Bevan Brittan

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

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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

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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 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)

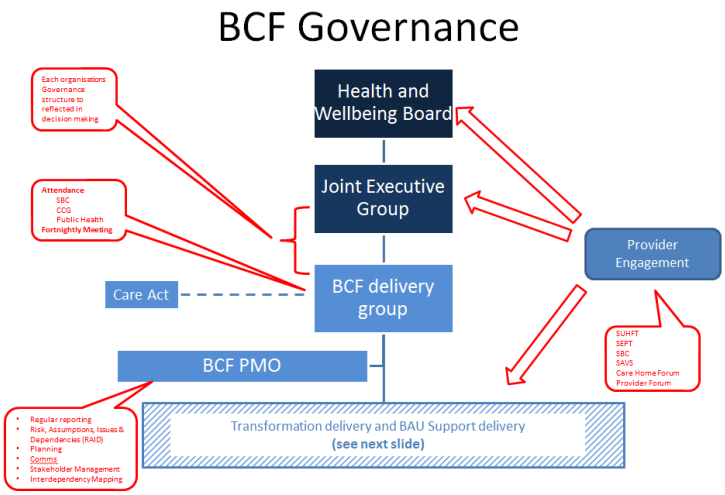
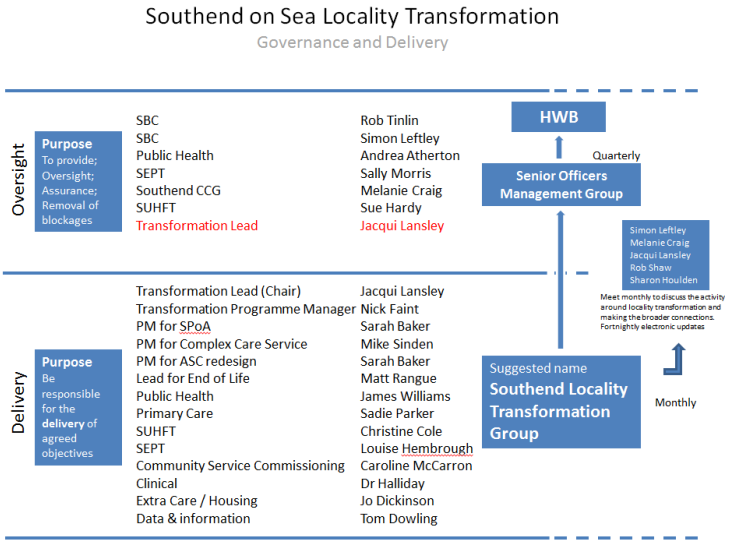


Diagram 2 (Governance structure post Feb 2016)

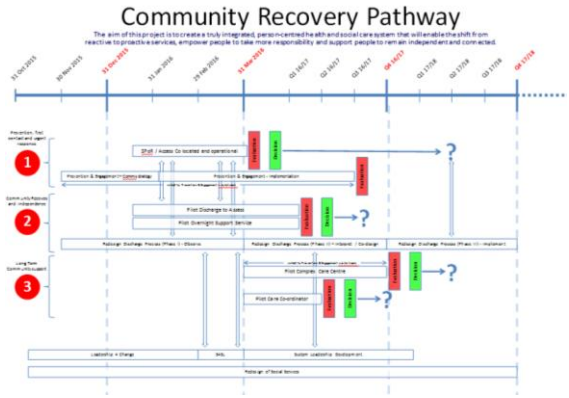


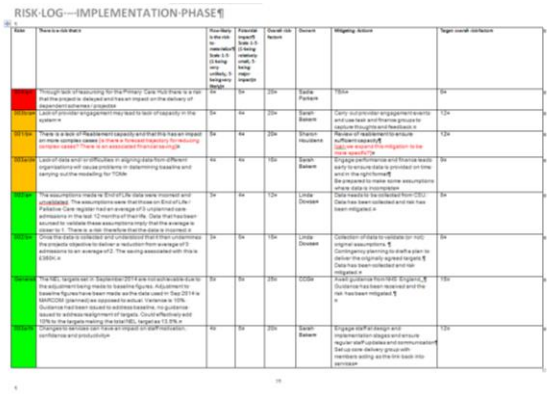
2.31 Responsible for the BCF delivery is HWB. With multi organisational representation the HWB receives regular reports from the BCF programme to assure financial and operational performance. HWB meet 5 times per annum.

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

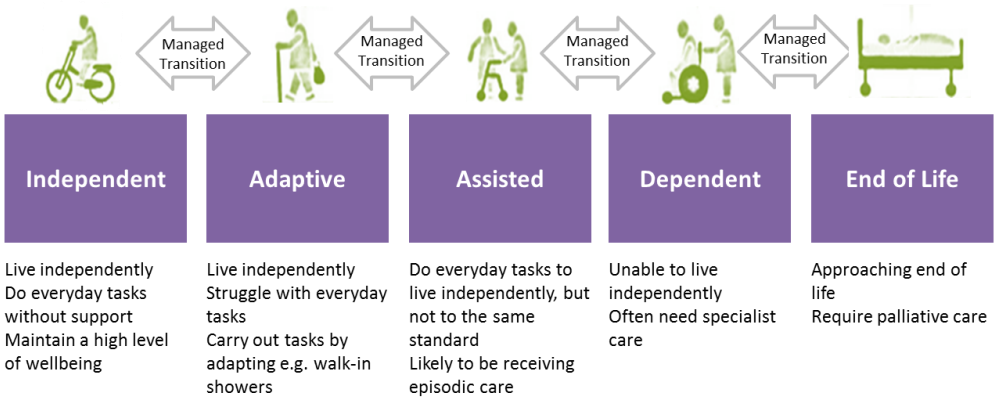
4.11 We recognise that a significant proportion of the cohort will be those with dementia and in need of dementia services. Further, we recognise the need to continually develop our dementia services. The providers are key to developing our services and through our Dementia Support Group (DSG) we have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

