HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s).

Southend-on- Sea Health and Wellbeing Board

Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

The Southend-on-Sea Plan for 2023/25 is part of a wider programme of work to integrate health and care across the City of Southend-on-Sea for the benefit of local residents and the community. The following bodies are those who are involved both strategically and operationally in preparing the plan:

Southend on Sea City Council;

Mid and South Essex Integrated Care Board;

South East Essex Alliance.

How have you gone about involving these stakeholders?

The current aims and objectives for Southend-on-Sea City Council's (SCC) Adult Social Care (ASC) are set out in its three core strategies; "Ageing Well", "Caring Well" and "Living Well". In addition to the three core strategies a number of supporting strategies and policies have been established with others scheduled for development.

Southend-on-Sea City Council and Adult Social Care have an established model for the co-production of its vision, strategies, policies, and services. This can be evidenced in the development of the new Supporting Living contracts, multiple engagement sessions were held with service users and providers. Adult Social Care acknowledges that further work is required to embed co-production at a strategic, planning, and operational level.

The Mid & South Essex Integrated Care Partnership (ICP) Strategy 2023-2033, has been developed in collaboration with key strategic partners, supported by the Chair of the ICP Board and the three Vice Chairs (respective Health & Wellbeing Board Chairs) and the three local Healthwatch organisations. The essential building blocks of the strategy were informed by a range of conversations with residents, community organisations, clinicians, care professionals and leaders in health and care.

At a local place-based level the South East Essex (SEE) Alliance has, through sustained and active engagement, developed a robust Alliance Framework Plan. This partnership plan focuses on the development of neighbourhoods, tackling the wider determinants of health and reducing health inequalities. The Alliance plan has established a strong foundation for working together as partners in Southend.

In Southend, opportunities for collaborative commissioning are explored at regular meetings with all organisations mentioned above, wherever appropriate. There are strong joint working arrangements across system partners which are well embedded to deliver an integrated approach to health and care in Southend-on-Sea. These are underpinned by regular meetings which focus on areas for development and transformation.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Governance for the BCF Plan sits with the Better Care Fund Management Group.

This group performs the governance function on behalf of the Health and Wellbeing Board, with the authority of the two key partners: Southend City Council and the Mid and South Essex Integrated Care Board (MSE ICB).

The role of the Southend Better Care Fund Management Group is to oversee the BCF plan and provide:

Direction

- Make recommendations to support the delivery of the programme (e.g: changes to the plans, schemes, or budget)
- Provide a solution planning forum for barriers to delivery
- Approval of project and work-stream proposals and initiatives
- Oversee and direct the work of the programme on behalf of SCC and MSEICB.

Assurance:

- Report on programme activity, including a quarterly report
- Manage risks, issues, and dependencies
- Evaluation of outcomes and associated decisions

Communication:

- Stakeholder engagement and management including assisting the programme to achieve a high profile within the local area and wider community.

Sustainability:

- Ensure that there is a sustainable approach beyond the life of the programme, including decommissioning of projects and/or transitioning activity to “business as usual” when funding decreases.

The BCF Management Group meets quarterly, with decisions being made by majority vote.

The BCF Group reports to the Southend Health and Wellbeing Board on a regular basis, with the voting members of the BCF Group also being on the Health and Wellbeing Board.

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

The City of Southend sits within the complex health and care system that makes up the Mid & South Essex Integrated Care Partnership (ICS). The ICS spans 3 local authorities, 5 district councils and multiple NHS providers of acute and community-based care.

In 2020, Southend-on-Sea was the second most densely populated area in the East of England region.

The population in the last decade has increased and the number of people of state pension age is estimated to be around 300 per 1,000 working-age population. There is an ageing population in Southend. In 2021, the proportion of the population aged 65+ (19.1%) is significantly greater than that for the population aged under 15 (17.8%).

Seven out of Southend-on-Sea's 17 wards are in the 10% most deprived neighbourhoods nationally (decile 1).

Southend City Council (SCC) and Mid & South Essex Integrated Care Board (ICB) are committed to working to build and empower strong and inclusive place-partnerships at the Alliance level, joining up care and support with local partners, including NHS, local authorities, district councils, schools, communities, and the local voluntary and community sector.

Our Joint Southend Health and Wellbeing Strategy 2021/24, considers how we can influence the wider determinants of health and wellbeing, which includes the social, economic and environmental conditions that influence the health of individuals and populations.

Within the Southend Health & Wellbeing Strategy, we describe the challenges we face but also describe some of the opportunities too. We know that, within Southend, despite the challenges, our strong partnerships and commitment to working together in the health and social care system, means we are well-placed to deliver sustainable, long-term improvements. Together, we will protect people and help them to live longer in good health.

We must change the culture, mobilise our collective leadership and work more effectively hand-in-hand with local communities, so better health outcomes can be achieved for the people of Southend. We have already made great strides in our collaboration and whilst partnering is crucial in delivering our vision, we have a responsibility to collaborate in delivering the NHS long-term strategy and the Southend 2050 outcomes, all informed by the Joint Strategic Needs Assessment (JSNA) and the Annual Public Health Report.

The alignment of organisational priorities and actions will serve to advance local service development and shared outcomes.

Southend-on-Sea's BCF plan has an initial focus on hospital discharge but will also incorporate admission avoidance during 2023-25.

