Southend-on-Sea Borough Council

From Councillor: David Norman M.B.E.

Civic Centre, Victoria Avenue, Southend on Sea, SS2 6ER

Telephone: 01702 212897

Date: 19th September 2014

By email

Dear Sir

We are delighted to submit our revised Better Care Fund plan. We see this as an excellent opportunity enabling the partners of Southend to further build and develop relationships and to sustain the momentum we are generating across the system. Please find attached the completed templates and we look forward to working with the Better Care Fund National team to refine our approach.

We see the Better Care Fund as a key point of focus for our plans to integrate health and social care services. We have a range of ambitious targets and also see the Better Care Fund as enabling us to meet the challenges of increasing demands and expectations. We are pleased to say that the whole health and social care economy in Southend has been engaged in the development of our transformational activity and our firm intention is for all partners to continue to be involved in its delivery.

We understand the challenges ahead in delivering on the Better Care Fund plan and have embedded a robust governance structure. We are committed to continue to work with the providers of Southend to increase their involvement in the development of our plans. We have developed a performance management framework that will give us assured information about spend, return on investment and impact on performance. The framework will also provide an early warning of risk to enable early mitigation and change of direction. Our plans for 2015/16 are well articulated and deliverable. The challenge for Southend will be sustaining the impact against the backdrop of increasing demand and financial pressure.

Please be aware that there has been significant challenge for Southend to ensure social services continue to be protected and total emergency admissions are reduced in line with our planned target, particularly when set alongside the CCG's well publicised financial position and the council's Medium Term Financial Strategy of the council. We will continue, as a Health and Wellbeing Board, to address these challenges vigorously and review them as ongoing challenges.

We look forward to working with you and your colleagues in future months in order to assure our delivery of our vision for people in Southend.

Yours faithfully

Cllr David Norman M.B.E.
Executive Councillor for Adult Social Care, Health and Housing
Chair – Southend Health & Wellbeing Board

Southend On Sea

Better Care Fund Summary

Southend's 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. In achieving this vision we aim to adopt a system wide view and understand impacts across all key constituents.

We want to build on our current successes in integrated care delivery to ensure that our prevention offer and self-management options are fully developed and optimised and where longer term care or support is needed it is provided around the service user/patient.

We are using the BCF to protect social care services and work as strategic partners to re-model our urgent care and community provision with a focus on out of hospital care. Pressure on A&E along with predicted growth in demand above the national average mean that in Southend we are focusing on how to deliver care and support through more integrated and coherent pathways to better serve the people of Southend.

A summary of our BCF schemes with benefits is outlined below.

001 – Protect Social Services through Independent living (£4.781m).

This investment funds a range of existing social care services including integrated assessment and support teams which are the core component of the GP hub development.

- Protects social care services
- Contributes to the achievement of 3.5% total hospital admission reductions
- Contributes to the achievement of 11.5% reduction in residential admissions. (£514k total benefit)
- Contributes to the achievement of reduction in the numbers of people requiring large care packages, (longer term support) £494k benefit.

002 – End of Life, Palliative Care & Community Services (£3m).

This scheme focuses on improving end of life care for people with a terminal illness as well as developing systems to better identify people with long term conditions who require palliative care.

- Reduces unnecessary hospital admissions for people requiring palliative care (£300k benefit)
- Improves identification of people with LTCs requiring palliative care

003 – Prevention including intermediate Care, Primary Care and transforming the Emergency Pathway (£3.051m); Reablement (£1.431m).

This scheme includes development of the Community Recovery and Independence pathway to improve out of hospital care options and the development of a discharge to assess scheme to optimise care planning following discharge from hospital.

The reablement scheme protects existing reablement funding to support decreases in the need for longer term support through utilisation of the Single Point of Referral, (SPOR) and continued access to safe and timely hospital discharge.

- Contributes to the reduction in total hospital admissions target of 3.5% via a reduction in ambulatory care demand. (£360K benefit)

004 – Integrated Care through the GP Hub (£50k)

This scheme continues to invest in the piloting of the GP hub which is the key area of focus for developing improved alternatives out of hospital care.

- Supports improved community pathways to prevent A&E attendance
- Contributes to the achievement of reduction in total hospital admissions of 3.5% (£350k benefit)

005 – Infrastructure to support integrated working (£0.459m)

This scheme funds the development of ICT to assist with new capital requirements under the Care Act and the further development of telecare and Extra Care schemes which require capital investment.

- Contributes to the implementation of the Care Act capital costs.
- Supports achievement of benefits in other schemes through the development of integrated initiatives such as use of telecare and ICT.

Total investment	Total financial benefit
£12.772m	**£2.018m**

By using best evidence and the latest available data we believe that our BCF investments outlined above will deliver improved health and wellbeing benefits for residents and well as the financial benefits identified above.

				National Conditions					
Scheme	Investment	Return	Residential admission reduction	7 day Services	Protect Social Services	Data Sharing	Joint Assessment	Accountable Professional	Impact on Acute
001 Protect Social Services through Independent Living	£4.781M	£0.494M	£0.514M	Yes	Yes	Yes	Yes	Yes	Yes
002 End of Life	£3.000M	£0.300M		Yes	Yes			Yes	Yes
003a Prevention, int care, Primary Care, transforming Emergency Pathway	£3.051M	£0.360M		Yes	Yes	Yes	Yes		Yes
003b Prevention with reablement	£1.431M				Yes		Yes		Yes
004 Integrated Care through GP Hub	£0.050M	£0.350M		Yes	Yes	Yes	Yes	Yes	Yes
005 Infrastructure	£0.459M				Yes	Yes	Yes		Yes
Total	**£12.772M**	**£1.504M**	**£0.514M**						

Seven day health and care services: to ensure that people can access the care they need when they need it

Data sharing, including the use of digital care plans and NHS number so people don't endlessly repeat their story and professionals spend less time filling out paperwork

Joint assessments so that services can work together to assess and meet people's holistic needs

An accountable professional who can join up services around individuals and prevent them from falling through gaps

Protecting social care to ensure that people can still access the services they need

Agreed impact on acute care sector to prevent people reaching crisis point and reducing the pressures on A&E

Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

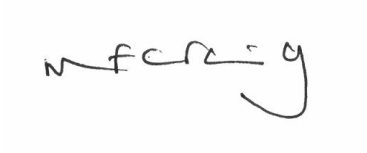
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

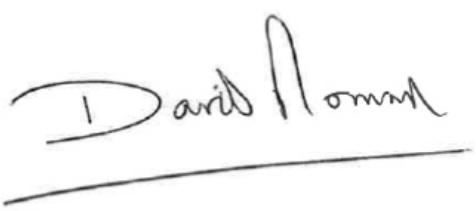
a) Summary of Plan

Local Authority	Southend Borough Council
Clinical Commissioning Groups	NHS Southend Clinical Commissioning Group
Boundary Differences	Southend is largely coterminous. The most significant boundary considerations are with neighbouring Castle Point & Rochford CCG (CP&R) (who are partnered in the South Essex resilience process) and Essex CC. The CP&R Accountable Officer is a member of the Joint Executive Group, so fully involved in strategic discussions and the Southend BCF. Essex CC are involved on a less formal basis via existing local authority networks
Date agreed at Health and Well-Being Board:	**3rd September 2014**
Date submitted:	**19th September 2014**
Minimum required value of BCF pooled budget: 2014/15	**£0.687M**
2015/16	**£12.772M**
Total agreed value of pooled budget: 2014/15	**£0.687M**
2015/16	**£12.772M**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Southend Clinical Commissioning Group
By	Melanie Craig
Position	Chief Operating Officer
Date	19th September 2014
Signed	

Signed on behalf of the Council	Southend-on-Sea Borough Council
By	Simon Leftley
Position	Corporate Director for Adult Social Services
Date	19th September 2014
Signed	

Signed on behalf of the Health and Wellbeing Board	Southend-on-Sea Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Norman
Date	19th September 2014
Signed	

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Appendix 1 – Better Care Fund Plan on a Page  Appendix 1_BCF on a page.pdf	An Executive Summary of our BCF submission.
Appendix 2 – Integration Agreement  Appendix 2_Integration Concor	Southend system partners have a shared joint vision and have formed a strategic alliance with major stakeholders and a governance structure that reports directly to the Health and Wellbeing Board.
Appendix 3 – Data Sharing  Appendix 3a_Data Sharing Report.pdf  Appendix 3b_CAG 5-05 (a) 2014 SoS ICI	Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs. In February 2014 the DH Informatics Support Team spent two days working with Southend to seek a national solution relating to information governance that hampers the integration process, their final report is embedded A deferred decision letter following the Confidentiality Advisory Group (CAG) on 24th July 2014 is also attached. The CAG considered an amendment to s251. The CAG are due to reconsider on 2nd Oct 2014.
Appendix 4 – Protection of social care	A strategic alliance and governance framework has been developed that will form the strategic oversight that ensures sustainability of social care. **Please refer to Appendix 2**
Appendix 5 – Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable	A successful track record of developing joint health and social care assessments underpinned Southend's successful bid to become one of 14 national Integrated Pioneer Pilots for integrating services.

Appendix 5_Integration Pioneer	**Please also refer to Appendix 2**
Appendix 6 – Agreement on the consequential impacted changes in the acute sector	Southend system partners have commissioned a System wide capacity review which reported in February and has informed planning and future commissioning. System partners have also formed a strategic alliance that seeks to ensure the risk associated with radical service change to improve outcomes is managed collectively. **Please refer to Appendix 2**
Appendix 7 – Perfect Week report Appendix 7_Perfect week.pptx	The Perfect Week was initiated by Southend University Hospital NHS Foundation Trust, supported by Emergency Care Intensive Support Team (ECIST) to support the improvement plan regarding A&E performance. Appendix 7 is a summary of the activity and an early indication of the findings.
Appendix 8 – Length of Stay Review Appendix 8_LOS Rev Southend and Comm	Southend recognised the need to understand the perceived and actual patient flow issues during a review of the length of stay

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Our vision is;

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

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

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

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

Our vision is underpinned by the Southend System Leaders Integration Agreement which includes the following focus areas:

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

b) What difference will this make to patient and service user outcomes?

We will build upon our current successes in integrated care delivery to ensure that our prevention offer and self-management options are fully developed and optimised and where longer term care or support is needed it is provided around the service user/patient.

We will build self-reliant confident communities to enable people to be in control of their care and self-manage.

We will invest in preventative services to allow people to be in control and demand less on statutory services through new procurement models which incentivise providers to work collaboratively, which reward support for reablement and independence and which reflect social value principles

We will improve the service user/patient experience through shared use of IT to support individual care planning as well as the use of CARETRAK to support mapping of local need, service planning and identifying more efficient ways of providing support across the system.

We will pilot pooled care budgets which follow the patient as a means of providing more integrated care and offering individuals more choice and control over how their services are delivered integrating budget arrangements which include pooling of resources within clear systems of delegation which recognise the statutory responsibilities of each partner.

We will focus on promoting the use of personal health and social care budgets where appropriate and develop new joint contracting and commissioning models to support this.

Service users and patients will have more choice and control over how their health and social care is delivered through developing a collaborative approach to resource planning and efficiency savings which builds on an open dialogue about partners service and financial pressures

People will experience health and social care as responsive and personalised to their needs and situations through developing commissioning partnerships which drive innovation and take responsibility for evaluation of outcomes which improve people's lives

People will feel enabled to take responsibility for their own health and wellbeing with access to good quality and accessible advice and guidance.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

The changes that will be delivered to the pattern and configuration of services during the next 5 years will be driven by robust, integrated and consistent commissioning intentions …..

The vision described above will be delivered through six Better Care Fund Schemes:

- Protect Social Services through Independent living including reducing the reliance on residential care
- End Of life, palliative care and community services
- Prevention including intermediate care, primary and community care and transforming the emergency pathway
- Prevention including reablement
- Integrated Care through the GP Hub
- Infrastructure to support Integrated working

We are now in the implementation phase of our 14/15 schemes and we are currently reviewing the effectiveness of these schemes at the appropriate time and develop a plan to either change direction or increase the resource. This allows us to build on what is working well and if our close monitoring of metrics shows we are not getting the shift in activity we expect we can amend our plans or move resources as required.

We are currently implementing the following schemes;

- Pilot S/W in A&E 7 days a week
- SPOR 7 day working assessment availability
- Falls pathway alignment
- Pilot of integrated care record
- Care Track Risk stratification
- Hospital Discharge - step down offer
- Pilot "GP Hub"
- Extra Care dementia pilot

The detailed changes noted above will be delivered through the BCF programme. To complement our intentions through the BCF our Health and Wellbeing Board and status as Integrated Pioneer will has the following focus:

- Supporting people to live independently and take responsibility for personal health;
- Integrated care provision for adults requiring health and social care services;
- Investment in our workforce to develop an integrated and joint partnership approach;
- Reducing activity at our Hospital through the provision of integrated services within a community based setting; and

- Integrating Prevention and Engagement activity within commissioning and service provision.

Our integrated teams have already had an impact on the 6 conditions set at a national level and our ambitions for extending health and social care integration, the development of the 'GP Hub', the enhancement of the SPoR, falls strategy alignment and the placement of a social worker at A&E 24/7 will impact on avoidable unplanned hospital admissions, delayed transfers of care and effectiveness of reablement, while ensuring a greater increase in service user satisfaction, choice and personal responsibility.

Our ambitions for the Better Care Fund also extend into the wider prevention agenda. We recognise that in the medium to long term demand for acute and specialised health and social care services can only be reduced at a population level through more effective approaches to prevention. This will involve engaging service users, the third sector, Primary Care through a systematic approach to build a holistic team around the patient for individuals with complex health and social care needs including long term conditions.

Integrated service commissioning

The provision of health and social services will be grouped around the 'GP Hub'. The aim of the GP Hub is to become the patients entry point for the prevention and treatment of illness, provide social services and support independence. The functions of the 'GP Hub' are;

- Risk stratification for people with long term conditions
- Introduction of a Care Coordinator within the practice to enhance whole system care planning and case management
- High intensity, pro-active care with own primary care physician
- Intermediate care, re-ablement and rehabilitation
- Information, advice and guidance to enable people to manage their own health conditions
- Discharge to assess
- Enhanced, pro-active working with care homes
- Integrated care records
- Seven-day services
- Rapid response and crisis prevention
- Falls prevention service
- Promotion of Telecare
- Single point of access / referral
- Risk stratification for people with long term conditions
- High intensity, pro-active care with own primary care physician
- Identification of Carers and referral pathway
- Integrated care records
- Whole system Care Planning
- Enhanced MDT's (children and adults)
- Enhanced working with care homes
- Intermediate Care, Re-ablement and Rehabilitation
- Rapid response - Crisis prevention
- Falls prevention
- Dementia support services
- Enhanced pharmacy services

And will focus on placing a team around the person. Each GP Hub will have a core team that will consist of GPs, clinical nurses, Mental Health professionals, social care, physio and occupational therapists.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Data and information derived from the Director of Public Health for Southend's Annual Public Health Report, the latest Southend Health Profile (2014) and additional sources including the Health and Wellbeing Strategy and current Joint Strategic Needs Assessment, cardiovascular risk profile and other sources highlight the key health and social care challenges facing the Borough of Southend.

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

Through joint partnership arrangements the CCG and the council have worked with NHS England to identify gaps and variation in primary care services. Locally there are significant challenges arising from variation in primary care that has a historical context. In common with a number of other areas workforce issues mean a number of GPs are due to retire over the next few years. These issues have been identified in the new Primary Care Strategy for Essex. Local partners have contributed to the development of this strategy. Current plans are that the strategy will enable the CCG and the council to co-commission primary care and community based services in new innovative ways to improve primary and secondary prevention interventions provided to vulnerable or hard to reach people who are currently accessing services in a way that is neither efficient nor cost effective. The impact of conditions affecting the population of Southend has been reviewed.

Currently the population of Southend is in the region of 175,000. By 2021, this is expected to rise by a further 7% to 186,399. Deprivation in Southend is higher than average and about 23.5% (7,700) children live in poverty. Life expectancy is 10.1 years lower for men and 9.7 years lower for women in the most deprived areas of Southend. This is worse than the average for England. The high levels of disadvantage in Southend give rise to a range of unhealthy behaviours. Locally, high levels of smoking prevalence, obesity, alcohol (significantly higher admissions than the average for England for alcohol attributable conditions) have a negative impact on the health of the population. There are also high levels of mental ill-health within Southend. This means we need to take action to address the links between the social determinates such as worklessness and mental ill-health and demand for health or social care services in specific areas of disadvantage in Southend. We are currently undertaking a community development programme to address the impact of disadvantage and poor health outcomes in specific localities. We need to integrate local health and social care interventions better in these areas and we will use the resources of the Better Care Fund to support this through the schemes outlined. Southend has an ageing population. We know the incidence and prevalence of ill health and disease increases with age and have identified a number of conditions, population groups and specific interventions where we believe more effective collaboration and coordination between partners will improve outcomes for local people and reduce costs to the health and social care economy. The key issues identified are:

- older people (falling, social isolation)
- people living with long term conditions (Cardiovascular disease, diabetes, respiratory disease, asthma)
- people living with dementia

There are a number opportunities to improve the support provided to local people through more effective collaboration and integration. For example, strategic partners are currently working to develop more effective local approaches to support people living with dementia. By doing this we hope to reduce the significant gap and variation between the number of people currently diagnosed with dementia and those known to be living with the condition. Given people living with dementia are more likely to require health care and support they are a major priority for us. Currently it is estimated that circa 7.5% of the Southend population are living with dementia (2,503 aged 65+ source: POPPI / QOF register for Southend CCG 1,139 in 2012/13). Given the future significant impact that supporting people living with dementia will have on local health and social care services, improved pathways and integration between health, social care and voluntary sector organisations will support early identification, treatment and care for local people living with dementia and also reduce costs through provision of early support for carers and families

Living longer does not always mean a better life. Locally we have looked the impact of long term chronic conditions on the health of local people. currently the prevalence of LTC within Southend is (Number: 32,116 / 18,493 per 100,000 population - taken from ONS neighbourhood stats).

Tackling long term conditions through joining up pathways and commissioning services across health and social care that enable people to be supported to self-manage existing conditions is a key focus for local partners. Although the early mortality rate for persons <75 has reduced in recent years, it is still higher than the national average (Directly standardised mortality rate for mortality from all causes, aged <75 is 339 per 100,000 for Southend. England is 350 per 100,000 source: PHE).

Consequently linking programmes and interventions such as increasing access to stop, smoking services, weight management services tacking hypertension and mental ill-health are all key challenges that require better integration and targeted action. We are also working to tackle the issue of social isolation which we know can lead to people deteriorating and ending up requiring intensive health and/or social care support. 323 people per 100,000 were admitted to hospital as a result of a mental illness in 2011/12 which was significantly higher than the England average. The rate of injurious falls and subsequent admission to hospital is also of concern (1592 per 100,000 population persons age 80+). Given the increasing elderly population we know we have to better integrate services to promote bone health and manage and prevent the consequences of falling.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Engagement of the Southend System with Programme activity

The Better Care Fund is closely aligned with the activity currently underway and planned within the Southend Pioneer. For this reason the Southend System are adopting a programme approach to the delivery of the Better Care Fund to ensure stakeholders are both engaged and take ownership for the delivery. Further, the stakeholders will be required to take ownership of the outcomes and the required transformational change to ensure the vision outlined in section 1 is realised.

Schemes identified within our BCF plan are subject to robust governance arrangements and

project planning procedures. Prior to implementation a detailed Project Initiation Document (PID) is required and will be subject to appropriate governance procedure. The PID states the benefits and identify the return on investment. The PID will also provide detail regarding timeline, milestones, risks, mitigations and interdependencies.

An outline to each of the schemes can be found at Annex 1.

Interdependencies

Within each of the PIDs noted above there is a recognition of the local interdependencies that exist.

Across the Southend System and between stakeholder there are interdependencies for Southend's BCF plan to respond to, these are;

Seven day services. Development of seven day services across the Hospital and in the community. Southend CCG, Southend University Hospital Foundation Trust (SUHFT), South Essex Partnership NHS Foundation Trust (SEPT), the council and Castle Point & Rochford CCG.We are working together to enhance existing care pathways across seven days as well as developing new approaches. The hospital is a national pilot site for seven day services.

The Single Point of Referral, an integrated community team with a focus on hospital avoidance and discharge, will be piloting a seven day service during FY 14/15. This will be evaluated over six months to monitor the impact on hospital admissions and attendances at A&E. We will align our falls prevention pathways across the system to be in place by winter 2014.

From Autumn 2014 we are piloting A&E based social workers providing a seven day service with a focus on preventing unnecessary admission to hospital or residential care. The project will enhance the prevention offer through advice, guidance and routine and screening, redirection to appropriate care pathways e.g. falls, reablement and prevent carer breakdown through early identification and intervention.

Plans are forming to develop a GP Hub across Southend which will give greater resilience to practices and enable them to deliver a wider range of services and enable greater access outside core hours. Options and feasibility will be developed over 2014/15.

Pooled Budgets. The development of pooled budgets which follow the patient across health and social care delivery. This opportunity has emerged from the Year of Care work and we are planning virtual pooled budgets from Autumn 2014. We will to evaluate throughout the year with a target of initiating actual budgets from financial year 2015/16.

Emergency readmissions. Reduction in emergency readmissions within 30 days of discharge. The Home from Hospital service is being commissioned from April 2014 to help ensure that older people do not remain in hospital longer than they need once clinical requirements have been met. It has been identified, that due to social isolation, many older adults need some support and assistance in the home to regain their confidence, strength and reconnection with the community in the early days after discharge from hospital. The 'Home from Hospital' scheme will provide support and other practical assistance for a short term period of up to six weeks. The service will be coherent with current and future provision. This will assist us in achieving our aim for no person to enter permanent residential care directly from hospital.

Falls Prevention. Southend has recognised the need for alignment of Falls Prevention across the partners of Southend and is progressing discussion on the most appropriate process to achieve the required alignment. We are considering the adoption of an integrated approach to a falls pathway with additional investment which will enhance the delivery of community assessment and provide additional equipment e.g. tilt table etc.

The Falls Service will support provision of Falls Prevention training delivered to Health and Social Care Staff, and a Falls Prevention and Bone Health Strategy - with a focus on early screening.

Dementia Pathways. Development of dementia pathways.

We are in Year 2 of our Dementia Plan and developing options for the redesign of existing

sheltered housing into dementia specialist extra care housing.

To ensure early diagnosis assessment and support pathways for people with challenging behaviour. This work is being undertaken by SEPT, Southend CCG and the council.

Review of existing assessment pathways is complete and consultation on proposed changes is planned for Early 2015.

Mental health. Mental health is a key priority for Southend CCG and we are fully committed to delivering parity of esteem. Throughout 13/14 the CCG made significant progress in a number of areas and intend to build on this over the next 2 years. The joint mental health commissioning strategy has driven key changes within Southend, namely, the development of a GP crisis line, improving dementia intensive support services, piloting psychological therapies in long term conditions, developing shared care protocols and reducing mental health delayed discharges.

We have recently formed a joint commissioning arrangement that establishes a new model of care for primary mental health services in Southend.

b) Please articulate the overarching governance arrangements for integrated care locally

Southend's Integration Pioneer Programme is overseen by the Joint Executive Group (JEG) and schemes developed through the Better Care Fund will be included in these Governance arrangements. The JEG is directly responsible to Southend's Health and Wellbeing Board (HWB) for Pioneer implementation, Better Care Fund, 7 day services and Southend's integration strategy.

The JEG includes membership from the council, the CCG, Southend University Hospital NHS Foundation Trust, South Essex Partnership University NHS Foundation Trust, Southend Association of Voluntary Services, Essex County Council, Castle Point & Rochford CCG and Public Health. The JEG will monitor performance targets and milestones and include the partners required to take any corrective measures required to keep the schemes on track.

The governance structure is summarised in diagram 1 below:

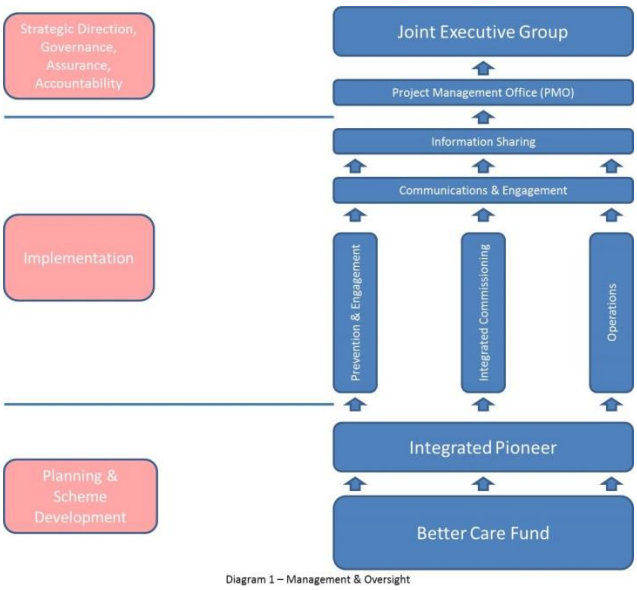


Diagram 1 – Management & Oversight

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Governance Structure

The Southend System will make use of an existing governance structure to oversee the delivery of the 6 BCF schemes, as indicated in section 4b above with responsibility for strategic decision maki resting with the **Health and Wellbeing Board**.

Implementation

BCF leads from Southend will be represented at the JEG which will:

- drive the delivery of all projects
- engage with senior staff
- assess project performance through highlight and exception reports
- manage delivery by exception
- produce a report for Health and Wellbeing Board Programme on status, immediate challenges and accountable actions.

Schemes will be individually considered with regard to roles and assignment, for example;

- Executive Sponsor
- Programme and Project Manager
- Corporate Support (Finance and Information)
- Clinical Lead / Social Services Lead

Monthly Project Boards

Project delivery will be managed via the Integrated Pioneer Programme and governed through the JEG.

Each project team will report against project impact and elements that are off track via the monthly Highlight Report.