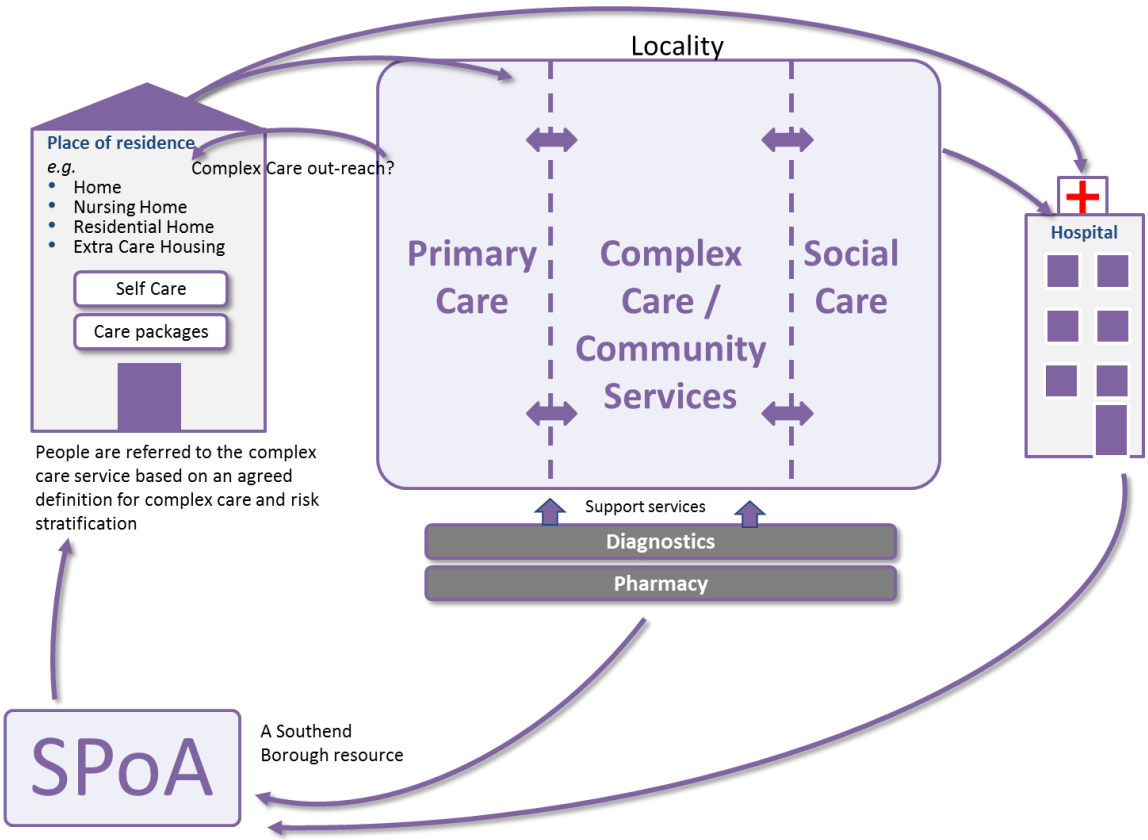
The transitional pathway



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

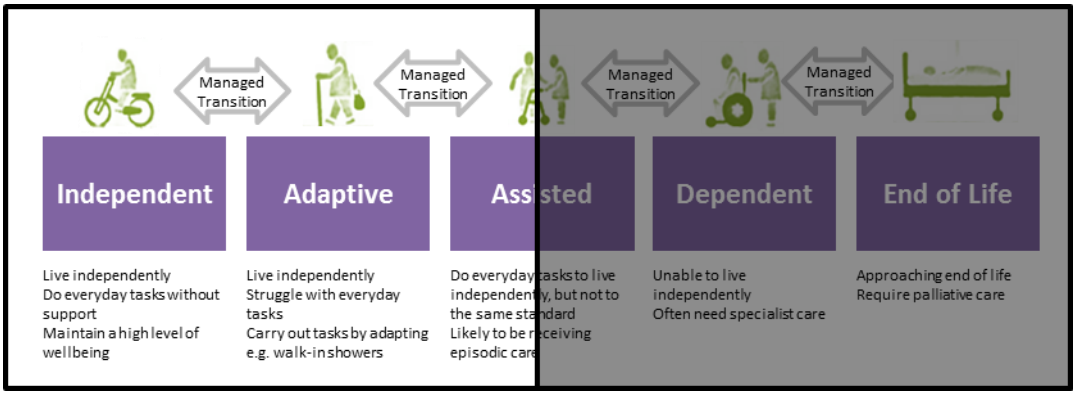


4.17 The Single Point of Access (SPoA) will be redesigned to focus on;

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;



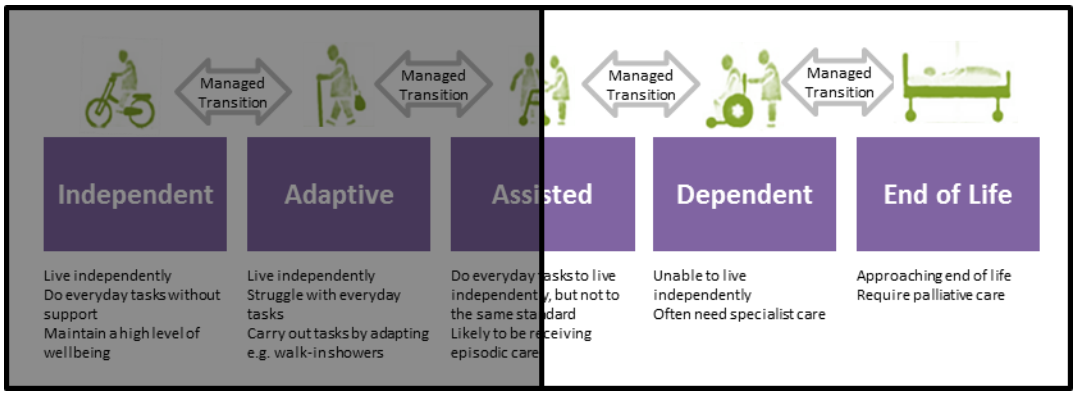
4.19 Complex Care / community services will work in an MDT environment co-locating teams of professionals which will include GPs, community nurses, care co-ordinators, therapies, social workers, pharmacists, voluntary sector, mental health practitioners, dieticians and Long Term Condition nurses, facilitated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

