Essex Health and Wellbeing Board

14:00	**Thursday, 27 March 2014**	**Braintree District Council, Causeway House, Bocking End, Braintree CM7 9HB**,

Quorum:
One quarter of membership and will include:

- At least one Essex County Council elected Member
- At least one Clinical Commissioning Group Representative
- Essex County Council *either* Director of Adults Services, Director for Children's Services or Director for Public Health

Membership:

Councillor David Finch	Essex County Council (Chairman)
Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Jacqui Foile	Voluntary Sector
Councillor John Galley	Essex District Councils
Dr Rob Gerlis	West Essex CCG
Dr Mike Gogarty	Essex County Council
Dr Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
David Marchant	Essex District Councils
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England
Dr Gary Sweeney	North East Essex CCG
Peter Tempest	Essex County Council
Co-opted Members:	
Nick Alston	Essex Police & Crime Commissioner
Simon Hart	Independent Chair ESCB & ESAB

For information about the meeting please ask for:
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Telephone: 01245 434929
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Part 1

(During consideration of these items the meeting is likely to be open to the press and public)

		Pages
1	**Apologies and Substitution Notices** The Secretary to the Panel to report receipt (if any)	
2	**Minutes of meeting held on 14 January and 12 February 2014**	**7 - 22**
3	**Declarations of Interest** Members are invited to declare any interest in any item on the agenda. Members may still declare an interest in an item at any time prior to its consideration.	
4	**Questions to the Chairman from Members of the Public** The Chairman to respond to any questions to the business of the Panel from members of the public, notice of which has been given in advance.	
5a	**Essex CCG 2 year operational plans and Essex 5 year strategic plan**	**23 - 506**
5b	**Presentation of the final Better Care Fund template for approval for submission**	**507 - 786**
5c	**Primary Care Strategy** To receive presentations by the CCG representatives, Dave Hill and Sheila Norris from Essex County Council and Andrew Pike, NHS England. **Please note the Board will take a 10 minute break during the course of item 5.**	**787 - 796**
6	**Children and Families Bill and SEN Commissioning / Education Health & Care Plans**	**797 - 812**
7	**OFSTED Inspection Feedback** To receive an oral report by Dave Hill, Essex County Council	

8 Date of Next Meeting

To note that the next meeting will be held on Tuesday 20 may 2014 at 2.00pm at Tendring District Council, Town Hall, sattion Road, Clacton-on-Sea, Essex CO15 1SE

9 Urgent Business

To consider any matter which in the opinion of the Chairman should be considered in public by reason of special circumstances (to be specified) as a matter of urgency.

Exempt Items

(During consideration of these items the meeting is not likely to be open to the press and public)

To consider whether the press and public should be excluded from the meeting during consideration of an agenda item on the grounds that it involves the likely disclosure of exempt information as specified in Part I of Schedule 12A of the Local Government Act 1972 or it being confidential for the purposes of Section 100A(2) of that Act.

In each case, Members are asked to decide whether, in all the circumstances, the public interest in maintaining the exemption (and discussing the matter in private) outweighs the public interest in disclosing the information.

10 Urgent Exempt Business

To consider in private any other matter which in the opinion of the Chairman should be considered by reason of special circumstances (to be specified) as a matter of urgency.

MINUTES OF A MEETING OF THE ESSEX HEALTH AND WELLBEING BOARD HELD ON 14 JANUARY 2014 AT ROCHFORD DISTRICT COUNCIL, HOCKLEY ROAD, RAYLEIGH SS6 8EB

Present:

Members

Mike Adams	Healthwatch Essex
Nick Alston, Co-opted Member	Essex Police and Crime Commissioner
Councillor John Aldridge	Essex County Council
Dr Kamal Bishai (Vice Dr Rob Gerlis)	West Essex CCG
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Councillor David Finch	Essex County Council (Chairman)
Jacqui Foyle	Voluntary Sector
Councillor John Galley	Essex District Councils
Dr Mike Gogarty	Essex County Council
Sunil Gupta	Castle Point and Rochford CCG
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Dave Hill	Essex County Council
Joanna Killian	Essex County Council
David Marchant	Essex District Councils
Councillor Ann Naylor	Essex County Council
Andrew Pike	NHS England

Officers

Tom Abel	Basildon and Brentwood CCG
Steven Allen	Essex County Council
Ann Coldicott	Essex County Council
Clare Hardy	Essex County Council
Sam Hepplewhite	North East Essex CCG
Barbara Herts	Essex County Council
Linda Hillman	Anglia and Essex Public Health England Centre
Sheila Norris	Essex County Council

1. Apologies and Substitutions

Apologies were received from:

Dr Rob Gerlis with Dr Kamal Bishai as his substitute	West Essex CCG
Simon Hart, Co-opted Member	Independent Chair ESCB and ESAB
Dr Gary Sweeney	North East Essex CCG (Vice-Chairman)
Peter Tempest	Essex County Council

2. Minutes

The minutes of the meeting of the Health and Wellbeing Board held on 21 November 2013 were approved as a correct record and signed by the Chairman.

The Board received updates regarding “Who Will Care” and Colchester and Basildon Hospitals.

3. Declarations of Interest

Councillor Terry Cutmore, Essex County Council advised that he had been appointed as a Governor of Southend Hospital Trust.

Nick Alston, co-opted member, Essex Police and Crime Commissioner advised that he was a non-executive director at Broomfield Hospital.

4. Questions to the Chairman from Members of the Public

No questions were submitted.

5. Integration Update: Better Care Fund and Integrated Plans

The Board received a presentation led by Sheila Norris, Essex County Council and a one page summary from each of the Integrated Commissioning Directors/ CCG’s.

The Board noted that on 20 December 2013 guidance had been received regarding the Better Care Fund: “A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities”.

The CCGs and ECC Integrated Commissioning Directors are working up schemes in each CCG locality and the Health and Wellbeing Board Business Management Group is co-ordinating and will pull together the Essex Health and Wellbeing Board submission.

The Health and Wellbeing Board Business Management Group agreed scheme headings for BCF as follows:

- Protection of Social Care to benefit health
- Community Health services incl admission avoidance
- Reablement
- Joint Nursing and Care Home commissioning inl CHC
- Discharge support
- Acute mental health and dementia
- Primary care
- Care Bill
- Early intervention and prevention
- Community resilience
- Carers
- Disabled Facilities Grant

- Other and enablers

The Board noted the Plans on a Page presented by each CCG. Andrew Pike, NHS England commented that having heard the presentations he was not clear how it was planned to turn strategic intent into action. Members of the Board and staff present agreed there was still a lot of work to be done before submission of drafts to the Board in February.

Resolved:

That the Plan on a Page presented by each CCG be noted.

6. Essex Police Crime Commissioner and Essex Health and Wellbeing Board Strategy

The Board received a presentation by Nick Alston, Co-opted Member of the Board, which provided an overview of the key elements of the Strategy.

The Board noted that the Plan contained eight priority areas of focus:

- Local solutions for local problems
- Tackling domestic abuse
- Supporting victims of crime
- Youth crime and reducing reoffending
- Reducing harm caused by alcohol and substance misuse
- Road safety
- Crime prevention
- Effectiveness and efficiency

The Board also noted the shared outcomes relating to crime and health, the impact of domestic abuse on health services in Essex, the scale of the problem in Essex, the health impacts of domestic abuse and what helps to reduce risk and recent progress that has been made.

The Board noted that the Police and Crime Commissioner would like all partners to undertake the following:

- Increase awareness of issues across health professionals
- Data Sharing
- Engaging in the information sharing arrangements of the Joint Domestic Abuse Triage Team.
- Train health professionals in domestic abuse awareness and risk assessment.
- Joint commissioning of IDVAs

During discussion on this item comments were made about how domestic abuse cases are referred and the need for a single contact number.

Resolved:

That the Strategy and how it fits with the wider Essex Health and Wellbeing Strategy be noted.

7. Essex Orthodontic Needs Assessment 2013 – Key Findings and Next Steps

The Board received a report by Linda Hillman, Anglia and Essex Public Health England Centre regarding orthodontics which is a specialist branch of dentistry concerned with aligning the teeth and jaws, usually during a specific period of a child's development, in circumstances where the natural alignment will develop outside a functional and aesthetic range perceived as normal. An orthodontic needs assessment was undertaken for the Essex Area Team, between May and July 2013, by a consultant in dental public health from Public Health England, in collaboration with providers in the Essex local dental network, dental public health colleagues, contract managers and the NHS Business Services Authority, following a recommended framework.

The Board were advised that demographic data showed that absolute numbers of children in the age groups where orthodontic care is most commonly begun are unlikely to have increased in the years since a nationally co ordinated survey that included assessment of orthodontic treatment need was carried out in 2009 – 10, although numbers will again begin to rise a little by 2020. At the time of the survey, data suggested that across the county, 6055 12 year old children either needed orthodontic care or were already in treatment and it was demonstrated that professional judgement was important to accurately identify who was eligible for care and when it should begin, and hence manage demand.

During discussions regarding this item the following comments were made:

- That the Essex Young Assembly be asked to give their comments on the service as it was possible some of them may have had Orthodontic care.
- Members of the Board discussed whether there was a link to mental health and other conditions due to poorly treated or untreated dental problems?
- Concern was expressed that the service was accessed by 1 in 3 12 year olds and whether this was appropriate as other specialist services to address improvements to physical appearance are not provided on the NHS.

The Board noted the following 11 recommendations:

1. An orthodontic network should be formally recognised as part of the local dental network in Essex. It should:

    - Support provision of good general dental services as a priority, to ensure basic, good quality preventive care for Essex residents.

    - Promote demand management for orthodontics.

- Promote the standards that are monitored by NHS Essex, using data provided through the Dental Services Division of the NHS Business Services Authority.

2. Long term population projections indicate that overall orthodontic need is unlikely to change radically over the next few years; some increase in capacity is achievable through measures to ensure that current services are delivered effectively, thought collaborative planning plus quality improvement supported and promoted by the local orthodontic network.

3. Care should be taken to ensure that orthodontic care is accessible to eligible special needs patients and those in vulnerable groups, informed by an equity audit.

4. It is clear that patients in the North and East of Essex have to undertake significant travel in order to access primary care services, and they are most likely to wait for their care to commence. Their perspectives on this should be understood by commissioners.

5. Orthodontic consultants are ideally placed to provide clinical leadership to the orthodontic network, and the large size of the population and the differences in the communities in the South and North of Essex support the need to retain current levels of consultant presence in the major urban areas.

6. It is important that the resources currently invested in secondary care orthodontics are identified and transferred to the NHS Essex dental budget.

7. Continued evidence of long waits and the need to establish the referral management centre in the North of Essex suggest that there is currently insufficient local capacity to meet the local demand as well as the needs of those of patients who travel a long way to reach services. Some capacity will be created through effective management by clinicians and through contract, performance and quality management by Essex Area Team, supported by the managed clinical network.

8. Capacity in primary care in West and South Essex is bolstered through Essex patients accessing care in adjacent counties, and this supports the observation that there is an under supply in other areas of Essex (see above), where the need and capacity calculations alone do not show this. Patients in the East, North and North East do not have similar opportunities to access services out of county.

9. Further information is awaited on cost, outputs and outcomes of the referral management service for orthodontics.

10. Better information is needed, in general, on patient perspectives.

11. The optimal configuration and contribution of secondary care orthodontic services is best decided once more data is available, and the greater skills and training of orthodontic consultants should be used to the full in order to

get the best possible care to all patients who need it, as close to people's homes as possible.

Resolved:

That the Eleven recommendations set out above be addressed through the following six actions that were put to NHS Essex, contributing to overarching aims to ensure service continuity and equity of provision for all population groups and that:

1. NHS Essex should work with the profession to address observed shortfall in capacity in North East Essex (this in part is caused by children being referred who don't need to be).

2. NHS Essex should support the establishment of an orthodontic sub-group of its existing Essex Local Dental Network. This should be consultant led and support further communications and work on all its orthodontic services. The network would also routinely monitor patient and public experience and views,especially those from people in vulnerable groups and their representatives.

3. Orthodontic consultants are well placed to support the Area Team to maintain and improve orthodontic standards across Essex in addition to their roles to undertake the most complex work, working with other specialists as required, and to provide specialist training. Levels of investment in current hospital services and specialist training should be identified and future service models developed in liaison with the current consultant staff, the Essex orthodontic network and Health Education England.

4. Work would continue within NHS Essex to ensure consistency and excellence in management of primary care orthodontic contracts, in line with the new national performance framework, and to review the referral management system in North East Essex.

5. Management time is required to tackle areas where contract delivery falls below standards expected nationally, and staff should be supported by the local orthodontic network as outlined in recommendation 2 above. Further work should begin to establish the extent of extra clinical capacity that this should release.

6. Pathways through local services should be clear and understandable for the public, and processes in place to deal with cases that might fall outside those agreed.

7. Health Watch and the Health and Wellbeing Boards provide patient and public perspectives, plus those from other local organisations and professional groups. Early feedback to the Area Team would be gratefully received, along with any recommendations for more detailed or specific investigations that should be undertaken, and any ongoing support that could be offered be agreed.

8. National Autism 2nd Self Assessment

The Board received a report by Linda Hillman, Anglia and Essex Public Health England Centre, in line with the request from Norman Lamb MP Minister of State for Care and Support dated 2nd August 2013 (see attached), all Health and Wellbeing boards are requested to endorse their local 2nd Adult Autism Self-Assessment submission as part of the evidence for local planning, health needs assessment strategy development and the supporting of local implementation work.

The purpose of this report is to provide the information submitted as the 2nd Adult Autism Self-Assessment framework for Essex in order for the Health and Wellbeing Board to endorse prior to the January 2014 deadline.

The Board noted that the Autism Strategy has five areas for action aimed at improving the lives of adults with autism:

- increasing awareness and understanding of autism;
- developing a clear, consistent pathway for diagnosis of autism;
- improving access for adults with autism to services and support;
- helping adults with autism into work; and
- enabling local partners to develop relevant services.

The Strategy is not just about putting in place autism services but about enabling equal access to mainstream services, support and opportunities through reasonable adjustments, training and awareness raising.

During discussion the following comments were made:

- Mike Adams Healthwatch Essex advised that he had spoken to Safe Watch and their view was that there was a lack of a coordinated approach across Essex.
- The adequacy of diagnostic pathways was also mentioned.
- Board members asked that the deficiencies highlighted must be worked on.
- Councillor Aldridge undertook to take back the issues raised.

Resolved:

That the Adult Autism Self-Assessment submission be endorsed and that the further submission from South Essex's CCGs be agreed.

9. Annual Public Health Report 2013

To receive a report by Mike Gogarty, Essex County Council seeking endorsement of the Annual Public Health Report: There is an expectation that Directors of Public Health (DPHs) produce an annual report pertinent to the needs of the local population.

Given the JSNA suite provides detail on needs, this report focusses on the evidence base around interventions to deliver productivity for health and social care.

During discussion on this item Members of the Board stated that there are a number of topics covered but little or no evidence to support some of them. Clear direction is still required even though there are big pressures coming up.

Resolved:

That the report and its recommendations be agreed.

10. Commissioning Intentions for Children Young People and Families

The Board considered a report by Barbara Herts, Essex County Council, which set out the commissioning Intentions and priorities of Essex County Council and the Clinical Commissioning Groups across Essex for children young people and families. The report included Commissioning Priorities also identified by Southend and Thurrock Unitary Councils.

The Board were asked to identify where there are opportunities for joint commissioning and collaborative working across key partners that support children, young people and families.

Resolved:

That:

The Board agree and support the document as a starting point and acknowledge that it will need to develop as a result of the implementation of the Children and Families Bill; and

the CCG's be encouraged to work with the ECC Integrated Commissioning Directors to support the Children's Integrated Planning and Commissioning Process, be agreed.

11. Date of next meeting

The Board noted that its next ordinary meeting is scheduled to take place on Thursday 27 March at 2pm, at Braintree District Council, Causeway House, Bocking End, Braintree CM7 9HB.

The Board also noted that there would be an extrordinary meeting which is scheduled to take place on Wednesday 12 February at 4:30pm, in Committee Room 1at County Hall, Essex County Council.

12. Date of future meetings

The Board noted that meetings be scheduled for 2014/15 as set out below:

Tues 20 May, 2pm at Tendring venue TBA
Tues 15 July 2pm, Brentwood venue TBA
Thurs 25 Sept 2pm, Harlow venue TBA
Tues 25 Nov 2pm, Castle Point venue TBA
Tues 13 Jan 2pm, Maldon venue TBA and
Tues 31 March 2pm, Colchester venue TBA.

13. Clare Hardy

The Board noted that this was the last meeting Clare would support as she was moving to a new role. .

The Board thanked Clare for all her hard work setting up the Shadow Board and ensuring the work undertaken during the Board's first year of operation was carried out efficiently. The Board wished Clare well for the future and welcomed Sheila Norris who would now be supporting the Board.

Chairman
27 March 2014

MINUTES OF A SPECIAL MEETING OF THE ESSEX HEALTH AND WELLBEING BOARD HELD ON 12 FEBRUARY 2014 AT ESSEX COUNTY COUNCIL, CHELMSFORD

Present:

Members

Mike Adams	Healthwatch Essex
Councillor John Aldridge	Essex County Council
Dr Kamal Bishai (vice Dr Rob Gerlis)	West Essex CCG
Dr Anil Chopra	Basildon and Brentwood CCG
Councillor Terry Cutmore	Essex District Councils
Ian Davidson	Essex District Councils
Councillor David Finch	Essex County Council (Chairman)
Dr Mike Gogarty	Essex County Council
Sunil Gupta	Castle Point and Rochford CCG
Simon Hart, Co-opted Member	Independent Chair ESCB and ESAB
Dr Lisa Harrod-Rothwell	Mid Essex CCG
Dave Hill	Essex County Council
Councillor Ann Naylor	Essex County Council
Dawn Scrafield (vice Andrew Pike)	NHS England
Dr Gary Sweeney	North East Essex CCG (Vice-Chairman)
Peter Tempest	Essex County Council

Officers

Charlotte Downes	Essex County Council
Colin Ismay	Essex County Council
Sheila Norris	Essex County Council
Tonia Parsons	Basildon and Brentwood CCG

1. Apologies and Substitutions

Apologies were received from:

Councillor John Galley	Essex District Councils
Dr Rob Gerlis (with Dr Kamal Bishai as his substitute)	West Essex CCG
Joanna Killian	Essex County Council
David Marchant	Essex District Councils
Andrew Pike (with Dawn Scrafield as his substitute)	NHS England

2. Better Care Fund and Clinical Commissioning Groups 2-Year Operational Plans for 2014-2016

The Board received a report by the Director for People Commissioning, Essex County Council, and presented by Sheila Norris, Director for Integrated Commissioning and Vulnerable People, Essex County Council, seeking agreement to submit by 14 February 2014 the Better Care Fund (BCF) templates

and Clinical Commissioning Group (CCG) 2-year operational plans as drafts to NHS England as required under NHS Planning Guidance.

Dave Hill, Director for People Commissioning, introduced his report saying that the documents represented an early draft so that the Board could endorse the work in progress although much still remained to be done. He also advised the Board that earlier in the day some information had been made available on the Quality Assurance process.

Further to the information provided at the last meeting, the Board noted that the BCF submission involves the completion of a template covering the Board's area. There is a narrative section covering vision, aims and objectives and sections showing how Essex has met the BCF requirements including provider and service user engagement; fulfilment of the national conditions; planned changes to services covering the BCF schemes; implications for the acute sector of these changes; governance and risks. The rest of the submission covers metrics: baselines and targets proposed against the required and locally- agreed measures; and details of BCF investment with expected financial benefits.

The draft versions of the BCF template Parts 1 and 2 were attached to the report for the Board's endorsement for submission to NHS England. The final version will be sent to NHS England in April, following endorsement by the Board in March. Progress in completing the template has been driven and monitored by the Board's Business Management Group (BMG).

Each CCG has produced its own BCF return. These will be embedded in the Essex submission and give detail on engagement with providers and proposed schemes. The typology for schemes provides some consistency to these submissions. Nonetheless BMG agreed that consistency should be improved between CCG submissions for the final submission and colleagues will be working together to achieve this.

The CCGs' 2-year operational plans, of which the BCF should be an integral part, were also attached for endorsement as drafts for submission to NHS England. The Board received presentations and 'plans on a page' setting out the main points from these Plans in January.

The Board noted that the timetable had been agreed by all partners on the BMG to ensure that the Essex BCF submission and CCG 2 year operational plans are completed for endorsement in March.

While there is clear agreement to the vision for Essex and to the direction of travel, there are several key aspects of the BCF submission which at this stage necessarily remain incomplete. All CCGs and the County Council have made a commitment to revising and completing the draft to the agreed timetable, following conclusion of CCG negotiations with acute hospitals. This is essential to meet submission deadlines.

Sheila Norris provided some information on the Quality Assurance process which will be led by the NHS Area Team and the East of England Local Government

Peers. Outcomes will be known on 21 April. A copy of the checklist to be used has been made available and this will help inform the content of the Essex submission.

Resolved:

(1) That the progress in completing the BCF template for Essex and the CCG operational plans be noted.

(2) That the timetable for further work to be undertaken to complete these documents for endorsement by the Board at its meeting on 27 March 2014 be noted.

3. Exclusion of the Press and Public

Resolved:

That, having reached the view that the public interest in maintaining the exemption (and discussing the matter in private) outweighed the public interest in disclosing the information, the public (including the press) be excluded from the meeting during consideration of the following item of business on the grounds that it involves the likely disclosure of exempt information as specified in paragraph 3 of Part 1 of Schedule 12A of the Local Government Act 1972.

4. Better Care Fund and Clinical Commissioning Groups 2-Year Operational Plans for 2014-2016

(Exempt under paragraph 3 - information relating to the financial or business affairs of a particular person)

The Board received a report by the Director for People Commissioning, Essex County Council, which contained exempt information referred to in the report on the same issue and decisions taken earlier in the meeting (minute 3 above refers).

Councillor Cutmore declared a personal interest as a Governor of Southend University Hospital.

In the ensuing discussion Dave Hill acknowledged that the following points needed to be addressed as part of the submission process:

- ensuring acute providers are aware of a shift in funding priorities;
- evidencing patient outcomes;
- the need for the market to respond to new requirements;
- data sharing
- emphasising the resources for reducing demand and meeting demand in different ways; and
- the need to develop metrics to be able to address local demands.

Dave Hill outlined the process for presenting the submission to the March meeting.

Dawn Scrafield asked that the immense challenge faced by the NHS and Social Care in meeting emergency provision be placed on record.

Resolved:

That the draft BCF documents attached as appendices 1 & 2 to the report for submission to NHS England by 14 February 2014 be endorsed.

Chairman
27 March 2014

Essex County Council

AGENDA ITEM 5A

Report to Health & Wellbeing Board **Report of Dave Hill**	**Reference number** **HWB/09/14**
Date of meeting 27th March 2014 **Date of report** 14th March 2014	**County Divisions affected by the decision** All Divisions
Title of report Essex CCG 2 year operational plans and Essex 5 year strategic plan	
Report by Dave Hill, Executive Director for People Commissioning **Enquiries to** Sheila Norris, Director for Integrated Commissioning	

1. Purpose of report

1.1. To seek the Health and Wellbeing Board's endorsement of the Clinical Commissioning Group (CCG) 2 year operational plans which are due to be submitted in final form to NHS England as required under NHS planning guidance by 4th April 2014.

1.2. To update the Health and Wellbeing Board on proposals for producing CCGs 5 year strategic plans, in preparation for submission to the Health and Wellbeing Board in June 2014; and for producing a larger 'Unit of Planning', in preparation for submission to the Health and Wellbeing Board in September 2014.

2. Recommendations

2.1. Endorse the CCG 2 year operational plans (attached as appendices) for submission to NHS England.

2.2. Agree proposals for progressing 5 year strategic plans.

3. Background and proposal

3.1 In line with the 2014/15-2018/19 NHS Planning Guidance, all CCGs are required to submit both 2 year operational plans and 5 year strategic plans to NHS England within an agreed timeline. A 5 year strategic plan is also needed for the chosen 'Unit of Planning'; to enable wider and more strategic planning, ensure that the strategies align in a holistic way and maximise the value for money from the planning resources and support.

3.2 CCG's 2 year operational plans were presented in summary to the Health and Wellbeing Board in January and in draft form in February. Final versions are attached as appendices to this report.

3.4 It is proposed that for Essex the 'Unit of Planning' should be the Essex HWB area. The Business Management Group (BMG) of the HWB proposes that the 5 year Plan should be an integrated plan for health and social care and has already discussed an outline for developing a draft. The Plan would set out:

- key messages from the JSNA and local needs assessments, including views from service users and patients
- plans for different populations eg older people, working age adults
- identify key Essex enablers and plans for developing these eg data sharing and workforce
- impact of these plans for citizens, commissioners, providers, staff etc
- governance for delivering the plans and monitoring performance and impact.

3.6 The BMG has also proposed that an event should be held in May 2014 on the model of the Accelerated Design Event that took place last year. This would provide an opportunity to revisit the vision agreed at last year's event, agree the main elements of the Plan and begin work on the content. A draft version will be presented to the Health and Wellbeing Board in June and then submitted to NHS England, with a revised final version submitted in September 2014.

4. Policy context

4.1. The 2 year plans are aligned with the Joint Health and Wellbeing strategy and the Whole Essex 5 year strategic plan will be based on the Joint Strategic Needs Analysis. Five year strategic planning will also be informed by these documents.

4.2 The plans also have direct relevance to the whole system leadership role of the Board and the challenge of integrating health and social care commissioning.

5. Financial Implications

5.1 The CCG Operational Plans bring together the priorities at a CCG level for the Health and social care system over the next two years and in some cases

beyond. At the core of these plans are Transformation Programmes that CCG's have developed with partner commissioners in Essex County Council and local health and social care providers. All CCG's have worked closely with ECC, in the development of proposals for application of the Better Care Fund (BCF) and their broader integrated Commissioning agendas.

5.2 The financial requirement of these plans is set nationally by the DH which is set out below.

2014/15

Minimum 0.5% contingency
1% cumulative surplus carry forward
2.5% non-recurrent spend (including 1% for transformation)

2015/16 – 2018/19

Minimum 0.5% contingency
1% cumulative surplus carry forward
2% non-recurrent spend
Better Care Fund spend as notified separately

5.3 The CCG 2 year plans are appended to this report. Any direct financial impact of these plans on ECC is reflected in the BCF paper which is a separate item on this agenda.

5.4 CCG's and ECC are working to produce a strategic 5 year plan which will come back to this board in May; this will build on the 2 year plans and the BCF.

6. Legal Implications

6.1. The proposals set out in this report do not give rise to any legal implications for ECC in addition to those set out in the BCF report.

7. Staffing and other resource implications

7.1. Any staffing implications of the 2 year operational plans will be managed by CCGs as part of the arrangements they are putting in place to take these forward. CCGs and ECC will work closely with providers on staffing and resource implications resulting from the Better Care Fund plans.

7.2. Workforce issues will be addressed as part of the strategic 5 year plan.

8. Equality and Diversity implications

8.1. Tackling health inequalities is a key theme of the Essex Health and Wellbeing Strategy 2013-18. The CCG 2 year operational plans identify the actions to be taken to reduce health inequalities across their regional areas. CCGs have equality impact assessment systems in place to support decision-making.

8.2. The Essex 5 year strategic plan is based on the whole Essex HWB area and is designed to improve health and social care outcomes for the whole population within that area. It will take account of equality considerations arising from the JSNA.

9. Background papers

9.1. Everyone Counts: Planning for Patients 2014/15 – 2018/19

NHS
Basildon and Brentwood
Clinical Commissioning Group

2014 – 2016

Operational Plan

Important Note:
This document is draft and subject to final review and consideration by the CCG Board.

Contents

This plan has been completed by the Executive and Governing Body of Basildon and Brentwood CCG in conjunction with member practices a number of partner organisations (relative to specific sections). Notably this includes joint working with Essex County Council and Castle Point and Rochford CCG in respect of proposals for implementation of the Better Care Fund and joint commissioning of services. The CCG also liaises closely with key provider organisations, e.g. Basildon and Thurrock University Hospital Trust (BTUH) and North East London Foundation Trust (NELFT) in respect of the system unplanned care programme, new pathways of care, etc.

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Document control	Reviewed by:/when	Comments:
Draft v1 and BCF proposals	• BBCCG Clinical Executive 16/1/14 • Patient and Community Reference Group 21/1/14	For information/comment
Draft v 2 and BCF proposals	• BBCCG Board (Governing Body) 6/2/14 • BCF system wide stakeholder event 28/1/14	Approval of draft; still subject to NHSE comment/approval
Draft v 3	• Submission to NHSE 31/1/14	
Draft v 3	• BBCCG Board 6/2/14	For information/further comment

Our plan on a page

Basildon and Brentwood health economy is a system of 264,000 patients across 44 GP practice members working with partner organisations to implement the following vision and objectives:

"A healthier population that is receiving the right care in the right place at the right time"

System Objective One

To achieve excellence in primary care service delivery

System Objective Two

Patients to have a named clinical lead as part of a wider integrated team

Teams will be built from geographic **GP Federations**, promoting clinical and professional leadership in communities and more holistic intermediate care offer. GPs to be lead professional working with multi-disciplinary team, centred around the patient and focused on early intervention and prevention. Support to include pump priming of **£5 per head of population** in 2014/15.

More people to pre-emptive receive care in primary care and community based settings. Resources to move from acute to community settings, with a range of joint budgets and commissioning with ECC.

System Objective Three

To develop specialist pathways of care, improving outcomes

The **integration** of existing community, acute and specialist services to provide comprehensive pathways for designated indications. Such pathways will be evidence based and time limited.

System Objective Four

To reduce reliance on urgent/unplanned use of hospital services by 15% by 2018

System wide **Urgent Care Working Group** and **Better Care Fund (BCF)**, both aimed at reducing unnecessary emergency admissions and developing fully integrated community alternatives across health and social care.

Proactive case finding, with reablement and rehabilitation as the default offer; more acute clinical and social care services moved to the community.

BCF to include community nursing services, community beds and reablement in year 1 expanding to include social care funds for elderly care in following years. Total value c£18.5m 2015/16.

Governance: System wide arrangements including:

- ECC, CPRCCG and BBCCG leadership group overseeing the **BCF** pooled budget
- **Business Management Group** of the H&WB Board.
- **Unplanned Care Working Group** and Access Group
- **BTUH** executive group with TCCG

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 2015/16 and beyond
- Delivery of the system objectives, inc those in BCF.
- No provider under enhanced regulatory scrutiny due to performance or quality concerns
- With the expected change in resource profile

System values and principles

- Services are always centred around the people we serve
- We will maximise value by seeking the best outcomes for every pound invested
- We work collaboratively with our population to design the services they need
- Work cohesively with colleagues to build tolerance, understanding and co-operation

Executive summary

This plan sets out the two year work programme for NHS Basildon and Brentwood CCG for the period 1st April 2014 to 31st March 2016.

Our first year of operation leading up to the publication of this plan has been a challenging one, yet one where we have taken significant steps forward to begin to put in place the foundations of an NHS locally which is safe, high performing and financially sustainable. But we recognise that we are very much at the start of this journey.

Our overarching priorities for the next two year is to see a step change in a number of key areas:

- Continued improvement in the safety and quality of local NHS services.

- The implementation of our transformation programme to deliver better outcomes for the people we serve.

- Consistently delivering the standards as set out in the NHS Constitution and strengthening our urgent care system further.

- A financially robust health and care economy which has the necessary resource to be able to deliver the priorities above.