Our priorities will focus on the key areas as noted below:

Health inequalities – Improving health outcomes by addressing and reducing variation within the wider determinants of health (education, housing, employment and income).

Effective Partnering – Partnership work in a coordinated way to ensure system alignment, shared resources and focus on co-production, to make Southend a healthier place.

Accessible Services – Ensure health services are designed to be as accessible as possible for users, identifying, reducing, and removing barriers to access.

Workforce Development – Skilled workforce to support the borough's health and well-being needs.

Spatial Planning – Use active environment design and spatial planning, so that the places and spaces in Southend-on-Sea encourage and facilitate activity in everyday life, making a healthy lifestyle as easy as possible.

Information and Digital Resources – Ensure all residents can access clear and consistent information and services.

Unpaid Carers – Looking after our unpaid carers and ensuring we provide the relevant support which they require. Ensuring we continue to work with the Caring Well Partnership Group to assure the right initiatives are in place.

Coordinated Communications – Work with partners to develop our communications and health campaign strategies, to increase awareness of health risks, raise awareness of local services and support and encourage people to take action to improve their health and wellbeing.

Over the next 2 years, Southend-on-Sea's plan will support the aims of the BCF by linking programmes of work such as urgent and emergency care, long-term conditions, prevention and early intervention. We will continue to deliver a range of projects in 2023-25 which were implemented in the previous BCF plan and will continue to develop existing services. As well as introducing new opportunities, avoiding duplication and inefficiencies within the system to ensure that delivery is meeting the right needs of targeted populations. We anticipate that our priorities will reduce gaps and support local people to live independently, meeting and receiving the care which they need.

The initiatives which have been demonstrated in our 2023-25 BCF plans for reablement and rehabilitation will continue to step up and step down where necessary. This will continue to fluctuate because we have capacity when required.

In Southend-on-Sea, we will continue to support and work with providers in health and care across our local system in finding solutions to the key challenges which include winter pressures.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Our Better Care Fund Plan builds upon the work undertaken in Southend through the last year of BCF funding. This saw the ongoing development and growth of the South East Essex (SEE) Alliance partnership and enhanced the ethos of the SEE Locality Strategy, bringing together local partners and stakeholders, including Providers, VCS, and Housing who share an ambition to improve the well-being and lives of the people they serve. South East Essex, covering Southend, Castle Point, and Rochford, is the local “place” that forms part of the Mid and South Essex Integrated Care Partnership.

In 2023-25 the BCF will ensure collaborative and joint partnerships working to streamline access to care and provide more proactive, personalised care with support from multidisciplinary teams of professionals ensuring healthy communities are created and meeting people’s needs for integration of health and social care.

Opportunities for collaborative commissioning are explored wherever appropriate. Our BCF plan incorporates the ambitions of all the strategic partners in SEE, all of which have been subject to a significant level of consultation and engagement with stakeholders and partners, drawing out a coherent strategic direction for the health and social care system across Southend. Central to our collective vision is our desire to see residents united with health and social care services around the single ‘Common Endeavour’ of reducing inequalities together. The BCF plan is grounded within our joint Health and Wellbeing Strategy, Mid & South Essex Integrated Care Strategy, joint strategic needs assessment (JSNA), Locality Strategy, and the plans of our Alliance partner organisations.

Southend City Council has developed three core strategies; ‘Ageing Well’, ‘Caring Well’, and ‘Living Well’, setting out priorities over the next five years. The three strategies were co-designed with people who use services and their friends and families, partners, and stakeholders.

Our BCF plan for 2023-25 recognises both national and local challenges, including affordability challenges for social care and the NHS. It includes consideration of both iBCF and Winter Discharge Fund with associated conditions to be met. The stabilisation of the home care and residential care markets, improving discharge arrangements and supporting the structural deficit in social care funding which would otherwise make such steps unsustainable are also included.

The programme across 2023-25 will deliver a range of initiatives within new models too including Trusted Assessor along with the development of a skilled workforce, to support the improvement and transformation of adult social care. The priorities together will ensure people get out of the hospital as soon as they are medically ready and will, wherever possible, return home. Anybody requiring ongoing care will be able to access the right care, in the right place at the right time.

Our BCF plan also acknowledges the growing pressures on community health services as a consequence of increasing demands in local acute hospitals and primary care services. Levels of demand across primary care, acute hospitals, community health, mental health, social care and VCS sectors are at unprecedented levels due to a number of factors. Through our BCF and other local collaborative planning processes, Southend City Council, MSE ICB, and other local partners will be working together through 2023/25 to balance these unprecedented demands on existing services and consequent system pressures.

The winter discharge fund in 2022/23 supported the delivery of a number of test and learn initiatives including:

Ward enablement – Pilot to bring a Reablement mindset and capacity into a frailty/DME ward at Southend Hospital, supporting a reduction in unintended Hospital Acquired Functional Decline. 3 staff, 7 days per week including a dedicated Trusted Assessor and two Care Assistants 6 hours per day. Outcomes show a reduction a ward-base falls and readmissions and measurable improvement in mobility at the point of discharge in comparison with similar wards.

Dedicated patient Transport Customer Relationships Manager – Based in Southend Hospital to optimise and prioritise complex discharges. This role assists in maintaining patient flow during periods of severe pressure and acts as a conduit between HTG-UK Control (PTS provider) and hospital colleagues. Outcomes show a significant reduction in re-bedded patients and reduced waiting times for patient readiness.