Project Tracking

A standardised monthly highlight report will be developed for each project team to track delivery:

Activity: key metrics to be reported on will include;

- Avoidable emergency admissions
- Permanent admissions of older people to residential and nursing care
- Effectiveness of reablement for people 65 and over
- Delayed transfers of care
- Patient/service user experience

Financial: outturns not achieving forecasted monthly targets (both savings and investments).

- Anticipated shifts in spending patterns. It is expected that the costs of community and social care will increase while the costs of acute hospital care will reduce. The extent of shifts in spending patterns indicates the degree of the success.
- Improved health outcomes should lead to reduction in costs of health and social care; healthier population requires less input from professional health and social care services.

Risks: exceeding agreed tolerances for:

- Quality in terms of impacts on the population and the proposed mitigating actions to remedy or reduce the risk.
- Delivery of Projects due to delays or dependencies and the proposed mitigations with impact analysis.

Please note that time did not allow for the CCG Governing body to sign off Southend's BCF plan.

This plan is therefore submitted as an intent for Southend and is subject to CCG Governing Body sign off on 26th September 2014.

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Please see embedded document for a summary of schemes


Southend Part 1 19.09.14_Summary (


Southend Part 1 19.09.14_Summary (

Ref no.	Scheme
001	Protect Social Services through Independent living including reducing the reliance on residential care
002	End Of life, palliative care and community services
003a	Prevention including intermediate care, Primary and community care and transforming the emergency pathway
003b	Prevention including reablement
004	Integrated Care through the GP Hub
005	Infrastructure to support Integrated working

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**
Reputational risk to all partner organisations in the event of failure to meet statutory duties occurs	3	4	12	• Appropriate governance structures Provision of regular, timely and accurate information to support monitoring of services

Failure to reduce acute activity causing financial pressure	3	4	12	• System planning is focused on a range of community interventions in a move away from hospital admission. • Regular joint monitoring of progress against identified deliverables and early identification of emerging risks will ensure that potential problems are spotted quickly and mitigation action taken. • Closely monitor demand for acute services and ensure that contingency plans are in place for diversion of funding if necessary • Development of the BCF plan across partnerships to explore sharing of risk and rewards
The transition to new models of working lead to risks to quality and safety.	3	4	12	• Clear lines of accountability up to and including the HWBB. • Ensure a clear mobilisation transition plan is developed and overseen by JEG • A robust performance and quality outcomes framework needs to be developed to monitor quality and safety.
The scale and pace of the change required with risk of increase in number of SUIs and safeguarding referrals across the partnership	3	4	12	• Review of quality and Safeguarding arrangements in place to respond to and learn from any issues that arise • Accountability to H&WB board as well as internal governance

				boards • Review of existing resource capacity to deal with SUIs and safeguarding referrals
Staff within partnership organisations do not receive sufficient support to manage the change with resultant impact on morale and service delivery	3	3	9	• Workforce strategies across partners need to take into account change requirements
We are unable to engage care homes sufficiently	2	3	6	• Training and incentive programme in development for care homes
We are not able to share data across organisations	3	3	9	• Use of anonymous data until CAG approval to application to amend s251. • Liaison with national team to use CARETRAK as a model of best practice and pilot to remove barriers.
Despite intentions and plans social care services are not protected. the council are subsequently not able to provide assurance to Cabinet that the BCF submission protects social care due to minimal protection of social services which will have an impact on robustness of 15/16 budget.	3	5	15	• Closely monitor demand for social care arising from demographic change and the new statutory duties under the Care Act • Robust governance process will ensure that risks are quickly identified.
Re investment and a changed commissioning focus may create viability problems for providers.	2	4	8	• Early and broad engagement with providers and organisations engaged in health and social care • Monitor of impact of savings plans on providers

				• Impact of plans on quality of service delivery monitored • Alignment of savings and investment plans through agreement of BCF plan and priorities within the H&WB strategy to be delivered • Resilient grant funding process. • Mapping the journey workshops to redefine pathways of care.
There is a risk that the local authority and Southend CCG are unable to agree actions to re direct resources to meet the requirement soon	2	4	8	• Health & Wellbeing Board strategic partnership • Development of robust business cases to support investment and disinvestment decisions • Agreement of strategic priorities within the BCF plan • Further development of integrated service delivery projects with robust evidence base to measure success
There is a risk that demand for crisis services (residential/ hospital services) will not reduce because of insufficient quality of Community & primary services.	3	5	15	• Early and broad engagement with community and primary care providers on the CCG and the council quality agenda. • Resilient grant funding
There is a risk that the acute services review in Essex will be out of sync with BCF implementation	2	3	6	• Close engagement with Monitor and the TDA as well as other local and national partners on emerging findings. • Use of CCG and the council plans to influence the outcome of the review.

				• Joint agreement on adaptions required to BCF planning for alignment with the wider strategic review
Lack of engagement and support from Providers	3	3	9	• CCG engaged with providers to remodel pathways and services. • Use the JEG to identify and obtain consensus on the key strategic priorities • Invite providers to submit their ideas and proposals for transformation and use these to inform on-going discussions • Use provider clinical forums to keep clinicians aware and engaged. • Incorporate specific change initiatives into the mainstream commissioning and contracting cycle to ensure that the BCF plans are part and parcel of everyday business. Develop a communication strategy for both internal and external stakeholders.
Staff are not fully aware of and engaged with the changes set out in the Better Care Fund plan	2	2	4	• Hold regular staff briefings • Post updates to organisations' websites • Use the organisations' comms channels to promote better understanding and flag examples of excellent performance and innovation

GP practices do not take up and fully implement the DES	2	2	4	• GP clinical leaders are working with practices to encourage sign up • Integrated communication plan enabling GP practices to learn lessons from the GP Hub pilot and implementation.

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

Background

Our BCF plans are factored into the 2-year operational and 5-year strategic plans produced by the CCG and are in turn reflected in the 5-year strategy of the Southend University Hospital NHS Foundation Trust. These have been considered and signed off by the CCG Governing Body and the HWB.

Our Plans clearly show a record of shifting activity to the community from the acute sector. We anticipate this will be further delivered as part of the next iteration of Operational and Strategic Planning.

Within the Southend Better Care Fund, the financial value of the non-elective admission saving/performance fund is calculated as £977K pa, representing a 3.5% reduction in Southend CCG responsible activity.

Risk sharing arrangements between providers and commissioners

Financial risk falls mainly on the CCG as commissioner, in that if the reduction in emergency admissions is not achieved, this would mean that the CCG will bear the cost of these admissions, as well as the cost of the investment in BCF initiatives. This risk is managed primarily through the setting and achievement of the CCGs QIPP programme that includes the BCF pressures in the totality of the CCGs cost programme. We have established robust arrangements with our acute providers to monitor delivery of QIPP plans.

The CCG has established a range of internal mitigations (such as general and earmarked reserves) and also external risk sharing arrangements with other commissioners which it can draw upon.

In terms of the risk to providers, if the BCF is successful in reducing emergency admissions, there is a risk to providers that there will be some 'stranded costs', primarily fixed costs that the trusts may not be able to take out of the system immediately.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

At Southend the BCF is viewed as part of a whole systems approach to health and social care integration, including our plans to implement the Care Act. The challenge for the Southend System is to ensure that Southend's activity re Pioneer, Year of Care and the pilot project for 7 day services are closely aligned with BCF plans.

Underpinning the work of the integrated teams in Southend is a whole systems approach to assessment, care coordination and choice and control that provides support to people to stay as independent as possible in the community and enjoy the best quality of life. For all people with social care needs, provision of a personal budget following assessment is key to ensuring that people have control over their circumstances and can make the best decisions about their own support, which could include telecare, community equipment and adaptations; homecare or a personal assistant or if required, a move to extra-care accommodation.

Our pioneer integration project extends the reach of health and social care integration to include primary care networks at its heart and to work with all client groups with complex needs. This integrated service will become part of the Southend landscape and will make use of existing care pathways and services.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Our BCF plan is incorporated within Southend CCG's 2 year operational and 5 year strategic plans. The financial impact of the BCF has been included in the financial model, and is one of a number of factors driving the CCG's QIPP requirement of £34.1m over the 5 year period to 2018/19. The BCF is not viewed by the CCG as a standalone initiative, rather it is an integral part of our delivery plans including the Operational Resilience and Capacity plan, which taken in the round describe the changes necessary to deliver a modern model of integrated care, alongside other key system changes that are required to achieve high quality, sustainable services.

Our BCF seeks to address the challenges presented by a significant increase in prevalence of chronic diseases, which would lead to increased levels of admissions to hospital, but with the implementation of the Ambulatory Emergency Care scheme together with changes to primary care and Community Reablement will mitigate these admissions ;

- COPD – projected increase of 11% by 2015
- Diabetes - projected increase of 12.5% by 2015
- Stroke - projected increase of 9.5% by 2015
- Hypertension - projected increase of 4.5% by 2015

Delivering these requires the BCF vehicle in order to transform and align Community and Social Care for patients outside of the hospital setting. Our five year operating strategy then supports a process to make this a sustainable landscape through measuring and delivering seven outcome measures going forward to which the BCF schemes contribute significantly towards;

1 – Potential years of life lost from causes amenable to healthcare

2 – Health related quality of life for people with one or more long term conditions

3 – Reducing the amount of time people spend avoidably in hospital through better and more

integrated care in the community

4- Increasing the proportion of older people living independently at home following discharge from hospital

5 – Increase the amount of people who have a positive experience of hospital care

6 – Increase the proportion of people having a positive experience of care outside of hospital, in general practice and in the community

7 – Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

BCF planning is consistent with Health and Wellbeing Board strategy, Council Corporate plan, Medium Term Financial Strategy and the council's plan to implement the Care Act.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

NHS Southend CCG has bid to shadow the area team as part of its co-commissioning proposals. This is commencing in October 2014 and the CCG has already joined regular Essex area team meetings. A steering group has been established and is developing terms of reference and governance processes.

We believe that co-commissioning will better:

- support the integration of health and social care services locally;
- drive quality improvement within primary care, and reduce health inequalities;
- increase citizen involvement in the development of primary care services;
- support the development of sustainable local services.

Co-commissioning would provide the CCG with the ability to influence how local services are commissioned to ensure that these align with the unit of planning's 5-year strategy and with a focus on outcomes for our local population.

Our 5-year Strategic Plan identifies the need to improve the delivery of care, particularly for people with long term conditions and older people living with frailty. The opportunity to commission locally sensitive services, if deemed more suitable than nationally specified enhanced services would be particularly helpful in supporting delivery of more integrated services in partnership with the council through increased engagement with our member practices.

A key project currently underway is developing a GP hub. This is being piloted in one of our larger practices which has a relatively high proportion of care home patients. Health and social care services are being designed to 'wrap' around the practice's registered patient population to improve and streamline how the different services are provided with an emphasis on integration, ensuring patients can access the right care at the right time.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

The current eligibility criteria for adult social care will remain at critical and substantial. It is not envisaged this will change over the next five years unless mandated by the Care Act, although this is dependent on the financial position. Our local definition of protecting social care services is, "ensuring eligibility criteria and investment remains at required levels with a focus on prevention and ensuring that health services are available earlier and in better co-ordinated ways to reduce demand on social care"

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Promoting independence and reablement, supporting carers and offering alternatives to longer term reliance on residential care are key elements of the Southend approach to protecting social care services. Our BCF schemes are focused on achieving these aims in tandem with a reduction in hospital admissions.

The CCG and the council will work together to agree levels of investment with a focus on achievement of agreed joint objectives. Investment in social care reablement and prevention services will reduce hospital admissions and admissions to residential care. This will support the achievement of a financially sustainable social care system.

There is recognition that in order to undertake radical change in services to achieve better outcomes requires support and commitment from all system partners. This ensures services are protected and risk is managed collectively. System leaders in Southend have formed a strategic alliance with a clear governance structure that reports directly to the Health and Wellbeing board.

We are currently scoping opportunities for joint commissioning across health and social care to achieve value for money and increased efficiencies and have identified the need for a wide ranging prevention strategy to support a shift in resources and manage demand. We will use the BCF to:

- Develop our prevention offer with a focus on increased utilisation of third sector opportunities
- Review our commissioning approaches with a view to developing joint commissioning where this can achieve better outcomes and value for money.
- Focus on integrated service delivery to improve efficiency and reduce duplication
- Support market development to broaden the range of alternatives to residential care.

The Care Act offers opportunities to review our approach to assessment and we will explore options for increased use of self-assessment and review options for the delivery of front end assessment with an increased focus on self-management and use of universal services. The Care Act is the catalyst for further developing our information, advice and guidance pathways and we will use the BCF to scope out opportunities for a joint IAG approach. Within our BCF schemes we have allocated £627k (of which £172K is capital) to support implementation of the

Care Act.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

The total amount allocated from the BCF for the protection of adult social care services in 2015/16 is £5.930M.

Funding currently agreed for 2014/15 via the NHS transfers monies has enabled the local authority to maintain current eligibility criteria, keep delayed transfers of care to a minimum and offer timely assessment and longer term support to people with eligible needs. This will need to be increased, within the funding allocations for 15/16 and beyond to maintain and develop further the current offer. In particular the Care Act is likely to impact on the numbers of assessments required with larger numbers of people needing an assessment who would previously have not had contact with Social Care. This also raises the opportunity to engage in preventative approaches with a wider range of Southend residents and strengthens the importance of a joint approach.

Due to the documented financial difficulties of Southend CCG it has not been possible, as yet, to find any additional allocation to protect Social Services within the BCF plan for 2015/16 beyond the minimum commitments and funding for the implementation for the Care Act.

If not successful, this will leave the council facing a deficit in the provision of Adult social services in the region of £4.7M (circa 11%) which is likely to impact on the provision of integrated front line services.

Both the CCG and the council have agreed a plan to work together on an open book basis to review the apportionment of BCF funding.

We can confirm that our local proportion of the £135M has been identified from the additional £1.9bn.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Our focus on prevention with an emphasis on promoting well-being and self-care will support the aims of the Care Act.

We recognise that underpinning all of the individual's care and support requirements is the need to ensure that what we are doing focuses on the needs and goals of the person concerned. We acknowledge that wellbeing cannot be achieved simply through crisis management; it must include a focus on delaying and preventing care and support needs, and supporting people to live as independently as possible for as long as possible

We are committed to ensuring that we consider how to meet each person's specific needs rather than simply considering what service they will fit into and we will adopt a co productive and flexible approach with service users and carers which concentrate on the aspects of wellbeing which matter most to them.

Our prevention work is well developed but is benefitting from a specific work stream focus led by Public Health and a third sector representative. A joint CCG and Local Authority prevention strategy is being developed focusing specifically on the frail elderly population which will bring together a joined up approach to commissioning prevention focused services.

A number of the BCF schemes have a clear connection to the new duties of the Care Act particularly around new duties to carers; prevention and wellbeing; assessment and eligibility;

care planning and personalisation. These are schemes to:

- Increase in carers' assessments and provision of services and support to carers
- Increase in assessments in preparation for the reform of funding which takes effect from April 2016.
- Work collaboratively with voluntary organisation and advocates to identify people who might have support needs that are not being met and to make services available which will enable a person to stay independent.
- To ensure that there is accessible and proportionate information available which meets the needs of the person, ranging from information on a web site to a face to face discussion or advocacy
- Invest in staff training to ensure that all professionals are trained in early identification of behaviours that can lead to poor health and the advice and information they should provide to promote wellbeing..
- Work closely with Public Health to target the vulnerable areas of Southend.

A project plan is in place to assure implementation of the Care Act, which is overseen by the Head of Adult Services.

We will use the Care Act monies identified in the BCF to support funding for a wider range of carer's services which are currently being scoped. This will include developing our carer's assessment and support offer.

v) Please specify the level of resource that will be dedicated to carer-specific support

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

- Identifying the carers who are not currently known to the council
- Increasing and developing the workforce in response to the increased demand.
- Investing in staff training of both health and social care staff to ensure that the staff have the skills to recognise the impact of the caring role on the carer as well as ensuring the carer has a self-directed service.
- Ensuring that there is accessible advice and information available to carers to support them in their caring role

£437k is allocated to carer specific services. The council and CCG currently commission a range of services to support carers and the joint Carers Strategy is currently being refreshed.

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

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no effect on the local authority's budget against what was originally forecast with the original BCF plan.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

In November 2013 Southend was accepted as an Early Adopter site to provide 7 Day services. Southend's aim for 7 Day services is ….

….. *"We want to refashion our services to our patients, their carers and families, so that they always feel supported and cared for, no matter where they are in the system or what day of the week it is."….*

During the course of 2014 we have been working to identify the improvement priorities and integrate these into existing programmes of work. New projects have been created where appropriate and progress is tracked through the governance of the Joint Executive Group (JEG).

Our review has focused on;

- access to health and social care outside of hospital;
- 7 day services in the hospital; and
- Leaving the hospital after treatment to the next place of care.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Our health and care systems will use the NHS Number. One of our BCF schemes is "Infrastructure to support integrated working" which aims to improve the service user/patient experience through initiatives which will include integrated care records, shared use of IT to support individual care planning, the use of CARETRAK to support mapping of local need, service planning and identifying more efficient ways of providing support across the system

Southend is a Year of Care pilot site and uses an integrated health and social care information system that enables individual patients to be tracked in terms of their utilisation of health and social care services to be tracked together with the associated costs.

Early 2014 the DoH Informatics Support Team spent two days working with Southend to seek a national solution relating to information governance that hampers the integration process. The outcome of Southend's engagement with the DoH has led to the Confidentiality Advisory Group (CAG) considering a proposal to amend the s251 agreement that would deliver a local solution to Southend. In July 2014 CAG considering the application and has deferred the decision to Oct 2014.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

All health and care systems will use the NHS Number. The CCG and SBC are committed to adopting systems that are based upon Open APIs and Open Standards, wherever possible, and

encouraging existing suppliers to adopt Open APIs and Open Standards in future releases of software.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

We are fully committed and have a Health and Adult Social Care Services - Information Sharing Protocol (April 2013) with 4-5 more detailed sharing agreements that sit below this e.g. CARETRAK, Major Adaptations. We also annually submit the NHS IG Toolkit.

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Since September 2012 the CCG and the council has commissioned a Single Point of Referral Service (SPOR), which acts as the key contact point for health care professionals both in primary care and acute discharge services, to the integrated teams which provides a multi-disciplinary response to urgent issues or needs of patients within the community who would otherwise attended A&E and experienced a 0-1 length of stay. We anticipate this service will be available 7 days a week once it is fully up and running. At present the threshold has yet to be established with regard to the number of referrals that can be made into the service upon full implementation although the numbers of referrals have increased year on year since the commencement of the service.

The risk stratification used to identify high risk patients are as follows:

- Patients over 65 years of age
- 2 or more A&E attendances over the last 6 months
- Patient with 2 or more LTC
- Polypharmacy
  Evidence of cognitive problems (acute or chronic)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

Our existing integrated teams bring together health and social care managers and front line staff into joint teams, delivering coordinated care with a clear focus on roles and responsibilities though practice level multidisciplinary team working for high risk patients though risk stratification. This style of patient management allows for the different professionals to shared information and knowledge to allow better care planning which results in better outcomes for patient and their families. This integrated care based model was developed and has been used as a model of best practice though the Year of Care National Programme.

GP led case management will improve care and efficient delivery of patient care in the community, and will allow for proactive case management therefore reducing unplanned acute especially A&E attendances and short stay admissions. It will also reduce the need for crisis management of patients as clear joint care plans will be in place.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

All patients moving through the Pioneer programme will have collaborative care plans in place.

There is a practice population of 186,000 in Southend and 2% of these are in receipt of an MDT which represents 3,720 people.

Southend was in the unique position of having a joint risk stratification system software system (CARETRAK) which can identify and risk assess people in the health and social care system via a patient identification number which is based on the NHS ID. Since the formation of the CCG on the 1st April 2012 it has not been possible to access this system as a consequence of the data protection and patient confidentiality issues that have been raised by the Department of Health. Southend BC and the CCG are currently awaiting a decision from the CAG (D of H Confidential Advisory Group) on the Section 251 Agreement which will enable the information sharing and risk stratification protocol to be utilised.

Please refer to **Appendix 3** for the evidence base re current position.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Patient, service user and public engagement

The application for Integrated Pioneer status was initiated by the council and has built upon a wide process for public, service user and patient engagement. This has been followed by a successful event, held by the CCG, in January 2014 which captured patient views on health and social care in Southend. This information has been used in developing our BCF and integrated pioneer plans and our five-year strategy. Essentially some of the main themes were as follows:

- Services available under one roof at the GP practice
- Better integration of care – a seamless service
- Better access to the GP practice
- Support for self-care

The CCG has a practice patient participation group (PPG) forum which is made up of representatives from many of our member practices. The PPG forum has a keen interest in the better care fund and how health and social care services work together to improve services to patients and has asked for regular update on our on-going projects.

The CCG has established a new patient and public engagement steering group to support the development of a new communications and engagement strategy. As well as including the CCG, Healthwatch and council Members, the group also includes representatives of our local population and the voluntary sector and will support and challenge the CCG in better engaging our citizens in commissioning. This group will also support the development of patient and public engagement in our better care fund plan and our integrated pioneer work.

The health and wellbeing board has also established a communications and engagement group with all major local partners represented. This group is responsible for ensuring good communications and engagement in relation to the health and wellbeing board strategy and, as part of that, our integration work in Southend.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

<u>NHS foundation trusts and NHS trusts</u>

Two workshops were held in May and June 2014 which included our key local health providers in order to develop our five-year strategy, with a key focus on integration of services across the borough.

ii) primary care providers

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

The broader membership of the CCG 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 (such as multi-disciplinary team meetings and the SPOR). In addition we are working closely with one of our member practices to design our GP hub pilot to wrap services around their registered population.

iii) social care and providers from the voluntary and community sector

Southend Association of Voluntary Services (SAVS) is a key member of the GP hub project board and also leads the prevention work stream under the Health and Wellbeing Board.

SAVS form part of our new patient and public engagement steering group which will be responsible for shaping the development of our communications and engagement strategy and for supporting its delivery.

Two workshops were held in May and June 2014 which included the council social care and SAVS in order to develop our five-year strategy, with a key focus on integration of services across the borough.

A whole system approach is being adopted for the modelling of a Community Recovery Pathway. The Community Recovery and Independence pathway includes a range of services traditionally referred to as intermediate care, reablement and rehabilitation. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a **single** pathway across health and social care.

This pathway would not only support efforts to keep people out of hospital and remain independent for as long as possible, but also mean further progress with integrated care and improve the local preventative services offer.

The model may include:

- Crisis and rapid response
- Early support hospital discharge
- Community rehabilitation and reablement
- Bed based rehabilitation
- Falls service

Key interdependencies:

- Hospital discharge team (social care)
- District nursing
- Community Matrons
- Locality social workers
- Primary Mental Health services
- Community geriatrician
- GPs

- Voluntary sector
- Private sector care providers

Who is the service for?

Adults with a primary need for short-term rehabilitation, recovery and/ or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence.

What does it look like?

At the centre of the model is an integrated multi-disciplinary team providing a 7-day service. The team may include:

- Occupational therapists
- Physiotherapists
- Social workers
- Nurses including psychiatric liaison
- Therapy assistants and support workers.

The team may also include a GP

The team will carry person-centred, **holistic** assessment, goal setting and review to enable people to achieve their outcomes and reach their maximum level of independence. Staff will have a common set of core skills, such as assessment, planning and case coordination, as well as retaining their specialist skills and knowledge.

Common principles:

- Person-centred and proportionate
- Prevention and maximising independence
- Recovery and enablement
- Focussed on goals and outcomes
- Effective case coordination
- Single referral route
- Single joint assessment
- Integrated care plan
- Positive risk taking

Throughout this pathway, a risk stratification tool may be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management. These cases may be identified through MDT meetings with clear outcomes agreed on a case-by-case basis.

What difference will it make?

The focus of the Community Recovery and Independence Pathway is on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for an on-going packages of care and thereby reducing long-term dependencies on care and support. Effective and coordinated services will achieve longer-term (financial) benefits for the health and social care economy.

What added value will this approach bring?

- Potential reduction in duplication of care planning and assessments leading to potential transactional efficiencies
- Proactive community offer and intervention to prevent hospital admission
- Better coordination and case management leading to better outcomes for the service user
- Bigger, more flexible resource may lead to efficiency savings
- Longer term savings from the care system as a result of effective interventions
- Focus on whole system working with all stakeholders, particularly Providers of services,

working as partners to achieve the best outcomes.

Things to consider:

- Step up and step down (not necessarily bed based)
- Day resource centres and assessment flats
- Community ward and care navigator model may be included
- In-house versus commissioned personal care
- Role of the hospital discharge team

How will the model of delivery be achieved?

Four multi-disciplinary workshops have been held (one in July, two in August and one in September with a further workshop planned for early October) to map out the "as is" pathways and to understand what is working well and where there are weaknesses in the system which impact on outcomes for individuals using the services; particular emphasis will be placed upon ensuring that there is sufficient capacity in the market to meet changing demand and to incorporate flexibility so that surges in demand can be met.

The output from the workshops will influence the redesign of the pathway which will take a multi-disciplinary approach; Healthwatch and representative organisations will be invited to participate in the re-modelling.

Health and social care will review the services currently commissioned within the current pathways and engage with Providers to disseminate the vision for integrated working. This will enable Providers to adapt services and diversify, where necessary, to meet the requirements of the integrated pathways.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The overall impact of CCG allocations and BCF and QIPP requirements over a five year period is already modelled within the operational planning submissions made by the CCG for the 2014/15 planning round. Commissioner plans outline significant reductions in activity across all points of delivery within acute settings, along with an increase in delivery within community settings. The CCG is working closely with providers to ensure that this service shift is managed proactively, and aligned to Southend University Hospital NHS Foundation Trusts' financial sustainability.