This plan covers the following areas:

Firstly, how we intend to **improve outcomes** for our local communities where we have set ourselves the following ambitions:

- Where we are below national average against a particular measure, to achieve or better the average.

- Where we are above the national average, to achieve the next appropriate quartile of performance.

In this section, we also demonstrate the steps we will take **to reduce health inequalities** in our local communities through the implementation of 8 high impact pathways, and the work we intend to undertake **to achieve parity of esteem** for people with mental health conditions and to break the silos in our current services between physical and mental health services.

The plan then moves onto the action we intend to take to ensure delivery of the **NHS Constitution**, in particular focusing on our work to introduce 7 day working, strengthening our urgent care system and improving cancer waiting times.

We also cover our **Financial and QIPP** position within the plan and how we intend to deliver the national planning requirements in terms of both our surplus and non-recurrent funding headroom.

A key development during the lifetime of this plan is the introduction of the **Better Care Fund** and the pooling of significant amounts of money from the NHS to social care. We see this as an exciting driver to improve the effectiveness and efficiency of care in our area and describe the things we intend to do to make this new fund deliver for our local communities.

Finally within the plan we outline our **Delivery** mechanisms and the ways we will **engage and work with patients and our local communities** to ensure that what we do reflects their needs as well as this actually coming to fruition.

Strategy and direction

Our strategy and direction
The CCG is currently developing its' five year plan and strategy which will outline the detailed aspirations and direction for the local NHS for the future. This 5 year plan will be published in June 2014.

However, we have outlined three core aims which are currently being developed to deliver care which delivers better outcomes for people whilst meeting the resource constraints faced by the local NHS.

Aim 1: Excellent primary care
We believe that our success as a CCG will be fundamentally based on high quality, consistent primary care which delivers to people's expectations.

A key part of this development is through supporting general practice to strengthen and develop their core primary care service and to align the focus on primary care to the commissioning work of the CCG. During the two year period of this plan, we are aiming to secure the following changes:

- Introducing a new mechanism to support practices to undertake an extended range of care processes for patients, aligned to our commissioning work streams, particularly focusing on developing a modern model of integrated care to support the frail elderly and people living with long term conditions.

- Working with primary care to develop federations of practices, based around our local communities to deliver the extended range of care processes and to move general practice towards a 7 day service, operating for longer hours each day.

- Working with NHS England to support general practice to improve the standard of care they can provide to patients, through adopting the requirements of 'training practices' as the gold standard of service that all surgeries should offer in Basildon and Brentwood.

Aim 2: Accountable professional teams
Our second aim is to transform the way that people with long term need are cared for within their local communities and to simplify the currently complex and overlapping arrangements we have across primary, community, secondary and social care.

It is therefore our aim that everyone with an identified long term need has a named 'accountable professional' who works as part of a wider GP Federation team who is accountable for co-ordinating care and maximising outcomes for their patients through the introduction of the 'House of Care' model of care planning to secure greater independence, control and self-reliance for their patients. As an Accountable Professional they will have enhanced authority to make decisions and allocate resources to achieve their aims.

This will involve the restructuring of existing community and community mental health services to base them around GP Federations and provide seamless care within the community.

Aim 3: Specialist pathways
For people who have additional needs which cannot be managed within their accountable professional team we will roll out a set of specialist pathways with the aim of breaking down existing barriers between specialist community and secondary care services.

Integral to this approach is the adoption of evidence based practice, interventions and timescales within these pathways as well as putting patient control and shared decision making at the centre.

During this two year plan, we intend to implement the following specialist pathways:

- Frail / complex specialist pathway.
- Cancer pathways.
- Stroke pathway.
- MSK pathway.

In particular we expect this area of work to drive both the creation of specialist centres and the 20% productivity gain in elective care.

Quality and safety

Safe, high quality NHS care
BB CCG is committed to ensuring the delivery of safe, high quality NHS care that provides a good patient experience with good outcomes for the population we serve.

One of the fundamental changes for delivering the PS&Q Plan (see annex A of this plan) is to bring the function of PS&Q into the CCG from a hosted position. This will enable PS&Q to become interwoven with all commissioning activity within the CCG and our commissioning partners.

The PS&Q delivery plan describes the ambitions for PS&Q against each domain and outcome, the mechanisms for delivery and the action we will take.

The plan describes the underlying fundamental mechanisms of internal structures such as governance within the CCG, the use of contracts and the development of integrated working whilst striving to reduce harm at every opportunity.

All of the above is underpinned by the commitment to create a culture of **C**aring and **C**ompassion, which delivers good **C**ommunication from **C**ompetent and **C**ommitted staff who have the **C**ourage to ensure the delivery of safe, good quality care at every point of care

Armed Forces Covenant
The Armed Forces Covenant Commitment sets out the relationship between the national, the state and the armed forces. It recognised that the whole nation has a moral obligation to members of the armed forces and their families and it establishes how they should expect to be treated.

The CCG's identified lead to support the delivery of the Armed Forces Covenant is Tonia Parsons, Chief Operating Officer. Although the CCG does not have any military bases in the locality, it is recognised that the military and veteran community may well be registered with GP practices in south Essex and will be accessing services through providers. To that end, it is recognised that there is a need to build strong mechanisms within services commissioned to ensure access routes into mental health and other health services are available.

• Ensure NHS employers are supportive towards those staff who volunteer for reserve duties.
• Ensure primary care is provided with information and signposting for military and veterans who access services
• To ensure veterans‟ prosthetic needs are met.

We will continue to work with South Essex University Partnership NHS Foundation Trust to implement a plan for managing military and veterans cases referred by GPs or other agencies, this plan will include:

• Follow-up protocols for regulars and reserves leaving the forces.
• Access arrangements for crisis services
• Specification of outreach and early intervention services.

Section A

Improving outcomes

A. Improving outcomes

We are committed to improving the health and wellbeing of our local communities, we can measure the impact of our work through the NHS Outcomes Framework which sets out 5 domains for improvement:

- Preventing people from dying prematurely.
- Enhancing quality of life for people with long term conditions.
- Helping people to recover from episodes of ill health or following injury.
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Each of these domains have aligned 7 outcome measures by which we can identify where we need to improve and those areas where we are doing well and where we need to set ourselves stretching ambitions.

To set our ambitions against each of the 7 outcome measures we have set out our current performance against that of other CCGs in England and have set 2 year targets on the basis of:

- Where we are below national average, to achieve national average.
- Where we are above national average, the next appropriate quartile.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Local measure

In addition to the national outcome ambitions the CCG has also selected the following measure as a local ambition for our population which we believe needs to improve.

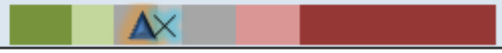
C3.7 People who have had a stroke who are discharged from hospital with a joint health and social care plan

For details on stroke performance and actions, see page 13.

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely) 1

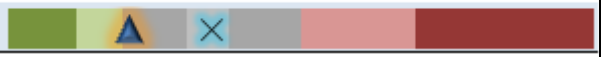
The following indicators benchmark current CCG premature mortality from the major causes of death. The indicators consist of directly age and sex standardised mortality rate (DSR) per 100,000 population.

Spine Chart Key			
highest 10%		lowest 10%	
highest 25%		lowest 25%	
CCG		National	

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 1.2 | Under 75 mortality from cardiovascular disease							
2012	65.47	66.35	77.46	61.71	▼6%	81	

Ambition: 56.71 or lower

CCG rate is 6% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally by the cardiology review described below.

CCGOF 1.6 | Under 75 mortality from respiratory disease							
2012	27.44	27.01	33.62	21.8	▼21%	58	

Ambition: 21.21 or lower

CCG rate is 21% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally by the respiratory review described below.

CCGOF 1.7 | Under 75 mortality from liver disease							
2012	15.4	14.8	18.8	10.18	▼34%	25	

Ambition: 10.18 or lower

CCG rate is 34% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally by the alcohol pathway.

CCGOF 1.8 | Emergency admissions for alcohol related liver disease							
Jul12 - Jun13	24.7	22.6	32.9	10.5	▼57%	17	

Ambition: 10.5 or lower

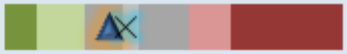
CCG rate is 57% lower than national average and currently in lowest 10% nationally. CCG is aiming to sustain this performance and implement with ECC the Alcohol treatment services.

CCGOF 1.9 | Under 75 mortality from cancer							
Directly age and sex standardised mortality rate (DSR) per 100,000							
2012	123.26	122.1	135.0	123.85	▲0%	114	

Ambition: 122.1 or lower

CCG rate is similar to national average. CCG is aiming to reduce to below national average.

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 1.1 | Potential years of life lost (PYLL) from causes considered amenable to healthcare							
Directly age and sex standardised potential years of life lost (PYLL) per 100,000							
2012	2,060.8	2,083.4	2,390.1	1,966.4	▼5%	81	

Ambition:
1,842.6
or lower

Overall, the CCG performs well on this standard and has lower mortality rates than the national average the overarching indicator as well as the majority of disease specific areas. However, we aspire to achieve upper quartile performance consistently across the key disease areas and are therefore implementing a number of key work programmes to improve overall outcomes. These are outlined below. A key priority for the CCG is the improvement in Cancer outcomes. For this disease area, the CCG mortality is worse than the national average.

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.1	Hypertension • Continue the roll out of the programme to identify patients with hypertension and manage them through primary care registers/QOF	**P** →				**O**			
A1.2.1	Respiratory review • Review existing service against DH best practice model • Improve management closer to home • Develop prescribing formularies • Develop a specification for high quality, cost effective provision • Patient engagement via survey to shaping model and stakeholder group			**R**		**I** →			

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.2.2	Respiratory Review - COPD passport • Patient self management and empowerment plan • Includes model for annual review	**I** →							
A1.3	Cardiology service review • Review pathways • Reduce duplication • Improve management closer to home • Develop prescribing formularies		**R**		**I** →				
A1.4	Heart Failure review • Explore gaps in service against NICE recommendations • Review model • Develop case for change (if required)		**R**		**I** →				
A1.5	Haematology review (warfarin, pathways for management including AF, Blood and other transfusions) • Explore existing pathways • Review systems to ensure patient safety • Work with Medicines Management to develop formularies and guidance for clinicians			**I** →					
A1.6	Implement new integrated alcohol treatment pathways (lead by Essex County Council) • Develop new pathway • Procure new solution • Mobilise				**I** →				

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.7	Health check for people with MH needs - SMI registers, cross reference with SEPT - Target smoking, obesity, diet - General wellbeing education for patients		I →	I →	I →	→	→	→	→
A1.8	Antenatal smoking and breastfeeding • Maintain UNICEF accreditation within BTUH	O →	→	→	→	→	→	→	→
A1.9.1	Cancer Services - Inter provider transfer policy • A more effective protocol around the Cancer pathways between South Essex Acute providers incorporating transfer dates and breach allocations.	I →	→	→	→	→	→	→	→
A1.9.2	Cancer Services - Patient tracking • Review of anonymous Patient Tracking List (PTL) on regular basis to identify themes and issues causing delays in patient pathways. • Regular meetings with BTUH cancer leads to ensure early identification and resolution of issues arising in Primary Care.	I →	→	→	→	→	→	→	→
A1.9.3	Cancer Services - Review of services Wider review of the South West Essex Cancer service including: • Review of patients with 1st cancer diagnosis seen via A+E to identify any missed opportunities in earlier intervention. • Children survival rates. • Effect of increased referrals and comparison of positive diagnosis conversion. • Capacity at South West Essex Trusts.		R			I →	→	→	→

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A1. Improving outcomes (Domain 1: Preventing people from dying prematurely)

Stroke Outcomes (SUBJECT TO ONGOING PROCESS – TO BE REVISED IN FINAL SUBMISSION)

Measure	Basildon Hospital 13/14
Standardised Hospital Mortality Rate	104.5 'As Expected'
Thrombolysis within 3 hours	16.2%
Admitted to a stroke unit within 4 hours	62.7%
90% of time spent on a stroke unit	83.3%
Early supported discharge	25.2%

The CCG has identified that whilst improvements have been made in the provision of stroke care, further development is required to consistently achieve key metrics and be top quartile nationally for overall stroke mortality and long term outcomes.

A number of initiatives have been identified that will support the transformation of the stroke pathway;

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A1.10	Stroke reconfiguration • Undertake a consultation on the future provision of HASU/ASU and Rehabilitation Pathways • Commence implementation • Utilise BCF process to commission increased capacity in Early Supported Discharge • Improve the transition between acute and community stroke services through the local stroke network.	**R**			**I** →	→	→	→	→
			I →	→	→	→	→	→	→
		O →	→	→	→	→	→	→	→

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]

CCGOF 2.6 | Unplanned hospitalisation for chronic ambulatory care sensitive conditions

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
Jul 12 - Jun 13	795.1	802.2	970.6	729.9	▼8%	78	

CCG rate is 8% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally through the Ambulatory Care Pathway developed with Basildon Hospital.

Ambition: 658.8 or lower

CCGOF 2.7 | Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
Jul 12 - Jun 13	326.2	308.6	397.3	197.6	▼39%	19	

CCG rate is 39% lower than national average. CCG is aiming sustain low rate to remain in lowest 10% nationally.

Ambition: 197.6 or lower

CCGOF 2.2 | People feeling supported to manage their condition

Weighted percentage of people who feel supported to manage their long-term condition

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
Jul 11 - Mar 12	69.57	70.5	72.7	69.39	▼0%	82	

Percentage of people feeling supported is in line with national average. CCG is aiming to increase to above national average.

Ambition: 70.5 or above

NHSOF 2 | Health related quality of life for people with long-term conditions (Local Authority Borough Level)

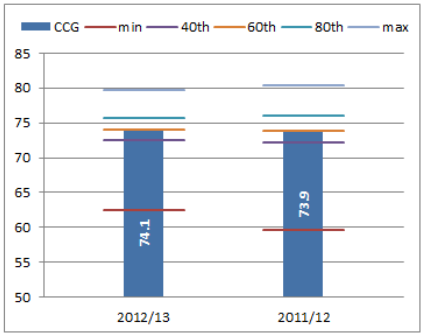
Average health status (EQ-5DTM) score for individuals aged 18 and over who identify themselves as having a long-term condition, weighted for design and non-response

2012/13	0.73	0.74	0.77	0.73	-	130		Basildon
2012/13	0.73	0.74	0.77	0.78	▲7%	306		Brentwood

There is a variation in the quality of life measure between the two boroughs within the CCG boundaries. The average health status score is the same as national average for Basildon and 7% higher than national average for Brentwood which is in the top 10% nationally.

In terms of the total score for the CCG this is at the 60th percentile.

Total EQ-5D per 100 people:



Ambition:
Basildon 0.74 or above
Brentwood 0.78 or above

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
N/A	Hypertension (see section A1.1)								
N/A	Respiratory (see section A1.2.1 and A1.2.2)								
N/A	Cardiology (see section A1.3)								
N/A	Heart Failure (see section A1.4)								
A2.1	Introduction of Ambulatory Emergency Care Pathways: • Initial 11 pathways (DVT, cellulitis, renal colic, chest pain, pleural effusion, UTI, falls, pulmonary embolism, TIA, seizure, pneumonia) fully implemented by April 2014 • Remaining 38 pathways implemented by April 2015	**P** →				**I**			
A2.2	Carers' strategy – • Education of relapse signs to carers		**I** →		**R** →		**I** →		
A2.3	Dementia and anti-psychotic meds – • Educational programme for GPs, audit lowest/most appropriate dose	**R**	**I** →						
A2.4	Continence programme – pan -Essex • Pathway review – adults • Pathway review – paediatrics • Procurement project – best value for products and standardisation across Essex					**I** **I** → **I**			
A2.5	Diabetes service review (including renal) • Review existing service against NICE guidance • Improve management closer to home • Develop prescribing formularies • Develop a specification for high quality, cost effective provision			**R**		**I** →			

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A2.6	Improving LTC management in patients with Mental Health conditions • Assigned MH well being practitioner to be supporting "Desmond" and "Dafne" courses (for diabetes) • Rollout RAID project – identification of MH symptoms for people on acute hospital wards • Shared care protocol to reduce gaps in service between primary and secondary care • South Essex Recovery College to enhance and promote healthy integrated living for people with MH • Increase medical cover on in patient psychiatric wards • Dementia screening (primary care QOF and acute)		I →						I →
		I →							
		I →							
									I
			I →						
		I →							
A2.7	Paediatric High Impact Pathways • Phased roll out of additional pathways	P →							I
A2.8	Roll out personal health budgets - CHC - Other health services - Mental health vol sector spend	I →							
				P →					
						P →			
A2.9	"Who Will Care?" recommendations – 5 proposals for improved integration and patient centred services; direct link to BCF delivery	P →							

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions)

Outcome Ambition 2: Improving the health related quality of life of people with long term conditions, including mental health

Outcome Measure 3: Roll out of Improving Access to Psychological Therapies service

Number of people with depression and/or anxiety:	32,743
Target (%):	12.6%
Target (number):	4,126

The number of people who have entered psychological therapies*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Actual (Volume)	421	384	270	295	254	328	313	279	116				2,660
Actual (%)	1.3%	1.2%	0.8%	0.9%	0.8%	1.0%	1.0%	0.9%	0.4%				8.12%
Plan (Volume)	344	344	344	344	344	344	344	344	344	344	344	344	3,094
Pan (%)	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	9.45%

CCG is currently aiming for 12.6% of the 32,743 people with depression and/or anxiety (4,126). The CCG (as at December 2013) is currently at 8.12% compared to trajectory of 9.45%. The CCG is aiming to meet 12.6% by end of year and achieve 15% by March 2015.

	2014/15				2015/16			
Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
IAPT integrated into LTC - focus on clusters 1-3 and to include COPD, diabetes and stroke.	**P**		**R**		**I**	→	→	→
Access to IAPT – increase to 15% coverage	**P**	→	→	→	→	→	→	→
Collaboration with IAPT service provider to provide easier access to self referral	**I**	→	→	→	→	→	→	→

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A2. Improving outcomes (Domain 2: Enhancing the quality of life for people with long term conditions) – Increasing Dementia Diagnosis

Supporting Measure 1: Increasing dementia diagnosis rate to 67% by March 2015

The forecast year end position for the CCG at the end of 2013/14 for dementia is 62.3% or 2,054 people identified on dementia registers of an estimated 3,298 people living with Dementia.

Based on the current trajectory the CCG is aiming to have identified 2,500 people of an estimated 3,364 people living with Dementia in the CCG area, or 75%.

	2014/15				2015/16			
Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Practice level audit of dementia registers (subject to IG permissions)	**R** →							
Refresher training to practices to identify potential dementia and referral routes.		**I** →						
Maintain dementia awareness and training within secondary care.	**O** →							

R: Complete Review **I:** Implement **P**: Phased Implementation **O:** On-going

A3. Improving outcomes (Domain 3: Helping people to recover from episodes of ill health or injury)

Outcome Ambition 3: Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.

Outcome Measure 4: Emergency admissions for acute conditions that should not usually require hospital admission

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 3.1 | Emergency admissions for acute conditions that should not usually require hospital admission							
Directly standardised rate (DSR) for all ages per 100,000 population							
Jul 12 - Jun 13	1184	1211.0	1456.5	887.9	▼25%	28	

Ambition:
868.7
or lower

CCG rate is 25% lower than national average. CCG is aiming to reduce the rate further to lowest 25% nationally.

		2014/15				2015/16			
No.	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
N/A	Stroke (see section A1.10)								
N/A	Ambulatory Emergency Conditions (A2.1)								
N/A	Paediatric High Impact Pathways (see section 2.7)								
A3.1	Geriatrician Reduction in admission/re-admission of frail elderly via 'Interface Geriatrician' model including Consultant Geriatrician-led CGA and Medical Management Planning via DMOP discharge and ED 'Frailty Stream'; and Community Geriatric MDT/Practice-level MDT Case-management approach during 2014/15	**P**	**I** →						
A3.2	Frail Elderly Extension of Case Management approach to achieve full integration of health/social care provision for Frail Elderly individuals in line with BCF plan			**P**		**I** →			

R: Complete Review **I:** Full Implementation **P**: Phased Implementation **O:** On-going

A3. Improving outcomes (Domain 3: Helping people to recover from episodes of ill health or injury) **PROMS, LRTIs and REABLEMENT**

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	Rank (of 211)	Spine Chart (Diff from Median) [Limited to +/-100%]
CCGOF 3.3a | Patient reported outcomes measures (PROMS) for elective procedures: Hip replacement							
2011/12	n/a	41.3%	42.9%	37.4%	n/a	23	

Ambition: 41.3% or higher

The PROMS percentage for Hip replacement is low in the bottom 10th percentile. CCG aims to increase this to national median.

CCGOF 3.3b | Patient reported outcomes measures (PROMS) for elective procedures: Knee replacement							
2011/12	n/a	30.1%	31.3%	30.0%	n/a	102	

Ambition: 30.1% or higher

The PROMS percentage for Knee replacement is in line with national median.

CCGOF 3.3c | Patient reported outcomes measures (PROMS) for elective procedures: Groin hernia							
2011/12	n/a	8.7%	10.0%	10.4%	n/a	166	

Ambition: 10.4% or higher

The PROMS percentage for Groin hernia is above the national median within highest 25%.

CCGOF 3.3d | Patient reported outcomes measures (PROMS) for elective procedures: Varicose veins							
2011/12	n/a	9.6%	11.0%	n/a	n/a	125	

Ambition: N/A

The CCG does not have a PROMS percentage for Varicose veins.

CCGOF 3.4 | Emergency admissions for children with lower respiratory tract infections							
Directly standardised rate (DSR) for all ages per 100,000 population							
Jul 12 - Jun 13	397.3	400.0	512.0	260.3	▼34%	31	

ASCOF 2B(1) | Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services (effectiveness of the service) (Local Authority Council Level)							
Proportion of older people (aged 65 and over) discharged from acute or community hospitals to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an							
2012/13	81.40	83.60	88.40	82.00	▲1%	63	

Ambition: BCF

A3. Improving outcomes (Domain 3: Helping people to recover from episodes of ill health or injury)

		2014/15				2015/16			
No.	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A3.3	MSK pathway: • Developing an enhanced Hub/triage model for referrals • First pathways for development – spinal and rheumatology • Collaboration with medicines management to develop standardised formularies	**P** →				**I** →			
A3.4	South Essex SRP review: • Policy review • Standardising procedural and treatment restrictions in line with other Essex CCGs and best practice (e.g. NICE) • Patient engagement with process of review and development of patient information • Collaborative working with Public Health, Clinicians, PCRG and Medicines Management	**I** →							
A3.5	Review of SPOR/Reablement • Through the BCF, review the SPOR and provision of reablement services • Develop long term model • Commission new model • Implement	**R**				**I** →			
A3.6	Continuing Health Care • Review of Mountnessing Court • Review requirements for reablement/rehabilitation pathway pre CHC assessment • Commission new mode	**R**		**I** →					
A3.7	Community Intermediate Care Review • Through the BCF, review the provision and requirements for health/social intermediate care • Develop long term model	**R**		**P** →		**I** →			

R: Complete Review **I:** Full Implementation **P**: Phased Implementation **O:** On-going

A4. Improving outcomes (Domain 4: Ensuring that people have a positive experience of care)

Outcome Ambition 5: Increasing the number of people having a positive experience of care.

Outcome Measure 7: Inpatient Friends and Family Test

Basildon University Hospital - RDD

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Response Rate	8%	19%	13%	12%	10%	10%	12%	15%	16%
Net Promoter Score	39	35	44	49	51	45	53	59	61

Accident & Emergency (Types 1&2)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Response Rate	3%	11%	6%	6%	4%	4%	4%	5%	11%
Net Promoter Score	-42	-13	16	21	9	6	-11	31	49

Currently our main provider has a very low response rate. The provider has been asked to provide and implement solutions to rapidly increase the response rate to least national average by the end of Q2 2014/15. To encourage this we have used the CQUIN scheme within the contract.

Once the response rate has increased, further work will be done to interrogate the data to ensure any issues are identified and addressed, thus improving patient experience by responding to concerns. All of this will be achieved within an improved culture of care, compassion, communication, courage, competence and commitment as described within the Patient Safety and Quality section of this plan

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A4.1	Increase response rate for FFT: • Trust to provide and implement solutions • Include as part of CQUIN to Improve response rate	P		O	→	→	→	→	→
A4.2	Improve outcome of FFT: • continue to identify area of concern and • ensure provider develop actions to address.	O	→	→	→	→	→	→	→
A4.3	Roll out FFT programme to: • Maternity • Staff	I	→	→	→	→	→	→	→
A4.4	The above three actions will be underpinned by: • increased utilisation of patient engagement programmes • creation of a learning culture with all providers • the establishment of the culture of the 6 Cs as described in the quality section of this plan	P			I	O	→	→	→

A4. Improving outcomes (Domain 4: Ensuring that people have a positive experience of care)

Outcome Ambition 6: Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.
Outcome Measure 8: Composite indicator of (i) GP services, (ii) GP out of hours services.

		2014/15				2015/16			
No	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A4.4	Primary Care Strategy Implementation of primary care strategy – named lead GP, services centric to patient care (see also BCF)	**P** →							
A4.5	Review of NHS 111 specification								**R**

R: Complete Review **I:** Full Implementation **P**: Phased Implementation **O:** On-going

A5. Improving outcomes (Domain 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm)

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

Outcome Measure 9: Hospital deaths attributable to problems in care (**under development**)

Supporting Measure 3: (i) MRSA zero tolerance (ii) Clostridium difficile reduction

Commentary on current position:

Historically our main provider has had a SHMI ratio above expected limits, and has moved to within expected limits in Q4 of 2013/14 (but still with a high ratio 1.11). Whilst this show movement in the right direction, the momentum must be continued. The Hospital Mortality Plan is closely monitored with key areas of performance monitored to drive down avoidable hospital deaths. Work has also commenced to influence factors external to the hospital to avoid inappropriate admissions that subsequently result in avoidable deaths e.g the End of Life pathway. This work will be further underpinned by the output from the Care Conversation.

C-Difficile (awaiting national trajectory)

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5.1	Reduce the number of avoidable deaths within the hospital • Care of deteriorating patient • Consultant review • 7 day working • Mechanisms used – contract and monitoring visits		**P**		**I**	**O** →			
A5.2	MRSA Maintain zero tolerance for MRSA bacteremia cases	**O** →							
A5.3	C-Diff Continue to drive down cases of Clostridium difficile	**O** →							
A5.4	Monitor Monitor on-going arrangements within the main provider to prevent and control infection: • Via the contract • Via the Clinical Quality Review Group • Quality visit programme	**O** →							

A6. Improving outcomes (Improving health and reducing health inequalities)

As part of the CCG Board's Strategic Commissioning Priority to improve the lifestyles of our population and reduce health inequalities, our Public Health aligned staff have undertaken a comprehensive 'deep dive' on Health Inequalities, Lifestyles and Prevention. The deep dive contains detailed analysis and commissioning recommendations for the CCG on:

- Reducing Health Inequalities
- Reducing the prevalence of smoking
- Tackling Obesity including improving diet and increasing physical activity with our population
- Delivering vascular health checks
- Reducing alcohol misuse
- Improving childhood and adult immunisation coverage
- Breastfeeding
- Improving participation of our population in cancer screening programmes.
- Improving the health of older people

BBCCG is committed to working collaboratively with Essex County Council Public Health staff to support delivery of their commissioned health improvement programmes by:

- Delivering 'Making Every Contact Count' at practice level and commissioning our providers to do the same
- Developing a 'Lifestyles Balanced Score Card' for each GP practice with detailed recommendations for improving the health the practice's population and reducing health inequalities.
- Delivering consistent high performance on health improvement programmes commissioned by ECC Public Health and Public Health England at practice level including smoking cessation, health checks, alcohol brief screening and intervention, immunisation and screening and sexual health

NHS England has published "Commissioning for Prevention" which outlines 5 steps which CCGs should take to improve health and reduce health inequalities. Within this section we outline the work undertaken so far within the CCG and that planned to put these 5 steps into action.

Steps 1 and 2: Analyse key health problems and Prioritise and set common goals.

The CCG's public health aligned staff have undertaken a 'deep dive' on health inequalities, lifestyles and prevention together with a wider clinical JSNA that analysed all of our areas of commissioning in terms of spend and outcome for our patients

This work has identified the following groups of people in our community who have worse outcomes and experience of care:

- The communities of:
  - Vange – Basildon town
  - Pitsea – Basildon town
  - St.Martins – Basildon town
  - Fryerns – Basildon town
  - Laindon Park – Basildon town
- People with mental health problems

It has also identified priority areas for action within these groups and more broadly across the entire CCG:

- Area 1: Respiratory Disease
- Area 2: Circulatory Disease
- Area 3: Diabetes
- Area 4: Cancer
- Area 5: Falls in Older People
- Area 6: Lifestyle issues, particularly smoking and alcohol misuse
- Area 7: Mental health

The CCG 's resource allocation framework, and business case template for new investment require that programmes demonstrate how they will positively impact on reducing health inequalities.

A6. Improving outcomes (Improving health and reducing health inequalities)

Steps 3 and 4: Identify high impact programmes and plan resources

The CCG has identified the following high impact work areas to implement over the next two years to improve health and reduce health inequalities:

High impact project 1: Prevention of Strokes through improving Hypertension QOF register completeness and improving clinical management of circulatory disease
Aimed at: Patients most at risk of hypertension and those with existing circulatory disease
Delivery start date: July 2013
Resourced through: ECC
Description: Use of the NHS Health Checks programme, Senior Health Checks programme, MIQUEST queries and Blood Pressure monitoring machines in GP surgery waiting areas to improve case finding of undiagnosed hypertension, and assist GP surgeries to improve the management of hypertension, CHD and stroke. If successful the programme will prevent 316 strokes in three years

High impact project 2: Preventing strokes through improved anti-coagulation in patients with Atrial Fibrillation
Aimed at: Patients on GP AF QOF registers
Delivery start date: November 2013
Resourced through: ECC
Description: AF is a significant cause of stroke which is preventable with identification and good management. The age-specific prevalence of AF is rising due to improved survival of patients with CHD. AF is associated with a five-fold risk of stroke, but this can be reduced by 66% through anti-coagulation. The programme incentivises GP practices to increase the percentage of AF patients who are anti-coagulated over and above what is required to achieve maximum QOF points.

High impact project 3: Integrated Public Health Commissioning Programme
Aimed at: Reducing harm caused by alcohol misuse, reducing falls in older people, improving recovery from stroke and improving continence care
Delivery start date: April 2014.
Resourced through: ECC and CCG
Description: Our JSNA Lifestyles Deep dive identified significant harm being caused to our population through alcohol misuse, and in the over 65s by falls. The programme, jointly commissioned between ECC and the CCG and forming part of our integrated commissioning programme, provides a substantial increase in investment of alcohol brief screening and intervention and treatment programmes, and in integrated falls clinics locally by ECC in return for the CCG increasing investment in stroke early supported discharge and continenc services.

High impact project 4: Reducing Health Inequalities through stop smoking services
Aimed at: Smokers in deprivation quintiles 4 and 5
Delivery start date: April 2014.
Resourced through: ECC
Description: A health equity audit on smoking has identified that differences in access to stop smoking services and quit rates between affluent and deprived communities across the CCG are resulting in a failure of smoking cessation to address health inequalities. The project aims to increase referral rates of smokers from GP practices serving our 40% most deprived communities to levels that address this.

A6. Improving outcomes (Improving health and reducing health inequalities)

High impact project 5: Making Every Contact Count
Aimed at: Patients engaging in health damaging behaviour and poor lifestyle choices.
Delivery start date: On-going
Resourced through: CCG
Description: All contracts with our front line providers include a requirement to deliver MECC including performance metrics. The CCG will systematically monitor these to ensure that providers are delivering the programme.

