaches to support people living with dementia. By doing this we hope to reduce the significant gap and variation between the number of people currently diagnosed with dementia and those known to be living with the condition.

2.28 Living longer does not always mean a better life. Locally we have looked the impact of long term chronic conditions on the health of local people. currently the prevalence of LTC within Southend.

2.29 Tackling long term conditions through joining up pathways and commissioning services across health and social care that enable people to be supported to self-manage existing conditions is a key focus for local partners.

A co-ordinated and integrated plan of action for delivering change

Governance

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

Diagram 1 (Governance structure pre Feb 2016)

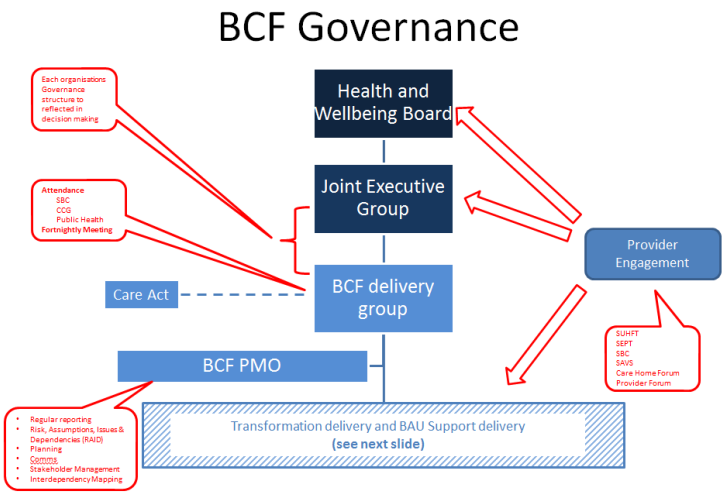
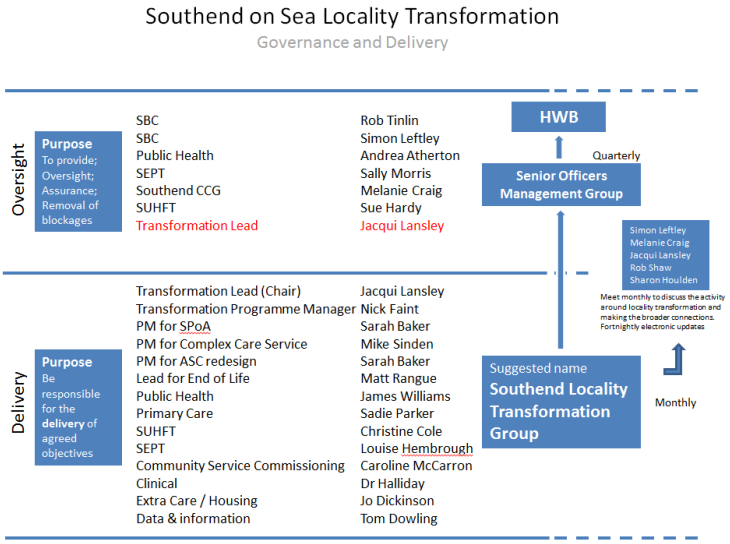


Diagram 2 (Governance structure post Feb 2016)

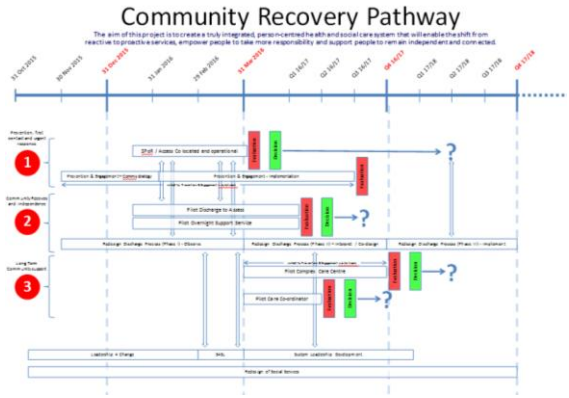


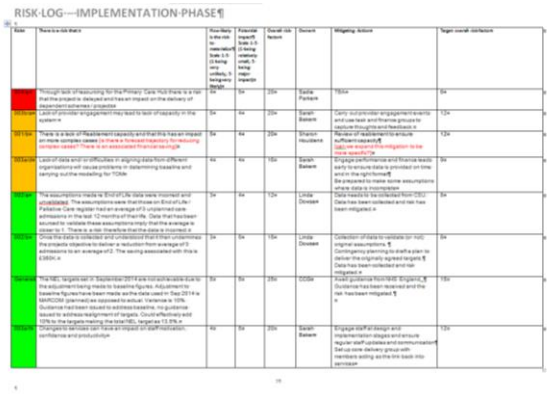
2.31 Responsible for the BCF delivery is HWB. With multi organisational representation the HWB receives regular reports from the BCF programme to assure financial and operational performance. HWB meet 5 times per annum.

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

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

2.34 A detailed BCF programme plan has been developed and a high level timeline is shown below, alongside a snapshot of the BCF risk log. Both documents are at Appendix 1 and 2.





A clear articulation of how we plan to meet each national condition

2.35 Please refer to Section 3.

An agreed approach to financial risk sharing and contingency

Risk Sharing

2.36 Section 29 of the Better Care Fund Planning Requirements for 2016/17 (Technical Guidance Annex 4) published in February 2016 outlines that where local areas have successfully delivered their agreed 2015/16 emergency admission reduction and all partners are confident that the 2016/17 BCF plan can meet its objectives they can choose to invest the full element of the risk money associated with commissioning out of hospital services upfront.

2.37 For 2015/16 and aligned with national conditions Southend BCF planned to deliver a 3.5% reduction in non elective admissions. At end of Q3 2015/16 non elective YTD admissions had reduced by 5.7%.

2.38 Aligned with section 2.37 above our HWB have decided to not pool any funding at risk and that the BCF plan would commit funding for out of hospital community services upfront.

2.39 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Subsequently, no risk sharing is planned regarding DToC.

2.40 The risk associated with Southend taking the approach outlined above is fully recognised within both the operational and governance structure of delivery. Risks are managed proactively and through the RAID log at Appendix 1.

Additional Risk

2.41 The HWB has recognised that there is significant financial challenge across both commissioners and providers. The BCF plan is aligned with SCCG's operational plan, Council budget setting and the ESR (which has the challenge of reconfiguring finances in the acute sector). Our HWB further recognise that organisations are proactively managing their respective financial circumstances and continue to monitor the risk status.

3 Narrative plan – national conditions

Plans jointly agreed

3.1 This plan, submitted on 3rd May 2016, has been signed off by the HWB. Operationally SCCG and the Council have signed off this plan.

3.2 HWB formally signed off the BCF plan on 7th April 2016.

3.3 Through the governance process outlined in Section 2 we have engaged with health and social care providers to fully understand the impact of the fund. We continue to work proactively with our providers to mitigate any negative impacts and build on positive impacts.

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

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

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

3.5.2 Secondly, with the support of our system facilitator we are conducting a gap analysis of our workforce needs which will then support the design of a transformation programme. The programme will be developed by end Q2 2016/17 with HWB taking responsibility for sign off.

Maintain provision of social service

3.6 The total amount from the BCF allocated for supporting adult social care services, and agreed locally, is £4.199M. This budget will be allocated to maintain and support the provision of social care services. This agreed approach is aligned with the BCF Policy Framework 16/17 and consistent with the DoH guidance to NHS England on the funding transfer from NHS to social care in 2013/14. Full details, which include a comparison of approach and spend, are provided in Section 4.

3.7 The total amount from the BCF allocated for supporting adult social care services has been maintained in real terms compared to 2015/16. In 2015/16 a total of £4.087M was allocated in 2016/17 a total of £4.199M has been allocated, this represents an increase of 2.7%. The increase in spend will not destabilise but help support and maintain services provided throughout 2016/17.

3.8 The Department of Health (DoH) and Local Government Association (LGA) recently published the local apportionment of the £138m set aside for Care Act Duties. The apportionment to Southend is £0.474M and this plan confirms both its identification and allocation within the BCF.

3.9 We are currently waiting for the apportionment of the carer specific funding. In the interim we have allocated £0.421M to the provision of Carers Break. Our plan is therefore aligned with BCF national conditions.

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

3.10.1 Identifying the carers who are not currently known to the Council

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

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

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

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

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

Agreement for the delivery of 7 day services

3.12 The work to introduce 7 day services commenced mid 2014 and was sponsored by an Exec Lead from SUHFT, which demonstrates provider engagement. A gap analysis and reports were produced and discussed through various governance structure (See Appendix 5). A plan to implement 7 day services was developed which focused on hospital activity and activity in the community. Please refer to Appendix 2 for a milestone / plan re activity in the community.

3.13 Through the development of community services (see section 4) we are developing a plan to provide appropriate 7 day services across the community, primary, mental health and social care.

3.14 The high level ambition of our plan is to prevent unnecessary non-elective admissions through provision of an agreed level of infrastructure across out of hospital services 7 days per week which will support the timely discharge of patients from acute physical and mental health settings, on every day of the week helping to avoid unnecessary delayed discharges.

3.15 We are currently developing a delivery plan to support the transformation to 7 day services as it is part of our wider transformation work we need to ensure it is aligned with both the ESR and our Primary Care strategy.

3.16 In April 2015 the Secretary of State for Health approved the sharing of data for the purposes of commissioning and risk stratification in Southend. Since April 2015 we have been working proactively to build on this progress.

3.17 As a system we are committed to sharing data across health and social care. Both providers and commissioners agree that data sharing across organisations is the key to making services more appropriate to individual needs and efficiency savings.

3.18 Our senior leaders sponsor the data sharing activity to ensure appropriate governance is in place and any risks and issues are appropriately scoped and mitigated.

3.19 Our health and care systems, in the majority of areas use the NHS Number as the consistent identifier for health and social care services.

3.20 SCCG and SBC are committed to adopting systems that are based upon Open APIs and Open Standards (in line with NHS contractual guidance), wherever possible, and encouraging existing suppliers to adopt Open APIs and Open Standards in future releases of software. This would be specifically addressed within the information schedules and / or the data quality improvement plans of each of the contracts with providers.

3.21 We confirm that there are appropriate Information Governance (IG) processes in place and that our agreements are in line with the revised Caldicott principles.

3.22 An agreed condition, as part of the Secretary of State approval in April 2015, was that residents and patients have clarity about how data about them is used, who has access and how they can exercise their legal rights. We undertook a detailed programme of engagement with our residents between April 2015 and July 2015 ensuring that residents were engaged with through multi channels and with various formats of communication.

3.23 In support of our data sharing work we have developed a local digital roadmap, aligned with national requirements that will support progress.

3.24 We anticipate for the steps outlined above to have a positive impact on both service users and patients.

Ensure a joint approach to assessments and care planning

3.25 Since September 2012 SCCG and the Council has commissioned a Single Point of Referral Service (SPoR), which acts as the key contact point for health care professionals both in primary care and acute discharge services, to the integrated teams which provides a multi-disciplinary response to urgent issues or needs of patients within the community who would otherwise attended A&E and experienced a 0-1 day length of stay.

3.26 At present the threshold has yet to be established with regard to the number of referrals that can be made into the service upon full implementation although the numbers of referrals have increased year on year since the commencement of the service.

Agreement on the consequential impact on providers

3.27 Southend GPs and member practices have been engaged at various levels. The GPs elected to SCCG's Governing Body and appointed to the clinical executive have been directly involved in the development of this plan, and key elements of the BCF schemes have been supported by GP colleagues working as clinical project leads (as part of our overall QIPP and Transformation Programme). In addition SCCG has appointed a GP as clinical lead for integration, who works with SCCG one day a week.

3.28 The broader membership of SCCG has been engaged through our GP members forum and kept updated through the weekly inbox bulletin. All practices have been key to shaping some of our key schemes.

3.29 The overall impact of SCCG allocations and BCF and QIPP requirements over the 2016/17 period is modelled within the operational planning submissions currently being finalised by SCCG for the 2016/17 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. SCCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Southend University Hospital NHS Foundation Trusts' financial sustainability, the ESR and the STP.

3.30 We have attended dozens of events to engage face to face with members of the public across a range of different topics and issues. In May 2015 we held our annual public event which was a great success and attended by more than 150 people.

3.31 Southend Association of Voluntary Services (SAVS) is a key member of our integration work and attends HWB.

Agreement to invest in NHS commissioned out of hospital services

3.32 Section 29 of the Better Care Fund Planning Requirements for 2016/17 (Technical Guidance Annex 4) published in February 2016 outlines that where local areas have successfully delivered their agreed 2015/16 emergency admission reduction and all partners are confident that the 2016/17 BCF plan can meet its objectives they can choose to invest the full element of the risk money associated with commissioning out of hospital services upfront.

3.33 For 2015/16 and aligned with national conditions Southend BCF planned to deliver a 3.5% reduction in non elective admissions. At end of Q3 2015/16 non elective YTD admissions had reduced by 5.7%.

3.34 Aligned with section 2.33 above our HWB have decided to not pool any funding at risk and that the BCF plan would commit funding for out of hospital community services upfront.

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

3.35 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Subsequently, no risk sharing is planned regarding DToC.

3.36 A target for DToC is in the process of being agreed. The process is led by both SCCG and the Council and engages providers who have an impact on DToC. We recognise that whilst our DToC performance is extremely good there are always areas for improvement. Subsequently, the agreed targets will support a further decrease in DToC. The agreement will be made between SCCG, the Council, Southend Hospital and our community service provider.

3.37 We are also in the process of agreeing a structure and action plan to further improve our consistent low levels of DToC in support of the targets. Details for the action plan, including issues to focus on and historic performance can be found at Appendix 6.

3.38 The plan is currently being aligned between our transformation activity and the priorities set by the System Resilience Group.

3.39 The targets will be reflected in both CCGs (Southend and neighbouring CCG) operational plans.

3.40 A discharge summit is planned for Q1 2016/17 which will consider the further development of responsibility, accountability and monitoring. The summit will also consider the high impact interventions recommended by ECIP.

4 Scheme level spending plan

Disabled Facilities Grant

4.1 Southend BCF will allocate £1.193M in capital to the Council for use under the DFG guidance.

4.2 During 2016/17 the provision of services funded under the DFG will be brought in-house within the Council. This action will be taken following the cessation of our contract with our private sector provider and the recommendation of an independent review.

4.3 The transition of private sector provider to in-house will also review the outcomes we are currently achieving with the use of the DFG with the aim of aligning the spend to influence outcomes associated with those residents with complex care needs.

Commissioning. maintaining and transforming community services

4.4 Southend BCF will allocate £6.288M in revenue to SCCG for use to commission, maintain and transform community services. A detailed draft expenditure plan is at Appendix 3.

4.5 During 2016/17 we will maintain the existing community services with our providers which will include services such as our Single Point of Referral (SPoR), tissue viability, leg ulcers, the community element of stroke services, continence, intensive dementia support and occupational therapy.

4.6 Whilst we maintain services we will develop a transformation plan which will change our existing service delivery model to a locality approach, as outlined below;

Locality approach

4.7 SCCG's approach within the BCF for 2016/17 to transforming community services for the benefit of Southend residents is through an integrated 'locality approach'. A locality will provide comprehensive integrated out of hospital care for provision, co-ordination and signposting ensuring that the shift is taken away from the hospital. This locality approach may not necessarily be a physical location but will use existing Council and health estate and provide services in a range of different ways.

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

4.9 There will be a focus on retraining the workforce to play their role in delivering whole person care that enhances self-management.

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

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

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

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

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

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

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

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

4.10.8 Reduced unplanned attendances at Accident and Emergency

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

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

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

4.10.12 Release of GP time to address other patient groups

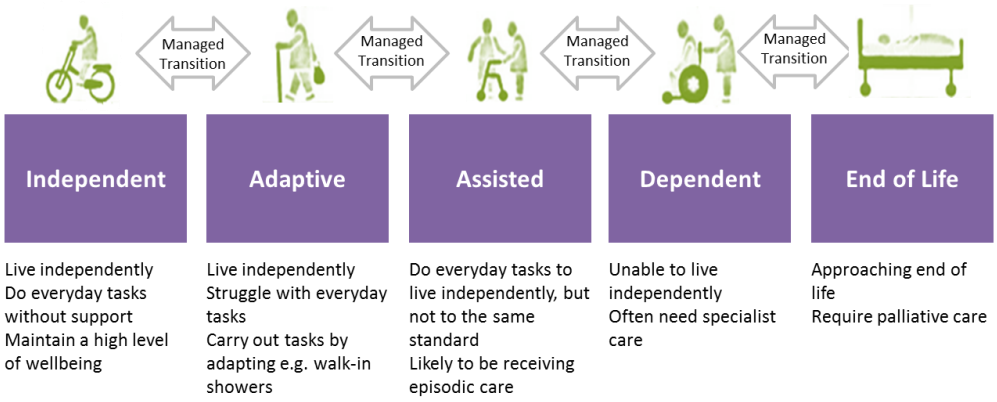
4.11 We recognise that a significant proportion of the cohort will be those with dementia and in need of dementia services. Further, we recognise the need to continually develop our dementia services. The providers are key to developing our services and through our Dementia Support Group (DSG) we have developed an action plan which has been jointly developed between commissioners and providers and is aligned to enhancing our existing services. The action plan for the DSG can be found at Appendix 7.

4.12 Our early analysis suggests that, based on resident need, location of primary care provision and the social care redesign, either three or four localities are appropriate for Southend.

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

4.14 To support the implementation of the locality approach SBC and SCCG have agreed to jointly review opportunities for SBC to invest in SCCGs 'invest to save' programme. For example Support to Care Homes, Community Geriatrician and End of Life. The identification of the schemes will form part of the initial journey which will also identify the investment required and the savings available.

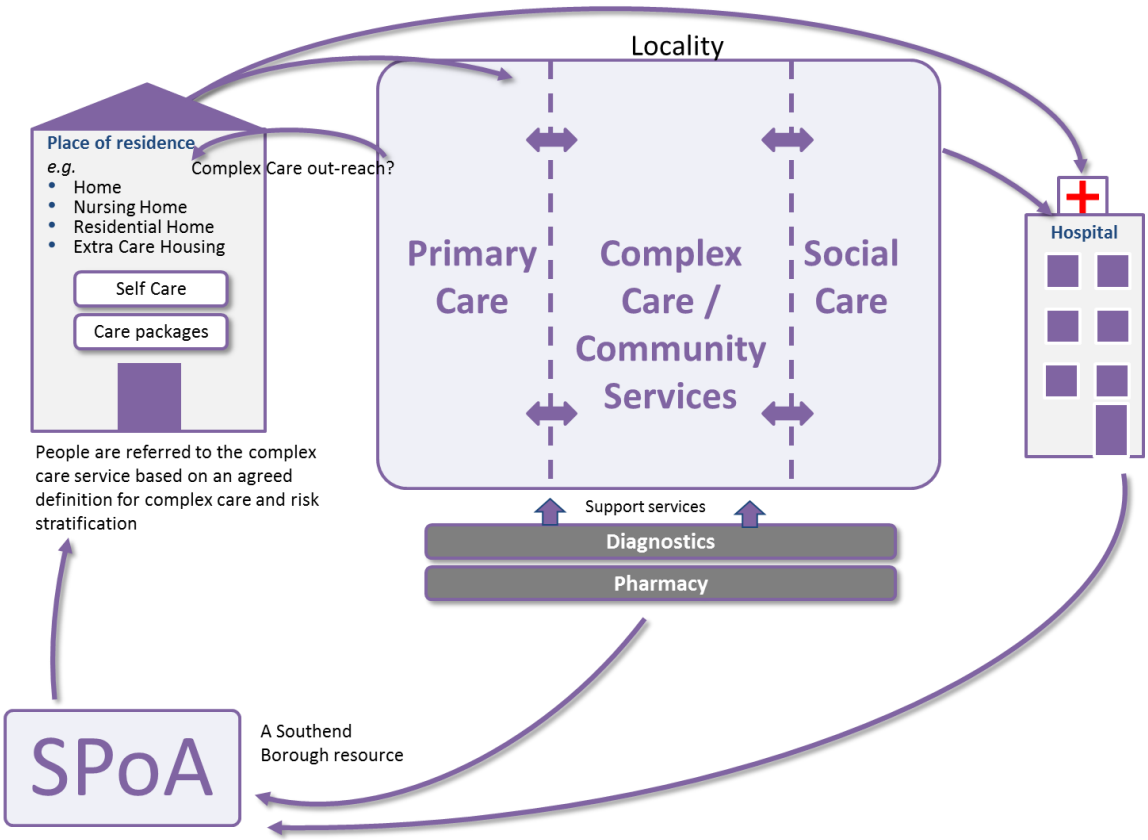
The transitional pathway



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

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

The proposed model

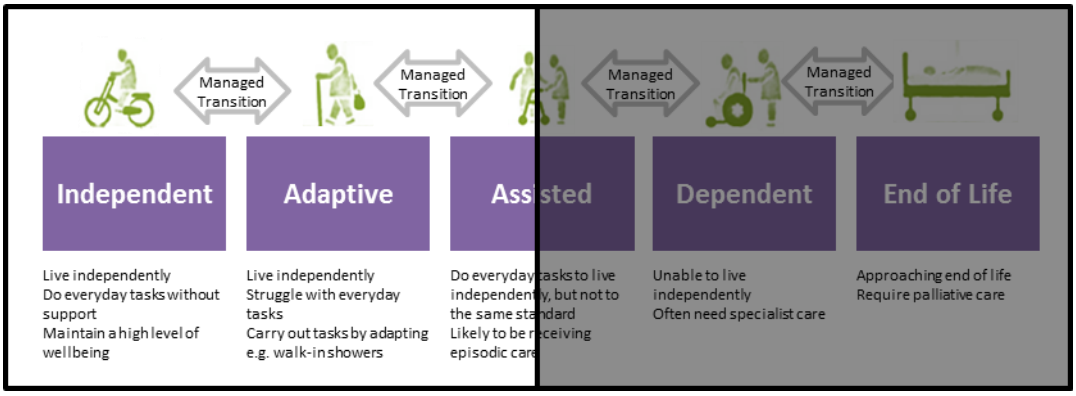


4.17 The Single Point of Access (SPoA) will be redesigned to focus on;

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

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

4.18 The SPoA will target those individuals who sit within the transitional pathway as outlined below;



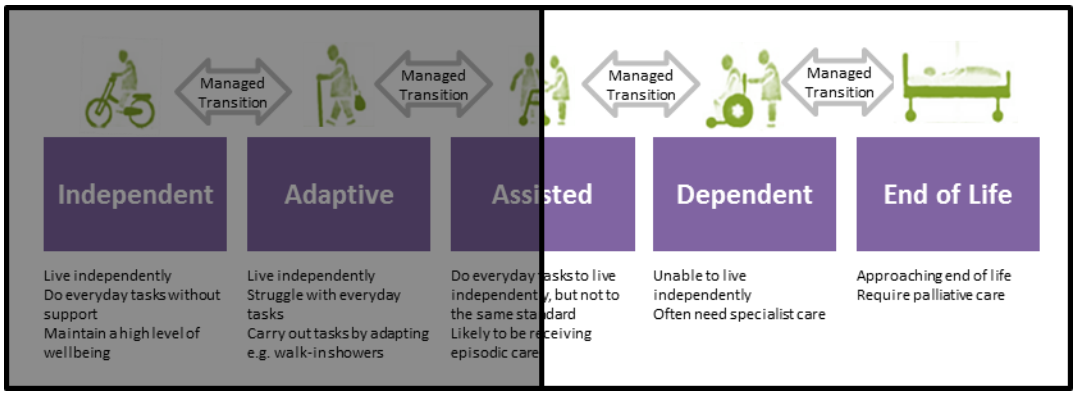
4.19 Complex Care / community services will work in an MDT environment co-locating teams of professionals which will include GPs, community nurses, care co-ordinators, therapies, social workers, pharmacists, voluntary sector, mental health practitioners, dieticians and Long Term Condition nurses, facilitated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

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

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

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

4.20 The complex care service will target those individuals who sit within the transitional pathway as outlined below;



Outcomes

4.21 The provision of community services and transformation to a locality approach will be measured through the following performance metrics;

4.21.1 non elective hospital admissions;

4.21.2 Delayed Transfers of Care;

4.21.3 reablement;

4.21.4 friends and family (in patient) test; and

4.21.5 those with a Long Term Condition feeling supported

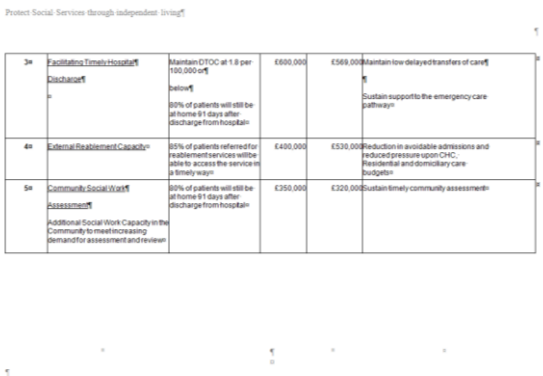
4.22 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

Provide, maintaining and redesign social care

4.23 Southend BCF will allocate £4.199M in revenue to the Council for use to provide, maintain and redesign social care. A detailed draft expenditure plan is at Appendix 4a.

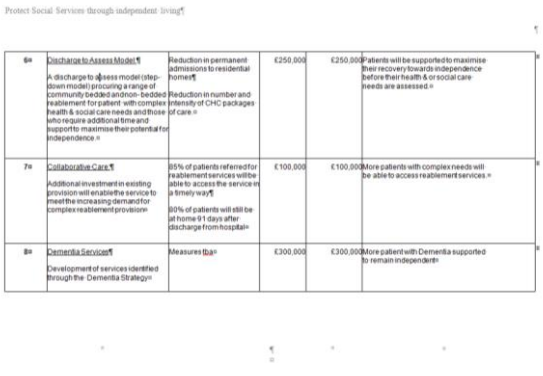
4.24 During 2016/17 we will maintain social care services which will include services such as our Single Point of Referral (SPoR), community social work assessments, a discharge to assess model, dementia services and the Falls service.

4.25 A detailed analysis has been undertaken which compares planned spend with 2015/16 and has supported a review process which aligned outcomes with spend. A snapshot of this review is available below;



Protect Social Services through independent living

3	Facilitating Timely Hospital Discharge	Maintain DTOC at 1.8 per 100,000 or below 80% of patients will still be at home 91 days after discharge from hospital	£600,000	£569,000	Maintain low delayed transfers of care Sustain support to the emergency care pathway
4	External Reablement Capacity	85% of patients referred for reablement services will be able to access the service in a timely way	£400,000	£530,000	Reduction in avoidable admissions and reduced pressure upon CHC, Residential and domiciliary care budgets
5	Community Social Work Assessment Additional Social Work Capacity in the Community to meet increasing demand for assessment and review	80% of patients will still be at home 91 days after discharge from hospital	£350,000	£320,000	Sustain timely community assessment



Protect Social Services through independent living

6	Discharge to Assess Model A discharge to assess model (step-down model) procuring a range of community bedded and non-bedded reablement for patient with complex health & social care needs and those who require additional time and support to maximise their potential for independence	Reduction in permanent admissions to residential homes Reduction in number and intensity of CHC packages of care	£250,000	£250,000	Patients will be supported to maximise their recovery towards independence before their health & or social care needs are assessed
7	Collaborative Care Additional investment in existing provision will enable the service to meet the increasing demand for complex reablement provision	85% of patients referred for reablement services will be able to access the service in a timely way 80% of patients will still be at home 91 days after discharge from hospital	£100,000	£100,000	More patients with complex needs will be able to access reablement services.
8	Dementia Services Development of services identified through the Dementia Strategy	Measures tba	£300,000	£300,000	More patient with Dementia supported to remain independent

4.26 Whilst we maintain services we will develop a plan which will redesign our existing service delivery model (as outlined below) and be aligned to the locality approach, outlined above;

Redesign of Adult Social Care (ASC)

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

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

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

4.30 Adopting a collaborative and preventative approach to our practice will minimise admissions into long term residential care, admission into hospital and minimise the need for large domiciliary care packages. Social Care will create a robust multi-disciplinary front-end adult social care team where advice, information and signposting to the wider community and universal services can minimise the long term dependency on health and social care services.

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

Outcomes

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

4.32.1 Residential care admissions;

4.32.2 Delayed Transfers of Care; and

4.32.3 Reablement.

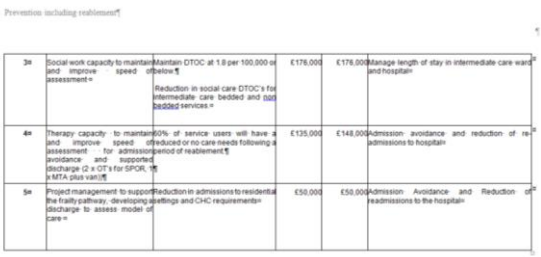
4.33 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

Reablement & Care Act

4.34 Southend BCF will allocate £1.450M in revenue to the Council for use to provide, reablement services and continue with the implementation of the Care Act. A detailed draft expenditure plan is at Appendix 4b.

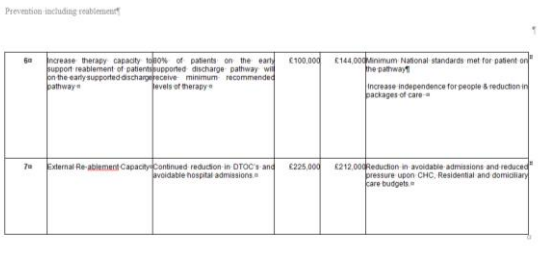
4.35 During 2016/17 we will commission reablement services which will include services such as our Single Point of Referral (SPoR), Stroke early supported discharge pathway, discharge to assess and home again services.

4.36 A detailed analysis has been undertaken which compares planned spend with 2015/16 and has supported a review process which aligned outcomes with spend. A snapshot of this review is available below;



Prevention including reablement

3	Social work capacity to maintain and improve speed of assessment	Maintain DTOC at 1.8 per 100,000 o below Reduction in social care DTOC's for intermediate care bedded and non bedded services	£176,000	£176,000	Manage length of stay in intermediate care ward and hospital
4	Therapy capacity to maintain and improve speed of assessment for admission avoidance and supported discharge (2 x OT's for SPOR, 1 x MTA plus van)	60% of service users will have a reduced or no care needs following a period of reablement	£135,000	£148,000	Admission avoidance and reduction of re-admissions to hospital
5	Project management to support the frailty pathway, developing settings and CHC requirements discharge to assess model of care	Reduction in admissions to residential	£50,000	£50,000	Admission Avoidance and Reduction of readmissions to the hospital



Prevention including reablement

6	Increase therapy capacity to support reablement of patients on the early supported discharge pathway	80% of patients on the early supported discharge pathway will receive minimum recommended levels of therapy	£100,000	£144,000	Minimum National standards met for patient on the pathway Increase independence for people & reduction in packages of care
7	External Re-ablement Capacity	Continued reduction in DTOC's and avoidable hospital admissions	£225,000	£212,000	Reduction in avoidable admissions and reduced pressure upon CHC, Residential and domiciliary care budgets

4.37 The joint evaluation of spend on reablement will achieve greater focus and/or resource on particular areas initially looking at improving effectiveness of the service and intermediate care aligned to preventing hospitalisation and institutional care and re-admissions. The exec leads for this evaluation will initially focus on the review of reablement and intermediate care needs including financial savings.

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

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

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

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

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

Outcomes

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

4.43.1 A reduction in avoidable admissions to hospital

4.43.2 Facilitate timely hospital discharges

4.43.3 Prevention and maximising independence

4.43.4 Recovery and enablement services.

4.43.5 Community rehabilitation and re-ablement.

4.43.6 Processes to minimise delayed discharge

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

5 National metrics

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

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

5.2.1 transforming community services to a locality;

5.2.2 redesigning social care;

5.2.3 discharge to Assess service;

5.2.4 overnight support service;

5.2.5 reablement services;

5.2.6 working closer with care homes;

5.2.7 engagement of a Community Geriatrician;

5.2.8 designing a co-ordination service for those with complex care needs;

5.2.9 redesigning our end of life pathway;

5.2.10 implementation of a Falls service;

5.3 We are confident that our track record of delivery (outlined below), delivery and governance structure provides the appropriate assurance that our planning for 2016/17 has been undertaken and undergone a rigorous planning process. Our BCF plan for 2015/16 has as at end Q3 2015/16;

5.3.1 delivered a reduction in non-elective admissions of 5.7%. Our target was 3.5%. Detailed analysis has been undertaken regarding our performance for 2015/16 and our success has been assigned to the commissioning of a number of services that are aligned to delivering services within the community. Our plan for 2016/17 is a continuation of our plan for 2015/16.

5.3.2 delivered a reduction in residential care admissions of 11.5%. Our target was 11.5%. Detailed analysis has been undertaken regarding our performance for 2015/16 and our success has been assigned to a revised approach to panel review, the implementation of a discharge to assess model and closer management of the discharge pathway.

5.3.3 delivered a reablement metric that shows 81.4% of those (over the age of 65) discharged from hospital are still at home 91 days after discharge. Detailed analysis has been undertaken regarding our performance for 2015/16 and our success has been assigned to closer management of the reablement services, the implementation of a discharge to assess model and closer management of the discharge pathway.

5.4 We are proud of our low levels of delayed transfers of care (DToC) in Southend, consistently achieving significantly better levels of performance than the national average. Southend achieved a DToC rate of 3.5 people for every 100k of population in 2014/15; by comparison the national rate is approx. 9 people for every 100k of population. Subsequently, no risk sharing is planned regarding DToC.

5.5 A target for DToC is in the process of being agreed. The process is led by both SCCG and the Council and engages providers who have an impact on DToC. We recognise that whilst our DToC performance is extremely good there are always areas for improvement. Subsequently, the agreed targets will support a further decrease in DToC. The agreement will be made between SCCG, the Council, Southend Hospital and our community service provider.

Development of 2016/17 targets

5.6 Reablement. The trajectory of those still at home 91 days after discharge from hospital into a reablement service has steadily improved from an historic review. Our vision is to continue this improvement and we are mindful of the challenges we face in achieving this. The target for 2016/17 demonstrates this vision and the actions we are taken and discussed in this plan acknowledge the challenge we face. For example, we have recently commissioned a Discharge 2 Assess service with the aim of easing flow through hospital and also increasing the proportion of population still at home 91 days after discharge. Service commenced mid February 2016.

5.7 Long term conditions. Our BCF plan for 2016/17 is focused on the cohort of patients with long term conditions and complex care needs, for example the locality approach. We are confident that the actions we are and plan to take will continue to increase those at home, with a long term condition, and feeling supported to manage it themselves. For example we plan to introduce a complex care co-

ordination service which will support a complex care cohort in navigating their way through our system.

5.8 Patient experience. The friends and family score of our hospital in patients is recognised as a particular challenge for our system. Through contract negotiations for 2016/17 we will be requesting an action plan from the hospital to improve the score. We have, therefore, agreed to target a maintenance of 2015/16 performance.