Local provider plans are consistent with commissioner plans to the extent that both forecast a reduction in non-elective activity over the five year planning period. However, they are not fully consistent in that the provider has adopted a different approach to setting a baseline for activity, and is planning for a more modest reduction in non-elective activity. Consequently, a significant gap remains between provider and commissioner plans.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute

provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
001
Scheme name
Protect Social Services through Independent Living including reducing the reliance on residential care
What is the strategic objective of this scheme?
To invest in services which support independent living and reduce reliance on all forms of institutional care. This scheme also protects social care services which support the local health and social care economy. It contributes to admission avoidance and timely effective discharge from hospital and is a core platform of our vision for health and care services which includes "adopting a system wide view and understanding impacts across all key constituents". The scheme aims to reduce permanent admissions to residential care and reduce or delay reliance on longer term social care support in line with Southend Borough Council's corporate requirements. Lack of resource for this scheme will fail to protect social care and put at risk the existing social care system which supports reductions in hospital admissions and timely discharge.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme is a significant contributor to our approach to increasing independence and includes key areas of social care delivery by Southend Borough Council which specifically address the following: • Reduction in unplanned hospital admissions and A&E attendances • Promotion of timely and safe transfers of care from hospital to the community and continuing low levels of delayed transfers of care. • Reduction in the numbers of long term residential placements • Promotion of people's ability to stay safely in their own home or the community with an optimum level of independence • Promotion of choice and control particularly for the frail, elderly who may be at increased risk of hospital admission. • Reducing the impact of carer stress and maintain levels of carer support. Southend has an ageing population; currently 18.3% of the population are aged over 65 and this is expected to double by 2020. This scheme focuses on supporting existing services to better promote independent living particularly among frail older people. It is predicated on the existing provision of services which are aligned to BCF objectives. Measures of health and social care gains from this scheme include: 1. Increase in the numbers of people with dementia supported at home

2. Dementia pathway fully integrated into intermediate care pathway through Single Point of Referral (SPoR)
3. Reduction in the rate of emergency hospital admissions for injuries due to falls in persons aged 65 and over (PHOF 2.24)
4. Reduction in the rate of emergency hospital admissions for fractured neck of femur in persons aged 65 and over (PHOF 4.14)
5. Reduction of 11.5% in the number of people aged over 65 admitted to permanent residential care.
6. To reduce the number of preventable re-admissions to hospital within 30 days of hospital readmissions (PHOF 4.11) and reduced social isolation (PHOF 1.18)
7. Reduction in non-medical admissions of people with dementia into acute hospital beds
8. Reduction in length of stay and delayed discharges from acute hospital settings
9. Increase in the health related quality of life and wellbeing for older people

We will use some of the Better Care Fund to protect social care by:

1. Maintaining hospital social work services to support early assessment and discharge. Although supporting all adults with eligible needs; this is particularly focused on the frail, elderly population and their carers. This service supports the provision of timely advice, information, guidance and assessment within the acute hospital. The service works closely with the Acute Trust
2. Maintain capacity within integrated teams and the reablement service to minimise waiting times for assessment and support. Our assessment and support teams work as part of multi-disciplinary teams centred around GP practices or clusters of practices.
3. Developing a discharge to assess model focusing on reducing admissions to residential care homes and hospital re-admission. Investment will focus on reviewing existing domiciliary care contracts to flex the provision of services.
4. Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.
5. Extending the Single Point of Referral, (SPoR) to provide a seven day assessment and therapies service. The SPOR is an integrated, multi-disciplinary assessment and reablement service and supports early hospital discharge and admission prevention. This service has been successful in ensuring that high numbers of people being discharged from hospital are offered and receive reablement. The admission prevention role is underdeveloped at weekends and our plan to extend assessment hours will help to change this. However, success in this area requires engagement with primary care which currently operates a skeleton locum service at weekends. This is being addressed through the Primary Care Strategy.
6. Dementia Extra care scheme. Extra Care Housing is an innovative alternative for older people to residential care which can help them live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle. Although we have extra care schemes in Southend none are specifically commissioned for people with dementia. This project will provide for extra care accommodation with communities of people with a range of needs of which those with dementia will be a part. The cohort of those initially targeted will predominately be those with dementia whose needs can be met in mixed level of need communities. Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve will achieve an efficiency of £200k per annum from 15/16; The project will span both health and social care and aims to demonstrate the potential for the development of extra care provision both in short term and medium to long term.

   The investment in extra care supports a personalised, community based approach and will highlight the health and social care benefits of investing in quality housing for older people and those with a long term condition to prevent a move to institutional residential care and “reable” individuals to avoid frequent hospital readmissions

7. Telecare

   It is our intention to invest in additional Telecare equipment and other technology within

the scheme to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations.

Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person

8. Disabled Facilities Grant, (DFG). This funds adaptations to individuals homes to support independent living and ranges from a ramp to a complex adapted kitchen and beyond. Although we have had some success in reducing the cost of DFG work and the time taken to get the works done the Council will be exploring innovative ways to see whether there is some scope to achieve a more joined up service for both those disabled people living in the private sector and those living in Council accommodation. In addition the possibility of exploring whether there could be a new approach developed to help with hospital discharge cases where adaptations need to be done quickly
9. Southend has over 150 care homes. During 2014/15 we are extending our Single Point of Referral (SPoR) to care homes to ensure maximum benefit of community and social care services are delivered to care home residents including those with dementia. This will mean that care home residents have access to reablement services. During 2013/14 we piloted a new service with GP practices to improve quality of care for patients in care homes. We will evaluate and extend this service (with appropriate modifications) and link the service to MDTs, and the accountable GP model.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Southend Borough Council commissions a range of local providers to provide reablement, home care, non-statutory advice and support and care home placements.

Southend CCG commissions the South Essex Provider Trust to provide community health services.

The delivery chain is well established as it relates to existing services.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Southend's performance on delayed transfers of care is very good with only six delays attributable to social care in March 2014. Overall in 13/14 there were 41 delayed discharges suggesting current discharge arrangements are working well. We are therefore keen to maintain at least current levels of resource.

Reablement performance is good with high numbers of people going through reablement and averaging 80% still at home 91 days following reablement.

The reduction in permanent residential home placements demonstrate continued improvement in this area.

Reductions in residential care placements are on target for 14/15 demonstrating the impact of reablement and offering more choice and control to individuals to remain in their own homes. The DFG was used to adapt 178 separate homes in 13/14 enabling people to remain independent at home rather than requiring institutional care because of unsuitable accommodation.

Research has identified the financial and economic benefits of extra care schemes for people

with dementia and the detail of impact and outcomes will emerge from a three month review by assessment and care management locality teams. This will be within a clear framework which will provide the evidence base required.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment is £4.781M

Impact of scheme

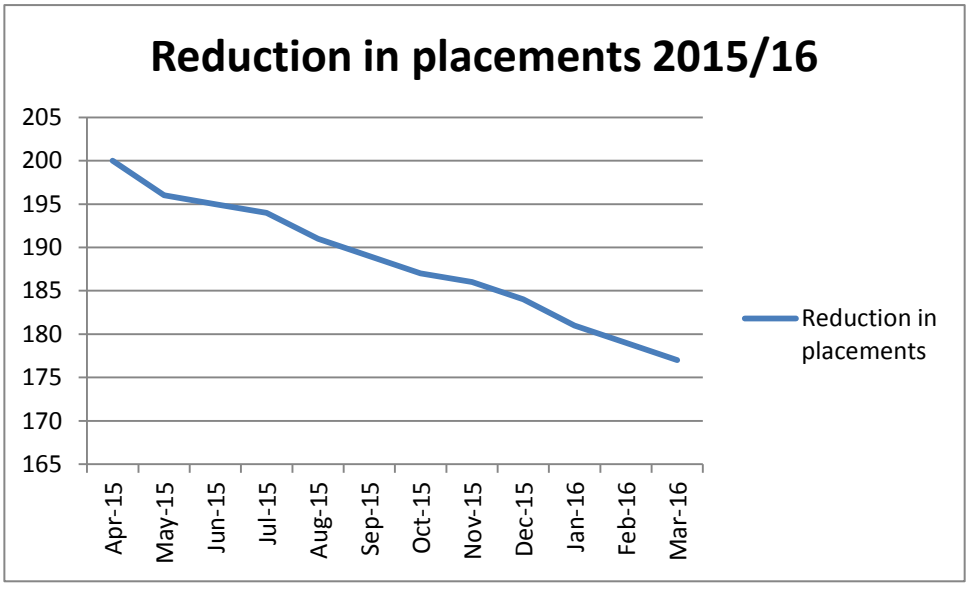
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

In 2012/13 performance on reducing admissions to residential care dipped. This improved in 13/14 and continues to be on course for improvement in 14/15. Our trajectory for improvement is a reduction in permanent residential placements from 200 per year in April 2015 to 177 by March 2016

Current performance puts us in a good position for achievement of this trajectory with forecasts predicting we will not exceed the maximum number target. However, this activity is greatly influenced by factors we cannot control such as the weather and prevalence of coughs/colds/flu in the community. As happened in previous years a challenging set of external factors can increase admissions by a very significant amount. These circumstances have a disproportionate effect in Southend with our very high elderly population.

For this reason we are not complacent about the performance in 14/15 or 15/16. The trajectory below anticipates reductions in residential admissions over 15/16.



Financial benefits expected as result of the above target are a saving of £514k in 15/16 in the cost of residential care

Additionally we anticipate a reduction in the number of people requiring high care packages over an extended period of time due to this scheme and others. We anticipate a saving of £494k through reduced demand for longer term support up to March 2016.

Non-financial benefits include closer more joined up working with health provider colleagues and improved approaches to joint commissioning. This work is being taken forward through our

Pioneer Programme which provides the framework and governance for all BCF schemes.
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The formal feedback loop is via the Governance submission outlined in Section 4 of Part One. We will monitor the quality of the services received through patient and service user feedback and engagement with key local groups such as Healthwatch. All new schemes will be subject to our evaluation and governance processes as set out. Impact on admissions to hospital will be monitored via the Resilience Working Group and impact on residential admission will be monitored via the existing performance monitoring group**.**
What are the key success factors for implementation of this scheme?
Securing funding for continued services will support the health and social care system locally to respond proactively and focus on prevention. Without this there is a risk of a crisis driven response which is not personalised or effective in the longer term.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
002
Scheme name
End Of life and Palliative Care
What is the strategic objective of this scheme?
To redesign and remodel existing services to increase the number of people supported to remain in their home and community setting who achieve their preferred place of care during the final stages of their lives to reduce hospital admissions and to protect social services.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Model & Support There are approximately 3,500 deaths in South East Essex each year of which approximately 10% would be considered sudden death and therefore not amenable to community care. Patients in the end stages of their lives with a diagnosis of cancer are normally known to services, however care is not always coordinated in a way that supports them to achieve their preferred place of care and or death. Additionally whilst the identification of patients with cancer in the terminal stages of their lives is normally well documented this is not the case for patients with long term conditions who are not recognised as moving into the palliative stages of their illness at an early stage. The overarching aim of the scheme is to redesign & decommission as appropriate existing end of life pathways to align with the new model for the delivery for integrated community services through the GP Primary Care Hub, the Community Recovery Pathway and the wider integrated approach to care set out in the BCF plan to ensure better coordinated case managed care for people in the end stages of their lives that . Early identification of patients in the palliative stages of their illness is essential to ensure appropriate wrap around services can meet the e needs of the patients, their families and wider carers. Risk stratification and primary care level multidisciplinary team meetings will the vehicle by which the patients, particularly those with long term conditions will be identified as moving into the palliative stages of their illness. Patients identified will be notified to all services through an end of life register and supported to remain as well as they can, with effective symptom control through coordinated proactive case management and additional support for family and carers to reduce the average number of inappropriate admissions within the last 12 months of life from 3 to 2. Key to the model is effective communication across all services and clearly documented care records to ensure that services are mobilised in a way that enable patients care needs

to be met in the most appropriate setting this will include clearly documented DNARs.

The development of 7 day working, the primary care hub and enhanced support to care homes and a community palliative care consultant will further support a multidisciplinary team approach to ensure that families, carers and care providers are confident to meet the care needs and wishes of patients and residents.

Underpinning the delivery of the palliative care pathway will be a comprehensive communication plan that will deliver an education programme facilitated by both professionals and carers.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The pathway will be jointly commissioned through the Southend Borough Council and Southend CCG joint commissioning team, and will be procured from a range of statutory and third sector organisations.

Service delivery will be through an integrated pathway from a range of statutory and third sector providers. We will be working with the following stakeholders to redesign & remodel the end of life pathway.

- South Essex Partnership Foundation Trust: EOL Register Community Services, Integrated Teams, Case Coordination, EOL Facilitators. Long Term Condition Matrons
- Southend University Hospital Foundation Trust:
- Havens Hospices: Community bed base and day centre services
- St Luke's Hospices.
- SPNDS: Hospice at Home Respite
- Ashley Care: Emergency Respite
- Primary Care: GPs Primary Care Hub, Enhanced Care Home Services, Care coordination MDT care.
- Ambulance Services:
- Care Home Providers
- Domiciliary care providers

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Within the South East Essex area, there are approximately 3,500 deaths, of which it is suggested 10% are considered to be sudden, due to accident etc., and therefore beyond the ability to manage in the community;. This leaves just over 3,100 potential cases for management within the community setting; approximately 60% of those deaths occur in an

acute hospital setting despite the fact that there is no clinical need for the person to be there. Based upon current data, within the last 12 months of life the average number of unplanned admissions (i.e. not for routine treatments and therefore planned) is 3.

It is expected that the redesign and remodelling of the current pathway to improve case management and care coordination will reduce the average number of admissions to hospital will reduce from 3 to 2 in the last 12months of a patient's life .

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investment of £3.0m with allocation to individual projects within this scheme to be agreed.

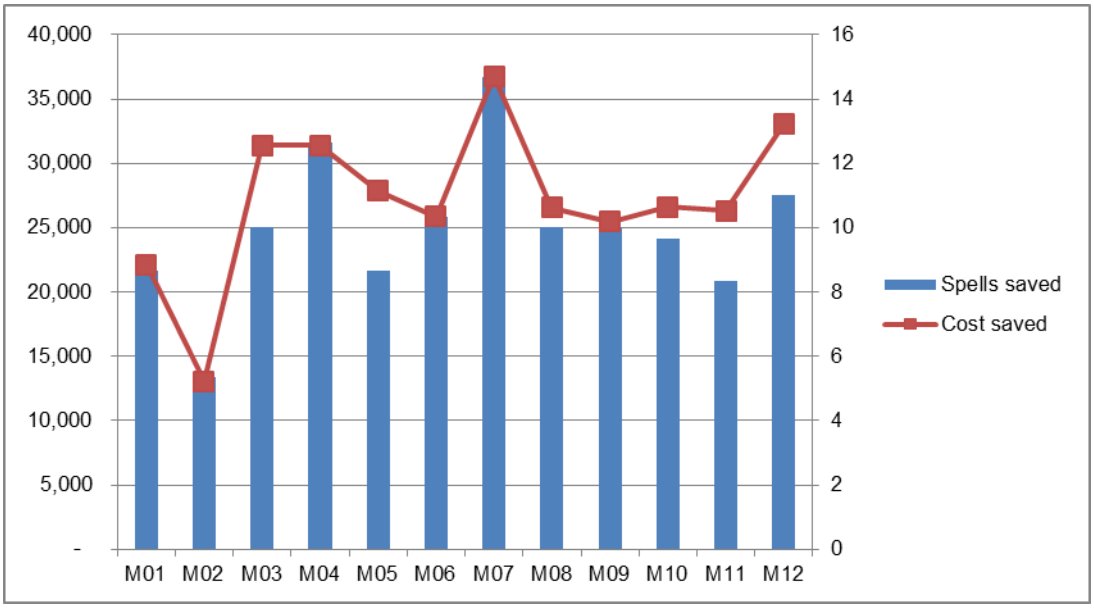
Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below.

Review of hospital deaths for palliative care and EoL patients indicated 358 spells a year costing £980k. The implementation of these schemes would see a decline of 1/3 of spells resulting in a saving of £267k through reduction of 119 Spells per annum

The following chart indicates the profile of the savings over 2015_16 accounting year.



In addition to the Trust spell savings there will also be financial savings for;

- 116 A&E attendances £18k per annum
- 116 ambulance journes £15k per annum

This results in annual savings of £300k per annum and will make a significant impact upon sustainability of the 95% target.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The formal feedback loop is via the Governance submission outlined in Section 4 of Part One.

- Monthly reporting to the implementation group to include :
    - Numbers of patients recorded on the EOL register
    - Number of people achieving their preferred place of care and death
    - Reduction in the number of inappropriate attendances at A&E and Non Elective admissions for patients on the register

What are the key success factors for implementation of this scheme?

- Increase in the number of people achieving their preferred place of care in the final stages of their lives.
- Increase in the number of people identified on the end of life register as being in the palliative stages of the illness and offered additional support
- Increase in the number of non-cancer patients on the end of life register.
- Decrease in Non elective admissions for patients on End of Life Pathway

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
003a
Scheme name
Prevention including intermediate care, primary and community care and transforming the emergency care pathway
What is the strategic objective of this scheme?

The strategic objective of this scheme is to reduce hospital admissions and protect social services by funding a change in approach to the treatment of patients with Ambulatory conditions. The scheme seeks to transfer the care of these patients out into the Primary and Community Care setting together with reablement with Social Services.

The strategy has been developed through the following three phases;

Phase 1 November 2014

The outcome (see below for Agenda packs and notes) of the 5 community recovery pathway multi-disciplinary workshops will be used to formulate the service specification for the revised pathways which will provide a range of options for functional integration of services aligned to the pathway.

Agenda w/shop 1	Agenda w/shop 2	Notes w/shop 1	Notes w/shop 2
003a Mapping the Customer Journey W	003b Mapping the Customer Journey W	003c Output from Mapping the Custome	003d Output from Mapping the Custome

Phase 2 – March 2015

The functions aligned to the integrated pathway (including discharge to assess) will be reviewed and re-modelled

- Demand management forecasting, capacity modelling and options for functional integration will have been carried out for all functions within the pathway namely:-
    - CICC – Cumberledge Intermediate Care Centre (multi-disciplinary step down beds delivered by SEPT)
    - SPOR – Single point of referral for professionals
    - ACCESS – Single point of referral (general public)
    - START intermediate care services including re-ablement – South Essex Partnership Trust/Southend On Sea Borough Council
    - Ambulatory Care – Southend University Hospital Foundation Trust, (SUHFT)

- Hospital Discharge (incorporating discharge to assess) – SUHFT
- Independent sector domiciliary care (generic, specialist and re-ablement)
- Falls provision including proactive and reactive modelling across health, social care and public health
- Voluntary sector provision
- Community equipment provision

- Joint re-modelling of the re-ablement function based on the Department of Health 80/20 criteria.
- The development of systems, processes and protocols to underpin the delivery of the new pathways and re-modelled services
- Communication and engagement strategy to ensure that the system is fully conversant with the revised pathways and referral routes.
- A fully endorsed implementation plan for the community recovery pathway
- The development and implementation of a further three ambulatory care pathways (DVT and Cellulitis are now operational)

Phase 3 –2015 - 2016

- Test and learn of the revised pathways using the initial GP Hub (Valkyrie Practice)
- Roll out across Southend to reduce hospital and residential care admissions and improve citizen experiences within the customer journey.
- The development and implementation of a whole system workforce development strategy and implementation plan.
- The development and implementation of 5 new ambulatory care pathways during 2015/16 to include congestive heart failure, COPD and UTI

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Community Recovery and Independence pathway includes a range of services traditionally referred to as intermediate care, reablement and rehabilitation. Rather than commissioning separate services to provide reactive, short-term interventions and support to help people maintain or regain their independence, this model represents a **single** pathway across health and social care and may include, but is not exclusive to:-

- Crisis and rapid response
- Hospital supported discharge
- Community rehabilitation and reablement
- Bed based rehabilitation
- Domiciliary care
- Falls service
- Voluntary sector provision (including universal provision to sign posted services)

The pathway is being designed to meet the needs of individuals entering the health and social care economy irrespective of their eligibility for on-going social care, the pathway is

also a key component of the prevention agenda and the development of GP Hubs in the locality. It will also support the discharge to assess and the ambulatory care pathways.

The focus of the community recovery pathway will be on early intervention, prevention and maximising independence. It will deliver services aimed at preventing admissions into hospitals, reducing length of stays, preventing and reducing the need for on-going packages of care and thereby reducing long-term dependencies on care and support.

This pathway will not only support efforts to keep people out of hospital and remain independent for as long as possible, but also achieve further progress with integrated care and improve the local preventative services offer.

The service will be for adults with a primary need for short-term rehabilitation, recovery from and/or prevention of inappropriate admission to hospital following a period of illness, injury or general deterioration in condition or independence. The service will include crisis and rapid response, early supported hospital discharge, community rehabilitation and reablement, bed based rehabilitation and a falls service.

At the centre of the model will be an integrated multi-disciplinary team providing a sevenday service. The team will include occupational therapists, physiotherapists, social workers, nurses (including psychiatric liaison) and therapy assistants and support workers. The team may also include a GP and a nurse prescriber.

The team will carry out person-centred care, holistic assessment, goal setting and review to enable people to achieve their desired outcomes and reach their maximum level of independence. Staff will have a common set of core skills including assessment, planning and case coordination, as well as retaining their specialist skills and knowledge. Risk stratification will be used to identify people who would benefit from a targeted intervention to increase confidence and promote self-management.

The re-modelling of the pathway will include a review of the processes and systems across partner organisations aligned to the pathway to ensure that recipients do not experience delays in the discharge and referral process, and that services are in place to avoid people going into crisis in the community. This will have a positive impact on the number of people presenting at A&E, the time taken to discharge patients from hospital, the number of people being admitted inappropriately into residential care contributing towards the 11.5% reduction in admissions to residential care, achieving the optimum level of throughput thereby avoiding blockages in the system; and a reduction in the number of people requiring long term care and support.

The delivery chain

Community Recovery Pathway (including discharge to assess)

Pioneer Programme Operations Workstream – joint health and social care leads and multi-disciplinary project group

- Integration Programme Director SCCG – Susan Anderson-Carr
- Pioneer Programme Manager – Nick Faint
- Project Manager – Nadine Hassler

Ambulatory Care Pathway

- SUHFT multi-disciplinary project group led by Dr.J Peasegood – Consultant Ambulatory Care.
- Project Manager – Traci Manton, General Manager, Medical Specialities, SUHFT

Key inter-dependencies and stakeholders involved in the planning, development and implementation

- Southend Hospital Foundation Trust – hospital discharge team (health and social care)
- SEPT – Southend Therapy and Recovery Team (START)
- District Nursing
- Community Matrons
- Locality social workers
- Primary Mental Health Services
- Community Geriatrician
- GP's
- Voluntary Sector
- Independent sector domiciliary care providers
- Healthwatch
- Commissioners (health and social care)
- Clinical Leads – unplanned care, mental health and children & young people
- Public Health
- GP Hub – Valkyrie Practice

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

During February 2014 we held a "Look Back" event with all stakeholders to identify the challenges in the system which are particularly demanding during the winter period. This included an analysis of what is working together with areas that require the system to resolve in order to deliver long term sustainable services. This event together with the following reviews has shaped the strategic direction for integrated services and the re-modelling of pathways:-

- Intermediate care and community Review
- Referral to Treatment review, Intensive Support Team review and Recovery Action Plan
- Emergency Care Summit and Review leading to a Recovery Action Plan
- The "Perfect Week" pilot and Emergency Care IntensiveSupportT eam , (ECIST)reviews on length of stay

Furthermore we have also used the National Minimum standards for Urgent Care checklist to bench mark our plans and to assist in the identification of gaps and resolving these within the development of aligned strategies. The overall vision is to provide more community facing services and intermediate care capacity around the SUHFT. This requires a fundamental system shift from a pure focus upon acute beds to manage the Urgent Care agenda to focusing upon non admitted pathways to manage the Referral ToTreat trajectories. We have therefore identified the following seven themes which will form the direction of travel for the system.

- Improved system governance
- Embedded escalation process
- Improved performance management
- Community Recovery Pathway
- Referral To Treat Recovery Plan
- Emergency care recovery plan

- GP Hub in Southend

In addition to the aforesaid during 2013/14 demand for admission avoidance services through the single point of referral (SPOR) and community reablement services to support discharge from hospital outstripped supply.

This meant that some people were admitted to hospital when they could have been better supported in a community setting.

While community services and integrated services in Southend have provided high quality care to people, we have identified that there is sometimes pressure on reablement and domiciliary care services particulary at weekends and during periods of unexpected surges in demand. This capacity gap is being addressed through continued investment in reablement and the development of the community recovery pathway. .

Ambulatory Care and Discharge to Assess

In anticipation of increasing pressure on A & E departments nationally, a number of measures were introduced by SUHFT from 2010. These include:

- Applying the Emergency Care Intensive Support Team (ECIST) model of an acute mediccaldmissions Unit in 2010
- A 'See and Treat' approach, implemented for A&E minor accidents
- Increased availability of sevenday diagnostics for emergency patients
- Improved discharge processes, especially around complex discharges
- The improved availability and scope of the discharge lounge

However, the measures outlined above were not sufficient to deliver sustainable solutions. A total of fourteen projects have been identified within SUHFT which will improve and ensure sustainability of the Emergency Pathway. This is inclusive of the development of an ambulatory care model which includes the design and implementation of an effective system for reducing overnight admissions which are not clinically indicated.

The discharge to assess project (one of the fourteen identified projects) will introduce a comprehensive process for discharge planning for patients. This includes an objective not to assess anyone for residential care from an acute setting in accordance with the Department of Health Guidance.

The following table provides evidence of high levels ambulatory care admissions which we will see reduce through the implementation of the scheme. The data is from Southend University Hospitals NHS Foundation Trust and for Southend CCG patients only.

AEC Conditions	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Angina	20	15	20	10	19	12	13	14	12	9	14	18
Asthma	4	10	8	12	5	10	14	14	9	8	8	8
Atrial Fibrillation & Flutter	17	19	19	18	18	19	24	14	14	12	15	17
Cellulitis	3											
Chronic	40	30	21	28	24	20	25	30	38	34	25	45

obstructive pulmonary disease												
Congestive heart failure	20	23	26	24	17	11	16	14	21	25	11	22
Convulsions and epilepsy	13	6	18	5	15	7	8	7	7	6	7	10
Dehydration and gastroenteritis	1											
Dementia	2	3	2	6	2	5	7	2	5	7	3	5
Diabetes complications	8	6	5	11	7	8	9	8	8	6	12	9
Gangrene	1											
Hypertension	1	2	2	3	1	2	1	2	2	4	7	4
Influenza and pneumonia	6	1										
Iron deficiency anaemia	4	2	5	1		4	1		1	4	2	2
Grand Total	140	117	126	118	108	98	118	105	117	115	104	140

Please refer to data from our Winters Plan for further evidence base.