High impact project 6: Respiratory Services Review
Aimed at: Reducing the health impact of respiratory disease amongst our patients.
Delivery start date: December 2013
Resourced through: CCG
Description: Patients with respiratory disease (particularly COPD) have poorer outcomes than expected, whilst local services cost considerably more than our ONS cluster CCG mean. The project is undertaking a deep dive review into the respiratory services pathway, with a view to whole pathway redesign to improve outcomes for patients. As respiratory disease impacts more significantly on our more deprived populations, the project should also reduce health inequalities.

High impact project 7: Diabetes and Endocrine Pathway re-design.
Aimed at: Reducing the health impact of diabetes on our patients
Delivery start date: February 2014
Resourced through: CCG
Description: Our JSNA identified that patients with diabetes have poorer outcomes than expected, whilst local services cost considerably more than our ONS cluster CCG mean. The project is undertaking a deep dive review into the diabetes and endocrine care pathway, with a view to whole pathway redesign to improve outcomes for patients. As diabetes disease impacts more significantly on our more deprived populations, the project should also reduce health inequalities

High impact project 8: Improving the mental health of vulnerable people and groups
Aimed at: Older people, people accessing IAPT and secondary mental health services
Delivery date: July 2014
Resourced through: ECC
Description: Research shows that there is a high prevalence of undiagnosed depression in older people and that patients of all ages who access mental health services have poorer physical health outcomes. This scheme will commission a suite of initiatives aimed at improving the mental health of older people and vulnerable groups, including screening and treating older people for depression, social prescribing to address loneliness and isolation in older people, floating support to assist patients with mental health problems to deal with housing problems and debt, and providing health trainers to people accessing secondary care mental health services to assist them to address health damaging behaviour such as smoking and alcohol misuse.

A6. Improving outcomes (Improving health and reducing health inequalities)

EDS2

The CCG refreshed its Equality & Diversity Strategy recently and this was approved by the Board in November 2013. A further revision will be required in the coming months to reflect the new requirements of EDS2. However a number of steps have already been taken to ensure that the CCG fulfils its public sector equality duty :

- Information about the composition of the CCG's workforce has been published on the dedicated equality & diversity section of the CCG website;
- Within the Equality & Diversity Strategy, the CCG has published its interim EDS goals;
- Equality & diversity (including a refresh of the EDS goals) to be a topic for a meeting of the recently established Patient & Community Reference Group (PCRG) in the next few months. The PCRG will be a key vehicle for agreeing priorities with the community and assessing progress;
- Equality & Diversity Policy in place;
- Chief Nurse appointed as Board-level lead for equality & diversity;
- Equality impact assessments are undertaken on all CCG policies, QIPP plans and commissioning cases.

A5. Improving outcomes (Domain 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm)

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

Outcome Measure 9: Hospital deaths attributable to problems in care (**under development**)

Supporting Measure 3: (i) MRSA zero tolerance (ii) Clostridium difficile reduction

Commentary on current position:

Historically our main provider has had a SHMI ratio above expected limits, and has moved to within expected limits in Q4 of 2013/14 (but still with a high ratio 1.11). Whilst this show movement in the right direction, the momentum must be continued. The Hospital Mortality Plan is closely monitored with key areas of performance monitored to drive down avoidable hospital deaths. Work has also commenced to influence factors external to the hospital to avoid inappropriate admissions that subsequently result in avoidable deaths e.g the End of Life pathway. This work will be further underpinned by the output from the Care Conversation.

C-Difficile (awaiting national trajectory)

		2014/15				2015/16			
	Actions	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
A5.1	Reduce the number of avoidable deaths within the hospital • Care of deteriorating patient • Consultant review • 7 day working • Mechanisms used – contract and monitoring visits		**P**		**I**	**O** →			
A5.2	MRSA Maintain zero tolerance for MRSA bacteremia cases	**O** →							
A5.3	C-Diff Continue to drive down cases of Clostridium difficile	**O** →							
A5.4	Monitor Monitor on-going arrangements within the main provider to prevent and control infection: • Via the contract • Via the Clinical Quality Review Group • Quality visit programme	**O** →							

A7. Improving outcomes (Parity of esteem)

Improving outcomes for people with mental health
We are committed to reducing the inequality in outcomes that we currently see for people living with a mental health problem, and intend to integrate mental and physical health services during the course of this plan in order to improve access to physical health services for people with mental health problems and equally improving access to mental health services for people with physical health problems. To this end we have appointed a Clinical Director for Mental Health to lead this work.

We intend to take the following steps over the next two years to achieve better parity of esteem:

	2014/15				2015/16			
Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Training NHS staff to better identify and respond to the needs of people with mental health needs								
All GPs to have had training to recognise signs of risk indicators for suicide and severe mental illness and correct referral paths.								
All medical and nursing staff in Basildon Hospital to have received training to identify mental health problems and correct referral paths.								
All mental health inpatient and community staff to have received appropriate training in physical health care and the identification of physical health needs.								

A7. Improving outcomes (Parity of esteem)

	2014/15				2015/16			
Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Integrating physical and mental health care								
All people with low-level mental health need (clusters 1-3) to be principally cared for by their GP as their Named Accountable Professional.							I →	
Community mental health teams to form part of primary care multi-disciplinary teams	I →							
Community mental health teams to be integrated into primary care federation based health teams								I
IAPT services to be integrated into primary care federation based health teams, focusing on long-term conditions.								I
Psychogeriatricians and older people community mental health teams to be integrated into the new care of the elderly community 'step up' teams.							I →	
Introduce specified pathway of health prevention work with individuals who suffer from a mental health problem (e.g. obesity / alcohol).					I →			

A7. Improving outcomes (Parity of esteem)

	2014/15				2015/16			
Action	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Other areas								
Introduce audit programme of GP SMI registers and health checks for people with mental health needs.			I	→	→	→	→	→
Cross reference GP and secondary care SMI register to identify unidentified individuals.			I	→	→	→	→	→
Implement formulary for mental health services across primary and secondary care and supporting audit programme.			I	→	→	→	→	→
Implement the 'South Essex Recovery College'								I
Implement personal health budgets for people in recovery.								I
Specific actions to identify and support young people with mental health problems								
Extend IAPT to 14-18 year olds				I	→	→	→	→
Review of eating disorders service			I	→	→	→	→	→
Audit of A&E attendances to identify high risk young people.				I	→	→	→	→
Training of schools and health visitors in mental health identification and referral paths.				I	→	→	→	→

Section B

Delivering the NHS Constitution

B. Delivering the NHS Constitution

The CCG is committed to ensuring the delivery of the NHS Constitution for our local community.

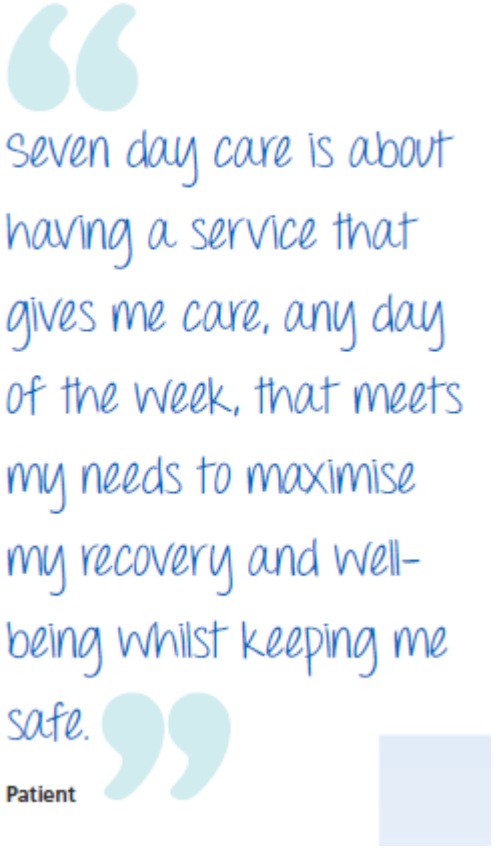
This section of the report sets out the steps we are taking, or plan on taking in order to ensure the delivery of the Constitution through to 2016, including system wide plans for 7 day working.

B. 7 day working

The CCG has established a cross economy 7 day working group which is focusing on improving access to services across 7 days. We have used the levels of service provision as outlined by NHSIQ in *"NHS Services – Seven Days a week"* to establish our current position and to set ambitions regarding how this should be extended. For the period of this two year plan this will principally focus on emergency and urgent care services.

The full mapping is attached to this plan at Annex D which shows the current and proposed hours for service operational across our local health economy for urgent care services.

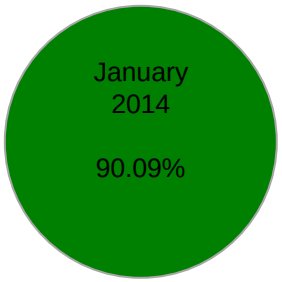
In addition it also outlines the current position in regard to the extent to which services meet the draft clinical standards published by NHS England.



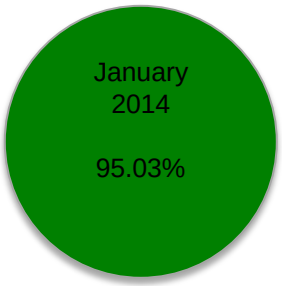
B. Delivering the NHS Constitution

Referral to treatment times for non-urgent consultant led treatment

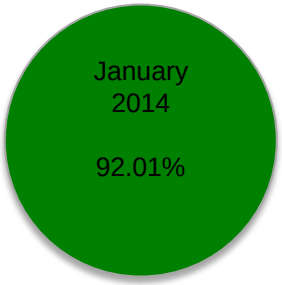
Percentage of admitted patients starting treatment within 18 weeks from referral.



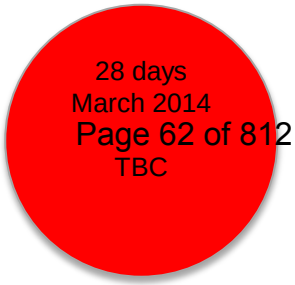
Percentage of non-admitted patients starting treatment within 18 weeks from referral.

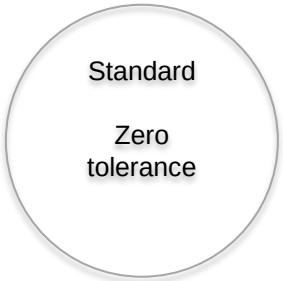


Percentage of patients who are yet to start treatment who have been waiting less than 18 weeks



Number of people who have had to wait for 52 weeks or longer for treatment in the year / who are cancelled and are not offered an appointment within 28 day.





Commentary

Although the CCG is delivering the three core targets for non-urgent treatment, it recognises that work is required in two key areas during the period of this plan to reduce waiting times further and to ensure equity in service delivery for all patients. These are (i) the delivery of compliance with the standards across every specialty and (ii) the introduction of chronological booking.

Chronological booking implementation / specialty level compliance

The CCG has agreed a further action plan (available on request) to deliver chronological booking across all specialties in a phased manner over the next 5 (TBC) months.

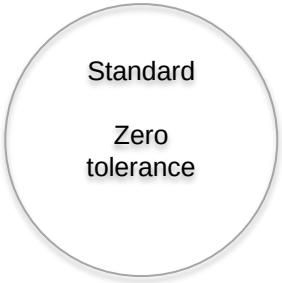
An outline of the RTT action plan is attached at Annex E for reference.

B. Delivering the NHS Constitution
Diagnostics and A&E

Percentage of patients who have waited less than 6 weeks for a diagnostic test

Percentage of people who have been admitted, transferred or discharged within 4 hours of their arrival at an A&E department

Number of people who have had to wait for longer than 12 hours following a decision to admit them in A&E.



A&E

During 2013/14 the CCG implemented an Urgent Care Recovery and Improvement Plan and significantly revised Winter Plan which resulted in significant changes across the local health economy in regard to the operation of unplanned care services.

This has resulted in a significant improvement in A&E performance with the delivery of the standard in Quarter 3. At the time of writing we forecast achievement of the 4 hour standard in Quarter 4 and overall for the year.

Our next steps in regard to further strengthening and improving our urgent care system is overleaf.

Establishing a safe and effective urgent care system

Urgent care working group
The CCG, with its partners will continue to use the Urgent Care Working Group (UCWG) as the principle driver of ensuring that we maintain and drive up the performance of our local urgent care system.

Overall urgent care performance this winter is significantly improved from the previous winter, although there remains too much variation and the need to improve the consistency of delivery across every day of every week.

We will also extend the representation at the UCWG from March 2014 to include the following agencies: GP Practices, Essex Cares and members of the voluntary and third sector.

Objectives of the UCWG
The objectives of the UCWG for the duration of this plan will remain as:

- Strengthening collaboration across health and social care in respect to the day to day operation of the urgent care system, proactively tackling and removing barriers when these are identified.

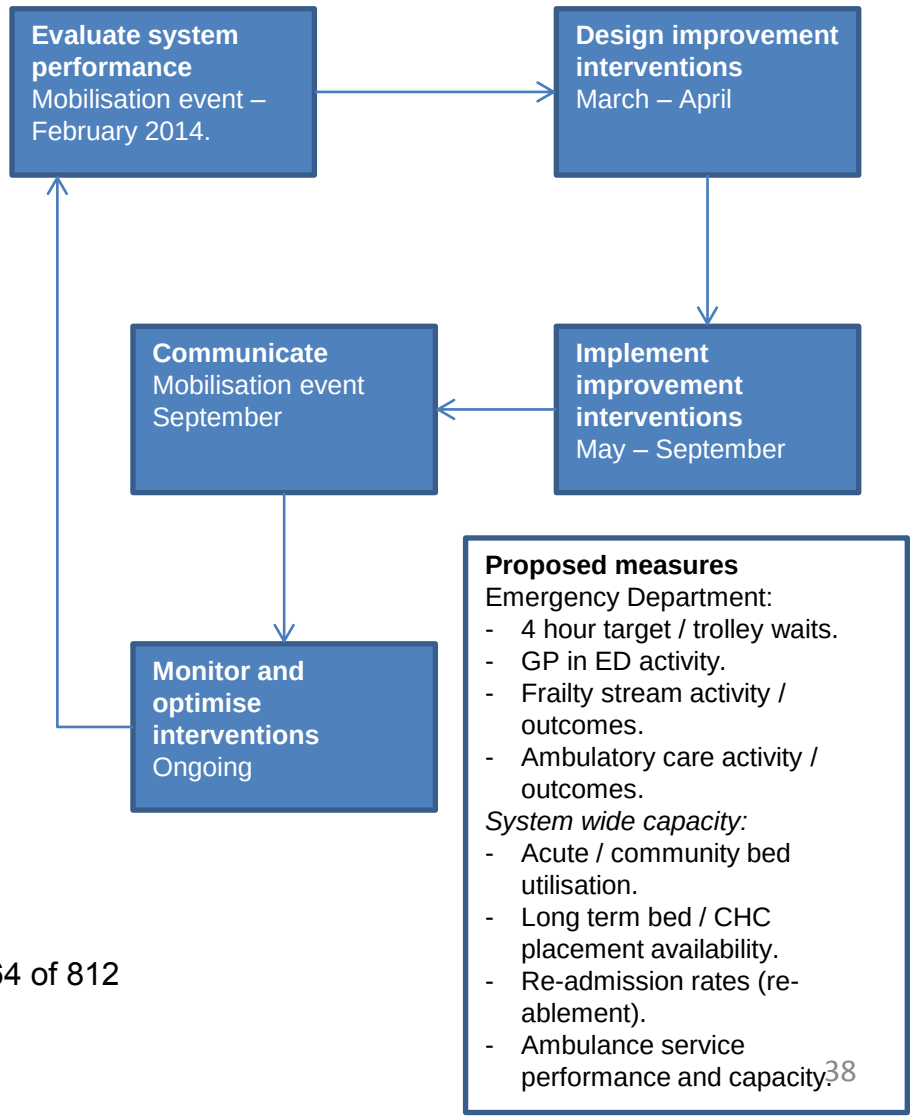
- Facilitating joint operational and tactical planning, including leading the work in respect to winter and other key challenges to urgent care performance as well as the allocation of any winter pressures funding.

- Evaluating the performance and resilience of the urgent care system and making decisions as to the action which should be taken to strengthen the system when this is required.

Key actions for the UCWG are identified on the diagram on this page.

Designation and unplanned care system structure
The CCG, alongside the CCGs and acute providers in greater Essex is fully engaged the in county wide scoping exercise on the future of acute services, anticipated to be published in Spring/Summer 2014.

Urgent care system: improvement approach



Learning from Winter 2013/14

The CCG is co-ordinating a cross system mobilisation event with the aim of agreeing the learning from our experiences during Winter 2013/14 to improve system resilience further in 2014/15 for all stakeholders within the local health and care system.

The agenda for the event has been agreed by the Urgent Care Working Group and will cover:

- **Reflections on Winter Period** (including a range of patient stories on their experiences where things went well / less well). - Supported by a breakout sessions on successes/failures, improvement areas for 14/15, engagement and communication with primary care.
- **System wide risk management** focusing on the definition of 'medically fit' and a focus on respiratory indications and management.
- **Pathways out of hospital** focusing on the findings/outcomes of a series of system workshops the CCG has led on reablement/rehabilitation/placement pathways.

Areas of focus for future winter pressures funding

Our expectation is that any winter pressures funding will be used to expand the capacity of existing service models, including those introduced and refined during the spring and summer 2014, rather than for commencing new or untested ideas immediately prior or during the winter period.

Key areas will include:

- supporting the expansion of community health & social care capacity to support vulnerable individuals and their carers, in line with the System-wide Urgent Care Plan
- enhancing primary care-led prevention targeting key patient groups (e.g. individuals with COPD, frailty, carers of vulnerable individuals)

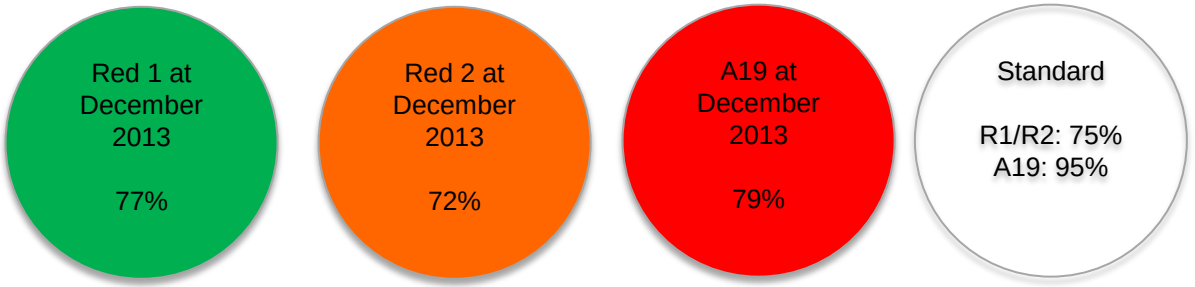
Key learning / improvement opportunities identified

The local health and social care system has made significant progress in taking a collaborative approach to both managing the general increased levels of demand associated with winter, and recovering rapidly from those periods where a surge in demand has represented a significant test to the system. In turn, this more integrated approach has allowed us to identify further opportunities for improvement to be developed in preparation for the winter of 2014/15:

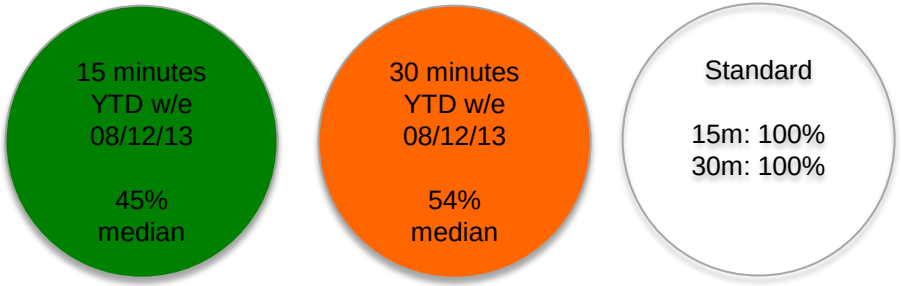
- **Improved involvement of key groups into the wider system planning and response -** in particular GP practices, East of England Ambulance Trust, and critically patients and carers.
- **Improved co-ordination through better information** – current process for collecting data to reflect demand and capacity within the system will be revised in order to incorporate information on key areas which are not currently included (e.g. capacity in primary care) and thereby both inform improved co-ordination in system-wide responsiveness, and support development of a predicative model.
- **Improvements in key organisational processes** – including
  - emphasis on increasing access to timely assessments by senior decision makers to ensure individuals receive the right care in the right place – e.g. key decision points for attention – prior to decision to admit to secondary care or into long term residential/nursing care ;
  - increase access to, and utilisation of, mechanisms to effectively navigate the health & social care system (e.g. SPOR/RRAS) by all stakeholder organisations;
- **Development of a 'convalescence' model** – offering short-term (i.e. up to 2 weeks) enhanced sub-acute care, providing clinical/social support to individuals with complex needs within a community environment. The intention being to reduce inappropriate hospital stays, and support individuals to maximise their recovery in order to ensure that any further packages of care to be provided are set at the appropriate level.
- **Multi-disciplinary training around early detection , intervention and on-going management of conditions affecting vulnerable individuals** – e.g. frail elderly

B. Delivering the NHS Constitution
Ambulance

Category A calls for an ambulance resulting in an emergency response within 8 minutes (R1 / R2) and ambulance arriving in 19 minutes



Percentage of ambulance handovers completed by 15 minutes of arrival and to be ready to accept a new call by 30 minutes of arrival

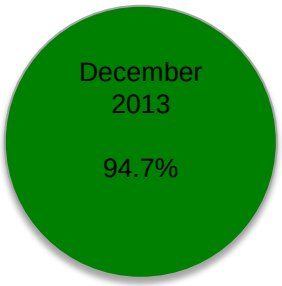


Commentary

Performance issues with East of England Ambulance Service NHS Trust (EEAST) are well documented. We will continue to work with the CCG collaborative commissioning arrangement to support EEAST to move to a more sustainable position. The key issues of focus are capacity and recruitment, alongside the wider requirement for transformation of the ambulance service.

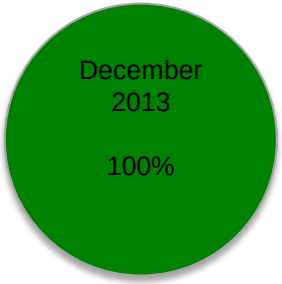
B. Delivering the NHS Constitution
Cancer

Percentage of people referred by their GP with suspected cancer seen within 2 weeks

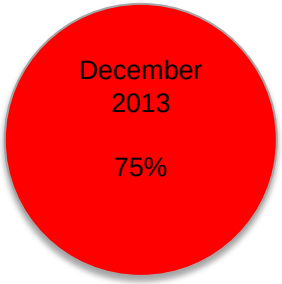


Percentage of people referred urgently with breast symptoms seen within 2 weeks

Percentage of people receiving first definitive treatment for cancer from diagnosis within 31 days



Percentage of people receiving subsequent treatment within 31 days where that treatment is surgery



Commentary:

2 Week Waits & 32 Day Treatment Standards

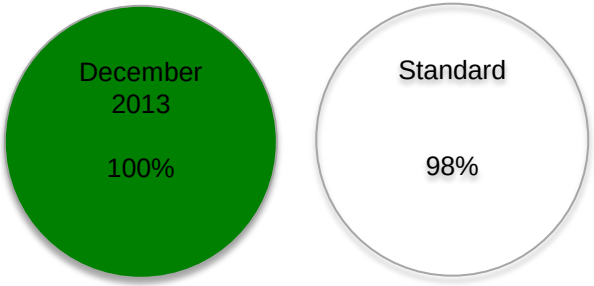
Although Performance on Operational Standards for 2 Week Wait and 31 day treatments are consistently above the relevant thresholds the CGG continues to proactively engage with Trusts to address any recurring delays and themes in site specific Cancer pathways.

This includes (full list of actions is available on page 13 under action A1.9.3):

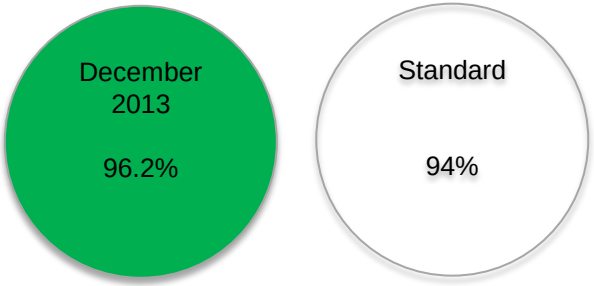
- Regular review of Patient Tracking Lists and early identification of issues arising at Trusts and in Primary Care for resolution.

B. Delivering the NHS Constitution
Cancer

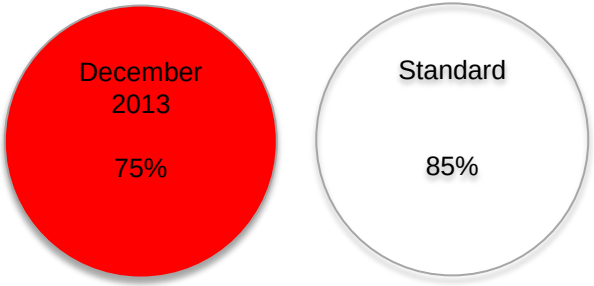
Percentage of people receiving subsequent treatment within 31 days where that treatment is an anti-cancer drug regime.



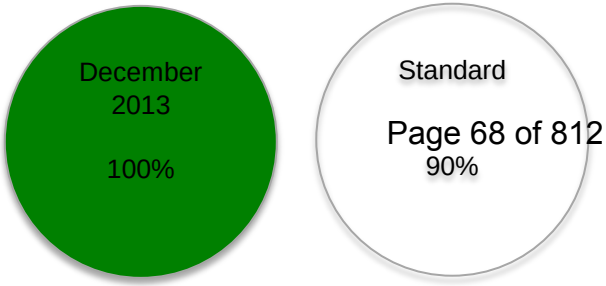
Percentage of people receiving subsequent treatment within 31 days where that treatment is radiotherapy.



Percentage of people receiving first definitive treatment for cancer from GP referral within 62 days.



Percentage of people receiving first definitive treatment within 62 days following a referral from an NHS screening service.



Commentary:

<u>62 Day Operational Standard</u>

The 62 day pathway continues to be an outlier. Breaches have been mainly due to clinical and patient delays overall.

BTUH are also receiving referrals into the CTC after target. The number of 2 week wait referrals continues to grow. (250 more in quarter 3 than in quarter 1), this is adding pressure in regards to capacity for 2 week wait patients being seen right on 14 days.

Patient cancellations for first outpatient appointments and diagnostics, putting pressure on the 62 day target.

The CCG is working in collaboration with the South Essex Trusts to address issues in Cancer pathways.

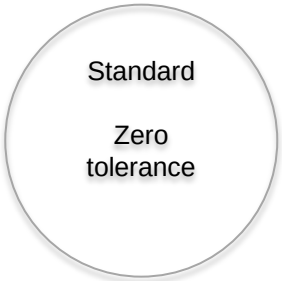
These include (full list of actions is available on page 13 under action A1.9.3):

- Implementation of an Inter-Provider Transfer Policy to ensure a smooth transfer of patient care across South Essex Tertiary Providers minimising delays in the pathway.
- Discussions around localisation of site specific “Timed pathways” implemented in Anglia.

B. Delivering the NHS Constitution

Mixed Sex Accommodation and Care Programme Approach

Number of people who breach mixed sex accommodation requirements



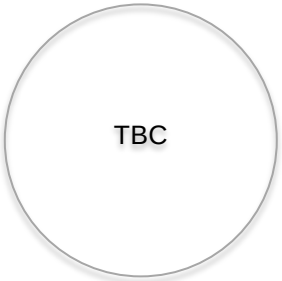
EMSA
Breaches within main provider is not an issue.
However work around privacy and dignity related to EMSA has been undertaken to ensure the survey process is meaningful. Monthly collation of data has shown a response that patients are not always content with privacy and dignity, but current methodology does not enable interrogation to understand what the real issues are. Therefore a less frequent, but more in-depth, audit will take place to enable more narrative and therefore better understanding of issues, so that they can then be addressed.

There have been a number of breaches at some of the Specialist hospitals – mechanisms to better engage with the relevant commissioners is underway.

We will continue to monitor for breaches within our other main providers (NHS and private). Currently there have been no reported breaches (23.01.14)

Governance process in via the monthly Provider update for Patient Safety and Quality Report which goes to the CCG Quality and Governance Committee to the Board

The proportion of people under adult mental illness services on CPA who were followed up within 7 days of discharge from inpatient care.



Section C

Finance, Activity and QIPP

C. Finance and Activity - Financial Plan

The table on the right shows the summary of the CCGs' Financial Plan which demonstrates that the CCG is planning to achieve a 1% surplus in all financial years of the planning cycle. The plan has been developed using the agreed national planning assumption (see later slide) and a number of local assumptions reflecting the expected changes in population, technology and drug changes and the impact of the CCG's QIPP programme.

In 2014-15 the CCG is planning a QIPP programme of £10.009m in order to achieve the required level of surplus. The plan has been developed over a number of months and subject to robust challenge and risk assessment. The CCG used a number of benchmarking tools to identify potential QIPP including the commissioning for value tool and information. The majority of the plan is being negotiated into the contracts . The QIPP plan for 2015-6 is £7.1m and includes the 10% reduction in running costs.

In 2014-15 and 2015-16 the CCG will have 2.5% and 1% non recurrent monies available for transformation projects to start the delivery of the 5 year strategy. This non recurrent resource will also be used to support provider organisations as they make the necessary structural changes to enable them to support the revised ways of working required to deliver a strong integrated service. The 70% marginal rate investment is being discussed with the Trust and UCWG as part of the 14/15 SLA negotiations and will form part of this agreement. This is also the case with the readmissions funding.

The CCG has also provide a 0.5% contingency in each year. This will be used to address any potential financial risks as they arise in year.

The CCG has made significant progress in 2013-4 to improve financial stability and planning. The plan developed reflects this and the confidence of the CCG in future delivery.

Financial Position

Revenue Resource Limit

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Recurrent	306,129	312,540	321,955	327,559	332,947	338,427
Non-Recurrent	2,919	286	3,129	3,500	4,047	4,442
Total	309,048	312,826	325,084	331,059	336,994	342,869

Income and Expenditure

Acute	173,701	173,721	171,671	168,772	173,666	178,702
Mental Health	30,592	30,163	27,445	27,444	27,691	27,939
Community	38,538	36,397	36,106	36,106	36,432	36,760
Continuing Care	12,629	13,891	15,280	16,808	17,396	18,005
Primary Care	38,572	40,353	39,391	41,361	43,635	45,259
Other Programme	8,337	7,211	24,322	29,118	26,303	23,501
Total Programme Costs	**302,369**	**301,736**	**314,215**	**319,609**	**325,123**	**330,166**
Running Costs	6,390	6,387	5,743	5,743	5,743	5,743
Contingency	-	1,574	1,626	1,660	1,686	1,722
Total Costs	**308,759**	**309,697**	**321,584**	**327,012**	**332,552**	**337,631**

£ 000	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Surplus/(Deficit) In-Year Movement	(15)	2,840	371	547	395	796
Surplus/(Deficit) Cumulative	289	3,129	3,500	4,047	4,442	5,238
Surplus/(Deficit) %	0.09%	1.00%	1.08%	1.22%	1.32%	1.53%
Surplus (RAG)	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN
Net Risk/Headroom		863	626	160	186	222
Risk Adjusted Surplus/(Deficit) Cumulative		3,992	4,126	4,207	4,628	5,460
Risk Adjusted Surplus/(Deficit) %		1.28%	1.27%	1.27%	1.37%	1.59%
Risk Adjusted Surplus/(Deficit) (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN
Underlying position - Surplus/ (Deficit) Cumulative	4,851	15,955	10,519	11,156	11,631	12,518
Underlying position - Surplus/ (Deficit) %	1.58%	5.10%	3.27%	3.41%	3.49%	3.70%
Contingency	-	1,574	1,626	1,660	1,686	1,722
Contingency %	0.0%	0.5%	0.5%	0.5%	0.5%	0.5%
Contingency (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN
Notified Running Cost Allocation	6,390	6,387	5,743	5,743	5,743	5,743
Running Cost	6,390	6,387	5,743	5,743	5,743	5,743
Under / (Overspend)	-	-	-	-	-	-
Running Costs (RAG)	GREEN	GREEN	GREEN	GREEN	GREEN	GREEN
Population Size (000)	255,603	255,603	255,603	255,603	255,603	255,603
Spend per head (£)	0.02	0.02	0.02	0.02	0.02	0.02

C. Finance and Activity - Planning Assumptions

The table below details the planning assumptions that have been used by the CCG in developing the financial plan. In addition to this the CCG is planning to achieve the 1% surplus requirement.

