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

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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)

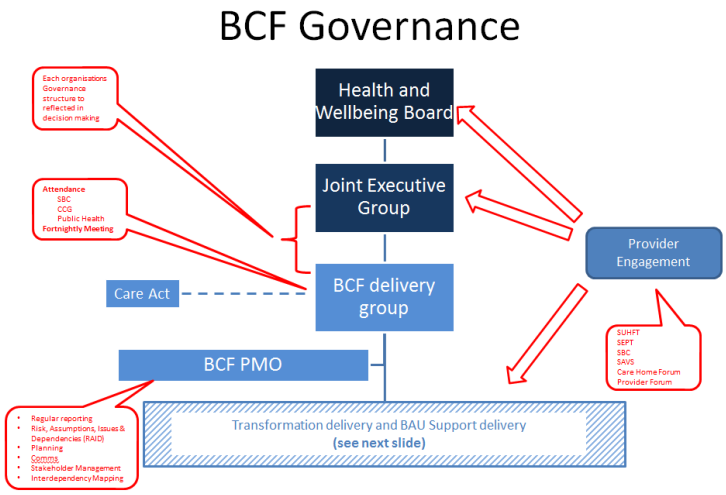
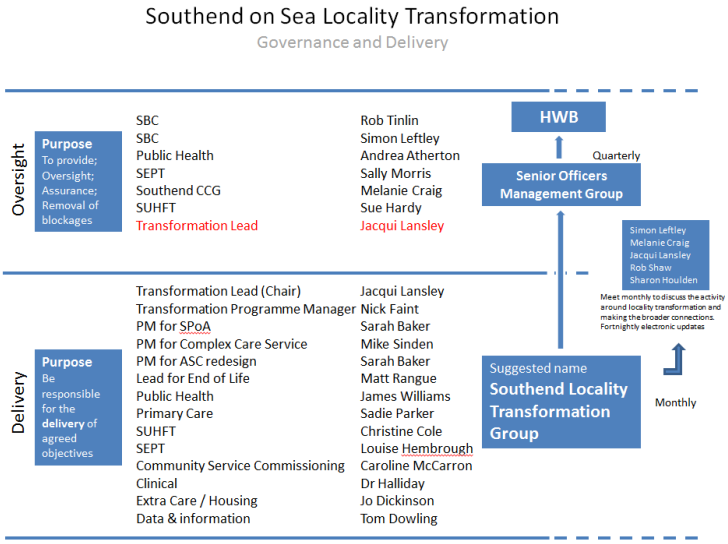


Diagram 2 (Governance structure post Feb 2016)

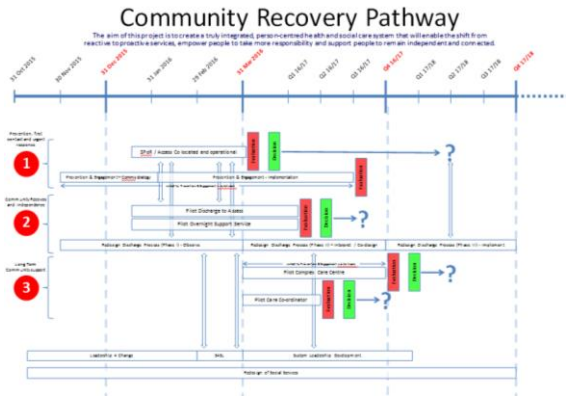


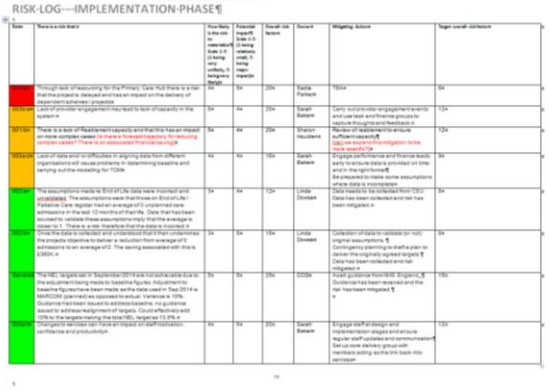
2.31 Responsible for the BCF delivery is HWB. With multi organisational representation the HWB receives regular reports from the BCF programme to assure financial and operational performance. HWB meet 5 times per annum.