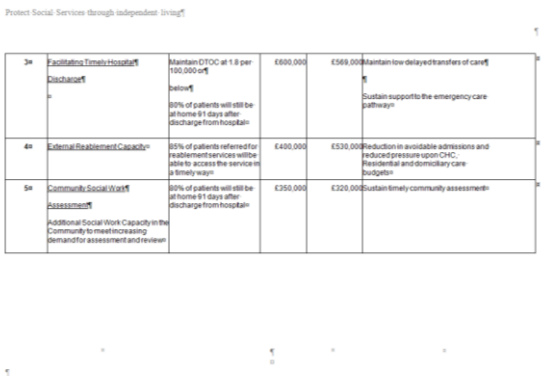
4.22 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

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.

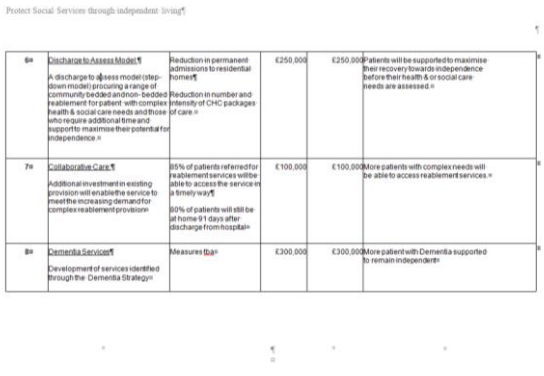
4.24 During 2016/17 we will maintain social care services which will include services such as our Single Point of Referral (SPoR), community social work assessments, a discharge to assess model, dementia services and the Falls service.

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.

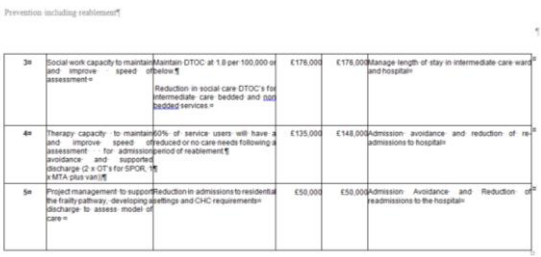
4.33 The detail of the performance metrics are available in the BCF planning return template that accompanies this narrative plan.

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.

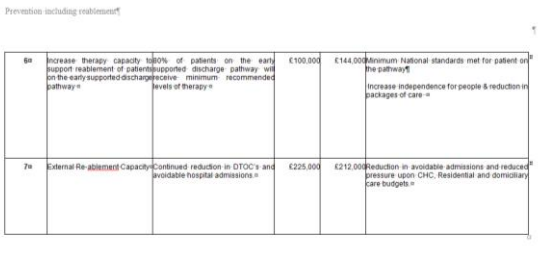
4.35 During 2016/17 we will commission reablement services which will include services such as our Single Point of Referral (SPoR), Stroke early supported discharge pathway, discharge to assess and home again services.

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 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)¶	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

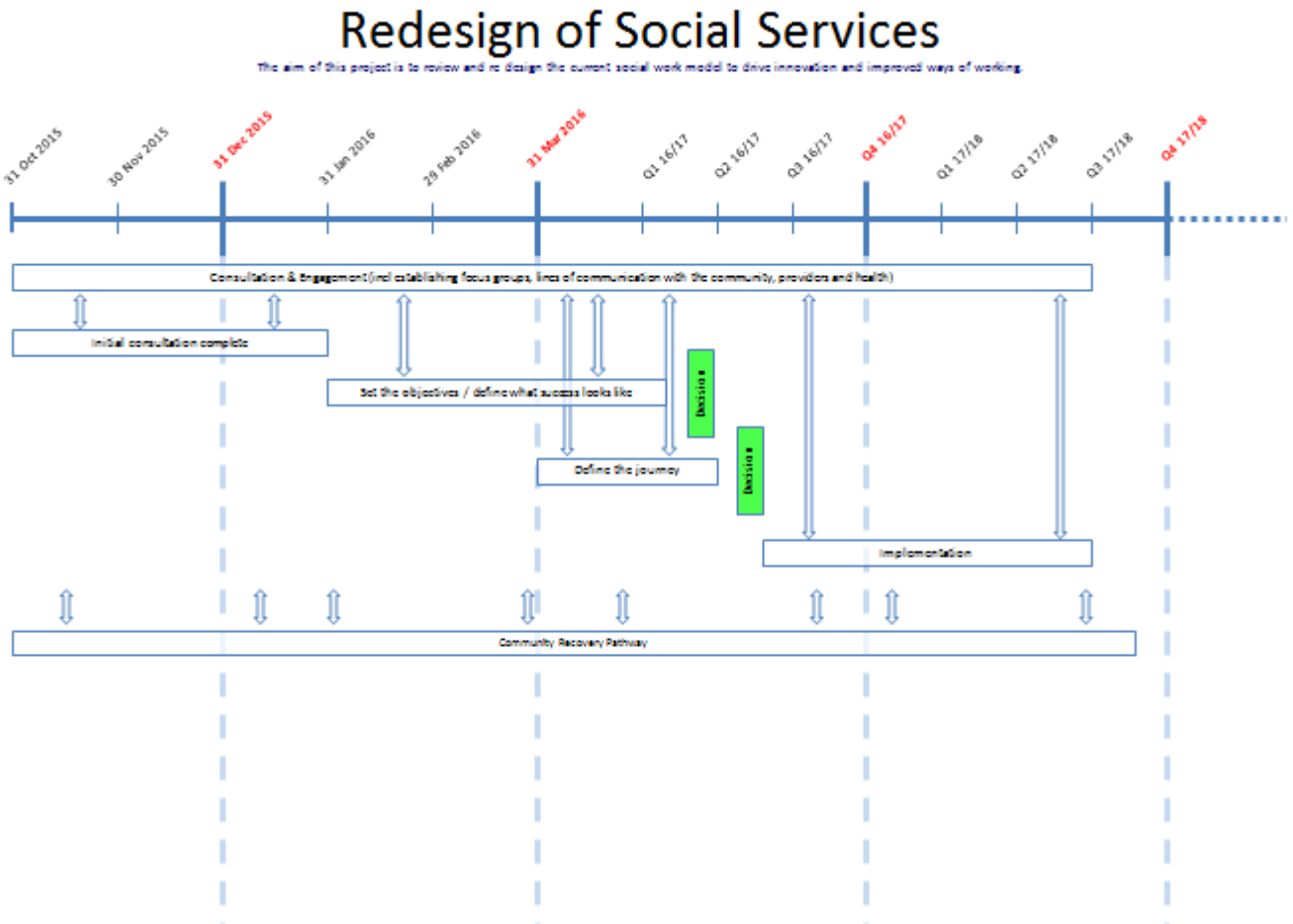
						possible Agree principles for co-design	
003b/d	Lack of service user engagement regarding reablement, preference to have things done for them	2	2	4	Sarah Baker	Engage people and carer reference groups, use SHIP and advice and information sources to promote the benefits of reablement and the positive 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		