For running costs the CCG has assumed that for 2014-15 the overall envelope will remain the same but that from 2015-16 there will be a 10% reduction. In 2014-15 the CCG has set aside 2.5% of the funding for non recurrent expenditure. In 2014-15 the majority of this will be used for the transformation agenda, both for the £5 per head allocation to practices and for the local health economy to move towards the introduction of the Better Care Fund.

The £5 per head will be developed for use by practices to support two key things:

- Activities within primary care related to the improvement actions and schemes as outlined within this document.
- Support the formation of Named Accountable Professional Teams.

Planning Assumptions

		2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	2.14%	1.70%	1.80%	1.70%	1.70%
	Running Costs	-0.05%	-10.08%	0.00%	0.00%	0.00%
	Weighted Average	2.09%	1.46%	1.77%	1.67%	1.67%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.50%	2.50%	3.00%	3.40%	3.40%
	Non Acute	2.30%	2.20%	3.00%	3.40%	3.40%
Demographic Growth (+/- %)		1.00%	1.00%	1.00%	1.50%	1.50%
Non-Demographic Growth (+/- %)	Acute	1.50%	1.50%	1.50%	2.00%	2.00%
	CHC	9.00%	9.00%	9.00%	2.00%	2.00%
	Prescribing	4.00%	4.00%	4.00%	4.00%	4.00%
	Other Non Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Contingency (%)		0.50%	0.50%	0.50%	0.50%	0.50%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.01%
Running Cost (spend per head (£)			0.02	0.02	0.02	0.02

C. Finance and Activity - Activity Plan

The activity plan is based on the forecast outturn activity for 2013-4 and is then adjusted across the five years for :

- Predicated growth levels – this includes both demographic change and changes in disease profile.
- Activity reductions associated with QIPP schemes

The QIPP schemes over the next 5 years assume a reduction in non elective activity of 15%

Activity Plan	Baseline	2014-15	2015-16	2016-17	2017-18	2018-19
Elective	**(13/14 FCOT)**	**Plan**	**Plan**	**Plan**	**Plan**	**Plan**
Ordinary	5783	5851	5910	5969	6029	6089
Daycase	26349	25921	26180	26442	26706	26973
Non-Elective						
Non-elective	22868	22118	21726	21330	20930	20527
Outpatients						
All Firsts	72474	72381	72805	73233	73665	74102
All Subsequents	151588	153393	154927	156476	158041	159621
A&E						
Type 1	71619	72472	73196	73928	74668	75414
All Attendances	78197	79127	79919	80718	81525	82340
Referrals						
GP Referrals	43362	43878	44317	44760	45208	45660
Other Referrals	37940	38391	38775	39163	39554	39950
First OP following GP Referral	37601	38048	38429	38813	39201	39593

C. Finance and Activity- QIPP

QIPP is the day to day business of the CCG and the basis of all decisions made by the CCG. The aim of the CCG is to develop integrated commissioning and locality teams in partnership with the Local Authority and community health care. This will be achieved by:

- Integrating operationally existing health and social care teams under the leadership of GPs
- Increasing responsibility for case management
- Building the infrastructure in primary care and the community to manage our population
- Developing more specialist services in the community that will avoid the need for a hospital referral
- Developing one route of referral to simplify access
- Targeting resource at those patients who need it most
- In reviewing data and risk stratifying in partnership we are increasing responsibility for case management

The QIPP plans for 2014-15 are still work in progress as part of the 2014-15 planning round. To support this the CCG has employed a QIPP lead to work with the groups to develop robust , deliverable plans. The CCG has developed a comprehensive business case and financial analysis process for the QIPP.

Delivery of the CCG QIPP plans is subject to a strong Programme Management Office process. All schemes have a detailed project plan with achievement milestones. The QIPP schemes are reviewed fortnightly with each of the programme leads and then jointly by exception at a monthly QIPP meeting. The GP leads and their commissioning managers are held to account by the CCG Finance and Performance Committee if scheme slippage occurs. This is also reviewed by the Governing Body as part of the monthly finance report. QIPP is visible and owned by all areas of the CCG and is subject to both high level and operational scrutiny in the CCG. The attached QIPP checklist evidences how well the PMO processes for QIPP are embedded within the CCG.

C. Finance and Activity- QIPP

The table below details the QIPP schemes for 2014-15. These have been developed since September via a robust process of challenge and scrutiny. The activity implications of the QIPP schemes have been reflected in the activity plan.

Scheme	Value £000s	Confidence of Delivery	Key Milestones
C2C Referrals	759		Secured in contract baseline- Audits quarterly, agreed protocols
Service Restriction Policy	453		Secured in contract baseline- Audits quarterly, agreed protocols
Unplanned Care (secured in contract)	956		Secured in contract- part of service design chnages- low figure for start position
Mental Health	990		£600K secured in contract, remainder NCA etc changes to provision
Paediatric Services	715		Changes to service provision, high impact pathways secured in contract
MSK	250		Secured in contract baseline
Prescribing	1600		Extension of exisiting schemes and new, history of achievement
Pathology	70		Secured in contract baseline
Contract issues e.g. CQUIN removed from pass through etc	900		Secured in contract baseline
Blood Transfusion	43		Decommissioned service
Community	509		Secured in contract baseline
Smaller schemes	964		Secured via budget reduction, contracts
Unplanned Care not secured in contract	1800		Expected additional savings, part of risk share- also no plan in
			contract for fines, challenges etc to BTUH
TOTAL	**10009**		

C. Finance and Activity- Contracts

The CCG is the lead Commissioner for one major contract:

- Basildon and Thurrock University Hospital Foundation Trust

The CCG also leads for Essex on other contracts including Barking, Havering and Redbridge NHS Trust and the Nuffield Hospitals.

There is a strong process for enabling the contracts to be signed by 28th February. This involves regular meetings and teleconferences around all the areas of the contract e.g. finance, activity, KPI's, CQUIN, Information etc. Progress has been good and are on line to deliver the contract in the required timescale.

There is also a bi-weekly Executive to Executive meeting for the Basildon contract to ensure timely resolution of issues.

Timeline

4th February BTUH/CCG Contract Meeting
6th February Contract update to Board
11th February BTUH/CCG Contract Meeting
13th February Executive to Executive Meeting
18th February BTUH/CCG Contract Meeting
24th February Executive to Executive Meeting
25th February BTUH/CCG Contract Meeting
28th February Contract sign off

C. Finance and Activity- Risk

The key risks to the delivery of the financial plan are outlined below along with the potential mitigating actions. All financial risk will be carefully monitored and discussed at both the Finance and Performance Committee and the CCG Board.

Risk	**Mitigation**
Delivery of financial savings through QIPP	• All schemes currently being worked up for review • PMO in place to support development of robust project plans with milestones, financial information and monitoring data • Engagement with providers to ensure realistic plans, actions and trajectories are agreed by all parties • Clinical leads own the plans and are fully engaged in delivery • Further schemes will be developed in year as part of normal CCG workplans
In year unplanned cost pressures	• Regular monitoring o the overall budget and contractual positions which will alert early notice of potential cost pressures • Finance and Performance committee requires action plans for areas of concern • A 1% contingency reserve (£1.5m) has been built into the financial plan. This can be prioritised for use when required in year
Impact of changes to PbR (Payment by results)	• Implications are being reviewed as part of the contract negotiations • CCG will be undertaking modelling of impact once data is made available centrally

C. Finance and Activity- Risk

Mental health activity changes – move to PbR	• Engagement with providers to ensure joint management of the impact • Establishment of risk share arrangements
CSU delivery	• Strong performance management of CSU with intervention where necessary • Relationships built with service leads • Robust KPIs • Review of CSU and development of strategy for service lines underway
Allocations from changes to NHS- especially impact of specialist services changes	• Work with LAT to resolve current allocation issues • Potential for risk shares across Essex
Impact of changes to the national allocations process	• CCG fully engaged in process for allocations change • Input to process for management of changes • Regular updating of MTFM to model potential impacts
Impact of retrospective continuing healthcare claims	• Additional resources in place from September • Engagement with CSU for early sight of impact on CCG resources

C. Finance and Activity- Risk

Governance of financial risk

During the production of the monthly financial position, the finance team updates the CCG risk register if any risk regarding the financial position is identified or an existing risk changes. The Finance and Performance Committee receives monthly finance and performance reports which detail the financial position and flag any existing or emerging risks to achievement of the financial position. In the event of significant budget variances the Committee requests an action plan from the relevant clinical lead and the commissioning manager to be presented.

Financial risks are escalated to the CCG Board via the Finance and Performance committee.

Financial risks are also monitored by the rest of the CCG as part of the regular QIPP monitoring process.

Strong financial governance is in place across the whole of the CCG and the finance team work with staff to ensure that high standards are maintained. There is also in place a strong internal and external audit process to ensure the CCG Board that risks to finance are being managed and mitigated where possible.

Section D

Better Care Fund

D. Better care fund

The Better Care Fund is a sum of money that will transfer funds for a range of community health and social care funds into an integrated pooled budget arrangement with Essex County Council (ECC). The fund comes into being in 2015/16 with 2014/15 seeing a modest increase in the Social Care Protection monies currently transferred to Local Authorities. The key objectives for the use of the BCF in Basildon and Brentwood are:

- To commission services that target frail and older people (>75yrs) who are vulnerable or at risk of losing their independence. The newly developed integrated community services teams will ensure a multidisciplinary approach that is targeted and risk based.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services;
- To move care closer to home so that our hospitals have manageable demand, one of the enablers for this will be the newly commissioned integrated health and social care rehabilitation and reablement service;
- To work together to ensure people are supported to look after their health and wellbeing, reducing unnecessary stays in hospital;
- To support providers to join up, share information, and make services easier to navigate;
- To create an Integrated Commissioning Board or similar with ECC and other local authorities as appropriate, to align our work and have a single commissioning process, services and work.

Patient and Public Engagement

Our vision is to design and implement an integrated care system based on what our resident population needs, that need will be articulated by the residents themselves via the various patient and service user engagement forums that we have already established. We already have established mechanisms to engage with our population to steer this work (see section E).

Provider Engagement

We have initiated a structured provider engagement strategy to ensure that we keep our providers alongside us as we bring about the changes required. The aim is not only to deliver the benefits that the BCF pooled funding arrangements but also the wider system changes that will be necessary if we are to deliver an efficient and accessible health and social care provision for Basildon and Brentwood.

Partnership Arrangements

Working with Essex County Council in an open and transparent partnership we are focusing our energies on:

- Ensuring that there are very clear synergies with ECC
- There are opportunities to prevent admissions to secondary care
- Maximising health deterioration prevention opportunities, ensuring people can manage their own conditions at home
- Developing a mechanism to deliver a reduction in Health Inequalities
- Realising financial economies of scale and benefits from Joint commissioning is driven by the needs identified in the JSNA and the HWBS.

Elements included for 2015/16

In 2015/16 the minimum investment into the BCF for BBCCG is £16,041k (as determined by the national formula). However, initial proposals for year 1 investment exceed this amount with the intention of achieving maximum benefit of the scheme rather than to simply meet minimum funding levels. In future years it is intended that social care funding for elderly care services will be added to the fund, including those for Telehealth and Telecare, home support, day care, etc.

Year 1 proposals are set out in the following slide – full details of the BCF fund and supporting metrics are appended.

Key changes expected as a result of the BCF:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy;
- Clinical pathways will be designed around the needs of patients, carers and their families.

How will we know if it is working?

We will use the NHS and Social Care Outcome Frameworks as our guides, we intend to measure specific nationally mandated and local metrics, the specific details of which are included in the full BCF plan (appended).

The success factors include elements such as reductions in hospital attendance and admissions. The advances in IT capability will help us to drill down deeper into the data held which in turn will lead to more information on specific reasons for admissions and by doing so will present opportunities to develop additional preventative measures.

In order to manage and track outcomes, we will be developing business cases to enhance developments in data warehousing, that will help us to work with all available care data, information and intelligence, getting as close to “real time analysis” as we can to allow us to make rapid and accurate decisions - including total activity and cost data across health and social care for individuals and whole segments of our local populations. Our vision is to develop interoperability between all systems to provide this “real time” information and managerial analytics capability. This ambition is in line with the recommendations of the “Who Will Care” report on the Essex system.

Min / Max Funding Amounts (subject to Board Decision)

Minimum requirement Function:	Min - 2015/6 £
Protection of Social Care (PSC)	£3,790,000
Uplift in PSC	£1,063,000
Reablement	£1,400,000
Community Beds	£4,600,000
Mountnessing	£
Continence	£
COPD	£
LTC's	£
Community Geriatrician	£
Community Nursing	£7,509,000
Discharge Support	£
Mental Health/dementia	£
Carers	£82,000
Total - Minimum	**£18,444,000**

Proposed maximum for 2015/16 Function:	Max - 2015/6 £
Protection of Social Care (PSC)	£3,790,000
Uplift in PSC	£1,063,000
Reablement	£1,400,000
Community Beds	£4,600,000
Mountnessing	£450,000
Continence	£400,000
COPD	£593,000
LTC's and Community Matrons	£691,000
Community Geriatrician	£250,000
Community Nursing	£7,509,000
Early Stroke Discharge Support	£507,000
Mental Health/dementia	£71,000
Carers	£82,000
Emergency threshold fund (70% tariff)	£1,800,000
Total - Maximum	**£24,006,500**

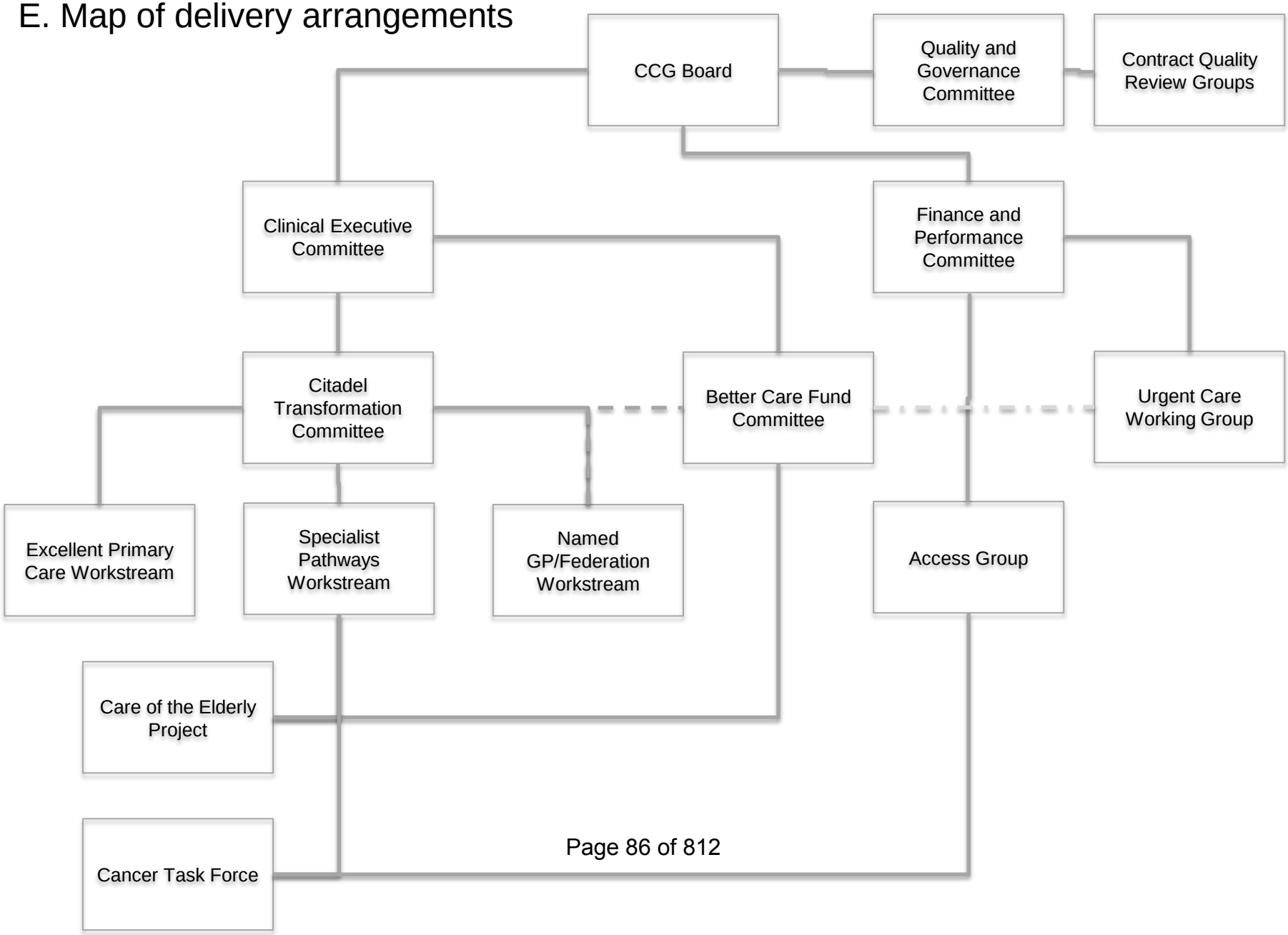
South Essex BCF metrics

Metrics		Current Baseline		
		Essex(Total of 5 x CCG & ECC)	B&B CCG	CP&R CCG
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	583.0	576.7	565.0
	Numerator	1575	254	215
	Denominator	270160	44041	38055
		(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	82%	82%	82%
	Numerator	692	130	133
	Denominator	844	158	163
		(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	199.3	202.8	23.2
	Numerator	2212	395	32
	Denominator	1109834	194784	138052
		2012-13 outturn		
Avoidable emergency admissions (composite measure)	*Metric Value*	1674	1621	1636
	Numerator	5296.4	987.7	603.1
	Denominator	316466	60923	36864
		(TBC)		
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]		*(insert time period)*		
Additional Local Measure - Coverage of reablement	*Metric Value*	1451.0	1934.6	1842.1
	Numerator	3920	852	701
	Denominator	270160	44041	38055
		2012-13 data		

Section E

Delivery

E. Map of delivery arrangements



E. Governance, Delivery and Engagement

In order to deliver this plan, the CCG is currently reviewing the governance and working arrangements which it has in place. This slide summarises our current thinking on the structural arrangements which are required to ensure successful delivery.

Segment	Measure	Primary delivery mechanism	Supporting delivery mechanism
Outcomes	Domain 1/Ambition 1/Measure 1 Securing additional years of life	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 2/Ambition 2/Measure 2 Health related quality of life	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 2/Ambition 2/Measure 3 Roll out of IAPT	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 2/Ambition 2/Supp' M 1 Dementia Diagnosis	Citadel Transformation Committee	Care of the Elderly Workstream
	Domain 3/Ambition 3/Measures 4-7 Emergency admissions for acute conditions Unplanned hospitalisation for ACSC Under 19 hospitalisation Emergency admissions for children with lower resp. tract inf.	Citadel Transformation Committee	Named GP Teams Workstream
	Domain 3/Ambition 4/ Supp' M 2 65+ at home 91 days after discharge	Better Care Fund Committee	Care of the Elderly Workstream
	Domain 4/Ambition 5/Measure 8 Inpatient Friends and Family	Basildon Hospital Contract Quality Review Group	N/A
	Domain 4/Ambition 6/Measure 9 GP and OOH experience	Citadel Transformation Committee	Excellent Primary Care Workstream

E. Delivery

Segment	Measure	Primary delivery mechanism	Supporting delivery mechanism
Outcomes	Domain 5/Ambition 7/Measure 10 and S.Measure 3 Hospital deaths attributable to problems in care MRSA and C-Diff	Basildon Hospital Contract Quality Review Group	
Improving Health and Reducing Health Inequalities	Project 1		
	Project 2		
	Project 3		
NHS Constitution	Elective waiting times and diagnostics	Access Board	N/A
	A&E and Ambulance	Urgent Care Working Group	N/A
	Cancer	Access Board	Cancer Task Force
	Mixed Sex Accommodation	Basildon Hospital Contract Quality Review Group	N/A
	CPA 7 day follow-up	SEPT Contract Quality Review Group.	
Better Care Fund	Delayed Transfers of Care	Urgent Care Working Group	Better Care Fund Committee
	Avoidable emergency admissions	See Domain 3/Ambition 3	
	Residential and nursing home admissions	Better Care Fund Committee	Care of the Elderly Workstream
	Effectiveness of Reablement	Better Care Fund Committee	Care of the Elderly Workstream
	Patient/Service User Experience	Better Care Fund Committee	
	Local Measure 1		

Establishing **Excellent Primary Care** across Basildon and Brentwood

We will support the development of 'Excellent Primary Care' by practices across Basildon and Brentwood by outlining the core expectations of any practice. This is being done by:

- Asking our patients – consultation from January 2014 and through our Patient and Community Reference Group
- Working with our localities to draw out the added value of good existing working relationships
- Using known markers of good quality practice, such as those set out by the Royal College of GPs, the East of England Deanery, etc.
- Promoting the spread of training practices, both to raise the quality standard but also to attract registrars and improve recruitment and retention. The environmental standards required to achieve training status will also be used to help define the ambition for non-training practices.

Once this has been defined this will be applied to all practices within Basildon and Brentwood to be used as the basis of developing practice specific development plans and support from the CCG and/or their localities.

We will promote the 'federation' model of general practice be developed within the local area (as outlined by the Royal College of General Practitioners) in order for the necessary partnerships to be built in order to:

- Allow for peer-support between GPs to achieve the standards set out in the definition of 'Excellent Primary Care'.

- To provide the mechanism through which practices could use to tackle financial sustainability issues, such as shared back-office and front office functions.

- To provide the basis upon which consistent appointments, across both extended hours and 7 days a week could be facilitated.

- To allow for interested GPs to specialise in particular care areas, such as leading named GP teams (see below) or focusing on the provision of episodic, sophisticated diagnosis care.

Establishing **Excellent Primary Care** across Basildon and Brentwood, contd

The formation of the federated teams will take place within the four CCG localities, although it is likely that some arrangements will span different locality groups where this makes community or geographic sense. The four localities will continue to work jointly under the auspices of the single CCG Governing Body so any local arrangements will not affect the boundary of the CCG as a statutory body.

We have a total of 44 practices, clustered into 4 localities:

	Total patients (actual)	Average practice list size (actual)
Arterial	67128	4972
Brentwood	76077	9510
Partnership/BIC	66020	5502
SEMC	56194	5352
BBCCG	**265419**	**6032**

Based on locality profiles, the expectation is that there would be 4 or 5 federations each serving a population of between 50,000 and 75,000 patients.

We will continue working with Essex NHSE AT to address the workforce issues and encourage the spread of training practices. The expected level of growth in the area suggests a further 12-13 GPs may be necessary to keep pace with current delivery, in addition to the requirement for new infrastructure and estate.

The creation of **Named GP Teams**

The aim is that geographic, federation configured, 'Named GP Teams' would be the sole deliverer of front line care to people with complex needs and long term conditions, this would include existing generic community, social care and mental health resources. This clearly aligns with the requirements of the new GP contract.

In practice, this would mean that every patient who is covered within these teams has a named GP who is responsible and accountable for their care and outcomes.

In order to deliver this responsibility, the named GPs would directly instruct (either through virtual or structural integration) a range of health and social care professionals as identified below:

- General Practitioners
- Practice Nurses
- Generalist community nursing:
  - District Nurses
  - Community Matrons
- Social workers
- Therapies
- Pharmacists
- Psychological therapy staff
- CPNs and SWs

An integral part of the effectiveness of these teams would be the ability to access specialist advice and support to inform the care plan of an individual and to reduce the reliance on specialist pathways of care.
It is proposed that these teams would initially operate as shadow integrated care organisations with access to a combined health and social care budget. Initially this will be for specific related service areas, moving to include all relevant budgets over time. Over the medium term funding for these services could be on a capitation basis with risk share between the CCG and team.

Section F

-Engaging and working with the people we serve

-Criminal Justice

- Digital / data

F. Engaging with our community and the people we serve

The CCG has implemented a wide range of activities to help ensure that our patients and community experience service improvements and are fully engaged with the planning and quality monitoring of local services :

- All 4 locality groups have Patient Engagement Groups (PEGs) which meet monthly to hear patient views and act as an information exchange about service development, enabling patients to make informed decisions about their care.

- The CCG and Basildon hospital are working collaboratively to recruit Patient Leaders who will participate in visits and quality assurance of provider services (first visits due March 2014). These are paid representatives, recruited and trained jointly by the CCG and Basildon hospital. They report to the PCRG and CCG Board, ensuring that the patient voice is at the heart of quality monitoring.

- In 2013 the CCG established a Patient and Community Reference Group (PCRG) to act as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc. Members include 9 lay reps, 2 x CVS, 3 local authorities, Healthwatch Essex and GP chair of the CCG. Lay reps were recruited on the basis on their existing links to the wider community, e.g. one is the chair of the Disability Equality forum, another of the Cancer Survivor's Group.

  Key roles of the PCRG include receiving reports from the Patient Leaders for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year such as feedback from the Friends and Family test (especially where BTUH was an early adopter for the maternity F&F test), complaint and comments, etc. The PCRG then has direct access to the CCG Board to ensure that emerging issues are acted upon. The PCRG links to the locality PEGs through lay members and CCG locality managers to ensure local views and connections are maintained. The workplan of the PCRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval. http://www.basildonandbrentwoodccg.nhs.uk/patient-and-community-reference-group.

- The PCRG received a presentation and was asked to comment on both the CCG's Operational Plan and BCF submissions/proposals at its January 14 meeting.

F. Engaging with our community and the people we serve

- The GP Chair of the CCG is the CCGs representative on the Essex Health and Wellbeing Board and a member of the Basildon Health Forum. A Brentwood GP is a member of the Brentwood Council health forum.
- CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients,.
- Board meetings are held in public, with questions invited, and some GP locality groups have patient representatives as members.
- The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.
- We publish periodic information leaflets (e.g. for our winter campaign) and website links to help people manage their own conditions. We have a wide range of information available for patients with specific conditions, such as the bespoke "patient passport" we had published for every patient known to have respiratory disease, allowing them to manage their own care plans in conjunction with the clinical teams.
- The CCG runs an annual winter information campaign, helping patients make the best choice of where to seek help. The south Essex 111 service was successfully implemented in 2013.
- The CCG has its own website where all plans (including the more detailed Engagement Strategy, Commissioning Plans, etc), policies and documents are published and accessible to the public www.basildonandbrentwoodccg.nhs.uk. A prospectus for patients is published in printed hard copy and on the website each year.
- Contact details for the CCG and a general enquiry email account has been set up to receive comments and messages from the public.. Bbccg.contacts@nhs.net

F. Criminal justice

The Chief Officer of the CCG is both a member of Safer Essex as well and the Basildon Community Safety Partnership (CSP).

The final priorities of joint NHS / CSP working will be discussed at a joint workshop on 13th February – the draft findings from the 2014/15 Strategic Assessment are:

- Night Time Economy
- Domestic Abuse
- Hate Crime

Particular areas of joint work that the CCG would like to explore during the workshop are:

- Learning from the CCG led work on the Night Time Economy during Christmas and New Year 2013.

- Improving responsiveness and joint working of mental health services with the Police and Probation services.

- Reviewing the effectiveness of NHS input into Family Solutions locally and opportunities to improve NHS input into this.

F. Digital / data

Integrating and providing better access to electronic records
The CCG is committed to improving both the quality of care through integrating healthcare records for its patients, as well as providing better electronic access to the NHS for patients.

The CCG already has a good foundation for the integration of healthcare records with a common system (SystmOne) being in place across general practice and community services, allowing for a single health record and shared care plans for people accessing both general practice and community services.

The next stage of our work is to improve the integration, or integrated use of primary and community care data within an acute hospital setting. The technical work has already been completed, including the necessary data sharing protocols to allow hospital staff to access SystmOne records within hospital, with pilots having taken place within the A&E department at Basildon Hospital.

Within our contract for services with Basildon Hospital, we have agreed a CQUIN to support the roll out and more systematic use of SystmOne within a hospital setting. This is in addition to our standard contractual requirements for all our providers to comply with NHS data standards, be this the use of the NHS number or other requirements such as IAPT reporting.

In addition, through our **Excellent Primary Care work stream** we will specifically consider better use of technology for people to access general practice such as:

- Online appointment booking and telephone/video consultations.
- Implementation of e-prescribing and improving e-referrals to secondary care.

A clear ambition through our **Accountable Professional Teams** is the implementation of the House of Care model for care planning, an integral element to the implementation of this model is improving health literacy as a means of supporting an individuals own self-management and independence, as well as the use of telehealth and telecare as a tool to support this further.

Finally, during 2014/15 the CCG intends to develop and re-launch its website, aligned and integrated (where possible) with NHS Choices or its' successor website.

Annex A

Quality and safety

See separate attachment

Annex B

QIPP Checklist

See separate attachment

Annex C

Better Care Fund Template – BBCCG section

See separate attachment

Annex D

Seven day working mapping

See separate attachment

Annex E

RTT Action Plan

Reducing elective waiting times for patients

Vision and values for RTT pathway management
There are two key principles by which the CCG and Basildon Hospital operate in regard to pathway management for patients:

- Patients with the greatest clinical need / risk are dated first.
- Patients who have experienced the longest waits will be booked chronologically, whilst ensuring that newly referred patients do not wait longer than 18 weeks.

Current performance
The Trust is meeting month on month RTT performance indicators for admitted, non-admitted and incomplete pathways. However the backlog of patients waiting over 18 weeks remains static. To address this a series of modelling has been undertaken in establish the correct approach which should be taken to reduce this backlog and begin the process of booking patients chronologically and, in turn, to consistently deliver 18 week performance across all specialities at the Trust.

As with any model, it is based on a number of assumptions all of which are available in the detailed plan.

Action plan to reduce waiting times for patients
The action plan agreed between the Trust and CCG establishes the following actions which will be undertaken to tackle waiting times:

- We will maintain the focus on ensuring that patients with the greatest clinical need/risk are dated first.
- With immediate effect, the following specialities which have no patients waiting over 18 weeks will be booked in chronological order:
    - Cardiology
    - Fertility

- With immediate effect, the following specialities which have a low number of patients waiting over 18 weeks will be booked in chronological order:
    - Gynaecology
    - Rheumatology

- A phased approach will then be implemented across all remaining specialities, in the following order:
    1. Cardiothoracic Surgery
    2. Pain Management
    3. ENT
    4. CTC Cardiology
    5. Urology
    6. General Surgery
    7. Oral Surgery
    8. Trauma and Orthopaedics

This order has been established to minimise the overall total waiting of patients who have waited both over and under 18 weeks.