SOUTHEND BCF RAID LOG

Document Name	BCF RAID Log
Version	Version 9, Circulated
Date	8th March 2016
Author	Nick Faint

RAG RATING

RAG	Defn
	The risk is on track.
	The risk has a problem but action is being taken to resolve this OR a potential problem has been identified and no action may be taken at this time but it is being carefully monitored
	The risk requires remedial action to get back on track
	The risk / issue has been completely mitigated or closed

RISK LOG

Risk	There is a risk that:	How likely is the risk to materialize Scale 1-5 (1 being very unlikely, 5 being very likely)	Potential impact Scale 1-5 (1 being relatively small, 5 being major impact)	Overall risk factor	Owner	Mitigating Action	Target overall risk factor
004/e	Through lack of resourcing for the Complex Care Service there is a risk that the project is delayed and has an impact on the delivery of dependent schemes / projects	4	5	20	Caroline McCarron	TBA	6
003b/a	Lack of provider engagement may lead to lack of capacity in the system	5	4	20	Sarah Baker	Carry out provider engagement events and use task and finance groups to capture thoughts and feedback.	12
001/b	There is a lack of Reablement capacity and that this has an impact on more complex cases	5	4	20	Sharon Houlden	Review of reablement to ensure sufficient capacity	12
003a/d	Lack of data and/ or difficulties in aligning data from different organisations will cause problems in determining baseline and carrying out the modelling for service specification	4	4	16	Sarah Baker	Engage performance and finance leads early to ensure data is provided on time and in the right format Be prepared to make some assumptions where data is incomplete	9
002/aa	QIPP savings agreed for delivery of BCF 16/17 are not realised; End of Life (£TBC) Complex Care Service (£TBC)	4	4	16	Jacqui Lansley	Robust governance requiring regular reporting of QIPP savings and trajectory	
002/a	The assumptions made re End of Life data were incorrect and unvalidated. The assumptions were that those on End of Life / Palliative Care register had an average of 3 unplanned care admissions in the last 12 months of their life. Data that has been sourced to validate these assumptions imply that the average is closer to 1. There is a risk therefore that the data is incorrect.	3	4	12	Matt Rangue	Data needs to be collected from CSU. Data has been collected and risk has been mitigated.	8
002/b	Once the data is collected and understood that it then undermines the projects objective to deliver a reduction from average of 3 admissions to an average of 2. The saving associated with this is £360K.	3	5	15	Matt Rangue	Collection of data to validate (or not) original assumptions. Contingency planning to draft a plan to deliver the originally agreed targets. Data has been collected and risk mitigated.	8
General	The NEL targets set in March 2016 are not achievable, not met and therefore placing undue financial and operational pressure on the system	4	4	16	Jacqui Lansley	Targets have been agreed though an Operational planning process led by CCG. Mitigations in place to ensure early flagging of increasing risk include; • Robust and regular reporting of progress within governance structure. • Robust governance and operational delivery structure to assure implementation of locality approach and the redesign of ASC.	15

RISK LOG

003a/f	Changes to services can have an impact on staff motivation, confidence and productivity	4	5	20	Sarah Baker	Engage staff at design and implementation stages and ensure regular staff updates and communication Set up core delivery group with members acting as the link back into services	12
001/e	Providers are unable to recruit sufficient staff to meet capacity requirements	3	5	15	Sharon Houlden	Need to work proactively with providers to ensure that they are able to meet our requirements	9
003a/a	Delay in meeting project timescales may pose risks to funding, ability to deliver on new pathways and achieve agreed outcomes	5	3	15	Sarah Baker	Ensure robust governance arrangements are in place to track progress and highlight any delays and risks	10
003a/b	Lack of commitment to whole system change	5	3	15	Sarah Baker	Engage partner organisations at design and implementation stages, agree firm principles for the TOM and ensure regular communication	9
001/a	There is an increase in residential care admissions which will undermine the targets	3	5	15	Sharon Houlden	Robust placement process to ensure that the use of residential care is the last resort once all other options have been considered including step down	9
003a/e	Change in referral pathways can cause confusion in acute and community services leading to putting patients at risk	3	5	15	Sarah Baker	Engage key staff and managers at design and implementation stage and ensure regular updates and communication	9
003a/h	Lack of market engagement may lead to lack of capacity in the system and confusing over referral pathways	5	3	15	Sarah Baker	Plan and carry out market engagement events and ensure on-going communication with providers	9
003b/b	Providers are unable to increase capacity within the required timescales	3	5	15	Sarah Baker	Ensure providers are fully involved in the process and support them with the requirements to enable them to increase capacity	9
003b/c	Lack of data regarding the impact of reablement makes it difficult to determine the productivity of the service	3	4	12	Sarah Baker	Engage performance and finance leads early to ensure data is provided on time and in the right format Be prepared to make some assumptions where data is incomplete	8
001/f	Data is insufficiently robust to support data analysis and performance reporting	3	4	12	Sharon Houlden	Work is continuing to improve robustness of data and the development of an appropriate reporting framework	8
003a/c	Lack of confidence in new system leads to lower than expected referrals from GPs and staff bypassing agreed process	4	3	12	Sarah Baker	Ensure providers are fully involved in the process and understand the benefits of the new system. During transition periods ensure effective communication of capacity and timescales for change	8
001/c	Lack of staff capability and capacity to implement the scheme	2	5	10	Sharon Houlden	Supervision will be used to ensure that plans are on track in terms of capability and capacity	6
003a/g	Lack of engagement with patients and service users, their carers and families	4	2	8	Sarah Baker	Engage people and carer reference groups and Healthwatch in as early as	4

RISK LOG

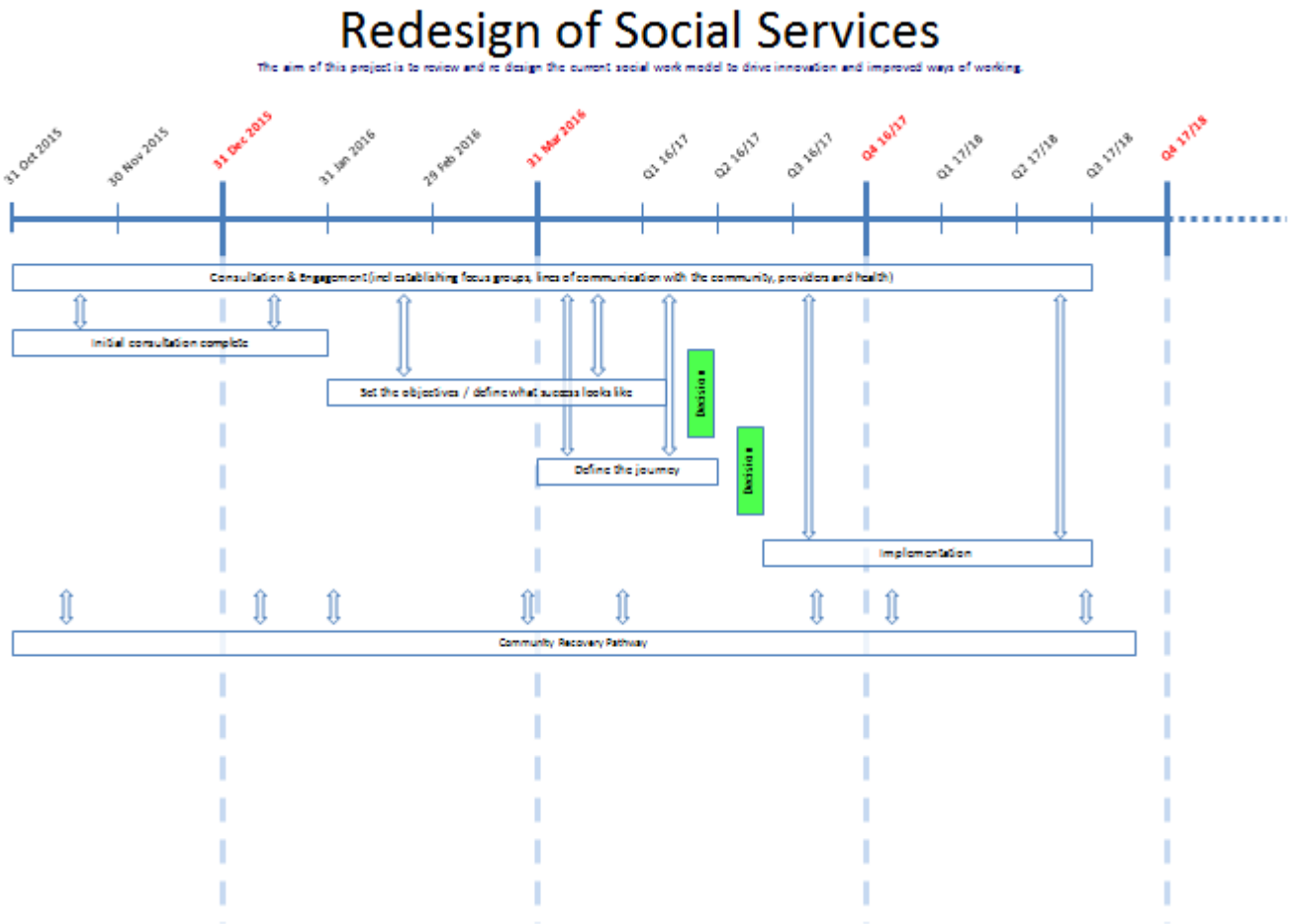
						possible Agree principles for co-design	
003b/d	Lack of service user engagement regarding reablement, preference to have things done for them	2	2	4	Sarah Baker	Engage people and carer reference groups, use SHIP and advice and information sources to promote the benefits of reablement and the positive impact on a person's wellbeing	2
001/d	Current contractual arrangements prevent required changes to support the implementation of this scheme	1	3	3	Sharon Houlden	Work with procurement colleagues to ensure that contracts changes are actioned appropriately	3
004/a	GP's may not engage or they may resist the changes	TBC	TBC		Sadie Parker	Communications with GP's to be managed sensitively and appropriately so that they understand the impact and can communicate the changes to patients. GP's to be involved in selection of an appropriate model and implementation	
004/b	Inability to use resources within the current financial year	TBC	TBC		Sadie Parker	If likely to happen, this needs to escalate in a timely manner and plans put into place	
004/c	Staff in the CCG and across partner organisations unable to commit time for the project alongside their other duties	TBC	TBC		Sadie Parker	Senior managers to ensure communication goes out highlighting this is a key Better Care Fund objective and health priority so that managers can allow the time to work on this project, and plan appropriately	
004/d	Lack of ownership of the communications and engagement plan	TBC	TBC		Sadie Parker	A decision needs to be taken about Comms and Engagement and who will lead on this Or Health Communications and Engagement to deliver specific plan for the Primary Care Hub.	

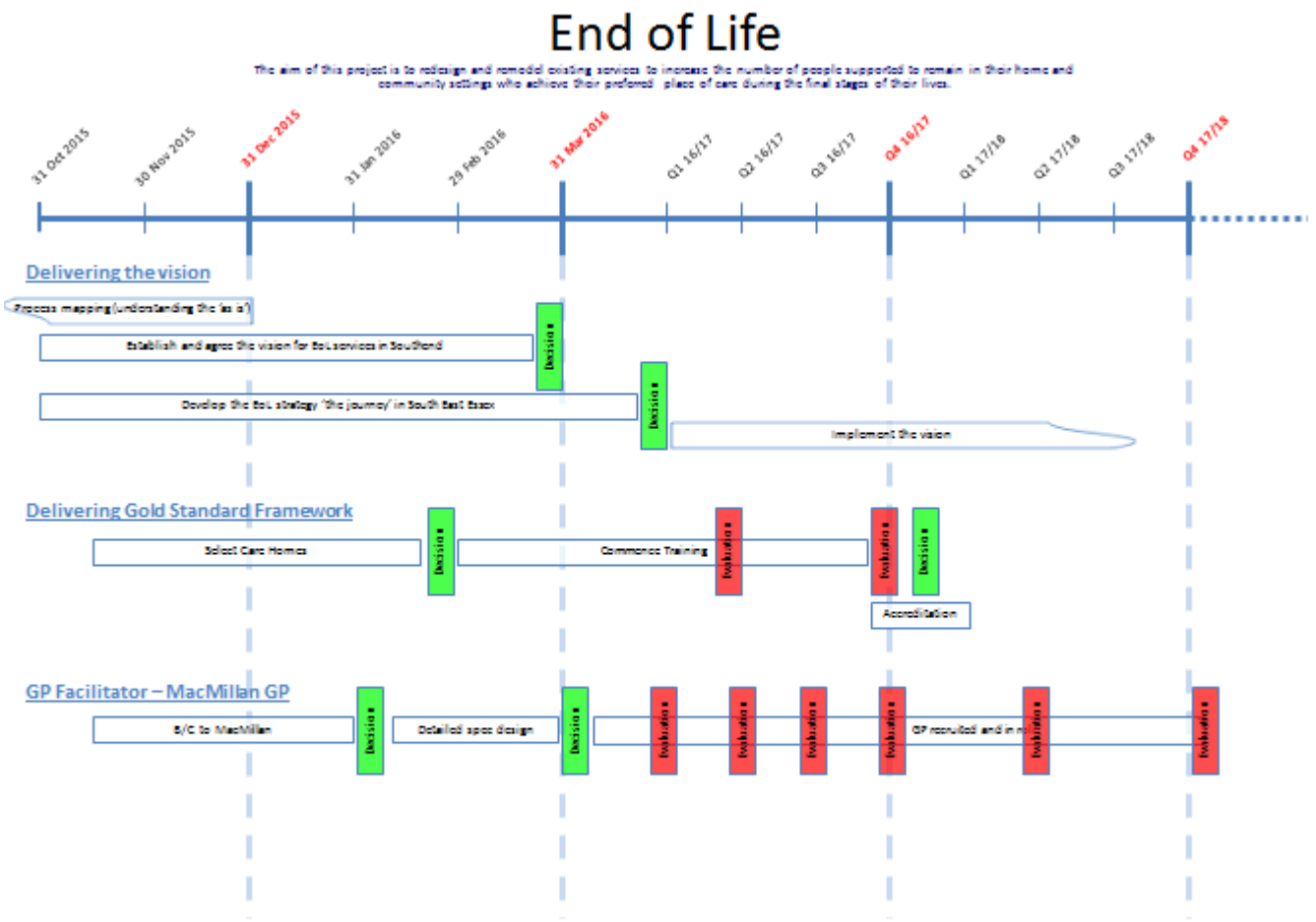
ISSUE LOG

Issue	Description	Priority (H, M, L)	Assigned to	Status (B / R / A / G)	Date to be resolved
001/a	Need to ensure that the implementation of Adult Social Care redesign supports adult social care's 2016 / 17 efficiency programme	H	Sharon Houlden		
003a/a	Lack of clarity regarding governance structure makes it difficult to define project governance	M	Prog Bd		
003a/b	Lack of clarity regarding enabling workstreams, such as IT	H	Prog Bd		
003a/c	There is significant overlap between schemes in some areas requiring some realignment and re-scoping as soon as possible	H	Prog Bd		
003b/a	IT systems are not in place to support an integrated approach	H	Prog Bd		
003b/b	A lack of clarity about how reablement aligns with the community recovery pathway could cause duplication	H	Sarah Baker		

Dependency	Title – there is a dependency ……	Date raised	Date resolved	Status (B / R / A / G)	Date to be resolved
001/a	On Scheme 001 for adult social services saving plans for 2016 / 17	Jan 2016			
001/b	On activity in scheme 001 and Care Act –	Jan 2016			
001/c	On hospital admissions being reduced through activity in Scheme 001 –	Jan 2016			
001/d	BCF schemes will have dependencies on scheme 001 – what are they?	Jan 2016			
003a/a	On 001 - This project will contribute to the successful delivery of the Protecting social services scheme.	Jan 2016			
003a/c	On 003 (reablement) - The availability of high quality Reablement support is a key enabler for this project. Without an increase in effectiveness and capacity of these services, this project will be at risk of not being able to support people to reach their maximum level of independence.	Jan 2016			
003a/d	On Care Act - This project is dependent on the following developments in particular: • Information, advice and guidance • Prevention approach/ strategy • Market shaping At the same time, the Care Act programme is dependent on the successful implementation of the fully integrated system to have the best chance at meeting the requirements under the Act.	Jan 2016			
003a/e	On 004 - This project is **highly dependent** on the complex care service. The model for the hub will provide a blueprint for alignment of resources. One of the options for community recovery and independence is to create intermediate care functions on a locality basis.	Jan 2016			

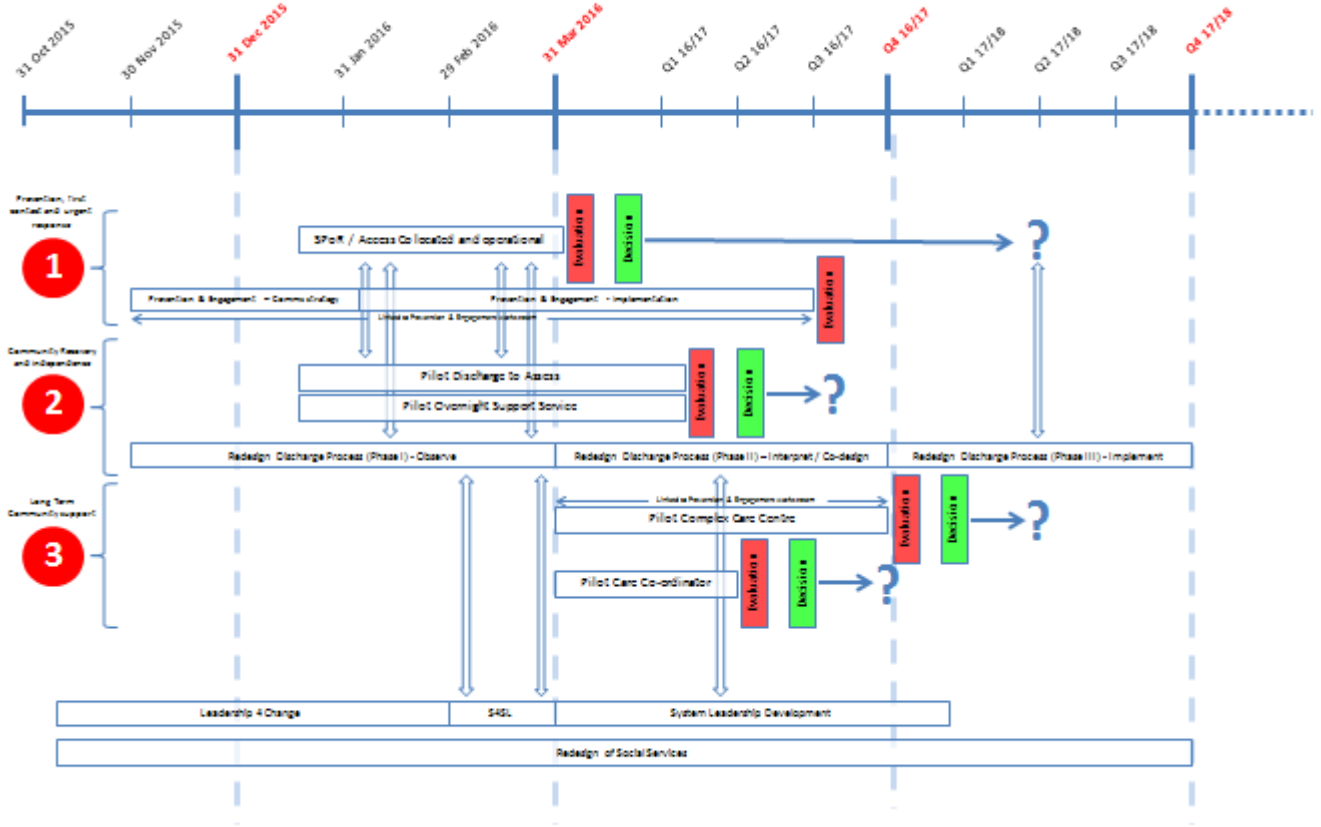
APPENDIX 2 – BCF TIMELINE




End of Life
The aim of this project is to redesign and remodel existing services to increase the number of people supported to remain in their homes and community settings who achieve their preferred place of care during the final stages of their lives.
31 Oct 2015
30 Nov 2015
31 Dec 2015
31 Jan 2016
29 Feb 2016
31 Mar 2016
Q1 16/17
Q2 16/17
Q3 16/17
Q4 16/17
Q1 17/18
Q2 17/18
Q3 17/18
Q4 17/18
Delivering the vision
Process mapping (understanding the 'as is')
Establish and agree the vision for EoL services in Southend
Develop the EoL strategy 'the journey' in South East Essex
Implement the vision
Decision
Delivering Gold Standard Framework
Select Care Homes
Commence Training
Accreditation
Publication
GP Facilitator – MacMillan GP
S/C to MacMillan
Detailed spec design
GP recruited and in

Locality Approach

The aim of this project is to create a truly integrated, person-centred health and social care system that will enable the shift from reactive to proactive services, empower people to take more responsibility and support people to remain independent and connected.



APPENDIX 3 – CCG BREAKDOWN IN COSTS

Current source of funding	Committed / Non	Services	Resources
SEPT	Committed	Integrated community teams	2,145,512
	Committed	Collaborative Care Teams	155,297
	Committed	SPOR(Health Element)	102,942
	Committed	Tissue Viability	45,604
	Committed	Leg Ulcers	97,169
	Committed	Stroke (Community Element)	148,252
	Committed	Pressure Relieving Equipment	127,157
	Committed	Continence	468,539
	Committed	Dementia Intensive Support Team	203,000
	Committed	Older People Community MH Teams(inc Assessment service)	819,456
	Committed	Older people Day Care (MH)	178,138
	Committed	Wheelchair Services	481,523
	Committed	Occupational Therapy	285,593
	Committed	Reablement Beds	563,178
SUHFT	Committed	Community Geriatricians	45,640
Carers		Carers	421,581
		Revsied Total	6,288,581
Southend CCG			6,288,581

APPENDIX 4

APPENDIX 4A PROTECT SOCIAL SERVICES

BCF Scheme	Protecting Social Care
Total Value	£4,199M

	Details	Outcome Measures	Revised Value	Estimated Impact on system
1	Maintaining Independence and Health To support the changes planned for reconfiguration Rochford hospital for section 117 patients and to facilitate move on of other long term care	Reduction in permanent admission to care homes	£334,000	Reduction in the numbers of people living in residential and nursing care.
2	Reducing length of Stay NHS employees funded by the Council to facilitate time effective discharge from the hospital	Maintain DTOC at 1.8 per 100,000 or below	£136,000	Reduction in LOS in general medical and elderly medicine wards at SUHFT

3	Facilitating Timely Hospital Discharge	Maintain DTOC at 1.8 per 100,000 or below 80% of patients will still be at home 91 days after discharge from hospital	£569,000	Maintain low delayed transfers of care Sustain support to the emergency care pathway
4	External Reablement Capacity	85% of patients referred for reablement services will be able to access the service in a timely way	£530,000	Reduction in avoidable admissions and reduced pressure upon CHC, Residential and domiciliary care budgets
5	Community Social Work Assessment Additional Social Work Capacity in the Community to meet increasing demand for assessment and review	80% of patients will still be at home 91 days after discharge from hospital	£320,000	Sustain timely community assessment
6	Discharge to Assess Model: A discharge to assess model (step-down model) procuring a range of community bedded and non- bedded reablement for patient with complex health & social care needs and those who require additional time and support to maximise their potential for independence.	Reduction in permanent admissions to residential homes Reduction in number and intensity of CHC packages of care.	£250,000	Patients will be supported to maximise their recovery towards independence before their health & or social care needs are assessed.

7	Collaborative Care: Additional investment in existing provision will enable the service to meet the increasing demand for complex reablement provision	85% of patients referred for reablement services will be able to access the service in a timely way 80% of patients will still be at home 91 days after discharge from hospital	£100,000	More patients with complex needs will be able to access reablement services.
8	Dementia Services Development of services identified through the Dementia Strategy	Measures tba	£150,000	More patient with Dementia supported to remain independent
9	Community Recovery Pathway Investment in the social care requirements of the CRP	Assisting with avoidance of unplanned admissions and appropriate discharge. Specifically to provide advice, information and reduce social isolation.	£150,000	

10	<u>Health Inequalities/Maintaining Existing Services</u> Part funding for the complex packages for individuals who wish to remain at home but due to their conditions do not trigger continuing healthcare (£245K) Funding for care provision in Century House previously funded by CCG (£100k) South East Essex Advocacy for Older People supporting them to remain at home with independence (£50K) Deprivation of Liberty Social Worker required due to the new requirements under the Mental Capacity Act (£50K) DPS broker (£35K) Daily Assessment Unit Social Worker at weekends (£10K) Review of high cost care packages (OT /social worker input) (£34K)	80% of patients will still be at home 91 days after discharge from hospital Maintain DTOC at 1.8 per 100,000 or below	£558,000	Further details on this to be agreed Part funding for the complex packages for individuals who wish to remain at home but due to their conditions do not trigger continuing healthcare (£279K) Funding for care provision in Extra Care placements (£100k) South East Essex Advocacy now funded from BCF Care Act. Deprivation of Liberty Social Worker required due to the new requirements under the Mental Capacity Act (£50K) DPS broker (£35K) Daily Assessment Unit Social Worker at weekends (£10K)
11	<u>Protecting Social Services</u>		£422,000	

12	The Falls Service The service will support provision of Falls Prevention training delivered to Health and Social Care Staff, and a Falls Prevention and Bone Health Strategy - with a focus on early screening.	Reduction in admission to hospital for fragility fractures (%TBC)	£130,000	Reduction in admissions to hospital and permanent residential placements
13	7 Day social work service in A&E pilot. The project will enhance the prevention offer through advice, guidance, routine screening, and redirection to appropriate care pathways.	Reduction in avoidable hospital admissions to hospital. (%TBC)	£60,000	Prevent unnecessary hospital admission
14	Social Care contribution to SPoA. Development of a single point of access to health and social care.	Reduction in avoidable admissions to hospital . (%TBC) Maintain DTOC at 1.8 per 100,000 or below	£70,000	Reduction in A&E attendance and admissions to hospital.
15	Hospital Discharge Pathways This scheme will improve coordinated discharge pathways for people with complex needs likely to require ongoing care.	Maintain DTOC at 1.8 per 100,000 or below	£220,000	

16	Social Care contribution to Complex Care service To pilot an enhanced proactive multidisciplinary team approach to improving pathways for patients primary care.	Reduction in attendance at A&E & avoidable hospital admissions(%TBC)	£100,000	
17	Risk Stratification This scheme focuses on bringing together health and social care information about individual patients to proactively identify those patient who may be in need of additional services	Reduction in attendance at A&E, hospital admission and permanent admission to residential settings(%TBC)	£100,000	
	Total		**£4,199,000**	

APPENDIX 4B - REABLEMENT

BCF Scheme	Reablement
Total Value	£1,450M

	Details	**Outcome measures.**	**Revised Value**	**Estimated Impact on system**
1	Maintain home Again Service to cover NHS and social care delays	60% of service users will have a reduced or no care needs following a period of reablement Maintain DTOC at 1.8 per 100,000 or below	£196,000	Reduction in re-admissions to hospital
2	Social Work Post to work across intermediate care beds supporting the development of a discharge to assessment	Reduction in admissions to residential settings and CHC requirements	£50,000	Manage length of stay in intermediate care ward
3	Social work capacity to maintain and improve speed of assessment	Maintain DTOC at 1.8 per 100,000 or below. Reduction in social care DTOC's for intermediate care bedded and non bedded services.	£176,000	Manage length of stay in intermediate care ward and hospital

4	Therapy capacity to maintain and improve speed of assessment for admission avoidance and supported discharge (2 x OT's for SPOR, 1 x MTA plus van))	60% of service users will have a reduced or no care needs following a period of reablement. 80% of patients will still be at home 91	£148,000	Admission avoidance and reduction of re-admissions to hospital
5	Project management to support the frailty pathway, developing a discharge to assess model of care	Reduction in admissions to residential settings and CHC requirements	£50,000	Admission Avoidance and Reduction of readmissions to the hospital
6	Increase therapy capacity to support reablement of patients on the early supported discharge pathway	80% of patients on the early supported discharge pathway will receive minimum recommended levels of therapy	£144,000	Minimum National standards met for patient on the pathway Increase independence for people & reduction in packages of care
7	External Re-ablement Capacity	Continued reduction in DTOC's and avoidable hospital admissions.	£212,000	Reduction in avoidable admissions and reduced pressure upon CHC, Residential and domiciliary care budgets.

8	Care Act new duties	Costs associated with funding the new duties of the Care Act Additional Carers Support £200,000 New statutory Safeguarding board £36,000 Increased South East Older People Advocacy £50,000 Additional Advocacy IMCA £50,000 Contribution towards additional Social Work staff to support implementation of new Care Act duties and carers assessments £119,000	£474,000	
	Total		**£1,450,000**	

APPENDIX 5

APPENDIX 5A – 7 DAY SERVICE REPORT

Joint Executive Group (JEG)

Title	Project: 7 day services
Sponsoring Director	Neil Rothnie Medical Director
Author	Project Manager Dominic Hall / Jan China Director EFM
Purpose	To update the JEG on progress with the national project: Seven Day Services in South East Essex.

Executive Summary

The JEG agreed in August that a gap analysis of 7 day services in and out of hospital needs to be completed. Current programmes of work will then be compared with the analysis to understand their impact on moving towards 7 day services. The JEG will then confirm the improvement priorities for the project to focus on.

This paper sets out the gap analysis work that has been completed, the remaining analysis work and the next steps in developing the detailed programme of work.

The gap analysis work that could be completed in the hospital demonstrates that improving access to diagnostic investigations is a priority in the hospital and work is underway to assess the implications of meeting the standard.

The gap analysis of 'out of hospital' services has provided a clear description of service levels. This analysis will be compared with the community improvement project work.

Further works not included in the existing assessment due to the lack of information available to support the assessment will be reviewed.

Conclusion

We need to gather more information on service availability by audit and surveys as part of a number of work streams as the data is not readily available to evidence compliance with some of the clinical standards.

Some of the Better Care Fund projects will have an impact on delivering seven day services and these will be identified using workshops, with unmet need and resource implications being clarified.

There will be gaps in resources or opportunities for service redesign and these will be identified and plans / proposals made to address them, a number of work streams will take this work forward.

It is hoped as this work develops it will integrate the outcome from the acute work streams and community workshops to support the development of 'virtual' integrated seven day services across all service areas (Acute, Community, Local Authority, Mental Health etc).

Recommendations

Following completion of the above tasks, a detailed programme of work and progress report will be submitted to the JEG for review in February 2015.

Introduction

Historically the JEG agreed this project should focus on three improvement priorities:

- Access to health and social care outside of the hospital
- 7 day services in the hospital
- Leaving the hospital after treatment to next place of care e.g. home, residential, palliative care

The JEG agreed each area (Acute and Community Services) should complete a gap analysis, following this the projects would map the out comes to initiatives, identifying current programmes of work and new works required, which potentially could support the move towards 7 day services.

1 Gap Analysis

A gap analysis had to be undertaken based on software provided by the national project. This focused initially on an assessment required from the Acute Trust and was undertaken with the Medical Director and clinical colleagues.

1.1 Acute Trust Gap Analysis

The software required a number of questions to be answered against a number of domains:

- Patient Experience
- Equality of Service Provision
- Finance / Commissioning
- Workforce
- Measurement and Outcomes

Each domain has a range of questions to be assessed and scored against a number of service levels:

- Level 0: five days a week Monday to Friday 9-5pm
- Level 1: Monday to Friday 8-8pm
- Level 2: Seven days a week but limited on a Saturday and Sunday
- Level 3: Seven days a week with departments working together
- Level 4: Integrated service 7 days a week across a whole system.
- Or Don’t Know

Compliance in the hospital with the 10 clinical standards published by NHS England was also assessed.

Some of the questions were considered complex and required more than a no / yes or don’t know answer, as the information to respond was not always available without undertaking further work or audits, e.g.: what percentage of patients receive a complex multidisciplinary assessment within 14 hours of

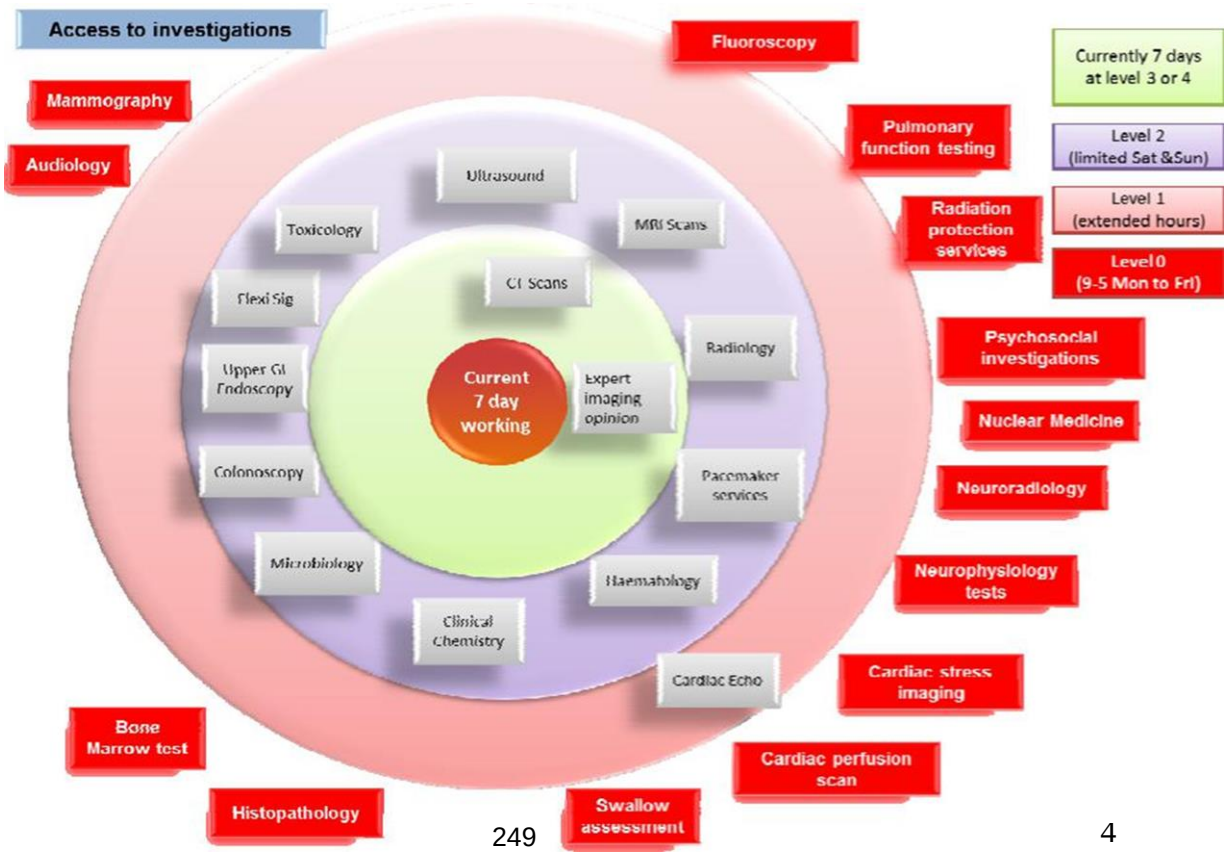
admission? Please see a summary of some of the questions against the standard in Table 1 below.

Table 1. Synopsis of issues raised against assessment standards

	Area	Description	Current status
1	Patient experience	Shared decisions and access to information occurs	Information to be collected from patient surveys
2	Time to First Consultant Review	Occurs in < 14 hours for emergency admissions	Audit process to be undertaken
3	MDT Review	Occurs in < 14 hours for emergency inpatients	Audit process to be undertaken
4	Shift Handovers	Formalised, standardised and electronic	Project and software bid from national project: "Nerve Centre"
5	Diagnostics	Scheduled 7 day access for inpatients is available	See Diagram 1 below
6	Intervention / Key services	24/7 7 days a week, consultant-directed	See Diagram 2 below
7	Mental Health	Assessed in <1 hour for emergency and <14 hours for urgent patients	Joint audit with SEPT to be organised
8	On-going review	High dependency occurs x2 per day, routine daily ward rounds 7 days a week	Audit process to be undertaken
9	Support for discharge	Available 7 days a week	See Diagram 3 below
10	Quality Improvements	Review of outcomes, learning and supervision is available	Review of current arrangements required

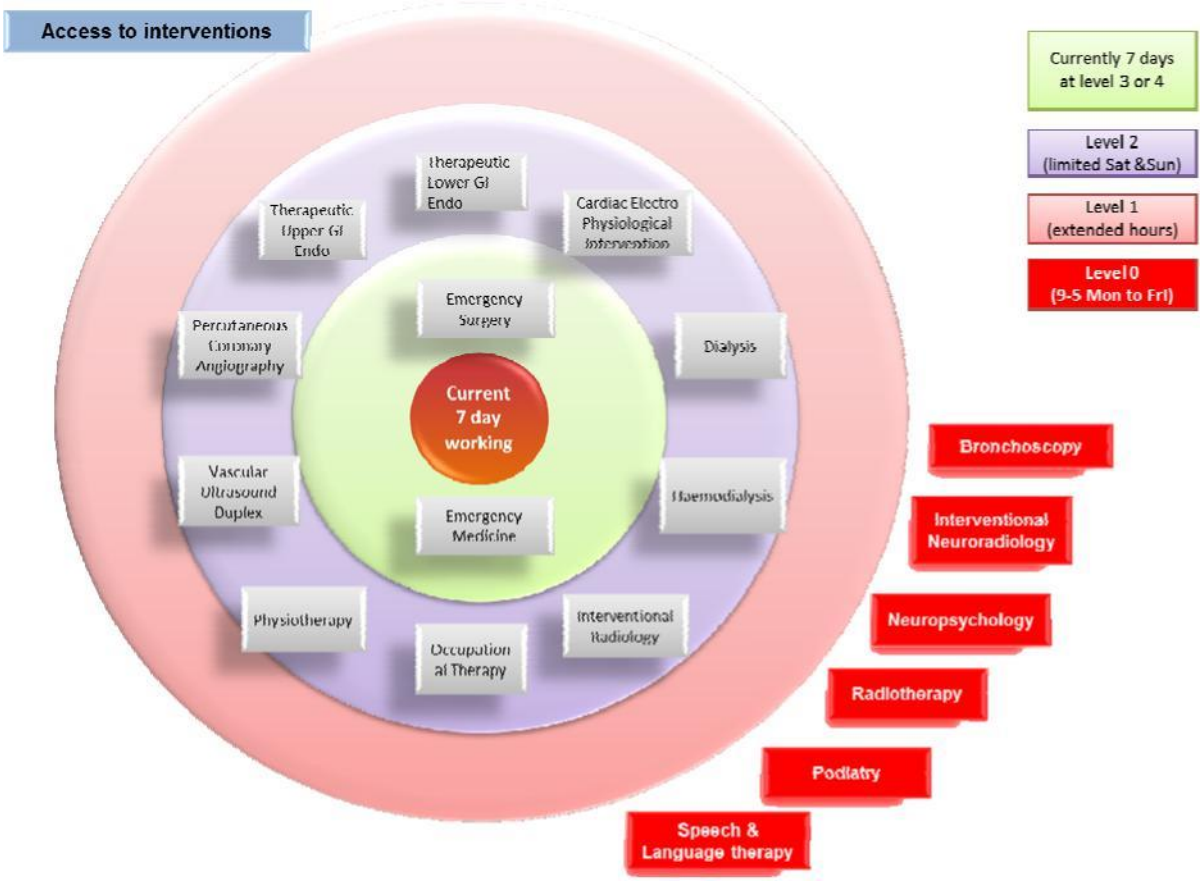
The analysis in the hospital relating to standard 5 is shown below:

Diagram 1 Standard 5 - Access to diagnostic investigations



The analysis in the hospital relating to standard 6 is shown below:

Diagram 2 Standard 6 - access to key interventions and consultant-directed services



The analysis shows that diagnostic services at weekends need to be improved. The current levels of service were discussed with clinical staff and there was broad consensus that increased services will benefit patient care. Assessment of the implications which will enable the Trust to meet the standards is commencing.

A programme of work has begun to gather missing data and to identify works/resources required to meet the defined standards.

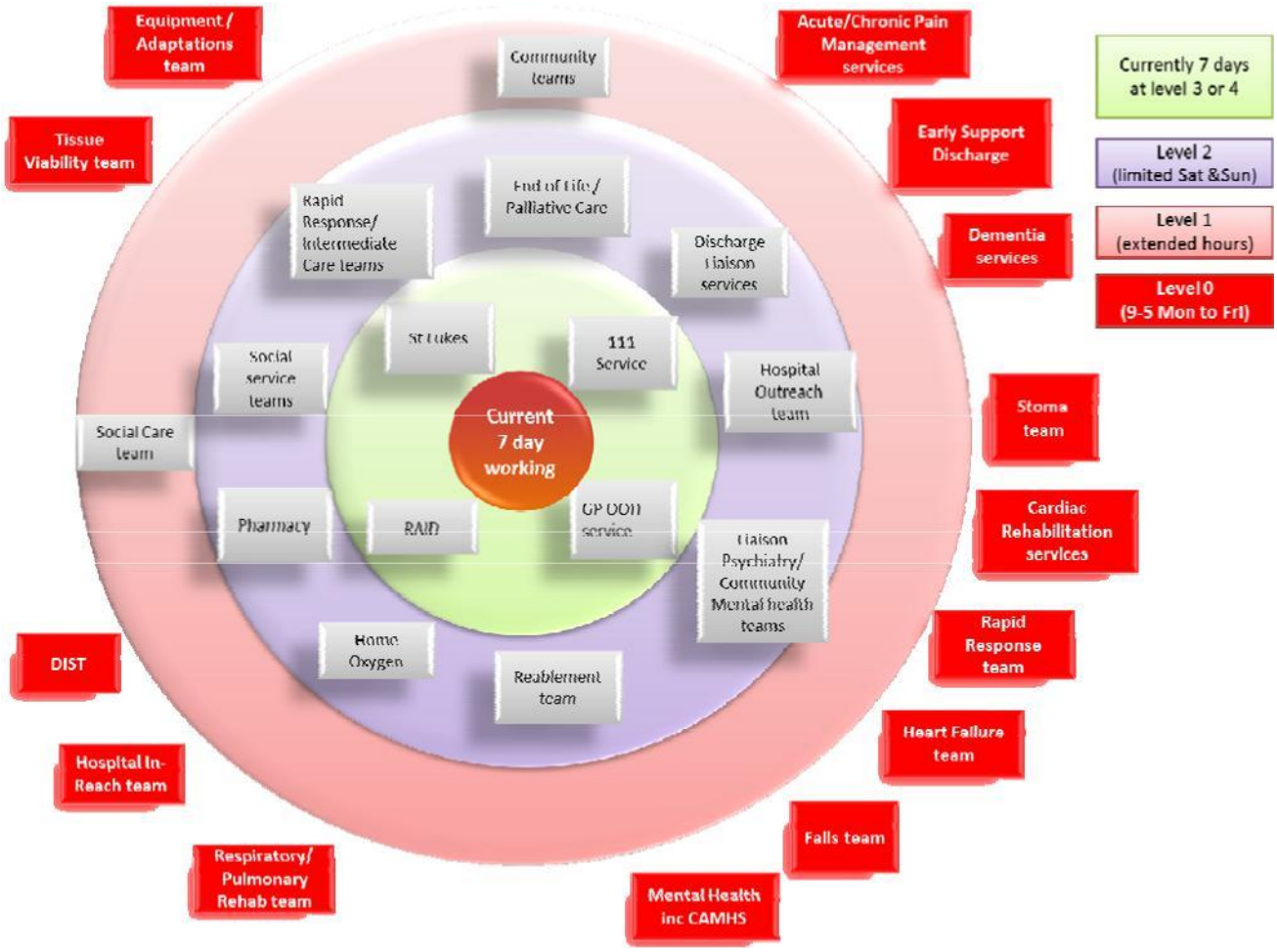
1.2 Out of hospital standards

The 7 day services Out of Hospital standards for primary and community care were released in July 2014 and are still in draft. The tool asks a range of service level availability questions and specific questions on service delivery in relation to Primary and Community Services.