003a BCF - Summary of this winters plans.(

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The £3.051m will cover investment in the following projects to enable the change of delivery of patient care from the acute setting into primary and community care together with Social Care;

- Community recovery pathway.
- Ambulatory care cathway.
- Transforming Emergency Care Pathway.

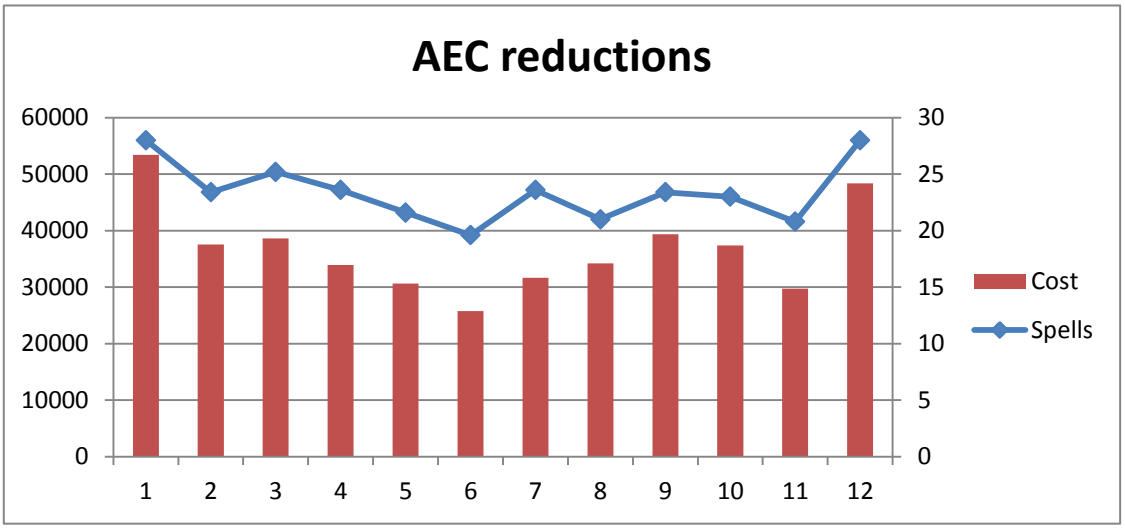
Further details of the £3.051m allocation to these projects are to be agreed.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of the scheme is the reduction of non elective spells for patients with ambulatory care conditions of 332 spells a year with financial savings of £360k per annum.



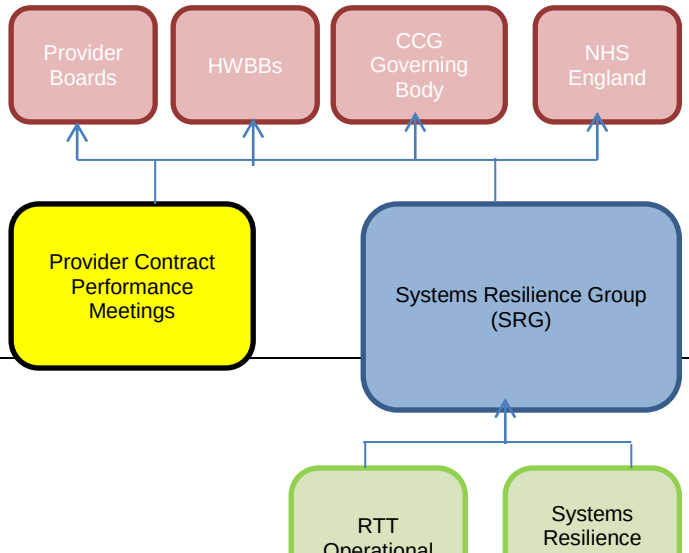
Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The formal feedback loop is via the Governance submission outlined in Section 4 of Part One.

Quality and impact will be measured via the governance framework that has been established in Southend which takes a whole system approach to measuring success.

Partners in the system have recognised that the impact of various initiatives cannot be reviewed in isolation of each other and that the challenges faced by the system require a collaborative approach and an agreed governance framework to which all stakeholders are signed up to. This will ensure that the system focuses on the priorities and is able to mitigate against any risks in a timely manner, moreover the system and partners within it have a shared understanding that projects and services within the transformational change programme must deliver against the key performance indicators and that action is taken to de-commission services that are unable to evidence that they are delivering against the specified key performance indicators. In order to achieve this the endorsed governance framework is depicted in the diagram below:-



The system has agreed that the most effective performance management monitoring will be facilitated via the following:-

Joint Executive Group

- Monthly meeting of senior executives within SBC, SCCG, SUHFT, SEPT, SAVS (voluntary sector representative group) and Public Health

System & Resilience Strategic Group (meets fortnightly) and Operational Group (meets weekly)

- An Integrated Performance Scorecard which will be monitored on a monthly basis by the System and Resilience Group
- Alignment with the Operational Resilience Plan
- A performance monitoring framework for Providers and reporting to the respective SRG Groups

Southend Hospital Foundation Trust

- Weekly performance meeting

Southend Clinical Commissioning Group

- Weekly operational executive meeting
- Monthly Clinical Executive Meeting
- Monthly Governing Body Meeting

Southend Borough Council

- See Annex 003b

Citizen Feedback

- Service user and patient satisfaction surveys
- SUHFT friends and family surveys
- GP patient survey
- Service users and patient satisfaction surveys
- Friends and family surveys in the trust

What are the key success factors for implementation of this scheme?

- Reduction in non elective spells
- Improved patient outcomes
- Increased adherence to end of life plan
- Improved performance on the national and local indicators
- NHS constitutional standards
- To make our current health and social care financially challenged system sustainable
- Enhanced GP engagement in the local urgent care agenda
- Support the trust in the recruitment of ED staff and wider engagement on a workforce development strategy across the system

ANNEX 1 – Detailed Scheme Description –

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
003b
Scheme name
Prevention including reablement service
What is the strategic objective of this scheme?
The strategic objective this scheme is to protect social services and reduce hospital admissions through funding re-ablement services with the aim of improving Social Care discharge management and admission avoidance including developing existing re-ablement services. 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. Re-ablement complements the work of intermediate care services and aims to provide a short term, time limited service to support people to retain or regain their independence at times of change and transition. It is intended to promote the health, well being, independence, dignity and social inclusion of the people who use the service.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
What is the model of care and support? The Service Provider is expected to work in partnership with the service users, their families and carers in assessing problems and needs, goal setting, planning and implementing re-ablement programmes. In order to meet the objectives, re-ablement 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. **Which patient cohorts are being targeted?** Patients who have had a hospital stay and are assessed as benefitting from a period of re-ablement 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.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
• External re- ablement providers • In house reablement provision The delivery chain is firmly established as it is using current providers.

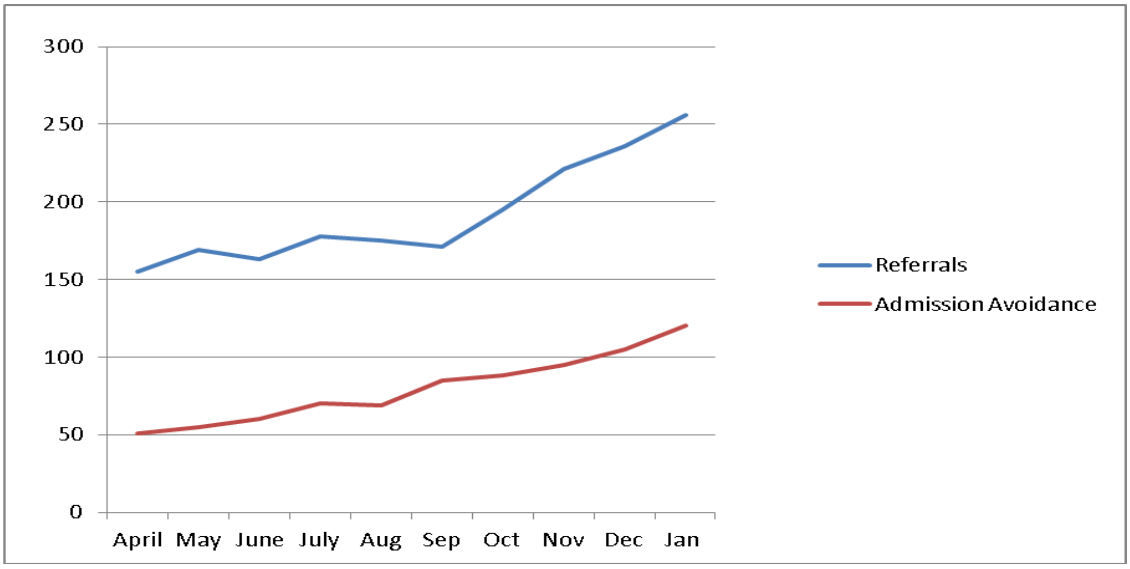
The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

National studies have established that reablement improves outcomes, particularly in terms of restoring people's ability to perform usual activities and improving their perceived quality of life. According to Francis, J et al (2014) "Research evidence demonstrates that reablement improves independence, prolongs people's ability to live at home and removes or reduces the need for commissioned care hours (in comparison with standard home care). The best results show that up to 62 per cent of reablement users no longer need a service after 6−12 weeks (compared with 5 per cent of the control group), and that 26 per cent had areduced requirement for home care hours (compared with 13 per cent of the control group)"

Evidence gathered in Southend established that the avoidance of admissions to hospital increased from 50 in April 2013 to 120 in January 2014. The cost of long term care provision that a person receives following on from their period of reablement has reduced further resulting in an increase in the average weekly saving per person from £64.80 in April 2013 to £77.60 in January 2014.



Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2015-16 Reablement Projects £1,431,000 – This represents current reablement investment from the BCF. SBC invest in reablement over and above this. We are currently scoping what level of increased investment is required to increase capacity and keep pace with rising demand.

Details of Project	Estimates of Potential Impact	Value £000s	Outcome measures.
Maintain home Again Service to cover NHS and social care delays	Reduction in re-admissions to hospital	£240k	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
Social Work Post to work across intermediate care beds supporting the development of a discharge to assessment	Manage length of stay in intermediate care ward &	£50k	Reduction in admissions to residential settings and CHC requirements
Social work capacity to maintain and improve speed of assessment	Manage length of stay in intermediate care ward and hospital	£176k	Maintain DTOC at 1.8 per 100,000 or below. Reduction in social care DTOC's for intermediate care bedded and non bedded services..
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))	Admission avoidance and reduction of re-admissions to hospital	£135k	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 days after discharge from hospital
Project management to support the frailty pathway, developing a discharge to assess model of care	Admission Avoidance and Reduction of readmissions to the hospital	£50k	Reduction in admissions to residential settings and CHC requirements
Increase therapy capacity to support reablement of patients on the early supported discharge pathway	Minimum National standards met for patient on the pathway Increase independence for people & reduction in packages of care	£100k	80% of patients on the early supported discharge pathway will receive minimum recommended levels of therapy
External Re-ablement Capacity	Reduction in avoidable admissions and reduced pressure upon CHC, Residential and domiciliary care budgets.	£225K	Continued reduction in DTOC's and avoidable hospital admissions.

Implementation of the Care Act		£455k	Costs associated with implementation of the Care Act.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- A reduction in avoidable admissions to hospital
- Facilitate timely hospital discharges
- Prevention and maximising independence
- Recovery and enablement services.
- Community rehabilitation and re-ablement.
- Processes to minimise delayed discharge
- Contribute towards an integrated single pathway across health and social care.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

We will monitor the following anticipated outcomes to ensure that the expectations are being achieved;

- The reduction in delayed discharges
- The reduction in inappropriate hospital admissions
- The reduction in long term care provision
- The reduction in residential care admissions
- The number of positive feedbacks from patients at the end of their period of re-ablement regarding the level of independence they have reached.

These outcomes will be monitored via a variety of mechanisms including the System Resilience Group, Discharge Management Group and the Council's Performance Management Group. These forums highlight where problems are occurring and seek to reslve issues as they arise. Overarching governance is via the Joint Executive Group which reports to the Health and Wellbeing Board.

What are the key success factors for implementation of this scheme?

- Buy-in / engagement of staff / patients
- Robust referral pathway for re-ablement
- Sufficient re-ablement provider capacity

The key success for reablement will be demonstrated in the outcomes outlined above**.**

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
004
Scheme name
Integrated care through the GP Hub
What is the strategic objective of this scheme?

The strategic objective of this scheme is to reduce hospital admissions and protect social services. The GP Hub will act as an 'early adopter, and a catalyst for improvement that will deliver seven-day services across the whole system which will ensure better outcomes and improved patient experience. Services will be monitored and evaluated to understand impact and effectiveness which may lead to further project design, or full roll-out to other GP practices.

This is deployed across the following phases

Phase 1 – November 2014

Discovery Stage

Deliverable – Final report

Please refer to the attached project documentation for tasks aligned to the deliverable

Phase 2 – March 2015

Design Stage

Deliverable – Target Operating Model for User Testing

Please refer to the attached project documentation for the tasks aligned to the deliverable

Phase 3 – March 2015

Deliverable – Implementation of the pilot and testing

- Test and learn of the GP Hub (Valkyrie Practice)

Please refer to the attached project documentation for the tasks aligned to the deliverable

Phase 4 – 2015_2016

Deliverable – roll out across Southend (phased approach) of the target operating model

GP Hub PID	Governance ToRs	Governance
004a GP HUB PID as at 17 Sept.docx	004b PMG TOR V1.doc	004c SCCG GP Hub governance arrangm

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The rationale for GP Hubs in Southend and what they will deliver.

Advances in technology and changing demographics means that, with the right premises and correct skills mix, more integrated care can be delivered in a primary care setting. Citizens who have historically gone to hospitals to receive their care will no longer need to make hospitals their first port of call. Similarly, people who are supported by social care can be referred to the service via a variety of routes.

Exciting new initiatives are being developed which will deliver improved outcomes for citizens, the supply chain and the health and social care economy. The target operating model will ensure that functional integration of system partners is developed and tested.

The Community Recovery Pathway will be implemented initially around the GP Hub as this will enable on-going evaluation and monitoring of the model and the effectiveness.

Southend's vision for the GP Hub is that it will act as an 'early adopter' and catalyst for improvement that will deliver 7-day services across the whole system from which the following outcomes and benefits will be accelerated:

- Helping citizen's manage their own health conditions
- Helping citizen's to live independently for as long as possible
- Better co-ordination of complex care across multiple agencies
- Improved patient experience and improved outcomes
- Delivering care as close to home as possible
- Reduction in admissions to residential/nursing care and the need for longer term support
- Single point of access
- Citizen's will not experience gaps between services and services will be joined up and seamless
- Personalised, cost effective care
- Shared decision-making and continuity of care
- Enhanced skills and flexibility of the general practice
- Easy access to health information when needed inclusive of sign-posting, advice and referrals
- Multi-agency working will enable earlier intervention and a more co-ordinated approach which will reduce A & E attendances and admissions into hospital
- GP Hub services supporting Care Homes to improve quality and the outcomes for residents
- Seven-day services will increase levels of early discharges from hospital with the community recovery and ambulatory care pathways and discharge to assess being modelled around the GP Hubs
- An integrated approach which enables early intervention and support for people at risk of losing their independence or going into crisis
- The development and implementation of whole system community facing services modelled around the needs of a local population using public health analytics as a robust evidence base.

The Joint Executive Group has endorsed the model and the proposal to use the lessons

learned to roll out the target operating model across Southend.

Engagement and Collaboration

We know that successful re-modelling, innovation and change depends on active and on-going partnerships between people who use the services, their families, carers, patient representatives, commissioners and providers of services across the public, independent and third sectors.

Throughout the discovery, design and implementation stages of the GP Hub Project the views of users, their carers and families and providers of services will be sought to further define the outcomes to be achieved. We will do this through the use of workshops and consultation groups. The outputs from these sessions and other evidence captured via the governance and communication frameworks will form the basis by which services delivered through the GP Hub will be monitored and evaluated.

The Initial GP Hub Site

The premises from which the GP Hub will be configured and services delivered has been identified as the Valkyrie Practice. This site offers a number of opportunities to configure health and social care services around the citizen which puts them at the centre of their care and in control which is at the heart of the national personalisation agenda and primary care strategy. Valkyrie has a patient list of approximately 14,000 patients which offers a good opportunity to target a larger population group with a range of challenges within the system.

Services to be Modelled around the GP Hub

- Risk stratification for people with long term conditions
- The introduction of a Care Co-ordinator within the practice to enhance whole system care planning and timely interventions
- High intensity (where required) , pro-active care with a named GP for the over 75's
- Intermediate care, reablement and rehabilitation delivered via the Community Recovery Pathway
- Information, advice and guidance
- Discharge to assess
- MDT's
- Integrated care records
- On site pharmacy – enhancement of services
- Enhanced working with Care Homes
- 7 day services which meet the needs of the local population
- Rapid response and crisis avoidance
- Falls prevention
- Promotion of Telecare/Telehealth
- The de-commissioning (where required) and re-commissioning of services to meet the health and social care needs of the local population
- Any new initiatives that are identified which would benefit from testing within the GP Hub.

The delivery chain

Pioneer Programme Operations Workstream – joint health and social care leads and multi-disciplinary project group

- Integration Programme Director SCCG – Susan Anderson-Carr
- Head of Primary Care SCCG – Sadie Parker
- Pioneer Programme Manager SBC – Nick Faint

- Project Manager SCCG – Jennifer Jallim

Key inter-dependencies and stakeholders involved in the planning, development and implementation

- Southend Hospital Foundation Trust – hospital discharge team (health and social care)
- SEPT – Southend Therapy and Recovery Team (START)
- District Nursing
- Community Matrons
- Locality Social Workers
- Primary Mental Health Services
- Community Geriatrician
- GP's
- Voluntary Sector
- Independent Sector Domiciliary Care Providers
- Healthwatch
- Commissioners (health and social care)
- Clinical Leads – unplanned care, mental health and children & young people
- Public Health
- GP Hub – Valkyrie Practice
- Care Homes

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The rationale for configuring services around a 'GP Hub' stems from the fact that primary care is the citizens' entry point for the prevention and treatment of illness. It already includes a rich diversity of professionals ranging from GP's, nurse practitioners, nurses, opticians and pharmacists through to allied health professionals and social workers. Primary care is at the heart of the wider health and social care system.

During February 2014 we held a "Look Back" event with all stakeholders to identify the challenges in the system which are particularly demanding during the winter period. This included an analysis of what is working together with areas that require the system to resolve in order to deliver long term sustainable services. This event together with the following reviews has shaped the strategic direction for integrated services and the re-modelling of pathways:-

- Intermediate Care and Community Review
- RTT review, Intensive Support Team review and Recovery Action Plan
- Emergency Care Summit and Review leading to a Recovery Action Plan
- The "Perfect Week" pilot and ECIST reviews on Length of Stay

Furthermore we have also used the National Minimum standards for Urgent Care checklist to bench mark our plans and to assist in the identification of gaps and resolving these within the development of aligned strategies. The overall vision is to provide more community facing services and intermediate care capacity around the SUHFT. This requires a fundamental system shift from a pure focus upon acute beds to manage the Urgent Care agenda to focusing upon non admitted pathways to manage the RTT trajectories. We have therefore identified the following seven themes which will form the direction of travel for the system.

- Improved system governance

- Embedded escalation process
- Improved performance management
- Community Recovery Pathway
- RTT Recovery Plan
- Emergency Care Recovery Plan
- GP Hub in Southend

A review of the hospital data evidences that citizens were admitted to hospital when they could have been managed better in a community setting and/or were unable to be discharged, despite being medically fit. The initiatives outlined in the Community Recovery and Ambulatory Care Pathways and Discharge to Assess will support the target operating model which focuses on community facing services in the right place, at the right time.

To better understand which services are working well a number of interactive workshops have been held during July, August and September. This gave us the 'as is' position across health and social care which was drawn from the experiences of front-line professionals, independent and third sector providers and patient representatives; they told us what services they believe are working well and those that require improvement, streamlining or enhancing.

We reviewed primary care data, A & E and acute performance and Southend's demographics; we also engaged with care home providers to obtain patient un-identifiable data to better understand the reasons why residents are presenting at A & E from residential and nursing homes.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

There is already an investment to the pilot project in 2014_15 of £100k. The subsequent deployment of the pilot across the remaining Southend on Sea practices in 2015_16 has yet to be agreed. However we have allocated £50K for this scheme. This scheme has been included within the BCF as it forms a key element of the Primary Care enablement for transforming the emergency care pathway and the funding will be agreed between the Health and Social care partners of Southend

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Once the pilot is deployed across Southend on Sea the impact of the scheme will be a reduction in A&E attendances and any resulting Non elective admission from that attendance. It's planned to reduce attendances at A&E by 1% and corresponding non elective admissions;

Current annual attendances – 54,000 therefore reduction of 540 attendances

Admissions based upon 540 attendances – 540 *0.38 = 205 Non Elective admissions at a saving of £350k per annum

The impact on Social Care through reducing admissions to care homes is currently being agreed.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand

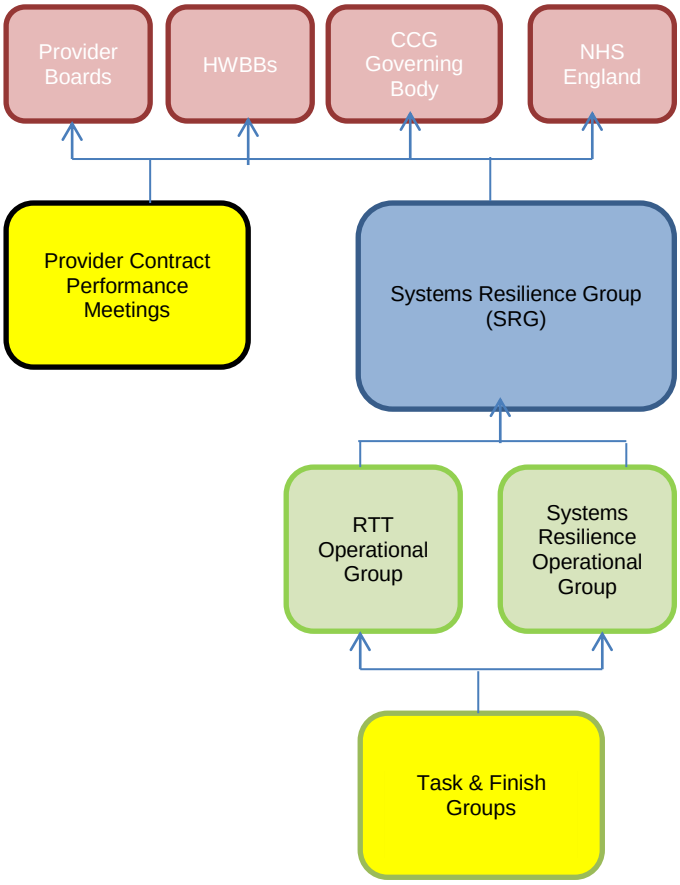
what is and is not working in terms of integrated care in your area?

The formal feedback loop is via the Governance submission outlined in Section 4 of Part One.

Quality and impact will be measured via the governance framework that has been established in Southend which takes a whole system approach to measuring success.

Partners in the system have recognised that the impact of various initiatives cannot be reviewed in isolation of each other and that the challenges faced by the system require a collaborative approach and an agreed governance framework to which all stakeholders are signed up to. This will ensure that the system focuses on the priorities and is able to mitigate against any risks in a timely manner, moreover the system and partners within it have a shared understanding that projects and services within the transformational change programme must deliver against the key performance indicators and that action is taken to de-commission services that are unable to evidence that they are delivering against the specified key performance indicators.

In order to achieve this the endorsed governance framework is depicted in the diagram below:-



The system has agreed that the most effective performance management monitoring will be facilitated via the following:-

Joint Executive Group

- Monthly meeting of senior executives within SBC, SCCG, SUHFT, SEPT, SAVS (voluntary sector representative group), Public Health

System & Resilience Strategic Group (meets fortnightly) and Operational Group (meets weekly)

- An Integrated Performance Scorecard which will be monitored on a monthly basis by the System and Resilience Group
- Alignment with the Operational Resilience Plan
- A performance monitoring framework for Providers and reporting to the respective SRG Groups

Southend Hospital Foundation Trust

- Weekly performance meeting

Southend Clinical Commissioning Group

- Weekly operational executive meeting
- Monthly Clinical Executive Meeting
- Monthly Governing Body Meeting

Citizen Feedback

- Service user and patient satisfaction surveys
- SUHFT friends and family surveys
- GP patient survey
- Feedback from Healthwatch

Project Governance

Please refer to the attached project documentation

What are the key success factors for implementation of this scheme?

- Reduction in none elective stays
- Improved patient outcomes
- Increased adherence to end of life plan
- Improved performance on the national and local indicators
- NHS constitutional standards
- To make our current health and social care financially challenged system sustainable
- Enhanced GP engagement in the local urgent care agenda and the development and implementation of evidence based services
- Reduction in the number of people presenting at A & E

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
005
Scheme name
Infrastructure to support integrated working
What is the strategic objective of this scheme?

Extra care - £233k

Investment of capital monies to deliver extra care services for people with dementia through case review and assessment living to achieve an efficiency of £200k per annum from 15/16; The project will span both health and social care and aims to demonstrate the potential for the development of extra care provision both in short term and medium to long term. This is line with Southend on Sea's vision for older people which is:-

"Older people will have opportunities to live independently and remain active for longer. They will have greater choice and control over their lives and will be valued and respected"

The investment in extra care supports a personalised, community based approach and will highlight the health and social care benefits of investing in quality housing for older people and those with a long term condition to prevent a move to institutional residential care and reable individuals to avoid frequent hospital readmissions

Extra Care Housing is an innovative alternative for older people to residential care which can help them live in the most appropriate accommodation via a range of housing options for differing levels of need and lifestyle.