- A central booking mechanism will be implemented.

The modelling suggests that this work can be completed over a [20 TBC] week period and will deliver Trust level RTT performance over this period. This assumes that c.[200 TBC] patients take up an offer of choice.

Patient choice and rights under the NHS Constitution
Alongside this process the CCG has also agreed with the Trust to implement a mechanism during this period that should a patient be referred to a speciality where we know there is a potential they may have to wait longer than 18 weeks then they will be proactively offered the choice of attending another provider at the point of a decision to admit being made. In addition, where patients are already listed and either have waited longer than 18 weeks, or are anticipated to have to wait longer than 18 weeks choice will also be offered.

Patient Safety and Quality Delivery for Operational Plan 2014 15

For the purpose of patient safety & quality assurance; the approach BB CCG has adopted in its quality framework, is to use the definition first set out by Lord Darzi in his report *"High Quality Care for All" 2010.*
This definition sets our three dimensions to quality, all three of which must be present in order to provide a high quality service:
Clinical effectiveness – quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
Safety – quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety; and
Patient experience – quality care is care which looks to give the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to what that individual wants of needs and with compassion, dignity and respect.

These three dimensions feed directly in to the 5 domains and the 7 outcome measures within the planning framework for 2014-15

1.0 Patient Safety and Quality Ambitions against the Domains and Outcomes

Ambition within 2 years	Mechanisms for delivery	Actions	Timeframe for completion of actions
Domain 1 - Encompasses outcome 1 Preventing people from dying prematurely;			
To improve outcomes by enhancing access, ensuring early intervention and treatment to healthcare. To drive down avoidable deaths within acute hospitals	Plans will reflect the key findings of the Francis, Berwick, Koegh and Winterbourne reports. *It is of note that the Keogh review directly reflected the aims of the 6Cs*	Set up a series of workshops with providers to share learning and develop cross economy strategies	End of Q1 2014/15
		Feed recommendations of Francis, Berwick, Keogh and Winterbourne into contracts	By Q1 2014/15
		Share ideas for contractual levers for BTUH with other commissioners to be included for other providers	By Q1 2014/15
		Use Quality Visit schedule to test embedment	On-going
		Hold BTUIH to account at Clinical Quality Review Group	On-going
		Attend Winterbourne commissioner meetings to track patients	On-going
		Work collaboratively with LD commissioners	On-going
		Review provider and CCG risk assurance frameworks	On-going
	To utilise evidenced based tools such as early warning systems to prevent , identify and address	Learn from incidents and complaints to prevent reoccurrence of themes and trend in harm	On-going
		Implement a dynamic methodology to share learning from	End of Q1 2014/15

	harm events thus facilitating a high focus on learning and improvement (and those described above)	BTUH across commissioned services	
		Use Quality Visit schedule to test embedment	On-going
	Seven day services 10 principles: 1. Experience 2. Time to first consultant review within 14 hrs 3. MDT review for emergency pat 4. Shift hand overs 5. Diagnostics – access 7 days 6. Intervention of key services 7. Mental health 8. On-going review twice daily 9. Transfer out with support services 10. Quality improvement	Use contract to monitor progress of implementation of programme	On-going
		Receive regular update of plans and issues of implementation as they arise at the CQRG	By Q1 2014/15
		Use Quality Visit schedule to test embedment	On-going
		CCG to have oversight of provider CIPs to ensure there is no negative impact of the quality driver	By Q1 2014/15
		Use clinical audit to test and inform	As required
		Develop emergency care pathways to prevent admission	Q2 2014/15
		Develop discharge processes to enable safe early discharge	Q2 2014/15
	To work collaboratively with NHS England to encourage access to preventative measures such as access to health checks within primary care	Enable discussions to improve delivery of health care through the Care Conversation	Throughout 2014/15
		Where appropriate to work with NHS E to improve uptake of contractual obligations such as Health Checks of LD patients in primary care	On-going
	To work collaboratively with PH England to encourage participation of healthy living initiatives	CCG to participate in the NICE Implementation Group at BTUH	On-going
		CCG to recruit a Public Health representative to the above Group	By Q1 2014/15
		Report through to the PS&Q Committee to inform CCG staff of issues and changes required when commissioning services	On-going
		To work collaboratively with colleagues in PHE and ECC to ensure full understanding of available initiatives, that can then be worked into commissioning plans	Throughout 2014/15
Domain 2 - Encompasses outcome 2			

Enhancing quality of life for people with long-term conditions;			
To review and redesign care pathways to enable and optimise patient safe care by being responsive to patient need and changes in their condition. Thereby enabling access to healthcare and appropriate intervention at the right time to prevent inappropriate hospital stays. To ensure the integration of mental health and physical health care needs for those with MH/LD reducing marginalisation.	Patient Engagement initiatives	Use information from patient engagement sessions to better inform commissioning decisions	Throughout 2014/15
		Recruitment of patient leaders to enhance ability of the programme to deliver meaningful engagement	End of Q1 2024/15
		Work collaboratively with the Local Authority, utilising their existing networks to reach vulnerable people in order to inform commissioning decisions (for example, people with mental health and alcohol related conditions).	Throughout 2014/15
	To deliver improved outcomes for Vulnerable People	Improve access and redesign pathways aiming to improve healthcare experiences and outcomes.	Throughout 2014/15
		Use contractual levers to ensure provider staff have access to training about the needs of vulnerable people	By Q1 2014/15
	Improve care planning for people with LTC, aiming to give control to the individual and improving co-ordination of care across services	Use contractual levers to embed individualise care planning	By Q1 2014/15
		Re-design of care pathways for those LTCs	Throughout 2014/15
		Review and re-design of care pathways for those over the age of 75yrs	Throughout 2014/15
		To review cost-effectiveness and innovative methods to provide psychological support for patients with LTC	Throughout 2014/15
Domain 3 - Encompasses outcomes 3 and 4 **Helping people to recover from episodes of ill health or following injury;**			
To reduce avoidable admissions to hospital by commissioning new out of hospital services. To keep people out of hospital when better care can be delivered in a different setting through the redesign of new pathways providing seamless care. To ensure effective joined up working between primary,	Re-design of pathways to ensure best delivery of health services that are also integrated	Work with partners to develop patient focused pathways	Throughout 2014/15
		Implementation of Quality Impact Assessment programme	On-going
		Use contractual process to embed changes in pathways	Throughout 2014/15
		Develop emergency care pathways to prevent admission	Q2 2014/15
		Develop discharge processes to enable safe early discharge	Q2 2014/15
	Engagement with NHS providers and third sector to develop out-of-hospital services to deliver future requirements	Enable discussions to improve delivery of health care through the Care Conversation	Throughout 2014/15
	Engagement with Local Authority to develop out-of-hospital care,	Enable discussions to improve delivery of health care through the use of the Better Care Fund	Throughout 2014/15

community and secondary care. To commission high quality safe and effective hospital care. To work with the Local Authority to ensure and coordinate re-ablement and post discharge care allowing people to achieve their optimal potential for recovery	prevent unnecessary admissions and enable early discharge		
	Promote openness and transparency to ensure meaningful information is shared between providers	Utilisation of information sharing protocols	On-going
		Promote use of shared systems (using contractual levers as appropriate)	On-going
Domain 4 - Encompasses outcomes 5 and 6 **Ensuring that people have a positive experience of care**			
Through improved utilisation of the patient reference group and the introduction of the patient leader programme inform commissioning decisions to enhance patient experience. Aiming to improve reliability of FFT by increasing response rate and net promoter score for Basildon Hospital. Review and triangulate data information e.g.,: •National and local patient surveys •FFT •CQUIN •Healthwatch •Complaints and Comments •Incidents •Patient Stories	To work with partner organisations to re-design services which promote clinical effectiveness, patient safety, quality of care and enhances patients experience	Ensure that there is patient / carer engagement in all re-design projects	On-going
		Ensure quality is central to all service re-design initiative, using the QIA process	On-going
		Work collaboratively with the local authority and other CCGs on re-design projects	On-going
		Identify and use evidence from research and innovative practice to inform service redesign.	On-going
		Measure outcomes for patients following re-design to check that patient experience has improved	On-going
	Promote a 'fair blame' culture, increase the reporting of harm (and near harm) to patients, focusing on learning and improvement.	Attend at provider meetings to review data (and therefore provider understanding of data and improvements needed)	On-going
		Use the CQRG to hold the providers to account, seeking evidence to implementation of initiatives to improve openness and transparency within their organisation	On-going
		Closely monitor provider systems to report all levels of incidents and review reports generated from investigations e.g. Serious Incident process	On-going
		Review and monitor actions from the annual provider staff survey	On-going
		Follow-up of Central Alert System (CAS)	On-going
		Use Quality Visit schedule to test embedment	On-going

•Direct patient feedback Work with the Local Authority, third sector partners, carers , patients and providers to enable integration of mental health and physical health care.		Report through to Board of CCG	On-going
		Report through to the Essex Quality Surveillance Group	On-going
		Await further guidance and establishment of Patient Safety Collaborative by NHS England	To be directed by NHSE
		Work via the membership of the CCG to improve understanding of need for primary care to become actively involved in the PS&Q agenda (need to go back to basics for primary care colleagues)	On-going
	Set measurable ambitions to reduce poor experience of inpatient and emergency care	Set and agree baselines – using national survey data and FFT	By Q1 2014/15
		Use internal provider and point prevalence data (including EMSA)	On-going
		Work with LA and other partners to develop carers strategy. Setting ambitions against carers strategy	On-going
		To monitor provider utilisation of national matrix to improve staffing levels and competence	On-going
		Work with partners to develop patient focused pathways (as described above)	On-going
		Implementation of Quality Impact Assessment programme	On-going
		Use contractual process to continually monitor patient experience	On-going
	Assess the quality of care experienced by vulnerable groups of patients and how and where experiences will be improved for those patients and their carers.	Develop and use patient and carer engagement strategies e.g. use of Patient Reference Group, development of Patient Leaders programme	On-going
		Agree and then review of action plans to improve baseline	On-going
		Use Quality Visit schedule to test embedment	On-going
		Hold provider to account at CQRG	On-going
		Work with LA and other partners to monitor implementation of agreed strategies	On-going
	Demonstrate improvements from FFT, complaints and other feedback	To review data via CQRG thus enabling challenge to provider to implement any agreed actions	On-going
		Improve response rate and net promoter scores for FFT	Q2 2014/15
		Improve national surveys results	Q4 2014/15
		Improve availability of benchmarking data	Q2 2014/15

	Understanding of the factors affecting staff engagement and staff satisfaction in the local health economy such as its impact on patient experience and how staff satisfaction locally benchmarks against others.	Review staff satisfaction survey response against previous responses	On-going
		Review provider action plan to address issues highlighted in the survey	On-going
		Use Quality Visit schedule to test staff satisfaction	On-going
	Ensure measurable improvements in staff experience in order to improve patient experience	Monitor Staffing levels	On-going
		Monitor Staff training levels	On-going
		Monitor levels of sickness and absence	On-going
		Triangulate with patient experience data	On-going
Domain 5 - *Encompasses outcome 7* **Treating and caring for people in a safe environment; and protecting them from avoidable harm**.			
The CCGs priority is to ensure the safety of people who use the health services commissioned. The key aims will be to: To improve safety measures and outcomes across all commissioned providers using contractual leverage and CQUIN. (please refer to section 2.0 below re: mechanism to further enable delivery) To ensure evidenced based Early Warning Systems are utilised effectively to care for the deteriorating patient. (as described above) To understand mortality data and ensure learning from mortality	Take a strategic lead to ensure responsibilities for safeguarding (children and adults)are embedded and delivered as per national guidance such as *Safeguarding Vulnerable people in the Reformed NHS; Accountability and Assurance Framework*	**Safeguarding Children**	
		Work collaboratively across Essex to best provide for safeguarding of children	On-going
		Attend and contribute to the Health Executive Forum for Children's safeguarding as a sub-committee of the Essex Safeguarding Children's Board	On-going
		Work with designate staff to hold commissioned organisations to account for processes and systems in place to safe guard children	On-going
		Work in partnership with local authority to drive the safeguarding agenda for children	On-going
		Ensure the section 11 audit is completed, implemented and improved	On-going
		Ensure key priorities such as child sex exploitation and domestic abuse feature in appropriate plans	
		Safeguarding Vulnerable Adults	
		Work collaboratively across Essex to best provide for safeguarding of vulnerable adults	On-going
		Attend the Essex Safeguarding Adults Board	On-going
		Work with commissioned organisations to hold to account	On-going

reviews. (as describe above) To enable sharing of and learning from incidents (as described above) To implement the finding of Francis, Berwick , Keogh and Winterbourne. (as described above) To ensure delivery of Infection Prevention Control strategies and actions this includes continued reduction of C diff and zero tolerance of MRSA infection. To secure compliance with NHS England safeguarding assurance framework working with local authority partners and community groups to safeguard and address the needs of vulnerable groups, such as, frail elderly and looked after children. To continue to work with commissioned providers to ensure that any proposed efficiency measures and transformational change will not have a detrimental impact on their ability to deliver clinically effective, high quality and safe care.(as described above		for processes and systems in place to safe guard vulnerable adults	
		Work in partnership with local authority to drive the safeguarding agenda for vulnerable adults	On-going
		Ensure the section 11 audit is completed, implemented and improved	On-going
		Work with partners to implement the Winterbourne recommendations.	On-going
		Ensure CCG involvement in the PREVENT workstream and provider compliance	On-going
	C.diif target for 2014/15 BB CCG = 33 cases (reduction from 39) Thurrock = 22 cases (reduction from 26) Giving us a total of 55 cases in SWE (reduction from 65) Of which BTUH can have up to 18 cases (reduction from 26) MRSA bacteraemia target for 2014/15 – remains as zero tolerance	Monitor HCAI trajectories as per the contract and hold to account for performance at the CQRG	On-going

2.0 Mechanisms to further enable the delivery of the above ambitions to reduce harm are:

Mechanism	Delivering success	Timeframe
2.1 To review CCG governance for Patient Safety and Quality	Review the functionality and Governance of the Quality and Governance Committee, making recommendations for change and implementing agreed framework	Implementation of new governance framework for PS&Q – Q1 2014/15
	Review the delivery of the functions of the Quality Support Team, bringing functions into the CCG from the hosted arrangement.	Q1 2014/15
	Attendance at appropriate meetings internal and externally to the organisation, promoting the PS&Q agenda in all forums	Q2 2014/15
2.2 Continue to work with partners to gain the required level of assurance for patient safety and quality of care within BTUH	To work with the Trust to drive improvement. Monitoring compliance with recommendations from Francis, Keogh and Berwick. With specific regard to the Keogh recommendations directed at BTUH following their own review	Continue tracking of all related actions until evidence of sustained improvement Q4 2014/15
	To ensure the contract is used to its best effect to provide safety, good quality care that provides a good patient experience	Q1 2014/15
	To have a programme of assurance to monitor standards of patient safety and quality of care	Q1 2014/15
	To work with regulatory partners to share intelligence and drive improvements	Q1 2014/15
	To work with key stakeholders to enable sound knowledge of standards achieved by the Trust and provide assurance of processes of monitoring	Q2 2014/15
2.3 Continue to work with partners to gain the required level of assurance for patient safety and quality of care within all commissioned services	To work with partner CCGs to ensure BB CCG gains assurances of the standards of care with all commissioned providers • Queens hospital • NELFT • SEPT • SUHFT	Q1 2014/15

	• EEAST • Private hospitals • Hospices • Continuing Health Care • NHS 111	
2.4 To develop integrated working patterns with the local authority with specific regards to resident safety and quality of care within care homes	To establish a pro-active, collaborative working relationship with the local authority in regards to care homes	End of Q1 2014/15
	Ensure the sharing of intelligence about standards of care in care homes, to enable the best outcomes to improve standards	On-going
	To work in partnership with the local authority, to monitor care homes where health care is delivered, to drive improvement	On-going
	To ensure the input of the Continuing health Care Team is appropriate and timely to monitor and improve standards with care homes	On-going
2.5 To understand and measure the harm that can occur in healthcare services, to support the development of capacity and capability in patient safety improvement	CCG Quality Team to act as conduit for all PS, Q &PE data, information and intelligence within the CCG	On-going
	CCG relationship with regulators	On-going
	Use of local data	On-going
	Use of Benchmarking data (including Patient Safety Thermometer data to continue to drive improvements in pressure ulcers, falls and management of VTE).Note: currently no issues with VTE – however it is subject to on-going review via the CQRG)	On-going
	Use of Benchmarking data (including Patient Safety Thermometer data to continue to drive improvements in pressure ulcers, falls and management of VTE) within mental health care, medicines safety and maternity	Q2 2014/15
	Awareness and follow-up and reporting of Central Alert System (CAS)	On-going
	Review of Serious Incidents	On-going
	Review of provider reports and action plans	On-going
	Review of Pressure Ulcers, falls and IPC data (all harm events)	On-going
	Attendance at provider meetings to review data (and therefore provider	On-going

	understanding of data and improvements needed)	
	Use of contractual process	On-going
	CQRG – hold provider to account for improvement	On-going
	Use of clinical audit	On-going
2.6 Fulfil our statutory responsibilities to support research	Member of CRN – North Thames	On-going
	Have oversight of implementation of research programme	On-going
	Oversight of programmes of research in providers (including primary care)	On-going
2.7 Use Academic Health Science Networks to promote research	Member of HEE	On-going
	Developing role for Clinical Director	From Q2 2014/15
2.8 Adopt innovative approaches using the delivery agenda set out in *Innovation Health and Wealth: accelerating adoption and diffusion in the NHS* to drive improved outcomes for patients and local communities	Promote senior clinical leadership across organisations	On-going
	NICE implementation programme – membership of BTUH NICE implementation group	On-going
	Use of data from Clinical Audit	On-going
	To pro-active engage with the work of national bodies such as the Institute for Innovation and Improvement and Regional Innovation Fund to support and promote the adoption of innovation and the spread of best practice across the NHS	On-going

3.0 The 6 Cs

The 6Cs

The actions detailed within the Patient Safety and Quality Delivery Operational Plan will be underpinned by the principles identified in Compassion for Practice (DH 2012) to improve the culture within the health system known as the 6Cs;

1. **Care** – delivering high quality care is what we do. People receiving care expect it to be right for them consistently throughout every stage of their life.
2. **Compassion** – is how care is given, through relationships based on empathy, kindness, respect and dignity
3. **Competence** – means we have the knowledge and skills to do the job and the capability to deliver the highest standards of care based on research and evidence.
4. **Communication** – good communication involves better listening and shared decision making – 'no decision about ne without me'.

5. **Courage** - enables us to do the right thing for the people we care for, be bold when we have good ideas, and to speak up when things are wrong
6. **Commitment** – will make our vision for the person receiving care, our professions and our teams happen. We commit to take action to achieve this.

In line with the ambitions of the Patient Safety and Quality Delivery Operational Plan the CCG will work to ensure that the 6Cs are embraced by the provider services to form the values and behaviours that underpin the 6 'areas for action' identified within Compassion for Practice (DH 2012). The 'areas for action' and mechanisms for delivery succinctly align with the domains of the NHS Outcomes Framework represented in the operational plan.

Areas for Action	Link to Domains of Operational Plan	Mechanisms for delivery
Helping people to stay independent, maximising well-being and improving health outcomes	**1,2,3.**	Deliver evidence-based care & extent evidence through research. Explicitly demonstrate our impact on outcomes. Make 'every contact count' to promote health & well-being at individual, family & community levels across all care pathways. Support people to remain independent. Maximise the contribution to specialist community public health nursing.
Working with people to provide a positive experience of care	**4**	Design our services so people, and their carers and family (where appropriate) are active participants in their care. Prioritise patients and the people who receive care in every decision we make. Collect, listen to and act on feedback and complaints. Promote personal responsibilities for health and wellbeing and taking preventative action.
Delivering high quality care and measuring impact.	**5**	Follow evidence-based best practice to deliver high quality outcomes to those that use health and care services (many of which are older people). Measure what we do and our contribution to quality. Be transparent and publish the outcomes. Promote careers in research to strengthen the focus on evidence-based practice.
Building and	**4**	Ensure all registered nurses, midwives & registered care home managers understand

Strengthening leadership		their leadership role with the wider care-giving team. Free out leaders to have time to lead e.g. supervisory status, better use of technology Empower nurses, midwives & care managers to make local changes to improve care.
Ensuring we have the right staff, with the right skills in the right place	**4**	Use evidence-based staffing levels. Commit to and support lifelong learning for the whole care-giving team. Recruit staff with the right culture & values.
Supporting positive staff experience	**4**	Create worthwhile & rewarding jobs. Create equality of opportunity. Support each other & new entrants to the professions. Be professionally accountable. Embrace new technology Be productive and efficient

In summary, the above 6 actions will be realised by ensuring provider contracts reflect the expectation that principles of the 6C's have embraced. Existing monitoring processes such as the Clinical Quality Review Group's and quality visits will be used to test embedment within provider organisations and to hold providers to account for failing to deliver a culture that promotes a positive patient experience a culture that ensures that every contact counts.

Effective QIPP Delivery Checklist Basildon and Brentwood CCG

What is QIPP?

QIPP stands for "Quality, Innovation, Prevention and Productivity".

You will know when you have delivered QIPP because…….

① The outcome of the project or scheme will have transformed a service or pathway **resulting in demonstrable improvement** in a measurable way
② Clinicians will be following a different process, which is clear and well documented and measurable
③ Patients will benefit by an improved outcome

QIPP is **NOT** Decommissioning, Disinvestments, Cost Improvements, Contract Management - These are good business management processes.

Planning

		New to consider	Plan to implement	Commenced	First 3 months	Embedded
	☑ Tick Relevant column					
1.	There is a regular forum for innovation/ ideas generation?	☐	☐	☐	☐	✔
2.	A wide range of clinicians are proactive in identifying and participating in QIPP development & delivery?	☐	☐	☐	☐	✔
3.	New QIPP Schemes are implemented throughout the year?	☐	☐	✔	☐	☐
4.	Schemes are developed through a business case template, with full project scope and clear success metrics ?	☐	☐	☐	☐	✔
5.	Schemes are based on clear evidence,use comparisons/ robust data sources to validate success metrics and reference Lessons Learnt Logs where applicable?	☐	☐	✔	☐	☐
6.	A robust process has been defined and is in operation for signing off individual QIPP schemes, both internally and externally to the organisation?	☐	☐	☐	☐	✔
7.	Project schedules are to include start, lead-in time, mobilisation time, project closure and the date benefits are to commence?	☐	☐	☐	☐	✔
8.	Every Scheme has an active lead delivery manager, quality assurance, financial sign off and clear commencement & end delivery dates?	☐	☐	☐	☐	✔
9.	There is scheme alignment across stakeholders, local providers are involved in the development and sign off of schemes and the whole system impact is documented and understood?	☐	☐	☐	☐	✔
10.	Information requirements to measure scheme success are clear and proactively requested?	☐	☐	✔	✔	☐
11.	For each scheme there is a whole system impact assessment process?	☐	☐	☐	☐	✔

Governance

12.	There is an effective PMO in operation, with qualified staff, sufficient capacity and appropriate management information tools?	☐	☐	☐	☐	✔
13.	There is an active decision making structure within the organisation to approve QIPP schemes?	☐	☐	☐	☐	✔
14.	A robust escalation process is in place to address schemes that are off plan/ trajectory?	☐	☐	☐	☐	✔
15.	QIPP delivery is part of a "Whole System" routine arrangement, not just within the organisation?	☐	☐	☐	☐	✔
16.	Clinical Leads and delivery managers are held to account to deliver QIPP schemes?	☐	☐	☐	☐	✔
17.	There is a clear decision making structure to cease schemes that are no longer appropriate?	☐	☐	☐	☐	✔
18.	Well documented and approved procedures for QIPP are in place?	☐	☐	☐	☐	✔
19.	The PMO has authority to hold delivery managers to account and appointed board level executive ownership?	☐	✔	☐	☐	☐

Delivery

20.	Delivery managers are trained in project management?	✔	☐	☐	☐	☐
21.	The organisation has a culture that embraces programme management?	☐	☐	☐	☐	✔
22.	For every project there are clear milestones, timelines and granular actions with delivery managers?	☐	☐	☐	✔	☐
23.	Scheme project teams are established with properly constituted project groups, with action logs and risk and issue logs?	☐	☐	☐	☐	✔
24.	Project teams meet regularly and have fully participating project members?	☐	☐	☐	☐	✔
25.	The PMO meets regularly with project leads to assure the Board of delivery and identify cross scheme dependencies?	☐	☐	☐	☐	✔
26.	Schemes are rated clearly and consistently to stratify the highest risk schemes?	☐	☐	☐	☐	✔

	New to consider	Plan to implement	Commenced	First 3 months	Established
	☑	Tick Relevant column			
27. Appropriate capacity is in place to deliver the schemes as signed off in the business case?	☐	✔	✔	☐	☐
28. Early warning data is accessible and routinely reviewed to gauge delivery and triangulate with anticipated impact?	☐	☐	☐	☐	✔
29. Providers are actively participating in the delivery of the scheme?	☐	☐	✔	☐	☐
Monitoring					
30. Project teams provide regular progress reports back to the PMO in line with the project milestones & timescales?	☐	☐	☐	☐	✔
31. The Governing body reviews QIPP delivery progress monthly and is actively involved in escalation?	☐	☐	☐	☐	✔
32. Clear, consistent paperwork is used to document and monitor progress?	☐	☐	☐	☐	✔
33. Key Performance Indicators are concise and are the measure for assessing QIPP success?	☐	☐	✔	☐	☐
34. Clinicians are actively involved in reviewing and evaluating the progress and achievements to validate?	☐	☐	☐	☐	✔
35. QIPP achievements are triangulated back across the system to validate success?	☐	☐	✔	☐	☐
36. QIPP schemes are monitored against the risk rated values, net of reinvestment and not against the scheme ambition?	☐	☐	☐	☐	✔
Post Project Review					
37. All projects are subject to a project implementation review after 6 months of delivery?	☐	☐	✔	☐	☐
38. Is there a clear demarcation of project close and transfer to 'Business as usual'?	☐	✔	☐	☐	☐
39. Projects are routinely assessed, either gaining approval to progress or agreement to activate the project exit strategy?	☐	☐	☐	✔	☐
40. A lessons learnt log is maintained on all projects that are closed?	☐	☐	☐	☐	✔
***** Is there an effective change control established or in place?***					✔

Annex C

NHS
Basildon and Brentwood
Clinical Commissioning Group

BETTER CARE FUND
PLANNING AND PROPOSALS
2015/16

Document Control

Change history

VERSION	REASON/SUMMARY OF CHANGES	DATE	AUTHOR
V0.1 & V0.2	**1st Drafts for review**	**10/01/14**	**Stuart A Brown**
V0.3	**3rd Draft incorporating Risks and Finance**	**30/01/2014**	**Stuart A Brown**

Document approvals - this document requires the following approvals

NAME	TITLE	VERSION AND DATE
Dr Anil Chopra	**CCG Chairman**	**V0.3 - January 2014**
Tom Abel	**Chief Accountable Officer**	V0.1 -January 2014 **V0.3 - January 2014**
Tracey Easton	**Chief Finance Office**	**V0.3 - January 2014**
Tonia Parsons	**Chief Operating Officer**	**V0.3 - January 2014**
CCG Governing Body	**All**	**V0.3 - January 2014**
Nick Presmeg	**Director of Integration - ECC**	**V0.3 - January 2014**

Distribution

NAME	TITLE	DATE OF ISSUE	VERSION
BBCCG Governing Body		06/02/14	V0.3

Better Care Fund planning template – Part 1

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

Plans are submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

1. CONTEXT

Basildon and Brentwood CCG is responsible for the area of Basildon, Billericay, Brentwood and Wickford, which has a total population of 264,630. As a CCG we work with four locality groups for Basildon, Billericay, Brentwood and Wickford. This enables us, as a CCG; to work more closely with the populations we serve and allows us to have insight into the diversity of our population.

We were authorised as a statutory commissioning body in April 2013, with a number of conditions and directions we had to meet before we could take on full commissioning responsibilities. We have worked hard to address these and we are now confident that from April 2014 we will be able to assume full responsibility for our statutory functions.

We recognise that we still need to describe and provide more specific details about how and when we will deliver the planned system change envisioned for not just the BCF but the wider health and social care system in Basildon and Brentwood. This is currently constrained to a certain extent by the planning that we are doing and contractual arrangements we are in the process of concluding with our providers for 2014/15.

One of our most immediate priorities it so procure and implement a risk stratification tool.

Our key objectives of the Better Care Fund (BCF) are:

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence. The newly developed integrated community services teams will ensure a multidisciplinary approach that is targeted and risk based.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services;
- To move care closer to home so that our hospitals have manageable demand, one of the enablers for this will be the newly commissioned integrated health and social care rehabilitation and reablement service;
- To work together to ensure people are supported to look after their health and wellbeing;
- To support providers to join up, share information, and make services easier to navigate;
- To create an Integrated Commissioning Board or similar with ECC and other local authorities as appropriate, to align our work and have a single commissioning process, services and work.

The CCG's draft 5 year strategy outlines three care concepts underpinning the future of Healthcare in Basildon and Brentwood:

1. The establishment of **Excellent Primary Care** consistently across Basildon and Brentwood.

2. The creation of **Named GP Teams, working as Lead Professionals** for people at risk providing GPs with the responsibility and authority to ensure the provision of integrated and co-ordinated evidence based care to each individual. These teams will be built from geographic Primary Care Federations, with an opportunity to consider differing integration forms and models.

3. The development of **Specialist Pathways of Care**, integrating existing community, acute and specialist service provision for designated indications. Such pathways will be evidence based and time limited.

Whilst we have some high performing services, the system has become complicated with overlaps, and involves too many hand overs between organisations and services. For example, our management of long term conditions and services to the frail and elderly require much greater integration particularly focussing on who is in charge, or who is responsible for their health and care.

This situation provides a clear driver for integration across health and social care. This document describes our high level plan for the implementation of the integration agenda in Essex and Basildon and Brentwood in particular - and specifically the implementation of the first tranch of the Better Care Fund (BCF) in 2014/15.

Basildon & Brentwood CCG will work in collaboration with Essex County Council; striving to achieve seamless provision of health and social care where integration can work in the best interests of the local people of Basildon and Brentwood.

2. PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council (ECC)**
Clinical Commissioning Groups	**Basildon and Brentwood CCG**
Boundary Differences	**One of five CCG's co-terminus with ECC**
Date agreed at Health and Well-Being Board:	**<dd/02/2014**
Date submitted:	**<dd/02/2014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

b) Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	**Basildon and Brentwood CCG**
By	**Tom Abell**
Position	**Chief Accountable Officer**
Date	**<date>**
By	**Anil Chopra**
Position	**Chair of the CCG**

Signed on behalf of the Council	**Essex County Council**
By	**Nick Presmeg**
Position	**Director of Integrated Commissioning & Vulnerable People**
Date	**<date>**

Signed on behalf of the Health and Wellbeing Board	**<Name of HWB>**
By Chair of Health and Wellbeing Board	**<Name of Signatory>**
Date	**<date>**

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

Basildon and Brentwood CCG and the South Essex sub- economies

BBCCG is not the sole commissioner for our main acute provider - Basildon and Thurrock University Hospital. It is a shared provider with Thurrock CCG, this means there will be overlaps between the BBCCG part of the Integrated Plan and the Integrated Plans of Thurrock and to some degree Southend.