Access to Health and Social care outside of hospital and support for discharge home has been assessed together due to commonality in management and provision.

Using a workshop approach the first stage review of the assessment for the gap analysis has been undertaken for the acute and community services and this is shown diagrammatically below:

Diagram 3: "Out of hospital" levels of service



2 Next steps

We will gather more information on service availability by audit and surveys as part of a number of work streams as the data is not readily available to evidence compliance with some of the clinical standards.

There will be gaps in resources or opportunities for service redesign and these will be identified and plans / proposals made to address them, a number of work streams will take this work forward.

Some of the Better Care Fund projects will have an impact on delivering seven day services and these will be identified using workshops, with unmet need and resource implications being clarified.

It is hoped as this work develops it will integrate the outcome from the acute work streams and community workshops to support the development of ‘virtual’ integrated seven day services.

Following completion of the above tasks, a detailed programme of work and progress report will be submitted to the JEG for review in February 2015.

14.7.2014

JC/DH/NR

1

APPENDIX 5B – 7 DAY SERVICES REPORT

Southend University Hospital NHS
NHS Foundation Trust

Joint Executive Group (JEG)

Title	Project: 7 day services
Sponsoring Director	Neil Rothnie Medical Director
Author	Jan China Director EFM Project Manager Caroline Baker
Purpose	To update the JEG on progress with the national project: Seven Day Services in South East Essex.

Executive Summary

The JEG in November reviewed progress on the gap analysis of 7 day services in the Acute and Primary Care services. In January 2015 further national guidance was provided on Key Performance Indicators (KPI) to be monitored against the 10 clinical standards set for Acute Trusts, these have been reviewed.

NHSIQ at short notice have requested a site visit to review progress against five of the clinical standards and they will be coming to Southend University Hospital NHS Foundation Trust on Monday 9th March 2015.

In February the Trust received a request form Public Health England to participate in a national assessment which is being piloted to identify areas where support could be provided for the 7 day project. The initial focus of this work is on standard 8 'on going consultant review' as concern was expressed by Medical Directors nationally that this is one of the more difficult standards to measure and achieve. Southend was suggested as a second pilot site as NHS IQ identified that we had completed the self-assessment tool. We have agreed to undertake this pilot.

The gap analyses of 'out of hospital' services has been completed and staff have agreed some of the resource shortfalls and actions will be completed through current projects such as the Better Care Project. The Trust needs to receive updates on this work and has now resources a new project manager to work with other organisations project managers.

Conclusion

This paper sets out the current position of the work against the 10 clinical standards and provides an action plan in the appendices.

Despite services coming under pressure during the winter period and the absence of a project manager to support this work, services have continued to drive forward audits / training and developments which will progress the delivery of the 7 day standards. Concerns remain that achieving them all will need additional resources.

Recommendations

A detailed programme of works with timescales needs to be drafted to include this project and all of the other work which will support the delivery of the 7 day standards for acute (Emergency Care Action Plan) and community services projects (Better Care Funding).
The Trust has now replaced its project manager, this resource is key to the development of a detailed programme of work which identifies all projects / service developments that will deliver 7 day working and in turn support exception reporting to the JEG.
This does however require community project managers to work towards this objective, as one project manager cannot do this in isolation.

Introduction

Each area (Acute and Community Services) completed a gap analysis against the standards set out in the national model and have now mapped out initiatives and new works required, which potentially could support the move towards the national 7 day service standards.

1. Compliance in hospital with the 10 clinical standards

The baseline assessment identified standards are only partially met for a variety of reasons. A summary of the current position and work being undertaken in the Acute Trust is described below:

1.1 Standard 1

KPI 1: Patients, and where appropriate families and carers, must be actively involved in shared decision making .This should happen consistently, seven days a week.

An assessment of this standard at weekends is currently being undertaken.

1.2 Standard 2

KPI 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 1 hour for high risk patients and 14 hours for all other patients.
KPI 3: All patients must have a National Early Warning Score (NEWS) determined on admission.

KPI 2: The standard cannot be met out of hours as consultant staff are not on duty – a system and resource issues need to be identified, this work is part of the Trusts transformation project work and forms part of the emergency care pathway. The ambulatory care model has been introduced and monitoring of the KPI 1 / 14 hour target has commenced.

KPI 3: An audit of current performance and an assessment of changes to the model of service delivery has been undertaken in the medical services which demonstrated the progress of implementing NEWS. 98% of patients had been assessed using this model over the seven day week; this is significant progress as NEWS was not used in the Trust prior to this project. The biggest discrepancy was between day and night, the Trust is now working towards implementing a hospital at night project.

Further training and work across the other specialties (e.g. Surgery) has commenced and NEWS will be part of all medical staff induction programmes in the future.

1.3 Standard 3

KPI 4: All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker, unless deemed unnecessary by the responsible consultant.

Acute and Community providers need to review further current processes for multi-disciplinary team (MDT) assessments of emergency admissions. MDT are occurring over the five day week and at weekends, the latter however is not supported by pharmacists or therapists. Concerns are also being raised about the impact of the withdrawal of resilience funds.

A second audit will now be undertaken to assess the process of MDT input over the patients stay utilising whiteboards that inform MDT assessment work.

1.4 Standard 4

KPI 5: Handovers must be led by a competent senior decision maker and take place at a designated time and place, with multi-professional participation

The Trust bid for an information hand held technology system: the Nerve Centre bid was successful. A policy for shift handover, using the Nerve centre software, will be produced and all relevant staff trained it its use. The Trust is currently piloting this model on the Acute Medical Unit.

1.5 Standard 5

KPI 6: Hospital inpatients must have scheduled seven-day access to diagnostic services

- Within 1 hour for critical patients
- Within 12 hours for urgent patients
- Within 24 hours for non-urgent patients

Audits are being undertaken to assess performance against the within 1 hour of referral target. Simple actions are being taken e.g. a review of referral guidelines and outsourcing of reporting of simple tests. The Trust will however need to look at additional resources; an example of this is the need to recruit 8 additional Radiographers and 2 radiologists.

1.6 Standard 6

KPI 7: Hospital inpatients must have timely 24 hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines.

The Trust is still completing a detailed review of the gap for specialist interventions and options to deliver this standard.

1.7 Standard 7

KPI 8: Where a mental health need is identified following an acute admission the patient must be assessed by psychiatric liaison within the appropriate timescales 24 hours a day, seven days a week:

- Within 1 hour for emergency care needs
- Within 14 hours for urgent care needs

Detailed evidence needs to be collected to assess performance against this standard. A meeting will be held with SEPT to agree an improvement strategy and method for assessing performance against the standard.

1.8 Standard 8

KPI 9: All patients on the high dependency areas must be seen and reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week,

Information is being collected from each speciality about arrangements for daily reviews 7 days a week. Audits of medical notes are being undertaken and the process to achieve this standard is being reviewed.

1.9 Standard 9

KPI 10: 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.

The assessment has identified the need to have a reablement 'Collaborative Care Team' with availability to take all care packages from hospital and to assess in the community (reablement is meant to do this but there is not enough resource availability). The Essex BC reablement service contract is to take patient within 24hrs – it is needed on the day of referral.

SPOR (Single point of referral) closes at the weekend so causes issues with putting care packages in place – as well as the option for GPs to access care over the weekend – which means more patients coming through A&E.

No real escalation plans in the community re beds, there is no plan – just 'we are full', this needs to be reviewed.

Lack of intermediate care beds – when they are full they close to admissions. KPI reporting systems need to be introduced to ensure excessive lengths of stay do does not occur and reablement teams move these patients back into the community.

Therapy / Palliative Care Support: Access to these services varies at weekends and Bank Holidays. The Trust is currently looking at how it addresses these shortfalls.

1.10 Standard 10

KPI 11: All those involved in the delivery of acute care must participate in the review of patient outcomes to drive care quality improvement.

Clinical Audit and the Trusts newly created Mortality and Morbidity group partially address this standard; a programme of quality improvements will be identified.

2.0 Out of hospital standards

The gap analyses of 'out of hospital' services has been completed and staff have agreed some of the resource shortfalls and actions will be completed through current projects such as the Better Care Fund. The Trust needs to integrate this into a programme of works and has now resources a new project manager to work with other organisations project managers.

3.0 Recommendations

A detailed programme of work with timescales needs to be drafted to include this project and all of the other projects which will support the delivery of the 7 day standards for acute (e.g. Emergency Care) and community services
(Better Care Fund).

The Trust has now replaced its project manager, this resource is key to the development of a detailed programme of work which identifies all projects that will deliver 7 day working and in turn support exception reporting to JEG. This does however require community project managers to work towards this objective, as one project manager cannot do this in isolation.

3.3.2015
JC /NR/CB

APPENDIX 6

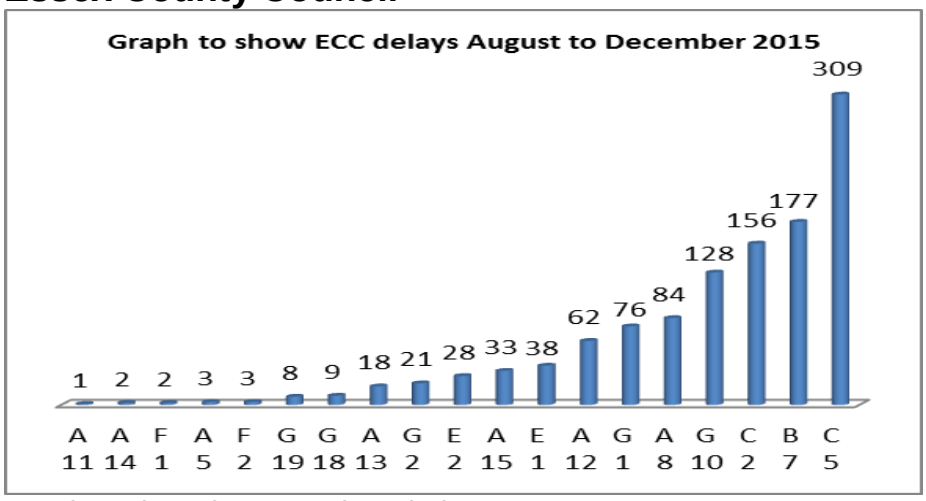
APPENDIX 6A – ACTION PLAN TRAJECTORY FOR DTOC

Action Plan trajectory to reduce system wide delayed discharges from Southend Hospital

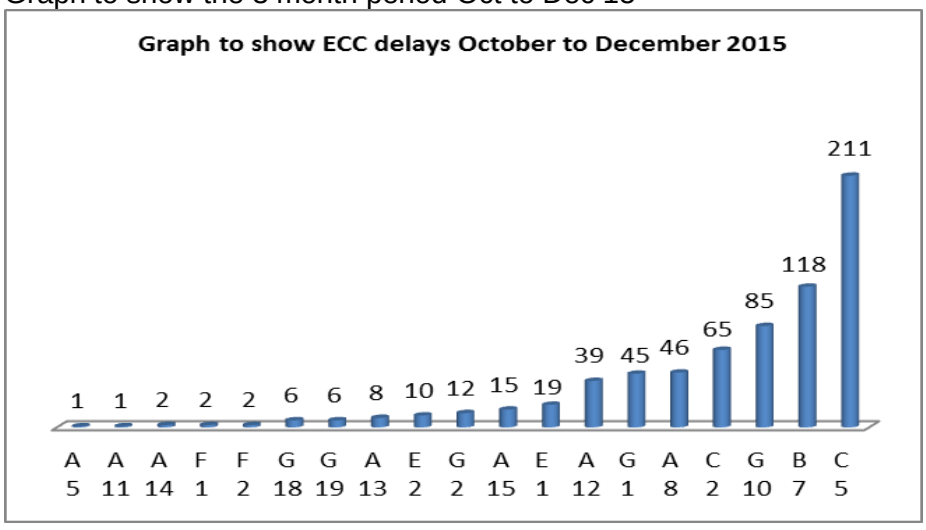
Introduction
This report is an update to the action plan trajectory to reduce DTOC.
The data in this report is based on codes applied to every bed day following the agreed Medically Fit for Discharge date. The 52 codes are published from the Department of Health (DH).
The definition of *Medically Fit for Discharge (MFD)* is also published by the DH as the date the patient no longer requires the care of a Consultant over a 24 hour period, as on-going care needs can be met in the community.

Between the dates August to December 2015, the following graphs demonstrate lowest to highest delay codes.

Essex County Council



Graph to show the 3 month period Oct to Dec 15



1. The code with the highest number of delays is C5 with 211 bed days over 3 months – this code is used to highlight delays waiting for Neurological Rehab centres across the country. There are no centres locally to Southend. As Southend is a stroke centre there is a high demand for these beds.

2. The second highest number of delays is B7 with 118 days - this code relates to the total process for arranging funding and care for all Continuing Healthcare(CHC) patients in Castle Point, Rayleigh and Rochford. Some of these delays are caused by lack of nursing home beds / care agency availability in the area.

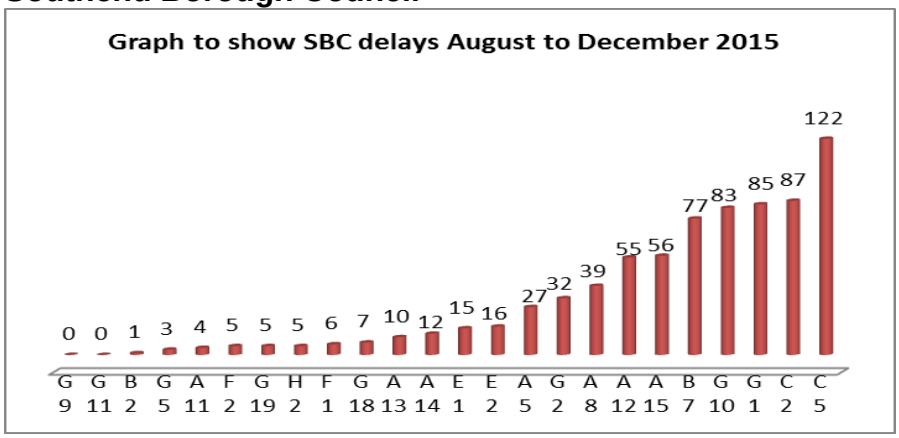
3. The third highest number of delays is G10 with 85 days. These relate to patients refusing discharge, relatives being unavailable, patients accommodation problems, joint meetings with the MDT. These are shared health and social delays that on Sitrep resort to a Health code

4. The forth highest number of delays is C2 is a code used for Intermediate Care with 65 days. There are only 10 community rehab beds in the CP&R area and insufficient Collaborative Care availability. 15 days were delayed due to CCT and 50 were Rosedale. A further 96 days were used in Stepdown beds waiting for Intermediate care – split by 66 days for CCT and 30 days for Rosedale.

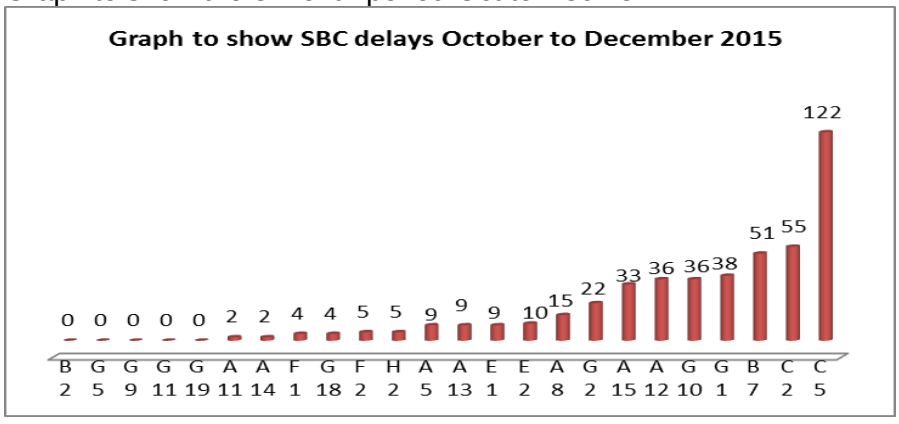
5. A8 is for Rehabilitation delays within the hospital, this accounts for 46 days over 3 months. These delays are related to waiting for home visits, the process of ordering equipment and the completion of rehab goals on Assessment of Needs referral forms.

6. The sixth highest delay is G1 with 45 days. This is an amalgamation of the codes Di1 and G1, which are both codes waiting for placement.

Southend Borough Council



Graph to show the 3 month period Oct to Dec 15



1. C5 with 122 bed days over 3 months – this code is used to highlight delays waiting for Neurological Rehab centres across the country. There are no centres locally to Southend. As Southend is a stroke centre with a HASU there is a high demand for these beds.

2. C2 is a code used for Intermediate Care, with 55 days. There are 22 community rehab beds in the Southend area and insufficient START availability. The criteria for referring to START from hospital is for stroke rehab and unstable fractures only (39 days for CICC and 15 for START). A further 35 days were used in Stepdown beds waiting for Intermediate care – split by 9 days for START and 26 days for CICC.

3. B7 (51 days) – this code relates to the total process for arranging discharge for all Continuing Healthcare patients in Southend. Some of these delays are caused by lack of nursing home beds / care agency availability in the area.

4. The forth delay is G1 with 38 days over 3 months. This is an amalgamation of the codes Di1 and G1, which are both codes waiting for placement.

5. G10 is for patient related delays and accounts for 36 days over the 3 months. These relate to patients refusing discharge, relatives being unavailable, patients accommodation problems, joint meetings with the MDT. These are shared health and social delays that on Sitrep resort to a Health code

6. The code A12 (36 days over 3 months) is the assessment period for the 24 DST's that were completed for the Southend area during this period.

Summary

Looking at whole system delays, there are some improvements that can be made to reduce delays. The action plan is attached below. The report will be updated quarterly to monitor and reflect the issues. Our stretch target for DTOC is 2.5% (NHS England) and year to date we are on track to meet this. However, for the first time in February, we are not meeting the stretch target as we are at 3.6% for that month (year to date, we are 2.6%).

There are various other delays in the system that although account for smaller numbers of delay days, still affect the patient experience. For example:

- Transport delays – In 3 months 10 days were due to Patient transport resulting in those patients staying in hospital an extra night. Meetings are in place to plan a safe and effective service.

Sandra Steeples
General Manager, Admissions & Discharge / March 2016

Action plan – looking at the top 6 reasons for DTOC

Essex County Council

Code	Issues	Action plans	Trajectory
C5 Neuro rehab beds	• Long waits due to lack of availability	1. Hospital and CCG are working on a pathway to accommodate neuro rehab patients in the local area. Timescale June 2016. Discharge To Assess beds will accommodate some of these patients. 2. ABI meetings set up from April 2016 to review pathway.	1. Local rehab pathway would reduce delays by 20 days per month (estimate)
B7 Continuing Healthcare process	• The hospital send an average of 62 Fast Tracks/DST's a month to the CHC team and there is an average of 37 days delayed a month waiting for the process from sending the assessment to discharge. • There is currently no agreement for 24 hour care at home and these discussions often result in a longer delay when families request this.	1. CHC have now agreed to fund from the date of discharge which allows the Discharge Team to find the placement etc whilst waiting for decisions to take place. 2. Hospital and CCG working towards Discharge To Assess beds which will be in place in June 2016	1. This would reduce each patients delay by 1 day bringing the delay to 2.2 days 2. Discharge To Assess will reduce the delays to 1.5 days per patient
G10 Patient delays	• Relatives often refuse local care homes offered by Social Care due to financial constraints on what can be funded due to budget control. • Patients refuse to pay for their own care. • The new Care Act suggests more time should be given for patient choice • Average of 21 days per month	1. Upfront information is given on admission regarding expectations and plans for discharge 2. Social Care to provide information on assessment on finances, expectations and timescales. 3. Discharge To Assess beds would allow planning to take place outside the hospital 4. Discharge Planning booklet has been updated to emphasise information regarding discharge planning given to patient.	1. Discharge To Assess beds would reduce delay days by 7 days per month
C2 Intermediate Care	• There were 15 days waiting for CCT and 50 days waiting for Rosedale. • There were another 96 delay days in Stepdown waiting	1. Three recent reviews of Intermediate Care services for the local population indicate the need for 72 beds across Southend and	1. Provision of 50% of the recommended capacity would reduce days in hospital by 123

	for Intermediate Care (66 for CCT and 30 for Rosedale) • There is no provision for bariatric patients • There is no provision for younger patients as the facility is in a nursing home • The contract KPI states that Rosedale must physically assess every patient before accepting which can often cause a delay	CP&R.	days, resulting in nil delays 2. This would reduce the burden on Stepdown by approx. £14000
A8 Inpatient rehab	• A large population of elderly patients in hospital results in an increase in assessments and referrals for the hospital rehab team to deal with. • Process issues in predicting discharge dates in line with rehab plans • 46 days delayed waiting for rehab assessments	1. Discharge To Assess beds would allow these rehabilitation assessments to take place outside the hospital 2. Meeting held on 02/12/15 to discuss process changes and training for rehab staff with the aim to reduce delays with rehab	1. Reduce approx. 10 days delays per month
G1 Social care placements	• 45 days waiting for social care to arrange a placement • This is partly due to lack of available placements	1. The issues have been escalated to Caroline Sharp for ECC	1. To be updated by Social Care

Action plan – looking at the top 6 reasons for DTOC

Southend Borough Council

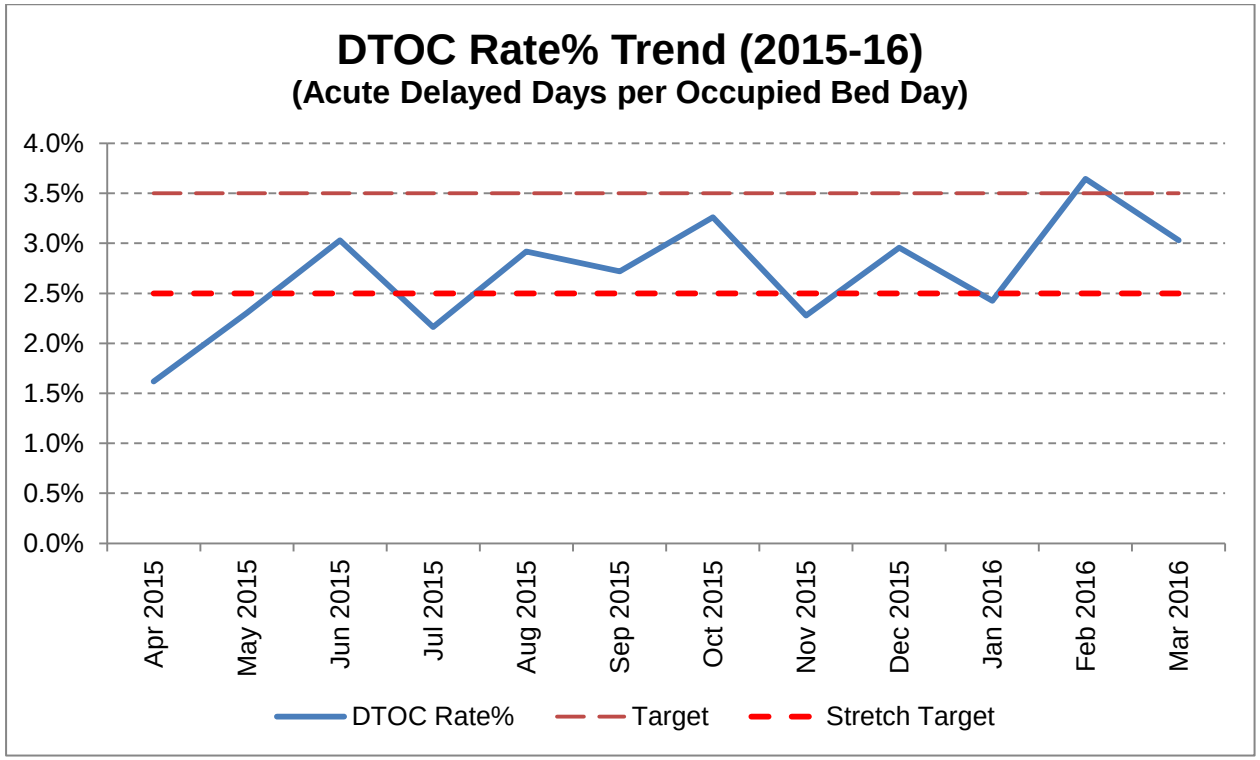
Code	Issues	Action plans	Trajectory
C5 Neuro rehab beds	• Long waits due to lack of availability • There is an average wait of 12 days per patient (this reduction from 40 days per patient is mostly due to the improvement in the patient status as they have received rehab on the ward and moved to a lower level of care	1. Hospital and CCG are working on a pathway to accommodate neuro rehab patients in the local area. Timescale April 2016	2. Local rehab pathway would reduce delays by 20 days per month (estimate)
C2 Intermediate Care	• There were 55 days waiting for Intermediate Care – 15 days waiting for START and 39 days waiting for CICC. • There were another 35 delay days in Stepdown waiting for Intermediate Care (9 for START and 26 for CICC) • There is no provision for bariatric patients • CICC have designated male and female areas which causes delays with same sex issues	1. Three recent reviews of Intermediate Care services for the local population indicate the need for 72 beds across Southend and CP&R.	1. Provision of 50% of the recommended capacity would reduce days in hospital by 123 days, resulting in nil delays 2. This would reduce the burden on Stepdown by approx. £4000
B7 Continuing Healthcare process	• The hospital send an average of 62 Fast Tracks/DST's a month to the CHC team and there is an average of 13 days delayed a month waiting for the process from sending the assessment to discharge.	1. CHC have now agreed to fund from the date of discharge which allows the Discharge Team to find the placement etc whilst waiting for decisions to take	1. This would reduce each patients delay by 1 day bringing the delay to 2.2 days 2. Discharge To Assess will reduce

	• There is currently no agreement for 24 hour care at home and these discussions often result in a longer delay when families request this.	place. 2. Hospital and CCG working towards Discharge To Assess beds which will be in place in January 2016	the delays to 1.2 days per patient
G1 Social care placements	• The DPS system is not conducive to hospital discharges as there is often a delay in waiting for homes to bid (Stepdown is used to reduce this delay and would be much higher without the use of Stepdown beds) • Average of 12 delay days per month • The DPS system is driving residential home prices up as there is no agreed declared rate for Social Care anymore	1. To remove the DPS system from the hospital	1. Action plan would reduce delays by approx. 6 days per month
G10 Patient delays	• Relatives often refuse local care homes offered by Social Care due to financial constraints on what can be funded due to budget control. • Patients refuse to pay for their own care. • The new Care Act suggests more time should be given for patient choice • Average of 12 days per month	1. Upfront information is given on admission regarding expectations and plans for discharge 2. Social Care to provide information on assessment on finances, expectations and timescales. 3. Discharge To Assess beds would allow planning to take place outside the hospital	1. Discharge To Assess beds would reduce delay days by 10 days per month
A12 CHC assessments	• 36 days were waiting for 24 DST's to be completed by the Discharge Co-ordinators, during the three month period. •	1. Discharge To Assess beds will reduce these delays, which is due to come online in June 2016.	1. Predicted to reduce by 20 days in a three month period.

APPENDIX 6B – DTOC RATE

DTOC Rate ***(Acute Helath & Social Care Delayed Days per Occupied Bed Day)***

Month	Acute Delayed Days			Occupied Bed Days		Days in Quarter	Days in Month	DTOC Rate%	Target	Stretch Target
	Health	Social Care	Total	Quarter	Month					
Apr-15	221	18	239		14,756.7		30	1.62%	3.50%	2.50%
May-15	325	26	351	44,762	15,248.6	91	31	2.30%	3.50%	2.50%
Jun-15	426	21	447		14,756.7		30	3.03%	3.50%	2.50%
Jul-15	293	16	309		14,292.7		31	2.16%	3.50%	2.50%
Aug-15	381	36	417	42,417	14,292.7	92	31	2.92%	3.50%	2.50%
Sep-15	353	23	376		13,831.6		30	2.72%	3.50%	2.50%
Oct-15	460	15	475		14,570.7		31	3.26%	3.50%	2.50%
Nov-15	316	5	321	43,242	14,100.7	92	30	2.28%	3.50%	2.50%
Dec-15	393	38	431		14,570.7		31	2.96%	3.50%	2.50%
Jan-16	344	15	359		14,810.2		31	2.42%	3.50%	2.50%
Feb-16	465	40	505	43,475	13,854.7	91	29	3.645%	3.50%	2.50%
Mar-16	415	34	449		14,810.2		31	3.03%	3.50%	2.50%
YTD	4392	287	4679	173,896	173,896	366	366	2.69%	3.50%	2.50%


DTOC Rate% Trend (2015-16)
(Acute Delayed Days per Occupied Bed Day)
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
DTOC Rate%
Target
Stretch Target

South East Essex DToC Delivery Plan v0.1 draft				Version 1.0 13.4.16	

RAG Rating Progress	RAG Rating Impact	RAG
Not on track/slipped or not started	Little or no positive changes / KPI no achieved	RED
Action partially implemented	Likely to achieve desired outcome / KPIs	AMBER
Action on track	On track to achieve desired outcome / KPIs	GREEN
Action fully implemented	All KPIs fully met with strong evidence that shows positive impact	BLUE

System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex	Reduce C5 Neuro Rehab Delayed Transfer Breaches			1.1										
				1.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Southend	Reduce C5 Neuro Rehab Delayed Transfer Breaches			2.1										
				2.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex	Reduce B7 Continuing Healthcare Delayed Transfer Breaches	Tricia Dorsi	Matt Gillam	3.1										
				3.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Southend	Reduce B7 Continuing Healthcare Delayed Transfer Breaches	Matt Rangue	tbc	4.1										
				4.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex & Southend	Reduce C2 Intermediate Care Delayed Transfer Breaches	Louise Hembrough	Caroline Hanna	5.1										
				5.2										

System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex & Southend	Reduce G10 Acute Patient & Family Decision Delayed Transfer Breaches	Jon Findlay	Sandra Steeples	6.1										
				6.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex & Southend	Reduce A8 Rehabilitation Delayed Transfer Breaches	Jon Findlay	Noreen Buckley	7.1										
				7.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Southend	Reduce G1 Social Care Placements Delayed Transfer Breaches	Sharon Houlden	Paul Mavin	8.1										
				8.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex	Reduce G1 Social Care Placements Delayed Transfer Breaches	Katherine Willmette	Caroline Sharp	9.1										
				9.2										
System / Organisation	DToC Definition	Exec Lead	Sub-Project Lead	Ref	Actions Required	Impact on DToC Trajectory	RAG Rating Progress	RAG Rating Impact	Planned Completion Date	Actual Completion Date	Revised Completion Date	% Complete	Any constraints/ interdependencies	Comments
Essex & Southend	Reduce A12 DST Assessment Delayed Transfer Breaches	Jon Findlay	Sandra Steeples	10.1										
				10.2										

APPENDIX 7 – ACTION PLAN FINAL

	Preventing Well Work Stream	Objective	Lead	T&F Group	Timescale
1	Raise awareness of dementia information and support to include developing the engagement of general practice **(same work stream as action point 7)**	Engage with primary care and community groups to ensure prevention and diagnostic information is readily available to the public. To include cultural risk factors. Map dementia journey to ensure information is available at the right place, in the right format and at the right time.	Nevada Shaw	Nancy Smith, SUHFT, Southend Carers Alzheimer's Society, Get Healthy; Peaceful Place; Mind (Reason project); Emma Mills; Jackie Smith; Andrea Bann and GP Rep (Dr Syed?)	April 16- March 17
2	Raise awareness of lifestyle factors (vascular dementia)	Health checks for the over 65's to 74's to reinforce dementia risk and raise awareness of lifestyle support. Promote PHE 'One You' campaign to raise awareness of life style factors for those aged between 40-60 yrs. Use the Dementia Intelligence Network (DIN) to understand level of risk in local population and respond accordingly.	Lee Watson	Get Healthy, Active Life , Pearl Ray , Mind Reason Project , Nancy Smith; CCG Rep and GP Rep	April 16- March 17

3 269	Promoting mental health and well being **(same work stream as action point 12)**	Raise awareness of the importance of positive mental health and the impact of psychosocial issues for example, loneliness/isolation, depression and MCI, and midlife approaches to delay and to prevent the onset of dementia in later life. Increase access to psychological therapies through IAPT Raise the profile of dementia, reduce stigma and create opportunities for social contact through open and honest conversations; the Dementia Friends initiative and cognitive stimulation. Promoting Netparks 'Generating Lasting Legacies', peer support, including BAME and Schools.	Jo Dickinson	Frances Stevens, Nevada Shaw, Shidaa Adjn- Tettey, Emma Mills, Southend Carers, Alzheimer's Society and Peaceful Place	April 16- March 17.

	Diagnosing Well **Work Stream**	**Objective**	**Lead**	**T&F Group**	**Timescale**
4	Re-model pathway from pre-diagnosis through to post diagnosis including referral point and assessment. Ensure no one waits more than 6 weeks for an initial assessment following GP referral. **(same work stream as action point 5 and 6)**	Work with local partners and stakeholders to develop an integrated pathway encompassing community health and support services including memory services, specialist acute and community nursing, older people's mental health, advocacy and carers support. Ensure pathway is accessible, timely and culturally sensitive. Include people with delirium on the pathway. Crisis response integrated into the pathway.	Dr Garcia (Hugh Johnston and Jo Dickinson)	Jackie Smith, Spencer Dinnage, Nancy Smith, new CNS, Carer's Forum, Dr Reddy, Alzheimer's Society, Peaceful Place, Jo Dickinson, Hugh Johnston, Andrea Bann, SEPT and Kylie Locke	April 16- March 17.
5	Diagnosis – support for people with dementia and carers at point of diagnosis **(same work stream as action point 4 and 6)**	One register in Southend for all dementia diagnoses. Support to consider End of Life plan and advanced decisions which align to religious & cultural beliefs Information and/or contact point for people with dementia & carer (for example dementia personal assistants?), 6 month medication reviews in GP Surgery, specialist care, access to other treatment (ie; psychosocial interventions). Explore the possibilities of one electronic recording system	Dr Garcia (Hugh Johnston and Jo Dickinson)	Jackie Smith, Spencer Dinnage, Nancy Smith, new CNS, Carer's Forum, Dr Reddy, Alzheimer's Society, Peaceful Place, Jo Dickinson, Hugh Johnston, Andrea Bann, SEPT and Kylie Locke	April 16- March 17.

6	Post Diagnosis **(same work stream as action point as 4 and 5)**	Primary care support, understand what's in the community and how to get GP practices to use information available/GPs to give continuity of care and personalised care plans. Carer support, consulting Validation techniques and training Provide information in training forums so trainees know where to signpost people to Information packs and contact numbers for support	Dr Garcia (Hugh Johnston and Jo Dickinson)	Jackie Smith, Spencer Dinnage, Nancy Smith, new CNS, Carer's Forum, Dr Reddy, Alzheimer's Society, Peaceful Place, Jo Dickinson, Hugh Johnston, Andrea Bann, SEPT and Kylie Locke	April 16- March 17.

	Living Well **Work Stream**	**Objective**	**Lead**	**T&F Group**	**Timescale**
7	Information, Provision & Awareness and advocacy **(same work stream as action point 1)**	Develop and support best practice with GPs Information provision for patients and families Consistency across all the community.	Nevada Shaw	Alzheimer's society, Nancy Smith, Nevada Shaw, carers rep, SUHFT, SEPT, Peaceful Place; appropriate members of DAA/Stakeholders (ie: Airport) CCG and GP Rep	April 16- March 17.
8	Enable Southend to keep its working towards being a 'Dementia Friendly Community' status	Engage all sectors of the community to enable people with dementia to maintain their independence, relationships, and leisure activities and to feel safe in the community. Roll out a continuing programme of the Dementia Friends sessions within the community and enhance the role of dementia champions. Package DF's to business using the 3 days per year workforce volunteering model. Dementia toolkit to become a dementia friendly organisation (see results of 10 businesses pilot programme)	Nancy Smith	DAA members, including Emergency Services and Transport services plus others to help achieve the objective.	April 16- March 17.