Mental Health Discharge to Assess Nurses – Based in the Emergency Department at Southend Hospital, providing an immediate/rapid triage to determine the safety and appropriateness of conveying the person home and carrying out a full assessment at home.

The market provider incentives were used to support timely and safe discharge from the hospital to where ongoing care and support are needed. One of the key challenges we wanted to address through this initiative was to support our homecare providers to best handle the local workforce capacity pressures and thereby improve timely and safe discharge from the hospital where ongoing care and support is needed at home.

Southend Enhanced Discharge Service (SEDS) - Developed jointly with key strategic partners this service brings together hospital staff, occupational therapists, physiotherapists, social workers, and community workers to collectively support people to recover at home and maintain their independence following a hospital stay. At the moment we are committed to a one full year review. At this stage, we are looking at undertaking evaluations following the first year of running the service.

Community Hubs – Established to reduce both length of stay and readmissions to hospital, through a risk-assessed onward support package. Key to the success of this project is the confidence of the hospital teams to discharge in the knowledge that welfare is being picked up on discharge and support provided in the community via the voluntary sector (VCSE). Working in partnership with the VCSE sector will enable social support, for people through “Hospital to Home” to ensure their

Carers Intensive Support Services – This pilot service has provided practical and emotional support to carers approaching a crisis with time-limited intensive interventions adopting a person-centred bio psycho social approach. The service will be further enhanced in 2023/24 to focus on Carers Health Checks (Physical, Mental, Social and Emotional Health incl housing).

Each of the above services will continue and be further developed and enhanced through the BCF plan going forward.

An established Southend BCF Management Group with key partners which include senior management from Southend-on-Sea City Council, ICB/Alliance and colleagues from local voluntary organisations have been established. This group is part of our governance arrangements whilst planning priorities and reviewing key themes and activities across Southend. They also have financial oversight of BCF governed through Section 75 Agreement agreed through the Health Wellbeing Board.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

The relationship and partnership between Southend City Council and the Integrated Care System is very strong. Together we all continue to expand our collaborative approach with key strategic partners, aligning strategic commissioning with integrated neighbourhood/locality approaches.

Embedding a strength and asset-based approach is a key priority, utilising a different lens to view individuals, families, and communities. A strength and asset-based approach seeks to view individuals holistically and explore their abilities and circumstances, rather than focusing on their weaknesses and deficits. The most critical variable in this approach is where individuals are encouraged to identify the goals that they want to achieve and work towards attaining these goals that empower the individual. Reablement, active recovery and tools for independent living are central to this approach and are adopted across services.

We have been working towards Integrated Neighbourhood Teams in Southend and have made considerable inroads, all of which align with the recommendations arising from the Fuller Stocktake. PACT (PCN Aligned Community Teams) integrates the delivery of health and care to people with complex needs, so services and support are coordinated and aligned in ways which make sense to the local population. PACT is not a service, but an operational model which unites workflow at the neighbourhood level to deliver real-time multi-agency working between primary care, community nursing, mental health dementia teams, palliative care, adult social care, care providers and voluntary sector assets to provide efficient proactive care. Digital and IT solutions are enabling this live, day-to-day, working across multiple professionals who are creating a ‘one team’ identity. In turn, this is reducing repeated, reactive, urgent demand on teams and services as capacity becomes united and efficiently coordinated ensuring local residents get the right support, by the right team, at the right place and time for them. In the two most advanced PACT’s, both frailty focussed, readmissions have been reduced by approximately 10%, this is a significant gain for both resident and family experience and also system demands. Resident and family feedback is overwhelmingly positive.

In SS9 PCN a dedicated Mental Health PACT is emerging, building on the success of the frailty model outlined above, the mental health PACT will include Primary Care Mental Health practitioners, other community mental health teams, community physical health, ASC and voluntary sector partners. Early indications are positive and we fully expect the model to change the outlook and approach to mental health in Primary Care.

The overall direction for adult social care is built on three core strategies named ‘Ageing Well’, ‘Caring Well’, and ‘Living Well’, setting out priorities over the next five years. The three strategies were co-designed with people who use services and their friends and families, partners, and stakeholders.

The strategies are only one part of a process, and to move forward delivery of each strategy, there are associated annual action plans of activities to enable movement from the starting point of where we are to where we want to be by 2027. Partnership groups including all strategic partners have been formed to manage the development, delivery, and monitoring of the yearly action plans for each strategy which will build on the work of the previous year and in reaction to emerging needs and trends.

Alongside the ambitions of these strategies, SCC has developed a Market Position Statement, which summarises supply and demand in the local area along with highlighting business opportunities. The Market Position Statement starts the process of explaining what care services and support are needed in the area and why. Based on a review of supply, demand quality, diversity, cost challenges and workforce pressures the sustainability in Southend-on-Sea is challenged, though it has seen small improvements since severe challenges in 2021. In addition, SEE Alliance and Southend City Council, regularly review supply, demand, and market sustainability in addition to local data available through the Social Care JSNA.

The collaborative development of the Southend Enhance Discharge Service (SEDS) model will continue to be enhanced through working with acute, community and VCSE partners. SEDs provide a full and complete therapy-led hospital discharge assessment at home, helping to determine future needs and critically support recovery in the home environment fully utilising the home-first ethos.