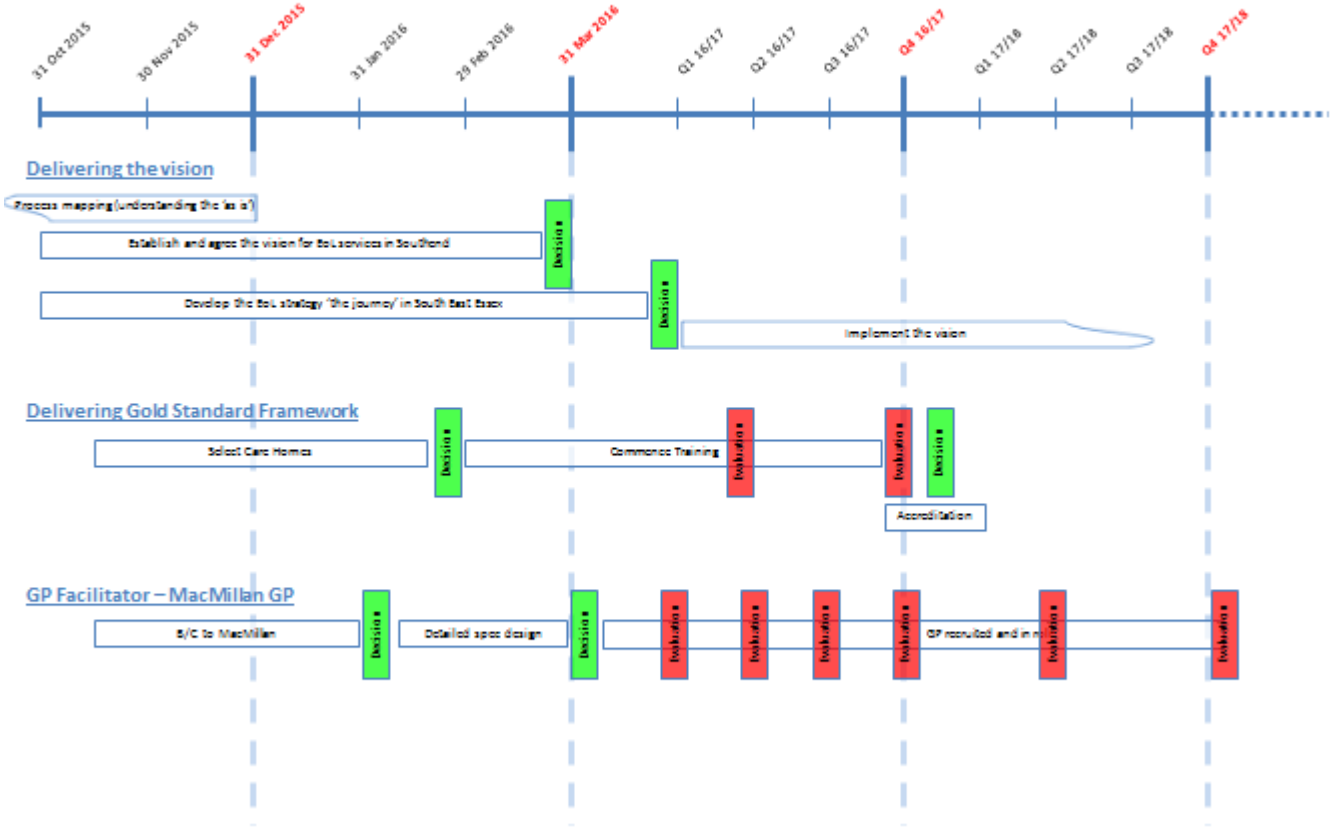
Dependency	Title – there is a dependency ……	Date raised	Date resolved	Status (B / R / A / G)	Date to be resolved
001/a	On Scheme 001 for adult social services saving plans for 2016 / 17	Jan 2016			
001/b	On activity in scheme 001 and Care Act –	Jan 2016			
001/c	On hospital admissions being reduced through 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