9	Carer Support (sits across both supporting and living well) **(same work stream as action point 13)**	Information, advice and advocacy for carers and people with dementia Improved mental health information Workshops for carers Support and recognition for the caring role Support for carers beyond caring for people in their own home & care homes	Joan Brown, Dawnette Fessey	Alzheimer's society, Shidaa Adjin - Tettey, Matt Mint, Nancy Smith, Nevada Shaw	April 16- March 17
10	Develop integrated care in the community to enable people to stay in their own homes as long as possible. **(same work stream as action point as 15)**	Develop alternative offer for admission/re-admission through 'Transformation through Technology' pilot.	Ingrid Harvey	Transformation through technology working group	April 16- March 17.
11	Domiciliary Care support for people with dementia in their own homes (sits across both supporting and living well) **(same work stream as action point 14)**	Improved support and information and training / timely visits from the services	Karen Peters	Home Care Forum, CCG, Julie Thompson, Nancy Smith, Jeremy Dorne or DIST, or Michael Daley, Shirley Lough - START team	April 16- March 17
12	Promoting mental health and well being **(same work stream as action point 3)**	Raise awareness of the importance of positive mental health and the impact of psychosocial issues for example, loneliness/isolation, depression and MCI, and midlife approaches to delay and to prevent the onset of dementia in later life. Increase access to psychological therapies through IAPT	Jo Dickinson	Frances Stevens, Nevada Shaw, Shidaa, Emma Mills, Southend Carers, Alzheimer's Society and Peaceful Place	April 16- March 17

		Raise the profile of dementia, reduce stigma and create opportunities for social contact through open and honest conversations; the Dementia Friends initiative and cognitive stimulation. Promoting Netparks 'Generating Lasting Legacies', peer support, including BAME and Schools.			

	Supporting Well Work Stream	Objective	Lead	T&F Group	Timescale
13	Carer Support (sits across both supporting and living well) **(same work stream as action point 9)**	Information, advice and advocacy for carers and people with dementia Improved mental health information Workshops for carers Support and recognition for the caring role Support for carers beyond caring for people in their own home & care homes	Joan Brown, Dawnette Fessey	Alzheimer's society, Shidaa Adjin - Tettey, Matt Mint, Nancy Smith, Nevada Shaw; Peaceful Place	April 16- March 17
14	Domiciliary Care support for people with dementia in their own homes (sits across both supporting and living well) **(same work stream as action point 11)**	Improved support and information and training / timely visits from the services	Karen Peters	Home Care Forum, CCG, Julie Thompson, Nancy Smith, Jeremy Dorne or DIST, or Michael Daley, Shirley Lough - START team	April 16- March 17
15	Develop integrated care in the community to enable people to stay in their own homes as long as possible. **(same work stream as action point 10)**	Develop alternative offer for admission/re-admission through 'Transformation through Technology' pilot.	Ingrid Harvey	Transformation through technology working group	April 16- March 17
16	Encourage people to live independently for as long as possible	Explore the housing offer for the frail elderly population, including those with dementia through the outcomes of the sheltered housing review and the development of localities within the community recovery	Ingrid Harvey	Sheltered Housing review project group Community Recovery pathway steering group	April 16- March 17

		pathway.			
17	Care Home Support	Clear training pathway peer support Create links to the GP care home pilot project including EOL planning Create dementia friendly environments in care homes in Southend on Sea	Karen Peters Link to Andrea Bann	Care Home Forum, CCG, Julie Thompson, Nancy Smith, SECHA, EICA, Carers Forum, an exemplar Care Home Forum champions	April 16- March 17
18	Training	Pathway and implementation	Julie Thompson	Nancy Smith, Nevada Shaw and Michael Daley	April 16- March 17
19	Hospital care and safe, timely and appropriate discharge for people with dementia who become inpatients.	Cross reference the action plans described by Southend DSG with the Hospital dementia steering group. Dementia Support Workers supporting people with dementia/carers in hospital wards not just at point of diagnosis in Memory Assessment Service. Links to discharge care planning through the CRP discharge to assess project.	Nancy Smith	Nancy Smith to link with hospital DSG includes membership of DIST, Carers Reps, EofE Ambulance Service, hospital discharge service – note interdependence with CRP	April 16- March 17
20	Care Planning for people with dementia to maximise choice and control.	Personal budgets/care act compliant/joint health and social care planning.	Carol Cranfield	Frances Stevens, Carers Reps, CRP team?	April 16- March 17

	Dying Well Work Stream	Objective	Lead	T&F Group	Timescale
21	Empower professionals to have conversations about end of life and dying well. **(same work stream as action point as 22 and 23)**	Conversation about dying able to happen at any stage, in particular early stages by all sector professionals and encourage people to think about advance care plans (consider specific EOL dementia support worker)	Matt Mint	All service providers within dementia care and working in EOL care Alzheimer's Society SEPT / SUHFT Southend Carers	April 16- March 17
22	Access to information across organisations **(same work stream as action point as 21 and 23)**	Integrated IT system with PPC/PPD – DNAR information culturally sensitive Spiritual information and/or requests	Matt Mint	SBC / CCG / SEPT / SUHFT	April 16- March 17
23	Palliative Care **(same work stream as action point as 21 and 22)**	Ensure patients are offered the chance to go on the Palliative care support register	Matt Mint	Jackie Smith	April 16- March 17

APPENDIX 8 – SUCCESS REGIME NEWSLETTER ISSUE 1 APRIL 2016

Signed by the authorised signatory of)
THE COUNCIL OF THE BOROUGH OF)
SOUTHEND-ON-SEA)
in the presence of:)

Signed by the authorised signatory of)
NHS SOUTHEND CLINICAL)
COMMISSIONING GROUP)
in the presence of:)

This page is intentionally left blank

Bevan Brittan

Dated **31 March 2015**

SOUTHEND-ON-SEA BOROUGH COUNCIL

and

NHS SOUTHEND CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES

Fleet Place House | 2 Fleet Place | Holborn Viaduct | London EC4M 7RF
T 0870 194 1000 F 0870 194 7800

Kings Orchard | 1 Queen Street | Bristol BS2 0HQ
T 0870 194 1000 F 0870 194 1001

Interchange Place | Edmund Street | Birmingham B3 2TA
T 0870 194 1000 F 0870 194 5001

www.bevanbrittan.com

Contents

THIS AGREEMENT is made on day of 2015

PARTIES

(1) **SOUTHEND-ON-SEA BOROUGH COUNCIL** of Civic Centre, Victoria Avenue, Southend on Sea, Essex, SS2 6ER (the **"Council"**)

(2) **NHS SOUTHEND CLINICAL COMMISSIONING GROUP** of Harcourt House, 5-15 Harcourt Avenue, Southend on Sea, SS2 6HE (the "**CCG"**)

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Southend-on-Sea.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Southend-on-Sea.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose. The Partners may wish to extend the use of pooled funds to include funding streams from outside of the Better Care Fund.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future position of health and social care services through lead or joint commissioning arrangements. It is also means through which the Partners will to pool funds and align budgets as agreed between the Partners.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue and capital expenditure on the Services,

for the benefit of the population of Southend on Sea.

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments pursuant to clause 7.4

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

BCF Contribution means the Financial Contribution made by the CCG under the provision of Section 223GA(3) of the 2006 Act

Better Care Fund Requirements means any and all requirements on the CCG and Council in relation to the Better Care Fund set out in Law and guidance published by the Department of Health.

BCF guidance means such guidance in relation to the Better Care Fund as issued from time to time by the department of Health, the department of communities and local Government, NHS England or the Local Government Association either in concert or separately.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1 April 2015

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider of the delivery of an Individual Scheme under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment

Financial Contributions means the financial contributions made by each Partner to a Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Social Care Functions

Social Care Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for each Pooled Fund the Partner that will host the Pooled Fund and for each Non Pooled Fund the Partner that will host the Non Pooled Fund

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification.

Information Governance Protocol means the insert name of information governance protocol as agreed between the Partners from time to time.

Joint (Aligned) Commissioning means a mechanism by which the Partners jointly commission a Service. For the avoidance of doubt, a joint (aligned) commissioning arrangement does not involve the delegation of any functions pursuant to Section 75 of the 2006 Act.

Joint Executive Group means the Joint Executive Group responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Law means:

(a) any statute or proclamation or any delegated or subordinate legislation;

(b) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(c) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(d) any judgment of a relevant court of law which is a binding precedent in England.

Lead Commissioning Arrangements means the arrangements by which one Partner commissions Services in relation to an Individual Scheme on behalf of the other Partner in exercise of both the NHS Functions and the Council Functions.

Lead Commissioner means the Partner responsible for commissioning an Individual Service under a Scheme Specification.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month, and Monthly shall be interpreted accordingly.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

National Guidance means any and all guidance in place from time to time published by the NHS Commissioning Board in relation to the Better Care Fund.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Service Schedule

Non Pooled Fund means the budget detailing the financial contributions of the Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification

Non-Recurrent Payments means funding provided by a Partner to a Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause 8.4.

Overspend means any expenditure from a Pooled Fund in a Financial Year which exceeds the Financial Contributions for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Payment for Performance Framework means the framework set out by the Department of Health which determines the Payment for Performance Fund

Payment for Performance Fund means the value of the Payment for Performance element of the Better Care Fund as calculated in accordance with National Guidance

Payment for Performance Shortfall means the value of the Payment for Performance Fund relating to the shortfall in the Performance Target in the relevant Quarter

Performance Target means the performance target in respect of non-elective admission as set out in the Better Care Fund Plan or such other relevant performance target that may be introduced from time to time under National Conditions or by agreement of the Partners

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause 7.3.

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the relevant Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause 8.1.2.

Programme Transformation Board means the Programme Transformation Board, established by the Joint Executive Group in February 2015, to support the management of all aspects of the Better Care Fund's (BCF) work, taking day to day decisions on the running of the BCF and being responsible for ensuring the BCF delivers its objectives, manages risk and for ensuring that there is a comprehensive and effective approach for stakeholder participation and involvement.

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations mean the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other

subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause 21.

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.2.4 Mange the system of accountability and performance management in such a way as to support then overall objectives and to support the partnership.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme Specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish one or more of the following:

4.1.1 Lead Commissioning Arrangements;

4.1.2 Joint (Aligned) Commissioning

4.1.3 the establishment of one or more Pooled Funds

in relation to Individual Schemes (the "Flexibilities")

4.2 The Council may in any specific scheme delegate to the CCG and the CCG agrees to exercise, on the Council's behalf, the Social Care Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG may in any specific scheme delegate to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Social Care Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such Functions as shall be agreed from time to time by the Partners as set out in the Scheme Specifications.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners. The initial scheme specification is set out in schedule 1 part 2

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by Joint Executive Group.

6 COMMISSIONING ARRANGEMENTS

6.1 The Partners shall work in cooperation and shall endeavour to ensure that the NHS Functions and Social Care Functions are commissioned with all due skill, care and attention.

6.2 Both Partners shall work in cooperation and endeavour to ensure that the relevant Services as set out in each Scheme Specification are commissioned within each Partners Financial Contribution in respect of that particular Service in each Financial Year.

6.3 The Partners shall comply with the commissioning arrangements as set out in the relevant Scheme Specification.

6.4 Each Partner shall keep the other Partner and the Joint Executive Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund through the reporting mechanisms. .

Appointment of a Lead Commissioner

6.5 Where there are Lead Commissioning Arrangements in respect of an Individual Scheme the Lead Commissioner shall, in accordance with any further agreement set out in the Scheme particulars, :

6.5.1 exercise the NHS Functions in conjunction with the Social Care Functions as identified in the relevant Scheme Specification;

6.5.2 endeavour to ensure that the NHS Functions and the Social Care Functions are funded within the parameters of the Financial Contributions of each Partner in relation to each particular Service in each Financial Year.

6.5.3 commission Services for individuals who meet the eligibility criteria set out in the relevant Scheme Specification;

6.5.4 contract with Provider(s) for the provision of the Services on terms agreed with the other Partners;

6.5.5 comply with all relevant legal duties and guidance of both Partners in relation to the Services being commissioned;

6.5.6 where Services are commissioned using the NHS Standard Form Contract, perform the obligations of the “Commissioner” and “Co-ordinating Commissioner” with all due skill, care and attention and where Services are commissioned using any other form of contract to perform its obligations with all due skill and attention;

6.5.7 undertake performance management and contract monitoring of all Service Contracts, including where appropriate enforcement action under the contract;

6.5.8 make payment of all sums due to a Provider pursuant to the terms of any Services Contract;

6.5.9 keep the other Partner and the Joint Executive Group regularly informed of the effectiveness of the arrangements including the Better Care Fund and any Overspend or Underspend in a Pooled Fund or Non Pooled Fund;

6.5.10 the day to day operation and management of the Scheme Specification including payment arrangements with the Provider;

6.5.11 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification; and

6.5.12 ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with this Agreement.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for expenditure as set out in the Scheme Specifications.

7.2 Each Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement and the Scheme Specifications.

7.3 Subject to Clause 7.4 it is agreed that the monies held in a Pooled Fund may only be expended (by the partner to whom it is transferred or directly) on the following:

7.3.1 the Contract Price;

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 Performance Payments;

7.3.4 Grants payable out of capital contributions to the Fund

7.3.5 Approved Expenditure pursuant to clause 7.4

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of the Joint Executive Board.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities or compensating either Partner for Losses or Indirect Losses unless this is agreed by all Partners in accordance with Clause16 .

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for each of the Pooled Funds set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Pooled Fund shall have the following duties and responsibilities:

8.2.1 management of the Pooled Fund;

8.2.2 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.3 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.4 reporting to the Joint Executive Group as required by the Joint Executive Group and the relevant Scheme Specification;

8.2.5 preparing and submitting to the Joint Executive Group Quarterly reports (or more frequent reports if required by the Joint Executive Group) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Executive Group to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns; and

8.2.6 preparing and submitting reports to the Health and Wellbeing Board as may be required by it and any BCF Guidance including (without limitation) supplying Quarterly reports referred to in clause 8.2.5 above to the Health and Wellbeing Board.

8.3 In carrying out their responsibilities as provided under Clause 8.2 the Pooled Fund Manager shall have regard to the recommendations of the Joint Executive Group and shall be accountable to the Partners.

8.4 The Joint Executive Group may agree to the varying of Individual Schemes provided that any variation is for the purpose of furthering the aims and outcomes of that particular Individual Scheme.

8.5 The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

9 NON POOLED FUNDS

9.1 In the event that the partners introduce a scheme based on Non-Pooled Funds the following provisions of this clause shall apply.

9.2 Any Financial Contributions agreed to be held within a Non Pooled Fund will be notionally held in a fund established for the purpose of commissioning that Service as set out in the relevant Scheme Specification. For the avoidance of doubt, a Non Pooled Fund does not constitute a pooled fund for the purposes of Regulation 7 of the Partnership Regulations.

9.3 When introducing a Non Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

9.3.1 which Partner if any shall host the Non-Pooled Fund

9.3.2 how and when Financial Contributions shall be made to the Non-Pooled Fund.

9.4 The Host Partner will be responsible for establishing the financial and administrative support necessary to enable the effective and efficient management of the Non-Pooled Fund, meeting all required accounting and auditing obligations.

9.5 Both Partners shall ensure that Services commissioned using a Non Pooled Fund are commissioned solely in accordance with the relevant Scheme Specification.

9.6 Where there are Joint (Aligned) Commissioning arrangements, both Partners shall work in cooperation and shall endeavour to ensure that:

9.6.1 the NHS Functions funded from a Non-Pooled Fund are carried out within the CCG Financial Contribution to the Non- Pooled Fund for the relevant Service in each Financial Year; and

9.6.2 the Social Care Functions funded from a Non-Pooled Fund are carried out within the Council's Financial Contribution to the Non-Pooled Fund for the relevant Service in each Financial Year.

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to any Pooled Fund or Non-Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 The Partners shall agree any proposed contributions no later than 31 December in any year for the Financial Year following, subject always to final approval by the relevant body at the Council and CCG. Such final approval shall be provided no later than 31st March unless agreed otherwise between the Partners.

10.3 Financial Contributions will be paid as set out in the each Scheme Specification.

10.4 With the exception of Clause 13, no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Joint Executive Group minutes and recorded in the budget statement as a separate item.

11 NON FINANCIAL CONTRIBUTIONS AND STAFF

11.1 The Scheme Specification shall set out non-financial contributions of each Partner including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

11.2 Save as provided in the Scheme Specifications, no staff are expected to transfer between the council and the CCG. The Council and the CCG may implement integrated commissioning arrangements, including the making available of staff under S113 of the Local Government act 1972

11.3 Where staff are made available under s113 the provisions of the Information Governance Protocol shall apply and the Partners shall decide who shall be responsible for any vicarious liability for the staff so made available.

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Better Care Fund scheme Risk share arrangements

12.1 In relation to the schemes set out in Schedule 1 part 2, and subject to this clause the commissioner responsible for the individual schemes as set out in that part of Schedule 1 shall carry the risk of any overspend in relation to that scheme. In the event that any underspend arises in relation to any scheme, they shall be applied

12.1.1 Where the scheme is led by the CCG, firstly in respect of meeting any shortfall in the pooled fund caused by the failure to meet the emergency admissions target, and consequent non release of the Performance payment or any part of it.

12.1.2 Secondly, to be used to meet any overspend in any other scheme managed by the same Partner.

12.1.3 And finally by being released to the Partner responsible for managing the scheme which has underspent, subject always to that Partner retaining the discretion to make payments for the purpose of health and social care either within or outside the Better care schemes to the other party.

12.2 Any savings generated in services which are not commissioned as part of the Better care fund shall accrue to the partner responsible for that service.

Overspends in Pooled Fund Non BCF

12.3 Subject to Clause 12.2, the Host Partner for the relevant Pooled Fund shall manage expenditure from a Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.4 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend occurs PROVIDED THAT the only expenditure from a Pooled Fund has been in accordance with

Permitted Expenditure and it has informed the Joint Executive Group in accordance with Clause 12.5.

12.5 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Joint Executive Group is informed as soon as reasonably possible.

Schemes outside the Better care fund

12.6 Subject always to the terms agreed in any scheme specification, the following shall apply to any new schemes introduced after 1 April 2015.

12.7 Where in Joint (Aligned) Commissioning Arrangements either Partner forecasts an overspend in relation to a Partners Financial Contribution to a Non-Pooled Fund or Aligned Fund that Partner shall as soon as reasonably practicable inform the other Partner and the Joint Executive Group .

12.8 Where there is a Lead Commissioning Arrangement the Lead Commissioner is responsible for the management of the Non-Pooled Fund and Aligned Fund. The Lead Commissioner shall as soon as reasonably practicable inform the other Partner and the Joint Executive Group.

Underspend

12.9 In the event that expenditure from any Pooled Fund or Non Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners.

13 CAPITAL EXPENDITURE

13.1 Except as provided in Clause 13.2 Pooled Funds shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

13.2 The Partners agree that capital expenditure is included in Pooled Funds as set out set out in the Scheme Specification 1 and 5 of the Better care fund.

13.3 Capital assets purchased from the capital in the Better Care pooled fund shall be owned by, and be the responsibility of the Council.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the relevant Pooled Fund and shall require the appropriate person or body appointed to exercise the functions of the Audit Commission under section 28(1)(d) of the Audit Commission Act 1998, by virtue of an order made under section 49(5) of the Local Audit and Accountability Act 2014 to make arrangements to certify an annual return of those accounts under Section 28(1) of the Audit Commission Act 1998.

15.2 Both Partners shall comply with relevant local government and NHS finance and accounting obligations as required by relevant Law and/or National Guidance.

15.3 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties in relation to the body whose accounts they are responsible for auditing. . This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 Subject to Clause 16.2, and 16.3, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Joint Executive Group.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled

Funds are therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with their own policy for identifying and managing conflicts of interest.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Well Being Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Joint Executive Group to:

19.2.1 Approve commencement of new activity

19.2.2 Approve roles and responsibilities

19.2.3 Delegate assurance roles

19.2.4 Review definition documents

19.2.5 Agree scope extensions to existing activities

19.2.6 Agree addition of projects

19.2.7 Act as an escalation point for any issues that cannot be resolved at the project or work stream level

19.2.8 Monitoring and programme finances

19.2.9 Ensuring progress against significant milestones and strategic objectives

19.2.10 Approving any required changes

19.2.11 Monitoring any significant risks and issues

19.2.12 Agree communications

19.2.13 Agree project closures and benefit reports

19.2.14 Issue instructions to the Programme Transformation Board

19.3 The Joint Executive Group is based on a joint working group structure. Each member of the Joint Executive Group shall be an officer of one of the Partners or other nominating organisations and will have individual delegated responsibility from that organisation employing them to make decisions which enable the Joint Executive Group to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 Subject to clause 19.5, the terms of reference of the Joint Executive Group shall be as set out in Schedule 2.

19.5 The Partners shall review Schedule 2 and agree any amendments within 1 month of the Commencement Date.

19.6 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.7 The Joint Executive Group shall be responsible for the overall approval of the Individual Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.8 Each Services Schedule shall confirm the governance arrangements in respect of the Individual Service and how that Individual Services is reported to the Joint Executive Group and Health and Wellbeing Board.

19.9 The Joint Executive Group shall co-operate with the Pooled Fund Manager in relation to reporting requirements set out in the BCF Guidance.

20 REVIEW

20.1 The Scheme Commissioning Lead in respect of each Scheme Specification shall provide a monitoring report to the Programme Transformation Board for onward transmission to Joint Executive Group on a monthly basis and the report shall be in such form as may be specified by the Transformation project board.

20.2 Save where the Joint Executive Group agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, any Pooled Fund and Non Pooled Fund and the provision of the Services within 3 Months of the end of each Financial Year.

20.3 Subject to any variations to this process required by the Joint Executive Group , Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.4 The Partners shall within 30 Working Days of the annual review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Joint Executive Group.

20.5 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination of the obligations on the parties to maintain a Better Care Fund.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund Requirements continue to be met.

22.3 If any Partner ("Relevant Partner") fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) and/or any Individual Scheme shall be without prejudice to the Partners' rights in respect of any antecedent breach and the provisions of Clauses 12,15,16,21,22,25,26,27,28,32,33,37 and 39

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of the integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Lead Commissioner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Lead Commissioner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Lead Commissioner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Lead Commissioner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows and is within the Law the other Partner may request that the Lead Commissioner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 the Joint Executive Group shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme (as though references as to this Agreement were to that Individual Scheme).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Council's Corporate Director for People and the CCG's Accountable Officer, or any person acting in these positions, shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.2 has taken place, the Council's Chief Executive and the CCG's chair, or their nominees, shall meet in good faith as soon as possible after the relevant meeting and in any event within fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative,

governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Regulations to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Regulations. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Regulations.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol, and in so doing will ensure that the operation this Agreement complies comply with Law including (without limitation) the 1998 Act and the Better Care Fund Requirements.

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Corporate Director for People, Simon Leftley;

Tel: 01702 215000
Fax: 01702 534618
E.Mail: simonleftley@southend.gov.uk

and

29.3.2 if to the CCG, addressed to the Acting Accountable Officer, Melanie Craig:

Tel: 01702 314299
Fax: 01702 313703
E.Mail: melaniecraig@nhs.net

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or

delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of **THE COUNCIL OF THE BOROUGH OF SOUTHEND-ON-SEA** was hereunto affixed in the presence of:)

THE CORPORATE SEAL of **NHS SOUTHEND CLINICAL COMMISSIONING GROUP** was hereunto affixed in the presence of:)

SCHEDULE 1 – SCHEME SPECIFICATION

AGREED SCHEME SPECIFICATIONS

The schemes set out in appendices 1- 6 comprise the Better care fund schemes for the financial year 2015/16.these schemes shall be funded through a single pooled fund Hosted by the Council and managed as set out below

1 FINANCE

1.1 Pooled fund contributions for 2015/16:-

1.1.1 The Council :- £1,153,000 payable in twelve equal monthly instalments

1.1.2 The CCG :- £10,641,560 payable in twelve equal monthly instalments, together with £977,440, payable quarterly in arrears against the performance of the Schemes against the Payment for Performance target for Emergency admissions.

1.2 The pooled fund shall be divided into sub funds to reflect the six schemes as set out below

	Scheme	**Lead Partner**	**Amount**
BCF001	Independent Living	Council	£4,781,000
BCF002	End of Life	CCG	£3,000,000
BCF003a	Prevention including Intermediate Care	CCG	£3,051,000
BCF003b	Prevention including reablement	Council	£1,431,000
BCF004	GP Hub	CCG	£50,000
BCF005	Infrastructure to support integrated working	Council	£459,000
Total			£12,772,000

1.3 Payments from the pooled fund shall be made to each partner for their respective schemes in accordance with the table below

Partner	**Core Amount**	**Payment for Performance**	**Total**
Council	£6,671,000	-	£6,671,000
CCG	£5,123,560	£977,440	£6,101,000
Total	£11,794,560	£977,440	£12,772,000

1.4 The core amount will be paid to the Partners by 12 equal monthly instalments. The Payment for Performance will be paid to the Partners quarterly in arrears, subject always to the Payment for Performance released by the pool being no more than the Payment for Performance received by the pool under clause 1.1.2 above.

1.5 The Council shall host the pooled fund, and appoint the pooled fund manager.

1.6 The initial pooled Fund Manager shall be Ian Ambrose, Group Manager – Financial Management.

1.7 Payments from the pooled fund shall be to the lead authority for the purpose of payments due under contracts or by way of grant in accordance with the individual schemes only.

2 SCHEME DESCRIPTIONS

2.1 The scheme descriptions set out in the appendices to this schedule shall be supplemented by and read in the context of the relevant annexes to the Better care plan set out at Schedule 6

3 REPORTING

3.1 The Council and the CCG shall ensure that the individual scheme leads report back to the Programme Transformation Board, the Joint Executive Group and the Health and Wellbeing Board as required under this agreement, and any BCF Guidance, to provide accountability and transparency as to the use of the money, and the effectiveness of its use in accordance with the timetable and format to be agreed by between the Partners.

Appendix 1 - Protect Social Services through Independent Living including reducing the reliance on residential care

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The strategic objective of this scheme is to invest in services which support independent living and reduce reliance on all forms of institutional care.

1.2 The scheme is a significant contributor to increasing independence and includes key areas of social care delivery by the Council.

1.3 Southend has an ageing population; currently 18.3% of the population are aged over 65 and this is expected to double by 2020. This scheme focuses on supporting existing services to better promote independent living particularly among frail and older people.

2 AIMS AND OUTCOMES

2.1 The scheme aims to reduce permanent admissions to residential care and reduce or delay reliance on longer term social care support in line with Southend Borough Council's corporate requirements.

2.2 In particular the scheme aims to:

2.2.1 Increase in the numbers of people with dementia supported at home

2.2.2 Dementia pathway fully integrated into intermediate care pathway through Single Point of Referral (SPoR)

2.2.3 Reduction in the rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over (PHOF 2.24)

2.2.4 Reduction in the rate of emergency hospital admissions for fractured neck of femur in persons aged 65 and over (PHOF 4.14)

2.2.5 Reduction of 11.5% in the number of people aged over 65 admitted to permanent residential care.

2.2.6 To reduce the number of preventable re-admissions to hospital within 30 days of hospital readmissions (PHOF 4.11) and reduced social isolation (PHOF 1.18)

2.2.7 Reduction in non-medical admissions of people with dementia into acute hospital beds

2.2.8 Reduction in length of stay and delayed discharges from acute hospital settings

2.2.9 Increase in the health related quality of life and wellbeing for older people

3 THE ARRANGEMENTS

The Council shall be responsible for commissioning the services.

4 FUNCTIONS

4.1 The Council will be responsible for commissioning a range of local providers to provide reablement, home care, non-statutory advice and support and care home placements. The functions are all Social Care Functions.

5 SERVICES

5.1 The following services will be delivered within this scheme:

5.1.1 Maintaining hospital social work services to support early assessment and discharge. Although supporting all adults with eligible needs; this is particularly focused on the frail, elderly population and their carers. This service supports the provision of timely advice, information, guidance and assessment within the acute hospital. The service works closely with the Acute Trust

5.1.2 Maintain capacity within integrated teams and the reablement service to minimise waiting times for assessment and support. Our assessment and support teams work as part of multi-disciplinary teams centred around GP practices or clusters of practices.

5.1.3 Developing a discharge to assess model focusing on reducing admissions to residential care homes and hospital re-admission. Investment will focus on reviewing existing domiciliary care contracts to flex the provision of services.

5.1.4 Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.

5.1.5 Extending the Single Point of Referral, (SPoR) to provide a seven day assessment and therapies service. The SPOR is an integrated, multi-disciplinary assessment and reablement service and supports early hospital discharge and admission prevention. This service has been successful in ensuring that high numbers of people being discharged from hospital are offered and receive reablement. The admission prevention role is underdeveloped at weekends and our plan to extend assessment hours will help to change this. However, success in this area requires engagement with primary care which currently operates a skeleton locum service at weekends. This is being addressed through the Primary Care Strategy.

5.1.6 Dementia Extra care scheme. Extra Care Housing is an innovative alternative for older people to residential care which can help them live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle. Although we have extra care schemes in Southend none are specifically commissioned for people with dementia. This project will provide for extra care accommodation with communities of people with a range of needs of which those with dementia will be a part. The cohort of those initially targeted will predominately be those with dementia whose needs can be met in mixed level of need communities. Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve will achieve an efficiency of £200k per annum from 15/16; The project will span both health and social care and aims to demonstrate the potential for the development of extra care provision both in short term and medium to long term.

5.1.7 The investment in extra care supports a personalised, community based approach and will highlight the health and social care benefits of investing in quality housing for older people and those with a long term condition to prevent a move to institutional residential care and “reable” individuals to avoid frequent hospital readmissions

5.1.8 Telecare

It is our intention to invest in additional Telecare equipment and other technology within the scheme to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations.

Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge

doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person

5.1.9 Disabled Facilities Grant, (DFG). This funds adaptations to individuals homes to support independent living and ranges from a ramp to a complex adapted kitchen and beyond. Although we have had some success in reducing the cost of DFG work and the time taken to get the works done the Council will be exploring innovative ways to see whether there is some scope to achieve a more joined up service for both those disabled people living in the private sector and those living in Council accommodation. In addition the possibility of exploring whether there could be a new approach developed to help with hospital discharge cases where adaptations need to be done quickly

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

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The Council will commission the services

Contracting Arrangements

6.2 The Council shall enter into any relevant Provider Contracts required or make arrangements to provide the service in house.

Access

6.3 The scheme is for the benefit of those individuals ordinarily resident in Southend On Sea Borough council area, who meet the eligibility criteria for care and support under the Care Act and the regulations made thereunder.

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Martin Wintle (Head of Adult Operations)	Same as Council	01702 215000	martinwintle@southend.gov.uk	01702 534618

Appendix 2 – End of Life and Palliative Care

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The strategic objective of this scheme is to redesign and remodel existing services to increase the number of people supported to remain in their home and community setting who achieve their preferred place of care during the final stages of their lives to reduce hospital admissions and to protect social services.

2 AIMS AND OUTCOMES

2.1 The overarching aim of the scheme is to redesign & decommission as appropriate existing end of life pathways to align with the new model for the delivery for integrated community services through the GP Primary Care Hub, the Community Recovery Pathway and the wider integrated approach to care set out in the BCF plan to ensure better coordinated case managed care for people in the end stages of their lives.

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the CCG.

4 FUNCTIONS

4.1 The CCG will using the Scheme to fulfil in part its NHS functions

5 SERVICES

5.1 Service delivery will be through an integrated pathway from a range of statutory and third sector providers. We will be working with the following stakeholders to redesign & remodel the end of life pathway:

5.1.1 South Essex Partnership Foundation Trust: EOL Register Community Services, Integrated Teams, Case Coordination, EOL Facilitators. Long Term Condition Matrons

5.1.2 Southend University Hospital Foundation Trust:

5.1.3 Havens Hospices: Community bed base and day centre services

5.1.4 St Luke's Hospices.

5.1.5 SPNDS: Hospice at Home Respite

5.1.6 Ashley Care: Emergency Respite

5.1.7 Primary Care: GPs Primary Care Hub, Enhanced Care Home Services, Care coordination MDT care.

5.1.8 Ambulance Services:

5.1.9 Care Home Providers

5.1.10 Domiciliary care providers

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The commissioning will be carried out by the CCG commissioning Team

Contracting Arrangements

6.2 The CCG shall enter into any relevant Provider Contracts required.

Access

6.3 Access will be in accordance with the referrals for patients for whom the CCG is the responsible Commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
CCG	Linda Dowse (Chief Nurse)	Same as CCG	01702 314299	linda.dowse@nhs.net	01702 313703

Appendix 3 - Prevention including intermediate care, primary and community care and transforming the emergency care pathway

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 This scheme seeks to transfer the care of patients with ambulatory conditions into the Primary and Community Care setting together with reablement with social services.

2 AIMS AND OUTCOMES

2.1 The strategic objective of this scheme is to reduce hospital admissions and protect social services by funding a change in approach to the treatment of patients with Ambulatory conditions.

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the CCG.

4 FUNCTIONS

4.1 The CCG will be commissioning the services as part of its fulfilment of the NHS Functions

5 SERVICES

5.1 The Community Recovery and Independence pathway includes a range of services traditionally referred to as intermediate care, reablement and rehabilitation. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a single pathway across health and social care and may include, but is not exclusive to:-

5.1.1 Crisis and rapid response

5.1.2 Hospital supported discharge

5.1.3 Community rehabilitation and reablement

5.1.4 Bed based rehabilitation

5.1.5 Domiciliary care

5.1.6 Falls service

5.1.7 Voluntary sector provision (including universal provision to sign posted services)

5.2 The pathway is being designed to meet the needs of individuals entering the health and social care economy irrespective of their eligibility for on-going social care, the pathway is also a key

component of the prevention agenda and the development of GP Hubs in the locality. It will also support the discharge to assess and the ambulatory care pathways.

5.3 The focus of the community recovery pathway will be on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for on-going packages of care and thereby reducing long-term dependencies on care and support.

5.4 This pathway will not only support efforts to keep people out of hospital and remain independent for as long as possible, but also achieve further progress with integrated care and improve the local preventative services offer.

5.5 The service will be for adults with a primary need for short-term rehabilitation, recovery from and/or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence. The service will include crisis and rapid response, early supported hospital discharge, community rehabilitation and reablement, bed based rehabilitation and a falls service.

5.6 At the centre of the model will be an integrated multi-disciplinary team providing a sevenday service. The team will include occupational therapists, physiotherapists, social workers, nurses (including psychiatric liaison) and therapy assistants and support workers. The team may also include a GP and a nurse prescriber.

5.7 The team will carry out person-centred care, holistic assessment, goal setting and review to enable people to achieve their desired outcomes and reach their maximum level of independence. Staff will have a common set of core skills including assessment, planning and case coordination, as well as retaining their specialist skills and knowledge. Risk stratification will be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management.

5.8 The re-modelling of the pathway will include a review of the processes and systems across partner organisations aligned to the pathway to ensure that recipients do not experience delays in the discharge and referral process, and that services are in place to avoid people going into crisis in the community. This will have a positive impact on the number of people presenting at A&E, the time taken to discharge patients from hospital, the number of people being admitted inappropriately into residential care contributing towards the 11.5% reduction in admissions to residential care, achieving the optimum level of throughput thereby avoiding blockages in the system; and a reduction in the number of people requiring long term care and support.

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The commissioning will be carried out by the CCG commissioning Team

Contracting Arrangements

6.2 The CCG shall enter into any relevant Provider Contracts required.

Access

The service is commissioned for individuals for whom the CCG is the responsible commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
CCG	Linda Dowse (Chief Nurse)	Same as CCG	01702 314299	linda.dowse@nhs.net	01702 313703

Appendix 4 – Prevention including reablement service

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

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

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

2 AIMS AND OUTCOMES

2.1 The strategic objective this scheme is to protect social services and reduce hospital admissions through funding re-ablement services with the aim of improving Social Care discharge management and admission avoidance including developing existing re-ablement services.

2.2 In particular the scheme aims to:

2.2.1 reduce avoidable admissions to hospital

2.2.2 Facilitate timely hospital discharges

2.2.3 Prevent and maximise independence

2.2.4 Recovery and enablement services.

2.2.5 Community rehabilitation and re-ablement.

2.2.6 Processes to minimise delayed discharge

2.2.7 Contribute towards an integrated single pathway across health and social care.

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the Council.

4 FUNCTIONS

4.1 The functions are all Social Care Functions, and commissioned to fulfil in part the Council's obligations under those functions

5 SERVICES

- Maintain home Again Service to cover NHS and social care delays
- Social Work Post to work across intermediate care beds supporting the development of a discharge to assessment
- Social work capacity to maintain and improve speed of assessment

- Therapy capacity to maintain and improve speed of assessment for admission avoidance and supported discharge (2 x OT's for SPOR, 1 x MTA plus van))
- Project management to support the frailty pathway, developing a discharge to assess model of care
- Increase therapy capacity to support reablement of patients on the early supported discharge pathway
- External Re-ablement Capacity
- Implementation of the Care Act

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The commissioning will be carried out by the CCG commissioning Team

Contracting Arrangements

6.2 The CCG shall enter into any relevant Provider Contracts required.

Access

6.3 The service is commissioned for individuals for whom the CCG is the responsible commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Martin Wintle (Head of Adult Operations)	Same as Council	01702 215000	martinwintle@southend.gov.uk	01702 534618

Appendix 5 – Integrated care through the GP Hub

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The GP Hub will act as an 'early adopter, and a catalyst for improvement that will deliver seven-day services across the whole system which will ensure better outcomes and improved patient experience. Services will be monitored and evaluated to understand impact and effectiveness which may lead to further project design, or full roll-out to other GP practices.

1.2 Advances in technology and changing demographics means that, with the right premises and correct skills mix, more integrated care can be delivered in a primary care setting. Citizens who have historically gone to hospitals to receive their care will no longer need to make hospitals their first port of call. Similarly, people who are supported by social care can be referred to the service via a variety of routes.

1.3 Exciting new initiatives are being developed which will deliver improved outcomes for citizens, the supply chain and the health and social care economy. The target operating model will ensure that functional integration of system partners is developed and tested.

1.4 The Community Recovery Pathway will be implemented initially around the GP Hub as this will enable on-going evaluation and monitoring of the model and the effectiveness.

2 AIMS AND OUTCOMES

2.1 The strategic objective of this scheme is to reduce hospital admissions and protect social services.

2.2 Southend's vision for the GP Hub is that it will act as an 'early adopter' and catalyst for improvement that will deliver 7-day services across the whole system from which the following outcomes and benefits will be accelerated:

2.2.1 Reduction in none elective stays

2.2.2 Improved patient outcomes

2.2.3 Increased adherence to end of life plan

2.2.4 Improved performance on the national and local indicators

2.2.5 NHS constitutional standards

2.2.6 To make our current health and social care financially challenged system sustainable

2.2.7 Enhanced GP engagement in the local urgent care agenda and the development and implementation of evidence based services

2.2.8 Reduction in the number of people presenting at A & E

3 THE ARRANGEMENTS

3.1 The scheme will be commissioned by the CCG.

4 FUNCTIONS

4.1 The CCG will be commissioning the services as part of its fulfilment of the NHS Functions

5 SERVICES

5.1 Premises and a pilot GP service are to be identified by the CCG so as to meet the criteria for the scheme of accessibility, and suitability of premises and size of practice list. .