Telecare – £50k

It is the intention to invest in additional Telecare equipment and other technology within the scheme to maintain health and well-being as well as to support virtual communities in the local area to reduce isolation and respond to identified emergency situations.

Telecare systems can include personal alarms, environmental sensors to detect smoke, water flooding, unlit gas and temperature, or movement sensors that detect if fridge doors are opened, a bed is occupied or if a person has fallen and cannot get up. Systems that are more sophisticated monitor many aspects of the home environment and communicate interactively with the person

Care Act capital monies £176k

Investment in IT

The strategic objective is the Investment of capital monies to improve the IT systems in preparation for the implementation of the Care Act.

The Care Act requirements and the priorities for data and technology include

- Transparency – drive better care through release of data about health care services
- Transactions – Modernise services to match expectations of today's online society
- Interoperability – health and social care systems
- Patient participation and control – Enable patient access to their own professional held

records

- Patient participation and control – Enable patients to control their own health/care (Citizen Driven Health)
- Reduce admin burden – Provide front line with information required enter information only once.

National Information Standards – all systems to use NHS number as identifier

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The Extra care housing scheme will give people the opportunity to live independently in a home of their own, but with other services on hand if they need them. These extra facilities vary depending on the site, but can include:

- 24-hour access to emergency support
- an on-site care team
- rehabilitation services
- day centre activities
- a restaurant or some kind of meal provision
- laundry
- fitness facilities and classes
- a base for healthcare workers

It is anticipated that enabling people to remain as in the community with as much independence as possible but with the 24 hour support they require will contribute towards the target of 3.5% reduction in hospital admissions.

Every council with responsibility for social care will have IT systems in place to manage their case records. The care and support reforms will change the requirements of these systems. Having in place the right information systems to support the reforms is critical to successful implementation.

The system is required to be able to accommodate the

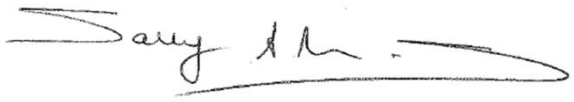
- Increased focus on self assessment and the needs of self funders as well as links with health/housing services
- The increase in assessments
- The requirement to be able to record assessment outcomes and have measurement tools
- The requirement to record eligible needs, as well as well as non eligible needs.
- The need for a system which records carer's assessments and plans, linked to the individuals information where appropriate.
- Recording deferred payment information and level of accruals
- The necessity to have up to date care account information
- The expectation that there will be an IT system for calculating financial assessments
- An on line financial assessment tool which will enable cases to be triaged and essential information gathered.

The need for a system for calculating personal budgets (PBs) and independent personal budgets
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
• Procurement • IT providers • IT staff within the LA
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
There is a statutory requirement to implement the Care Act and information and technology both have an important contribution to make in supporting the transformational change in the commissioning and delivery of care and support services that will be required by the act.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£459K
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Reduction in residential placements • Reduction in avoidable hospital admissions • Reduction in individuals who are social isolated • Better on line information & advice services for individuals and carers • The required information of individuals and carers to meet the expectations of the care act is recorded electronically. • Technical changes are in place to support better data sharing
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The formal feedback loop is via the Governance submission outlined in Section 4 of Part One.
What are the key success factors for implementation of this scheme?

- Appropriate sites available
- Provider engagement
- IT solutions are available which offer the requirements
- Staff are trained to use the systems

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Southend
Name of Provider organisation	South Essex Partnership University NHS Foundation Trust
Name of Provider CEO	Sally Morris
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	18,645
	2014/15 Plan	18,399
	2015/16 Plan	18,111
	14/15 Change compared to 13/14 outturn	(246)
	15/16 Change compared to planned 14/15 outturn	(288)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	(356) To achieve the 3.5% reduction over and above planned

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Not Yet
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Southend Health and Social Care partners to do so.

3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by SEPT. We are fully engaged in the system approach to caring for patients in the community and using the hospital expertise appropriately

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Southend
Name of Provider organisation	Southend University Hospital NHS Foundation Trust
Name of Provider CEO	Jacqueline Totterdell
Signature (electronic or typed)	

For HWB to populate:

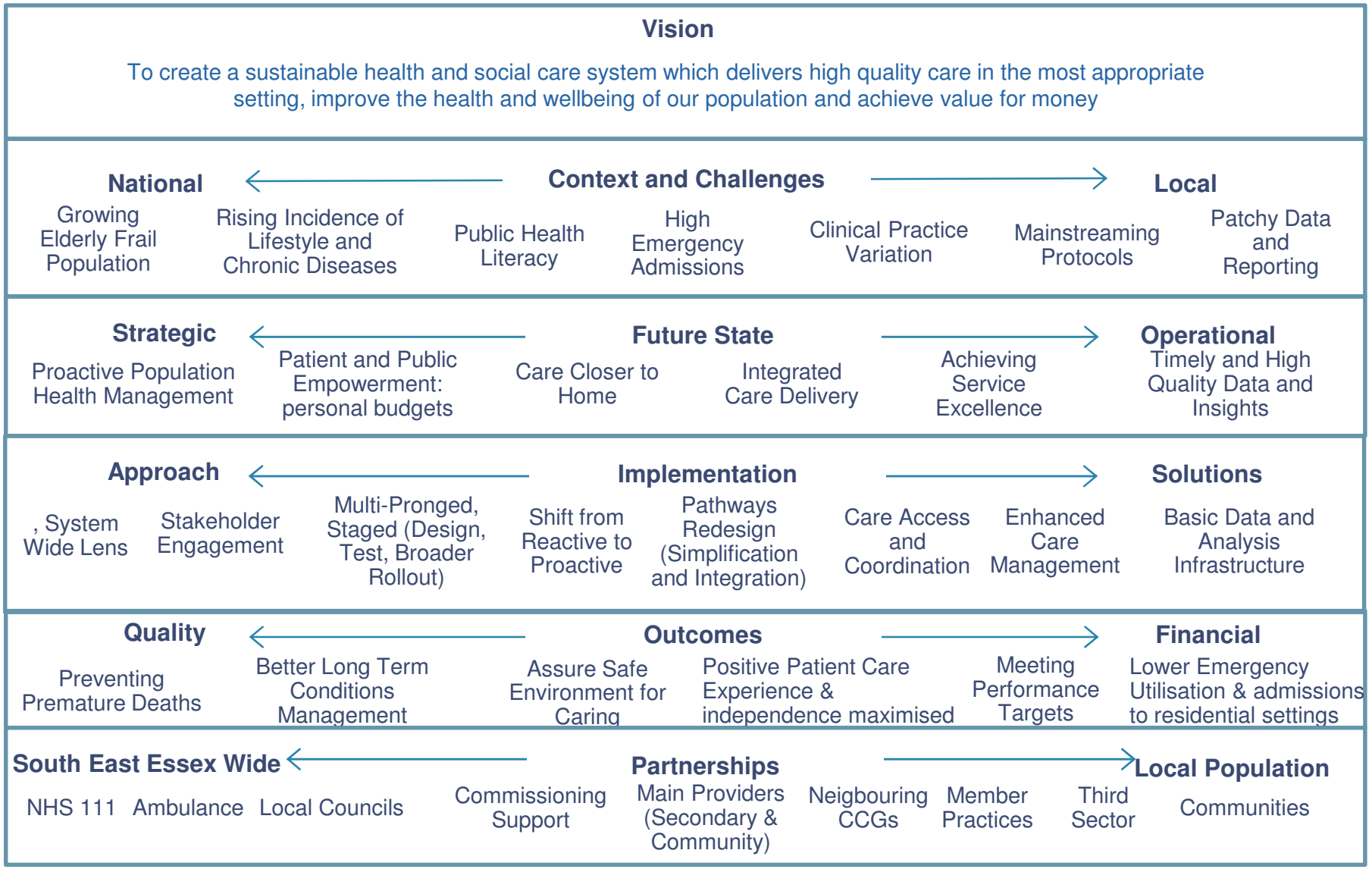
Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	18,645
	2014/15 Plan	18,399
	2015/16 Plan	18,111
	14/15 Change compared to 13/14 outturn	(246)
	15/16 Change compared to planned 14/15 outturn	(288)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	(356) To achieve the 3.5% reduction over and above planned

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Not yet
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Southend Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Yes

Executive Summary: Our Plan on a Page

Our plan on a page articulates the future vision for health and social care services in Southend, the context and challenges that are currently faced by the system and the planned future state which will focus on proactive population management care closer to home delivered in an integrated way. The plan identifies our approach to implementation and



Integration Agreement

Members of the Strategic Alliance:

Southend Borough Council

Southend Clinical Commissioning Group

Southend Acute Hospital Trust

South Essex Partnership Trust

Overarching Agreement

All have agreed commitment to the vision of a transformational change programme through a strategic alliance to deliver a step change in health and social care in Southend.

Primary Aim

Southend to be the healthiest town in England by 2020

Agreed Areas of Development

This will be achieved by commitment to the vision and supported by a willingness to see radical change in services to achieve better outcomes through integration and an agreement to manage risk collectively.

We will build on existing initiatives and trial new ways of working. This will include:

- Roll out the use of Caretrak for case finding,
- Risk stratification,
- Joint commissioning
- Development of Community MDTs
- Consistent use of the SPOR
- Pilot 7 day working across a range of services.
- Specific work on reducing admissions to institutional care to release social care and health funding
- Explore use of social work in A &E
- Integrated care record
- Targeted Public Health interventions e.g obesity programme, substance misuse
- Address key issues impacting on primary care provision
- Work through the challenges facing acute hospital sector in Essex
- Focus on prevention/recovery in Mental Health

Governance

HWBB supported by the JOG
Individual agency Boards

Chief Officers to meet monthly to troubleshoot and support the process

Department of Health - Informatics Support Visit Report

Wednesday 8th and Thursday 9th January 2014

WORK IN PROGRESS: DRAFT

Executive Summary

Integrated Care Pioneers are a ministerial priority, they aim to enable and drive change throughout the whole health and social care system. An issue has arisen which suggests that information governance is hampering rapid advancement by the Pioneer sites. In addition to the support NHS IQ is offering, Norman Lamb has asked for a team of experts to work with one Pioneer site [Southend on-Sea] to resolve issues and produce ministerial advice on how a solution could be achieved.

The DH Team and the Southend Integrated Care Pioneer [SICP] team undertook an intensive and productive face to face exploratory and evaluative dialogue over 1.5 days to produce this report. The contents were completely open and transparent to all participants.

SICP are correct in their assertion that there is not a legal basis for the data flows they were using and wish to use in the future.

SICP and the DH team have an almost complete specification of what is needed and how it is envisaged to work specified within this report, including steps SICP needs to undertake to improve its own information governance.

The DH team with strong SICP scrutiny and input have proposed a short and long term solution, which requires senior officer support. The extent to which both are extensible and generalizable to the other Pioneer sites remains to be tested in a workshop with or without further visits to other sites. The long term solution will require a new regulation under the section 251 of the NHS Act 2006.

The findings from this study also bring the need for further policy clarification in a small number of issues relating to the nature of controlled environments and accredited safe havens, the degree of local versus national data collection, and the criteria applied to objection considerations, which have further impacts on the role of the Health and Social Care Information Centre and the potential rises in burden and bureaucracy from local collections.

This study strongly suggests that information governance should not be an impediment to the advancement of integrated care pioneers if the proposals put forward are accepted. Two potential groups of issues may have an impact of the rapidity of advancement these are policy issues and the degree to which local information governance practice needs to improve to meet the standards expected.

Context

Integrated Care Pioneers are a ministerial priority, they aim to enable and drive change throughout the whole health and social care system. An issue has arisen which suggests that information governance is hampering rapid advancement by the Pioneer sites. In addition to the support NHS IQ is offering, Norman Lamb has asked for a team of experts to work with one Pioneer site to resolve issues and produce ministerial advice on how a solution could be achieved. This will be followed by a workshop including all 14 pioneer sites to share and disseminate findings and practice, as well as ascertain whether any significant issues remain outstanding and hence require a second site visit. The minister is fully involved and keen for this work to be completed early in the New Year, with a workshop for all Pioneers in either late January or early February

The Pioneer site visited was Southend on-Sea and involved representatives from Southend on-Sea Borough Council, Southend CCG, NHS Central Eastern CSU and PI Benchmark

Objectives

1. Describe in detail the issues, which are hampering rapid development of integrated care and highlight where and how information governance is a or the causative factor
2. Confirm or refute information governance as a causative factor
3. Where information governance is confirmed as a causative factor agree an issue resolution plan for immediate implementation OR
4. Formulate advice to the minister by which resolution can be achieved through governmental action
5. Where IG as a causative factor is refuted the visitors should signpost to a person or service to resolve the issue.

Working Practice

- The work took place under Chatham House rule so that full exposure of the issues could take place
- Inception; the owners of the issues are the local team, these were captured with a one to two sentence high level description and a one to two sentence quantification of why it is important to solve this issue.
- Elaboration of the problem space for all issues took place, this was through local description and expert team seeking clarification and explanation through a round table discussion
- Design of a solution or plan for getting a solution was undertaken by the Department of Health Team and then tested with local team to assure not only systemic desirability but practical feasibility
- Implementation will take place through the local team for refuted items or agreed resolution plans. Implementation will take place through the DH visiting team for issues which require governmental action
- Reporting of the outputs to support the objectives was undertaken by the DH visiting team and shared with all participants.

- If in an unlikely scenario there are any issues where there are unresolved fundamental differences of opinion a resolution plan using a trusted third party will be set.
- Specific local IT system issues are outside scope but general issues of standards etc are in scope

Timetable and Participants

These are set out in Appendix 1.

Exclusions

1. A general assessment of the proposal in general or information governance in particular was excluded
2. The report only focuses on the perceived information governance issues from the Pioneer site and nothing more.
3. Direct care other than that stimulated via risk management case finding is not highlighted because there are no information governance issues deemed to exist in this space and practice with regard to this domain is viewed as advanced. The site will be providing a one page brief on that situation particularly their award winning SPOR service. This is set out in Appendix 2

Inception

There was only one issue identified that was causing concern and that issue was risk stratification.[1]

The Southend on-Sea Integrated Care Pioneer site agreed with the common description of risk management as set out in the footnote.

The Southend on-Sea Integrated Care Pioneer site felt it was crucially important to be able to undertake risk management [all types] because it was an essential aspect of better commissioning to[2]:

- Identify high cost individuals whose care may need to be reviewed by the multidisciplinary team with whom they have a legitimate relationship
- Map the density of one or more pathologies, impairments, functions, services and events within services across their locality for example by [political] ward
- Identify those with abnormal or perceived abnormal outcomes for example emergency admissions for alternative interventions
- Commission new services in an affordable manner by identifying populations of clients with certain constellations of features
- Assess whether new services are having the desired effects
- Feed into the Joint Strategic Needs Assessment
- Provide health and wellbeing boards with the data they require
- Support service planning
- Produce emergency plans
- Underpin the locality strategic plan
- Enabling analysts to investigate the data and come up with new commissioning innovations

[1] Risk stratification tools can help determine which people in a population are at high risk of experiencing outcomes, such as unplanned hospital admissions, that are simultaneously: undesirable for patients; costly to the health service; and potential markers of low-quality care.

Also known as *predictive risk models,* these tools are used widely in the health and social care system, both for:

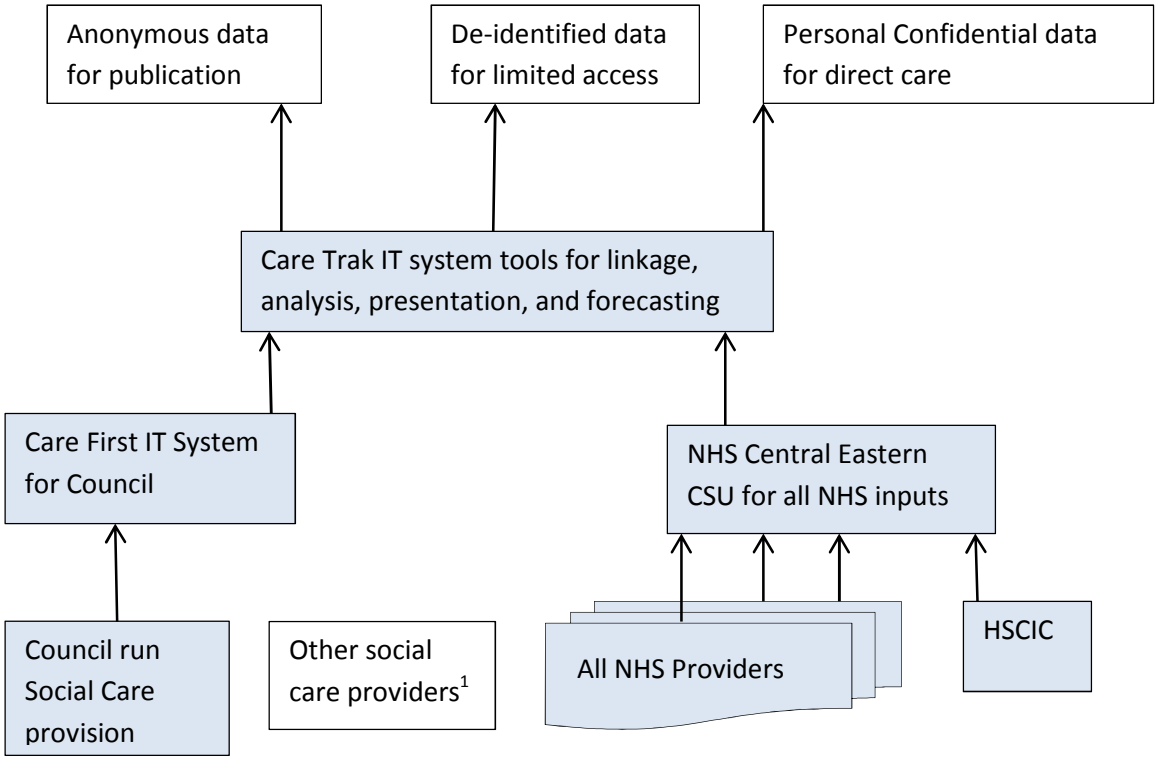
- analysing the health of a population ("risk stratification for commissioning"); and
- targeting additional preventive care interventions, such as the support of a community matron, to high-risk patients ("risk stratification for case finding").

[2] Please note this list was produced from the elaboration process over the first day of the visit

Elaboration

1. Information Architecture

   The information architecture described below emerged from the elaboration activity, it was not something that had been discussed at depth between the parties prior to the visit, but the parties were comfortable with it.



[1] The collection of social care provider data and how it would be used within the integrated care has not yet been considered in depth

It should be noted that the NHS are looking to the CSU for all their linkage, analysis, presentation and forecasting support. Social Care is looking to Care Track to provide the same. Within the integration Pioneer the Care Trak system is the preferred IT system with analysis being performed by CSU and Council staff with "super-user" [see later] rights.

ACTION 1: Southend Pioneer will confirm agreement of all parties to this model; Any changes to it especially direct flows from providers to Care Trak should be shared with the DH visiting team as it may affect the proposed solution

2. Types of data

   Three types of data emerged as needed within the Pioneer site:

   - Anonymous or aggregate data for publication, reporting and strategic planning
   - Personal confidential data which is only exposed to those health and social care professionals undertaking direct care and with whom the person [patient/client] has a legitimate relationship

- Patient level data, which is required for linkage and presentation for limited access which does not need to be identified, but may be identifiable. This could best be described as weakly pseudonymised or de-identified for limited access

3. Data Flows Previous and Aspirational

The first table below describes the situation which existed in the Southend on-Sea Pioneer site. This is not the situation now as the legal basis for the health flows was not able to be demonstrated and has therefore stopped, the social care flows continue as they are supported by the legal basis of consent [see 6 below]

A Table showing the previous data flows to support integration

Flows From	Flows to	Data Description	Identifiers
Community Provider [SEPT][5]	Care Trak	Community Events and activity inc. clinical data	TBC[1]
Mental Health Provider [SEPT][5]	Care Trak	Mental Health Events and activity inc. clinical data	TBC[1]
Acute Hospital Provider	Care Trak	Hospital activity data inc clinical data that does not flow to the HSCIC	TBC[1]
HSCIC	PCT and then to Care Trak	Data from the secondary uses service [SUS][2]	TBC[1]
GP Practice	Care Trak	Prescribing data and some clinical data[3]	TBC[1]
Southend Borough Council Care First IT system	Care Trak	Case Management file data of adults and children receiving social care involving events, activity, social care data and financial assessments[4]	TBC[1]

TBC[1] refers to the position that a detailed analysis of the identifiers has not taken place. This work will be done by the Pioneer site and the data sets provided to the DH visitors and presented in appendix 3. However it is believed that only NHS number, Care First unique ID, postcode, gender, age, and client type are the key identifiers that flow

[2] Excludes supersensitive data

[3] This was a one-off extraction and the staff member has moved on, the status of this extraction and its purpose is yet to be confirmed

[4] Only adult data flows and of those adults only those who have not opted out flows. {See section 6 re-those people deemed not to have capacity}
[5] It should be noted that SEPT does have a contract with PI the owners of CareTrak. This contract and activity is outside the integrated care pioneer scope, but may have a bearing on the information architecture hence action 1 on page 5

The table below sets out the aspirational data flows that the Pioneer site would wish to pursue. The reasons why they are wanted fall into three main groupings:

a. Risk stratification for commissioning
b. Risk stratification for case finding
c. Identifying care pathways and the type of individuals who travel them

Flows from[1]	**Flows through**	**Flows to**	**Description**	**Identifiers**
Continuing Health Care IT System in CSU	N/A	Care Trak	Assessment data on those receiving CHC	TBC[2]
SBC commissioned providers[3]	National Treatment Authority[3]	Care Trak[3]	Drug and Alcohol event, activity and clinical data[3]	TBC[2]
NHS 111	CSU	Care Trak	Event and activity data inc. clinical data from NHS 111 not onward flow services	TBC[2]
Out of Hours [OOH]	CSU	Care Trak	Event and activity data inc. clinical data from OOH	TBC[2]
Ambulance and Paramedic provider	CSU	Care Trak	Event and activity data inc. clinical data from OOH	TBC[2]
GP[3]	CSU[3]	Care Trak[3]	Event and activity data inc. clinical data in excess of care.data[3]	TBC[2]
Hospital Provider[3]	CSU[3]	Care trak[3]	Event and activity data inc. clinical data in excess of SUS/care.data[3]	TBC[2]
Any other qualified provider [health] commissioned locally	CSU	Care Trak	Event and activity data inc. clinical data	TBC[2]
Any other qualified provider [social care] commissioned locally[3]	CSU[3]	Care Trak[3]	Event and activity data inc. confidential data[3]	TBC[2]

[1] There is an assumption this data will be provided free in the volumes, scope and format as required, but it is understood that high level policy discussions are ongoing and data not flowing from the HSCIC ie direct from the provider may be subject to a charge

TBC[2] The absolute requirements have not reached consensus but must include NHS Number, some component of post code, some component of age, equality data, client type.

[3] There is more work to do within the Pioneer economy to properly specify this aspiration further than a very high level description

Action 2: The Pioneer will undertake further work to clarify the aspirational data flows and ensure it does not significantly change the information architecture

4. Dissemination
    a. Anonymous data
    It was expected that this would be put into the public domain but specifically would be targeted at commissioners and their support units for health and social care, public health, providers and the public.

    More specifically the data would be used for the Joint Strategic Needs Assessment, Strategic Plans and to focus clinical and service audit and to support Health and Wellbeing Boards.

    b. De-identified data for limited access
    This data would not be made public and access to it would be limited to certain individuals in specific roles for specific purpose under tightly controlled permissions [governance and contracts with liabilities and penalties]

    More specifically the data would be used to enable better commissioning, provision, scrutiny through the Health and Well Being Boards. Purposes may include:
        - Emergency planning [identifying the whereabouts of vulnerable adults who require early rescue service intervention]
        - Service review
        - Pathway re-design
        - Improved deployment of other services eg housing, police, fire
        - Identification of poor outcome cohorts who require at least a direct care assessment [see next section]

    c. Personal Confidential data
    This data would only be made available to a registered and regulated health or social care professional with a legitimate relationship with the person [patient/client]. There are three courses of action:

- A multi-disciplinary team assessment of the person's situation resulting in specific action by one or more members of the direct care team
- Direct action by the professional highlighted to the case management issue
- If the first two do not resolve the issue and/or highlight further issues individual funding requests or a bespoke commissioning plan may be needed. If PCD is required to be shared patient consent will be sought.

5. Potential new initiatives outside health and social care
   A number of scenarios were worked through which could potentially widen the scope of this data beyond the health and social care system for example involving police, education and other services. There was a clear consensus that there must be a legal basis for the data processing, consent was the favoured model to support both the common law duty and DPA when the type of data was personal confidential data or involved sharing de-identified data for limited access outside of the health and social care system in any agreed solution.

6. Legal basis for flows
   SBC established consent as the basis for enabling the flow of personal confidential data from their client IT system [Care First] to Care Track. They did enable a client opt out and automatically opted clients out if their family and/or care home manager deemed the patient not to have capacity. This involved 4000 clients each receiving a letter. There were some doubts about whether the recipients had been informed that their data was being processed by PI in the Care Trak system explicitly.

   Action3: The Pioneer will establish whether the clients were explicitly informed that the data processor was PI.

   In the world view going forward the scope of the data is not just the 4000 clients in receipt of services from SBC but the whole of the catchment population 175,000 and all health and social care data. As already alluded to the legal basis for flowing the NHS data and some national social care data is not apparent so the data has stopped flowing into Care Trak from the NHS.

7. Other
   a. Data Controller
      The Data Controller for the data within Care Trak appeared to have not been fully clarified. Care Trak includes health and social care data and super-users have access to both. The questions around who decides what happens to this data and who has access to this data produced some uncertainty. It would appear that SBC and the CCG and CSU may be data controllers in common.