Carers of all ages, play a significant role in preventing the need for more formal care and support for the people they look after. The health and social care system continues to rely heavily on unpaid care, it has a central role in our health economy and there would be a huge cost involved should we need to replace this care. In Southend, we recognise that supporting carers is the responsibility of everyone. This includes organisations working directly with carers and the cared for, across the statutory and voluntary sector, and with the community, and families. We have shared responsibility to provide an effective, efficient and coordinated service to support carers’ health and wellbeing.

Through the BCF a pilot Carers Intensive Support service has been mobilised, the service will be further enhanced in 2023/24 with the dedicated capacity to support the proactive identification and support offered to carers of older adults, or to support carers over the age of 65 who are carers of any age 'cared for', as well as an annual carer 'health check' that will link back to health to ensure we are mitigating against carer breakdown.

Virtual wards are developing and evolving at pace in Southend and across MSE, they are delivering improved outcomes compared to traditional pathways, by reducing functional decline and risk of infections. Virtual Wards are one of the biggest opportunities we have to reduce system pressures and improve flow. MSE is being recognised nationally for the progress we have made so far in rapidly mobilising Virtual Wards, and the clarity of understanding that we have developed around the next steps However, we recognise that there are challenges and opportunities to improve as we go through 2023/24/25.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

  how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

We recognise the challenges in the local system particularly market capacity and sustainability. We have winter planning short-term mitigations in place locally and are enacting long-term workforce plans and price reviews to increase the hourly rate for the care sector. Albeit the care market capacity issue will remain a significant risk to the system of any further unexpected upsurge. The implementation of a care settings meeting in order that the Local Authority has the management of market pressures escalation level.

There has been a substantial focus on hospital readmission rates at both South East Essex place and wider Mid and South Essex system levels. The MSE Clinical Care and Outcomes Review Group has oversight and leads on readmissions for the ICP. At a local level, this system-level work and plans link with the South East Essex Urgent and Emergency Care Delivery Group. Detailed analysis to identify root causes and contributory factors to readmissions will be undertaken in 2023. This will inform future work that will be coordinated and reported to the BCF management group.

Improving flow to support the discharge of people home, alongside the demands of flu, COVID, industrial disputes and capacity has exerted pressures impacting the whole health and care system, and this is likely to continue in the short to medium term.

A Seasonal Intelligence team has recently been established to analyse and produce regular reporting for adult social care, this information is used to plan and adapt services to best meet local needs. Unfortunately, there have been no previous data in place to enable the plotting of trends for this current year and therefore we cannot understand the full gap reduction for 2023-24. However, reporting needs are developing and evolving as intelligence improves and trends emerge so we will have better knowledge in future years. Joint working with strategic partners will support an evolving picture of access and

delivery of key services, identifying any potential gaps and challenges/barriers in system flow. This will enable us to ensure our priorities are in the right area, at the right time for the right people.

SHREWD has been in place since 2022/23 and is used in all partner daily situational seasonal intelligence awareness meetings to monitor and review system flow, pressure and risk. Monitoring of data and close collaboration with partner colleagues in MSEFT and ASC Operations, to identify challenges/barriers in system flow, investigate causation and mitigate. Development work is ongoing to support a cycle of continuous improvement.

The winter discharge fund also supported a Patient Transport Customer Relations Manager to optimise discharges. Dedicated senior capacity in the acute setting focussed on building ward-level relationships, identifying and mitigating any issues and prioritising journeys for those with care packages ready to start, end-of-life patients etc. Positive feedback evidence increased communication and better relationships, improved patient experience and a significant reduction in both delays and the number of patients re-bedded overnight due to insufficient capacity/delays. This initiative will be extended into 2023/24 for continued benefit.

Development work is ongoing to support a cycle of continuous improvement.

The Hospital Discharge activity has been provided from the draft activity submission of the NHS Operational Planning 2023/24 and is based on actual trend data across the three MSEFT sites and then on a % across Essex 69%, Southend 17% and Thurrock 14%.

We are expanding and considering our Mental Health pathway and also the connection with the Voluntary Sector. Progress in this area continues and is required in this area.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

The Southend Enhanced Discharge Service (SEDs) model was collaboratively developed with strategic health and care partners and is jointly funded through the BCF. SEDs are a discharge service which provides a full and complete therapy-led hospital discharge assessment at home for Southend residents rather than an assessment being provided by the hospital before discharge. It enables patients to leave the hospital sooner with appropriate provision of care at home, where they then tend to recover more quickly.

Physiotherapists and Occupational Therapists are involved in assessing patients in the context of their own homes rather than in the hospital ward. It has also led to significantly more efficient triage to appropriate community-based services (such as reablement services, long-term home care support, voluntary sector support, occupational therapy and physiotherapy) than previous systems. This creative model of discharge has resulted in considerable efficiencies and improvements to patient care.

2023/24 will see the development of a Trusted Assessor Pilot, which will be working alongside the SEDs service and supporting residents who have accessed reablement post-SEDs and are identified as needing long-term care provision. It is anticipated the pilot will ensure packages of support are adjusted appropriately will improve flow. We recognise that implementing this model as soon as possible will be crucial to enable early engagement with patients, families and carers.