All parties are seeking very similar outcomes and recognise the importance of giving clear direction to providers and the market place that will only come through close working. We will utilise existing forums such as the Unplanned Care Working Group to ensure that there is consistency in appropriate levels of strategic and operational commissioning intentions.

This first draft reflects a number of existing programmes that are designed to include health and social care providers as active participants; together with a range of GP locality groups, and our voluntary and community sector as a whole. Our intention is to encourage providers to take and active role in developing future plans.We have a major provider engagement event jointly with Castle Point and Rochford CCG planned for the end of January 2014.

It is our intention, as the programme gathers momentum, to invite representatives from key providers to join the South Essex BCF Commissioning Group, currently chaired by ECC which meets weekly. This will ensure that the design of future services and clinical pathways is jointly driven and jointly owned.

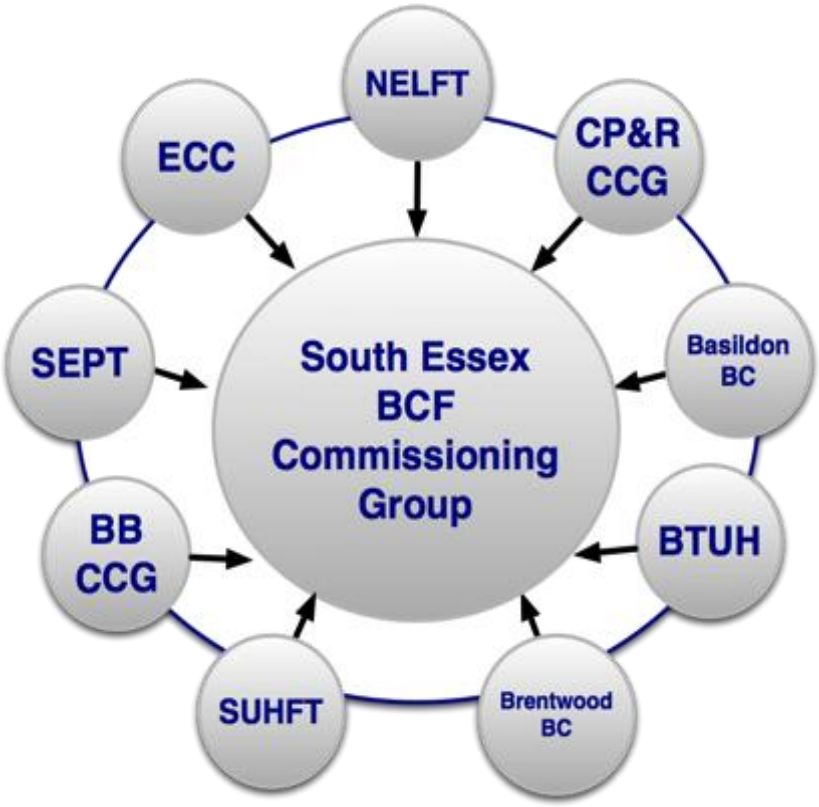


Fig 1 - South Essex BCF Commissioning Group

We recognise that there will be difficult and challenging conversations to be had across the provider landscape as there will be both winners and losers as we move to the new ways of working, particularly when it comes to moving activity from one provider to another and the inevitable movement of revenues.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision is to design and implement an integrated care system based on what our resident population needs, that need will be articulated by the residents themselves via the various patient and service user engagement forums that we have already established and a number of additional groups that we are planning to establish over the coming weeks.

The CCG has implemented a wide range of activities to help ensure that our patients and community feel fully engaged with the planning and quality monitoring of local services:

All 4 locality groups have Patient Engagement Groups (PEGs) which meet monthly to hear patient views and act as an information exchange.

The CCG has a formal Patient and Community Reference Group (PCRG)in place, acting as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc.

Members include 9 lay reps, 2 x CVS, 3 local authorities, Healthwatch Essex and GP chair of the CCG. Key roles of the group include receiving reports from the Patient Leaders for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year, etc

The PCRG links to the locality PEGs through lay members and CCG locality managers to ensure local views and connections are maintained. The workplan of the PCRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval. http://www.basildonandbrentwoodccg.nhs.uk/patient-and-community-reference-group

As well as being the CCGs representative on the Essex Health and Wellbeing Board, the GP Chair of the CCG is a member of the Basildon Health Partnership and a Brentwood GP is a member of the Brentwood Council health forum.

CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients,.

Board meetings are held in public, with questions invited, and some GP locality groups have patient representatives as members.

The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.

The CCG has its own website where all plans (including the Integrated Plan), policies and documents are published and accessible to the public www.basildonandbrentwoodccg.nhs.uk

Contact details for the CCG and a general enquiry email account has been set up to receive comments and messages from the public.. Bbccg.contacts@nhs.net

Our current engagement map is described below in Fig 2:

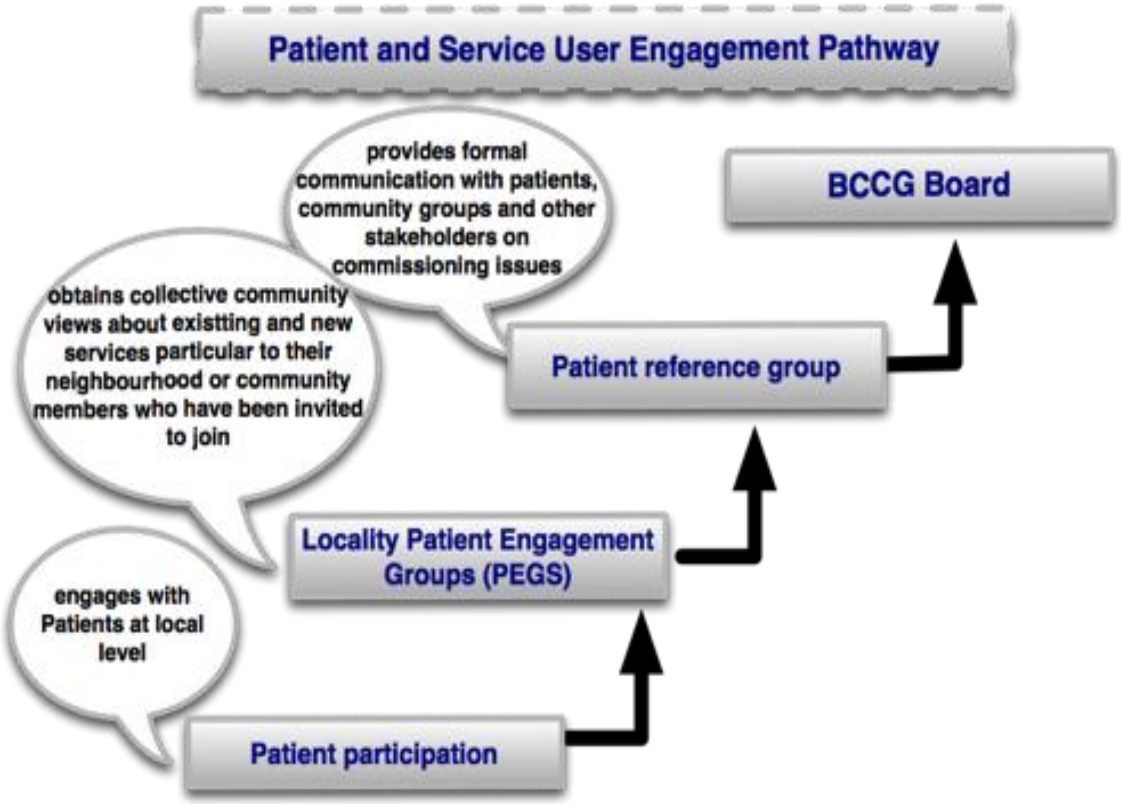


Fig 2 - Patient and public engagement process

e) Residency versus GP Registration

All residents within the geography of Essex County Council are covered by ECC's social services. Access to health services is dependent on the address of the GP that the individual is registered with. This can lead to ECC residents receiving their healthcare from CCG areas outside of ECC's geography and some residents from neighbouring local authorities receiving their healthcare from within the Essex Health and Wellbeing geography.

f) 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.

The table overleaf describes the key Basildon and Brentwood documents that feed and inform the development of the BCF submission. There are other national documents and guidance that also inform the BCF submissions including :

The NHS Outcomes Framework;

The ASC Outcomes Framework;

The BCF Planning and Technical Guidance;

The "Everyone Counts" planning guidance.

Document or information title	Synopsis and links
BBCCG Integrated Commissioning Plan	Describes the five year plan for Basildon and Brentwood Clinical Commissioning Group - setting out in detail the services we intend to commission, the services we intend to reform and improve and the services we may wish to de-commission.
BBCCG Strategic Plan	This document sets out the challenges and the issues we face as a CCG and defines the strategy we will adopt to address those challenges in the coming years as we strive to reform and modernise the local health economy
BBCCG Operational Plan 2014-2016	Provides the specific detail that describes how and what we will measure in relation to such things as improving Patient Safety, Safeguarding, Standards of Care in our providers.
Citadel Healthcare Future State V0.2	A mindmap translation of the Citadel Workshop held in November 2013 and attached as an appendix to this document
Citadel Healthcare Workshop Scan - Graphic	A graphic representation of the Citadel workshop held in November 2013, a copy of which is attached as an appendix to this document

2. VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

The current provision of health and social care services is not sustainable from either a quality or capacity perspective or a financial perspective in the long term. Therefore we are committed to significant radical reform to design and build a health and social care system that is: based on quality and safety, is accessible, affordable, responsive, agile, patient centric and delivers the levels of quality that our residents demand and rightly deserve.

Our vision for the future requires whole system change; in terms of how we commission work from providers, how our providers interact with patients and with each other. Working together across the local government and health landscapes we are committed to driving behavioural change in partnerships in all areas of the health & social care system, which will include a much more prominent role for the voluntary, community sectors, and not least our residents themselves.

NHS Basildon and Brentwood CCG (BBCCG) is commencing a process to undertake significant reform of the local NHS and wider care system. The objectives of these reforms are to:

- Design, develop and implement a patient centric integrated health and social care system that delivers the right care in the right place at the right time;
- Improve the quality and safety of local services;
- Improve outcomes for our local populations and reduce health inequalities;
- Move to a local health and care system that is financially sustainable.

The system reform proposed focuses on three core work elements:

- The establishment of 'Excellent General Practice' consistently across the area;
- The creation of integrated 'Named Accountable Professional Teams' who will be responsible for managing the health and care of people with long term complex needs;
- The creation of integrated 'Specialist Pathways of Care' for people with specialist needs.

What changes will have been delivered in the pattern and configuration of services over the next five years?

Patients, Service Users and Carers will be empowered to direct and manage their care and support, and to receive the care they need in their homes or local community and:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;

People have a named GP and someone from the surgery co-ordinates all the different services within their joint Care plan. A single patient and care record which can be accessed and controlled by the clinicians and care workers who are involved in their care. Which gives them the assurance that they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell. The GP will , using teams consisting of Community nurses, OT's, Social Workers and Geriatricians, co-ordinate the patients care ensuring a fully integrated delivery model.

- Systems will enable and not hinder the provision of integrated care;

People have a single care plan and where appropriate have been provided with simple devices and support that allows them to self-manage as much of their conditions as possible on a daily basis. With clearer information and advice, and knowing that professional support will be provided if they need it.

- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy.

Frail and Elderly are linked into local voluntary schemes for older people, which facilitates the sharing of experiences for mutual support.Care coordinators are proactive

in ensuring that support is available to them within their communities, through difficult times. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

- Clinical pathways will be designed around the needs of patients, carers and their families

This work starts and ends with individuals experience of care. Through mapping the current experiences, capabilities and needs of our patients and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas.

This is about not simply looking at people in terms of the cost of their care under the current service model of provision,or the types of interactions with those services that they currently have, but looking further to the root cause of the challenges many of our patients and their families experience today, and how these can be converted into more positive experiences and outcomes in the future.

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

As a result of these changes:

In line with the NHS Outcomes Framework and the five domains of:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm

and the four domains of the Adult Social Care Outcomes Framework of:

- Enhancing quality of life for people with care and support needs;
- Delaying and reducing the need for care and support;
- Ensuring that people have a positive experience of care;
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

We aim to help people to feel confident about the quality and level of care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including local A&E departments, is significantly reduced. If they do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission.

People routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

Overall pressures on Essex hospitals and health budgets will have reduced, as we shift from high-cost reactive services to lower cost preventative services, supporting greater self management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved

care at home which in turn reduces the need for high-cost nursing and care home placements.

To achieve this we will engage with local health and social care providers, and associated public, private and voluntary and community sector groups, to "co-design" models of care that will engage with and meet people's aspirations and needs.

People will be empowered to direct their care and support, and to receive the care they need in their homes or other appropriate community setting.

Over the next 2 to 5 years we will enable community healthcare and social care teams to work closely together in an increasingly integrated way, with single health and social care assessments providing for rapid and effective joint responses to identified needs, provided in and closer to home.

Our teams will also increasingly work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring a level of health or social care support, so that we help them to remain healthy, independent and well. We will make considerable investment available to empower local people through effective care signposting, peer support, mentoring, self-management and personal healthcare budgets to maximise their independence and wellbeing.

We will design and implement integrated Community Independence teams tasked with providing a rapid response service to support individuals in crisis and help them to remain at home.

Community Independence Teams will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication.

We will also seek to introduce individuals to the potential of assistive technologies and, where these can be employed, we will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;
- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

In doing so our plan is to go far beyond using BCF funding to back-fill existing social care budgets, instead working in a truly integrated fashion to reduce long-term dependency across the health and social care systems, promote independence and drive improvement in peoples overall health and wellbeing.

As a result of the planned changes we expect the volume of emergency activity in hospitals to reduce and we also expect planned care activity in hospitals to also reduce because we will have developed alternative community-based services.

A managed admissions and discharge process, fully integrated into local specialist provision and Community Independence provision, will mean we will be able to eliminate delays in transfers of care,reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

Mental health is a key priority, with rising demand on mental health service provision will be given consideration alongside frail and elderly which is the main thrust of our integration planning. Our plans therefore are designed to ensure that the work of community mental health teams is seamlessly integrated with community health services and social care teams, thereby superseding traditional CMHT's; they will organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

By improving the way we work with people to manage their conditions, we expect to reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

The overarching objective for the CCG is to improve health outcomes, reduce health inequalities and develop a sustainable affordable health and social care system.These aims will be achieved by proactive case management, by stratifying the risk and needs of the patients and service users -through responsive provision of local and regional services channelled through an effective community, social and primary care offer with a single point of access - Integrated Care through a lead professional and using a multi-disciplinary team approach focused on early intervention and prevention.

We have already agreed and implemented work in five specific areas with ECC which are:

- Commitment to jointly procure the risk stratification tool and share the data;
- To jointly specify and procure an enhanced reablement and rehabilitation service (this will include all current hospital discharge, intermediate care and continuing healthcare pathways);
- To develop and implement an integrated community services specification that will bring together social care assessment and care management services and community health provision;
- A joint programme approach to the implementation of the BCF;
- To ensure effective governance though the Joint Board that we have established.

What are the aims and objectives of your integrated system?

We see the implementation of the BCF as a two phased programme, the initial phase being that which we will deliver in 2014/15 and phase two which will go forward from April 2015.

The BCF is also a key enabler for the long term strategy that we are looking to deliver in Basildon and Brentwood which is a large scale modernisation programme that will

transform the health economy landscape for the area. This programme of modernisation and reform, which we have named Citadel, is an integral part of our planning activities for 2014/15.

BBCCG is basing the approach to the integration fund (BCF) as part of an opportunity to transform the health and social care system for our population, to make it patient/person centric with the system being responsive, sufficient and necessary to meet their needs.

Based on this proviso we have structured the services/pathways that will form part of the BCF in order to meet that criteria. A full list of the current proposed schemes/service lines that we are considering is detailed in Part II of this submission with relevant values where we have clarity at this point in time.

Essentially we are focussing on areas that :

1. There are very clear synergies with ECC
2. There are opportunities to prevent admissions to secondary care
3. The are obvious health deterioration prevention opportunities
4. There will be a reduction in Health Inequalities
5. There are financial economies of scale to benefit from
6. Joint commissioning is driven by the needs identified in the JSNA and the HWBS.

How will you measure these aims and objectives?

Using the NHSOF and the ASCOF as our guide, we intend to measure specific nationally mandated and local metrics, the specific details of which will be covered in the Outcomes and Metrics tab of the excel submission template. The success factors will include such things as reductions in hospital attendance and admissions.The advances in IT capability will help us to drill down deeper into the data held which in turn will lead to more information on specific reasons for admissions and by doing so will present opportunities to develop additional preventative measures.

In order to manage and track outcomes, we will be developing business cases to enhance developments in data warehousing, that will help us to work with all available care data, information and intelligence, getting as close to “real time analysis” as we can to allow us to make rapid and accurate decisions - including total activity and cost data across health and social care for individuals and whole segments of our local populations. Our vision is to develop interoperability between all systems to provide this “real time” information and managerial analytics capability.

Our GP practices all use the same IT system,System 1 providing the opportunity for our care providers to all use the same patient record[1]; the BCF will help ensure this happens by joining up Health and Social Care data across the County provider landscape, all linked together via the NHS number.

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow

1 Subject to Information Governance constraints

effective identification and management of need and outcomes across our health and care economy as a whole.

What measures of health gain will you apply to your population?

We will be using the national mandated indicators[2] and we will be using locally developed indicators and KPI's that will use the JSNA and the JHWS as the key drivers and sources of intelligence that informs them.

A key measure of success for our CCG will be the impact that the changes we set in motion has on our Acute providers and specifically our A&E departments - how quickly does demand begin to reduce on A&E departments, how quickly do emergency admissions of frail and elderly start to reduce and how much can we reduce our Continuing Health Care bill because we are seeing more people going through a rehabilitation and reablement model that actually works for them and allows/facilitates them to lead a relatively independent lifestyle for longer.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including: The key success factors including an outline of processes, end points and time frames for delivery

As mentioned previously these are the key changes we will be implementing:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy;
- Clinical pathways will be designed around the needs of patients, carers and their families.

Working closely with ECC, and using a programatic approach based on Managing Successful Programme (MSP). The following diagram (Fig 3) describes the three main stages of the MSP process which we will be following.

At the time of submission we can say with a degree of confidence that we[3] are in the Development phase of the programme. A description of phase 1 - Define can be found in Appendix III of this document

2 As driven by the NHSOF & ASCOF

3 South Essex Commissioning Programme Group

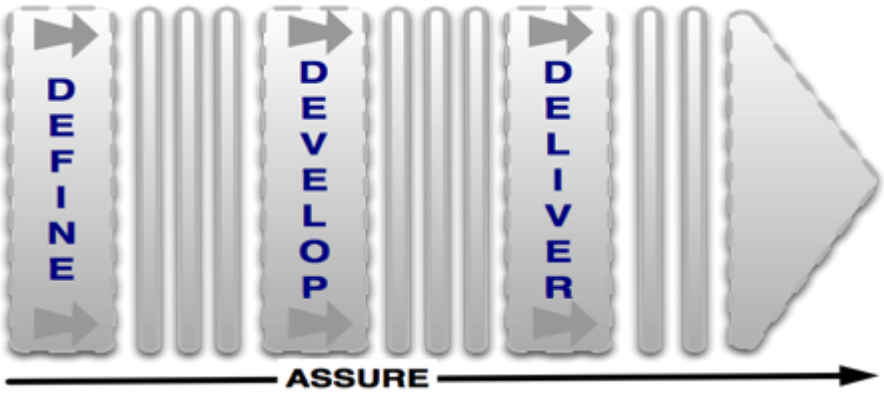


Fig 3 - MSP Programme phases

The weekly meetings that take place with ECC has ensured that we have gained momentum in planning terms and the membership of the group has meant that we have executive decision making capability and authority in the room at all times which has ensured that we have not been unnecessarily delayed whilst we wait for decisions.

In line with the guidance issued on the 20th of December we will be submitting our initial plans to NHSE and ECC in February, albeit that they may not have gone through our desired full approvals process of ECC Cabinet and HWB.

A fully detailed plan is being developed in collaboration with ECC and with Castle Point and Rochford CCG as well as NHSE and local district councils. The detailed plan may or may not be ready for the initial submission date of 14th of February, if it is a copy will be attached in the appendices and if not it will be forwarded as soon after as is practicable

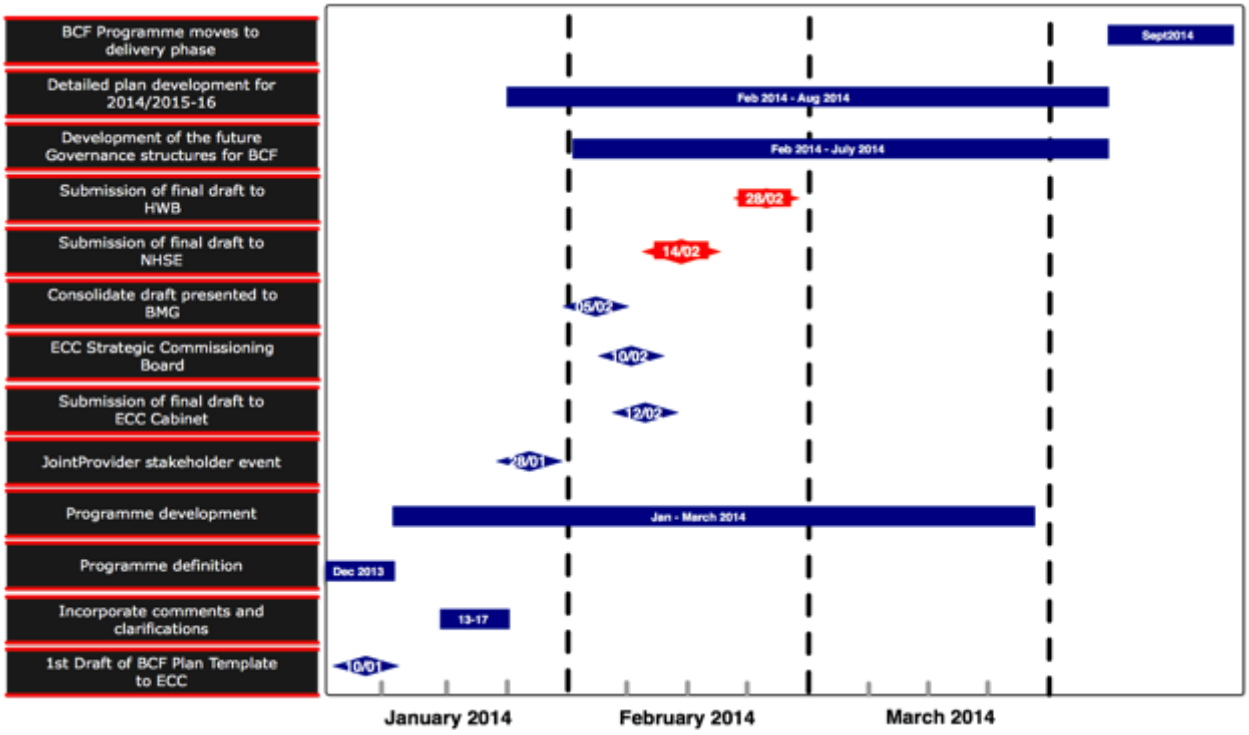


Fig 4 - Short term high level BCF programme plan

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The JSNA will be used to provide the evidence to support our commissioning intentions as it does for the Health and Wellbeing Strategy

d) Implications for the acute sector

Implications of the plan on the delivery of NHS services

Not dissimilar to many other parts of England our Acute providers are feeling the strain of excessive demand, particularly in the Unplanned Care pathway. Clearly the level of demand being placed on our Acute Trusts is not sustainable so something has to change. This is recognised by both Commissioners and Provider. The CCG has a productive dialogue with Basildon and Thurrock University Trust Hospital, a dialogue that has already started to explore and agree new approaches to commissioning and payment models which will be reflected in the 2014/15 contracts currently under negotiation.

At the time of writing CCG's are in advanced stages of contract negotiation and specification, the current timeline for the conclusion is the 28th of February 2014 when all CCG's are required to have signed contracts in place. This will be reflected in the final draft submission for the BCF.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Governance around BCF is considered to be two workstream that apply to separate and distinct phases of the implementation and delivery of the BCF programme :

a. The programme definition and development stage which encompasses 2014/15

b. The programme delivery and move to business as usual stage which will manage the delivery of BCF from April 2015 going forward.

The diagram overleaf (Fig 5) describes the current Governance structure that we have developed to manage Phase 1.

ECC has a strong history of collaborative working with health commissioners and providers across the county. This has continued under the new structure for Health with the authorisation of multiple CCG's in Essex, of the seven CCG's in Essex only two of which are not aligned to ECC's health and wellbeing board.

Under this current structure the South Essex Commissioning Programme Group meets weekly and the Business Management Group, whose membership includes the Accountable Officers from the five CCG's, ECC and NHSE, meets fortnightly.

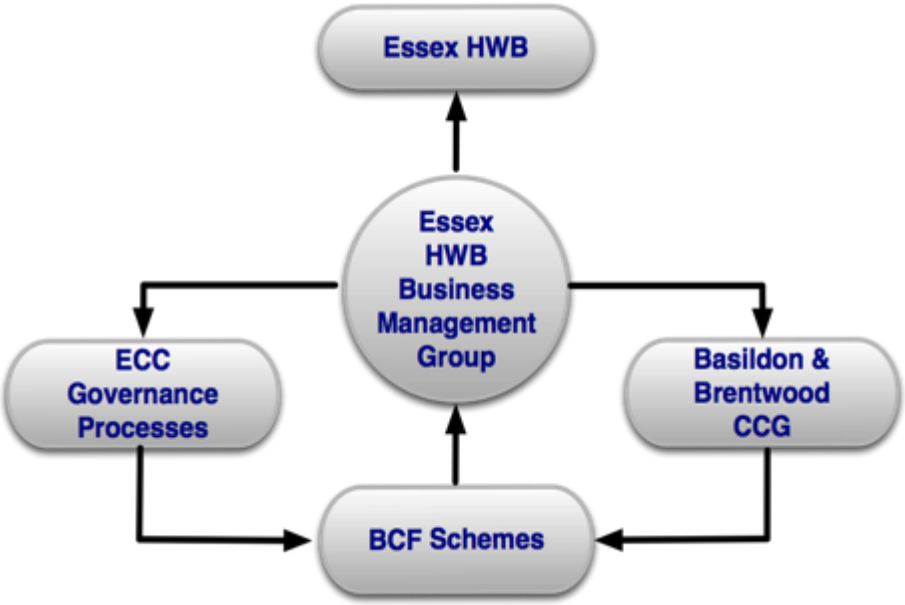


Fig 5 - BCF Phase 1 Governance structure

Joined up management - an integrated approach to commissioning management

To deliver the ambition that the establishment of the BCF offers, we recognise that we need to develop robust yet agile strategic and operational governance arrangements that will stand the test of both internal and external scrutiny and possibly public scrutiny. We therefore propose to consider, as part of this process, what are the specific arrangements that will work best in order to discharge our management responsibilities and accountability across social care and health services, whilst at the same time ensuring that we deliver for our residents and patients and as a whole.

We are still in the process of developing potential commissioning scenarios which will form part of our options appraisal that will determine which is the most appropriate vehicle to deliver the joint commissioning functions - be this a jointly resourced commissioning team or a legally constituted Commissioning Trust. Whichever the model we select we would see our future commissioning management team for the commissioning of integrated care, accountable through the Health and Wellbeing Board, to both the Local Authorities and the CCGs.

In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

We are in the process of developing detailed programme plans for the implementation of the BCF programme in collaboration with ECC.

f) BCF Programme structure

The development and delivery of the BCF programme is expected to be complex and challenging, particularly the communications, engagement and governance elements of the programme. Therefore based on this we have adopted a working group and task and finish group approach to programme management. The following diagram overleaf (Fig 6) describes the main standing groups that will sit during the development and

early stages of delivery. These will be complimented, when and where necessary by task and finish groups which will be convened for a time limited task specific period.

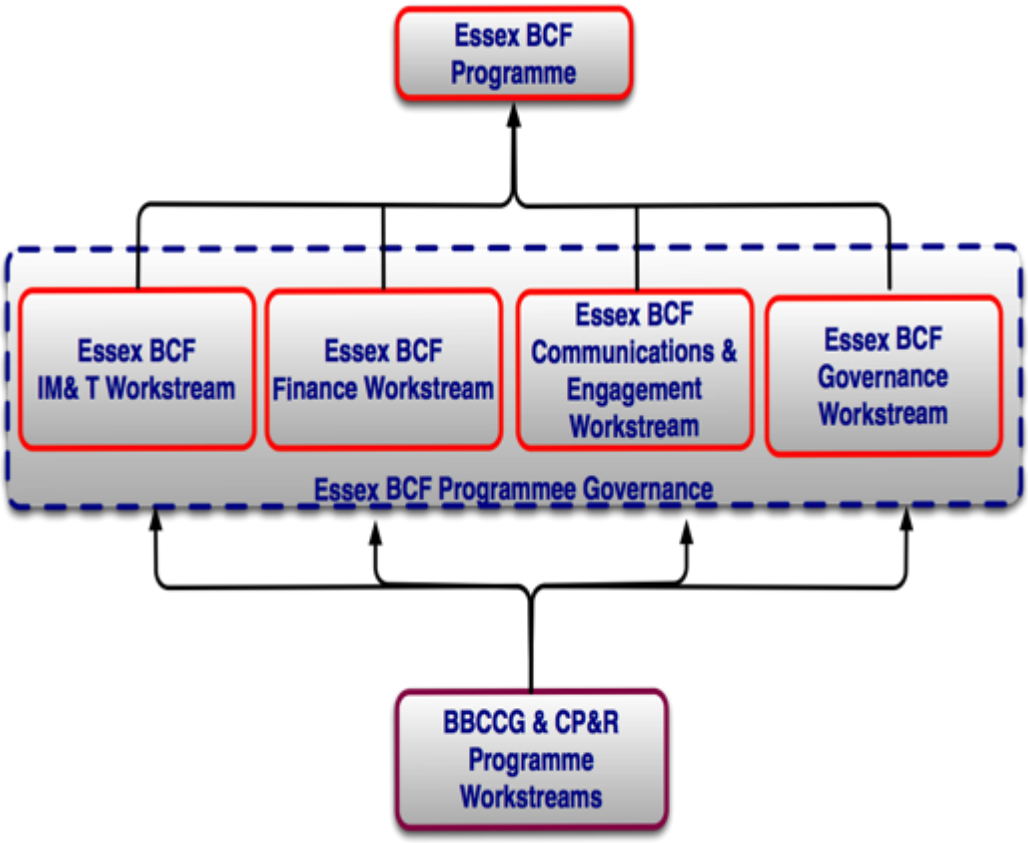


Fig 6- BCF Programme Structure

3. Financial Implications

We see the implementation of the BCF as a phased programme in 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure to provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

BBCCG and ECC are having productive discussions around the sums that should go into the integrated fund, both parties recognise that if we simply deposit the minimum amounts as allocated by NHSE then it is unlikely that there will be sufficient monies to bring about real transformation of our health and social care systems in Essex. So whilst we still have considerable work to do[4] we are confident that we will collectively be contributing more to the pooled fund than the minimum amounts stipulated.

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for

4 this work will be taking placduring quarters 1 7 2 of the 2014/15 financial year

2014/15 will be considerably different and smaller scale than those transferring in 2015/16.

a) 2014/15 BBCCG Investment

Following a recent meeting of the Business Management Group it was agreed that consistency of terminology would make ongoing development easier and reduce potential confusion between the various collaborating organisations. Based on the agreement the tables overleaf for 2014/15 will be identical in terms of structure to that for 2015/16 although the numbers will obviously differ.