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

6.1 The CCG commissioning team to manage the commissioning arrangements .

Contracting Arrangements

6.2 To be awarded by the CCG

Access

6.3 Access will be in accordance with the referrals for patients for whom the CCG is the responsible Commissioner

7 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
CCG	Linda Dowse (Chief Nurse)	Same as CCG	01702 314299	linda.dowse@nhs.net	01702 313703

Appendix 6 - Infrastructure to support integrated working

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

1.1 The Extra care housing scheme will give people the opportunity to live independently in a home of their own, but with other services on hand if they need them.

1 AIMS AND OUTCOMES

1.1 The scheme will assist in the following:

1.1.1 Reduction in residential placements

1.1.2 Reduction in avoidable hospital admissions

1.1.3 Reduction in individuals who are social isolated

1.1.4 Better on line information & advice services for individuals and carers

1.1.5 The required information of individuals and carers to meet the expectations of the care act is recorded electronically.

1.1.6 Technical changes are in place to support better data sharing

2 THE ARRANGEMENTS

2.1 The scheme will be commissioned by the Council.

3 FUNCTIONS

3.1 The functions are all Social Care Functions, and commissioned to fulfil in part the Council's obligations under those functions

4 SERVICES

4.1 Extra care - £233k

4.1.1 Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve an efficiency of £200k per annum from 15/16; The project will span both health and social care and aims to demonstrate the potential for the development of extra care provision both in short term and medium to long term. This is line with Southend on Sea's vision for older people which is:-

4.1.2 "Older people will have opportunities to live independently and remain active for longer. They will have greater choice and control over their lives and will be valued and respected"

4.1.3 The investment in extra care supports a personalised, community based approach and will highlight the health and social care benefits of investing in quality housing for older people and those with a long term condition to prevent a move to institutional residential care and reable individuals to avoid frequent hospital readmissions

4.1.4 Extra Care Housing is an innovative alternative for older people to residential care which can help them live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle.

4.2 Telecare – £50k

4.2.1 It is the intention to invest in additional Telecare equipment and other technology within the scheme to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations.

4.2.2 Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person

4.3 Care Act capital monies £176k

4.3.1 Investment in IT

4.3.2 The strategic objective is the Investment of capital monies to improve the IT systems in preparation for the implementation of the Care Act.

4.3.3 The Care Act requirements and the priorities for data and technology include

(a) Transparency – drive better care through release of data about health care services

(b) Transactions – Modernise services to match expectations of today's online society

4.3.4 Interoperability – health and social care systems

4.3.5 Patient participation and control – Enable patient access to their own professional held records

4.3.6 Patient participation and control – Enable patients to control their own health/care (Citizen Driven Health)

4.3.7 Reduce admin burden – Provide front line with information required enter information only once.

5 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

5.1 The council shall be responsible for the purchasing of equipment and the provision of equipment to individuals in accordance with eligibility criteria.

Contracting Arrangements

5.2 At the discretion of the Council for the purchase of equipment.

Access

5.3 For support of housing and telecare, individuals who are ordinarily resident in in Southend on sea borough Council; the care act capital investment directly benefits the council and indirectly benefits the local eligible population

6 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Jacqui Lansley (Head of Procurement, Commissioning and Housing to become Joint Associate Director of Integrated Care Commissioning as of 1 April 2015)	same as Council	01702 215000	jacquilansley@southend.gov.uk	01702 534618

SCHEDULE 2 – GOVERNANCE

Joint Executive Group

Terms of Reference

1 BACKGROUND

The purpose of the Joint Executive Group is to set the strategic vision for South East Essex and to act as the programme board for key integration change initiatives currently:

- Health and Wellbeing strategy
- Integration Pioneer Programme
- Better Care Fund
- Seven day services

2 GOVERNANCE AND ACCOUNTABILITY

The Joint Executive Group will be chaired by Simon Leftley, Corporate Director Department for People and will report regularly to the Health & Wellbeing Board

3 MEMBERSHIP

1. Accountable Officer, Southend CCG, Melanie Craig (Acting)
2. Chair, Southend CCG, Dr Jose Garcia
3. Corporate Director Department for People, Southend Borough Council, Simon Leftley (SBC)
4. Head of Adult Operations, Southend Borough Council, Martin Wintle (interim)
5. Head of Children Services, Southend Borough Council, John O'Loughlin
6. Head of Procurement, Commissioning and Housing, Southend Borough Council (to become Joint Associate Director of Integrated Care Commissioning as of 1 April 2015), Jacqui Lansley
7. Chief Executive, SUHFT, Sue Hardy (Acting)
8. Chief Executive, SEPT, Sally Morris
9. Executive Director for Integrated Care, SEPT, Malcolm McCann
10. Accountable Officer, CP&R CCG, Ian Stidston (CP&R CCG)
11. Chief Executive, SAVs, Alison Semmence
12. Director, Public Health, Dr Andrea Atherton

Other colleagues will be invited to attend specific items as agreed in advance by the Chair.

4 SUBSTITUTIONS

Substitutions for annual leave or short term sickness absence are required and subject to the Chair's agreement.

5 FREQUENCY

The group will convene once each calendar month

6 RESPONSIBILITIES

The Joint Executive Group has ultimate responsibility for the definition and delivery of Health and Social Care Integration in Southend. It has ownership of, and authority for, the overall direction and management of the integration programme, projects and initiatives, and is accountable for delivery. As the 'voice' to the outside world, the JEG is responsible for any communication about the integration programme, projects and initiatives.

Specific responsibilities include:

- Approving commencement of new activity via acceptance of a mandate.
- Approving roles and responsibilities
- Delegation of any Assurance roles
- Reviewing definition documents including PID, business cases, benefits plans, project plans etc
- Agreeing scope extensions to existing activities
- Agreeing the addition of projects to the Programme
- Agreeing to bring projects under the purview of the Joint Executive Group as is necessary
- To act as escalation point for any issues that can not be resolved at the project or workstream level
- Monitoring and programme finances
- Ensuring progress against significant milestones & strategic objectives
- Approving any required changes
- Monitoring any significant risks and issues
- To agree communications
- Reviewing project closure and benefit reports
- To issue instructions to the Programme Transformation Board
- Report directly to the Health and Wellbeing Board on a Quarterly basis in accordance with relevant BCF Guidance

For the purposes of integrated commissioning activity it may be necessary for a sub group of the JEG to meet and agree integrated commissioning related plans and proposals. If the need arises then a subgroup will meet with the following organisations represented;

- Southend CCG
- Southend on Sea Borough Council
- Public Health

Specific responsibilities include:

- Jointly commission activity as recommended by the Programme Transformation Board;
- Agreeing extensions to existing jointly commissioned services as recommended by the Programme Transformation Board; and
- Agreeing the de-commissioning of integrated services as recommended by the Programme Transformation Board
- Overseeing delivery of the BCF as defined by the Section 75 agreement, effective 1st April 2015
- Agreement to include or exclude revenue expenditure other than expenditure agreed within the section 75 agreement.

7 REPORTING

Reporting will be carried out using Joint Executive Group approved templates.

- Highlight reports will be presented monthly.
- Exception reports will be produced as required, and may necessitate the convening of an additional meeting, or for a “meeting” to be held virtually.

8 RECORDING

All JEG meetings will be minuted, with agreed actions and timescales

In normal circumstances, papers will be made available to all attendees at least 3 working days in advance. Papers will only be ‘tabled on the day’ with the agreement of the Chair.

SCHEDULE 3– TEMPLATE SERVICE SPECIFICATION

This Schedule is for illustrative purposes only.

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SERVICE

Insert details including:

(a) Name of the Individual Scheme
(b) Relevant context and background information
(c) Whether there are Pooled Funds:

The Host Partner for Pooled Fund X is [ ] and the Pooled Fund Manager, being an officer of the Host Partner is [ ]

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

3 THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme:

(1) Lead Commissioning;
(2) Joint (Aligned) Commissioning;
(3) the establishment of one or more Pooled Funds and/or Non Pooled Funds as may be required.

4 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Social Care Functions)

5 SERVICES

What Services are going to be provided within this Scheme. Are there contracts already in place?
Are there any plans or agreed actions to change the Services?
Who are the beneficiaries of the Services? [1]

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning/Joint (Aligned) commissioning. How will these arrangements work?

[1] This may be limited by service line –i.e. individuals with a diagnosis of dementia. There is also a significant issue around individuals who are the responsibility of the local authority but not the CCG and Vice versa See note [ ] above

Contracting Arrangements
Insert the following information about the Individual Scheme:

(a) relevant contracts

(b) *arrangements for contracting. Will terms be agreed by both partners or will the Lead Commissioner have authority to agree terms*

what contract management arrangements have been agreed?
What happens if the Agreement terminates? Can the partner terminate the Contract in full/part?
Can the Contract be assigned in full/part to the other Partner?

Access
Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible.

7 FINANCIAL CONTRIBUTIONS

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial resources in subsequent years to be determined in accordance with the Agreement

8 FINANCIAL GOVERNANCE ARRANGEMENTS

[(1) As in the Agreement with the following changes:

(2) *Management of the Pooled Fund*

Are any amendments required to the Agreement in relation to the management of Pooled Fund
Have the levels of contributions been agreed?
How will changes to the levels of contributions be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the pooled fund manager require training?
Have the pooled fund managers delegated powers been determined?
Is there a protocol for disputes?

(3) Audit Arrangements

What Audit arrangements are needed?
Has an internal auditor been appointed?
Who will liaise with/manage the auditors?
Whose external audit regime will apply?

(4) Financial Management

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
Has the scale of contributions to the pool been agreed?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?
Will there be a facility to carry forward funds?
How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?
What management costs can legitimately be charged to pool?
What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
What closure of accounts arrangement need to be applied?][2]

9 VAT

Set out details of the treatment of VAT in respect of the Individual Service consider the following:

- *Which partner's VAT regime will apply?*
- *Is one partner acting as 'agent' for another?*
- *Have partners confirmed the format of documentation, reporting and*
- *accounting to be used?*

10 [GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

[2] We note that some of the information overlaps with the information that is included in the main body of Agreement, however, we consider it is appropriate that this is considered for each Scheme in order to determine whether the overarching arrangements should apply.

Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?
Who does that group report to?
Who will report to that Group?

Pending arrangements agreed in the Partnership Agreement, including the role of the Health & Wellbeing Board, Partners to confirm any bespoke management arrangements for the Individual Scheme

11 NON FINANCIAL RESOURCES

Council contribution

	Details	Charging arrangements[3]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

	Details	Charging arrangements[4]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

12 STAFF

Consider:

- *Who will employ the staff in the partnership?*
- *Is a TUPE transfer secondment required?*
- *How will staff increments be managed?*
- *Have pension arrangements been considered?*

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.

If the staff are being seconded to the CCG this should be made clear

CCG staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the Council.

If the staff are being seconded to the Council this should be made clear.

[3] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

[4] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

13 ASSURANCE AND MONITORING

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.
In relation to the Better Care Fund you will need to include the relevant performance outcomes. Consider the following:

- *What is the overarching assurance framework in relation to the Individual Scheme?*
- *Has a risk management strategy been drawn up?*
- *Have performance measures been set up?*
- *Who will monitor performance?*
- *Have the form and frequency of monitoring information been agreed?*
- *Who will provide the monitoring information? Who will receive it?*

14 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council					
CCG					

15 INTERNAL APPROVALS

- *Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;*
- *Consider the scope of authority of the Pool Manager and the Lead Officers*
- *Has an agreement been approved by cabinet bodies and signed?*

16 RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?
Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

17 REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

18 INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing arrangements?
How will charges be managed (which should be referred to in Part 2 above)
What data systems will be used?

Consultation- staff, people supported by the Partners, unions, providers, public, other gency
Printed stationary

19 DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all of the Individual Scheme be terminated on notice by a party? Can part/all of the Individual Scheme be terminated as a result of breach by either Partner?
What is the duration of these arrangements?

Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreement

(1) maintaining continuity of Services;

(2) allocation and/or disposal of any equipment relating to the Individual Scheme;

(3) responsibility for debts and on-going contracts;

(4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

(5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

Consider also arrangements for dealing with premises, records, information sharing (and the connection with staffing provisions set out in the Agreement.

20 OTHER PROVISIONS

Consider, for example:

- *Any variations to the provisions of the Agreement*
- *Bespoke arrangements for the treatment of records*
- *Safeguarding arrangements*

SCHEDULE 4– JOINT WORKING OBLIGATIONS

Part 1 – LEAD COMMISSIONER OBLIGATIONS

This Schedule is for illustrative purposes only.

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Lead Commissioner shall notify the other Partners if it receives or serves:

1.1.1 a Change in Control Notice;

1.1.2 a Notice of a Event of Force Majeure;

1.1.3 a Contract Query;

1.1.4 Exception Reports

and provide copies of the same.

2 The Lead Commissioner shall provide the other Partners with copies of any and all:

2.1.1 CQUIN Performance Reports;

2.1.2 Monthly Activity Reports;

2.1.3 Review Records; and

2.1.4 Remedial Action Plans;

2.1.5 JI Reports;

2.1.6 Service Quality Performance Report;

3 The Lead Commissioner shall consult with the other Partners before attending:

3.1.1 an Activity Management Meeting;

3.1.2 Contract Management Meeting;

3.1.3 Review Meeting;

and, to the extent the Service Contract permits, raise issues reasonably requested by a Partner at those meetings.

4 The Lead Commissioner shall not:

4.1.1 permanently or temporarily withhold or retain monies pursuant to the Withholding and Retaining of Payment Provisions;

4.1.2 vary any Provider Plans (excluding Remedial Action Plans);

4.1.3 agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;

4.1.4 give any approvals under the Service Contract;

4.1.5 agree to or propose any variation to the Service Contract (including any Schedule or Appendices);

4.1.6 suspend all or part of the Services;

4.1.7 serve any notice to terminate the Service Contract (in whole or in part);

4.1.8 serve any notice;

4.1.9 agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the [JCB]) such approval not to be unreasonably withheld or delayed.

5 The Lead Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Lead Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution

7 The Lead Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports)

Part 2– *OBLIGATIONS OF THE OTHER PARTNER*

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 Each Partner shall (at its own cost) provide such cooperation, assistance and support to the Lead Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Lead Commissioner to:

1.1 resolve disputes pursuant to a Service Contract;

1.2 comply with its obligations pursuant to a Service Contract and this Agreement;

1.3 ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

2 No Partner shall unreasonably withhold or delay consent requested by the Lead Commissioner.

3 Each Partner (other than the Lead Commissioner) shall:

3.1 comply with the requirements imposed on the Lead Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;

3.2 notify the Lead Commissioner of any matters that might prevent the Lead Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Lead Commissioner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

NOT USED

SCHEDULE 6 – BETTER CARE FUND PLAN

Updated July 2014

Better Care Fund planning template – Part 1

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

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

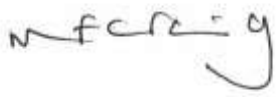
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Southend Borough Council
Clinical Commissioning Groups	NHS Southend Clinical Commissioning Group
Boundary Differences	Southend is largely coterminous. The most significant boundary considerations are with neighbouring Castle Point & Rochford CCG (CP&R) (who are partnered in the South Essex resilience process) and Essex CC. The CP&R Accountable Officer is a member of the Joint Executive Group, so fully involved in strategic discussions and the Southend BCF. Essex CC are involved on a less formal basis via existing local authority networks
Date agreed at Health and Well-Being Board:	**3rd September 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.687M**
2015/16	**£12.772M**
Total agreed value of pooled budget: 2014/15	**£0.687M**
2015/16	**£12.772M**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Southend Clinical Commissioning Group
By	Melanie Craig
Position	Chief Operating Officer
Date	19th September 2014
Signed	

Signed on behalf of the Council	Southend-on-Sea Borough Council
By	Simon Leftley
Position	Corporate Director for Adult Social Services
Date	19th September 2014
Signed	

Signed on behalf of the Health and Wellbeing Board	Southend-on-Sea Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Norman
Date	19th September 2014
Signed	

c) Related documentation

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

Document or information title	Synopsis and links
Appendix 1 – Better Care Fund Plan on a Page  Appendix 1_BCF on a page.pdf	An Executive Summary of our BCF submission.
Appendix 2 – Integration Agreement  Appendix 2_Integration Concor	Southend system partners have a shared joint vision and have formed a strategic alliance with major stakeholders and a governance structure that reports directly to the Health and Wellbeing Board.
Appendix 3 – Data Sharing  Appendix 3a_Data Sharing Report.pdf  Appendix 3b_CAG 5-05 (a) 2014 SoS ICI	Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs. In February 2014 the DH Informatics Support Team spent two days working with Southend to seek a national solution relating to information governance that hampers the integration process, their final report is embedded A deferred decision letter following the Confidentiality Advisory Group (CAG) on 24th July 2014 is also attached. The CAG considered an amendment to s251. The CAG are due to reconsider on 2nd Oct 2014.
Appendix 4 – Protection of social care	A strategic alliance and governance framework has been developed that will form the strategic oversight that ensures sustainability of social care. **Please refer to Appendix 2**
Appendix 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	A successful track record of developing joint health and social care assessments underpinned Southend's successful bid to become one of 14 national Integrated Pioneer Pilots for integrating services.

Appendix 5_Integration Pioneer	**Please also refer to Appendix 2**
Appendix 6 – Agreement on the consequential impacted changes in the acute sector	Southend system partners have commissioned a System wide capacity review which reported in February and has informed planning and future commissioning. System partners have also formed a strategic alliance that seeks to ensure the risk associated with radical service change to improve outcomes is managed collectively. **Please refer to Appendix 2**
Appendix 7 – Perfect Week report Appendix 7_Perfect week.pptx	The Perfect Week was initiated by Southend University Hospital NHS Foundation Trust, supported by Emergency Care Intensive Support Team (ECIST) to support the improvement plan regarding A&E performance. Appendix 7 is a summary of the activity and an early indication of the findings.
Appendix 8 – Length of Stay Review Appendix 8_LOS Rev Southend and Comm	Southend recognised the need to understand the perceived and actual patient flow issues during a review of the length of stay

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision is;

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

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

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

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

Our vision is underpinned by the Southend System Leaders Integration Agreement which includes the following focus areas:

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

b) What difference will this make to patient and service user outcomes?

We will build upon our current successes in integrated care delivery to ensure that our prevention offer and self-management options are fully developed and optimised and where longer term care or support is needed it is provided around the service user/patient.

We will build self-reliant confident communities to enable people to be in control of their care and self-manage.

We will invest in preventative services to allow people to be in control and demand less on statutory services through new procurement models which incentivise providers to work collaboratively, which reward support for reablement and independence and which reflect social value principles

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

We will pilot pooled care budgets which follow the patient as a means of providing more integrated care and offering individuals more choice and control over how their services are delivered integrating budget arrangements which include pooling of resources within clear systems of delegation which recognise the statutory responsibilities of each partner.

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

Service users and patients will have more choice and control over how their health and social care is delivered through developing a collaborative approach to resource planning and efficiency savings which builds on an open dialogue about partners service and financial pressures

People will experience health and social care as responsive and personalised to their needs and situations through developing commissioning partnerships which drive innovation and take responsibility for evaluation of outcomes which improve people's lives

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

The Patients and residents of Southend have been consulted with regarding what they want to see as an integrated Health and Social Care model towards 2018 / 19.

Patients want to feel confident and safe at home with support in the community. They want an involvement in the development and delivery of their care plan, they require an involvement from friends and family and they want to be at the centre of their own care planning and provision.

The staff of Southend's Health and Social Care economy have been consulted with regarding what they want to see as an integrated Health and Social Care model towards 2018 / 19.

Staff want to commission and provide a service that is measured by outcomes, that provides individuals with the ability to live independent lives and take responsibility for their own care. Staff want capacity to be built within the community and meet the needs of those residents that are harder to reach.

The JSNA is currently being reviewed and will be used to inform the process of developing a vision for Southend once available.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The changes that will be delivered to the pattern and configuration of services during the next 5 years will be driven by robust, integrated and consistent commissioning intentions …..

The vision described above will be delivered through six Better Care Fund Schemes:

- Protect Social Services through Independent living including reducing the reliance on residential care
- End Of life, palliative care and community services
- Prevention including intermediate care, primary and community care and transforming the emergency pathway
- Prevention including reablement
- Integrated Care through the GP Hub
- Infrastructure to support Integrated working

We are now in the implementation phase of our 14/15 schemes and we are currently reviewing the effectiveness of these schemes at the appropriate time and develop a plan to either change direction or increase the resource. This allows us to build on what is working well and if our close monitoring of metrics shows we are not getting the shift in activity we expect we can amend our plans or move resources as required.

We are currently implementing the following schemes;

- Pilot S/W in A&E 7 days a week
- SPOR 7 day working assessment availability

- Falls pathway alignment
- Pilot of integrated care record
- Care Track Risk stratification
- Hospital Discharge - step down offer
- Pilot "GP Hub"
- Extra Care dementia pilot

The detailed changes noted above will be delivered through the BCF programme. To complement our intentions through the BCF our Health and Wellbeing Board and status as Integrated Pioneer will have the following focus:

- Supporting people to live independently and take responsibility for personal health;
- Integrated care provision for adults requiring health and social care services;
- Investment in our workforce to develop an integrated and joint partnership approach;
- Reducing activity at our Hospital through the provision of integrated services within a community based setting; and
- Integrating Prevention and Engagement activity within commissioning and service provision.

Our integrated teams have already had an impact on the 6 conditions set at a national level and our ambitions for extending health and social care integration, the development of the 'GP Hub', the enhancement of the SPoR, falls strategy alignment and the placement of a social worker at A&E 24/7 will impact on avoidable unplanned hospital admissions, delayed transfers of care and effectiveness of reablement, while ensuring a greater increase in service user satisfaction, choice and personal responsibility.

Our ambitions for the Better Care Fund also extend into the wider prevention agenda. We recognise that in the medium to long term demand for acute and specialised health and social care services can only be reduced at a population level through more effective approaches to prevention. This will involve engaging service users, the third sector, Primary Care through a systematic approach to build a holistic team around the patient for individuals with complex health and social care needs including long term conditions.

Integrated service commissioning

The provision of health and social services will be grouped around the 'GP Hub'. The aim of the GP Hub is to become the patients' entry point for the prevention and treatment of illness, provide social services and support independence. The functions of the 'GP Hub' are;

- Risk stratification for people with long term conditions
- Introduction of a Care Coordinator within the practice to enhance whole system care planning and case management
- High intensity, pro-active care with own primary care physician
- Intermediate care, re-ablement and rehabilitation
- Information, advice and guidance to enable people to manage their own health conditions
- Discharge to assess
- Enhanced, pro-active working with care homes
- Integrated care records
- Seven-day services
- Rapid response and crisis prevention
- Falls prevention service
- Promotion of Telecare
- Single point of access / referral
- Risk stratification for people with long term conditions
- High intensity, pro-active care with own primary care physician
- Identification of Carers and referral pathway
- Integrated care records

- Whole system Care Planning
- Enhanced MDT's (children and adults)
- Enhanced working with care homes
- Intermediate Care, Re-ablement and Rehabilitation
- Rapid response - Crisis prevention
- Falls prevention
- Dementia support services
- Enhanced pharmacy services

And will focus on placing a team around the person. Each GP Hub will have a core team that will consist of GPs, clinical nurses, Mental Health professionals, social care, physio and occupational therapists.

The BCF is necessary but not sufficient to deliver the required transformation across Southend. Without BCF there will be a number of critical new activities that will not be delivered over the period to 2018 / 19. Additionally, without BCF the Southend plan will not enable change and transformation in services that have been identified as providing an opportunity to transform in support of the HWBs vision, specifically;

- Southend's social services are fully integrated into hospital health operations in support of admission avoidance and discharge from hospital. For example, Southend CCG and the council currently commission a Single Point of Referral (SPoR) with the aim of avoiding admission from GPs and supporting the hospital discharge team. Our BCF plan includes the aim of reviewing the SPoR and aligning the activity with the 7 day service plan currently in development.
  The review and subsequent change to operations will require investment in both infrastructure and staff structure.
- Southend's plan to develop a Primary Care Hub model in Southend is contingent on both partnership working and investment. Our plans to develop the proposed model are articulated in Annex 1, scheme 004.
- Southend's plan to invest funding into the 'End of Life' pathway is defined in Annex 1, Scheme 002. The evidence base and planned impact is well supported by data that has been made available through analysis of historic performance. The investment in redesigning the pathway is significant from both a resource and financial perspective. Without the BCF Southend would not have the opportunity to transform this partway and therefore support admission avoidance for patients in this cohort.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Data and information derived from the Director of Public Health for Southend's Annual Public Health Report, the latest Southend Health Profile (2014) and additional sources including the Health and Wellbeing Strategy and current Joint Strategic Needs Assessment, cardiovascular risk profile and other sources highlight the key health and social care challenges facing the Borough of Southend.

Key commissioners specifically Southend on Sea Borough Council (the council) and NHS Southend CCG (the CCG), previously used CareTrack, a computer based care and support tool. CareTrack enables the partnership to undertake risk stratification of local citizens in receipt of health or social care support. Through using this tool we have been able to identify whether needs could be better met through collaborative/ integrated service delivery. As a Year of Care pioneer and an integrated health pioneer local partners have also undertaken a number of complex mapping exercises including an epidemiological analysis of hospital attendances and admissions. This data has been used to complement the CareTrack information and identify issues and interventions where integrated service delivery would improve outcomes for local people and make service delivery more efficient and cost effective. (Care Track use is currently suspended pending resolution of data sharing issues).

Through joint partnership arrangements the CCG and the council have worked with NHS England to identify gaps and variation in primary care services. Locally there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years. These issues have been identified in the new Primary Care Strategy for Essex. Local partners have contributed to the development of this strategy. Current plans are that the strategy will enable the CCG and the council to co-commission primary care and community based services in new innovative ways to improve primary and secondary prevention interventions provided to vulnerable or hard to reach people who are currently accessing services in a way that is neither efficient nor cost effective. The impact of conditions affecting the population of Southend has been reviewed.

Currently the population of Southend is in the region of 175,000. By 2021, this is expected to rise by a further 7% to 186,399. Deprivation in Southend is higher than average and about 23.5% (7,700) children live in poverty. Life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend. This is worse than the average for England. The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity, alcohol (significantly higher admissions than the average for England for alcohol attributable conditions) have a negative impact on the health of the population. There are also high levels of mental ill-health within Southend. This means we need to take action to address the links between the social determinates such as worklessness and mental ill-health and demand for health or social care services in specific areas of disadvantage in Southend. We are currently undertaking a community development programme to address the impact of disadvantage and poor health outcomes in specific localities. We need to integrate local health and social care interventions better in these areas and we will use the resources of the Better Care Fund to support this through the schemes outlined. Southend has an ageing population. We know the incidence and prevalence of ill health and disease increases with age and have identified a number of conditions, population groups and specific interventions where we believe more effective collaboration and coordination between partners will improve outcomes for local people and reduce costs to the health and social care economy. The key issues identified are:

- older people (falling, social isolation)
- people living with long term conditions (Cardiovascular disease, diabetes, respiratory disease, asthma)
- people living with dementia

There are a number opportunities to improve the support provided to local people through more effective collaboration and integration. For example, strategic partners are currently working to develop more effective local approaches to support people living with dementia. By doing this we hope to reduce the significant gap and variation between the number of people currently diagnosed with dementia and those known to be living with the condition. Given people living with dementia are more likely to require health care and support they are a major priority for us. Currently it is estimated that circa 7.5% of the Southend population are living with dementia (2,503 aged 65+ source: POPPI / QOF register for Southend CCG 1,139 in 2012/13). Given the future significant impact that supporting people living with dementia will have on local health and social care services, improved pathways and integration between health, social care and voluntary sector organisations will support early identification, treatment and care for local people living with dementia and also reduce costs through provision of early support for carers and families

Living longer does not always mean a better life. Locally we have looked the impact of long term chronic conditions on the health of local people. Currently the prevalence of LTC within Southend is (Number: 32,116 / 18,493 per 100,000 population - taken from ONS neighbourhood stats).

Tackling long term conditions through joining up pathways and commissioning services across health and social care that enable people to be supported to self-manage existing conditions is a key focus for local partners. Although the early mortality rate for persons <75 has reduced in recent years, it is still higher than the national average (Directly standardised mortality rate for mortality from all causes, aged <75 is 339 per 100,000 for Southend. England is 350 per 100,000 source: PHE).

Consequently linking programmes and interventions such as increasing access to stop, smoking services, weight management services tacking hypertension and mental ill-health are all key challenges that require better integration and targeted action. We are also working to tackle the issue of social isolation which we know can lead to people deteriorating and ending up requiring intensive health and/or social care support. 323 people per 100,000 were admitted to hospital as a result of a mental illness in 2011/12 which was significantly higher than the England average. The rate of injurious falls and subsequent admission to hospital is also of concern (1592 per 100,000 population persons age 80+). Given the increasing elderly population we know we have to better integrate services to promote bone health and manage and prevent the consequences of falling.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Engagement of the Southend System with Programme activity

The Better Care Fund is closely aligned with the activity currently underway and planned within the Southend Pioneer. For this reason the Southend System are adopting a programme approach to the delivery of the Better Care Fund to ensure stakeholders are both engaged and take ownership for the delivery. Further, the stakeholders will be required to take ownership of the outcomes and the required transformational change to ensure the vision outlined in section 1 is realised.

Schemes identified within our BCF plan are subject to robust governance arrangements and

project planning procedures. Prior to implementation a detailed Project Initiation Document (PID) is required and will be subject to appropriate governance procedure. The PID states the benefits and identify the return on investment. The PID will also provide detail regarding timeline, milestones, risks, mitigations and interdependencies.

An outline to each of the schemes can be found at Annex 1.

Interdependencies

Within each of the PIDs noted above there is a recognition of the local interdependencies that exist.

Across the Southend System and between stakeholder there are interdependencies for Southend's BCF plan to respond to, these are;

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

The Single Point of Referral, an integrated community team with a focus on hospital avoidance and discharge, will be piloting a seven day service during FY 14/15. This will be evaluated over six months to monitor the impact on hospital admissions and attendances at A&E. We will align our falls prevention pathways across the system to be in place by winter 2014.

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

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

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

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

Falls Prevention. Southend has recognised the need for alignment of Falls Prevention across the partners of Southend and is progressing discussion on the most appropriate process to achieve the required alignment. We are considering the adoption of an integrated approach to a falls pathway with additional investment which will enhance the delivery of community assessment and provide additional equipment e.g. tilt table etc.

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

Dementia Pathways. Development of dementia pathways.

We are in Year 2 of our Dementia Plan and developing options for the redesign of existing

sheltered housing into dementia specialist extra care housing.

To ensure early diagnosis assessment and support pathways for people with challenging behaviour. This work is being undertaken by SEPT, Southend CCG and the council.

Review of existing assessment pathways is complete and consultation on proposed changes is planned for Early 2015.

Mental health. Mental health is a key priority for Southend CCG and we are fully committed to delivering parity of esteem. Throughout 13/14 the CCG made significant progress in a number of areas and intend to build on this over the next 2 years. The joint mental health commissioning strategy has driven key changes within Southend, namely, the development of a GP crisis line, improving dementia intensive support services, piloting psychological therapies in long term conditions, developing shared care protocols and reducing mental health delayed discharges.

We have recently formed a joint commissioning arrangement that establishes a new model of care for primary mental health services in Southend.

b) Please articulate the overarching governance arrangements for integrated care locally

Southend's Integration Pioneer Programme is overseen by the Joint Executive Group (JEG) and schemes developed through the Better Care Fund will be included in these Governance arrangements. The JEG is directly responsible to Southend's Health and Wellbeing Board (HWB) for Pioneer implementation, Better Care Fund, 7 day services and Southend's integration strategy.

The JEG includes membership from the council, the CCG, Southend University Hospital NHS Foundation Trust, South Essex Partnership University NHS Foundation Trust, Southend Association of Voluntary Services, Essex County Council, Castle Point & Rochford CCG and Public Health. The JEG will monitor performance targets and milestones and include the partners required to take any corrective measures required to keep the schemes on track.

The governance structure is summarised in diagram 1 below:

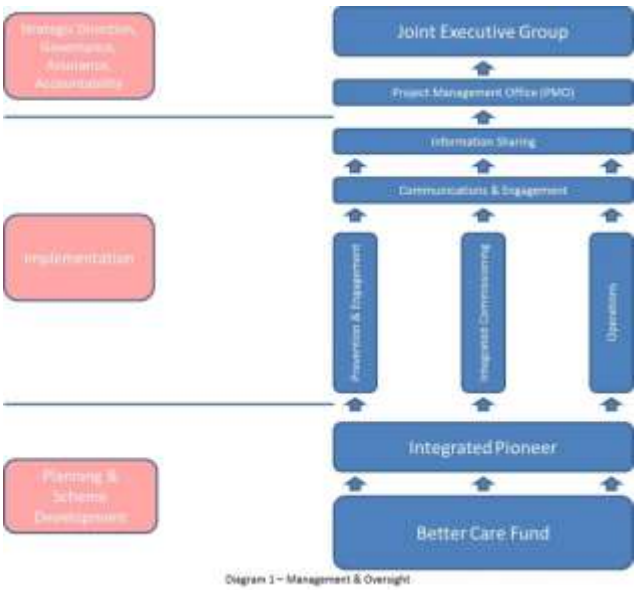


Diagram 1 – Management & Oversight

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Governance Structure

The Southend System will make use of an existing governance structure to oversee the delivery the 6 BCF schemes, as indicated in section 4b above with responsibility for strategic decision maki resting with the **Health and Wellbeing Board**.

Implementation

BCF leads from Southend will be represented at the JEG which will:

- drive the delivery of all projects
- engage with senior staff
- assess project performance through highlight and exception reports
- manage delivery by exception
- produce a report for Health and Wellbeing Board Programme on status, immediate challenges and accountable actions.

Schemes will be individually considered with regard to roles and assignment, for example;

- Executive Sponsor
- Programme and Project Manager
- Corporate Support (Finance and Information)
- Clinical Lead / Social Services Lead

Monthly Project Boards

Project delivery will be managed via the Integrated Pioneer Programme and governed through t JEG.

Each project team will report against project impact and elements that are off track via the monthly Highlight Report.

Project Tracking

A standardised monthly highlight report will be developed for each project team to track delivery:

Activity: key metrics to be reported on will include;

- Avoidable emergency admissions
- Permanent admissions of older people to residential and nursing care
- Effectiveness of reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience

Financial: outturns not achieving forecasted monthly targets (both savings and investments).

- Anticipated shifts in spending patterns. It is expected that the costs of community and social care will increase while the costs of acute hospital care will reduce. The extent of shifts in spending patterns indicates the degree of the success.
- Improved health outcomes should lead to reduction in costs of health and social care; healthier population requires less input from professional health and social care services.

Risks: exceeding agreed tolerances for:

- Quality in terms of impacts on the population and the proposed mitigating actions to remedy or reduce the risk.
- Delivery of Projects due to delays or dependencies and the proposed mitigations with impact analysis.

Please note that time did not allow for the CCG Governing body to sign off Southend's BCF plan.

This plan is therefore submitted as an intent for Southend and is subject to CCG Governing Body sign off on 26th September 2014.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Please see embedded document for a summary of schemes


Southend Part 1 19.09.14_Summary (


Southend Part 1 19.09.14_Summary (

Ref no.	Scheme
001	Protect Social Services through Independent living including reducing the reliance on residential care
002	End Of life, palliative care and community services
003a	Prevention including intermediate care, Primary and community care and transforming the emergency pathway
003b	Prevention including reablement
004	Integrated Care through the GP Hub
005	Infrastructure to support Integrated working

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs Effect – the reputation of each partner is damaged.	3	4	12	• Appropriate governance structures Provision of regular, timely and accurate information to support monitoring of services • **Owner – Joint Executive**

				Group
Failure to reduce acute activity causing financial pressure Effect – continued financial pressures which will impact commissioning and provision of services.	3	4	12	• System planning is focused on a range of community interventions in a move away from hospital admission. • Regular joint monitoring of progress against identified deliverables and early identification of emerging risks will ensure that potential problems are spotted quickly and mitigation action taken. • Closely monitor demand for acute services and ensure that contingency plans are in place for diversion of funding if necessary • Development of the BCF plan across partnerships to explore sharing of risk and rewards • **Owner – Joint Executive Group**
The transition to new models of working lead to risks to quality and safety. Effect – patients experience low levels of quality and safety to patients is a risk of being compromised.	3	4	12	• Clear lines of accountability up to and including the HWBB. • Ensure a clear mobilisation transition plan is developed and overseen by JEG • A robust performance and quality outcomes framework needs to be developed to monitor quality and safety. • **Owner – Joint Executive Group**

The scale and pace of the change required with risk of increase in number of SUIs and safeguarding referrals across the partnership	3	4	12	• Review of quality and Safeguarding arrangements in place to respond to and learn from any issues that arise • Accountability to H&WB board as well as internal governance boards • Review of existing resource capacity to deal with SUIs and safeguarding referrals • **Owner – Southend BC**
Staff within partnership organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery Effect – detrimental impact on staff morale.	3	3	9	• Workforce strategies across partners need to take into account change requirements • **Owner – Joint Executive Group**
We are unable to engage care homes sufficiently Effect – admissions from Care Homes continue to increase which enhances the gap between commissioner and provider.	2	3	6	• Training and incentive programme in development for care homes • **Owner – Southend BC**
We are not able to share data across organisations Effect – the ability to risk stratify diminishes which leads to un-evidenced service redesign.	3	3	9	• Use of anonymous data until CAG approval to application to amend s251. • Liaison with national team to use CARETRAK as a model of best practice and pilot to remove barriers. • **Owner – Joint Executive Group**
Despite intentions and plans social care services are not protected. The council are subsequently not able to provide assurance to Cabinet that the BCF	3	5	15	• Closely monitor demand for social care arising from

submission protects social care due to minimal protection of social services which will have an impact on robustness of 15/16 budget. Effect – continued pressures on council social services which could potentially lead to effects on front line services.				demographic change and the new statutory duties under the Care Act • Robust governance process will ensure that risks are quickly identified. • **Owner – Southend BC**
Re investment and a changed commissioning focus may create viability problems for providers.	2	4	8	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of savings plans on providers • Impact of plans on quality of service delivery monitored • Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered • Resilient grant funding process. • Mapping the journey workshops to redefine pathways of care. • **Owner – Joint Executive Group**
There is a risk that the local authority and Southend CCG are unable to agree actions to re direct resources to meet the requirement soon Effect – delayed development of the implementation plan.	2	4	8	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan • Further development of integrated service delivery

				projects with robust evidence base to measure success • **Owner – Joint Executive Group**
There is a risk that demand for crisis services (residential/ hospital services) will not reduce because of insufficient quality of Community & primary services.	3	5	15	• Early and broad engagement with community and primary care providers on the CCG and the council quality agenda. • Resilient grant funding • **Owner – Joint Executive Group**
There is a risk that the acute services review in Essex will be out of sync with BCF implementation Effect – a continued provision of inefficient acute services.	2	3	6	• Close engagement with Monitor and the TDA as well as other local and national partners on emerging findings. • Use of CCG and the council plans to influence the outcome of the review. • Joint agreement on adaptions required to BCF planning for alignment with the wider strategic review • **Owner – Joint Executive Group**
Lack of engagement and support from Providers Effect – commissioner and provider plans are not aligned.	3	3	9	• CCG engaged with providers to remodel pathways and services. • Use the JEG to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for transformation and use these to inform on-going discussions

				• Use provider clinical forums to keep clinicians aware and engaged. • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business. Develop a communication strategy for both internal and external stakeholders. • **Owner – Joint Executive Group**
Staff are not fully aware of and engaged with the changes set out in the Better Care Fund plan Effect – reduced morale and staff buy-in to transformation.	2	2	4	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' comms channels to promote better understanding and flag examples of excellent performance and innovation • **Owner – Joint Executive Group**
GP practices do not take up and fully implement the DES	2	2	4	• GP clinical leaders are working with practices to encourage sign up • Integrated communication plan enabling GP practices to learn lessons from the GP Hub pilot and implementation. • **Owner – Southend CCG**
The significant gap that remains between	2	3	6	• The Southend System has an

Commissioners and Providers forecasted reduction in non-elective activity is not addressed substantially so that plans may be aligned.				established formal partnership. This partnership works within a robust governance structure that promotes and facilitates provider and voluntary sector engagement. The providers to the Southend market are represented at all levels of Southend System leadership, for example; the Health and Wellbeing Board (HWB), Joint Executive Group (JEG), operational working groups and resilience planning groups. • We continue to regularly review the robust governance structure in place to assure the system leaders with regards to issues concerning delivery and stakeholder engagement. As part of the BCF plan implementation process a 'data, analytics and communications work stream' has been incorporated with the remit of data, baseline and engagement assurance. This group will report directly to the JEG. Providers are represented on this working group. • A priority for this work stream is the agreement between all stakeholders with regards to the baseline position. • **Owner – Joint Executive Group**

The Southend Borough council may be exposed to a deficit of circa £4.7M even if the benefits of BCF are realised.	3	4	12	• It is recognised that the BCF, in its own right, will not deliver the required transformational change across the Southend system. Therefore, the BCF is aligned with other transformational programmes, e.g. QIPP, System Resilience. We continue to develop this alignment and programme approach within the governance process. • A well-established partnership approach that facilitates and enables the early identification of issues and a robust approach to addressing the issues proactively. • A robust structure to monitor performance and evaluate delivery. • We would expect for a fully developed contingency plan to have been completed as part of the implementation programme governance arrangements, noted above.
The partners do not work to meet the milestones defined in the 7 Day services plan	2	3	6	• It is recognised that the BCF, in its own right, will not deliver the required transformational change across the Southend system. Therefore, the BCF is aligned with other transformational programmes, e.g. QIPP, System Resilience.