SHREWD is a Resilience Application led by MSEFT Resilience and Operations, partner organisations across South East Essex have implemented the SHREWD system. Supporting holistic, integrated oversight. It is a system resilience dashboard which visually identifies areas of pressure. The system shows current and inbound demand, bottlenecks, flow and the capacity in use and available.

We have continued to strengthen the discharge process according to “home first” principles. We have introduced reablement capacity (1200 hours per week) with the Southend Reablement Service which will support this home-first model. This was

increased from a starting point of around 500 hours delivered per week in February 2022 which then increased to 900 hours.

Winter funding supported the development of a pilot ‘ward enablement’ service at Southend Hospital, this therapy lead initiative focused on supporting and encouraging patients to be physically active. Simple things like getting dressed every morning and increasing physical activity levels have successfully reduced length of stay, readmissions and the number of ward-based falls, all of which contribute to reduced demand for complex care packages. This initiative will be extended into 2023/24 and further enhanced for maximum benefit.

Most of our BCF initiatives, seek to enable more people to live longer, independent lives within their communities and ensure more high-cost, high-dependency care in residential and nursing homes is only used when absolutely needed.

In Southend-on-Sea, the priority for local people is to ensure it is “Home First” wherever possible. We continue to aim to minimise permanent admissions into residential and nursing care homes for people aged 65+. Our outturn for 2022-23 was 429.79 and the number of permanent admissions to residential care is in line with the target figure. It is anticipated that the data for Quarter 2 will be more meaningful for reporting.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

The Southend Enhanced Discharge Service (SEDs) is a discharge service which provides a full and complete therapy-led hospital discharge assessment at home for Southend residents rather than an assessment being provided by the hospital before discharge. It enables patients to leave the hospital sooner with appropriate provision of care at home, where they then tend to recover more quickly. Physiotherapists and Occupational Therapists are involved in assessing patients in the context of their own home rather than in the hospital ward. It has also led to significantly more efficient triage to appropriate community-based services (such as reablement services, long-term home care support, voluntary sector support, occupational therapy and physiotherapy) than previous systems. This creative model of discharge has resulted in considerable efficiencies and improvements to patient care. To support flow Southend-on-Sea City Council are active partners at the SEDS strategic forum where improvements and performance are mediated. This will ensure that care and support interventions are provided at the right time, by the person with the most appropriate skills, in order to get the right care, first time, every time.

Winter funding supported the development of "Community Hubs", based on support services established during the Covid pandemic, the Community Hubs provided essential voluntary sector support at the point of discharge. The main focus of Community Hubs is to reduce both length of stay and readmissions to hospital, through a risk-assessed onward support package. Key to the success of this project is the confidence of the hospital teams to discharge in the knowledge that welfare is being picked up on discharge and support provided in the community. This is the driving force behind safely improving discharge speed to reduce the length of stay. A critical element is being able to ensure there is support in the community, hence the engagement and involvement of voluntary sector-delivered

community hubs to support with a wide range of services that prevent readmissions and a positive onward path for individuals who have been discharged.

Integrated Neighbourhood Teams/PACT (PCN aligned community teams) in Southend is developing at pace, building on existing partnership working and taking a broader and more holistic approach to the delivery of integrated health and care to people with complex needs, so services and support are coordinated and aligned in ways which make sense to the local population. PACT is not a service, but an operational model which unites workflow at the neighbourhood level to deliver real-time multi-agency working between primary care, community nursing, mental health dementia teams, palliative care, adult social care, care providers and voluntary sector assets to provide efficient proactive care. Digital and IT solutions are enabling this live day-to-day working across multiple professionals who are creating a 'one team' identity supporting discharges and ensuring local residents get the right support, by the right team, at the right place and time for them.

The priorities for the 2023-25 Better Care Fund plans continue to maintain Home First to keep local people out of residentidential care homes unless really necessary. The priorities listed in our Capacity and Demand will ensure this is delivered. Our Community Hubs support our Home First approach by continuing to deliver transfer to care to maximise local people to having independence and using their offers to ensure this.

The ongoing development of a transfer of care hub (TOCH) is a key focus for the coming year, building on the existing infrastructure and resources to deliver responsive and coordinated care in the right place at the right time. Proactive and coordinated care, supported by community physical and mental health providers and voluntary and third-sector partners will support system flow both for admission avoidance and discharge.

The Dementia Community Support Team (DCST) are a dementia community team offering bespoke support from pre-diagnosis through to the end of life for people living with dementia and their carers. Forming part of an integrated service that wraps around people living with dementia with a focus on supporting the carers throughout the period of engagement, empowering and enabling both carer and cared for, to live the life they would like with their diagnosis. The service provides easy access, no wrong door approach for residents and our partners in health, social care and the community. This provides seamless care with no visible handoffs to the people supported. The team's ethos is that dementia is everybody's business and work with partners to develop bespoke training packages which are used to enhance knowledge, skills and understanding of how to support a person with dementia across the systems.