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

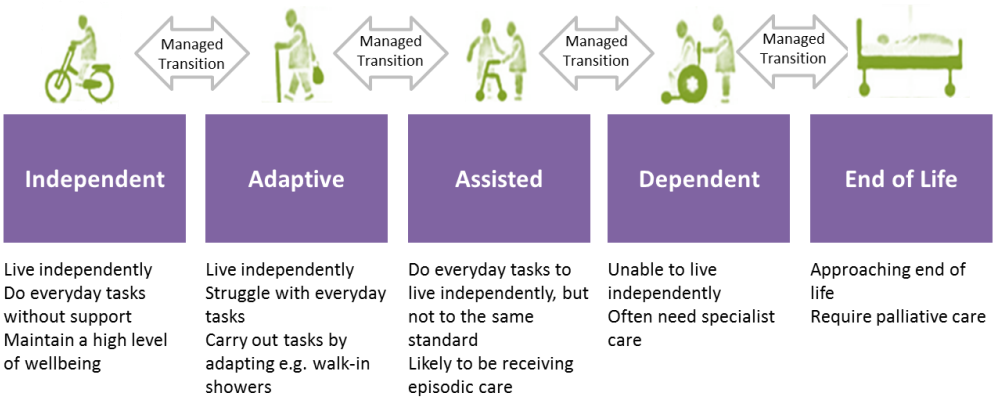
4.11 We recognise that a significant proportion of the cohort will be those with dementia and in need of dementia services. Further, we recognise the need to continually develop our dementia services. The providers are key to developing our services and through our Dementia Support Group (DSG) we have 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.