				We continue to develop this alignment and programme approach within the governance process. • A well-established partnership approach that facilitates and enables the early identification of issues and a robust approach to addressing the issues proactively. • A robust structure to monitor performance and evaluate delivery.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Background

Our BCF plans are factored into the 2-year operational and 5-year strategic plans produced by the CCG and are in turn reflected in the 5-year strategy of the Southend University Hospital NHS Foundation Trust. These have been considered and signed off by the CCG Governing Body and the HWB.

Our Plans clearly show a record of shifting activity to the community from the acute sector. We anticipate this will be further delivered as part of the next iteration of Operational and Strategic Planning.

Within the Southend Better Care Fund, the financial value of the non-elective admission saving/performance fund is calculated as £977K pa, representing a 3.5% reduction in Southend CCG responsible activity.

Risk sharing arrangements between providers and commissioners

Financial risk falls mainly on the CCG as commissioner, in that if the reduction in emergency admissions is not achieved, this would mean that the CCG will bear the cost of these admissions, as well as the cost of the investment in BCF initiatives. This risk is managed primarily through the setting and achievement of the CCGs QIPP programme that includes the BCF pressures in the totality of the CCGs cost programme. We have established robust arrangements with our acute providers to monitor delivery of QIPP plans.

The CCG has established a range of internal mitigations (such as general and earmarked reserves) and also external risk sharing arrangements with other commissioners which it can draw upon.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

At Southend the BCF is viewed as part of a whole systems approach to health and social care integration, including our plans to implement the Care Act. The challenge for the Southend System is to ensure that Southend's activity re Pioneer, Year of Care and the pilot project for 7 day services are closely aligned with BCF plans.

Underpinning the work of the integrated teams in Southend is a whole systems approach to assessment, care coordination and choice and control that provides support to people to stay as independent as possible in the community and enjoy the best quality of life. For all people with social care needs, provision of a personal budget following assessment is key to ensuring that people have control over their circumstances and can make the best decisions about their own

support, which could include telecare, community equipment and adaptations; homecare or a personal assistant or if required, a move to extra-care accommodation.

Our pioneer integration project extends the reach of health and social care integration to include primary care networks at its heart and to work with all client groups with complex needs. This integrated service will become part of the Southend landscape and will make use of existing care pathways and services.

From a housing policy perspective the BCF plans closely align with SBC's Housing Strategy 2011-21. This Housing Strategy builds on the aspirations of SBC's Older Peoples Accommodation and Support Needs Strategy 2008-11 which set out the Council's support for older people to remain in their own homes for as long as they are able to possibly with support, assistive technology and a commitment to lifetime homes.

Also in line with the implementation of the Housing Strategy, SBC will be undertaking a review of sheltered housing stock within the borough to identify whether it is fit for meeting the needs of older people in the 21st century and if this can be enhanced to meet the needs of frailer older people. SBC are also seeking to create a Southend definition of extra care housing and look at whether increased provision would support people to remain living independently and reduce the need for residential accommodation.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our BCF plan is incorporated within Southend CCG's 2 year operational and 5 year strategic plans. The financial impact of the BCF has been included in the financial model, and is one of a number of factors driving the CCG's QIPP requirement of £34.1m over the 5 year period to 2018/19. The BCF is not viewed by the CCG as a standalone initiative, rather it is an integral part of our delivery plans including the Operational Resilience and Capacity plan, which taken in the round describe the changes necessary to deliver a modern model of integrated care, alongside other key system changes that are required to achieve high quality, sustainable services.

Our BCF seeks to address the challenges presented by a significant increase in prevalence of chronic diseases, which would lead to increased levels of admissions to hospital, but with the implementation of the Ambulatory Emergency Care scheme together with changes to primary care and Community Reablement will mitigate these admissions ;

- COPD – projected increase of 11% by 2015
- Diabetes - projected increase of 12.5% by 2015
- Stroke - projected increase of 9.5% by 2015
- Hypertension - projected increase of 4.5% by 2015

Delivering these requires the BCF vehicle in order to transform and align Community and Social Care for patients outside of the hospital setting. Our five year operating strategy then supports a process to make this a sustainable landscape through measuring and delivering seven outcome measures going forward to which the BCF schemes contribute significantly towards;

1 – Potential years of life lost from causes amenable to healthcare

2 – Health related quality of life for people with one or more long term conditions

3 – Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community

4- Increasing the proportion of older people living independently at home following discharge from hospital

5 – Increase the amount of people who have a positive experience of hospital care

6 – Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

7 – Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NHS Southend CCG has bid to shadow the area team as part of its co-commissioning proposals. This is commencing in October 2014 and the CCG has already joined regular Essex area team meetings. A steering group has been established and is developing terms of reference and governance processes.

We believe that co-commissioning will better:

- support the integration of health and social care services locally;
- drive quality improvement within primary care, and reduce health inequalities;
- increase citizen involvement in the development of primary care services;
- support the development of sustainable local services.

Co-commissioning would provide the CCG with the ability to influence how local services are commissioned to ensure that these align with the unit of planning's 5-year strategy and with a focus on outcomes for our local population.

Our 5-year Strategic Plan identifies the need to improve the delivery of care, particularly for people with long term conditions and older people living with frailty. The opportunity to commission locally sensitive services, if deemed more suitable than nationally specified enhanced services would be particularly helpful in supporting delivery of more integrated services in partnership with the council through increased engagement with our member practices.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The current eligibility criteria for adult social care will remain at critical and substantial. It is not envisaged this will change over the next five years unless mandated by the Care Act, although this is dependent on the financial position. Our local definition of protecting social care services is, "ensuring eligibility criteria and investment remains at required levels with a focus on prevention and ensuring that health services are available earlier and in better co-ordinated ways to reduce demand on social care"

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Promoting independence and reablement, supporting carers and offering alternatives to longer term reliance on residential care are key elements of the Southend approach to protecting social care services. Our BCF schemes are focused on achieving these aims in tandem with a reduction in hospital admissions.

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

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

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

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

The Care Act offers opportunities to review our approach to assessment and we will explore options for increased use of self-assessment and review options for the delivery of front end assessment with an increased focus on self-management and use of universal services. The Care Act is the catalyst for further developing our information, advice and guidance pathways and we will use the BCF to scope out opportunities for a joint IAG approach. Within our BCF schemes we have allocated £627k (of which £172K is capital) to support implementation of the Care Act.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total amount allocated from the BCF for the protection of adult social care services in 2015/16 is £5.930M.

Funding currently agreed for 2014/15 via the NHS transfers monies has enabled the local authority to maintain current eligibility criteria, keep delayed transfers of care to a minimum and offer timely assessment and longer term support to people with eligible needs. This will need to be increased, within the funding allocations for 15/16 and beyond to maintain and develop further the current offer. In particular the Care Act is likely to impact on the numbers of assessments required with larger numbers of people needing an assessment who would previously have not had contact with Social Care. This also raises the opportunity to engage in preventative approaches with a wider range of Southend residents and strengthens the importance of a joint

approach.

Due to the documented financial difficulties of Southend CCG it has not been possible, as yet, to find any additional allocation to protect Social Services within the BCF plan for 2015/16 beyond the minimum commitments and funding for the implementation for the Care Act.

If not successful, this will leave the council facing a deficit in the provision of Adult social services in the region of £4.7M (circa 11%) which is likely to impact on the provision of integrated front line services.

Both the CCG and the council have agreed a plan to work together on an open book basis to review the apportionment of BCF funding.

We can confirm that our local proportion of the £135M has been identified from the additional £1.9bn.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Our focus on prevention with an emphasis on promoting well-being and self-care will support the aims of the Care Act.

We recognise that underpinning all of the individual's care and support requirements is the need to ensure that what we are doing focuses on the needs and goals of the person concerned. We acknowledge that wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible

We are committed to ensuring that we consider how to meet each person's specific needs rather than simply considering what service they will fit into and we will adopt a co productive and flexible approach with service users and carers which concentrate on the aspects of wellbeing which matter most to them.

Our prevention work is well developed but is benefitting from a specific work stream focus led by Public Health and a third sector representative. A joint CCG and Local Authority prevention strategy is being developed focusing specifically on the frail elderly population which will bring together a joined up approach to commissioning prevention focused services.

A number of the BCF schemes have a clear connection to the new duties of the Care Act particularly around new duties to carers; prevention and wellbeing; assessment and eligibility; care planning and personalisation. These are schemes to:

- Increase in carers' assessments and provision of services and support to carers
- Increase in assessments in preparation for the reform of funding which takes effect from April 2016.
- Work collaboratively with voluntary organisation and advocates to identify people who might have support needs that are not being met and to make services available which will enable a person to stay independent.
- To ensure that there is accessible and proportionate information available which meets the needs of the person, ranging from information on a web site to a face to face discussion or advocacy
- Invest in staff training to ensure that all professionals are trained in early identification of behaviours that can lead to poor health and the advice and information they should provide to promote wellbeing..
- Work closely with Public Health to target the vulnerable areas of Southend.

A project plan is in place to assure implementation of the Care Act, which is overseen by the Head of Adult Services.

We will use the Care Act monies identified in the BCF (Annex 1, Schemes 003b and 005) to support funding for a wider range of carer's services which are currently being scoped. This will include developing our carer's assessment and support offer.

v) Please specify the level of resource that will be dedicated to carer-specific support

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

- Identifying the carers who are not currently known to the council
- Increasing and developing the workforce in response to the increased demand.
- Investing in staff training of both health and social care staff to ensure that the staff have the skills to recognise the impact of the caring role on the carer as well as ensuring the carer has a self-directed service.
- Ensuring that there is accessible advice and information available to carers to support them in their caring role

£437k is allocated to carer specific services, this is the council and CCG commissioning a range of services to support carers and the joint Carers Strategy.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no effect on the local authority's budget against what was originally forecast with the original BCF plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

In November 2013 Southend was accepted as an Early Adopter site to provide 7 Day services. Southend's aim for 7 Day services is ….

….. *"We want to refashion our services to our patients, their carers and families, so that they always feel supported and cared for, no matter where they are in the system or what day of the week it is."….*

During the course of 2014 we have been working to identify the improvement priorities and integrate these into existing programmes of work. New projects have been created where appropriate and progress is tracked through the governance of the Joint Executive Group (JEG).

Our review has focused on;

- access to health and social care outside of hospital;
- 7 day services in the hospital; and
- Leaving the hospital after treatment to the next place of care.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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

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

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We are fully committed and have a Health and Adult Social Care Services - Information Sharing Protocol (April 2013) with 4-5 more detailed sharing agreements that sit below this e.g. CARETRAK, Major Adaptations. We also annually submit the NHS IG Toolkit. An application has been made to the Confidentiality Advisory Group (CAG) to amend the s251 agreement and achieve a local short-term solution. The CAG will consider the application on 11th December 2014. Previous applications have been deferred by the CAG with the request that identified issues are resolved. We have worked through these issues which have led to the revised application on 11th December 2014.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Since September 2012 the CCG and the council has commissioned a Single Point of Referral Service (SPOR), which acts as the key contact point for health care professionals both in primary care and acute discharge services, to the integrated teams which provides a multi-disciplinary response to urgent issues or needs of patients within the community who would otherwise attended A&E and experienced a 0-1 length of stay. We anticipate this service will be available 7 days a week once it is fully up and running. At present the threshold has yet to be established with regard to the number of referrals that can be made into the service upon full implementation although the numbers of referrals have increased year on year since the commencement of the service.

The risk stratification used to identify high risk patients are as follows:

- Patients over 65 years of age
- 2 or more A&E attendances over the last 6 months
- Patient with 2 or more LTC
- Polypharmacy
  Evidence of cognitive problems (acute or chronic)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Our existing integrated teams bring together health and social care managers and front line staff into joint teams, delivering coordinated care with a clear focus on roles and responsibilities though practice level multidisciplinary team working for high risk patients though risk stratification. This style of patient management allows for the different professionals to shared information and knowledge to allow better care planning which results in better outcomes for patient and their families. This integrated care based model was developed and has been used as a model of best practice though the Year of Care National Programme.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

All patients moving through the Pioneer programme will have collaborative care plans in place.

There is a practice population of 186,000 in Southend and 2% of these are in receipt of an MDT which represents 3,720 people.

Southend was in the unique position of having a joint risk stratification system software system (CARETRAK) which can identify and risk assess people in the health and social care system via a patient identification number which is based on the NHS ID. Since the formation of the CCG on the 1st April 2012 it has not been possible to access this system as a consequence of the data protection and patient confidentiality issues that have been raised by the Department of Health. Southend BC and the CCG are currently awaiting a decision from the CAG (D of H Confidential Advisory Group) on the Section 251 Agreement which will enable the information sharing and risk stratification protocol to be utilised.

Please refer to **Appendix 3** for the evidence base re current position.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Patient, service user and public engagement

The application for Integrated Pioneer status was initiated by the council and has built upon a wide process for public, service user and patient engagement. This has been followed by a successful event, held by the CCG, in January 2014 which captured patient views on health and social care in Southend. This information has been used in developing our BCF and integrated pioneer plans and our five-year strategy. Essentially some of the main themes were as follows:

- Services available under one roof at the GP practice
- Better integration of care – a seamless service
- Better access to the GP practice
- Support for self-care

The CCG has a practice patient participation group (PPG) forum which is made up of representatives from many of our member practices. The PPG forum has a keen interest in the better care fund and how health and social care services work together to improve services to patients and has asked for regular update on our on-going projects.

The CCG has established a new patient and public engagement steering group to support the development of a new communications and engagement strategy. As well as including the CCG, Healthwatch and council Members, the group also includes representatives of our local population and the voluntary sector and will support and challenge the CCG in better engaging our citizens in commissioning. This group will also support the development of patient and public engagement in our better care fund plan and our integrated pioneer work.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

<u>NHS foundation trusts and NHS trusts</u>

Two workshops were held in May and June 2014 which included our key local health providers in order to develop our five-year strategy, with a key focus on integration of services across the borough.

ii) primary care providers

Southend GPs and member practices have been engaged at various levels. The GPs elected to the CCG's Governing Body and appointed to the clinical executive have been directly involved in the development of this plan, and key elements of the BCF schemes have been supported by GP colleagues working as clinical project leads (as part of our overall QIPP and Transformation Programme). In addition the CCG has appointed a GP as clinical lead for integration, who works with the CCG one day a week.

iii) social care and providers from the voluntary and community sector

Southend Association of Voluntary Services (SAVS) is a key member of the GP hub project board and also leads the prevention work stream under the Health and Wellbeing Board.

SAVS form part of our new patient and public engagement steering group which will be responsible for shaping the development of our communications and engagement strategy and for supporting its delivery.

Two workshops were held in May and June 2014 which included the council social care and SAVS in order to develop our five-year strategy, with a key focus on integration of services across the borough.

A whole system approach is being adopted for the modelling of a Community Recovery Pathway. The Community Recovery and Independence pathway includes a range of services traditionally referred to as intermediate care, reablement and rehabilitation. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a **single** pathway across health and social care.

This pathway would not only support efforts to keep people out of hospital and remain independent for as long as possible, but also mean further progress with integrated care and improve the local preventative services offer.

The model may include:

- Crisis and rapid response
- Early support hospital discharge
- Community rehabilitation and reablement
- Bed based rehabilitation
- Falls service

Key interdependencies:

- Hospital discharge team (social care)
- District nursing
- Community Matrons
- Locality social workers
- Primary Mental Health services
- Community geriatrician
- GPs
- Voluntary sector
- Private sector care providers

Who is the service for?

Adults with a primary need for short-term rehabilitation, recovery and/ or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence.

What does it look like?

At the centre of the model is an integrated multi-disciplinary team providing a 7-day service. The team may include:

- Occupational therapists
- Physiotherapists
- Social workers
- Nurses including psychiatric liaison
- Therapy assistants and support workers.

The team may also include a GP

The team will carry person-centred, **holistic** assessment, goal setting and review to enable people to achieve their outcomes and reach their maximum level of independence. Staff will have a common set of core skills, such as assessment, planning and case coordination, as well as retaining their specialist skills and knowledge.

Common principles:

- Person-centred and proportionate
- Prevention and maximising independence
- Recovery and enablement
- Focussed on goals and outcomes
- Effective case coordination
- Single referral route
- Single joint assessment
- Integrated care plan
- Positive risk taking

Throughout this pathway, a risk stratification tool may be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management. These cases may be identified through MDT meetings with clear outcomes agreed on a case-by-case basis.

What difference will it make?

The focus of the Community Recovery and Independence Pathway is on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for an on-going packages of care and thereby reducing long-term dependencies on care and support. Effective and coordinated services will achieve longer-term (financial) benefits for the health and social care economy.

What added value will this approach bring?

- Potential reduction in duplication of care planning and assessments leading to potential transactional efficiencies
- Proactive community offer and intervention to prevent hospital admission
- Better coordination and case management leading to better outcomes for the service user
- Bigger, more flexible resource may lead to efficiency savings
- Longer term savings from the care system as a result of effective interventions
- Focus on whole system working with all stakeholders, particularly Providers of services, working as partners to achieve the best outcomes.

Things to consider:

- Step up and step down (not necessarily bed based)
- Day resource centres and assessment flats
- Community ward and care navigator model may be included
- In-house versus commissioned personal care
- Role of the hospital discharge team

How will the model of delivery be achieved?

Four multi-disciplinary workshops have been held (one in July, two in August and one in September with a further workshop planned for early October) to map out the "as is" pathways and to understand what is working well and where there are weaknesses in the system which impact on outcomes for individuals using the services; particular emphasis will be placed upon ensuring that there is sufficient capacity in the market to meet changing demand and to incorporate flexibility so that surges in demand can be met.

The output from the workshops will influence the redesign of the pathway which will take a multi-disciplinary approach; Healthwatch and representative organisations will be invited to participate in the re-modelling.

Health and social care will review the services currently commissioned within the current pathways and engage with Providers to disseminate the vision for integrated working. This will enable Providers to adapt services and diversify, where necessary, to meet the requirements of the integrated pathways.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The overall impact of CCG allocations and BCF and QIPP requirements over a five year period is already modelled within the operational planning submissions made by the CCG for the 2014/15 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. The CCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Southend University Hospital NHS Foundation Trusts' financial sustainability.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

SCHEDULE 7– POLICY FOR THE MANAGEMENT OF CONFLCITS OF INTEREST

NOT USED

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

NOT USED

SCHEDULE 9 STAFF ARRANGEMENTS

NOT USED

Southend Health & Wellbeing Board

Agenda Item No.

7

Report of Director of Public Health

……

to

Health & Wellbeing Board

on

1st August 2016

Report prepared by: James Williams Head of Health Development

For information only		For discussion X		Approval required	

Southend-on-Sea Joint Adult Prevention Strategy 2016-2021

Part 1 (Public Agenda Item)
Lesley Salter Executive Councillor for Health and Adult Social Care

1. Purpose of Report

1.1. To present the Southend-on-Sea Joint Adult Prevention Strategy 2016 -2021.

2. Recommendations

2.1. The Health and Wellbeing Board is asked to discuss and provide feedback on the draft Southend-on-Sea Joint Adult Prevention Strategy 2016-2021 and associated action plan.

3. Background & Context

3.1. The Care Act (2014) placed a new duty on local authorities to promote individual wellbeing and provide prevention services. This duty requires the Council and its partners (NHS Southend CCG) to provide or arrange services that prevent, reduce or delay the need for support among local people and their carers.

3.2. Prevention in the context of this paper refers to any intervention or action that prevents, reduces or delays deterioration in the physical and mental health of adults resident in Southend. For example, admission (or readmission) to hospital that could have been prevented if an individual was provided with the skills to self-manage their chronic condition, or permanent placement in a residential care setting due to an individual not being able to live independently due to social isolation.

3.3. There are 3 generally accepted types of preventative activity.

3.4 **Primary prevention**

Primary prevention is defined as interventions and services aimed at individuals who have no current particular health or social care support needs. The aim of primary prevention is to help people avoid developing needs for care and support by maintaining independence, good health and promoting wellbeing. Interventions include: providing universal access to good quality information and advice, supporting safer neighbourhoods and promoting healthy and active lifestyles.

3.5 **Secondary prevention**

Secondary prevention refers to interventions or services aimed at individuals who are at risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration. Screening or case finding may be used to identify those individuals most likely to benefit from targeted services Examples include NHS Health Checks and postural stability programmes for falls.

3.6 **Tertiary prevention**

Tertiary prevention refers to interventions aimed at minimising the impact of disability or further deterioration in people with existing health condition or complex care and support needs, including supporting people to regain skills and reduce need where possible. Action is taken to manage any adverse event that could trigger entry into a high cost service, which could include admission into hospital or residential/nursing care. Examples include re-ablement and support to people with serious mental health problems.

3.7 On the 2nd December 2015, a paper was presented to the Southend Health and Wellbeing Board. This paper provided the rationale for a Joint Adult Prevention Strategy for the Borough. The Board discussed the key issues underpinning the need for a Joint Adult Prevention Strategy and agreed the strategy scope and key outcomes.

3.8 The Board requested the development of the strategy take account of the needs of all partners with a specific focus on engagement with primary care and the voluntary sector. In line with the Boards direction, a multi-agency task and finish group was established to develop the strategy. This group comprised:

NHS Southend CCG-Chair and clinical lead	**NHS Southend CCG**-Lead commissioning manager
SAVs –Chief Executive	**Southend Health Watch**-Senior Officer
SBC- Group Manager Service Transformation	**SBC**- Programme Manager Health and Social Care Integration
SBC- Head of Health Development	**SBC**- Health Improvement Practitioner Advanced (Older Adults)

3.9 Following a process of revision and challenge, a draft strategy and outline action plan has been completed. The strategic aims of this strategy reflect partnership priorities and the key issues impacting on the health of local people. The high level priorities are:

- To focus action to embed prevention in all policies
- To improve access to high quality information, advice and signposting
- To support people to increase their sense of control and resilience in their lives by enabling them to effectively self-manage their condition
- To promote specific action to improve health & wellbeing
- To prevent, reduce and delay the use of health or care services.

3.10 The Board may wish to debate whether the strategy and its related action plan, reflect the desired population outcomes the Board highlighted previously.

3.11 The Board may wish to reflect on how frequently they would like to receive updates on the strategy progress, taking into account the 5 year span of the strategy and varying timelines for achievement for specific performance indicators within the action plan.

4. Health & Wellbeing Board Priorities / Added Value

How does this item contribute to delivering the;

- Nine HWB Strategy Ambitions (listed on final page)
- Three HWB "Broad Impact Goals" which add value;
    a) Increased physical activity (prevention)
    b) Increased aspiration & opportunity (addressing inequality)
    c) Increased personal responsibility/participation (sustainability)

4.1 The proposed Joint Adult Prevention Strategy aligns with the specific statutory duties of the Southend Health and Wellbeing Board namely:

- To assess the needs of their local population through a JSNA
- Set out how these needs will be addressed
- Promote greater integration, partnership working, including joint commissioning, integrated provision and pooled budgets

4.2 The scope of the strategy is restricted to the direct role of adult social care (in partnership with NHS Southend Clinical Commissioning Group). In practice this means adults (persons aged 18+).

These people may:

- Require or will require access to information, advice and advocacy services
- Care for someone currently in receipt of health and/or social care services
- Require or are be at risk of requiring, intensive health or on-going social care support
- Require or will require low level non health or social care based support to maximise their independence

*The specific cohort of adults are:

- Older People
- People with Learning Disabilities
- Older People with Mental Health Problems
- Mental Health
- Physical Disability including sensory impairment
- Carers
- People with chronic long term conditions in direct receipt of social care or health service support

4.3 **Programme of delivery**

4.3.1 The outcomes of this strategy will be delivered through collaboration and engagement with key partners. The Southend Health and Social Care Transformation Programme will provide programme oversight and governance in relation to specific initiatives and deliverables.

5. Reasons for Recommendations

5.1 The Health and Wellbeing Board are required to determine how the scope of the proposed strategy aligns with the Board's strategic ambitions.

5.1. The Southend Joint Adult Prevention Strategy and associated action plan, puts in place a shared preventative approach across all key organisations in the Borough. The strategy will help to develop community resilience. It will shift the emphasis away from service provision and empower local people to take steps to improve their own health. This approach is inline with the Boards long term ambition to tackle health inequalities within the Borough. It enables, earlier identification and action to be taken to address issues in those people at greater risk of poor health outcomes.

5.2. This strategy also provides a Southend locality prevention focussed programme. A clear strategy to deliver prevention, in localities is a requirement of the Mid and South Essex Sustainable Transformation Planning (STP) process. This process requires local NHS commissioners and providers of health care, to work with local authorities and their partners, to put in place a joint plan to deliver, sustain and improve health and care services for local people.

6. Financial / Resource Implications

6.1 There is a strong financial case to invest in evidence based preventative activities. Effective prevention done at the right scale, can reduce the cost of expensive NHS or social care services. The strategy action plan provides some examples of potential benefits that can be achieved through 'industrial scale ' action or specific targeted interventions. For example, the cost to health and social care commissioners of a single hip fracture related to an accidental fall in an older adult is in the region of £28,000 over 2 years. There is strong evidence that community based falls prevention programmes reduce the likelihood of older people falling. The key element for success in such programmes is identification of those at risk and supporting them to attend relevant courses.

7. Legal Implications

7.1. The Health and Social Care Act 2012 placed a statutory duty on Health and Wellbeing Boards to promote partnership working to improve the health of local people. The Care Act 2014 requires local authorities to provide prevention services.

8. Equality & Diversity

8.1. Equality issues have been taken into account in the development of this strategy. Southend Health Watch were part of the task and finish group. An equality impact assessment will be performed on the final agreed strategy.

9. Background Papers

9.1. Southend-on-Sea Joint Adult Prevention Strategy

10. Appendices

10.1.

HWB Strategy Priorities

Broad Impact Goals – adding value

a) Increased Physical Activity (prevention)
b) Increased Aspiration and Opportunity (addressing inequality)
c) Increased Personal Responsibility and Participation (sustainability)

Ambition 1. A positive start in life	Ambition 2. Promoting healthy lifestyles	Ambition 3. Improving mental wellbeing
a) Reduce need for children to be in care b) Narrow the education achievement gap c) Improve education provision for 16-19s d) Better support more young carers e) Promote children's mental wellbeing f) Reduce under-18 conception rates g) Support families with significant social challenges	a) Reduce the use of tobacco b) Encourage use of green spaces and seafront c) Promote healthy weight d) Prevention and support for substance & alcohol misuse	a) A holistic approach to mental and physical wellbeing b) Provide the right support and care at an early stage c) Reduce stigma of mental illness d) Work to prevent suicide and self-harm e) Support parents postnatal

Ambition 4. A safer population	Ambition 5. Living independently	Ambition 6. Active and healthy ageing
a) Safeguard children and vulnerable adults against neglect and abuse b) Support the Domestic Abuse Strategy Group in their work c) Work to prevent unintentional injuries among under 15s	a) Promote personalised budgets b) Enable supported community living c) People feel informed and empowered in their own care d) Reablement where possible e) People feel supported to live independently for longer	a) Join up health & social care services b) Reduce isolation of older people c) Physical & mental wellbeing d) Support those with long term conditions e) Empower people to be more in control of their care
Ambition 7. Protecting health	**Ambition 8. Housing**	**Ambition 9. Maximising opportunity**
a) Increase access to health screening b) Increase offer of immunisations c) Infection control to remain a priority for all care providers d) Severe weather plans in place e) Improve food hygiene in the Borough	a) Work together to; ○ Tackle homelessness ○ Deliver health, care & housing in a more joined up way b) Adequate affordable housing c) Adequate specialist housing d) Understand condition and distribution of private sector housing stock, to better focus resources	a) Have a joined up view of Southend's health and care needs b) Work together to commission services more effectively c) Tackle health inequality (including improved access to services) d) Promote opportunities to thrive; Education, Employment

Southend-on-Sea
Joint Adult Prevention Strategy
2016-2021

Contents

"Invest in prevention, not remediation.
Invest in flourishing lives, not in correcting problems after they appear."
'Professor James Heckman Nobel Laureate'

Foreword

I am delighted to introduce the Joint Adult Prevention Strategy for Southend-on-Sea 2016-2021. This strategy is focused on the adult population of the Borough. It sets out our ambition to reshape the landscape of Southend through preventing illness and disease to avoid the need for costly treatment and care.

We know that a quarter of the population of Southend-on-Sea live within the most deprived 30% of all areas in England. These people suffer worse health outcomes than people living in our more affluent areas. Men in the most deprived areas of Southend live 11.1 years less than men in the most affluent areas of Southend, for women this figure is 10 years. I am determined to redress this inequality.

We know that the biggest challenges to health and wellbeing in the 21st century are related to risks from diseases and conditions that we can do something about. These include cardiovascular disease, cancer, hypertension, obesity and lifestyle related dementia. By taking positive action to address modifiable risk factors for these conditions, we hope to create an environment in Southend where everyone can achieve their full potential.

I am clear we must change how we do things. Prevention ‘at scale’ is the only way to secure our communities health and tackle the siginficant inequalities that exist in some areas. We will provide greater access to information and advice to help people better manage their own health lifestyle risks. We will coordinate our programme of prevention to link with the programme of redevelopment and regeneration of the Borough.

My ultimate aim is to make Southend-on-Sea one of the healthiest towns in England by 2020. The implementation of this strategy will be pivotal in achieving this objective.

I recommend this Joint Prevention Strategy to you as one of the key vehicles that will help to improve the health and wellbeing of our local residents.

Councillor Lesley Salter
Portfolio Holder for Adults, Health and Social Care, and
Chair of Southend Health and Wellbeing Board

1.0 Our Vision

For Southend to be a Borough which promotes partnership working to improve the health and quality of life for individuals, families and communities, by moving the focus from ill health and disease to prevention and wellbeing.

Mission

Our mission is to enable Southend residents to live longer healthier lives. Local people will be able to take control and avoid or effectively manage issues that impact negatively on their health and wellbeing. Adults with a pre-existing health issue will be:

- Active partners with their care providers
- Able to problem solve and make changes
- Able to manage thinking and behaviours positively
- Able to access information and support that is useful for them

Strategic aims

To help us achieve our vision, we will use our influence and resources to deliver the following key strategic aims:

- To focus action to embed prevention in all policies
  We will look at transforming the way individuals and organisations recognise the importance of the prevention agenda, so that preventing illness and disease is at the forefront of local policy planning and commissioning.

- To improve access to high quality information, advice and signposting.
  We will create a communication and social marketing programme that provides helpful up-to-date advice and information to signpost people to where to access support.

- To support people to increase their sense of control and resilience in their lives by enabling them to effectively self-manage their condition.

  We will provide people with the necessary skills, knowledge and confidence to self-manage their long term conditions.

- To promote specific action to improve health & wellbeing.
  We will provide improved access to healthy lifestyle services.

- To prevent, reduce and delay the use of health or care services.
  We will support people to remain independent and reduce the need for hospital admissions or care home placement.

This strategy focuses on adults aged 18+ who are resident in the Borough .The specific priority areas for enhanced prevention are:

- Older people aged 65+
- People with learning disabilities
- Adults with mental health problems
- Physical disability (including sensory impairment)
- Carers
- People with chronic long term conditions

2.0 Introduction

The Southend health and social care system faces significant challenges. The population is getting older and frailer and there are more adults living with chronic long term health conditions such as diabetes, cardiovascular and respiratory disease. Added to these factors is the impact of fiscal austerity.

The NHS and publicly funded adult social care accounted for £157bn of public spending across the UK in 2015/16. This is equivalent to 8.4% of gross domestic product (GDP) or £1 in every £5 of government spending (1). Although national government made a commitment in 2015 to increase funding for the NHS by £8bn by 2020/21, there has been no equivalent commitment for adult social care, even though the pressures within the social care system are growing at a faster rate than pressures on health care. By 2020/21, it is estimated that 43.4% of national government spending will be allocated to older people and health services.

Locally Southend Clinical Commissioning Group has operated within a tight financial allocation over the last two years and their financial position is challenged particularly with issues within the acute hospital sector. There are also significant financial challenges for Southend-on-Sea Borough Council which has had to make financial savings of £56 million since 2011/12. Further cuts will be required in future years, totalling £33 million from 2016- 2019.

In order to prevent the system from becoming unsustainable, both health and social care will need to work in radically different ways than they did in the past. A key solution is to move ‘upstream’ and focus on prevention. This Joint Adult Prevention Strategy describes how the Southend health and care system will work in partnership to empower and engage individuals and communities to stay healthier for longer. It describes a fundamental shift from providing services that respond to a person’s ill health and care needs as they arise to a proactive model of services which aim to reduce, prevent and delay the onset of ill health and loss of independence.

There is good evidence that the introduction of large scale self-management interventions result in measureable benefits, particularly in terms of population health gain and reduced commissioning costs (2,3).

2.1 Definition of prevention

The term 'prevention' refers to a variety of measures taken to improve or maintain the health status of an individual or group of people. Prevention in the context of this strategy refers to any intervention or action that prevents, reduces or delays deterioration in the health of adults resident in Southend.

Prevention is often broken down into three general approaches: primary, secondary and tertiary prevention:

Primary prevention: measures to prevent ill health and promote wellbeing

Primary prevention is defined as interventions aimed at individuals who have no current particular health or social care support needs. The aim of primary prevention is to help people avoid developing needs for care and support by maintaining independence, good health and promoting wellbeing. Interventions include: providing universal access to good quality information and advice, supporting safer neighbourhoods, promoting healthy and active lifestyles.

Secondary prevention: measures to identify those at increased risk of poor health or wellbeing and intervene early

Secondary prevention refers to interventions aimed at individuals who are at risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration. Screening or case finding may be used to identify those individuals most likely to benefit from targeted services. Examples include; NHS Health Checks and postural stability programmes for falls.

Tertiary prevention: Measures that delay or minimise the impact of existing health conditions

Tertiary prevention refers to interventions aimed at minimising the impact of disability or further deterioration in people with existing health condition or complex care and support needs, including supporting people to regain skills and reduce need where possible. Action is taken to manage any adverse event that could trigger entry into a high cost service, which could include admission into hospital or residential/nursing care. Examples include re-ablement and support to people with serious mental health problems.

Preventative activity will only reduce demand within the health and care system, if interventions and outcomes are focussed on decreasing the gap between healthy life expectancy and life expectancy. Most strategies fail to achieve their

ambitions as they often establish new systems that do not take account of local need and pathways. The Southend Joint Adult Prevention strategy uses a placed based approach and existing systems to deliver preventative interventions at scale.

2.2 The case for prevention

People are living for longer than ever before – since 2002, life expectancy has been increasing year on year in Southend. However, the years lived in good health have not seen the same rate of increase. This means that many people will be living longer lives, but with more years of ill health or disability.

Population projections suggest that there will be an increase in the numbers in all older age groups from age 65 and over, both nationally and locally. With this increasing longevity there is also a noticeable increase in morbidity from long term conditions and disabilities within these age groups that causes concern. This increase also leads to increased pressure on health and care services.

2.3 The local population

Southend-on-Sea has an estimated population of 177,990 people, of which 18.9% are aged 65 and over - higher than the England average of 17.6%.

The overall life expectancy for men and women in Southend is similar to the England average (79.2 years men, 82.9 years women). Tables 1 and 2 provide 3 year rolling averages for healthy life expectancy in Southend and England, for males and females in the period 2009 to 2013.

Life expectancy is an estimate of the average expected life span, based on the current patterns of mortality; healthy life expectancy is an estimate of the years of life that will be spent in good health (illness free).