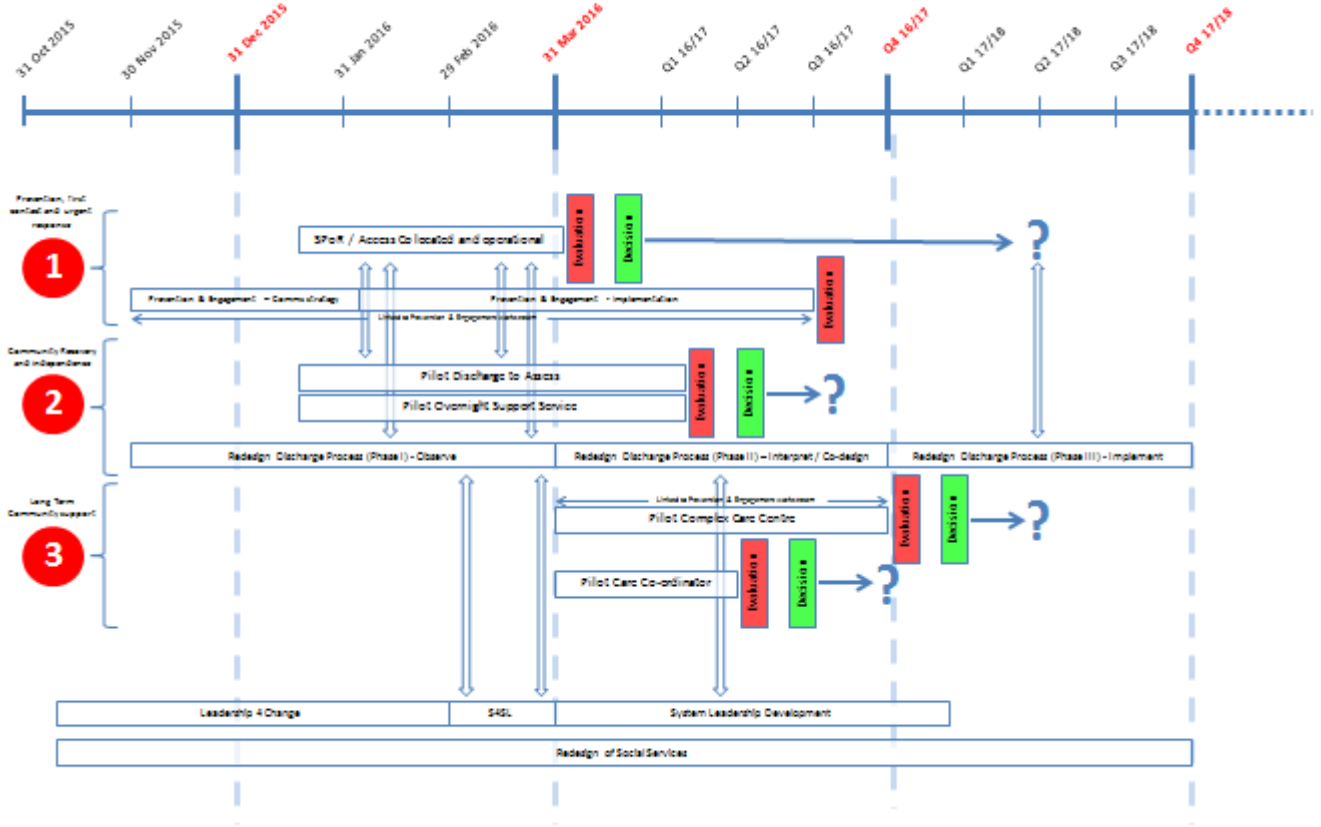
End of Life

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.



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	Health Inequalities/Maintaining Existing Services 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	Protecting Social Services		£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

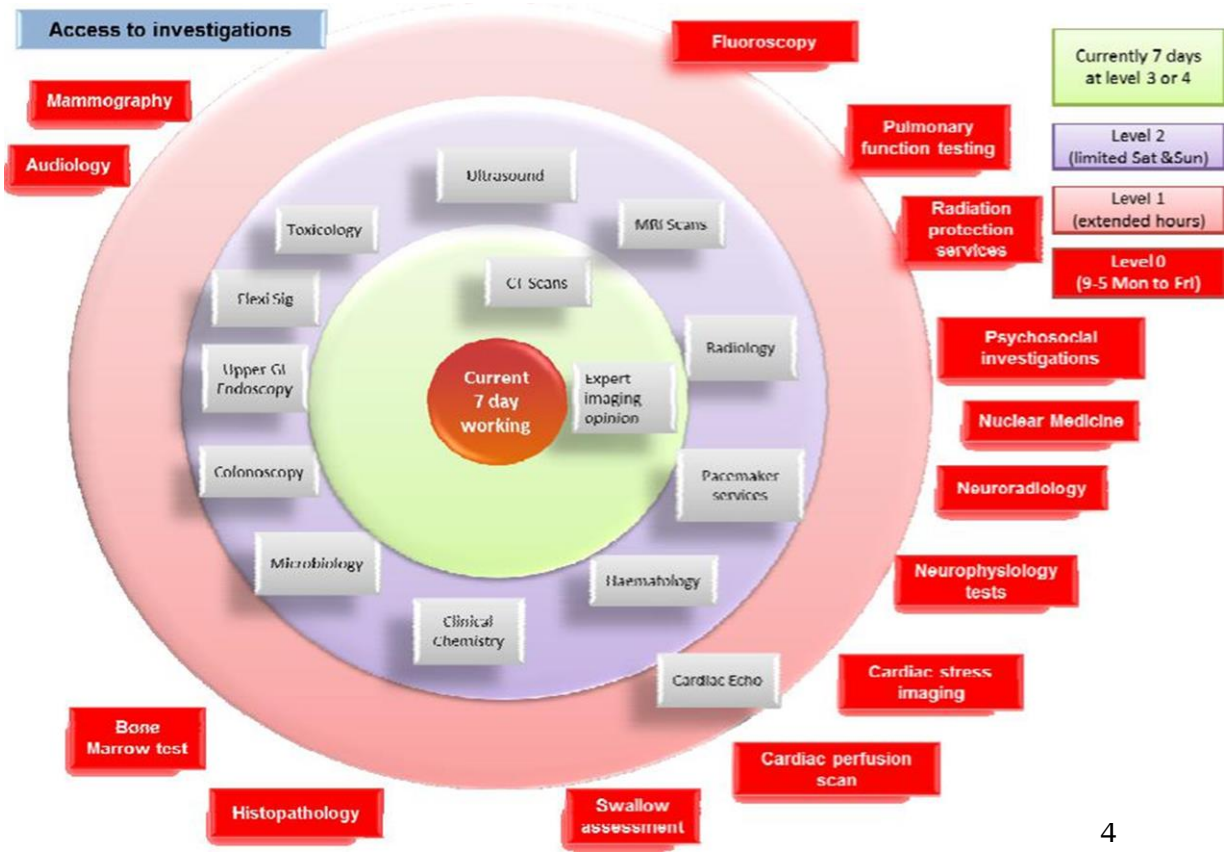
admission? Please see a summary of some of the questions against the standard in Table 1 below.