A number of transformation programmes and initiatives are already underway in Southend-on-Sea which can be built upon, and having the opportunity to avoid duplication and inefficiencies in the system and utilising the Better Care Fund as an enabler where appropriate to enable the right care, in the right place at the right time.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The Southend Enhanced Discharge Service (SEDs) model was developed in partnership with the Mid and South Essex NHS Foundation Trust (MSEFT) and Essex Partnership University NHS Foundation Trust (EPUT) and is jointly funded by SCC and the Mid & South Essex ICB (MSEICB). SEDs are designed to support prompt discharge from the hospital, providing appropriate assessment, care and support in the home environment. The service brings together an integrated team of hospital staff, occupational therapists, physiotherapists, social workers, and community workers to collectively support people to

recover at home and maintain their independence. Partners retain oversight of the activity and performance of SEDs through a dedicated strategic forum.

We are working positively to monitor patient experiences and outcomes in order to get a true sense of patient purpose. We anticipate that evaluation will be taking place in 2023-24 and with the implementation of a SHREWD

Not monitoring outcomes in the way we intended and we will be changing this process. Working on a positive move to monitor patient experience and outcomes to get a true sense of patient purpose.

Community Hubs – Established to reduce both length of stay and readmissions to hospital, through a risk-assessed onward support package. Key to the success of this project is the confidence of the hospital teams to discharge in the knowledge that welfare is being picked up on discharge and support provided in the community via the voluntary sector. These hubs were set up to support our community and based on feedback from those who use them, it has been recognised that they could have a meaningful impact for pathways 1 and 2.

The estimated net need for residential care to 2040 is c.-430 bed spaces. Whilst there is the sufficiency of supply for standard residential care there is a shortage of nursing care. There is an estimated net need for nursing care to 2033 c.370 bed spaces. This reflects the growth in the 75+ household population to 2040 (47%) and the projected increase in complex care needs amongst this population, including a projected increase in the number of older people living with dementia-related needs.

A move to a care home is not seen as “aspirational”, the evidence from local research is that older people are generally not interested in a move to a care home.

A majority of older people in Southend-on-Sea who have care needs or may develop care needs are seeking to receive care in their home, whether they “stay put” or move to specialised housing for older people.

Southend-on-Sea older people residents who want to “stay put” are seeking better support to remain living in their existing homes for longer, such as access to aids, adaptations and technology to support independence.

The outturn for permanent admissions into residential and nursing care for people 65+ is 429.79 in 2022/23. At present, we cannot draw significant conclusions as we require further quarter figures in this financial year. The number of council-supported older adults (aged 65+) whose long-term support needs were met by a change of setting to residential and nursing care during the year is currently 43 (rate: 124.03) with a target of 170 Sequels. This is based on the recording of outcomes for older adults where the intention is for a permanent placement.

However, the avoidance of residential care remains a focus to ensure people remain at home for as long as possible.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

The Southend Enhanced Discharge Service (SEDS) was implemented in 22 working days from the initial concept in the summer of 2022.

The SEDS is intended to help people leave the hospital sooner and be better supported at home. It is an innovative service which brings together a number of teams within the hospital, MSE Integrated Systems, and Southend City Council to collectively support people to return and remain at home after a hospital stay.

Its primary aim is the provision of a therapy-led assessment service. It also picks up people who have been discharged without support but where support is necessary. The service is delivering effective strengths-based person-centred interventions to help people to meet their personal goals.

After the service, people who need additional or ongoing support will move into either reablement or ongoing homecare.

A SEDS multidisciplinary team is in place, meeting regularly to review people's progress and make decisions regarding referrals, the best onward pathway and providing seamless links to other services.

This service has provided a significant amount of learning which will shape the future of this successful service.

SEDs are not the only answer to Hospital Discharge in Southend. We do offer contractual stability from care providers who deliver a service to the person returning home.

Ward Enablement – Pilot to bringing a Reablement mindset and capacity into a Frailty/DME ward at Southend Hospital, supporting a reduction in unintended Hospital Acquired Functional Decline. 3 staff, 7 days per week including a dedicated Trusted Assessor and two Care Assistants 6 hours per day. Outcomes show a reduction in ward-based falls and readmissions and measurable improvement in mobility at the point of discharge in comparison with similar wards. There are plans in place to further enhance this offer and further evaluate in 2023-24.

Mental Health Discharge to Assess Nurses – Based in the Emergency Department at Southend Hospital, providing an immediate/rapid triage to determine the safety and appropriateness of conveying the person home and carrying out a full assessment at home.

There are a number of supportive teams in Southend Hospital to support hospital discharge. These teams include Carers First and Dementia Support which aid carers.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

High Impact Change Model plans

Self-assessment against high-impact change model:

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Early discharge planning	Plans are developing Plans are in place	Set expectations on admission Southend enhanced Discharge Service	ongoing-2023/24	Improved patient flow Patients informed regarding plans/options
Systems to monitor patient flow	Plans are developing Plans are developing	Consistent systems within Trust which includes a live tracker which is staffed between 7am and 10pm, 7 days a week. This is updated with patient details, demographics and is accessible to SEDs therapists in order to add assessment data. SHREWD is a Resilience Application	Ongoing Ongoing	Identification of barriers to system flow. The SEDs data is reported into the IDT figures, which are shared across the trust and with external partners along with provided in system escalation calls. SEDS MDT meet 3 times weekly to discuss the flow through the system and escalation emails on top to support with system pressures. SHREWD is used in all partner daily situational seasonal