Table 1 Life Expectancy and Healthy Life Expectancy for Males and Females Southend

Year	Males		Females	
	Life Expectancy	Healthy Life expectancy	Life Expectancy	Healthy Life expectancy
2009-11	78.7	63	82.4	64.6
2010-12	79.7	64.1	82.6	64.9
2011-13	79.8	62.6	82.9	64.6

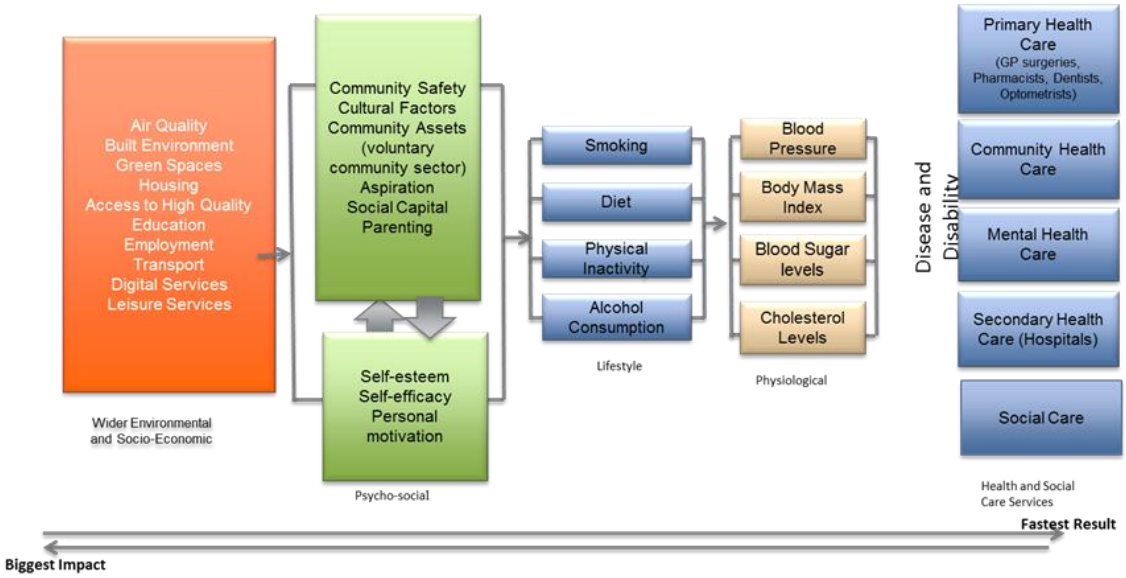
Table 2 Life Expectancy and Healthy Life Expectancy for Males and Females England

Year	Males		Females	
	Life Expectancy	Healthy Life expectancy	Life Expectancy	Healthy Life expectancy
2009-11	78.9	63.2	82.9	64.2
2010-12	79.2	63.4	83	64.1
2011-13	79.4	63.3	83.1	63.9

Life expectancy varies from population to population, men and women living in the most disadvantaged areas of Southend have a life expectancy 11.1 years and 10 years respectively, lower than men and women in the most affluent areas of Southend. We know that areas with high levels of deprivation have increased death rates attributable to conditions such as cardiovascular diseases, cancers, respiratory disease (3). Therefore any preventative action we take locally, must also address disadvantage and inequality (3,4).

Between 2012-2014, 1483 Southend-on-Sea residents died prematurely (before age 75) as a result of a condition that could have been prevented (335.1 deaths per 100,000 population). This high rate of premature deaths ranks Southend 67 out of 150 upper tier local authorities for premature mortality in England. Figure 1 shows the potential interaction of a range of risk factors on population health and wellbeing.

Figure 1 Interplay of risk factors on population health



3.0 The Context for Prevention

3.1 National policy

There are a number of statutory prevention related duties the Council and its partners are required to deliver. The Care Act 2014 places a duty on local authorities to provide or arrange for the provision of interventions, facilities or resources that contribute to preventing or delaying the development of care and support needs by adults. Local authorities must also contribute towards preventing or delaying the development of support needs by carers in their area.

The Five Year Forward View is the new plan setting out NHS policy for the next 5 years. This plan establishes a new vision for the English health and social care system (2). It envisages an integrated, flexible localised system, able to collaborate and respond rapidly to address the key issues impacting on the health of local people. The key thread within the Forward View is the prevention of disease and disability. This Five Year Forward View recognises the sustainability of the NHS, and economic prosperity of the country, depends on a radical upgrade in the manner in which people are supported to live healthier lives.

The current increase in the burden of avoidable illness and disease on the health and social care system in England was predicted in 2002 by Sir Derek Wanless (3).

The Wanless report warned of severe consequences for the Health and Social Care system unless there was a concerted effort focussed on prevention. This report identified 3 possible scenarios:

- ***Slow uptake*** –no change in the level of public engagement: life expectancy rises by the lowest amount in all three scenarios and the health status of the population is constant or deteriorates. The health and social care economy is relatively unresponsive with low rates of technology uptake and low productivity.

- ***Solid progress*** – people become more engaged in relation to their health: life expectancy rises considerably, health status improves and people have confidence in the primary care system and use it more appropriately. High rates of technology uptake and more efficient use of resources

- ***Fully engaged*** – levels of public engagement in relation to their health are high: life expectancy increases go beyond current forecasts, health status improves dramatically and people are confident in the system and demand high quality care. There is a high response and use of technology, particularly in relation to disease prevention. Use of resources is more efficient.

Wanless estimated the fully engaged would scenario would result in savings of up to £30bn, but he warned statutory organisations responsible for protecting and improving the public health, needed to take radical steps to fully engage the public in preventative endeavours.

The alternative to the fully engaged scenario was a rise in health inequalities, more illness and disease and higher costs for the NHS and Social care. The Five Year Forward View is a recognition the fully engaged scenario proposed by Wanless has not been achieved.

Other strategic drivers also advocate a greater focus on prevention. The Care Act 2014 and Health and Social Care Act 2012 place statutory duties on local authorities and their partners to take action to protect and improve the health of the population.

At a local level, the Southend Health and Wellbeing Board through its Health and Wellbeing Strategy, holds local partners to account for the way in which they deliver improved health outcomes for local residents. The Southend Health and Wellbeing Strategy, has 3 broad impact goals, underpinned by 9 wider ambitions to improve population health.

Impact Goals:

a) Increased physical activity (prevention)
b) Increased aspiration and opportunity (addressing inequality)
c) Increased personal responsibility and participation (sustainability)

Ambitions:

A positive start in life	Promoting healthy lifestyles	Improving mental wellbeing
A safer population	Living independently	Active and healthy ageing
Protecting health	Housing	Maximising opportunities

3.2 Sustainability and Transformation Plans (STP)

The Five Year Forward View has required NHS organisations to engage with local authorities and other partners to produce two separate but connected plans:

- Five year Sustainability and Transformation Plan (STP) - this is place-based and will drive the Five Year Forward View
- One year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

Prevention and early intervention is a key theme within STPs. These plans place an emphasis on system wide place based approaches to deliver better and more efficient health and care services. They require action to transform the environments where people live and work, as opposed to simply focussing on a particular behaviour do. This prevention strategy will help deliver the Southend locality aspirations for the South and Mid Essex Sustainability Transformation Plan. It will provide a vehicle for collaboration to deliver evidence based prevention across the NHS, social care, voluntary and community interface in Southend.

3.3 The extent of the problem

The main consumers of health care are older people. Nationally it is estimated the number of people of pension age will increase from a base of 12.4 million in

mid-2014, to 16.5 million by mid-2039 (9). There is good evidence that people aged 65 and over from lower occupational income groups, have higher levels of physical, psychological and overall frailty than the more affluent (5). Meeting the needs of these people as they move into old age poses a considerable challenge in Southend.

Southend-on-Sea has an estimated population of 177,990 people, of which 18.9% are aged 65 and over. This figure is higher than the average for England where 17.6% of the population are aged 65 and over. Over 87,000 Southend residents are aged between 40-85. This means there are a significant number of older adults in the borough, who may require preventative support to maintain or improve their health status at some stage during their life.
In the period 2012 to 2014, the premature mortality rate in Southend residents attributable to cardiovascular diseases, was significantly higher than the England average. There were 85.6 deaths per 100,000 population in Southend, compared to 75.7 deaths per 100,000 population in England.

The premature death rate associated with preventable cancers in the same period, was 87.1 per 100,000 population Southend, compared with 83 per 100,000 for England. Increasing levels of physical activity within the population; improving diets through reducing the amounts of sugar and salt consumed; increasing fruit and vegetable consumption and maintaining a healthy weight, are simple but effective ways to reduce a person's risk of adverse events related to cardiovascular disease and preventable cancers (5).

Prevention can also help to reduce deaths from respiratory disease which is another key issue impacting on the health of local people. In 2012 to 2014, the death rate from respiratory disease was 17.7 per 100,000 population in Southend, compared with 17.8 per 100,000 population in England. Helping people stop smoking, taking action to improve air quality will help to reduce the impact of respiratory disease. Working with vulnerable people to keep their homes warm in winter and increasing the uptake of seasonal influenza vaccination in those at risk will also help to reduce preventable deaths from respiratory disease.

The other major indicator of note is the number of older people aged 80 and over suffering a hip fracture. Falling and associated hip fractures, pose a major challenge in England. Treatment and care costs are in the region of £2 billion each year. The average cost of a single hip fracture is in the region of £28,000 over a 2 year period. Only 1 in 3 older people who suffer a hip fracture return to their former levels of independence and 1 in 3 will need to leave their own home and move into long-term care.

In the period 2012 to 2014, the rate of hip fracture for this age group in Southend was 1,822 per 100,000 population. This rate is significantly higher than the England average (4). Future projections suggest a 243% increase in costs associated with the treatment and care of people suffering a hip fracture. It is estimated these costs will increase to £5.6 billion by 2033 (10).

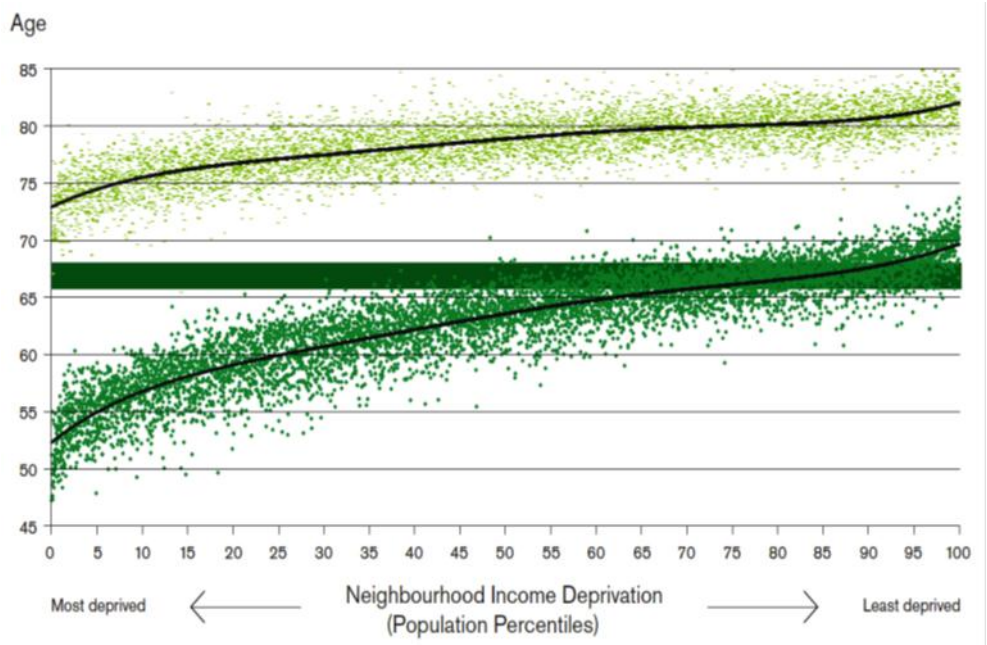
Prevention has an extremely important role to play to reduce the human and financial costs associated with hip fractures. Simple measures such as screening and identifying those at greatest risk of falling and taking steps to improve bone health through increasing weight bearing and physical activity can have a positive impact on reducing the number of people suffering a hip fracture.

3.4 Non communicable diseases

There is evidence to suggest that the increase in the prevalence of non-communicable diseases, such as diabetes, hypertension and cardiovascular conditions, may result in healthy life expectancy not keeping pace with current increases in life expectancy (4). This finding reinforces strong evidence of the relationship between socio-economic status and ill health in later life.

The Marmot review into healthy inequalities in England identified that people living in the poorest neighbourhoods; will on average die 7 years earlier than people living in the richest neighbourhoods (5). Figure 2 provides an overview of this inequality.

Figure 2 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

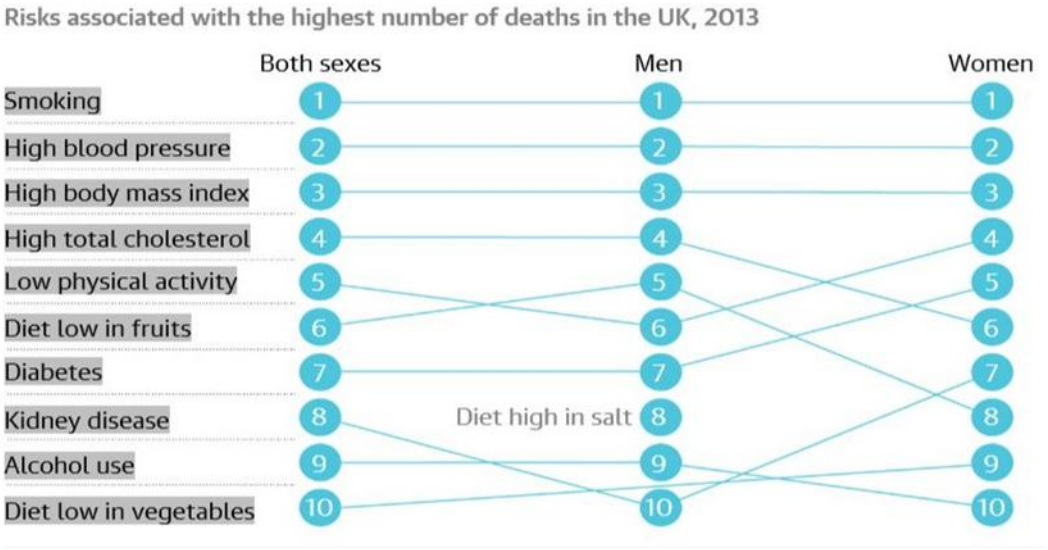


Source: Marmot Review Fair Society Healthy Lives 2010

Key:
- Life expectancy
- DFLE
- Pension age increase 2026–2046

In order to be successful, we need to focus on what will provide most benefit for our population. The recent update to the Global Burden of Diseases Study, found tobacco smoking, high blood pressure and obesity to be the risk factors attributable for **most mortality** in the UK (5). Figure 3 provides an overview of these risks and their ranking in terms of causing deaths for men and women in the UK.

Figure 3 Risks associated with the highest number of deaths in the UK, in 2013



Source: Global Burden of Disease Survey 2015

High blood pressure (blood pressure reading over 140/90mmHg) is one of the leading risk factors for premature death and disability. This condition can lead to stroke, heart attack, heart failure, chronic kidney disease and dementia. The average cost to health and social care commissioners of managing a person who has had stroke, is £12,000 initially and £6,000 every subsequent year.

There are 28,300 **people diagnosed** with hypertension living in Southend. This is well below the estimate of 47,700 people who are believed to have hypertension living in the Borough, which is significantly higher than the England average (8).

Of those diagnosed with hypertension, 22,300 have their condition effectively controlled. The number of people who are controlled is significantly lower than the England average (8). People from the most deprived areas are 30% more likely than the least-deprived to have hypertension. Southend ranks 184 out of 326 local authorities for negative lifestyle behaviours that increases the risk of hypertension. The total cost of prescriptions to treat hypertension was £620,000 in 2014/15 alone. At a cost of £3.98 per item, the Southend costs were 90p per item more than the average cost for England. Addressing this issue by

diagnosing and supporting people to effectively manage their high blood pressure is a local priority.

Over 670,000 people are thought to be living with dementia in England. Care and treatment costs are in the region of £19 billion each year. The cost of treating and managing people with dementia is higher than the costs of treating cancer, stroke or heart disease. Nationally over 550,000 people are caring for someone living with dementia and 1 in 3 people are expected to have to care for a person with dementia in their lifetime. Poor lifestyle can also trigger vascular dementia which account for 20% of all dementia cases diagnosed. Within Southend the number of people recorded on GP disease registers having with dementia as a proportion of the number of people **estimated** to have dementia locally was 68.49%. This figure is lower than the England average and significantly lower than 10 similar comparable areas to Southend (68.71% and 72.44% respectively).

The impact of chronic long term conditions (LTCs) on the Southend population is a major concern. Southend has an older population than the England average and one that is ageing faster. Thirty-one per cent of Southend residents report having at least 1 long term condition. There are also more people in Southend living with three or more LTCs (12.9%, compared to the national average of 10.5%). People with a multiple LTCs are more likely to have complex needs and require intensive health and care support. The average national annual cost to provide care and support to someone with a single LTC is around £1,000. This rises to £3,000 for someone with two conditions and £8,000 for people with three or more conditions. This is borne out by the evidence that suggests people with LTCs account for 70% of health and care spend nationally (11).

There is clear evidence that addressing lifestyle risk factors in the Southend population will help to reduce the impact of non-communicable diseases on the local health and care system.

3.5 What works

Interventions focussed on improving the key determinants of health and addressing wider environmental and socio-economic factors, will have the greatest impact on the life course and reduce health inequalities over the long term. Action to address modifiable risk factors related to non-communicable diseases, will improve health outcomes (categorised under lifestyle and physiological factors) but need to be delivered in a joined up way. This means prevention must be built into all aspects of service planning in Southend preferably through a placed based approach.

There is good evidence that taking **proportionate** action to support people with low or moderate risk factors is a more effective and efficient way to improve the health of the whole population over time. Everyone has different capabilities which will influence the way they respond to challenges to their health and

wellbeing. Interventions need to be tailored to enable people to take as much control of their treatment and care as possible. Those at greater risk of an adverse event should receive more support. Those who are able to support themselves should be given the tools to do so. The latter group may be supported to self-care by being signposted to information and advice, or through further intervention such as referral for lifestyle support.

Southend has the capacity to make this major change. There are dedicated professionals, working alongside equally dedicated and well established community groups and organisations. Southend residents are responsive when motivated. They want to make a positive difference to improve their health and that of their community.

All the required strategic enablers are available to take forward a place based approach to industrialising prevention in Southend. There is a single upper tier local authority, coterminous with one Clinical Commissioning Group. Southend is a health and social care integrated pilot area, with joint commissioning arrangements overseen by a strong partnership. There is a strong history of collaboration between commissioning and provider organisations.

4.0 Links with other local strategies

This Prevention Strategy does not aim to replicate the work of existing key plans. It does however aim to align local current and future initiatives to deliver an industrial scale, placed based prevention approach in Southend-on-Sea. The main local drivers for change are set out in Table 2:

Table 2: Key local strategies and interventions through which the objectives of this Joint Adult Prevention Strategy will be achieved (list is not exhaustive)

System Redesign	Population Focus	Wellbeing Interventions	Commissioning
Southend Community Recovery Pathway	Older People's Strategy	Lifestyle Service	LA Commissioning
Southend Complex Care Work stream	Dementia Strategy	Obesity Strategy	NHS Commissioning
Social Care Redesign	Carers Strategy	Physical Activity Strategy	Joint Commissioning
End of Life Strategy	Falls Prevention Strategy	Parks and Green Spaces Strategy	
Digital Strategy	Housing Strategy		
Sustainability Transformation Plans	Mental Health Strategy		

5.0 Delivering the strategy

5.1 Implementation, monitoring and evaluation

Within Southend there are a number of forums and strategic groups to enable effective delivery of health and social care interventions. In terms of prevention, the Southend Health and Wellbeing Strategy provides the overall direction of travel. Operationally, system leaders within Southend work collaboratively to facilitate the local delivery of programmes.

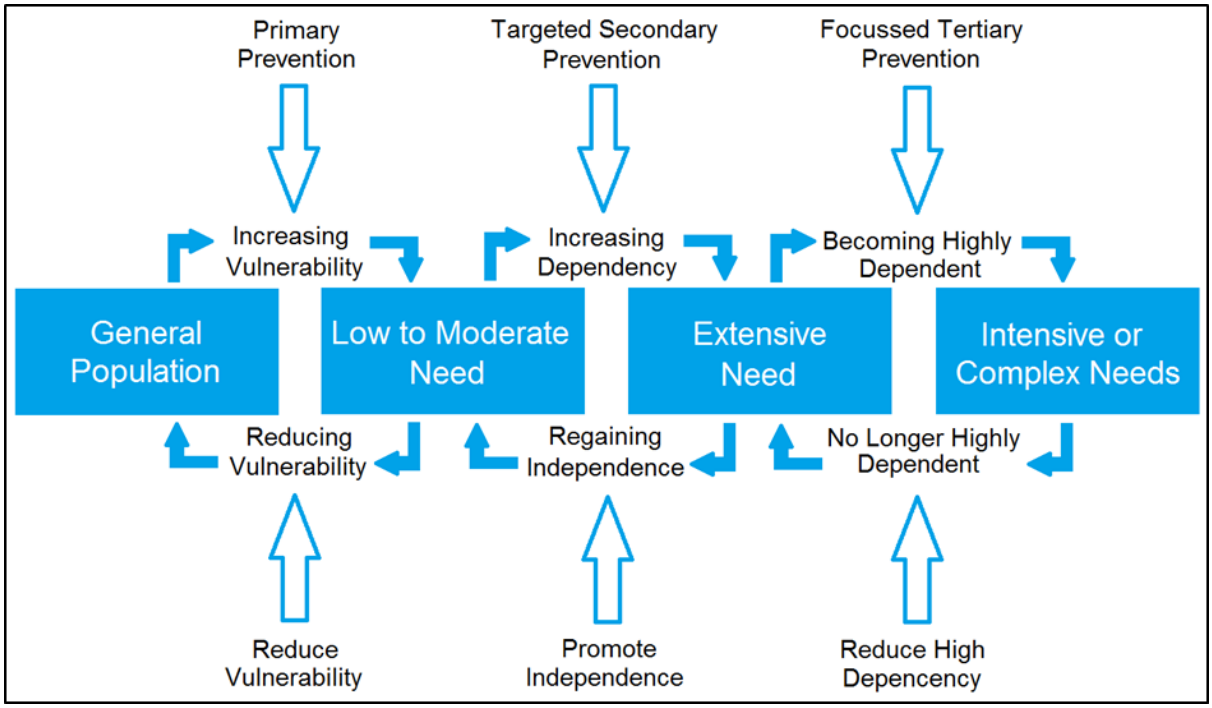
One key intervention that may prove to be a 'game changer' for prevention locally is the commissioning of a Southend Healthy Lifestyle Service. This service provides a single gateway for all locally commissioned preventative interventions. It enables individuals to access support and self-care options to meet their own particular needs. The Southend Healthy Lifestyle Service also facilitates access to interventions available from local Southend third sector providers and voluntary organisations.

Local primary care practitioners have expressed a desire for access to more holistic preventative interventions. The Southend Healthy Lifestyle Service will provide this crucial bridge between primary care and other settings. Social care practitioners will also able to access this service. These colleagues often identify people who are in need of support and are best placed to signpost or refer individuals according to need.

The Southend Healthy Lifestyle Service aims to help deliver the vision of a place based approach to prevention. It sits alongside key local programmes, including the Southend Community Recovery Pathway (core programme with the Southend Health and Social Care Transformation Programme). It fully supports secondary prevention. GPs will be able to utilise their expertise in particular targeted case finding and refer at risk individuals to the Lifestyle Service for in-depth, supported interventions.

Figure 4 provides an overview of how prevention can be used to support people at risk of an adverse health event, or who have already have a health issue, regain independence.

Figure 4 Opportunities to deliver prevention to promote independence



5.2 Innovation

In order to achieve the strategic shift to prevention focussed placed based commissioning within Southend, there needs to be a radical rethink of the way we do things.

There are real opportunities to harness technology to improve outcomes for local people. Southend is aligned with new technology providers through its 'Med Tech' partnership with Anglia Ruskin University. It has developed a Digital Strategy and is in the process of implementing a 'Smart Cities' programme that will revolutionise the way local people and those living and working in the Borough, access information, advice and support.

The regeneration of Southend offers the chance to 'design in' prevention opportunities within the local infrastructure. One example is the 'Queensway' regeneration project. This major building project, offers the chance to radically change the physical environment of the Borough, embedding prevention into the physical landscape of Southend.

To get 'full engagement' from the Southend community, we need to harness the power of local people. We have to empower them to take steps to improve their physical and mental health. To do this we propose to identify local 'Prevention Champions' and train them appropriately so they can support their community, friends and family, to improve their health and future life chances. There should be no shortage of volunteers to take up these roles. Elected members are an

obvious choice to become Prevention Champions given their direct contact with local people, but there are many who could be trained to build local capacity and capability. This approach also aligns with the aspiration of NHS Southend Clinical Commissioning Group to increase local case management for people with long term conditions.

There are a range of actions that will help to improve population outcomes within Southend. The following areas are those the evidence suggests are most effective in terms of reducing or delaying the impact of adverse events. It is important to note these actions focus on people at risk (as detailed in the prevention strategy scope) as opposed to the general adult population of Southend-on-Sea.

5.3 Key priority areas

Key Area 1: **Proactively support lifestyle behaviour change in adults with specific long term conditions (LTCs)**

- Roll out and use of patient activation measures in primary care.
- Increase the number of people living with chronic long term health conditions who access the Southend Healthy Life Style Service.
- Develop a local cadre of prevention champions trained in ***Making Every Contact Count*** behavioural change methodology.
- Increase the proportion of Southend adults (specifically those with a long term chronic health condition, physical disability, mental health) who regularly undertake the recommended weekly levels of physical activity.
- Reduce the proportion of the Southend adult population who are deemed to be overweight and obese.(in particular women of child bearing age)
- Continue to support the work to decrease tobacco use in Southend.
- Decrease excessive alcohol use in Southend.
- Deliver a targeted social marketing programme targeted at risk behaviours to facilitate lifestyle change.
- Use digital technology to improve access to health promotion, information and advice for people who are at risk of or recovering from an adverse event that has impacted on their health.

Key Area 2: Creating community capacity and enhancing community resilience.

- Improve support to carers so they feel they are able to cope more effectively with their caring responsibilities.

- Increase and improve interventions to address social isolation and loneliness in older people, people living with disabilities and carers.

- Supporting people with a long term condition to feel independent and in control of their own condition.

- Support local employers to improve and maintain the mental and physical health of employees.

- Increase the number of volunteers in Southend who are able to actively support people with long term chronic health conditions.

- Continue to address risk factors related to suicide and deaths undetermined

Key Area 3: Improve early detection and treatment of risk factors related to non-communicable diseases

- Increase the number of individuals diagnosed with:
  - Hypertension
  - Atrial fibrillation
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Diabetes
  - Osteoporosis (fragility fracture risk)

Appropriate treatment and management plans are in place to support these individuals in line with best practice guidance for each condition

- Use outreach services to make NHS Health Checks more accessible for the most vulnerable and harder to reach groups within the population.

- Increase uptake of learning disability health checks in primary care.

- Improve detection of risk factors liable to cause deterioration of physical and mental health status in frail older people.

- Reduce the ratio of expected to diagnosed dementia patients on GP primary care registers.

5.4 High level prevention indicators

In order to deliver the aspirations of this strategy we will:

- Consolidate a performance matrix to capture the contribution of existing strategies to health improvement outcomes
- Establish mechanisms to inform the inclusion of specific prevention outcomes within all future strategies/programmes within Southend

These two tasks are currently being taken forward. An outline action plan is set out in Appendix 1 that will be used to inform delivery of strategy outcomes. This plan is subject to regular revision in line with the dynamic nature of the Southend Health and Social Care Transformation Programme. The following section sets out an initial range of indicators across the 3 domains of prevention that will be subject to regular review and update.

Indicator	Source
Smoking prevalence (Smoking in Pregnancy)	Public Health Outcomes Framework (PHOF)
Percentage of physically inactive adults	PHOF
Excess weight in adults (Maternal Obesity)	Public Health England
Alcohol related hospital admissions	PHOF
Flu vaccination coverage, adults aged 65+ and those in defined “at risk groups”	INFORM, Public Health England
Percentage of adults eating 5 portions of fruit and vegetables each day	Active People Survey

Secondary Prevention Indicators

Indicator	Source
Health Checks Delivered	Local commissioned providers
LD Health Checks Delivered	Quality Outcomes Framework (QOF)
Number of patients who have had their activation levels monitored	Local Source (SBC PH)
Incidence of stroke	PHOF
% of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more)	QOF
Completeness of Hypertension registers	QOF
% of patients on QOF Hypertension register	QOF

with a blood pressure recorded in the preceding 12 months is <=150/90	
% of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis	QOF
% of adult carers who have as much social contact as they would like	PHOF
Completeness of COPD registers	QOF
The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March	QOF

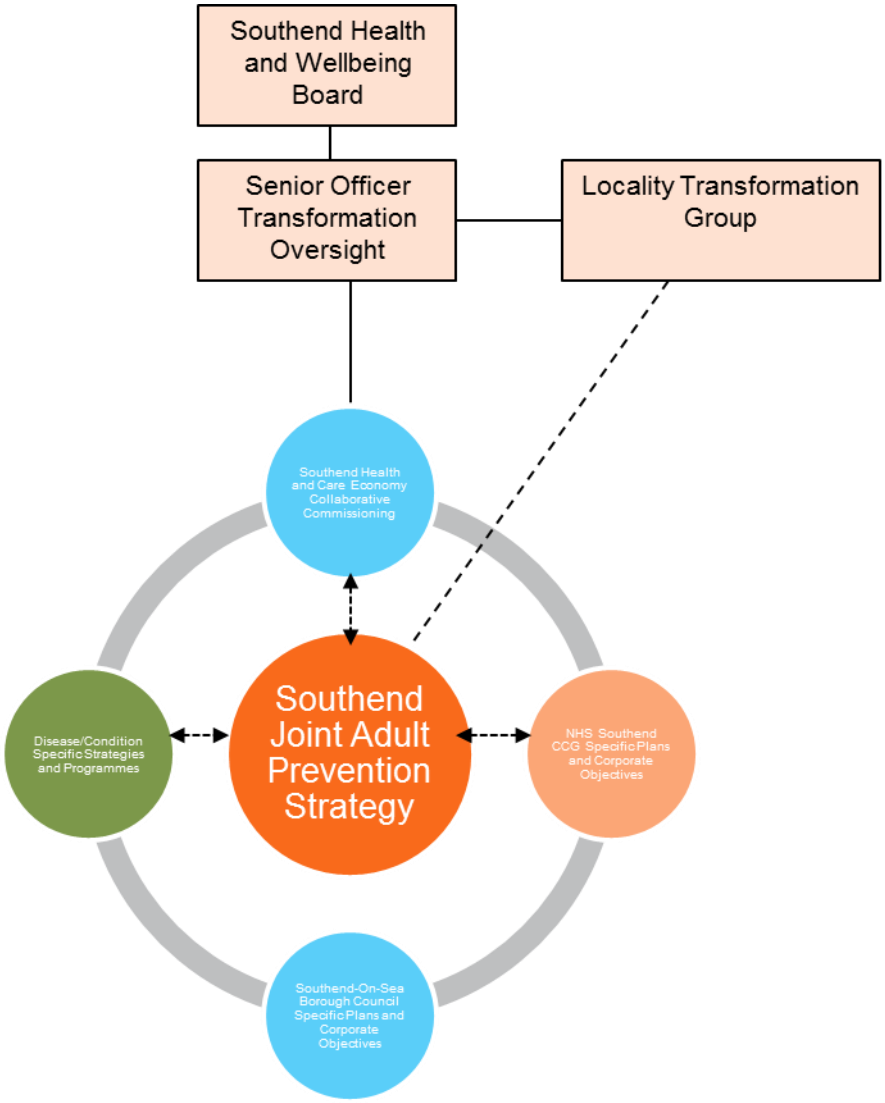
Tertiary Prevention Indicators

Indicator	Source
Number and rate of falls in population aged 65+	PHOF
Number and rate of falls resulting in fractured neck of femur as Primary Diagnosis in population aged 65+	PHOF
% of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken	QOF
% of stroke discharges that result in Early Supported Discharge	NHSSCCG/SBC
Completeness of GP COPD registers	QOF
Rate of unplanned hospital admissions for those ages 75+	PHOF
% of population in SBC funded registered care	SBC
% of clients self-caring following reablement	SBC
% of adults with a learning disability who live in stable and appropriate accommodation	SBC
Gap in employment rate between those with a learning disability and the overall employment rate	SBC
% of adults in contact with secondary mental health services who live in stable and appropriate accommodation	SBC
Gap in employment rate between those in contact with secondary mental health services and the overall employment rate	SBC

5.5 Oversight

Figure 5 provides an illustration of the relationship between this prevention and strategy and the Southend health and care economy. This diagram is subject to revision in line with pending changes to local governance arrangements within the Southend health and care economy.

Figure 5 Oversight arrangements



5.6 Summary

The Wanless ‘fully engaged’ scenario may take some time to achieve in Southend. Being able to contain demand at current levels and maintaining the status quo might be desirable in some cases. We will know we have made a difference when health and care costs reduce and demand for interventions reduce substantially overtime.

The action plan at Appendix 1 sets out the high-level prevention outcomes to be delivered throughout the lifetime of the Southend Joint Adult Prevention Strategy. Responsibility for delivering condition specific outcomes rests with the relevant strategy and associated local delivery mechanisms. For example, the Southend Physical Activity Strategy is the vehicle that will take forward actions related to increasing the rate of physical activity in at risk groups; the Southend Carers strategy, actions related to improving outcomes for carers.

Further debate is required to align the key outcomes that are set out in the partnership strategies referenced in this prevention strategy. This work is on-going. There is a need to be pragmatic and take account of the changing population needs and local priorities. The following section sets out how we will monitor the progress of the deliverables set out in this prevention strategy.