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

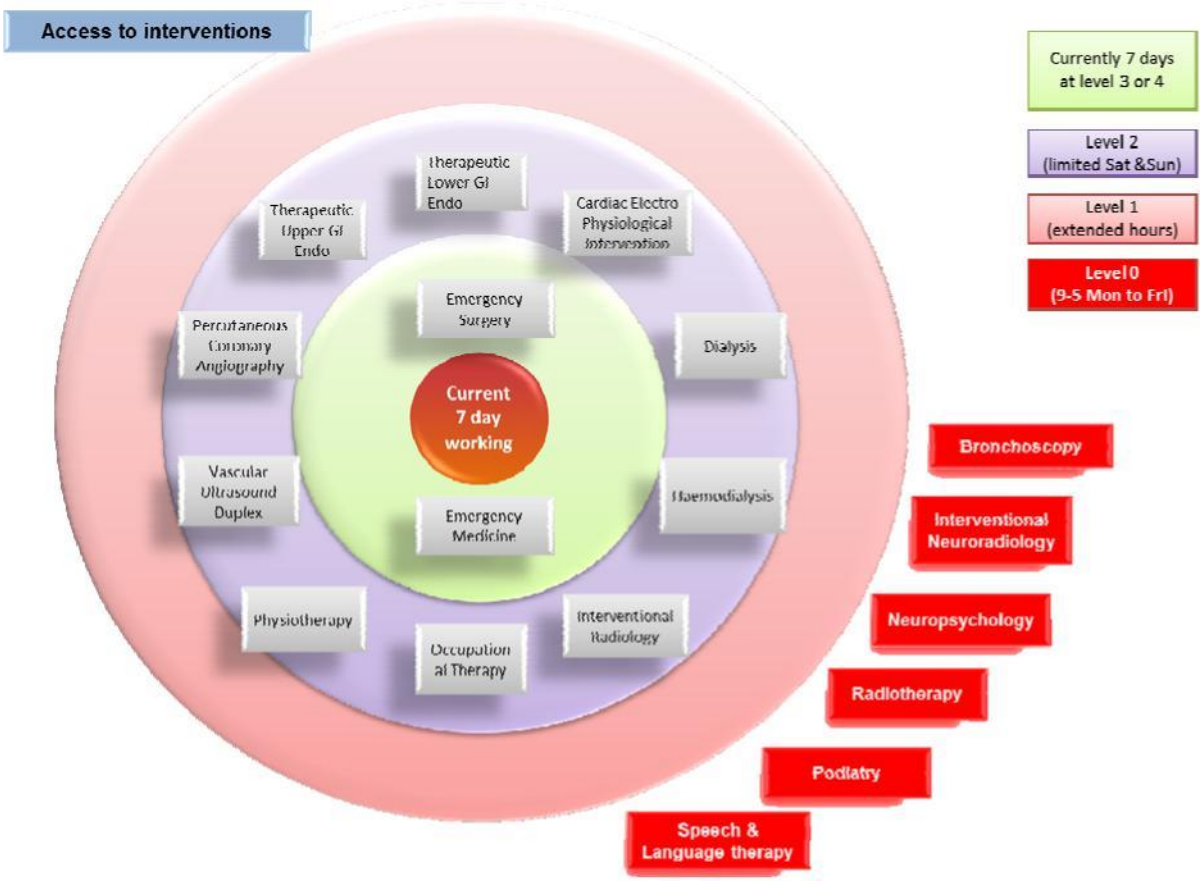
The analysis in the hospital relating to standard 5 is shown below:

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.