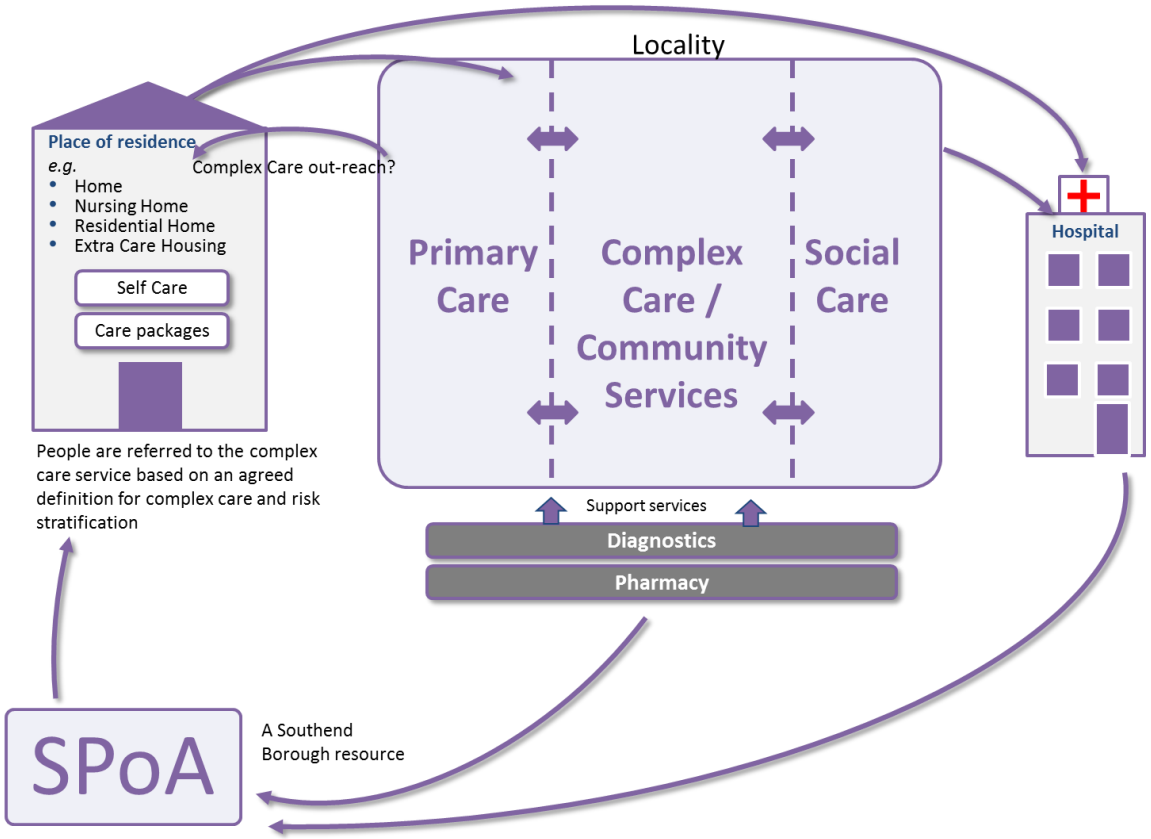
The transitional pathway



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

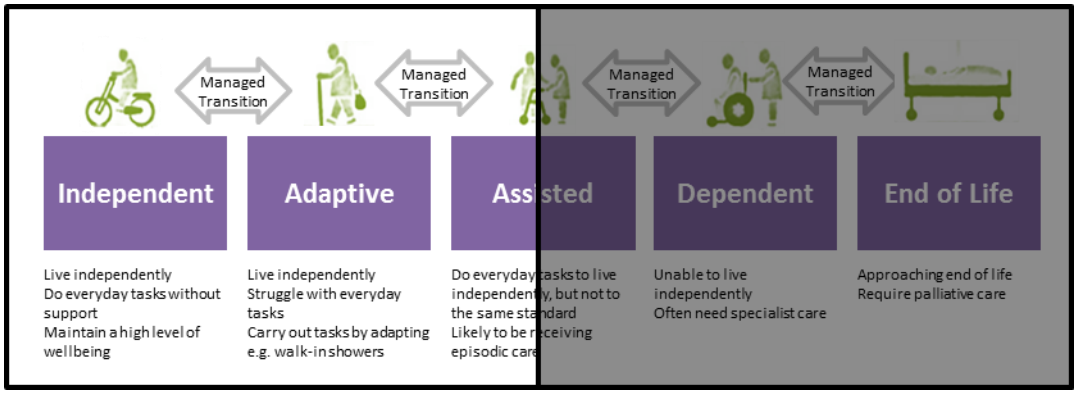


4.17 The Single Point of Access (SPoA) will be redesigned to focus on;

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;



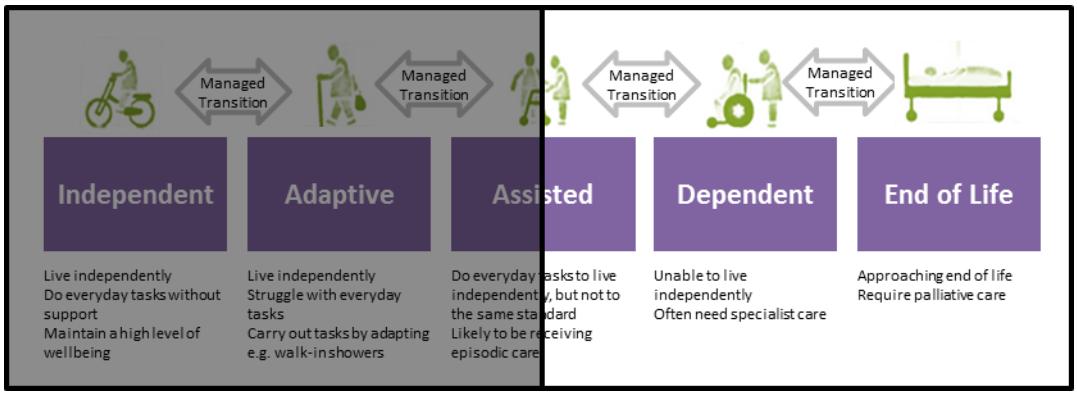
4.19 Complex Care / community services will work in an MDT environment co-locating teams of professionals which will include GPs, community nurses, care co-ordinators, therapies, social workers, pharmacists, voluntary sector, mental health practitioners, dieticians and Long Term Condition nurses, facilitated 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

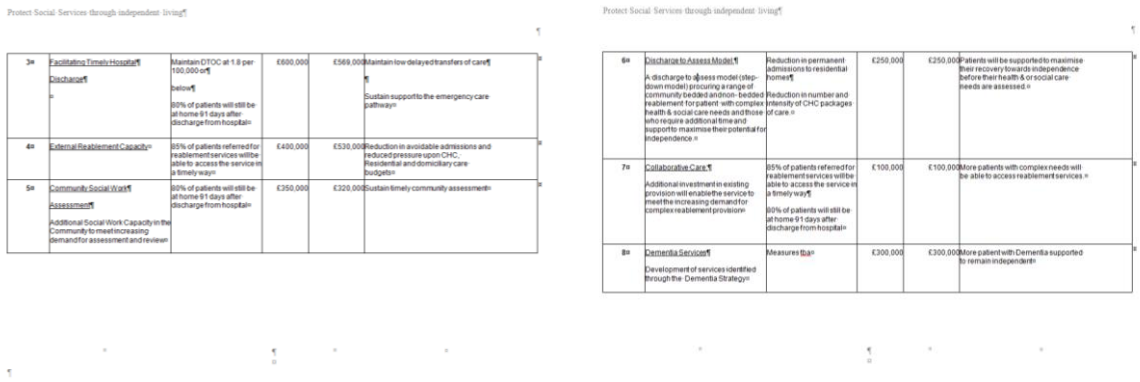
4.22 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

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 90% 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	90% 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 90% 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.

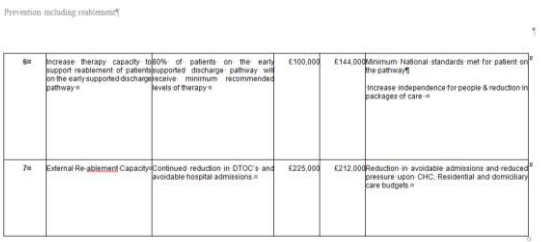
Reablement & Care Act

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.