		Led by MSEFT Resilience and Operations, partner organisations across South East Essex have implemented the SHREWD system. Supporting holistic, integrated oversight. It is a system resilience dashboard which visually identifies areas of pressure. The system shows current and inbound demand, flow and bottlenecks and the capacity in use and available.		intelligence awareness meetings to monitor and review system flow, pressure and risk. Monitoring of data and close collaboration with partner colleagues in MSEFT and ASC Operations, to identify challenges/barriers in system flow, investigate causation and mitigate. Development work is ongoing to support a cycle of continuous improvement.
Multi-disciplinary, multi-agency discharge teams (including voluntary and community sector)	Established Established	Hospital discharge team. Southend enhanced Discharge Service pilot	On-going	Improved flow and patient experience
Home First Discharge to Assess	Established Established Established	Hospital discharge team. Southend Enhanced Discharge Service Reablement therapy-led service	Ongoing	People are able to go home as soon as possible after acute treatment.
Flexible working patterns	Established	The whole system to operate at this level Clinical cover/decision-making over weekends for discharge	Ongoing	Consistent discharge picture through the week
Trusted assessors	To be implemented	Home care agencies trusted assessors trained with OTs to order equipment for	Ongoing	Minimise duplication

		reablement led support at home		
Engagement and choice	Established	Protocols and processes in place to be understood and followed	Ongoing	Choice issued at the correct time Patients aware of discharge expectations on admission
Improved discharge to care homes	Plans are developing	111 support to care homes and GP support Urgent Response Care Team Medication management pharmacy support	Ongoing	Reduction in readmission from care homes
Housing and related services	Established Plans are developing	Home aid and adaptation service Extra care	Ongoing	Independence at home

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

When considering how we will be using the BCF funding, iBCF and ASC Discharge Fund we have ensured that they are delivered under the duties of the Health and Care Act 2022.

In February 2021, the Government published the White Paper 'Integration and Innovation: working together to improve health and social care for all' and announced it would be followed by a Health and Care Bill. The White Paper had the following key themes: working together to integrate care; reducing bureaucracy; and improving accountability and public confidence.

The Health and Care Bill was published in July 2021 and provided a new legislative framework to facilitate greater collaboration within the NHS and between the NHS, local government and other partners, and to support the recovery from the pandemic. The Health and Care Act 2022 received Royal Assent on 28th April 2022.

The Act is a wide-ranging and complex piece of legislation with many measures that concern internal NHS operations. Provisions in the Act come into force at different times and has been supported by secondary legislation, statutory guidance, and good practice guidance.

Other key publications and policy reforms aimed at transforming health, care and wellbeing, in particular improving health and care services through better health and care integration and tackling growing health inequalities are:

- The health and care integration White Paper 'Joining up care for people, places and populations'
- The adult social care reform white paper 'People at the heart of care'
- The White Paper 'Levelling up the United Kingdom'
- The Government's report 'Build Back Better: Our Plan for Health and Social Care'.
- The Equality Act 2010: Equality Act 2010: guidance - GOV.UK (www.gov.uk)
- Core20PLUS5 – An approach to reducing health inequalities: Core20PLUS5

Taking these legislations and policy reforms into consideration, and system challenges described above, our plan sets out our aims to deliver the best outcomes for local people.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

In Southend we recognise that supporting carers is the responsibility of everyone. This includes organisations working directly with carers and the cared for, across the statutory and voluntary sector, and with the community, and families. We have shared responsibility to provide an effective, efficient, and co-ordinated service to support carers health and wellbeing.

Southend-on-Sea City Council's 'Caring Well' strategy is a joint strategy with health colleagues. It focuses on the needs of unpaid carers, sometimes called 'hidden carers', which can be anyone who finds themselves in a position of caring for another adult.

Carers play a significant role in preventing the need for a more formal care provision, and the health and social care system relies on this unpaid support. Priorities and action plans within this strategy focus on the following specific areas:

- identifying, respecting, and valuing carers.
- providing suitable information and support.
- developing carers, knowledge, and understanding.
- assessing carers' needs.
- maintaining carers' balance by connecting with communities and being able to take a break.
- recognising health and well-being needs.
- helping carers stay in, enter or return to work education or training (if appropriate).
- being prepared for changes and,
- encouraging integration and partnership working to meet people's needs.

Positive collaboration within Southend City Council Adult Social Care teams have produced a better service and approach for carers locally. There is now a new referral pathway, a dynamic new offer to support people in caring for their loved ones, along with more detailed information on Southend-on-Sea City Council's website. Further work will be undertaken from 2023, in fielding and carrying out non-complex carers assessments directly by the Carers First Service (Southend-on-Sea City Council's commissioned provider) to improve and deliver more targeted support. Southend-on-Sea City Council review people's experiences and views through the Carers' Survey along with service user feedback through Carers' First and finally on a monthly basis with the Caring Well Strategy meetings.

In collaboration with Carers' First, Southend City Council are working with people at a much earlier stage to prevent escalation through effective outreach. The aim is to prevent carer breakdown and support carers resilience thereby adding to the longevity of the caring role.

A Carers Partnership Group has been set up, which has representation from Health, Southend City Council, Carers Groups, Public Health and other interested parties. Using information gathered from Carers First and Southend Carers, many issues and actions have

been progressed this last year which have included Hospital Discharge, End of Life, Contingency Planning, Health Checks, GP Registration, Finance and Carers Assessment.