      Action 4: The Southend Integrated Care Pioneer group will in the context of the above three actions establish and confirm Data Controller arrangements.

b. Data Governance and Contracts

There are two types of license to access the Care Trak data an "ordinary user" and a "super-user"

Super-users include the system administrator and can use all the tools and create dash boards from the analyses, organise presentations and produce forecasts.

Ordinary users can access the data down to patient level ie see the weakly pseudonymised data but cannot change anything.

Existing super-users and users in the current and previous situation have access to other information which makes full identification of the person [patient/client] possible for example SBC staffs have access to Care First so can cross reference either the Unique number or NHS number from Care Trak with those on Care First which have the full suite of identifiers present.

Action 5: The Pioneer team need to work through arrangements so that patient anonymity can be upheld in health and social care when using the controlled environment planned to be provided by Care Trak.
[This should use the experience and expertise of the CSU and any supplementary advice from the DH Visiting Team]

The table below describes the current and proposed license arrangements:

	Ordinary		Super-user	
	Now	Future	Now	Future
CCG	0	TBC	2	TBC
SBC	0	12 {panel Members]	4	TBC
CSU	0	TBC	2	TBC
SEPP	4	3	3	TBC
GP Practice	0	1 per practice =37	0	0

It was not clear whether the contract with PI for Care Trak fulfils the governance arrangements the Information Commissioners Office would like to see in place for de-identified data for limited access and as well as those set out in the "IG Toolkit". Additionally it was not clear whether the user licenses contain the liabilities and penalties which are also expected to be in place by the ICO code of anonmysation in the section on de-identified data for limited access.

ACTION 6: The Southend Integrated Care Pioneer group were going to establish sound data governance practices to assure patient anonymity. Phil Walker offered a teleconference support if so desired

c. Data Destruction Policy

Data appeared to be kept since 2008 so that trends could be observed it did appear that any data once inside the Care Trak IT system was ever destroyed

Action 7: The Pioneer team acknowledged the need for a data destruction policy and will establish one as soon as is practical

d. Research

The question of research had not surfaced within the Pioneer site as a serious discussion issue

There was a view that commissioning innovatory activity for people identified from risk stratification for case finding should be viewed as service improvement rather than research even when there is no evidence to support the service commissioned

Commissioning pathways of care was discussed on two occasions during the day, the theoretical desirability of commissioning an integrated whole set of events and activities for people with long term conditions was widely supported. The approach was twin track with a clear aspiration to have more of the second type within the Pioneer:

a) Trying to ascertain the pathway of care for individuals and then changing it as deemed necessary
b) Designing the pathway of care based on best evidence, commissioning it and measuring the variation from it and discussing reasons with the providers. There was also a vision on having a prime provider who worked with secondary providers to provide the whole pathway

Design: short timescale ~3 months

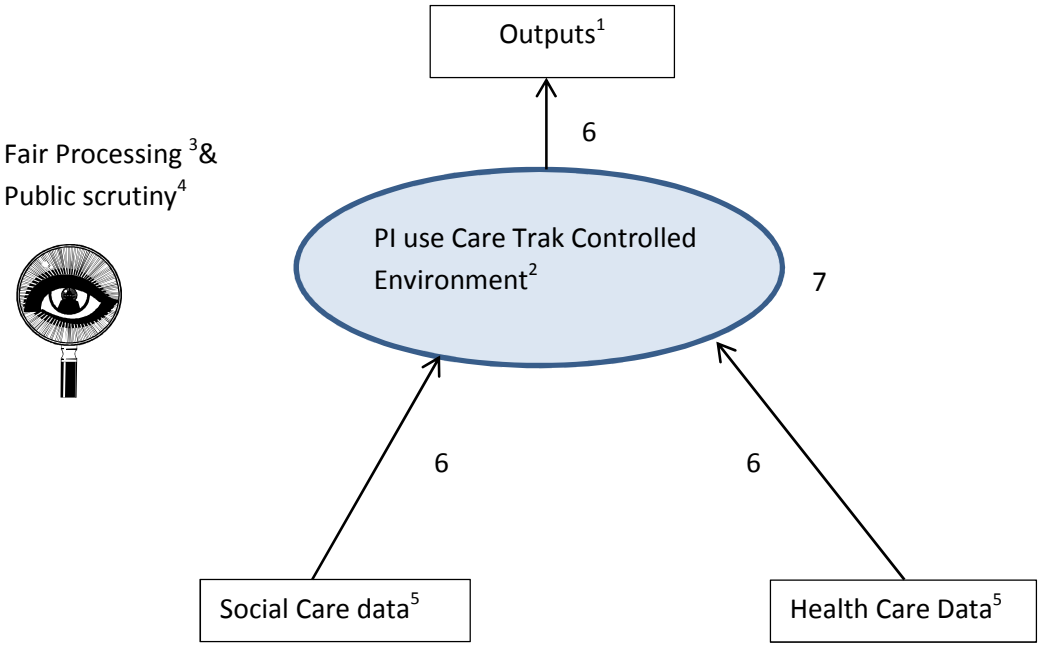
Assumptions

The current NHS England application to the Confidentiality Advisory Group is unlikely to be a successful model for supporting Pioneers as it only supports NHS organisations and data.

The proposal would support the core proposition as described in the preceding pages and diagrammatically represented by the information architecture

Additional data flows into Care Trak and from Care Trak that involve organisations outside the health and social care system would be dealt with by consent or a different legal basis to that described below

The Proposal



Explanation of Diagram	
1	Outputs will be diagrams, maps, graphs etc Age Bands, postcode stems, and NHS number will be only identifiers. NHS number will only be available to those with a direct patient care relationship with the patient or to people with the inability to re-identify and sound contracts/licenses to ensure it does not happen
2	Conforms to ICO and IG Toolkit Data Stewardship criteria set by HSCIC
3	A sound method of informing the public through multiple channels and by all participants should be in place
4	This proposal is a bespoke solution to SICP plus like Pioneers and therefore will need to be fixed term so as not to skew the market.
5	Input identifiers limited to NHS number, postcode, age, gender
6	Legal Basis of flow is a Section 251 approval
7	Data Controllers are SBC and CCG as data controllers in common

Design: Long term strategic solution ~14 months

a) Based on a new Section 251 Regulation
b) The regulation is supported by a clear policy which must include but is not limited to health and social care integration
c) Critically dependent on the ability to harmonise all the Pioneers requirements with regard to:
    a. Information architecture
    b. Purposes
    c. Scope
d) Conform to key policy decisions

Preparation

Leadership: Darren Sugg

Materials: SICP site report is available to participants before event

Attendees: Pioneers only each can have up to 3 people; an organisational leader, a professional leader, and an information governance leader

Venue: London

Agenda

1. Southend Integrated Care Pioneers: Our context and Issues [Presentation]
2. DH Visitors: Our analysis [Presentation]
3. Question and Answers
4. Group Working
    a. How do our issues compare with Southend?
    b. Is our context very different from Southend and if so does it matter?
5. Feedback and group learning
6. Proposed short and long term solutions [presentation]
7. Questions and Answers
8. Group working
    a. Would the short term solution work for us as is or with very minor tweaking?
    b. Would the long term proposal work for us, if not why not?
9. Feedback and Group Learning
10. Concluding Comments and Next Steps

Action Table

The single point of control for the DH visitors is Darren Sugg

Action	Page	Description	Responsibility
1	5	*Southend Pioneer will confirm agreement of all parties to this model; Any changes to it especially direct flows from providers to Care Trak should be shared with the DH visiting team as it may affect the proposed solution*	SICP[1]
2	8	*The Pioneer will undertake further work to clarify the aspirational data flows and ensure it does not significantly change the information architecture*	SICP[1]
3	9	*The Pioneer will establish whether the clients were explicitly informed that the data processor was PI.*	SICP[1]
4	9	*The Southend Integrated Care Pioneer group will in the context of the above three actions establish and confirm Data Controller arrangements.*	SICP[1]
5	10	*The Pioneer team need to work through arrangements so that patient anonymity can be upheld in health and social care when using the controlled environment planned to be provided by Care Trak.*	SICP[1]
6	10	*The Southend Integrated Care Pioneer group were going to establish sound data governance practices to assure patient anonymity*	SICP[1]
7	11	*The Pioneer team acknowledged the need for a data destruction policy and will establish one as soon as is practical*	SICP[1]
8	14	Darren Sugg will organise and Integrated Care Pioneers workshop ideally before the end of February	DS
9	N/A	Martin Severs will produce version 2 of the report and circulate DH team and SICP representatives via Mike Bennett. Please do not make the document public until advised to do so as commissioners of visit need to see and reflect on report	MPS
10	N/A	Phil Walker will brief Karen Wheeler and John Rouse and relevant senior colleagues	PW
11	N/A	Phil Walker will produce and lead on brief for Minister [Norman Lamb] with input from DH team	PW
12	N/A	Pending decisions PW will work with senior colleagues to progress short timescale proposal with a view of having proposal at March CAG meeting if proposal supported	PW
13	N/A	Clarify the level of public dissemination beyond participants	DS & PW

[1]SICP + Southend Integrated Care Pioneer

APPENDIX 1

Wednesday 8th January 2014			
Time (Approx.)	**Description**	**Attendees**	**Venue**
9:30 – 11:00am	Kick off Meeting/Presentation	Simon Leftley - SBC Mike Bennett – SBC Michael Barrett - SBC Paul Palmer - SBC Jane Marley – CSU Indiana Viknaraja – SBC Steve Downing – CCG Mark Golledge - CSU	Room 7.03, Civic Centre
11am – 12pm	Department of Health closed session	DoH Team	Committee Room 6, Civic Centre
12pm – 1.30pm	Lunch – **DoH Team**		Committee Room 6, Civic Centre
1.30 – 4pm	Joint Workshop	Mike Bennett - SBC Paul Palmer - SBC Michael Barrett – SBC Yvonne Campen - CCG Emma Branch – CCG Steve Downing – CCG Bill Wood - CSU Kashif Khan – PI Benchmark Mark Golledge – CSU (TBC)	[3]Committee Room 6, Civic Centre
4-5pm	(Department of Health closed summary session - if required)	Jane Marley – CSU (TBC) DoH Team	
Thursday 9th January 2014			
Time (Approx.)	**Description**	**Attendees**	**Venue**
AM	Room booked for DoH team (if required)	CSU/CCG staff available on site if required	[4]Bungay Room, Suffolk House, Baxter Avenue
12-1pm	**Lunch (Provided)**		Bungay Room, Suffolk House

Southend on-Sea Borough Council Simon Leftley – Corporate Director, Department for People Mike Bennett – Acting Group Manager, Performance & Systems Michael Barrett – Planning & Performance Manager Paul Palmer – Technical Team Leader Indirani Viknaraja – Data Governance Advisor **Southend CCG** Yvonne Campen – Deputy Chief Operating Officer Steve Downing – Head of Finance Emma Branch – Commissioning Manager	**NHS Central Eastern CSU** Paul Cook – Head of Information Governance – Essex & Herts Jane Marley – Information Governance Lead – Essex & Herts Bill Wood – Information Manager – Essex & Herts Mark Golledge – Head of Performance & Information **Department of Health** Professor Martin Severs – Health Care for Older Persons Chair of Information Standards Board & Professional Lead – Caldicott review Richard Wild – Director of Information Assurance

[3] Wi-fi access, flip chart/pens will be available
[4] Room booked all day. Wi-fi access, flip chart/pens will be available

PI Benchmark Kashif Khan – Business Analyst	Phil Walker – Information Governance Policy Lead David Riley – Dame Fiona's Independent Team Darren Sugg – Integrated Pioneer Lead Ming Tang – NHSE England

APPENDIX 2

The health and social care integration situation with regard to direct care highlighting the award winning SPOR service in the Southend Pioneer site

APPENDIX 3

Data Items that identify individuals which previously flowed to the Care Trak IT system

Health Research Authority

Confidentiality Advisory Group
On behalf of the Secretary of State for Health

Skipton House
80 London Road
London
SE1 6LH

Tel: 020 797 22557
Email: HRA.CAG@nhs.net

Darren Suggs
Integrated Care Team
Department of Health & Department for Communities and Local Government
Room 208
79 Whitehall
SW1A 2NS

05 August 2014

Dear Mr Suggs

Study title: **Southend on Sea Integrated Care Pioneer: disclosure of commissioning datasets from clinical commissioning group and social care datasets from Local Authorities to a local data processor(s), for the purposes of linking patient-level data in order to improve health and care services for the local population**

CAG reference: **CAG 5-05(a)/2014**

Thank you for your non-research application submitted for approval under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 to process patient identifiable information without consent. Approved applications enable the data controller(s) to provide specified information to the applicant for the purposes of the relevant activity, without being in breach of the common law duty of confidentiality, although other relevant legislative provisions remain applicable.

The role of the Confidentiality Advisory Group (CAG) is to review applications submitted under these Regulations and to provide advice to the Secretary of State for Health on whether an application should be approved, and if so, any relevant conditions. This application was considered on 24 July 2014.

Secretary of State for Health approval decision

The Secretary of State for Health, having considered the advice from the Confidentiality Advisory Group (CAG) as set out below, has determined the following:

1. An approval decision is deferred to enable the actions specified below to take place and an updated application to be resubmitted to an appropriate CAG meeting

Context

This non-research application from the Department of Health sought support to extend and build upon the NHS England risk stratification application (reference: CAG 7-04(a)/2013) to enable the linkage of social care data with risk stratified commissioning data sets as part of

integrated care. This set out the purpose of planning and assessing care interventions across health and social care needs for individual service users.

Support was requested until 31 March 2015 to cover the following activities:

1. Baseline application for one 'Pioneer' site (Southend) and supporting Commissioning Support Unit (CSU) and other data processor to receive information so as to undertake the indirect care element of risk stratification with future intention for remaining 'Pioneer' sites to be added once arrangements in place.

2. The existing Risk Stratification application (CAG 7-04 (a)/2013), from NHS England, enables the flow of a specified list of health datasets for risk stratification purposes with limited access to NHS numbers through an Accredited Safe Haven. This request seeks to extend this approach and to allow access to additional datasets based on consent (where practical) and fair processing with opt out arrangements.

The following links to pre-existing applications was noted:

a) CAG 7-04 (a)/2013 in that similar controls were indicated to be applied, and
b) Linked to data approved under CAG 2-03 (a)2013 '*transfer of data from the Health and Social Care Information Centre (HSCIC) to commissioning organisation Accredited Safe Havens (ASH)*'

Confidentiality Advisory Group advice

It was agreed that this was an important activity and there was a clear public interest in the overarching aims along with a clear, relevant, medical purpose. This integration was also considered to be an extremely important development. The CAG wished to express its thanks to the applicants for their attendance as this was found to be extremely useful in exploring further the detail of the activity. The discussions clarified that this was effectively a pilot activity that would be a baseline for further similar submissions for the remaining pioneer sites.

It was noted that a sub-group of the CAG had met in advance of the meeting with the applicants to provide informal advice prior to the formal submission. It had been advised that the application be clearly separated from the NHS England 'risk stratification' application where feasible, however, member feedback was that the Department of Health application seemed more closely aligned than expected and discussions had indicated that this separation had proven difficult to achieve. This was highlighted as the NHS England application is due for further review and clarification at the August CAG meeting, with the potential consequence that until clarifications are satisfactorily addressed by NHS England, this may prevent other applications progressing where they seek to lead on from these applications. Members also noted that due to similarity of purpose and core data items that the current application under consideration would need to comply with all of the conditions of approval in place for CAG 7-04 (a)/2013.

<u>Fair processing</u>

In particular, members noted that the pause around care.data had potentially changed the plan to utilise this campaign as the vehicle for suitable fair processing information provision. In light of the fact that any approval cannot be inconsistent with the provisions of the Data Protection Act 1998, members indicated that there should be a clear and consistent approach to satisfying this obligation in light of the issues experienced over care.data. Discussions indicated that there had been efforts to engage with stakeholders and Health Watch, some

engagement with GPs and leaflets were being developed to provide to patients via GPs. It was advised that discussions should take place with the Information Commissioner's Office to assess whether the proposed approach is likely to be consistent with the provisions of the Data Protection Act 1998, and the final opinion of the ICO provided back to the CAG. This was considered important as the understanding of the CAG was that only a small proportion of patients attend their GP so it was queried what steps would be taken to ensure knowledge of the activity reached the relevant population.

Patient objection

Separate to, but linked to the issue of fair processing, members queried what information on patient objection would be provided to patients; responses indicated that this was the responsibility of GPs however members felt that greater assurance should be provided that suitable mechanisms were in place. As this application was presented as a pilot, members agreed that this should be explored and a consistent approach applied with clearer information provided in the resubmission. Members also queried how patient objection would be managed if recorded at GP level, and how this would translate across into the social care environment with the resubmission addressing this aspect.

Information provision

Members raised a number of questions on the patient leaflet, including how patients would be made aware who the third party referred to was; attendees confirmed that this name had not been included due to potential re-tender in future, and it was advised that the public participation group should be approached to ascertain what could be appropriate.

Discussions on the practice letter confirmed that practice participation would be voluntary and members questioned the information that had been provided to practices. Concerns were raised over the phrasing of "national restrictions" that were understood to refer to the seeking of approval under the Health Service (Control of Patient Information) Regulations 2002, as not the most politic nor accurate of comments in terms of the privilege involved in processing information without patient consent and the common law duty of confidentiality, therefore review of this aspect was requested. The letter to practices also did not explain what data would be collected nor explain the extent of the datasets. The discussion indicated that a 'black box' technological methodology would be utilised where it would be pseudonymised upon landing and there would be no human intervention; it was advised that this letter be updated to make clear the precise scope of what was being requested and subsequent handling. It was also confirmed that GPs would be able to review social care data but social care workers would not be able to access GP data, and these restrictions should be specified within refined information. Members advised that while clearly some GPs were enthusiastic the letter would benefit from amendment in order to ensure that GPs were fully informed, that the upload would be understood along with the benefits, and to help discharge the GP responsibilities as data controllers. It was strongly advised that the LMC be engaged with to avoid any potential issues arising at a later date considering the extent of the data involved.

Data controller relationships

The ICO provided feedback that it would be advisable to map out explicitly within the application the data controller relationships for GPs and for the future so that there is no confusion or questions as other Pioneers join. It was indicated that there may be issues of joint data controllership so these should be clarified and set out for the avoidance of doubt. The ICO also provided feedback that the contract provided did not appear to meet the requirements of the seventh Data Protection principle, and advice should be sought from the ICO to ensure that it is likely to be compliant and a final corrected version submitted as part of the application.

Information items

Members noted that the dataset involved access to a greater number of data items than those set out in the NHS England applications. Discussions confirmed the rationale for this which members indicated should be updated within the application; the CAG also noted that the extent of data items clearly extended the proposals set out in the 'Caldicott2' Review Report in relation to commissioning activities so a clear justification should be specified in reflection of the discussions. Members also queried the scope of the datasets and it was confirmed that some of the datasets were national, while others were local; it was advised that these should be specified within the application, with clear separation on what was considered to be health and separate social care datasets.

Social care data

Linked to the information items point, members also queried which of the information items specified related to social care data, which was understood to be fully consented for the purposes specified within the application. This point of consent should also be clearly specified within the application; explaining when and how it was obtained and detail on what it covers. Members queried whether it explicitly covered the purposes specified within the application and requested that this be made explicit. Members also expressed uncertainty on how broad the definition of social care data was within the application; discussions clarified that social care data does not include activity data and data would be extracted from one source, therefore members advised that the resubmission should refine this section to capture the discussions, including, for example, that free text data would not be included.

Confidentiality Advisory Group conclusion

In line with the comments above, the CAG agreed that they were currently unable to provide a recommendation, and therefore agreed to defer providing their final advice to the relevant approval body to enable the actions specified above to take place via a resubmission so as to enable the minimum threshold in the Regulations to be achieved.

The following advice was also agreed to be provided back to the applicant:

1. The CAG strongly supports the purposes of this activity and encourages development of the application in line with the comments above to enable it to be reconsidered at the earliest applicant opportunity.

2. The link to the NHS England risk stratification application was noted. The applicants are encouraged to continue to work closely with NHS England due to the conditions of support applied to CAG 7-04 (a)/2013. Where clarifications and actions linked to the risk stratification application require a national solution, this should be explored; where solutions can reasonably be undertaken locally, in the absence of a national solution, these should be specified.

3. Members advised that there should be better use of public and patient involvement

4. There should be a better articulated integration of the health and social care environment and benefits from the patient perspective as it appeared to be heavily focused from a social care perspective.

5. The importance of transparency was highlighted as an overall theme and that the application should make clearer, to the patient, what is covered, particularly in relation to the fair processing leaflet.

6. The discussion covered a number of points of clarification; therefore these should all be incorporated into the revised application form.

7. References to the standards that would be applied was noted; members advised that these should be explicitly set out within the application due to evolving definitions and standards and to ensure this aspect was clear in future as the baseline application.

Please do not hesitate to contact me if you have any queries following this letter. I would be grateful if you could quote the above reference number in all future correspondence

Yours sincerely

Natasha Dunkley
Confidentiality Advice Manager

Email: HRA.CAG@nhs.net

Enclosures: *List of Members present*

Copy to: Dr Martin Severs, Mr Robert Shaw, Ms Dawn Foster, HSCIC
Ms Ming Tang, NHS England
David Evans, ICO

Reviewed documents

The documents reviewed are set out below:

Document	*Version*	*Date*
Application summary	-	-
Approval and CAG advice letter to NHS England – CAG 7-04(a)2013 '*Disclosure of commissioning datasets and GP data for risk stratification purposes to data processors working on behalf of GPs'*		23 January 2014
Southend on Sea Covering note	14/06/27	
ICO feedback and notes of CAG sub-group	14/06/27	
FORMATTED application – Southend on Sea		
Section R – embedded document		
Annex A Southend ICP visit 09 Jan 2014		
Southend caretrak 27-6-14 amended v2MT		
PI and CCG contract		
Applicant queries		
Letter data sharing 11072014		
Draft patient factsheet v 1		
SBC Sharing your information fair processing leaflet		
SBC Client Sharing information and agreement form from fair processing		
140717 Response to CAG query 2 diagram showing flows		
140715 10 Applicant Queries CAG DS at 21-7-14		

Confidentiality Advisory Group
Attendance at meeting on 24 July 2014

Group members

Name	Capacity
Dr Mark Taylor (Chair)	Lay
Professor Ann Jacoby	
Dr Kambiz Boomla	
Dr Tony Calland (Vice Chair)	
Dr Robert Carr	
Mrs Hannah Chambers	Lay
Professor Barry Evans	
Professor Julia Hippisley-Cox	(*Not present for item discussion/CAG recommendation due to declared conflict of interest)*
Dr Patrick Coyle (Vice Chair)	
Mr Anthony Kane	Lay
Professor Jennifer Kurinczuk	
Ms Clare Sanderson	*(Declaration only, no further action)*
Dr Murat Soncul	
Mr C. Marc Taylor	
Ms Gillian Wells (alternate vice-chair)	Lay
Dr Miranda Wolpert	

Standard conditions of approval

The approval provided by the Secretary of State for Health is subject to the following standard conditions.

The applicant will ensure that:

1. The specified patient identifiable information is only used for the purpose(s) set out in the application.

2. Confidentiality is preserved and there are no disclosures of information in aggregate or patient level form that may inferentially identify a person, nor will any attempt be made to identify individuals, households or organisations in the data.

3. Requirements of the Statistics and Registration Services Act 2007 are adhered to regarding publication when relevant.

4. All staff with access to patient identifiable information have contractual obligations of confidentiality, enforceable through disciplinary procedures.

5. All staff with access to patient identifiable information have received appropriate ongoing training to ensure they are aware of their responsibilities.

6. Activities are consistent with the Data Protection Act 1998.

7. Audit of data processing by a designated agent is facilitated and supported.

8. The wishes of patients who have withheld or withdrawn their consent are respected.

9. The Confidentiality Advice Team is notified of any significant changes (purpose, data flows, data items, security arrangements) prior to the change occurring.

10. An annual report is provided no later than 12 months from the date of your final confirmation letter.

11. Any breaches of confidentiality / security around this particular flow of data should be reported to CAG within 10 working days, along with remedial actions taken / to be taken.

Expression of Interest - Health and Social Care Integration Pioneer

Southend on Sea

1. Introduction

This expression of interest outlines Southend's case for becoming a Health and Social Care Integration Pioneer and covers the geographical area served by Southend-on-Sea Borough Council. It has been jointly prepared by Southend Borough Council and Southend Clinical Commissioning Group and is endorsed by key local stakeholders, including South Essex Partnership University NHS Foundation Trust (SEPT)*. **Southend's Health and Well Being Board is fully committed to, and has authorised, this bid.**

Southend's well established culture of responsive partnership working forms a vital backdrop to this expression of interest. Local public, private and voluntary sector partners collaborate frequently and successfully, jointly investing in the borough and making sustained improvements to services. Health and social care partners in particular have an enviable record of innovation and service integration. This means that we are perfectly positioned to make changes at the scale and pace required of a pioneer. We also know that Southend's densely populated and compact size lends itself to a localised, issues-focussed approach to integration work whilst at a scale that can make a real difference. In particular Southend has a number of characteristics that are particularly relevant to the pioneer role. We have;

- an impressive and demonstrable track record of delivery
- a history of innovation and sharing of good practice, both at a local and national level
- strong, well developed and sustainable local partnership working
- the ability to move at scale and pace
- affiliation with the Whole Essex Community Budget.

2. Background

Meeting local need is increasingly challenging

Southend on Sea has significant health and social care challenges. Compared with the England average the health of the 174,000 people that live in the borough is mixed. Deprivation is higher than average, resulting in 7,900 children living in poverty. The rates of violent crime, long term unemployment and drug misuse are higher than the national average. Life expectancy is around 9 years lower in the most deprived areas when compared with the least deprived areas. Around 18% of our year 6 children are obese, as is nearly a quarter of the adult population. The rate of hospital stays for alcohol related harm is worse than the England average and currently 5.3% of adults require and receive support from social services.