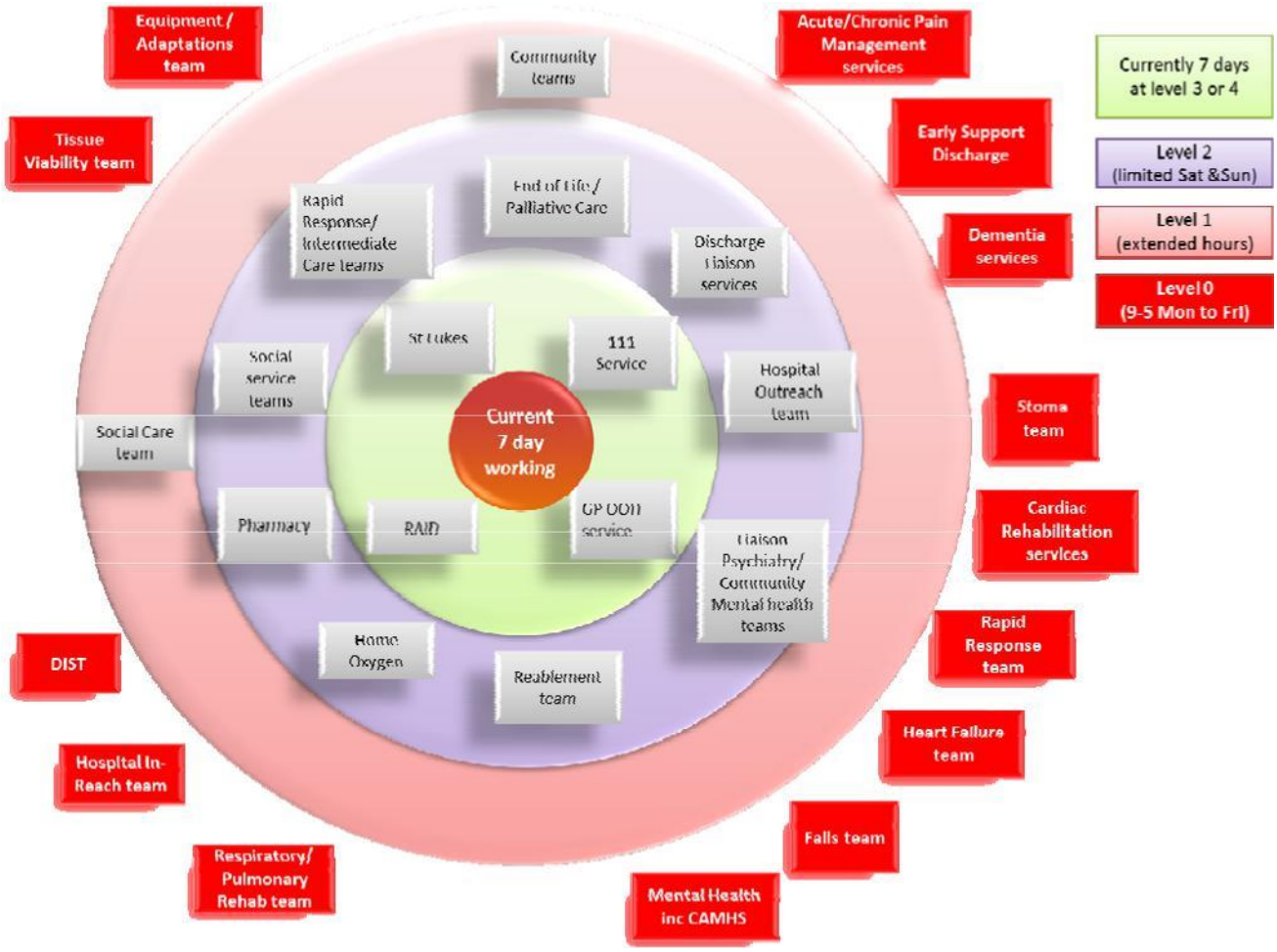
1.2 Out of hospital standards

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

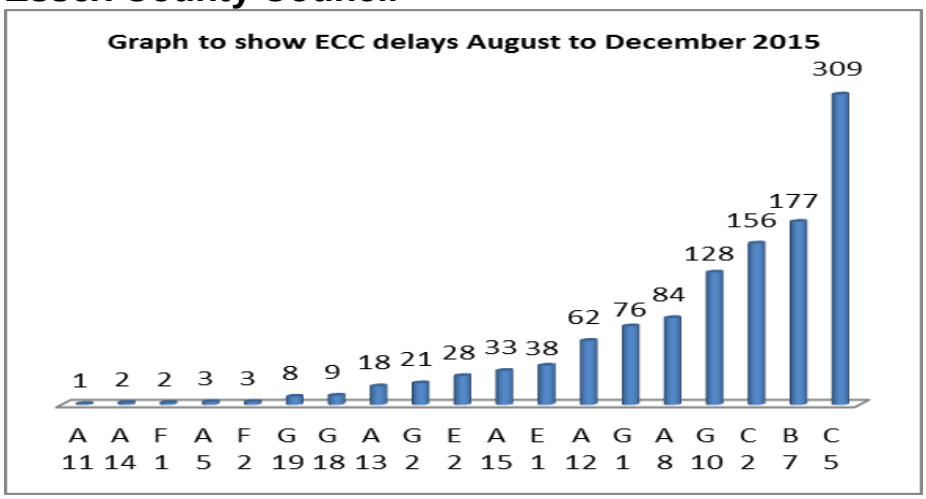
APPENDIX 6A – ACTION PLAN TRAJECTORY FOR DTOC

Action Plan trajectory to reduce system wide delayed discharges from Southend Hospital

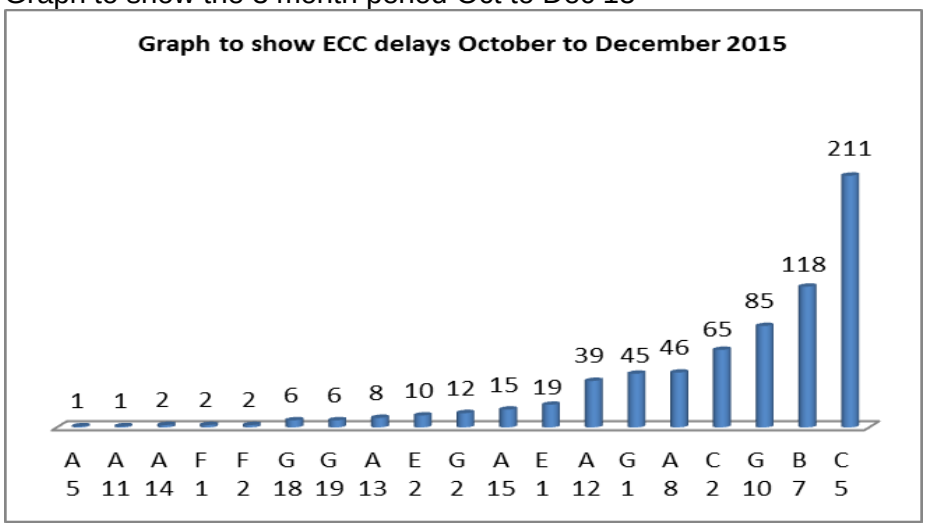
Introduction
This report is an update to the action plan trajectory to reduce DTOC.
The data in this report is based on codes applied to every bed day following the agreed Medically Fit for Discharge date. The 52 codes are published from the Department of Health (DH).
The definition of *Medically Fit 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.