Function/Service Identifier	Description	Min	Max
Protection of Social care to benefit health		**£3.7M**	**£4.854M**
Community Health Services (including admission avoidance)			
Reablement	Residential step-up/step down Community Beds Home from Hospital High Intensity Rehabilitation Hospital In reach Rapid Response SPOR	**£773K**	**£1.546M**
Joint nursing and care home commissioning including CHC			
Discharge support			
Acute mental health and dementia			
Care Bill			
Early intervention and prevention			
Community resilience			
Carers			
Disabled Facilities Grant			
Other and enablers			

Table 1 - 2014/15 Proposed investment

b) 2015/16

As we have established the size of the BCF will grow from 2014/15's allocation of £4.85M, which is mainly constructed from similar S256 amounts from 2013/14, to approximately £11.18M for 2015/16. Whilst we still have work to do and challenging conversations to have the table overleaf describes and sets out our ambition for 2015/16.

Function/Service Identifier	Description	Min	Max	Total Investment
Protection of Social care to benefit health		**£4.853M**	**£4.853M**	
Community Health Services (including admission avoidance)		**£9.809M**	**£14.834M**	
Reablement	Residential step-up/step down,Community Stats, Home from Hospital	**£3.700M**	**£1.850M**	
Joint nursing and care home commissioning including CHC				
Discharge support			**£507K**	
Acute mental health and dementia			**£71K**	
Care Bill				
Early intervention and prevention				
Community resilience				
Carers		**£82K**	**£82K**	
Disabled Facilities Grant				
Other and enablers			**£1.8M**	
	Totals	**£18.444M**	**£24.077M**	

Table 2 - 2015/16 proposed investment

4. National Conditions

BBCCG will align with the national requirements as mandated by NHSE and those that are contained in the planning guidance issued on the 20th of December 2012. Specifically in relation to BCF we are developing plans that meet the following preconditions:

- Plans to be jointly agreed.
- Protection for Social Care services (not spending)
- 7 day services in H&SC to support patients being discharged and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care, based on NHS number
- Ensure joint approach to assessments and care planning and ensure an accountable professional where integrated care package is funded.
- Agree on consequential impact of changes in the acute sector

We also recognise that there will be a significant performance linked payment(s) which CCG's and the Integrated commissioning functions will need to deliver.

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

The objective of integration is to develop a more effective, efficient and affordable health and social care economy. Integral to this will be the continued development and enhancement of social care services. Our stated ambition is to move more activity out of an acute setting and into a community based setting, this will require a stable and accessible social care system in order to make the changes sustainable.

ECC will continue to allocate additional spending for local social care services to the same financial level in 2014/15 as they did for 2013/14. This will enable the purchasing of community based social services within each CCG locality. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principle mechanism for this is ECC social care resource allocation system (RAS) and support planning

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)

ECC already operate a six day discharge support service and in line with national guidance BBCCG is working with ECC and our providers to deliver a seven day access to health services programme.

This work is being undertaken: Locally, across multiple providers and regionally across the County. The programme includes a number of clinical pathways including Social care discharge, Reablement, Step

down and Rapid response via an out of hours emergency duty team. Care homes are working with us to ensure they are able to accept 7 day planned admissions.

BBCCG has implemented a collaborative working arrangement with key providers across the borough, see Fig 7 below, to develop the necessary support and infrastructure that will facilitate a sustainable response to the requirements for 7 day working in the NHS.

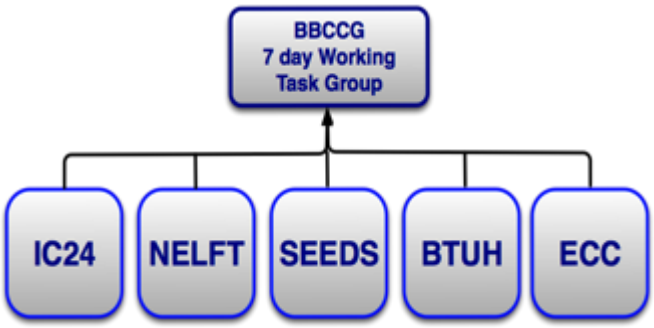


Fig 7 - BBCCG 7 day working task force

The following are some of the initiatives that are being developed :

- Paediatrician cover has shown a marked increase since the Paediatric review;
- McKinzie reviewed 10 specialties and validated job plans. Three workshops in September, October and December have driven this work at pace the success of which has been manifest in increased Attendance rates. The consultants are working to agree the standards and plug existing gaps;
- A pilot started on the 16th November for acute physicians, DMPO and general medicine to increase consultant cover. Improvements have been seen at the weekend, analysis is now underway to assess the impact of the upturn in discharge rates;
- January 2014 sees the implementation of a new model for Trauma &Orthopaedic (T&O) consultants;
- Additional locums have been brought in to increase from a half to full days at weekends. Respiratory coverage is increasing to 6 days per week;
- Discussions with anaesthetics, gastro and diabetes are ongoing to improvements that will be made. (This is managed through right place right time in workstream 3).
- ECC's pilot programme has been extended (moving from their previous 6 day supported discharge team's working window to 7 days). A further evaluation of the success and outcomes of this will be carried out at the end of the financial year.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We are not currently able to use the NHS number, due to Information Governance, but we, along with ECC, do have plans to do so in the future.

ECC also have plans in place to adopt the use of the NHS number as the default identifier.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

It is our expectation that we will be in a position to implement usage of the NHS number by Quarter 3 of the 2014/15 Financial year.

Because the use of the NHS number is governed by the rules around Information Governance, and until some of these issues are resolved, we cannot put a specific date against this item.

We will continue to work with NHSE and the Local Authority, ECC, to ensure that we are ready and able to implement the use of the NHS number as soon as it is possible following authorisation to do so.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Assuming that we mean: Application Programming Interface, then yes as a CCG we are open to exploring the use of API's[5].

Implementation will of course be subject to both organizations evaluating various issues in order to maximize the rewards, as well as manage the implications associated with an open API model and of course the requirements and constraints of the Information Governance arrangements for the NHS and CCG's in particular.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The changes that integration effects and the impacts it has will take place with due regard and compliance with our Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully
- Members of care teams should share confidential information only when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them must be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

5 The open API model is designed to reduce the process and resource requirements across partnerships and integrated working arrangements

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. professional.

Following the announcement by the Secretary of State for Health in December 2013 that everyone over the age of 75 would have a named GP lead who would monitor and manage their health BBCCG is in the process of working towards the implementation of this directive, we currently do not have full implementation.

One of the key benefits of a commissioning organisation led by local GPs is we know our patients and routinely interact with them as they move through each stage of their life. In 2013 we made extra efforts to make sure that we also heard from other people in our communities, both patients who don't regularly use services and organisations who see and hear from people in different ways.

The aim is that geographic, federation configured, 'Named GP Teams' would be the sole deliverer of front line care to people with complex needs and long term conditions, this would include existing generic community, social care and mental health resources.

As part of the BCF in practice, this **will** mean that every patient who is covered within these teams has a named GP who is responsible and accountable for their care and outcomes. Our plans for integrated community services within the BCF will ensure that Social Care resources are fully aligned on a multi-disciplinary basis.

Our plans to develop a fully integrated approach to reablement and rehabilitation will strengthen our existing arrangements and ensure we use a joint process to assess risk, plan care and allocate a lead professional

A step up approach to this could see the mobilisation of Multi Disciplinary Teams that may in be led by a Community Geriatician for example. BBCCG is in the process of trialling this along with other models of care in the community.

3 categories are being considered to help us define the level of health and social care that will be expected to be available to each individual who is 75 years or older:

- 'Well' – those individuals with a relatively non-complex health profile, who are able to maintain an appropriate level of wellbeing and independence, with minimal recourse to primary, community or secondary health care, and do not require social care. Care co-ordination will be via routine GP practice or patient initiated contact with relevant health services as required.
- 'Moderate complexity' – those individuals with a more complex health profile, including co-morbidities and/or frailty, and increasing social care needs, requiring frequent monitoring and intervention within primary and community environments, and close co-operation with secondary care consultants within the relevant medical specialties. The Lead Professional Care Co-ordinator for individuals within this category will be a named GP, and the care co-ordination vehicle will be the GP Practice-level MDT, on an ongoing basis.
- 'Significant complexity' – those individuals identified, either through the GP Practice level MDT, or following presentation at the ED/admission to an acute bed, as experiencing significant exacerbation in the complexity of their health needs and/or significant increase in their social care needs, requiring intensive specialist

intervention within a community environment, with a view to transferring the individual back to the care of the GP Practice-level MDT once their condition has been stabilised. The Lead Professional Care Co-ordinator for individuals in this category will be a Consultant Geriatrician, and the vehicle for assessment/planning and implementation of required care will be the Geriatric Case Management Team.

In order to take this model forward further it will be necessary to develop an effective risk stratification tool that will allow professionals across the health and social care system to apply a common approach to identifying individuals that fit within the 'moderate complexity' and 'significant complexity' categories. The CCG in partnership with ECC are fully committed to working together to evaluate and procure an appropriate risk stratification tool within 6-9 months, appropriately aligned to other BCF procurements.

a) RISKS

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

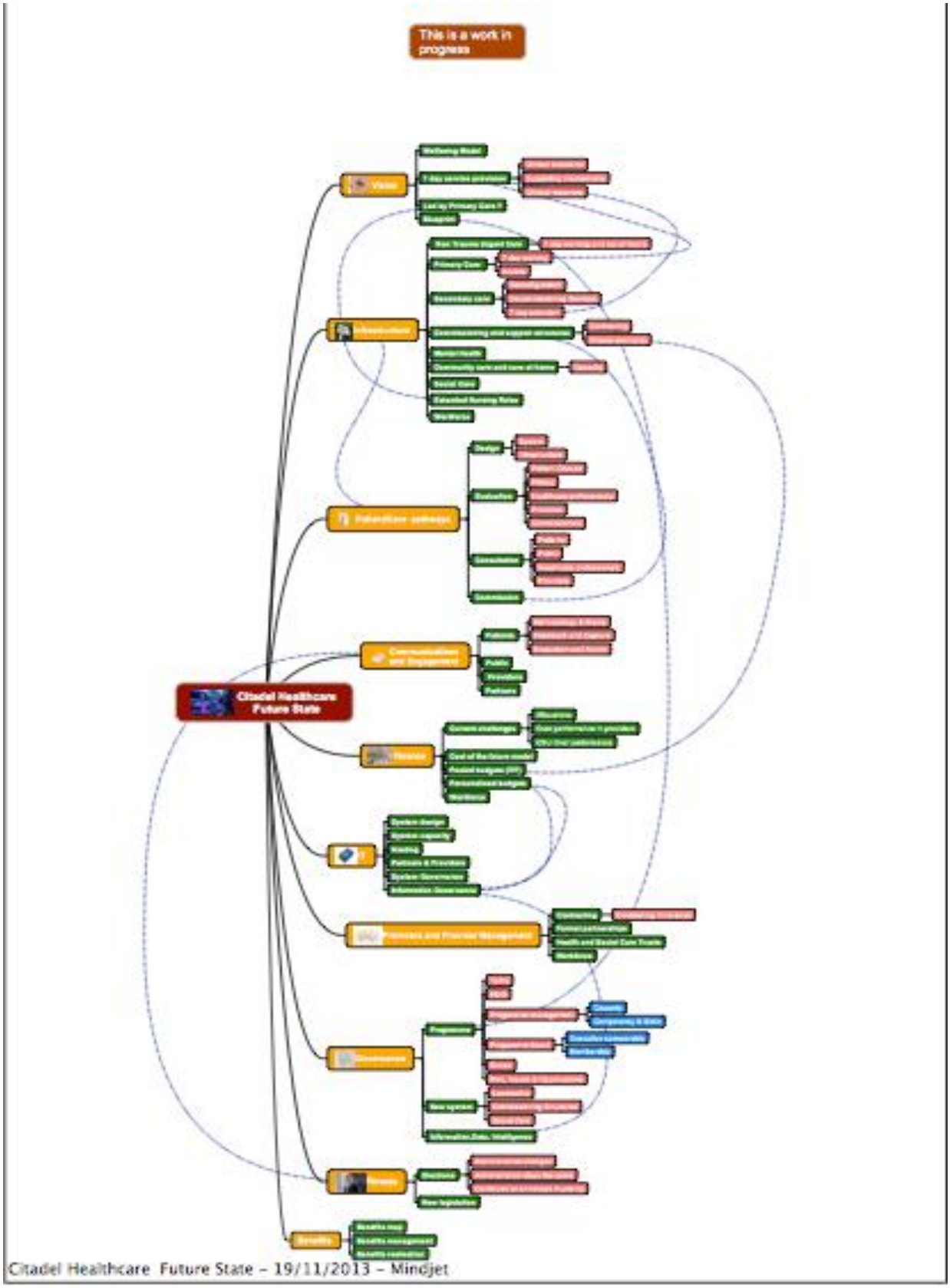
Risk	Risk rating	Mitigating Actions
There is a risk that moving funding from existing pathway provision will destabilise providers	Medium	We will work closely with providers, social care and partner organisations to ensure that when capacity is moved providers are supported and that when the capacity moves the patients move with it.
There is a risk that when services and capacity are moved from an Acute setting into a community or home based setting that patients will not be fully informed or engaged with the changes	Medium	The CCG will lead a programme of communication and engagement in partnership with GP's, Providers, Essex County Council and other partner organisations to provide consultation and educational programmes to support the implementation of the changes.
There is a risk that the current level of ambition for system change is not matched by available CCG resources which will impact on the ability of the partnership to deliver the full impact of the BCF on time	High	The CCG will need to consider the use of non recurrent transformational funding to deploy additional external and/or seconded resources to support the change agenda. Plans are currently being finalised to present to the governing body and to NHSE for assurance prior to implementation.
There is a risk that politicians if not feel fully briefed on the implications, advantages and benefits of the pooled funding arrangements and therefore unable to fully support the plans	Medium	The CCG (s) are working closely with ECC, and will continue to do so during 2014 to ensure that Elected members are fully engaged and briefed on progress towards to implementation of the BCF and the impact of implementation on their constituencies.
There is a risk that if the use of the NHS number by all parties to the pooled funding arrangement is not facilitated by the end of Quarter 2 of 2014 it will have a significant delaying effect on the full implementation of the BCF	High	CCG's have limited ability or scope to mitigate against this risk, the ownership of the risk in reality transfers to NHSE

b) Appendices

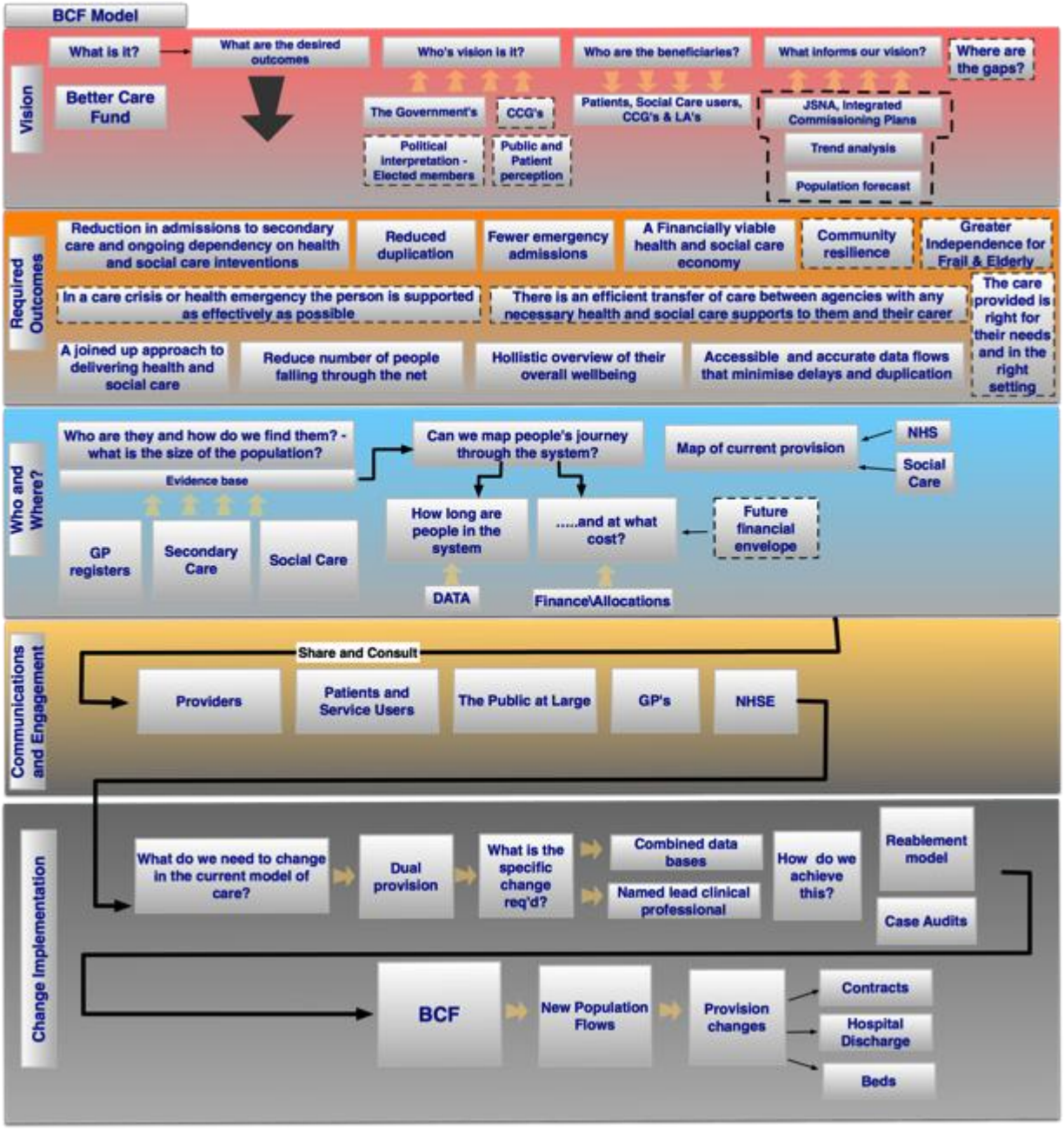
(I) Appendix 1

Fig x - Citadel Graphic representation

(II) Appendix II



(III) Appendix III - BCF Programme definition and initial build



7-Day Working Mapping 2

South West Essex Urgent Care Health System

Organisation	Service	Current Hours	Proposed New Hours	Draft 7-Day week Clinical Standards	Programme	Level of Service Provision (Levels 0-4)	Comments/ Risk(s)
➢ BTUH	Radiology. Ability to review scans off site from PACs system. 24/7 Radiologists / 7 Day Service	8-8 Monday to Friday 9-6 weekends	24/7 Radiologists /7 Day Service		Workstream 3 RPRT	Level 2/3	
	Medical Consultant cover 7 days a week Current weekend service enhanced - pilot	1 consultant 8am – 8pm 2 consultants 8am – 12.00	1 AMU consultant 8am – 8pm Both DMOP and GIM 8am – 8pm	Meets draft Standard 4 Shift handovers	Workstream 3 RPRT	Level 2/3	
	Enhanced 7-day services being planned for other specialities eg Trauma and Orthopaedics to pilot new was of working in Jan 2014	tbc	tbc				

	Paediatrics (additional paediatricians in place)	**9am -9pm 7 Days**			**Response to CQC Report**	**Level 2/3**	
	GP in A&E	**8am - midnight 7 days**	**As outlined**	**Meets Standard 7 re MH input**	**Winter Monies Action Plan**		
	Streaming – Frailty Stream	**9am - 8pm 7 days**	**As outlined**		**Winter Monies Action Plan**		
	Consultant / GP advice line (to community)	**10am-10pm**			**Winter Monies Action Plan**		**Via the extended community GP**
	Pharmacy discharge team will undergo recruitment for extra staff for discharge (Approved)	**tbc**			**Workstream 3 RPRT**		
	Hospital at night. There is now a handover of day team to the night team where patients of concern are flagged = Reduced Cardiac Arrests	**8.30pm every night**		**Meets draft Standard 4 Shift handovers**	**Workstream 3 RPRT**		
➢ **Thurrock**	**Thurrock social care – acute team**	**Monday - Saturday Inc. BH**					
	Reablement through emergency duty team (EDT) – equipment requests	**24/7**					
	Interim beds at Collin House – 24/7 access	**24/7**					

	Rapid Response team – OOH emergency duty team	9am – 9pm Monday-Friday Weekends 9am - 5pm					
➢ Essex	Essex social care – acute team	6 days	9am-9pm Mon – Fri 9am-5pm weekends			Level 2	
	Care homes will accept planned admissions	7 days				Level 3/4	
	Reablement team – 7 days	7am - 11pm				Level 3/4	
➢ SEPT	Inpatient – 7 days no medical input at weekends	7 days					
	Community team – weekends issues call crisis resolution and home treatment team. GP referral only		7 days 8am – 8pm				
	Psyche assessment team – pilot	7 days 9am - 5pm					
	Mountnessing Court – 7 days linked with DIST	7 days					
➢ NELFT	Integrated Community Teams – Community Treatment Team (CTT)	24/7		Standard 9 Transfer to community, primary	Winter Monies Action Plan	Level 4	

				and social care			
	RRAS	9am – 8pm Monday - Friday 9am – 5pm weekends	9am – 9pm weekends from 09/12/13	Standard 9 Transfer to community, primary and social care	Winter Monies Action Plan	Level 3	RRAS nurses can prescribe but community nurses can't. Pharmacy and equipment gap.
	SPOR	9am – 8pm Monday- Friday 9am – 5pm weekends	9am – 9pm weekends from 09/12/13	Standard 9 Transfer to community, primary and social care	Winter Monies Action Plan	Level 3	90k through winter monies funding for RRAS and SPOR 7-day working. Pharmacy and equipment gap.
	Community Hospitals – nurse led. IC24/seeds OOH GP cover. Admissions taken at weekends	24/7				Level 4	IC24 GP OOH – can they refer direct to community hospitals
	PCAT	9am -7pm Monday - Friday			QIPP	Level 2	
	COPD	9am - 8pm Monday - Friday 9am - 5pm weekends			Winter Monies Action Plan	Level 2	
	AAT – 365 days	9am – 8pm Monday – Sunday excluding BHs			QIPP	Level 4	

	MIU	**7-day working**			**QIPP**	**Level 3**	
	Admission Avoidance Team	**9am – 7pm 7-days a week**			**QIPP**	**Level 3**	
	DIST	**9am – 5pm Monday - Friday**			**QIPP**	**Level 2**	
➢ **St Lukes**	**Inpatient care 24/7 for 16yrs + excl Brentwood pats – admissions 7 days**	**24/7**					
	Hospice at home – 7 days – any stage of EoL	**7 days**					
	OOH – covered my Marie Curie inc Brentwood						
	Day services	**Monday - Friday 9-5**					
➢ **St Francis**	**Impatient 24/7 for 18yrs + Brentwood pats**	**24/7**					
	Hospice at home – Marie Curie for final 3 weeks only.						

	Day services	**Monday - Friday 9-5**					

NHS
Castle Point and Rochford
Clinical Commissioning Group

Commissioning Operational Plan 2014-2016

NHS Castle Point and Rochford Clinical Commissioning Group

V4.3

Feb 2014
Review Date:

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Name	Title	Organisation	Signature
Dr Sunil Gupta	Accountable Officer	NHS Castle Point and Rochford CCG	
Tom Abell	Accountable Officer	NHS Basildon and Brentwood CCG	
Claire Panniker	Chief Executive	Basildon and Thurrock Hospitals NHS Foundation Trust	
David Marchant	Chief Executive	Castle Point Borough Council	
Dr Anthony Marsh	Chief Executive	East of England Ambulance Trust	
Helen Taylor	Director of Integrated Commissioning & Vulnerable People	Essex County Council	
Cllr David Finch	Chairman, Essex Health and Well-being Board	Essex County Council	
Ian Stidston	Director of Commissioning	NHS England Area Team - Essex	
Sally Morris	Chief Executive	South Essex Partnership NHS Foundation Trust	
Dr Paul Husselbee	Accountable Officer	NHS Southend CCG	
Jacqueline Totterdell	Chief Operating Officer	Southend University Hospital NHS Foundation Trust	
Amar Dave	Chief Executive	Rochford District Council	
Dr Nimal Raj	Accountable Officer	NHS Thurrock CCG	

FOREWORD

Foreword by Dr Sunil Gupta, Accountable Officer, NHS Castle Point and Rochford CCG

The NHS is facing the great challenge of improving the quality of care provided to patients in an environment of flat cash. This plan outlines how Castle Point and Rochford CCG plans to rise to this challenge. Our vision is to enable the people of Castle Point and Rochford to live longer, healthier and happier lives by commissioning high quality, cost-effective, caring and compassionate services in partnership with our fellow health and social care commissioners. There are several components to this plan. We plan to help Patients and the Public have greater control and responsibilities for maintaining and improving their own health. We will support GPs to work more closely together and with community services to better manage long term conditions, support the frail elderly and reduce A&E attendances and admissions into hospitals and nursing homes. We will also work with other organisations in Essex to help the hospitals in Essex to work more closely together to provide centres of excellence. We welcome your comments, ideas and suggestions on how we can all jointly help to achieve these plans.

Sunil Gupta.

NHS CASTLE POINT AND ROCHFORD CCG VISION

Vision

Enable the people of Castle Point and Rochford to live longer, healthier and happier lives by commissioning safe, high quality, cost-effective, caring and compassionate services in partnership with our fellow health and social care commissioners. The Patients and Public will have greater control and responsibilities for maintaining and improving their own health. GPs will work more closely together and with community services to better manage long term conditions, support the frail elderly and reduce A&E attendances and admissions into hospitals and nursing homes. Hospitals in Essex will work more closely together to provide centres of excellence.

In pursuit of this vision over the next 5 years, the CCG will:

- Eliminate unnecessary waste in partnership with Southend CCG from our South East Essex system to maximise reinvestment, at the same time improving the quality of services, and to improve the health and quality of life for our population.
- Continue to deliver on both national and local commitments and targets as per NHS Constitution.
- Lead the local health community to ensure that patient insight shapes services, ensuring the best value for the best services.
- Face the challenges that are common across the NHS – the economic downturn, more people with long term conditions and an ageing population.
- As groups of GPs, the CCG will engage and work collaboratively with all stakeholders in redesigning patient pathways to improve efficiency, whilst maintaining standards of care, in such areas.
- Use the Public Health Data available, and by analysing performance reports for both secondary and primary care, will prioritise programmes with the greatest opportunity to deliver benefit in meeting the goals.
- Continue to deliver efficiency savings through clinical leadership and Peer Review process as the preferred approach to referral management.
- Work collaboratively with the neighbouring CCGs in South Essex on the comprehensive review and redesign of MSK (area of greatest expenditure).
- Work with the Essex County Council and neighbouring CCGs through Better Care Fund on the transformation of Community Services ensuring that the services commissioned ultimately meet the needs of our most vulnerable patients.
- Close working relationships will continue to be forged with local district and borough councils, in delivering the Health and Wellness agenda and health services in relation to older people.
- Focus on outlying our health indicators, which is deaths from CVD and cancer, which Public Health data attributes to the high elderly population. We will focus on raising awareness and initiatives aimed at early detection
- Focus on reducing variation in health care services evident across the member practices.
- Assist all member practices in becoming more efficient and cost effective by helping them through their CQC application processes, supporting their aspiration for developing GP Federations.

SYSTEM-WIDE PLAN ON A PAGE

The South Essex health economy is a system comprised of partners from Basildon and Brentwood, Castle Point and Rochford, Southend and Thurrock who have come together to agree, refine and implement the following vision

To make affordable high value health services available to all to improve the health and well-being of our population

System Objective One
Using a focus on personalised care and evidenced based innovative measures to empower individuals to manage their LTC more effectively, improving outcomes and reducing health inequalities

Delivered through intervention Self Management and Patient Education Programmes

- Focus on training primary care clinicians
- We will review and implement innovative technological solutions to support self management

System Objective Two
Improve patient experience for both physical and mental health services, using innovative methods to obtain real time patient feedback

Delivered through review of the following areas

- Stroke (Centralisation)
- Cancer (Centralisation)
- Maternity (Capacity Review)
- Vascular (Centralisation)
- Renal (Centralisation)

System Objective Three
As a Health Economy drive forward transformation of specialist services, supporting centres of expertise

Delivered through robust contract management

- Ensure adherence to WHO checklists / safety measures in Acute and Primary Care
- To commission safe services to ensure patient safety is paramount

System Objective Four
Improve patient safety to reduce harm and increase patient confidence in local health services

System Objective Five
Shifting 5% of resources from secondary to primary and community services

System Objective Six
Integrating Health Social Care through partnership working

System Objective Seven
Strengthened collaborative commissioning and contracting

Delivered through partnership working and contract negotiation

- Reducing acute emergency activity through integrated pathways, whole system working and proactive management of high risk patients
- Reducing planned care activity through redesign of pathways
- Transform primary and community care services delivered into Residential and Nursing homes
- Delivering the agreed outcomes for the Better Care Fund
- Community Contestability
- Integrated Nursing Model
- Mobilisation of Community Resources e.g. voluntary sector services
- Implement Dementia Network work programme
- All patients attending A&E to be reviewed by a consultant prior to admission
- GP and SPOR in A&E (front door model)

Overseen through the following governance arrangements

- ECC, CPR CCG & B&B CCG system leadership group overseeing implementation of the improvement interventions.
- Business Management Group of the H&W Board.
- System wide Urgent Care Group.
- Individual organisations leading on specific project

Measured using the following success criteria

- All organisations within the health economy report a financial surplus in 18/19
- Delivery of the system objectives
- No provider under enhanced regulatory scrutiny due to performance concerns
- With the expected change in resource profile

System values and principles

- No-one tries harder for patients and the community
- We will maximise value by seeking the best outcomes for every pound invested
- We work cohesively with our colleagues to build tolerance, understanding and co-operation

STAKEHOLDER ENGAGEMENT

NHS Castle Point and Rochford CCG has worked alongside local stakeholders in the development of our Strategic and Operational Plans for the next five years. This work includes:

Stakeholder	Engagement
Health and Wellbeing Board	Presentations of CCG vision for comments
Health and Wellbeing Board	Sign off of draft Operational Plan on the 12th February 2014
All Essex	BCF Fund event held with all local stakeholders - January 2014
SEPT	Board to Board meeting and QIPP Planning session – January 2014
Southend CCG	Board to Board meeting and QIPP Planning session – January 2014
Healthwatch	Essex Healthwatch representation on CCG Commissioning Reference Group
B&B CCG	Collaboration (aided by co-location) of Strategic and BCF Planning development
SUHFT	CAO direct engagement with SUHFT Chief executive and Essex system meeting in January
Patient and Public engagement	2 Call to Action Events in October across the both locality seeking patient feedback on services
Patient and Public engagement	Ongoing engagement via monthly Commissioning Reference Group (Patient Involvement Forum)

FINANCIAL SUMMARY

Supplementary Information to follow

1.1 IMPROVING OUTCOMES – 7 OUTCOME MEASURES

NHS Castle Point and Rochford CCG is committed to improving the health and wellbeing of our local population and will demonstrate the improvements made over the next two years, through the progress measured against the national NHS Outcomes Framework indicators included throughout this plan and the actions that the CCG plan to undertake to achieve these improvements in outcomes locally.

The CCG's performance against the five domains noted below and the seven national outcome ambitions has historically been better than the national average. However, the CCG continues to strive for the best outcomes for our population and further improvement in these areas. The focus for greater improvement has been set around the areas of greatest concern identified through the Joint Strategic Health Needs Assessment and this is highlighted in section 1.3 of this plan.