Local demographics and old ways of working are adding pressure

Perhaps the most significant challenge is our ageing population. Frail elderly people over 80 make up 9.8% of the population, far higher than the regional average of 7%. There are over 9,000 patients in the CCG area over the age of 75 whilst 18% of the population are over 65. There is a predicted increase of 5% for those aged over the age of 85 by 2020. A high number of these patients are burdened with long term conditions and social issues which require support. By 2015 we forecast increases in the numbers of people suffering from stroke (9.46%), diabetes (12.46%), CHD (9.1%), hypertension (4.5%, but already at 29% of the patient population) and COPD (11%). The number of people with Dementia is predicted to rise from 3,300 people to 5,098 by 2017.

The demographic data paints a stark picture of need, dependency and service utilisation. It is clear that without proactive needs based planning centred around case finding, prevention, crisis

response and rehabilitation, Southend is facing a demographic time bomb over the next 5 years. Against this backdrop we have the challenges of drastically reduced public sector funding. For example Southend Council is in the third year of a four year programme to reduce spending by £59.9m whilst seeing a growing demand for mental health, learning and physical disability and children's services. Other partners face similarly bleak financial pressures.

In response to this we have made real progress in stripping out waste and duplication from the local health and wellbeing infrastructure over recent times. Our interventions have yielded better outcomes and efficiencies for local people. But partners are agreed that there is scope for more change and are determined to see through the next stage of our reforms. We are unanimous that an integrated partnership approach is crucial if we are to manage the financial & demographic challenges in Southend.

So, we are on a journey of integration

Improving collaboration and integration of health and social care has been a driving strategic imperative for Southend's partners for some time. Our primary focus is very much on personalised care, something we are aware many CCGs and health partners have not prioritised as highly. For us personalisation is imperative. By giving people control over their lives, through the ability to decide how their support needs are met, we allow them to gain independence and exercise as much real decision making as possible. Evidence shows outcomes are improved when people have been actively involved in decisions about their care. And we know that individuals are often better equipped than the public sector to use resources in creative ways to achieve results. We do not see conflict between personalising care and driving up outcomes – in Southend we aim to deliver both.

3. Our journey so far

Innovative health and social care integration is not new in Southend

In 2009 Southend Council set out, and broadly delivered, an ambitious blueprint for transforming social care. It defined a structure and model of the future state of social services, the key drivers for change and what this change would look like. A focus on innovative and collaborative working with health partners was a central plank in this and since then the Council has worked with determined partners to bring about the blueprint. Southend CCG has, alongside its own ambitions, developed a linked integration strategy to help drive this work ahead. GP's and local people have been actively involved in the process of shaping the CCGs three key priorities of integration, personalization and quality care first time.

The separately realised, but consciously linked, ambitions of local partner organisations are brought together in Southend's Joint Health and Wellbeing Strategy which majors on integration as a key cross-cutting principle. The strategy, and resulting action plan, is owned and driven forward by a committed and highly engaged Health and Well Being Board. In developing a joint approach to integration, local partners have aligned their separate organizational strategies so that they;

- listen to the voice of people who use our services
- share a vision about the priorities for local services
- commit to continuing development of integrated work
- reflect the Joint Strategic Needs Assessment (JSNA) for the population of Southend
- contribute to the wider vision for communities shared with partner commissioners
- shape other local commissioning plans to enable integration of services and pathways
- integrate planning so that local resources are used to better effect.

Southend's major health and social care players agree that further integration is crucial. Perhaps the most compelling and tangible evidence of this joint belief are the many initiatives that we have conceived and driven forward together over several years. In short we have rolled up our sleeves

and are already delivering on our long term plans.

We have a track record of effective, practical and respected integration work

A strategic programme of joint work, combining focus, resource and thinking across key partners, has allowed partners to drive forward a range of integration initiatives. These include;

Community level multi-disciplinary teams – that bring together dementia nurse, CCG clinical leads, ambulance service, admission avoidance, consultant geriatrician, therapists and our single point of referral team to co-manage local delivery.

General Practice level multi-disciplinary teams – which allows GPs, district nurses, community matrons, social workers and community healthcare specialists to meet regularly to focus on case management and risk stratification. They collaborate with the acute and community trusts and develop pathways to manage patients with chronic long term conditions. Unlike other models there is an overarching specialist clinical model through links with Southend hospital.

Integrated Locality Teams – that align community nursing services to social care teams.

Integrated services and pathways – that streamline and ease patient and user journeys in areas such as chronic obstructive pulmonary disease (COPD), MSK and Diabetes.

Single Point of Referral – A SPOR for professionals has been established with the aim of reducing avoidable admissions to hospital and reductions in the delayed transfers of care, increasing the numbers of people being referred for and accessing re-ablement services. Since the SPOR became operational, and functioned as the referral point we have seen a continued improvement in the outcomes of those people who undergo re-ablement in an increase in their independence. This is reflected in a reduction in the size of care packages.

Joint work on preventing delayed discharge – partners have worked fruitfully together in this area against a challenging background. Statistics show major improvements. We are held up as best practice national and team have been asked to share learning.

Collaborative Care – a service where social care and community healthcare services work together to deliver intensive re-ablement services. It has significantly reduced admissions to hospital, long term residential care and the need for large care packages.

Streets Ahead – The national Troubled Families programme, has been radically re-engineered in Southend to allow agencies, voluntary sector and communities to work collaboratively to support families with complex needs. Partners have re-evaluated their service delivery to deliver better and more cost effective outcomes. So far we have successfully engaged with over 170 families, most of whom are working to address inter-generational health and social challenges for the first time.

Connected Care – a behavioural change programme that assists the ageing population to manage their long term conditions. It promotes patient self-management and has reduced urgent care admissions.

We have listened, engaged and brought local people with us on the journey

We are clear that listening to what users want from us is crucial if services are to be fit for purpose. We view the people of Southend as essential co-producers in the development of new ways of working. Use of National Voices 'I' statements has been central to this thinking and this has allowed us to engage with people in a new and refreshing way. Patients and service users have comprehensively used 'I' statements to articulate their expectations and this information is now fundamentally influencing our service redesign intentions. We recognise the intrinsic value of this approach and will seek to further embed the Narrative into our daily approaches. So far people have told us that they like what we have done to create more seamless services. Naturally we understand that their focus is on the immediate quality and ease of support rather than the infrastructure that sits behind it.

Partners, communities, public and patients regularly come together to set and develop priorities and

influence processes. In doing so, we continue to develop a clear picture of local need and the desired future state. VCS organisations are key partners and also play an important role in providing access routes to opinion and feedback. Recent examples of successful engagement methods include;

Deliberative sessions– set up to focus on hot topics, such as preparation for Healthwatch, joint provision of mental health services, new pathways of care and holistic approaches to supporting carers.

Direct engagement - with specific groups, such as the Older People's Assembly, to discuss the future of services that support people over 50 maintain health and independence; with people with learning disabilities; with carers/family, advocacy groups and other partner organisations about the choices people have over their daily lives.

'Come and tell us' events – high profile events in our major shopping centres using creative methods, such as drama, dances and personal challenges.

Consultation and focus groups – service users are engaged on a wide range of topics, ranging from their experience of services to specific discussions, such as the content of the Local Account. Our most recent consultation focussed on supporting people with physical or sensory impairments get the most out of life.

And we have backed up this work with sustainable and effective systems of information and finance management

We know that successful delivery on the ground is not enough. Governance is important in allowing us to baseline, evaluate and understand the impact of our efforts and to control and develop our work. Here are some key examples of our governance arrangements.

Year of Care Pilot - In 2011 Southend successfully secured one of 7 national pilots to support health and social care teams to integrate care in a more sustainable way by better aligning the funding flows and incentives with peoples' needs. The aim of our funding model is to improve outcomes and deliver a more effective use of resources by shifting the focus away from episodic, activity driven funding flows towards person centred care, irrespective of organisational boundaries.

Caretrak – a jointly commissioned health and social care information system that integrates health and social data care which maps individual patient's journey and spend. Southend was the first area nationally to launch such a system. It provides accurate information for caseload risk stratification to multi-disciplinary teams and at a strategic level assesses the impact of collective commissioning decisions, enabling decision makers to identify the evidence in support of transformation of social care. This includes the impact of personal budgets in social care and average spend per patient. Caretrak has proved to be a robust, timely and cutting edge data management tool. Phase 2 of implementation will see the inclusion of community services data.

Personal budgets - Personal budgets have been the focus of significant resource over the last few years. We have adopted this method of providing support to all community based service users as a means of giving the individual the choice and control over what and how support is obtained. We are seeing service users make good use of the resources to hand and are looking to maximise the benefits to them. For example, over 2012/13 we have had a number of MH service users take a one-off payment in order to buy a bicycle or gym membership. Getting out and about and taking physical activity have positive benefits on many mental health conditions.

Southend's Health & Wellbeing Information Point (SHIP) website – Launched in February 2012, SHIP provides information about health and social care services in an easy-to-search on-line directory: www.southendinfopoint.org The site includes information about a range of services and opportunities that help people enjoy independence at home and in their community. So far 700 local services are listed, service providers can manage their own records, visitors can 'rate and review' a service. Staff regularly use SHIP as a tool to signpost people to community services. In May 2013 the council launched a local PA (Personal Assistant) Register which

connects those needing support with people who provide services.

Partners have also been carrying out far-sighted organisational restructuring. The Council has reorganised its directorates for improved efficiency and better cross-service working whilst absorbing public health responsibilities. The Council and NHS have also implemented locality working with the NHS for services for older people and people with a physical and sensory impairment. Phase 1 in July 2012 saw the restructure of care management teams into generic locality teams that are co-terminus with CCG boundaries. Phase 2 will explore opportunities for close alignment/integration with CCG. Southend CCG has a carefully designed operational structure which makes best use of local expertise and knowledge whilst ensuring a clear route for people's voice.

Our successes have been built on solid and sustainable foundations

Genuine and productive working relationships A culture of mutual respect and understanding of each other's viewpoints has been built over many years. This allows for candid, challenging but always constructive conversations. In this atmosphere partners are often able to find consensus on seemingly intractable and long standing issues. The agreement of a Joint Mental Health Strategy across Southend, Thurrock and Essex County Councils plus 4 separate CCGs, for example, is testament to our determination to leverage the maximum benefits from joint working. Already, these partners are actively exploring pooled budgets and integrated commissioning.

A track record of pathfinding and innovation Partners in Southend have an appetite for thinking big and taking carefully calculated risks. This has seen us lead the country in many aspects of integration work. For example;

- Our Multi Disciplinary Teams were established before most parts of the country.
- We were first in the country to develop an integrated information system (Caretrak) and are pioneering high quality data management.
- We were one of only 6 national pilots for the Department of Health Year of Care Pilot.
- We are considered national best practice for managing discharge.
- We are a regional award winning pathfinder for a range of commissioning schemes and service developments such as SPOR and Admission Avoidance Cars.
- We are a National Pathfinder for patient Public Involvement.
- We have a notable national profile, for example recent coverage in the HSJ and the Guardian profiled our work on integration and the unplanned care agenda
- We participated in the Kings Fund desktop review for Integrated Working .
- We are East of England leads on integrated locality working.
- Southend Council was awarded LGC Council of the Year 2012, in part due to a track record of excellent partnership working.
- We are joint partners with Essex County Council and Thurrock Council in the Whole Essex Community Budget and have played an active part in the development of the Integrated Commissioning workstrand.

Importantly we can evidence how we have shared all of this learning with peers and stakeholders. Our doors have been, and will continue to be, firmly open to those that we can help and innovate with.

A grounded approach We have consciously taken a bottom up approach to the development of our integration work. Front line staff, operational managers, GPs and communities have all played a crucial part in designing and shaping new approaches. This means we know that our new ways of working are eminently workable, pragmatic and sustainable. And, perhaps more importantly, we know that the staff that make them work from day to day are committed to them.

4. But we know there is more to do

We have a clear vision of our where our integration work will take us.

Over the next few years we will continue to transform the local health and social care landscape in Southend . In doing so we will be guided by two main principles;

- **we will place the needs of people, and their carers, at the centre of our thinking, by truly understanding what integrated care and support looks like from an individual's perspective (through use of National Voices narrative)**
- **we will take a 'whole age' perspective so that the people's needs, from child to old age, lead our planning.**

So far we have made real and sustainable progress on improving care pathways, developing the way that we collectively use information, shifting our focus to preventing high cost care and better husbanding our resources. Therefore we will sustain momentum and **accelerate our integration journey** by playing to these strengths. Our combined vision is to deliver fundamental and far reaching changes, by 2018 or earlier. The tables below summarise our ambition.

What	By when
Better integrated services and better access to them • Services will be co-designed with patients and users to be more flexible and resilient • A wider range of providers, including those in housing and children's services, will be involved in delivering integrated services • Integrated health and social care teams will be wrapped around the individual and their family • There will be choice at every stage of the pathway • Wherever possible primary, social and community staff will work in integrated teams • Services will be responsive and able to flex to meet, and where appropriate, reduce the demand for urgent care at our local hospital • More specialist teams will be based in the community • A Single Point Of Referral will be the norm • There will be one route of route of access for all unplanned care	2013 ↓ 2016

What	By when
Better integrated information and knowledge • Multi-disciplinary teams will routinely use data to proactively manage the highest risk people • There will be universal joined up information and advice available for all individuals, including those that self assess or self fund. This includes a single, accessible directory of services • We will have uncomplicated pathways that are easy to understand and access • We will routinely risk-profile patient and service users across health and social care • We will have more effective business processes and systems that support mobile working, electronic care records, and common assessments • We will have comprehensive real time financial and performance information about health and social care so that we can monitor the financial impact of people's journeys through our systems • There will be a single integrated set of data across health and social care	2013 ↓ 2018

What	By when
A renewed focus on prevention and individual responsibility • There will be an increased emphasis on people that are able to take more responsibility for their health and wellbeing • Hospital specialists will proactively manage the highest risk patients • Prevention programmes will increase significantly. For example telecare and telehealth will be rolled out so that people are better supported to live in their own homes with less risk • Housing, with appropriate care and support will be an integral part of the care package available to users • Individualised budgets and direct payments will be widespread • Services will be able to be purchased and controlled directly by the individual to meet their need	2013 2016

What	By when
Better use of resources through joint planning and commissioning • We will have joint commissioning strategies that balance investment in prevention, early intervention and re-ablement with intensive care and support for those with high levels of need • Partners will have agreed the respective investments needed to get the best value for money from the local health and social care economy • Resources and buildings will not serve as a constraint on the provision of individual services • Staff will be able to access systems, resource and information from any partners building (data protection withstanding) • Staff will be co-located and will work in fit for purpose buildings	2013 2018

What	By when
Better understanding of local people and their experiences • New ways of measuring people's experiences of integrated care and support will have been developed, tested and adopted • A comprehensive and collaborative public mobilisation and community development campaign will promote concepts of self responsibility and prevention • People and communities in Southend will feel an increased level of community cohesion and pride of place • People will be better equipped and motivated to help themselves (through a range of asset based community development interventions) • The social and physical capacity of the community and voluntary sector will have been significantly increased. This will be sustainable • Partners will have significantly reduced cost to the public purse and redeployed resources	2013 2016

We recognise that we must take a whole-systems, big picture approach to bring about our vision. This means identifying, and convincing a wider range of partners to join us. And then helping them to realise that, in principle, no silo is protected, no budget ringfenced and no structure out of scope.

Through previous work on Total Place and Community Budgets we know that full organisational and financial integration is the pure and logical final stage of this process. But this may take many years, if at all, to come about. For us the real value is in the immediate benefits derived from the outcomes achieved during the journey. And this is where we will deliver both short and medium term learning for pioneers, national partners and wider stakeholders.

We have learned from, and will continue to work with, partners on the Whole Essex Community Budget

As a Unitary authority situated within the Greater Essex boundary, we are currently working with Essex County Council, Thurrock Council and Essex wide partners in health, public safety, VCS and probation, on aspects of the Whole Essex Community Budget (WECB). Because of this there is tangible commitment to better integration and service redesign in health, social care and many other areas. Positive outcomes are already beginning to emerge. As a committed signatory to the WECB we are clear that valuable innovation may come from this project. Indeed, most key partners have already invested resource, time and thinking into the community budget initiative.

We are fully committed to commissioning and delivering integrated care solutions beyond Southend's boundaries where it is demonstrated that this is the most effective approach. However, local partners in Southend are clear that any proposed changes to existing services resulting from WECB must first satisfy a simple question; 'Is this change in the best interests of Southend citizens?' For example Southend's GPs tell us that a very convincing business case would need to be made to demonstrate that our local communities would not be disadvantaged before any Essex-wide 'one size fits all' model of primary care were adopted locally. This stance is generally replicated throughout our local partnerships. Should Southend become a Health and Social Care Integration Pioneer we would be able to offer national partners and Pioneers an insight into this fascinating dynamic as a valuable source of learning.

Achieving the best outcomes for individuals, and ensuring the best use of resources, requires models and solutions of integrated care that demonstrate flexibility. This means identifying what elements of the system are best managed and delivered beyond administrative boundaries and what elements are best managed and delivered locally. We have continuous discussions with our partners across the South Essex health and social care economy to identify what parts of the system may require a broader geographical approach – e.g. South Essex or Whole Essex – and how this might best be facilitated.

5. What we will do next

Pioneer status will allow us to accelerate our journey.

We will take forward both our legacy projects and new projects with energy and focus. Firstly we will build on the successes of our existing work, by;

- Reaping further benefits from SPOR by further simplification of access and establishing a single route of referral
- Rolling out further multi-disciplinary teams – for example by developing practice level MDTs to single-handed-GP population (50% of population) and targeting re-admissions
- Leveraging even more benefits from Caretrak by enhancing its strategic analysis functions
- Taking forward the Year of Care pilot work by focussing on two areas, the development of shadow currencies for an LTC Year of Care and the testing of a concept that considers post acute Recovery, Rehabilitation and Reablement. We will develop, shadow and monitor a currency for patients with long-term conditions and develop a contracting and commissioning framework for local use in 2013/14. We will also test the RRR concept to establish whether funds can be liberated from within national tariffs (HRGs) to support rehabilitation and re-ablement services.
- Developing integrated locality teams and pathways – through joining existing health and social care teams and piloting new pathways for stroke rehab and intermediate care beds.
- Developing further community based specialist services that avoid the need for a hospital referral or more expensive forms of care.

However we will also open up major new areas of exploration. These will include;

- Developing a broader 'all ages approach' to integration work, thereby engaging and mobilising a wider range of partners in our work. Key partners will include children's services (particularly aspects of SEN, CAMHS and Troubled Families) and housing (particularly around home from hospital services, enhanced adaptations and home settings)
- Stepping up our ambition for service integration. In particular we are exploring options to leverage improved joint working from Learning Disabilities and services working with Frail Elderly. These areas are relatively untapped at present and we know we will be able to yield a number of quick integration wins.
- Improving the engagement of the third sector in our integration work
- Deepening our understanding of individuals perspectives through use of 'I' statements and truly effective engagement techniques.
- Additional work to ensure individuals feel empowered to take control of their own lives, treatment and care.
- Further, and more radical, collaborative commissioning for best value.

With Pioneer support we will accelerate at scale and pace

As well as contributing to the national knowledge base we also anticipate that national partners, experts and fellow pioneers will be able to help us explore the potential for specific pieces of work. These include development of our information sharing and data systems, broadening our stakeholder base and meeting the challenge of shifting the focus from an over reliance on acute care.

This last point is a good example. Whilst our work on integration has demonstrated improved outcomes in a number of areas, a particular local challenge is the increasing demands being placed on our local hospital for urgent care. The hospital is seen as a default for health care by the local population and attendances for urgent care continue to rise, resulting in many patients waiting more than 4 hours to be seen. As well as developing robust integrated community services to reduce demand, we will be looking to the pioneer pilot for support to work with our patients and public in making that more difficult cultural shift to reduce urgent care demand.

A dedicated account manager, skills matching and expert analytical work would be much valued and utilised. The kudos of becoming a pioneer, and the uplifting and invigorating positive effect that this would have on our partnership culture and rate of progress, should also not be underestimated.

We will drive out tangible efficiencies.

Our primary focus is on delivering better outcomes and experiences for local people. We will demonstrate that the public are better informed about where they can go to get the best information and advice about their care and support needs. And that they have higher levels of satisfaction with the support they received. But we also have a clear focus on using the public pound to best value. So, as this work progresses, we will regularly show that;

- service performance has improved
- joint planning has been able to apportion costs and benefits across the whole system
- cashable savings have been generated and then released for reinvestment.

Advances in IT will help us make the most of this unprecedented opportunity - we will have the data systems to measure and track our progress. Evidence of the above will be provided to the pioneer network, alongside rationale and analysis of how these results have been achieved.

6. How we'll make it happen

Now is the ideal time for this change

Recent reforms to national health and social care systems provide us with new opportunities to take

forward our local agenda. We are capitalising on these through improving our alignment and working practices wherever possible. We will, of course, continue to engage Government on what freedoms and flexibilities we need to drive forward our integration ambitions. We acknowledge that Government is demonstrating commitment by setting up the £3.8bn integrated care fund (announced on 27 June) and are pleased to see that this effectively increases by a further £2bn the current level of annual NHS resource allocated to social care – a strong sign that Whitehall is serious about integration. We view Southend's Health and Wellbeing Board as the central piece of architecture to influence and rally partners and local people. It is already providing a strong sense of leadership and sense of purpose in Southend.

But we will put in place further robust governance to oversee and scale up our integration work

Pioneer work will form a central strand in the workstreams overseen and driven by Southend's Health and Wellbeing Board. A Pioneer Strategic Group will be established to provide programme direction whilst an operational level Pioneer Delivery Group will meet regularly to establish a costed delivery plan to make day to day, ground level interventions. The Strategic Group will report quarterly on progress to;

- Southend Health and Well Being Board
- Southend CCG Governing Body
- Co-Pioneers and national partners

A particular focus of the Pioneer Strategic Group will be to work with national partners to develop new ways of measuring people's experiences of integrated care and support. Executive sponsors from each organisation will be identified.

7. How we'll help others on their journey

We will work fully, openly, honestly and enthusiastically with national partners, Pioneers and others to develop and share our ways of working and co-produce new approaches to shared challenges.

As we have shown, Southend is considered an integration exemplar in some fields. Our reputation as a go-to area has been established on our willingness and ability to share best practice across partners. We are also visibly committed to a culture of continuous improvement. For example, as national leader on data management, we are already talking to other upper tier authorities about plans to collaboratively develop Caretrak as a powerful diagnostic modelling tool.

We will offer our learning to national systems and processes, using case studies, workshops, peer to peer networking and other methods of dissemination. Areas of innovation continuously arise and we will participate fully in contributing to, and growing, the Integrated Care and Support Exchange (ICASE). We will work closely alongside peers, national partners, training bodies and leadership organisations to promote lessons for wider, rapid adoption. We are particularly keen to work with fellow pioneers to evaluate the medium and long term national impact of integration.

We hope that this Expression of Interest will be received favourably.

For further information, in the first instance, please contact Ade Butteriss, Southend Borough Council adebutteriss@southend.gov.uk **(01702) 215187**

**** Statement from Dr Patrick Geoghegan, Chief Executive, SEPT – June 2013***

I am delighted to support both Southend Borough Council and Southend CCG in the bid to be an Integrated Pioneer Site. As a provider organisation we have excellent relationships with both the Council and the CCG and work very closely together in pooling resources both from a commissioning and provider point of view so that we can enhance the services we provide to our local communities. We have developed a number of initiatives such as single point of referral, integrated teams for care of the elderly and many other projects of which we are seeing real benefits to some of the most vulnerable people who live in our society. We believe that we are in a very strong position to become an Integrated Pioneer Site and SEPT will play its full part in translating this into action.

Southend University Hospital NHS
NHS Foundation Trust

The Perfect Week

Sue Hardy - Chief Nurse /
Deputy CEO

Perfect Week

Our aim was

to improve performance and produce a step change in safety and patient experience

What happened in Perfect Week?

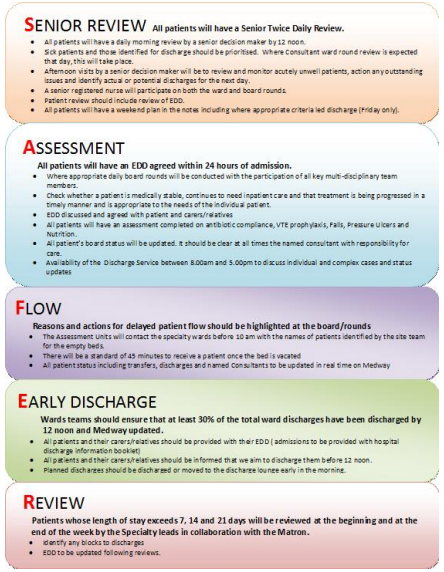
Action: *For one week all staff groups will work together to get patient care right by identifying and solving problems in patient flow*.

- We had 93 WLOs along with bronze, silver and gold commanders who between them gathered 972 issues
- 197 issues resolved in one week by WLOs alone
- Staff from all non-clinical areas, all business units and wards worked together

Action: *To ensure right care, right place, right people, right time, every time.*

- We introduced the SAFER bundle and focused on early consultant review.
- We met with 90 consultants to talk about the SAFER bundle and hear their thoughts on how it could work

- **SENIOR REVIEW**
- **ASSESSMENT**
- **FLOW**
- **EARLY DISCHARGE**
- **REVIEW**



SENIOR REVIEW **All patients will have a Senior Twice Daily Review.**

- All patients will have a daily morning review by a senior decision maker by 12 noon.
- Sick patients and those identified for discharge should be prioritised. Where Consultant ward round review is expected that day, this will take place.
- Afternoon visits by a senior decision maker will be to review and monitor acutely unwell patients, action any outstanding issues and identify actual or potential discharges for the next day.
- A senior registered nurse will participate on both the ward and board rounds.
- Patient review should include review of EDD.
- All patients will have a weekend plan in the notes including where appropriate criteria led discharge (Friday only).

ASSESSMENT

All patients will have an EDD agreed within 24 hours of admission.