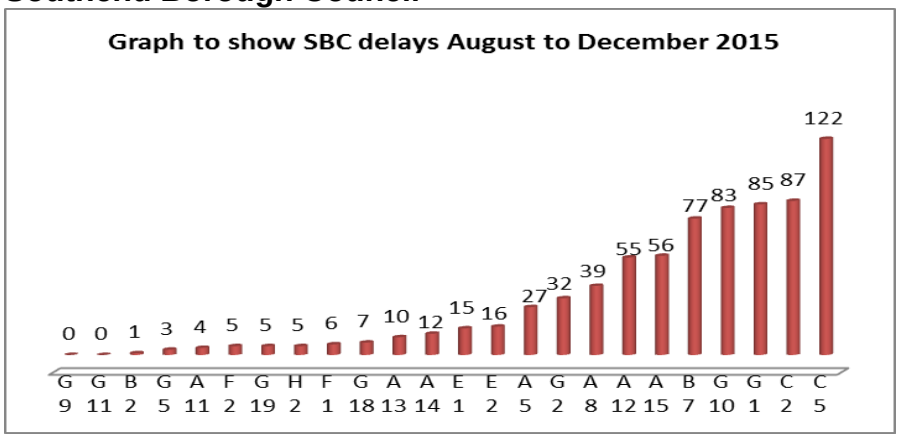
3. The third highest number of delays is G10 with 85 days. These relate to patients refusing discharge, relatives being unavailable, patients accommodation problems, joint meetings with the MDT. These are shared health and social delays that on Sitrep resort to a Health code

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.

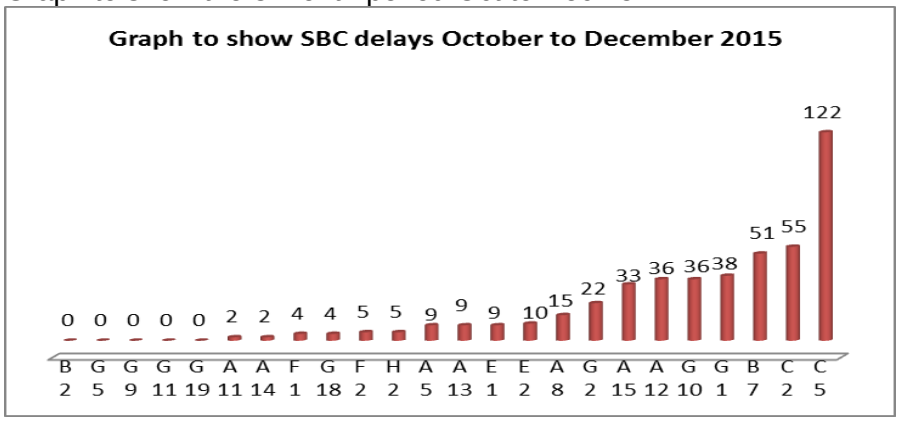
5. A8 is for Rehabilitation delays within the hospital, this accounts for 46 days over 3 months. These delays are related to waiting for home visits, the process of ordering equipment and the completion of rehab goals on Assessment of Needs referral forms.

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

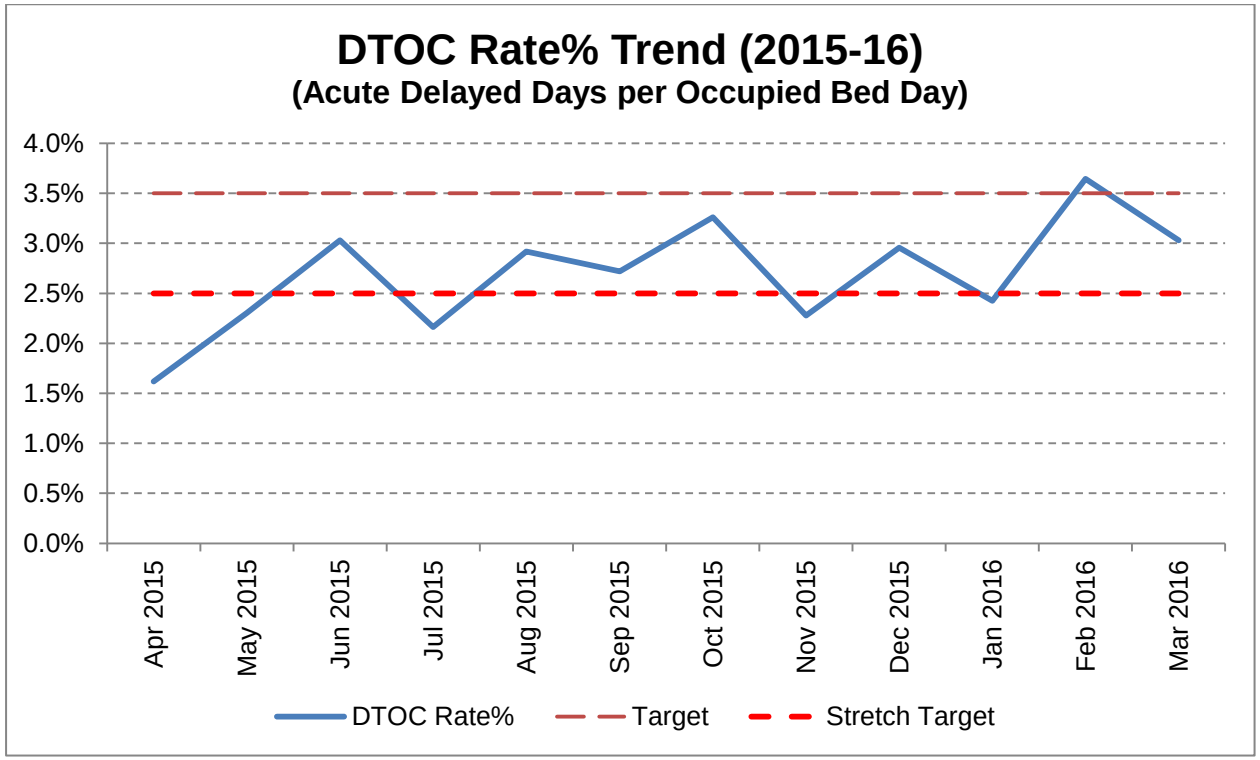
Code	Issues	Action plans	Trajectory
C5 Neuro rehab beds	• Long waits due to lack of availability • There is an average wait of 12 days per patient (this reduction from 40 days per patient is mostly due to the improvement in the patient status as they have received rehab on the ward and moved to a lower 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	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:)