5.7 Southend Joint Adult Prevention Strategy Action Plan

	Key Area 1: Proactively support lifestyle behaviour change in adults with specific long term conditions (LTCs)				
Action	**Outcome**	**Specific Actions**	**How it will be measured**	**Lead Organisation**	**Timescale**
1	Rollout use of patient activation measures in primary care (increase the ability of people to self-manage)	All GP Practices to use patient activation measures for routine assessment (annual reviews) with people LTC's People at low activation (1&2) to be referred appropriately for self-management support) Increase the number of people moving from activation levels 1&2 to level 3 or 4 by 10% each year for the period of the strategy (baseline to be established)	Primary Care Coding PH Audit/performance monitoring SBC-PH contract monitoring - KPI	NHS Southend CCG –SBC PH NHS Southend CCG –SBC PH	April 2017 April 2017
2	Increase the ability of people living with chronic long term health conditions to self-management	Increase referrals the Southend Healthy Lifestyle Service (at least 3600 people with LTC referred per annum)	Primary Care (Southend Community Recovery Pathway)	NHS Southend CCG, SBC Social Care, SBC-PH	2017-2020
3	Develop a local cadre of prevention champions trained in ***Making Every Contact Count*** behavioural change methodology.	Identify, train and establish a network of local Southend voluntary prevention champions Every GP practice to have an assigned prevention lead responsible for supporting the practice to improve health of people with identified LTCs in each practice.	SBC-PH audit	SBC – PH and NHS Southend CCG	2016-2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
4	Increase the proportion of Southend adults (specifically those with a long term chronic health condition, physical disability, mental health) who are regularly undertake the recommended weekly levels of physical activity	Southend physical activity strategy to develop specific baseline and target with interventions for people with LTC's and mental health problems	Active People Survey	SBC PH and SBC Department of Place	2016-2021
5	Reduce the proportion of the Southend adult population who are deemed to be overweight and obese	Implement the Southend Obesity Strategy	Public Health Outcomes Framework	SBC and NHS Southend CCG	2016-2021
6	Continue to decrease tobacco use in Southend	Implement Southend Tobacco control policy Increase number of local businesses in Southend Public Health Responsibility Deal signing up to tobacco control pledge	Local Audit	SBC –PH, SBC Department Place	2016-2021
7	Decrease excessive alcohol use in Southend	Reduce number of people alcohol related hospital admissions for Southend residents Increase identification of excessive alcohol intake in persons aged 40-74 through use of brief interventions following NHS Health Checks	Public Health Outcomes Framework	SBC – PH , SBC DACT, NHS Southend CCG	2016-2021
8	Deliver a social marketing programme targeted at risk behaviours to facilitate lifestyle change	Segment local at risk population (LTC) deliver social marketing programmes to support referrals to Southend Healthy Lifestyle Service	Programme evaluation	SBC - PH	2016-2018

9	Use digital technology to improve access to health promotion, information and advice for people who are at risk of or recovering from an adverse event that has impacted on their health	Implement Public Health Elements of Southend Digital Strategy	Audit TBC	SBC-PH, SBC Place Department	2016-2021
	Key area 2. Creating community capacity and enhancing community resilience				
Action	**Outcome**	**Specific Actions**	**How it will be measured**	**Lead Organisation**	**Timescale**
10	Improve support to carers so they feel they are able to cope more effectively with their caring responsibilities	Improved and more varied respite for the cared for	Carers survey	SBC Department for People/ Southend Carers Forum	2016-2018
11	Increase and improve interventions to address social isolation and loneliness in older people, people living with disabilities and carers	Develop capacity and capability to support lonely and social isolated older people Network (volunteers). Engage with volunteers and user led groups to discuss how they can help with improving interventions which address social isolation.	Take up of the opportunities provided Customer feedback	SBC Department for People/ Southend Carers Forum	2016-2018
12	Increase social connectivity and befriending	Develop local community resilience and local peer networks. Use learning from C2 community development programme to develop local community capacity. Focus on using strengths-based assessments and care planning, which concentrate on individual abilities and community assets, rather	Customer feedback/ SBC-KPI SBC - KPI	SBC Peoples Department	2016-2018

		than an approach that overly focuses on deficits and provision to meet need.			
Action	**Outcome**	**Specific Actions**	**How it will be measured**	**Lead Organisation**	**Timescale**
13	Establish network of Local Southend Prevention Champions	Work with council community development team to Identify and train local voluntary Prevention Champions to link with local communities and specific target groups	Evaluation criteria will feed into Connect metrics. Social Return on Investment also under consideration	SBC-PH – Vol Orgs	March 2017
14	Support people with a long term conditions to feel independent and in control of their own health	People with LTC able to access local self-management courses and opportunities	GP Survey	SBC PH- NHS Southend CCG	2020
15	Increase the number of people with respiratory conditions (COPD, asthma) who have a seasonal influenza vaccination	Work with primary care teams and NHS England to increase influenza uptake in at risk groups Reduce the rate (100,000) of people with respiratory conditions (COPD, Asthma) admitted to hospital	Inform returns	NHS Southend CCG/ NHS England	2018
16	Support local employers to improve and maintain, the mental and physical health of employees	Continue to support employers signed up to the Southend Public Health responsibility deal and increase the number of new local employers signed up to Southend Public Health Responsibility deal (by a minimum of 10% each year	PH Performance monitoring Employment Support Allowance Claimants	SBC- PH	2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
	Key area 3: Improve early detection and treatment of risk factors related to Non-Communicable Diseases				
17	Increase the number of patients diagnosed with hypertension by at least 19%	Increase opportunistic testing of blood pressure within primary care (GP and pharmacy), the Southend Get Healthy Service IHLS and the wider community	QOF IHLS KPI	NHSE/NHS Southend CCG - PH	April 2018
		Improve the uptake of the NHS Health check in 40-74 year olds to at least 75% of those offered a check (at least 200 new cases of hypertension identified)	PH contract monitoring and PHOF	SBC – PH	April 2018
		All people referred to Southend Get Healthy Lifestyle Service to have their BP taken. (Appropriate referrals made/action taken for all those identified)	PH -Performance monitoring	SBC -PH	July 2016
18	Improve the care of those already diagnosed with hypertension	9200 people with hypertension to have BP measured within appropriate range (150/90)	QOF	NHSE/NHS Southend CCG	April 2018
		Support adherence to treatment and lifestyle by increasing self-monitoring of BP	audit	NHS Southend CCG	April 2020
19	Improve the detection of atrial fibrillation (AF) to match that of comparator CCGs	Targeted action within primary care to identify AF (actions currently being scoped. Measure will be confirmed when finalised)	QOF	NHSE/NHS Southend CCG	April 2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
20	Improve the care of those already diagnosed with atrial fibrillation,	All patients with AF who could benefit from anticoagulants are offered treatment. (baseline 2015/16 QOF)	QOF	NHSE/NHS Southend CCG	April 2020
21	Increase uptake of learning disability health checks in primary care	At least 80% of people identified with a learning disability (LD) to receive LD health check People with LD are appropriately referred for lifestyle intervention to address risk factors related to non-communicable disease	QOF PH Contract monitoring	NHS Southend CCG SBC-PH	April 2020
22	Prevent the onset of type 2 diabetes in people at risk of the condition	100 people access the Southend diabetes prevention programme	PH contract monitoring	NHS Southend CCG/SBC PH	September 2017
23	Improve the prevention and detections management of those with diabetes.	Increase the uptake of the NHS health check to 75% (at least 51 new cases of type 2 diabetes identified)	PH contract monitoring	NHS Southend CCG/SBC – PH	April 2017
24	Improve the management of type 2 diabetes	Increase proportion of patients with optimal treatment to national good practice levels	QOF	NHSE/ NHS Southend CCG	April 2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
25	Improve the management of those diagnosed with COPD	Support people with COPD to stop smoking (% to be determined) Improve coverage of flu vaccination for those with COPD (baseline 2015/16)	QOF NHSE Flu returns	NHS Southend - CCG SBC-PH	April 2017 April 2017
26	Use outreach to make NHS Health Checks more accessible for the most vulnerable and harder to reach groups within the population	Percentage of people from routine and manual groups who receive an NHS Health Check through the outreach service (at least 800 people checked through outreach service)	SBC-PH and PHOF	SBC - PH	April 2017
27	Increase diagnosis of dementia	Reduce the ratio between expected and diagnosed dementia prevalence in GP primary care dementia registers (baseline 2015/16)	QOF	NHS Southend CCG	April 2020
28	Support older adults to achieve a healthy lifestyle to delay the onset of frailty	Increase throughput of older adults at risk of frailty to Southend Healthy Lifestyle Service to 20% by 2020. Support frailer adults to self-manage and address risk lifestyle behaviours including: stop smoking, physical inactivity, improve their diet, maintain a healthy weight, and reduce alcohol intake. Current baseline 2015/16 is 16% of service users are over 60	SBC PH contracting	SBC-PH	April 2020

Action	Outcome	Specific Actions	How it will be measured	Lead Organisation	Timescale
29 409	Prevent falls and fragility fractures in older people	Increase number of older people who receive falls risk assessment in primary care (specifically those with cognitive impairment) by 10% each year (107 additional referrals by 2018) (2016 baseline 510) Increase referral of older people at high risk of falls to community falls service/postural stability service Increase assessment and treatment of older people at risk of fragility fractures by 15% (referral baseline into community postural stability service 389 (58 additional referrals per year) 2015/16/ community falls service baseline in 2015/16 510 (77 additional referrals per year)	QOF/SBC PH Contracting	SBC-PH	April 2018

QOF: Quality outcome framework for General Practice in contracts PHOF: Public Health Outcome Framework KPI: Key Performance Indicator

6.0 References

1. Roberts et al (2015). Filling the gap; Tax and fiscal options for a sustainable UK health and social care system. The Health Foundation. London.

2. Van Gils et al (2010). 'Cost-effectiveness research on preventive interventions: a survey of the publications in 2008'. European Journal of Public Health, vol 21, no 2, pp 260–4

3. Buck D, Frosini F (2012). Clustering of Unhealthy Behaviours over Time: Implications for policy and practice. The King's Fund. London. www.kingsfund.org.uk/publications/clustering-unhealthy-behaviours-over-time.

4. Public Health England (2016). Public Health Outcomes Framework. http://www.phoutcomes.info/public-health-outcomes-framework#page/1/gid/1000042/pat/6/par/E12000006/ati/102/are/E06000033 (accessed 23rd February 2016)

5. Newton et al (2015). Changes in health in England, with analysis by English regions and areas of deprivation, 1990–2013: a systematic analysis for the Global Burden of Disease Study 2013. The Lancet, http://dx.doi.org/10.1016/S0140-6736(15)00195-6. (accessed 23rd February 2016)

6. Buck D, Gregory S (2013). Improving the public's health, a resource for local authorities. The Kings Fund. London.

7. Marmot M (2010) The Marmot Review Fair Society Healthy Lives. UCL Institute of Health Inequity. http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review.

8. Public Health England (2016). Hypertension profile Southend-on-Sea. https://www.gov.uk/government/organisations/public-health-england.

9. Office for National Statistics (2015). National Population Projections: 2014-based Statistical Bulletin: http://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2015-10-29.

10. White SM, Griffiths R (2011). Projected incidence of proximal femoral fractures in England: a report from the NHS Hip Fracture Anaesthesia Network (HIPFAN). Injury ;42:1230–3.

11. Department of Health (2012) Long Term Conditions Compendium of Information Third Edition. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216528/dh_134486.pdf

12. Department for Communities and Local Government (2015). English Indices of Deprivation 2015. http://tinyurl.com/op9k35j (accessed 23rd February 2016)

Summary of HWB Performance Indicators Progress Report – 1 Aug 2016

To add value to the 9 ambitions within Southend's Health and Wellbeing Strategy, the Health and Wellbeing Board established three "Broad Impact Goals";
A) Increased physical activity (prevention). B) Increased aspiration and opportunity (addressing inequality). C) Increased personal responsibility and participation (sustainability)

Benefits of performance monitoring during 2015/16

The HWB performance indicators have had a number of positive impacts. Specifically, the indicators have:

- Raised the profile of strategic HWB priorities and stimulated a central focus for operational teams
- Increased incentive and accountability for strong performance
- Promoted partnership working and highlighted new opportunities for direct involvement
- Brought a greater awareness of diverse operational activity
- Provided a baseline for consideration of future priority areas and effective use of resources

Reviewing indicators – Aug2016

-We are working to strengthen reporting for certain indicators now that we have a year's worth of data. i.e. we are now able to establish a baseline for several measures around physical activity which will enable us to set appropriate targets, in line with the Physical Activity Strategy & associated action plan.

-Additionally, we are looking to refine indicators where work programmes have changed, or where different measures can add increased value to the work of the HWB Board (see notes for B3.1 & B3.2)

-We are also looking at what new indicators might now be introduced to assess performance and need. i.e. monitoring levels of affordable housing in the borough.

Notable points from August's HWB Performance Indicators Progress Report:

Status @ Aug2016	Indicator number	Indicator summary	Reflections on progress
	A1	Development of Physical Activity Strategy	Draft physical activity strategy written and progressing through Council processes. Opportunity for HWB Board to input views in Physical Activity discussion, Aug 2016.
	A2.1/A2.2	Physical activity levels of adults in the borough	We have remained worse than the England average through 2015-16 (52.1% vs England Average of 57%). The Physical activity strategy will seek to improve outcomes in this area. We're seeking clarity from Public Health England re. delayed publication of stats since Dec15.
N/A	A3.1	Businesses featuring active and sustainable travel in their travel plans	We are looking to refine this indicator to a more holistic and effective measure on how businesses are contributing to physical activity in context of the Public Health responsibility deal (PHRD) rather than just travel plans in isolation. Proposed new indicator will look at the number of businesses signing up to PHRD physical activity related pledges.
	B1	Number of children participating in vocational skills mentoring initiatives (60 minute mentor)	This area continues to perform well with 384 young people participating in the 60 minute mentor programme through 2015-16 against a target of 90. More schools are becoming involved in the programme, specifically; St Nicholas Special School and Earls Hall Primary School, who have arranged for monthly sessions to take place in the next academic year. Ongoing need for health and care sector "mentors" to be involved in the programme.
	B3.1	Pre-start-up and start-up businesses supported	Annual target of 20 significantly exceeded, with 47 pre-start-up and start-up businesses supported during 2015-16. This revealed a higher than anticipated need for pre-start-up and start-up support and will be incorporated in further service development.
	B3.2	Small and Medium-sized enterprises (SME) supported	Progress for this area became a concern for the HWB Board back in Feb16 as the figures suggested a significant under performance for the year. Since then, performance has consistently improved, resulting in the annual target (of 80 SMEs) being met. Contractual changes mean that business support is now being delivered and measured across Essex rather than just Southend and with this in mind, it is proposed that indicators B3.1 and B3.2 are replaced with more meaningful and locally focused measures which clearly demonstrate progress towards increasing aspiration and opportunity (Broad Impact Goal B). Provisional consideration is being given to include new measures that support economic enhancement for existing parents and future parents who are associated with the Southend A Better Start programme. Such activity would focus on supporting employability, enterprise, skills and aspirations, all of which contribute to the realisation of A Better Start objectives.
	B7	Young people who are not in education employment or training (NEET) who live in areas that are within the 30% most deprived areas in England	The Indicators Progress Report now includes a breakdown of the quantities of young people in Southend who are not in education, employment or training and who live in an area which is classed as being within the; • 0-10% most deprived areas in England: 29 young people (previously 40 reported at April's HWB) • 11-20% most deprived areas in England: 44 young people (previously 53 reported at April's HWB) • 21-30% most deprived areas in England 23 young people (previously 29 reported at April's HWB) The notes in the HWB Indicators Progress Report highlight that some of these young people have medical or mental health conditions that are preventing them from re-engaging and that with the right support, individuals could move on to positive outcomes.

This page is intentionally left blank

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Aug16

PLEASE PRINT IN A3 COLOUR

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
A) Increased physical activity (prevention)																	
Development of a Physical Activity Strategy and Implementation Action Plan/Steering Group	A1	Lee Watson	Monthly / Period (Apr to Mar)	Completed March 31st 2016	N/A	On track	On track	**On track**	On track	N/A	Work with Chief Leisure Officer Association now complete. Sport England strategy now released which will inform future funding opportunities. Draft strategy has been to SBC People and Place pre-scrutiny commitees.	Draft strategy written, final ammendments from pre-scrutiny comments made- paper going to cabinet in June.	**Engage with strategy development + consultation process - Identify representatives to sit on strategy steering group.**	●	●	●	●
Percentage of adults achieving at least 150mins of physical activity per week (Active) (2.13i- Public Health Outcomes Framework)	A2.1	Lee Watson	Bi-Annually June & December	Increase % of Southend population defined as active to become statistically similar to England average by 2019 (Southend currently significantly below England average of 57%)	N/A	52.1%. In order to be at the England Average we need to move 8624 to achieve 150mins per week.	52.1%. In order to be at the England Average we need to move 8624 to achieve 150mins per week.	*52.1%. In order to be at the England Average we need to move 8624 to achieve 150mins per week.	Increase % of Southend population defined as active to become statistically similar to England average by 2019 (Southend currently significantly below England average of 57%)	Aim to maximise	*July16: Still awaiting December's data update (nationally provided). Currently liaising with Sport England to find out why physical activity indicator data hasn't been released yet	Development of Physical Activity Strategy. Active Southend developing external funding bids for 'at risk' populations such as those with low level Mental Health problems. ** Involvement in Chief Leisure Officer Association project provides us with a boosted sample for 2016	**Include promoting physical activity through Making Every Contact Count (MECC) in all contracts, consider impact on physical activity in future planning. All partners to promote physical activity to staff. There is free training and support funded by the Public Health Team for providers to deliver MECC**	●	●	●	●
Percentage of adults not achieving 30 mins of physical activity per week (Inactive) (2.13ii- Public Health Outcomes Framework)	A2.2	Lee Watson	Bi-Annually June & December	Reduce % of population defined as inactive to 27.7% (2014 England Average) by 2019	N/A	29.2% (Active People Survey Results released in June- we would need to move 2640 people from being inactive in order to be on the England Average)	29.2% (Active People Survey Results released in June- we would need to move 2640 people from being inactive in order to be on the England Average)	*29.2% (Active People Survey Results released in June- we would need to move 2640 people from being inactive in order to be on the England Average)	Reduce % of population defined as inactive to 27.7% (2014 England Average) by 2019	Aim to minimise	*July16: Still awaiting December's data update (nationally provided). Currently liaising with Sport England to find out why physical inactivity indicator data hasn't been released yet			●	●	●	●
Number of businesses with travel plans that have been reviewed in the previous 12 months featuring active and sustainable travel	A3.1	Lee Watson	Quarterly / Period (Apr to Mar)	Baseline so no target yet established	N/A	None reported	2	0	Baseline so no target yet established	Aim to maximise	July 16: We are looking to refine this indicator to a more holistic and effective measure on how businesses are contributing to physical activity in context of the Public Health responsibility deal (PHRD) rather than just travel plans in isolation. Proposed new indicator will look at the number of businesses signing up to PHRD physical activity related pledges. Whilst no businesses signed up to sustainable travel plans during this period, 9 businesses made physical activity related pledges as part of the public health responsibility deal (PHRD). 23 businesses gave signed up 16/17 to the PHRD, against a target of 40. These businesses have voluntarily pledged to take a range of actions to improve their staff health and wellbeing or their customer health and wellbeing. Whilst many of these have had a physical activity focus, some focus on other areas such as mental health and wellbeing, diet and nutrition etc. Sustainable travel is one element of this programme.		**All partners can sign up to the Active Travel pledge of the Public Health Responsibility Deal- actions including developing/updating travel plans, promoting active commuting to staff, cycle2work scheme, cycle parking, showers etc. Future infrastructure planning to promote active travel over less sustainable modes.**	Not yet established	Not yet established	Not yet established	Not yet established
Cycling Counts (There are 14 sensors on various cycle paths around the Borough which register every time a bicycle passes over them)	A3.2	Lee Watson	Bi-annually June & December	Baseline so no target yet established	129 (q4 daily average count 2014/15)	237 (q1 daily average count 2015/16)	218 (q2 daily average count 2015/16)	**134 (q3 daily average count 15/16)**	Baseline so no target yet established	Aim to maximise	Quarterly data always one quarter behind	Ideas in Motion campaign (http://www.ideasinmotionsouthend.co.uk/) Business engagement through new business engagement officer. Initiatives such as Bikeability training, Lead rides etc		Not yet established	Not yet established	Not yet established	Not yet established

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Aug16

PLEASE PRINT IN A3 COLOUR

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
B) Increased Aspiration and Opportunity (addressing inequality)																	
Number of children who have participated in extracurricular vocational skills mentoring initiatives (60 minute Mentor) (60 Minute Mentor is an initiative where local professionals/sector leaders host an hour long session with students, sharing their insights and experience and offering advice on vocational skills such as CV writing as well as answering student's questions)	B1	Rosie Powley/ Emma Crampton	Academic term: Sept-Dec15, Jan-Mar16, Apr-Jul16	90	Not prev counted	50 (Sept-Dec15)	15 so far (Jan-Mar16)	**67** total (April-June16) Cumulative year end status: **384** vs target of 90	30	Aim to maximise	St Nicholas special school has recently come on board. Earls Hall primary school have arranged for monthly sessions to take place in the next academic year, 3 have been confirmed. Schools are recently requesting mentors in entry level jobs in childcare, animal care and hair and beauty. Also a demand for mentors with different trades such a mechanics, builders and plumbers. SEPT pursuing participation in 60 minute mentor, following Dec15 HWB.	To expand the 60 Minute Mentor database of schools and industry mentors Specifically attempting to get involved with Futures Community College. Also trying to get 60 Minute Mentor running in primary schools.	**Health Sector Mentors:** **There is currently a gap in our mentor database for mentors across the Health and Social Care sectors. We have had schools, such as Westcliff High School for Girls, asking for a session in medicine or nursing. Some Grammar schools specifically ask for GP mentors for the programme. It would be appreciated if the Board could support in increasing appropriate mentors in these areas.** **All that is required for each session is a one hour presentation to up to 30 students and a 15 minute pre meet before the session to discuss practicalities.** **Opportunities for HWB:** **If the board feel there are any local skills gaps in terms of the health & care sector then we can assist in addressing this by encouraging schools to host, or by independently holding, sessions specifically on those professions.**	●	●	●	●
Number of Southend residents with learning disabilities who receive a long term social service and are in paid employment	B2 (ACS SC 08)	Tom Dowler/ Michael Barratt (MPR). Marnie Bowling/ Matt Harding for narrative ACS SC 08	Quarterly / Period (Apr to Mar)	10%	11.6% (Sept15)	10.3% (Nov15)	10.1% (Feb16)	**10.2%** (Apr16)	10%	Aim to maximise	Although we are above target, improved data quality used in the calculation has resulted in a slight drop from previous reporting. From 439 appropriate people with learning disabilities, there are 44 in paid employment. The increase in the denominator rather than a fall in the numbers employed has led to the fall in the percentage employed.	• The 'Making It Work' Team support Learning Disabled adults to access both paid and voluntary employment. • Currently we support 56 adults in paid employment and 69 adults in voluntary employment. Some adults have more than one position, for example we have one adult who has 2 different paid positions and 2 voluntary positions. Some adults require minimal support but others have regular face to face meetings and work placement visits. • The team offer Individual support for all who participate in the 'Making It Work' Employment Support Service and this includes vocational profiling, help to develop social skills, support to access mainstream facilities, a range of job seeking activities (to suit each adult), support to access education, work preparation, travel training, in work support as appropriate, good advice and information on welfare benefits and employment law, positive promotion of people with learning disabilities in the local and wider community. • We have promoted the employment of Learning Disabled adults within the Council and to its suppliers resulting in the employment of 10 adults within the Civic Centre. • We run a 'Making It Work' work preparation training course to prepare Learning Disabled adults for paid work and to increase their employability. Over the past year 11 adults have successfully completed this training. • Over the past year we have visited over 73 different employers within the Southend area to market our service and see what opportunities are available.	**• The 'Making it Work' Team regularly market the service both through direct approach to employers and through our attendance at public events however, we struggle to find opportunities with major employers within Southend and would benefit from stronger links with them.** **• Any assistance the HWB could provide in promoting the work that the 'Making It Work' Team do or providing the Team with introductions to local employers would be highly beneficial.**	●	●	●	●

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Aug16

PLEASE PRINT IN A3 COLOUR

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
Number of pre-start-up & start-up businesses supported in Southend	B3.1	Chris Burr/ Georgia Searle	Quarterly / Period (Apr to Mar)	20	5 (1Apr-30Jun)	2 (1Jul-31Oct)	15 (1Nov-27Jan)	**25** (28Jan-31Mar) Cumulative year end status: **47** vs target of 20	5	Aim to maximise	An extensive series of Small and medium-sized enterprises (SME) support workshops ran throughout March 2016 Between April and September 2015, the growth hub project that these metrics are associated with, went through a significant transition from Business Southend to Business Essex, Southend & Thurrock. This resulted in a hiatus in delivery during that period that affected the timeliness with which the outputs have been delivered (with far more being delivered towards the end of the period). Summary of what the growth hub team have achieved during this period: 01/09/2015 - 20/01/2016 9627 Unique website visits 5204 Social media profile visits 200 Businesses engaged (signed up with growth hub programme) 141 Businesses provided with bespoke information 93 Business diagnostics carried out 48 Business referrals on to other support agencies Nb. – these stats are for the whole of Essex, not just Southend, as per our current funding arrangement – and therefore not suitable for inclusion in regular HWB monitoring. Data suggests that over 40% of the calls and enquiries received by the growth hub team are concerning pre-start, start-up or new businesses. This is significantly higher than was expected when we designed the project and the output targets. It can be seen in the HWB KPI metrics provided above – and is something we will look to incorporate in further service development. We are currently in the process of signing a new contract to deliver a £12m European Regional Development Fund (ERDF) programme that will provide support to SMEs across the South East Local Enterprise Partnership (SELEP) region. This will make further financial support available to businesses in Southend through a grant scheme. We would hope that this will result in higher levels of engagement and a higher yield of outputs accordingly. July16: In view of the outcome of the recent referendum, current advice from DCLG is to continue working up business cases and progress this application for funding - they will continue to pay the grant claims of existing projects but will not be signing off any new projects (which ours would be) until such time as they have received guidance from central government as part of the BREXIT negotiations. In summary there is some risk to the project but we're hopeful that it will eventually be funded.		**There is potential to deliver specialist support such as workshops or training that targets a specific demography (i.e. those living in deprived wards). *Appropriate resource would be required to enable this.**	🟢	🟢	🟢	🟢
Number of Small & medium sized enterprises (SMEs) supported in Southend	B3.2	Chris Burr/ Georgia Searle	Quarterly / Period (Apr to Mar)	80	15 (1Apr-30Jun)	13 (1Jul-31Oct)	12 (1Nov-27Jan)	**40** (28Jan-31Mar) Cumulative year end status: 80 vs target of 80	20	Aim to maximise				🔴	🔴	🟡	🟢
Percentage of total attendance in secondary schools (Cumulative) (Academic Year)	B4.1 DP PI15	Michael Barrett for DMT report, Jane Arnold for narrative	Monthly / Period (Apr to Mar)	94.20%	96.05% (Oct15)	96.12% (Nov15)	96.02% (Feb16)	**95.76%** (Apr16)	94.80%	Aim to maximise	Apr 16: Attendance in secondary schools remains better than national figures at 95.76% (cumulative Apr 16 data) compared to national at 94.8%.	Early Help Family Support and Youth Offending Service, continue to work with Secondary & Primary schools to improve attendance. Schools carry out level one attendance meetings with pupils showing a cause for concern regarding their attendance. When the case escalates to level 2, the family are supported by the Early Help Family Support Practitioner, identifying barriers attendance and support to overcome these. Families can be supported with a lead professional and plan of support. Some cases will progress to prosecution or use of penalty notices.	**No specific opportunities yet identified**	🟢	🟢	🟢	🟢
Percentage of total attendance in primary schools (Cumulative) (Academic Year)	B4.2 DP PI16	Michael Barrett for DMT report, Jane Arnold for narrative	Monthly / Period (Apr to Mar)	95.30%	96.77% (Oct15)	96.97% (Nov15)	96.39% (Feb16)	**96.3%** (Apr16)	95.30%	Aim to maximise	Apr 16: Attendance in primary schools remains better than the latest national figures at 96.3 % (cumulative April 16 data) compared to national at 96.1%.		**No specific opportunities yet identified**	🟢	🟢	🟢	🟢
Percentage of total attendance in Special Schools (Cumulative) (Academic Year)	B4.3 DP PI17	Michael Barrett for DMT report, Cathy Braun? for narrative	Monthly / Period (Apr to Mar)	90.40%	90.75% (Oct15)	90.51% (Nov15)	90.18% (Feb16)	**90.03%** (Apr16)	90.40%	Aim to maximise	Apr 16: Attendance in special schools remains marginally lower than national figures at 90.03 (cumulative April 16 data) compared to national at 90.6% (Due to the nature of the cohort of special schools, medical needs are usually exceptionally higher than those of mainstream schools)	Due to the nature of the cohort of special schools, medical needs are usually exceptionally higher than those of mainstream schools. Special schools work closely with specialist services to ensure health needs of children are met.	**No specific opportunities yet identified**	🟢	🟢	🟡	🟡

HWB Indicators Progress Report Aug16

PLEASE PRINT IN A3 COLOUR

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
The proportion of persistent absence (over 10%)in Primary Schools (Cumulative) (Academic Year)	B4.4 DP PI 18(a)	Michael Barrett for DMT report, Jane Arnold for narrative	Monthly / Period (Apr to Mar)	9.2%	6.8% (Oct15)	6.8% (Nov15)	7.2% (Feb16)	**6.9% (Mar16)**	9.2%	Aim to minimise	Mar16: The figure of 6.9% (cumulative to March) is below the latest national benchmark of 8.4% This measure is reported half termly, and the latest figures are based on the first 3 half terms. This year the persistent absence threshold has been lowered to 10% and furthermore this is now calculated based on an individual's own possible sessions, rather than them having to be absent for a set threshold of sessions as in previous years. This will make PA data for schools on a half termly basis very variable.	The refresh of Early help, has resulted in an attendance strand of the service who will be supporting and challenging schools on early identification of PA students (10%) absence. The EHFSP will work in partnership with parents/ carers and schools in overcoming barriers and reducing absence.	**No specific opportunities yet identified**	●	●	●	●
The proportion of persistent absence (over 10%) in Secondary Schools (Cumulative) (Academic Year)	B4.5 DP PI 33(b)	Michael Barrett for DMT report, Jane Arnold for narrative	Monthly / Period (Apr to Mar)	9.0%	9.1% (Oct15)	9.1% (Nov15)	6.9% (Feb16)	**6.6%** (Mar16)	9.0%	Aim to minimise	Mar16: The figure of 6.6% (cumulative to March) is below the latest national benchmark of 13.8%. Target has been met. This excludes several months of data from 2 schools with absence feed IT issues so revised figure may differ. This measure is reported half termly, and the latest figures are based on the first 3 half terms. This year the persistent absence threshold has been lowered to 10% and furthermore this is now calculated based on an individual's own possible sessions, rather than them having to be absent for a set threshold of sessions as in previous years. This will make PA data for schools on a half termly basis very variable.		**No specific opportunities yet identified**	●	●	●	●

Southend HWB Strategy Refresh 2015-16

HWB Indicators Progress Report Aug16

PLEASE PRINT IN A3 COLOUR

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
Number of Southend residents in apprenticeships https://www.gov.uk/government/statistical-data-sets/fe-data-library-apprenticeships	B5	David Coleman	Annually (Academic year)	No local target	1400 starts (12-13)	1250 starts (13/14)	1400 starts (14/15)	**1100 starts so far** (Aug15-Apr16)	No local target	N/A	Following Dec15 HWB, SEPT are engaging with the apprenticeships lead, with a desire to increase their apprenticeships. Number of Southend residents accessing apprenticeships in 14/15 has increased slightly from the previous year but only back to the high of 12-13. Apprenticeships are a focus of the current government, looking at increasing to 3 million national (England and Wales) by end of term of the government.	Working with employers to increase the number of apprenticeships available. Working with providers to ensure provision is there to meet demands. Raising awareness in schools of apprenticeship opportunities. SBC developing their own health and social care apprenticeships in addition to its current apprenticeship offer	HWB partners can attend careers fairs to promote their organisations and engage with potential apprentices There are skills shortages in the health and social care sector and it would be beneficial to increase the opportunities of apprenticeships available in this sector. Health & Care sector partners could identify where vacancies can be accessed by apprentices. Forward planning would be useful, i.e. where are the current and future gaps caused by retirement and increase in demand for social care etc.	N/A	N/A	N/A	N/A
Residents who are 16-18 years who are not participating in education, employment or training (NEET)	B6 (Former NI 117)	Michael Barrett for DMT report, Wendy Hackett for narrative	Monthly / Period (Apr to Mar)	7% (Aiming to provide numerical context in future reporting)	5.5% (Oct15)	4.8% (Nov15)	3.8% (Feb16)	**3.6% (Apr16)**	7%	Aim to minimise	3.6% young people are currently NEET – this is reducing as the intelligence around young people's activities is being identified through tracking. There has been changes of funding to training providers – as they now get payment by results – this has had an impact on our most vulnerable young people – who may need extra support to stay engaged and complete training courses.	Apr16: Personal advisers continuing to support those young people who are NEET into employment, education or training	To identify what support can be put in place for those young people where health is a barrier for engaging into employment, education or training.	●	●	●	●
Those NEET in the 30% most deprived areas in Southend	**B7** (C&L PI 171)	Michael Barrett for DMT report, Wendy Hackett for narrative	Monthly / Period (Apr to Mar)	40%	56.9% (Oct15)	58.6% (Nov15)	58% (Feb16)	**59.4%** (Apr16)	40%	Aim to minimise	Jul16: Breakdown of destinations of young people (16-19s) in category **0-10% (29 young people** - prev 40**)** Long term illness: 1 Pregnant: 2 Seeking employ/ed'n/training: 10 Start date agreed (other): 1 Start date agreed (RPA compliant): 1 Teenage parent: 14 **11-20% (44 young people** -prev 53**)** Long term illness: 5 Not economically active: 1 Not yet ready for work or learning: 4 Pregnant: 2 Seeking employ/ed'n/training: 18 Start date agreed (other): 2 Start date agreed (RPA compliant): 1 Teenage parent: 9 Young carer: 2 **21-30% (23 Young People -**Prev 29**)** Long term illness: 3 Not economically active: 1 Not yet ready for work or learning: 2 Pregnant: 1 Seeking employ/ed'n/training: 10 Start date agreed (other): 2 Start date agreed (RPA compliant): 1 Teenage parent: 3	Some of these young people live in the hostels in these areas so need to establish a relationship with them to support the young people to re-engage with employment, education or training (EET) and also to share information when young people move on. On completion of the breakdown there were young people who had medical conditions that prevented them from re-engagement and also a few with mental health issues – that with the right support could move on to a positive outcome.		●	●	●	●

HWB Indicators Progress Report Aug16

PLEASE PRINT IN A3 COLOUR

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
Residents who are 18-24 years who have claimed Job Seeker's Allowance (JSA) for six months or more	B8	Andrew Newcombe (JCP) and nomisweb.co.uk	Annual comparative snapshot	N/A*	N/A	385 (Oct13)	190 (Oct14)	150 (Oct15)	N/A*	Aim to minimise	There has been a 21% reduction in numbers of Jobseekers Allowance (JSA) recipients from 18-24 claiming for six months or longer. Note: As Universal Credit (UC) has been available in Southend since March 2015, the JSA numbers are no longer the full picture for unemployed residents and particularly single ones, many of whom are under 25 years of age. There is currently no available public data on the UC numbers. *There is not a specific locally agreed measure for long term youth unemployment itself.	*Department for Work and Pensions (DWP) has an overarching strategy for reducing total level of unemployment. All customers have access to a national offer to support residents into employment See: https://www.gov.uk/browse/working/finding-job , https://www.gov.uk/jobcentre-plus-help-for-recruiters In addition, unemployed residents under 25 receiving a working age benefit have access to the additional offer of the Youth Contract with, in particular, a dedicated work coach for period of their claim (on UC this includes in work support as well), employer led opportunities for work experience and pre-employment training.	**Job Centre Plus would be happy to attend the HWB Board to discuss and agree collaborative measures on youth unemployment (or any other group of working age residents receiving benefits) to improve their health & wellbeing and prosperity**	N/A	N/A	N/A	N/A

Name	Ref	Contact/ Source	Reporting period	Annual Target 2015-16	Previous status +2	Previous status +1	Previous status	Current status	Current period target	Gauge format type	Latest notes/ considerations	What actions are being taken to improve this area?	Can the HWB Board help to improve performance in this area?	Dec15 RAG rating	Feb16 RAG rating	Apr16 RAG rating	Aug 16 RAG rating
C) Increased Personal Responsibility and Participation (sustainability)																	
Number of people having health checks	C1	Sally Watkins	Monthly / Period (Apr to Mar)	1st Invites: 10,433 HCs completed: 5673	Apr-Jun 1st Invites: 2257 (23.84%) HCs completed: 1741 (30.69%)	Apr-Oct 1st Invites: 9259 (86.94%) HCs completed: 4582 (80.77%)	Apr-Dec 1st Invites: 10038 (96.21%) HCs completed: 5046 (88.95%)	Apr-Mar 1st Invites: 11339 (106.47%) HCs completed: 6619 (116.68%)	1st Invites: 10,433 HCs completed: 5673	Aim to maximise	Target exceeded. (The target for invites is to invite 20% of the eligible population to attend for a health check each year and to reinvite every 5 years).	Outreach service commissioned and delivered to target Routine & Manual workers and areas of the borough where there is a low uptake.	**Yes – Members of HWBB can assist with raising awareness of NHS Heath Checks and Making Every Contact Count training and encourage staff/ individuals to have training on this.**	●	●	●	●
Number of people progressing through the scale of the Patient Activation Measures programme (PAM) *(An initiative which identifies the ability and motivation for positive lifestyle change of those with long term conditions and provides interventionary support accordingly)*	C2	Sally Watkins	Monthly / Period (Apr to Mar)	A maximum of 1200 participants to be PAM'd (and re scored to show an improvement level)	N/A	1068 PAM scored 127 on 3&6 week self-management courses 134 invited to Market Place Event – 2nd questionnaires to be given then	1252 PAM scores have been recorded to date. The process of rescoring participants is due to commence shortly. 128 people have completed the self management courses. 101 people attended the market place event.	A total of 1583 PAM scores have been carried out to date. The pilot phase of the project has been successfully completed and full evaluation of project outcomes is currently being undertaken. Full roll out of the project is being planned alongside the Healthy Lifestyle Service contract starting in June 2016. Trained volunteers will be used as well as SM UK Tutors to deliver the self management courses going forward.	1,200 overall	Aim to maximise	Self-Management UK are engaged to provide patients with low PAM scores with the knowledge and skills to better manage their long term condition. This management would be reflected in an improved PAM score.	Public Health are working closely with CCGs, particularly the clinical leads re planned and unplanned care. Also working with pilot GP practices who are identifying relevant patients for the programme.	**Pilot programme.** **Currently no anticipated input from HWB required.**	●	●	●	●
Smoking cessation: Number of 'Four week quitters'	C3	Sally Watkins	Monthly / Period (Apr to Mar)	1,300	245 (1Apr-6Aug15) Cumulative	495 (1Apr-31Oct15) Cumulative	724 (1Apr-12Jan16) Cumulative	1300 (1Apr-31Mar16) Cumulative	1,300 overall	Aim to maximise	Target achieved	Public Health are continuing to actively promote stop smoking services through public engagement events, social marketing initiatives and by closely supporting and training stop smoking advisers in general practice and community pharmacy	**Yes – Members of HWBB can assist with raising awareness of stop smoking service and Making Every Contact Count training and encourage staff/ individuals to have training on this.** **H&WB can also assist in the implementation of the recently agreed Tobacco Control Strategy**	●	●	●	●

Southend HWB Board 2016-17	Jun-16	Jul-16	**Mon 1st Aug**	**Wed 7th Sept**	Oct-16	Nov-16	**Wed 7th Dec**	Jan-17	**Wed 1st Feb**	**Wed 22nd Mar**
Governance - Progress against plans - Council/Democracy - Key Board decisions			Localities Approach Better Care Fund [A Better Start governance]	Physical Activity levels progress			Primary Care Access progress			
Policy/Landscape/Stakeholders Policy, Strategy & legislation developments, HWB landscape, Stakeholder engagement			Adults Health Prevention Strategy Transforming Care Performance progress	Strategy & Performance progress			Performance progress		<u>Annual Reports:</u> Children's & Adults Safeguarding Boards Performance progress	Performance progress
Board development										
Other										

This page is intentionally left blank

Health and Wellbeing Board– A Better Start Southend Progress Update, July 2016

10

Background

As the Board will know, we are now into our second year of delivering the Fulfilling Lives: A Better Start programme in Southend. This is a ground breaking 'test and learn' initiative funded by the Big Lottery Fund, involving five sites across England and an evaluation consortium led by Warwick University.

The aim of the initiative is to identify the best methods for laying the foundations for 0-3 year olds to improve their future health, social and emotional outcomes; and to put evidence based early intervention and prevention at the centre of service delivery and practice. The London School of Economics is delivering a study of the benefits and potential cost savings of shifting spending to early years' prevention services and support called Preventonomics: A Better Start – how will it pay?

The programme has five core outcomes

1. **System change**: The systems delivering support to young children and their parents will be transformed, with co-production and community engagement at their heart
2. **Children's social and emotional development**: Children will have positive social and emotional wellbeing, a nurturing and loving family environment leading to supportive and secure relationships.
3. **Children's communication and language developmen**t: Children will be spoken, read, sung to and praised, enjoying the increased stimulation that leads to speech and vocabulary development.
4. **Children's diet and nutrition:** Children and mothers will enjoy healthy perinatal, infant and child nutrition, preventing the issues that arise from poor diet in pregnancy and early years.
5. **Community resilience**: Communities in Southend will be self-supporting, influence change and take control of their families' lives, with raised aspirations for their children's future.

Progress to date

Much of our programme activity to date has been focused on outcomes 2, 3 and 4 – setting up the 'test and learn' of services and interventions in our 6 target wards (Kursaal, Milton, Shoeburyness, Victoria, Westborough and West Shoebury) with a view to up-scaling these across Southend where they prove to be effective in improving outcomes for children.

We are now focusing on projects which are key to achieving our systems change ambition which includes development of the Bank, setting up the Centre for Innovation / Excellence, workforce development and economic inclusion.

Running through all this activity – and at the heart of A Better Start - is the principle of **co-production** between partners and with the community. This will require a fundamental shift in the way that the need of services is identified, how services are commissioned, and how they are designed and delivered. And we will need governance arrangements at all levels that support and enable this.

There will be a short presentation at the meeting on different models of co-production and Members are invited to consider the challenges and opportunities this presents for achieving the A Better Start ambition in Southend.

Alison Clare
interim Programme Director, 22 July 2016

This page is intentionally left blank