- Where appropriate daily board rounds will be conducted with the participation of all key multi-disciplinary team members.
- Check whether a patient is medically stable, continues to need inpatient care and that treatment is being progressed in a timely manner and is appropriate to the needs of the individual patient.
- EDD discussed and agreed with patient and carers/relatives
- All patients will have an assessment completed on antibiotic compliance, VTE prophylaxis, Falls, Pressure Ulcers and Nutrition.
- All patient's board status will be updated. It should be clear at all times the named consultant with responsibility for care.
- Availability of the Discharge Service between 8.00am and 5.00pm to discuss individual and complex cases and status updates

FLOW

Reasons and actions for delayed patient flow should be highlighted at the board/rounds

- The Assessment Units will contact the specialty wards before 10 am with the names of patients identified by the site team for the empty beds.
- There will be a standard of 45 minutes to receive a patient once the bed is vacated
- All patient status including transfers, discharges and named Consultants to be updated in real time on Medway

EARLY DISCHARGE

Wards teams should ensure that at least 30% of the total ward discharges have been discharged by 12 noon and Medway updated.

- All patients and their carers/relatives should be provided with their EDD (admissions to be provided with hospital discharge information booklet)
- All patients and their carers/relatives should be informed that we aim to discharge them before 12 noon.
- Planned discharges should be discharged or moved to the discharge lounge early in the morning.

REVIEW

Patients whose length of stay exceeds 7, 14 and 21 days will be reviewed at the beginning and at the end of the week by the Specialty leads in collaboration with the Matron.

- Identify any blocks to discharges
- EDD to be updated following reviews.

What themes were revealed?

Main themes

- Processes: processes and escalation pathways aren't always followed - we need to make sure staff are aware of the right processes and use them
- Enabling and empowering staff: staff at all levels need to be supported to make key decisions in a timely manner, to speed up patient flow
- Staffing: some key additional posts need to be put in place to improve patient flow.
- Lack of consultant engagement
- Review of psychiatric patients in A&E
- Transport for discharges too late in the day
- Lack of intermediate care beds in the community

How are we responding?

Short, medium and longer term issues identified

- Short term – resolved during the week e.g. repair/replacement of facilities and IT equipment
- Medium term – solution identified during the week and action now being taken, e.g. staffing shortages
- Longer term – issues identified during the week, solutions being identified and longer term action needed, e.g. change in processes

- Partnership working through the Urgent Care Working Group

Was it a success?

Yes!

- Communications with Consultants improving
- The feedback from staff that ‘we are in it together’
- ‘Launch pad’ for work moving forward

- Identified the real issues we now need to address both internally and with our partners

What next?

- Plan the next Perfect Week
- Analyse the data we collected
  - Communicate the outcomes to all staff
- Prioritise the actions we need to take
- Partnership working through the UCWG

Interim Management and Support

Sent by email: 14th July 2014

Report from a Length of Stay review undertaken at Southend Health Community

1. Introduction

A Length of Stay (LOS) review was undertaken on the 17th June with an associated feedback and discussion session provided on 23rd June 2014. The purpose of the LOS review is to capture local intelligence of *perceived and actual patient* flow issues by capturing first hand information from ward staff, namely the person in charge of the ward. This report reflects the observations and discussions from a predominantly acute perspective. Other agencies may have a different perspective on some of the issues facing the local healthcare community. A wide range of issues were observed and discussed which will need to be addressed collaboratively to improve appropriate and safe movement of patients through the local health system.

The review also provided an opportunity to talk with ward staff about what they feel needs to work differently to improve patient flow. Each ward manager or representative was asked if they had a 'magic wand' what would they change both internally and externally to improve the flow of patients.

2. Structure

The review was facilitated by Liz Sargeant of the Emergency Care Intensive Support Team (ECIST) with a high level of system engagement. The review was completed by practitioners and service leads from the acute trust, community services, social care, GPs and commissioners. Liz briefed the team before the review to ensure consistency of approach across the team undertaking the review. The reviewers are encouraged to ask the question about plans for patients as if they were the patient or their relative. There are four key questions that all patients should expect staff on the ward that is caring for them to be able to answer:

- What is wrong with me?
- What is being done next to make it better?
- What do I need to be able to do or what needs to have happened for me to be able to go home?
- When am I going home?

We asked reviewers to note how clearly the person in charge of the ward could describe the clinical and discharge plans for patients. We know that for patients to understand what is happening good communication at ward level is essential.

A patient list was generated by the acute trust to capture all medical inpatients with a LOS >7days across both hospital sites. To support the generation of quantitative information a definitions chart, see Appendix 1, was given to reviewers to code responses gained from discussions with ward staff. The most comprehensive outcomes are from the qualitative information gathered during the review process and from discussions with ward staff. Ward staff were asked what the clinical plan was for each of the patients. What was the next thing patients were waiting for on the day of the review? In addition to this the group made observations of ward processes and discussed the themes highlighted.

3. The Length of Stay (LOS) review process

Matrons, ward managers and duty staff were aware that a LOS review was being completed. All responses shared in this report are anonymous. The aim is to capture the perceptions and evidence of known patient flow issues in order that improvement programmes can be refined and focused on issues that staff identify as consistent constraints. The primary objective was to ascertain what the patient was waiting for on the day of the review; this review is neither clinical nor correlative to the delayed discharge notification processes.

Patients whose reason for being in hospital is on-going rehabilitation, with no other acute medical or nursing needs, are identified as being in the 'fit'' category. The question is whether this care could be provided in other settings if the relevant services were available? Research evidence shows clearly the harm that occurs as a result of unnecessary extended hospitalisation, particularly for older people.

Gill et al (2004) studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity. Kortebein P et al. (2008) noted the functional impact of 10 days of bed rest in healthy older adults included a large loss of skeletal muscle particularly from the lower extremities. This factor combines with the physiological stress and other factors associated with hospitalization. The overall impact is that an unnecessary extended length of stay in hospital of 10 days equates to an associated 10 years of physiological muscle ageing.

Within this report 'medically fit' relates to the coding used, see Appendix 1 for further details. 'Not Fit' codes were used to highlight patients who were still in an acute stage of their illness and/or recovery. 'Fit' codes were assigned to patients that were deemed not to be in an acute phase of illness; beyond this no assumptions relating to 'best place of care' have been made.

We would like to thank the team of reviewers who worked with us for their enthusiasm and clear feedback on what they had heard and observed. Patient data

used was either returned to the Trust or destroyed following the electronic recording of results. No patient identifiable outcomes are recorded in this report.

4. Qualitative Feedback

The Length of Stay review teams found the ward leaders to be welcoming and open with information. The ward leaders had, almost without exception, an impressive level of knowledge on what was planned for their patients. Our assessment was that this was one of the best examples of empowered nurse leadership that we have seen across the country. This was particularly impressive as, although ward leaders have been supernumerary in the past, they are currently often working within ward numbers due to nurse staff shortfalls. We observed excellent practice on some wards including: clinical criteria being set for discharge; enhanced recovery approach adopted in surgery and evidence of forward planning for discharge.

There was good system engagement in undertaking the review including a high level of commissioning input and good primary care representation. Overall there were significantly less issues highlighted at the interface than in other systems we have reviewed across the country. It was clear to us, from both the length of stay profile and our observations on the day, that the system is working relatively well. Our assessment is that if the local health community is committed to building on this foundation to develop a full “Choose to Admit” / “Discharge to Assess” approach that Southend Local Health Community could become a national reference site for good whole system patient flow.

4.1 Internal Issues observed/heard

- The white boards were generally well-presented and included expected dates of discharges (EDDs) and medically fit for discharge dates. There were data quality issues on some wards but this was not common.
- We felt that there was a lack of consultant leadership to support timely decision making on the wards. The Trust has set a local standard that a registrar or above should lead daily board rounds. However senior ward rounds for every patient were often largely dependent on registrar support and were not consistently delivered on a number of wards.
- There were a number of patients without clear management plans. Consultant engagement in setting EDDs on admission and communicating with nursing staff appeared to be variable and sometimes limited. A number of patients were highlighted as awaiting medical review.
- There was a relatively high level of internal waits for various tests. We know that you already monitor internal waits on a daily basis but were not clear on how themes behind delays are escalated and addressed. We **recommend** you should continue to review and escalate internal waits on a daily basis with thematic delays highlighted to executive leads to support rapid resolution.
- We observed variation in how IV antibiotics were prescribed and suggest there is potential for more patients to be managed on oral antibiotics within the community.

- Our assessment was that some of the current inpatients could also be managed in ambulatory or outpatient settings. In particular the complex wound unit is managing care on an acute inpatient basis in a way that we have not seen elsewhere in the country. We **recommend** you review the complex wound pathways to reduce inpatient provision to a minimum level whilst developing alternative acute and community provision.
- A number of patients were receiving rehabilitation within an acute setting. We queried whether there is a default referral to therapists and **recommend** that you move to a "Choose to Admit" / "Discharge to Assess" model as an alternative to starting therapy assessments on acute wards.
- There is a specific challenge for therapists to consider the best place to assess and rehabilitate patients taking into account the adverse impact of hospitalisation on older people.
- TTOs appeared to be written up late in the day on a routine basis which increases the likelihood of a failed discharge.
- Lack of early appropriate clinical streaming appears to drive multiple patient transfers with an associated increase in length of stay. There appeared to be significant difficulties in getting patients into the right bed first time.
- The fractured neck of femur path was reported to work well from the ED. However concerns were raised that planned reconfiguration might adversely impact on the pathway. We **recommend** that you consider whether this is a significant risk and if so take action to mitigate the potential risk.
- The ortho-geriatric pathway was described as being provided within a shared care and multi-disciplinary model which is good. However we were told that the medically optimised date often did not align with the rehab fit date and that "fit" patients were being managed in hospital on a regular basis. We **recommend** that you review the ortho-geriatric pathway with the aim of reducing the "fit" days that patients spend in the acute hospital.
- Patient family choice was highlighted as a significant issue. We did not feel that clear expectations were being set with families early in the admission.
- Transport was highlighted by a number of staff as a significant constraint.

4.2 Pathway and Process Issues - Interface

- Our overall assessment is that the current arrangement where the hospital provides an effective outreach service into the community is working well with some of the smallest number of patients waiting in the discharge processes that we have seen across the country. This is good practice which we **recommend** should be incorporated within any future planned models.
- We observed some social care delays but significantly lower levels than in other hospitals. We felt that relationships with local partners were good and there was clear evidence of proactive joint working. We were told that social workers sometimes work to section 2s which is excellent practice. However there was also the suggestion that there were too many section 2s and a low level of conversion. We **recommend** that you review the numbers and appropriateness of section 2s and that social workers continue to respond to section 2s. It is relevant to note that as a result of the 2014 Care Act that the

notification process will be changed with effect from 1st April 2015 and your local policies and procedures will need to be amended to reflect this.

- We felt that there was some reliance on bed based pathways with staff highlighting the need for more community/bed based routes. We **recommend** you consider whether your current balance between bed and home based care is appropriate.
- There were a number of therapy delays reported. We **recommend** that you front load functional assessments by moving some therapists and some of the discharge team to the ED/AMU to set a plan for discharge at the point of entry. The same team should then follow the patient on their admission to achieve an early discharge through one member of the team joining the morning board rounds each day. This initiative would improve patient management at the same time as managing family expectation.
- There were a number of issues with regard to achieving timely transfers to tertiary centres – cardiology was a specific issue raised.
- We noted that there were also significant delays across the neuro-rehab and brain injury pathway. There was a suggestion that a local pathway might be commissioned which we felt would be a good way forward.
- CHC processes were not raised as an issue within the review but were raised as an area of concern during the feedback session.
- There appeared to be some avoidable admissions from nursing and residential homes. The evidence base on the impact of initiatives to reduce admissions from home is good and we **recommend** that you consider local options to reduce these admissions.
- Overall we **recommend** that you consider the potential to develop a full "Choose to Admit/Discharge to Assess" model. The Better Care Fund could be used as a lever to optimise the pace of implementation.

We reiterate key recommendations at the end of this report that we think it would be helpful to focus on as priorities across the local health community.

5. Quantitative information

5.1 Two hundred and thirty two patients were identified with a length of stay over seven days and were reviewed on the 17th June 2014 across both hospital sites. The table below shows the numbers who were judged by the review team to be 'fit' or 'not fit' from the information they were given. This was obtained from the person in charge of the ward, by asking the questions 'what is the plan for the patient?' and 'what is the next specific step they are waiting for?' The coding used is set out under Appendix 1.

	Fit	Not Fit	Grand Total
Southend Hospital	91	112	203
Community Hospital	26	3	29
Total Patients	117	115	232

Table 1: Numbers of patients judged to be "fit" or "not fit"

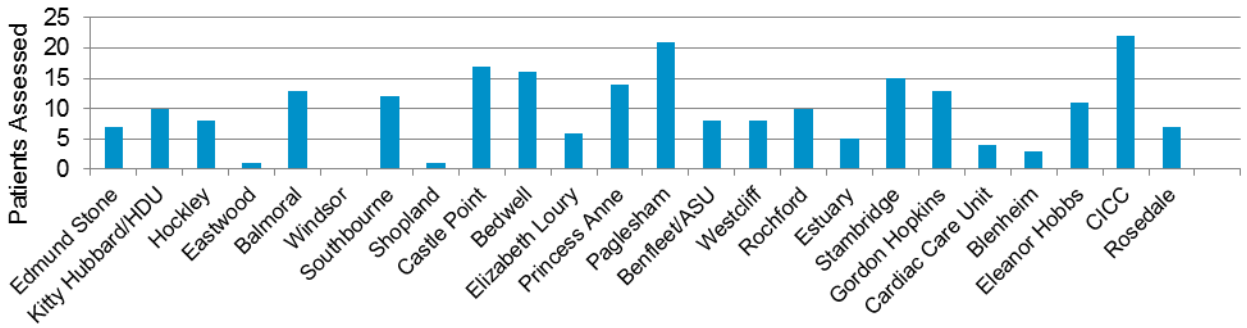


Chart 1: Numbers of patients seen on each ward across both hospitals

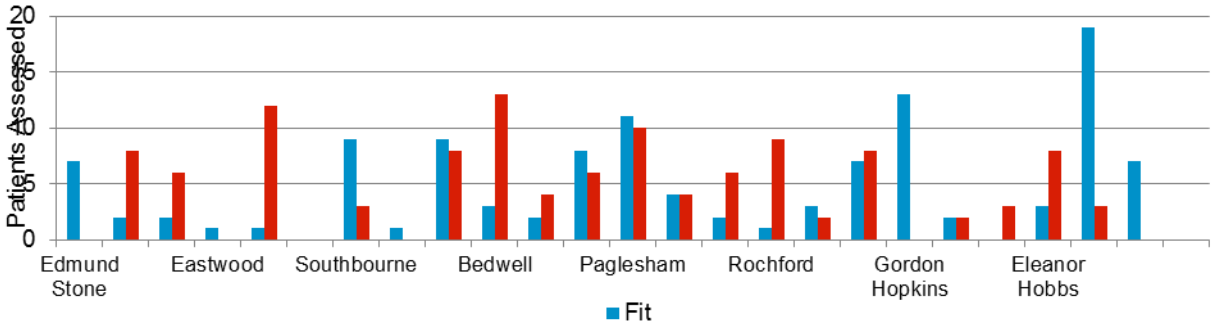


Chart 2: Numbers of patients 'Fit' and 'Not Fit' by ward across both hospitals

Age	Fit	Not Fit	Total
0-9	0	0	0
10-19	1	1	2
20-29	0	2	2
30-39	0	3	3
40-49	4	5	9
50-59	13	11	24
60-69	14	15	29
70-79	22	29	51
80-84	26	16	42
85-89	15	20	35
90-94	14	11	25
95-99	1	2	3

Table 2: Ages of Patients reviewed across both sites

Table 2, above, and Chart 3 overleaf highlight that the 80-84 year old age group appear to have the greatest potential to reduce length of stay overall. We have attached the raw data so you can pivot the data by hospital and specialty within the acute hospital to drill down to specific areas or into

specific issues. We can offer further support with the raw data if that would be helpful.

Chart 3: Ages of patients 'Fit' and 'Not Fit

5.2 Coding Outcomes for Southend Hospital

"Not Fit" Patients

Not Fit Patients	
5	End of life and wants to die in hospital
61	Active on-going (non-specific) clinical treatment (not as sick as below)
21	Waiting for test, investigation, specialist opinion or review
13	NEWs score of 5 or above, unpredictable erratic, intervention acute
11	Intravenous therapy that cannot be given in the community
0	Infectious a risk to others therefore cannot discharge
1	No Plan

Table 3: Detailed coding for Patients who were assessed to be "not fit"

Of the 112 patients who were assessed to be "not fit" where this is defined as being in need of care that could only be provided in the acute trust:

18 (16% of 112) were deemed to be seriously ill, or dying with a short prognosis and wished to be in hospital. Some patients had infections that meant they could not be discharged to another care setting.

61 (55%) were still 'medical', not as sick as the 18 above. Peer review of the management of some of the patients who stay longer in an acute setting may show that this is associated with variation in patient management. We **recommend** that a regular clinically led peer review should be undertaken of all inpatients with a LOS over 7 days.

21 (19%) were still needing medical interventions but the next step was not known. Decisions were delayed while waiting for internal responses to tests, investigations, specialist opinion from another specialty or review by their own consultant.

"Fit" Patients

Fit Patients	
4	Waiting for transfer to Acute Hospital for treatment- fit to travel/tertiary
8	Waiting for community hospital/other bedded intermediate care setting
1	Waiting for continuing health care/social care panel decision
4	Waiting for continuing health care package
1	Waiting for equipment / adaptations
1	Housing needs / homeless
5	Waiting for patient/family choice
2	Waiting for internal discharge referral processes e.g. checklists, section 2 and 5
6	Waiting for occupational therapy/physiotherapy approval for discharge
22	Ready for home today
1	Waiting for hospice place
4	Waiting for internal transfer - ward to ward
8	Discharge planned for tomorrow - what is stopping them going today?
3	Waiting for social care reablement or intermediate care at home
7	Waiting for internal assessments/results before discharge
3	Waiting for external agency assessment - social care,MH,RH,NH etc.
2	Waiting for Start Domiciliary Care Package - long term packages
0	Out of county/borough assessments
0	Waiting for placement Nursing/Residential Home CHC, Social Care, Self
7	No clear plan of clinical care and/or what is needed for discharge
2	Safeguarding

Table 4: Detailed coding for patients who were deemed 'fit'

Of the 91 patients reviewed deemed to be "fit" according to the ECIST codes:

22 (24% of 91) were going home on the day of the review or the next day. The review took place on a Tuesday which is a common day for peaks in discharges in many trusts. Reducing the variation by day of week of discharge will improve flow across the system. We **recommend** that the Trust monitors discharges on a daily basis as a measure for improvement. We **recommend** that expected discharge rates should be profiled and monitored on a

daily basis so that it is clear what level of discharge is required to remain in balance.

Of the remaining 69 patients who were deemed to no longer need acute care within the Trust using the ECIST codes:

7 (10% of the 69) were described as having no clear management plan.

6 (9%) were described as needing physiotherapy or occupational therapy assessments or treatment before the next step towards discharge could be undertaken.

5 (7%) were in the process of making a decision about what they wanted next. This included waits for families to attend meetings to discuss options. It appeared that there were delays in families and patients making decisions particularly related to 'homes of choice'. Once patients and families have been offered a suitable solution the onus should be with the Trust to manage the patient/family expectations and behaviours through a robust 'Patient Choice Policy'. Within the Direction of Choice it should be clear that remaining in an acute hospital bed is not one of the available choices. The setting of patient's and carer's expectation should commence from the point of admission using Welcome Card type approaches. We **recommend** that the Trust reviews any choice policy they have. If there is no agreed policy in place then one should be agreed with partners in social care as a matter of priority.

27 (39%) patients were waiting for some kind of external input. 6 patients were waiting assessments from external agencies. While 21 patients were waiting for a community based long or short term solution:

- 14 were awaiting a long or short term bed based option
- 7 patients were awaiting a home based option.

5.3 Coding Outcomes for the Community Hospital

The Community Hospital review was undertaken at the same time as the Southend review. Our overall impression was that the Community Hospital appeared to work within a traditional model. This often has an associated loss of pace for patients following transfer from the acute hospital. We would question whether the level of therapy provided within the hospital stay provides patients with a net benefit taking into account the adverse impact of the continued hospitalisation as we noted earlier in this report.

The detailed coding for the Community Hospital Length of Stay review is provided overleaf.

“Fit” and “Not Fit” Patients

Patients Fit	Not Fit	
	1	Active ongoing (non-specific) clinical treatment
1		Housing needs/homeless
	1	Waiting for test, investigation, specialist opinion or review
2	1	No clear plan of clinical care and/or what is needed for discharge
3		Waiting for equipment / adaptations
13		Waiting for occupational therapy/physiotherapy approval for discharge
1		Discharge planned for tomorrow – what is stopping them going home today?
1		Waiting for internal assessments/results before discharge
2		Waiting for patient/family choice
1		Waiting for Start Domiciliary Care Package - long term packages
2		Waiting for placement Nursing/Residential Home, Social Care, Self Funder

Table 5: Detailed coding for patients at Community Hospital

6. Interface Recommendations

The evidence for the impact of hospitalisation on older people in terms of immobility, nutrition and hydration are well described, as noted earlier. The culture of a bed being ‘safe’ needs to be challenged and services developed to see home as the preferred route with appropriate and sometimes short term significant support. This is possible if the investment in beds is reduced and services to support people at home increased. Professionals need to work with patients to assess and describe a plan which can be implemented by a pool of well trained and supervised care workers who can offer personal care, reablement and rehabilitation.

The systems across the country that appear to flow best have less reliance on bedded options for discharge and more support to get people home and to continue their recovery and assessment for long term care needs in a home based setting with support from well-trained carers. This support allows reablement and rehabilitation to continue in the place where the person is most comfortable and generally more motivated. This requires a flexible and responsive intermediate tier of services. Accessed through a single point where needs are described by referrers rather than services. This allows on-going assessment after discharge to ensure that people receive the right package of care in the longer term if they still require something after this intervention.

7. Conclusion and Next Steps

We **recommend** that you future proof changes in the context of delivering a "Choose to Admit"/ "Discharge to Assess" mind-set with no decisions about long term care being made in hospital:

- Develop the current board rounds to provide a consultant review of all patients on a daily basis. Consider scripting the board rounds to: incorporate a flow bundle approach; provide increased clarity and consistency of outcomes and begin to embed robust board rounds into clinical practice.
- Translate agreed EDDs into definitive actions for the multi-disciplinary team to deliver to support the planned discharge.
- Undertake clinically led peer reviews of all inpatients with a LOS over 7 days.
- Drive early discharge from admission through assertive multi-disciplinary front door assessment including relevant therapy assessments and follow up on admitted patients to facilitate early discharge.
- Review patients on IV antibiotics and consider what would need to be different both in terms of the treatment plan and community services to reduce the number of inpatients.
- Review TTO issues and transport constraints to consider if these constraints can be designed out of the system.
- Escalate internal waits on a daily basis and develop a thematic executive review to identify options to fast track solutions to the key constraints.
- Board to Ward – focus on every patient and every carer being able to answer the four questions.
- If you agree to implement a "Choose to Admit" /"Discharge to Assess" model it is essential that you also manage patient and family expectations early. This should be focused on communicating the local agreement that decisions about long term care will not be made in the acute setting and whenever possible will be made at home.

The underlying principles that support effective system working and against which solutions need to be tested are:

- Person centred care
- Blurred organisational and professional boundaries, networks of care
- Easy access to advice and information to allow people and their carers to be in control of their care.
- Simple information flow, sharing of information owned by the patient (children's red book principles, bus pass possibility)
- Effective, efficient, proportionate, timely assessment – reduce duplication, massive productivity and quality improvement opportunity
- Simple access to services, that always say 'yes'.
- Proactive rather than reactive management of patients – top 5% of practice population on risk stratification
- Continual system wide feedback loops with agreed system metrics to monitor impact of change and manage unintended consequences

Recommendations from this review should be shared with commissioners and provider services in order that actions plans can be aligned/updated with the intelligence collected from this review. Further length of stay reviews could be considered by the health system stakeholders to increase awareness of system constraints and better inform operational and commissioning decisions. ECIST can offer further support if required.

With regards

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Appendix 1

Ask the person in charge of the ward for each patient – What is the plan for the patient and is there an Expected Date of Discharge /Predicted Date of Discharge?
F 1 Waiting return to other Acute Hospital – fit to travel
F2 Waiting for transfer to Acute Hospital for treatment – tertiary fit to travel
F3 Waiting for community hospital placement or any other bedded intermediate care
F4 Waiting for continuing health care panel decision
F5 Waiting for continuing health care package
F6 Waiting for equipment / adaptations
F7 Housing needs / homeless
F8 Waiting for patient/family choice or input to decision making
F9 Waiting for internal CHC processes e.g. checklist completion, assessments
F10 Waiting for occupational therapy/physiotherapy approval for discharge
F11 Ready for home today – are they confident nothing will stop discharge?
F12 Waiting for hospice place
F13 Waiting for internal transfer – ward to ward
F14 Discharge planned for tomorrow – what is stopping them going today?
F15 Waiting for social care reablement or home based intermediate care time limited
F16 Waiting for internal assessments/results before discharge agreed
F17 Waiting for external agency assessment – social care/MH/RH/NH
F18 Waiting for Start or restart of domiciliary care package – long term packages
F19 Out of county/borough assessments
F20 Waiting for Residential or Nursing Home, Social Care or Self Funder
F21 Fit and no clear plan of what is needed for discharge
NF1 End of Life Pathway/ End of Life and wants to die in hospital
NF2 Active ongoing clinical treatment non-specific and not as sick as categories below
NF3 Waiting for internal test, specialist opinion or similar – state what
NF4 NEWS score 5 or above, unpredictable and erratic condition that may require immediate intervention. Care only available in the acute setting
NF5 Intravenous therapy that cannot be given in the community – can it be given elsewhere?
NF6 Infectious a risk to others therefore cannot be discharged
NF7 No clear plan
NF8 Other please free text
NF9 Other – waiting return to another acute trust not fit to travel
NF10 Other – waiting transfer to another acute trust for treatment and not fit to travel