In the first year of the Caring Well action plan where these elements were addressed and local actions taken, we have seen an increase from 1,037 to 1,333 carers registered with Carers First and an increase from 5,700 to over 7,000 of carers registered with a GP. Their Positive collaboration within Southend City Council Adult Social Care teams has produced a better service and approach for carers locally. There is now a new referral pathway, a dynamic new offer to support people in caring for their loved ones, along with more detailed information on Southend-on-Sea City Council's website. Further work will be undertaken from 2023, in carrying out non-complex carers assessments directly by the Carers First Service (Southend-on-Sea City Council's commissioned provider) to improve and deliver more targeted support. Southend-on-Sea City Council review people's experiences and views through the Carers' Survey along with service user feedback through Carers' First and finally on a monthly basis with the Caring Well Strategy meetings.

MSE ICB are committed to improving outcomes for carers and are active participants in the Commitment to Carers Programme and utilises an ICS/PLACE/Neighbourhood/PCN Maturity Matrix. Southend based initiatives include a pilot with our Primary Care Networks (PCNs) improving carer identification and access to annual health checks for Carers as well as improving the communication between carers support agencies, local authorities and health to provide a more consistent offer to carers and reducing the burden of care.

Through the BCF a pilot Carers Intensive Support and Carer Health Check service has been mobilised, providing additional and dedicated capacity to support the proactive identification and support offered to carers of older adults, or to support carers over the age of 65 who are carers of any age 'cared for', as well as an annual carer 'healthcheck' that will link back to health to ensure we are mitigating against carer breakdown.

The Dementia Community Support Team provides enhanced support to people living with dementia and their carers in Southend. This community-focused service offers accessible and flexible support tailored to reflect the needs of those they are supporting. The Locality Dementia Navigator supports people and their families throughout the dementia experience, offering support and guidance to give an understanding of dementia and the day-to-day challenges it may bring. The Dementia Navigators will also provide Information on preparing for the future and accessing other services within the city.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

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

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

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

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

Our dedicated DFG lead is the Adaptations Team Manager within the Adults & Communities Department who reports both finance and activity to the BCF Management Board (terms of reference embedded on Page 2 above) which holds oversight and governance responsibility of DFG spend.

In the health and social care side of the Disabled Facilities Grant (DFG), the demand for Occupational Therapy is increasing as their assessment and intervention skills are recognised as a critical element of ensuring people receive appropriate and effective care and support. At any one time, many assessment requests received by Adult Social Care are for individuals who are seeking non-complex adaptations through the DFG.

In complex cases, Occupational Therapists may require the support of a Technical Officer to identify what adaptations are reasonable and practicable to install given the structural limitations of the property.

Designated collaboration with Social Workers is often required to assist residents through the process of having the adaptations completed, especially if they require LD or MH support.

Housing plays a large part in the adaptation service as we work with the Housing Team to enable adaptations to Social Housing tenants who may be under-occupying the property but due to ill health or age are unable to move out, so adaptations support them to remain independent.

We also work with Housing Solutions to enable older tenants to look at moving to sheltered or residential complexes so that the property can be freed up for families who are on the housing waiting list.

An opportunity has also arisen for us to share our inclusive design skills with our Strategic Housing colleagues. With our own SCC developments and those of private developers, we can ensure, where possible, that the accessible standards required by the current building regulations are applied.

Also, the Adaptations Team have developed an inclusive specification for Southend-on-Sea City Council built homes, this is updated as new ideas or products are developed. With planning applications from private developers, we ensure, not only those properties are built to current inclusive Building Standards but where possible the scheme is a mixed tenure and `not creating a “them and us” situation.

Affordable, buy or rent are developed together across the site.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

Y

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

£29,824.04

There is only one unitary authority with no districts.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Equality and Health Inequalities

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

Reduce health inequalities

We will take a place-based approach for reducing health inequalities, including mental and physical health inequalities, and life expectancy inequality across Southend-on-Sea.

The needs of Southend's residents vary significantly from area to area. The ICS 5-year strategy outlines the reduction of health inequalities as a key ambition. Building on the Southend Localities Strategy comprehensive locality profiles are emerging to help build an in-depth understanding of local needs.

Adults Social Care JSNA Summary | Adults Social Care (arcgis.com)

About Southend General | About Southend (arcgis.com)

Our independent public health report for 2021/22 reflects on our some of our local health inequalities along with the focusing on work to tackle the wider determinants of health and the growing obesity epidemic, the approach with collective endeavours is shaping the local food environment. A number of areas have been highly impacted by COVID and we must refocus as we learn to learn to live with COVID. Some of the key areas in tackling health inequalities will be led jointly by the NHS and the City Council with a determined resolve of improving healthy life expectancy whilst accelerating recovery in health and care services.

COVID-19 has impacted significantly on mental wellbeing, from people dealing with illness and bereavement, the consequences of living with restrictions, the closure of schools, workplaces and businesses.

There are a number of other areas where we need to refocus our collective approach and refresh our thinking including: obesity and the food environment, drug and alcohol misuse, loneliness and self-care, the wellbeing of some our more vulnerable groups, such as ‘inclusion health groups’ (Core20Plus5 priority groups) people who are classed as unpaid carers, people living with autism and those who are affected by homelessness.

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

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

ICB-funded health and inequality programmes are focused on core20plus5 and are closely aligned with the priorities as defined in the Executive Summary.