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
1	Securing additional years of life for our local population with treatable conditions	1554	1553.6 (2014/15) 1553.2 (2015/16) 1552.8 (2016/17) 1552.4 (2017/18) 1552.0 (2018/19)	To improve the confidence and capability of GPs and Practice staff to recognise, assess, support and refer people with mental health problems. To improve primary care and preventative mental health services to facilitate support earlier and in the least restrictive environment.	MT	Mar 2016
2	Improving the health related quality of life for people with one or more long-term condition, including mental health conditions (2012/13 baseline 73.1 (Eng. Avg) and 74.4 (Essex avg.)	74.7 (CCG)	74.90 (2014/15) 75.10 (2015/16) 75.30 (2016/17) 75.50 (2017/18) 75.70 (2018/19)	Improving the case management of people who have been detained under the MH Act. Improving the case management of people who repeatedly attend A & E. Improve quality of reviews for people in residential and nursing care. Implement the use of personal health budgets to promote independence and individualised recovery focus service delivery. Facilitate the development of a Recovery College and Peer Support services.	MT MT MT MT JI	Apr 2015 Apr 2015 Apr 2015 Apr 2015 Apr 2015

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
3	Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	1636.1	1627.3 (2014/15) 1618.5 (2015/16) 1609.7 (2016/17) 1600.9 (2017/18) 1592.1 (2018/19)	Build on 2013/14 review of integrated community teams through establishing a dedicated service specification for SEPT to include all objectives set in BCF model. 100% GPs to have a named palliative care and community nurse, supporting practice level MDTs. In an effort to deliver integrated Teams across the locality the CCG will ensure that there is a health and social care provider in place that will support identification of patients at risk and ensure that appropriate care packages are in place to avoid unnecessary time spent in hospital: • BCF programme roll out to agree service specifications around integrated prime provider, funded by BCF. ○ Review risk stratification model and software to support. • Conclusion of Community Contestability and recommendations implemented. • Include at practice visits checks to ensure that high risk patients are being discussed at monthly MDT meetings. • 100% practices to have risk registers in place for high risk patients. • Finalise design of ambulatory care unit and associated pathways. • Commission community based intermediate care beds. • Recommission community geriatrician service to support proactive case management of patients in the community. • Commission dedicated Cancer Assessment Unit. • Implementation of Falls Prevention Strategy in partnership with ECC and B&B CCG. • A Continence Management Strategy to be developed and rolled out across Essex. • Redesign Diabetes Service to deliver and integrated service across acute, community and primary care to deliver improved services. • Develop a business case for improved carers support and commission jointly with ECC for implementation 2014/15. • To ensure all system specialist palliative care providers (including	EH KMK KMK KMK EH KMK KMK KMK EH EH EH EH (LP) EH (LP) EH (JM) EH KMK	Oct 2014 July 2014 March 14 June 14 July 14 Jun 14 July 14 March 15 Sept 14 Sept 14 June 14 April 14 TBC August 14

				voluntary sector) are fully integrated through one core MDT with strong clinical leadership. • By April all specialist palliative care providers will be using single electronic patient records (SystemOne). • Providing additional resource and support to practices in relation to managing patients in care homes.	KMK KMK	March 2014 April 2014
4	Increasing the proportion of older people living independently at home following discharge from hospital.			The CCG will enable locally integrated planning and commissioning (using BCF) across the following themes to deliver this ambition: Provide information and advice to minimise Social inclusion including prevention and early intervention • Deliver Dementia workstreams pathways as agreed through Dementia Network • With ECC Implement Falls Prevention Strategy • With ECC implement Incontinence Management Strategy • With ECC maximise support for Carers • Implement Urgent Care Pathways linked to admission avoidance including crisis response • With ECC ensure support for professional carers to raise standards in care homes, linking with providers of community services • End of Life Care - CCG will develop more integrated approaches and establish common areas to join up and improve End of Life care and support.	LP JM VM EH TD KMK	May 2014 Jan 2015 Sept 2014 Oct 2014 Dec 2014 Aug 2014
5	Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	134.6	132.0 (2014/15) 129.5 (2015/16) 126.9 (2016/17) 124.4 (2017/18) 121.8 (2018/19)	Improve the care planning and management process to help people recover from a crisis and get home as quickly as possible. Improve the discharge planning to ensure people go home as soon as they're ready minimising the distress caused by delayed discharges.	KMK KMK	Feb 2015 Feb 2015

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
6	Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	5.7	5.57 (2014/15) 5.44 (2015/16) 5.31 (2016/17) 5.18 (2017/18) 5.05 (2018/19)	Commission responsive crisis care to ensure quick access to services when needed, by the right skilled teams in a safe and least restrictive environment, with good integrated pathways to reduce risk of relapse and support reablement. Explore development of alternatives to inpatient services. Work closely with Public Health to ensure: • People aged 40 – 74yrs on SMI registers access NHS annual health checks. • People on SMI registers access "Making Every Contact Count" Initiative • People on SMI registers have access to screening programmes • Inclusion in targeted lifestyle support programmes of people with mental health problems. Increase mental health training for community services.	KMK	March 2015

	7 national improving outcome ambitions:	Baseline	2014/15 Standard	Action Required	Lead	Deadline
7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.			• Work with Acute providers to operate in a culture of openness, learning from SIs and transforming services dependent on patient feedback: o RCA undertaken o Quality visits / audits scheduled for 2014/15 o Working with provider to ensure mechanism in place to minimise the risk of preventable harm. o Safety thermometer compliance. o Mandatory training and investment in staff competencies via the appraisal process o Development of quality dashboard and quality outcomes framework.	TD	

1.1 IMPROVING OUTCOMES – 5 DOMAINS

The five NHS Outcome Framework Domains are outlined below and the subsequent delivery plan identifies how the CCG plans to achieve measurable improvements in performance against these areas during 2015/15 and over the next five years.

Although the CCG is historically performing significantly better than the national average in a number of areas, any area where performance is below the national average a standard has been set to ensure that performance improves to this level. In areas where the CCG is already performing better than the national average, performance has been stretched to achieve ongoing improvements in outcomes for our population with particular focus on the key health concerns for our population, as set out in section 1.3 below.

The CCG is committed to monitoring and improving the quality of services that are commissioned by moving from a traditional mode of performance monitoring to improving patient services by listening to and commissioning for the patients that access these services. This will be achieved by ensuring that our providers collect the views of service users through patient surveys, transactional websites to facilitate patient feedback and full roll-out of the Friends and Family test incentivised through CQUIN's. Quality outcomes will be developed with providers to focus not solely on activity but also, how well patients stay after treatments are accessed. The collection of soft data collection through a variety of methodologies will allow the CCG to proactively respond to complaints and concerns expressed by patients, the public and NHS staff. The CCG has recently reviewed its whistleblowing and complaints policies to ensure that there exist systems to capture any early warning signs of a failing service. The CCG is committed to listening to all concerns raised and ensuring that bespoke replies are delivered to all those raising concerns.

Domain 1	Preventing people from dying prematurely;
Domain 2	Enhancing quality of life for people with long-term conditions;
Domain 3	Helping people to recover from episodes of ill health or following injury;
Domain 4	Ensuring that people have a positive experience of care; and
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

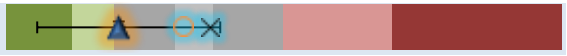
Domain 1: Preventing People from Dying Prematurely

The following indicators benchmark current CCG premature mortality from the major causes of death. The indicators consist of directly age and sex standardised mortality rate (DSR) per 100,000.

Spine Chart Key			
	highest 10%		lowest 10%
	highest 25%		lowest 25%
	CCG		National

Period	National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Under 75 Mortality from Cardio Vascualr Disease							
CCGOUT303 2012	66.90	*66.35*	*77.46*	46.43	▼ 30.6%	4.2	

CCG rate is significantly lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

Under 75 Mortality from respiratory disease							
CCGOUT304 2012	28.25	*27.01*	*33.62*	21.60	▼ 23.5%	26.6	

CCG rate is lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

Emergency admissions for alcohol released liver disease							
CCGOUT305 2012/13	25.73	*23.40*	*33.20*	7.90	▼ 69.3%	0.9	

CCG rate is significantly lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

Under 75 Mortality from cancer							
CCGOUT306 2012	123.83	*122.13*	*135.01*	115.70	▼ 6.6%	31.9	

CCG rate is lower than national average. The CCG is aiming to reduce the rate further through the actions outlined in the following delivery plan.

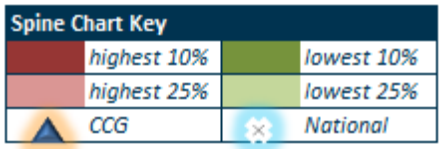
Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Reducing<75 mortality rate from respiratory	15.96	27.44	15.95	Co-ordinated network review to be undertaken on respiratory pathways, looking at gender specific variation in respiratory mortality.	KMK/ LP/ST	Feb 2015
		Reducing<75 mortality rate from liver (2012)	12.90	15.40	12.89	Fully integrated MDT service model for management of liver disease to be established, including raising awareness and early detection, with local liver specialist leadership to be identified to reduce mortality rates.	KMK/ EH/ SG	March 2016
		Reducing<75 mortality rate from cardiovascular	46.43	65.47	46.42	• Maximise the opportunity to utilise GPWSI, working through the CVD Network (including Public Health) to deliver new care pathways that enhance management of CVD in primary care and acute services. This will include GP education, diagnostics in primary care, patient awareness. • Support health promotion locally through initiatives around weight management, walking buses, establishing a credit bases system for patients with LTCs to incentivise healthy choices.	KMK/ JM/BK TD/AM/ DS	December 2014 June 2015
		Reducing<75 mortality rate from cancer disease	115.70	123.26	114.75	• Engage directly with member practices in relation to their responsibilities around early detection. • Roll out education programme across CP&R locality. • Supporting cancer specialisation through implementation of the strategic clinical network. • Ensure that our Governing Body is sighted on screening performance and takes responsibility for maximising uptake to national screening programmes e.g. bowel cancer screening.	KMK/ LP/MM	Oct 2014 Oct 2014 Feb 2015 Mar 2015
		Excess under 60 mortality in adults with learning disabilities – *measurement under development*	tbc	tbc		• Ensuring all patients with LD have the opportunity to access comprehensive physical health assessments within the primary care environment.	TD/AM/ ST	March 2015

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Life expectancy at 75	CP M: 11.2 CP F: 13.3 R: M 11.6 R: F 14.0	M:11.4 F: 13.2	M: 11.3 F: 13.1	• Through public health leadership on our Governing Body, prioritise and support public health initiatives that improve life expectancy at 75.	KMK/ DS	March 2015
		Excess under 75 mortality rate in adults with serious mental illness	tbc	436.2		Through South Essex Mental Health commissioning Board and the Strategic Clinical Network work collaboratively to deliver South Essex Mental Health strategy including reducing mortality rates and initiatives such as: • 100% of mental health patients to have an annual health check. • Identification of high risk patients in primary care settings, reviewing prescription items. • Working with lead providers to reduce suicide rates. • Ensure through contract that there are robust arrangements in place to maximise opportunities for patients to access employment post mental health acute episode. • Improving access to IAPT services to 15% (see IAPT below) • Through contract ensure early psychosis have high quality intervention / crisis plan.	 TD SW KMK MT/DS JI MT	 March 2015 March 2015 March 2015 Feb 2014 March 2015 March 2015

Area	Aim	Indicator	2012/13 Baseline	National Avg.	Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Potential years of life lost from causes considered amenable to healthcare: adults, children and young people	1553.9	2060.8	1553.6 (14/15) 1553.2 (15/16) 1552.8 (16/17) 1552.4 (17/18) 1552.0 (18/19)	• Supporting young people with LTCs by identifying a lead clinician, as a point of contact. • Robust self management plans developed with the patient and their family/carer. • Access to high quality information and support, embracing mobile phone technology, looking at Apps to support self management. Provide schools within CP&R with a named GP link with a view to creating opportunities to provide advice, support and education. To include education sessions for parents around LTCs. Review CHIMAT data to identify key areas of focus across the locality. Work with Local Authorities to ensure special educational needs are in place from Sept 2014. Ensure that appropriate measures are in place to identify better health outcomes for children and young people.	KMK/ KS/CM CM CM	Oct 2014 Oct 2014 Sept 2014 Sept 2014 Sept 2014
		Survival from cancers (adults): ➢ One year survival (all cancers) ➢ Five year survival (all cancers) ➢ One year survival from breast, lung and bowel cancer combined ➢ Five year survival from breast, lung and bowel cancer combined	B 1yr: 94.7% B 5yr 81.9% L 1yr 28.4% L 5yr 6.6% CR 1yr 70.0% CR 5yr 52.9% **(DATA FOR ESSEX NETWORK)**	B 1yr:94.7% B 5yr 83.3% L 1yr 28.4% L 5yr 8.0% CR 1yr 69.4% CR 5yr 51.9%	B 1yr:96% B 5yr 85% L 1yr 30% L 5yr 9% CR 1yr 71% CR 5yr 53%	• Supporting the initiatives to raise awareness campaigns locally. Ensuring we are utilising the CCG's communication strategy to raise awareness. • Programme of practice visits led by public health to inform and support GPs on early detection initiatives. • See early detection actions above. • Support primary care clinicians following national initiatives aimed at raising awareness that wold impact upon primary care e.g supporting the cascade of information to clinicians through desktop guides.	KMK/ LP/MM KP KMK	March 2015 December 2014 June 2014 and ongoing

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 1	Preventing people from dying prematurely;	Reducing deaths in babies and young children	4.8	4.2	4.2	• Review maternity model across south Essex, ensuring appropriate capacity and high level of care. • Through contract ensure robust arrangements in place to negate harm • Unique dedicated acute streamline pathways, ensuring appropriate intervention at the earliest point • Reviewing paed teams as part of Community Contestability	TD/HF/KS VG TD/HF/KS EH/JM	March 2016 Feb 2014 March 2016 Feb 2014
		Five year survival rate from all cancers in children				• Based on guidance from strategic clinical network for cancer, ensure the improving outcomes guidance for children and young people is fully implemented locally, with streamlined access to specialist centres, supported by robust local MDT arrangements. • Any recommendations arising from peer review of C&YP Cancer Services will be implemented by the CCG.	KMK/ CM/ MM KMK/CM/ MM	April 2014 TBC

Domain 2: Enhancing the quality of life for people with long term conditions

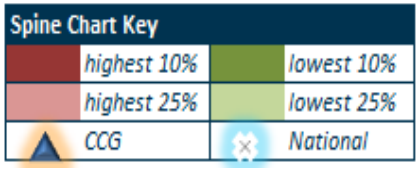


Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Unplanned hospitalisation for chronic ambulatory care sensitive conditions								
CCGOUT402	2012/13	826.52	*82180*	*989.00*	762.40	▼ 7.8%	39.0	
Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s								
CCGOUT403	2012/13	338.64	*327.80*	*40165*	258.30	▼ 23.7%	26.1	
% of patients with LTCs who feel supported to manage their condition								
CCGOUT401	2010	72.83	*73.13*	*75.41*	73.78	▲ 1.3%	59.0	
Level of Ambition Atlas #201 | Health-related quality of life for people with Long Term Conditions (OF 2) (crude rate) - CCG Level								
LOA201	2012/13	73.12	*73.41*	*75.29*	74.74	▲ 2.2%	69.5	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 2	Enhancing quality of life for people with long-term conditions;	Improved scores for being treated with dignity in national inpatient survey (2007/08)	75	78	78	• Contractually monitor performance around the Friends and Family Test results, requesting recovery plans if required.	TD/ AM/ KS	March 2015
		Reduce hospitalisation for unplanned chronic ambulatory care sensitive conditions (2012/13)	762.4	808.3	760	See Long Terms Conditions management above. • Review urgent care pathways and ensure MAU (key clinical facility for management of ACS conditions) is supported by a dedicated consultant physician. • Work towards integrating the Dementia Intensive Support team into Community Services to reduce admission to acute hospital for people with dementia.	EH/LP/ IL	Sept 2014
		Enhancing quality of life for people with LTCs – measured through GP patient survey (2012/13)	0.73	0.74	0.75	• Ensure self management programme rolled out in CP&R locality. • Utilising new provider arrangements in primary care to support consistency in management of Chronic diseases e.g GP Federation. • Use of technology to support self management and monitoring of patients with LTCs. • Ensure appropriate information available to patients to support self care management. • Roll out of personal health budgets across our locality.	LP LP LP VM MG	Aug 2014 June 2014 Nov 2014 Sept 2014 **TBC**

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 2	Enhancing quality of life for people with long-term conditions;	Reducing time spent in hospital by people with LTCs – Chronic ambulatory care - Length of Stay (2012/13)	205.5	228.3	204	• Reablement assessment to be included within the acute model. • Though Community Contestability improve facilitation of SPOR to support early discharge. • Increase access to IV therapy, rapid response nurses, physiotherapy, respiratory and COPD nurses.	MG LP EH	March 2014 Jan 2014 Aug 2014
		Reducing time spent in hospital by people with LTCs – asthma, diabetes and epilepsy - Length of Stay (q4 2012/13)	67.7	77.0	66	As above.	EH	
		Unplanned hospitalisation for asthma, diabetes and epilepsy under 19s (2012/13)	337.9	258.3	258	Implementation of further High Impact Pathways.	SMC	
		Proportion of people feeling supported to manage their condition (2012/13)	70.78	69.57	72	As above • Expanding our health coaching training programme. • Developing train the trainers to educate and support primary care clinicians.	TD/ AM/ BK ST/MK	May 2014 May 2014
		Health related quality of life for carers. (2012/13)	0.81	0.80	0.82	• Roll out of partnership initiatives • Practices to include carers on practice registers to ensure appropriate health checks undertaken • **Establish outcome measures to improve support to carers (see section xx)**	KMK	March 2015
		A measure of the effectiveness of post diagnosis care in sustaining independence and improving quality of life for people with dementia.				• Patients with Dementia are supported in primary care by the Community Dementia Nurses, thus enabling PWD to live longer in the community. Pathways have been developed to ensure all newly diagnosed patients with Dementia are reviewed appropriated and on the QOF registers	IL	
Domain 2	Enhancing quality of life for people with long-term conditions;	Estimated diagnosis rate for people with dementia (2012/13)	63%	48.7%	83%	Currently unable to view QOF data for 12/13. However, the standard for based on 58% should be 12/13 = 1029 13/14 1233 The current MH registers predicted outturn will be 1342, over performing against the existing standard. The MH Commissioning Team will over the coming 6mths validate the QOF with the MH registers	KMK/IL	July 2014

Domain 3: Helping people to recover from episodes of ill health or following injury



Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Emergency admissions for children with lower respiratory tract infections (OF 3.2) (indirectly standardised) - Upper Tier LA level								
LOA305	2012/13	373.61	*366.22*	*473.94*	268.98	▼ 28.0%	22.8	
Patient Reported Outcomes for elective procedures : Hip replacement								
CCGOUT503	2011/12	0.41	*0.41*	*0.43*	0.41	▼ 1.1%	38.3	
Patient Reported Outcomes for elective procedures : Knee replacement								
CCGOUT504	2011/12	0.30	*0.30*	*0.31*	0.31	▲ 3.0%	56.3	
Patient Reported Outcomes for elective procedures :Groin hernia								
CCGOUT505	2011/12	0.09	*0.09*	*0.10*	0.09	▲ 3.7%	41.0	

Stroke Standards – To be updated for final submission

Performance Indicator	CCG / Trust	Outturn 10/11	Outturn 11/12 YTD	2012/13 Target / Threshold	YTD/ 12/13 FOT	2013/14 Target / Threshold		APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	Q1	Q2	Q3	YTD/ 13/14 FOT	TREND
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (SHA Metric 4)	CPR					At least	80%		100%	90.5%	91.3%	100.0%	82.6%	81.8%	100.0%	92.0%		95.5%	91.3%	92.0%	92.7%	
Proportion of people who have had a stroke who spend at least 90% of their time in hospital on a stroke unit (SHA Metric 4)	SUHFT		90.1%	80%	91.10%	At least	80%	94.3%	98.0%	93.0%	94.9%	96.6%	88.60%	88.90%	98.10%	94.10%		95.1%	93.80%	93.70%	93.9%	
	BTUH		76.3%	80%	87.4%	At least	80%	96.6%	71.1%	85.7%	88.6%	88.2%	73.00%	91.30%	89.10%	85.40%		82.6%	84.00%	88.60%	85.2%	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (SHA Metric 5a)	CPR					At least	60%	100%	100%	100%	100%	100%	100.0%	75.00%	50.00%	0.00%		100%	100.0%	57.10%	78.6%	
Proportion of people at high risk of Stroke who experience a TIA are assessed and treated within 24 hours (SHA Metric 5a)	SUHFT		17.1%	60%	71.1%	At least	60%	60.00%	100%	100%	60%	75%	100%	83.30%	50.00%	0.00%		86.70%	76.90%	46.20%	71.40%	
	BTUH		55.1%	60%	66.1%	At least	60%	66.7%	63.2%	69.2%	72.2%	81.8%	53.80%	61.50%	59.10%	52.60%		66.0%	69.00%	57.40%	63.2%	
Suspected stroke: % access to a brain scan within 60 minutes - all patients (ASI 4a)	CPR					At least	50%	0%	62.50%	52.40%	52.40%	59.10%	43.50%	30.0%	70.40%	25.00%		57.80%	51.50%	43.70%	49.70%	
Suspected stroke: % access to a brain scan within 60 minutes - all patients (SHA Metric 6a)	SUHFT		44.7%	50%	62.6%	At least	50%	40.50%	55.80%	43.60%	49.10%	48.30%	44.20%	41.50%	64.80%	51.00%		47.90%	47.40%	52.50%	48.90%	
	BTUH		31.4%	50%	76.9%	At least	50%	63.6%	47.4%	65.6%	62.5%	57.1%	76.90%	70.00%	76.90%	87.80%		58.1%	94.20%	77.50%	66.7%	
% stroke patients receiving thrombolysis within 3 hours of onset (SHA Metric 7a)	CPR			12%		At Least	12%	0%	31.8%	11.8%	9.5%	18.20%	16.70%	4.5%	20.80%	8.30%		22.5%	14.80%	11.40%	14.8%	
% stroke patients receiving thrombolysis within 3 hours of onset (SHA Metric 7a)	SUHFT		10.6%	12%	18.0%	At Least	12%	15.2%	26.5%	16.7%	11.3%	12.7%	10.80%	13.10%	16.00%	10.40%		20.0%	11.70%	14.60%	15.0%	
	BTUH		4.2%	12%	8.3%	At Least	12%	7.7%	7.0%	15.6%	12.2%	12.5%	9.10%	9.30%	7.10%	11.10%		9.9%	16.40%	9.20%	12.1%	
% Low risk TIA patients seen and scanned within 7 days of onset (SHA Metric 8a)	CPR			65%		At Least	65%	*	50.0%	68.8%	72.70%	61.50%	64.70%	62.5%	75.00%	40.0%		63.6%	67.30%	58.80%	63.9%	
% Low risk TIA patients seen and scanned within 7 days of onset (SHA Metric 8a)	SUHFT		44.4%	65%	52.3%	At Least	65%	52.2%	67.4%	70.6%	70.2%	60.7%	65.90%	51.20%	71.40%	52.00%		67.2%	66.40%	56.20%	62.4%	
	BTUH		50.1%	65%	51.6%	At Least	65%	63.20%	61.70%	58.80%	51.90%	51.30%	60.40%	69.40%	63.60%	55.90%		61.30%	55.30%	57.10%	59.80%	

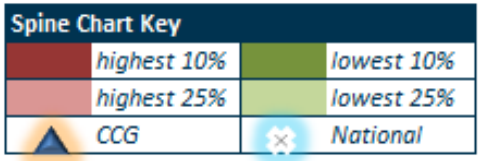
Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 3	Helping people to recover from episodes of ill health or following injury;	Access to psychological therapies (estimated release May 2014)			15% Q1 3.7% Q2 3.7% Q3 3.8% Q4 3.8%	• Implement recommendations from the Intensive support Team visit to deliver the 15% standard. Built into contract to ensure mechanism in place to hold provider to account for delivery.	KMK/ MT/ST	March 2015
		Survival from major trauma (estimated release May 2014)				• Working with NHS England to ensue that there is a co-ordinated Trauma Centre in place. • Ensure that response rates are met by the EEAST – Action plans to be developed to improve performance across the region. • Through contract ensure that we have a first class A&E services with access to specialist consultant support. Ensuring that there are sufficient ITU beds in place to meet demand.	KMK EH EH EH	 March 2015 March 2014 March 2014
		Proportion of stroke patients reporting an improvement in activity / lifestyle on the Modified Rankin Scale at 6 months (estimated release Autumn 2014)				• Implement the recommendations of the EoE Stroke review that sees SUHFT as a dedicated HASU. • Ensure related ambulances services and rehab provision are appropriate to support the local HASU. Ensure that there are appropriate support services in place post discharge, with ongoing stroke support.	EH	
	Helping people to recover from episodes of ill health or following injury;	Emergency admissions for acute conditions that should not usually require hospital admission.	738.6	1189.8	737	• Improve access to community based rapid response and crisis intervention team. • Roll out campaigns that maximise our marketing opportunities of NHS 111 e.g. book handing out at children's centres, media cover. • Enhance GP services to nursing and residential homes to prevent admissions, including dedicated support to care homes with high usage of ambulance services. • Ensuring very good uptake of flu vaccine in appropriate high risk groups through GP Federation and Locality Commissioning Groups. Sharing activity to identify practices that need greater support. • Ensuring access to urgent social care services in place for patients suffering with crisis. • Support lead commission MDT model in primary care through utilisation of risk stratification. • Implement risk stratification model such as Caretrack. • Improving timely access to day unit pathways e.g. DAU, MAU, SAU. • To establish a unique single arrangement to manage GP home visits, that a vast majority of home visits are taking place in the morning, so that those patients requiring acute review can be discharged home with	EH	

						appropriate support on the same day. • Improve optimisation of medicine usage by regular reviews of medication on appropriate patients. • Using technology to identify early indication of deterioration in long term conditions to avoid unnecessary admissions. • Work with Local authority to implement BCF initiatives around frail elderly and appropriate risk stratification. • Working with ECC to deliver streamlined models / pathways for the management/prevention of falls.		

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 3	Helping people to recover from episodes of ill health or following injury;	Emergency admissions within 30 days of discharge from hospital	10.5		9	• Included in contract and monitored via SUHFT CQRG meeting. Ensure penalty applied if breached. • Ensure appropriate access to reablement and other support services through planning and discharge e.g. dedicated reablement posts based in acute. • Monthly monitoring of reported failed discharges across all providers	VG KMK	Feb 14 Apr 14
		Total health gain as assessed by patients for elective procedures				• Ensure structured discussions with patients in relation to having elective procedures, utilising NHS Choices tools • Review of Service Restriction Policy and ensure good evidence base for the significant improvement in health outcomes from elective procedures. • Supporting patients to optimise their health prior to the elective procedures e.g. stop smoking • Ensuring medical and physical therapies are tried prior to surgical intervention where appropriate. • Review of elective pathways for areas identified as outlying compared to peers (highest decile): o Neurology o Clinical Haematology o Cardiology o Urology o Trauma & Orthopaedics o General Medicine • Focus on Pathway Commissioning to deliver high quality episodes of care and incentivise productivity and delivery of efficiencies e.g. cataracts.	KMK EH DS EH	
		Emergency admissions for children with LRTI	195.5	401.9	194	• Increase flu immunisation uptake for children. • Ensure early diagnosis and treatment of LRTI through education and training of GPs.	TD/ D.Stotum	
		Improving recovery from fragility fractures		30 days: 21.7 120 days: 47.3		• Through Essex-wide review of falls and falls prevention services led by ECC ensure Falls Strategy are embedded into the community and mental health providers. • Establishment of Falls Team and support for patients following fragility fracture, ensuring appropriate scans are undertaken. • Education and training around the falls agenda to be rolled out. • Support the ECC commitment to invest in Falls Prevention services. • Agree a specification and service improvement plan with a view to having a revised agreed specification for 14/15. • Include longer term planning linked to BCF on Falls related services. • Roll out of the GP risk assessment toolkit to identify those at greater risk of falls.	TD/ EH EH/ DS TD KMK/ EH/ DS KMK TD/ RT	March 2014

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 3	Helping people to recover from episodes of ill health or following injury;	Helping older people to recover their independence after illness or inquiry				• Working through BCF to develop and agree a service model that support frail elderly to remain independent. • Direct access to reablement assessment nurses. • Through community contestability ensure that we have high quality, responsive community services to match individual need. • Target support where there is a concern of patient isolation on discharge, to ensure that Befriending services are mobilised to support. • Ensure patients are given a named person and contact details to ensure rapid access to dedicated support if potential to fall into crisis.	KMK KMK EH EH EH	August 2014
		Improved PROMs scores for hip and knee replacements Improved scores in Outpatient Survey	TBC			• Through contract ensure all hip and knee replacements patients receive comprehensive post pre-op information. • Through contract ensure that appropriate pre-screening is undertaken to identify patients with greatest need.	VG VG	Feb 14 Feb 14

Domain 4: Ensuring that people have a positive experience of care



Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Patient experience of GP out-of-hours services								
CCGOUT601	2012/13	70.84	*70.98*	*74.48*	68.25	▼ 3.7%	36.6	
Patient experience of hospital care - average number of negative responses per 100 patients (selected questions; weighted; crude								
LOA501	2012	141.99	*147.02*	*158.68*	134.64	▼ 5.2%	19.0	
Patient experience of primary care - average number of negative responses per 100 patients (selected questions; weighted; crude								
LOA601	2012	6.11	*5.85*	*7.13*	5.71	▼ 6.5%	46.6	

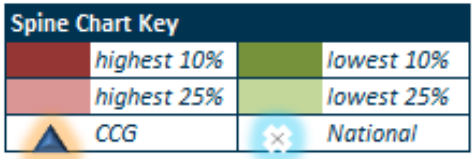
The above information demonstrates that further work is required in primary care to improve performance and move into the top 25% of performers. This work is set out within the primary care section of this plan (Section: 1.14).

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 4	Ensuring that people have a positive experience of care; and	Patient experience for acute inpatient care and A&E services, as measured by the Friends and Family Test				• Through contract hold secondary care providers to account for provision of high quality A&E services, meeting required national performance measures. • National CQUIN in place to support improvement in Friends and Family score. • Using CCG Patient Engagement Group (CRG) ensure direct involvement in the development of a robust marketing campaign to raise public awareness and reduce reliance on A&E. • Measure impact of above campaign through repeating initial Urgent Care survey and look to enhance campaign for Winter 2014/15.	VG TD KMK EH	Feb 14 Feb 14 March 14 Sept 14
	Ensuring that people have a positive experience of care; and	Responsiveness to inpatients personal needs				• Work with secondary care services to affect the culture of care delivery in line with the '6 Cs' philosophy. • Embrace the recommendations from Berwick and Francis Report. • Check and challenge quality visits through direct engagement with service users.	TD TD TD	
		Patient experience of outpatient services				• Through contract ensure that acute providers continue to undertake outpatient surveys and ensure that remedial actions are undertaken dependent on responses. • Discussions have been minuted to support the Trust in its ambition to generate timely and meaningful feedback. SUFHT now operates a system which expands on the Friends and Family test to identify how outpatient services can be enhanced. • Regular oversight at CQRG of staff surveys is key to ensuring that motivated staff are delivering front line patient services. The Trusts are challenged to address key issues that are identified to motivate and engage staff within provider organisations.	VG	
		Patient experience of primary care (2012/13)	TBC	76.3		• See local measures relating to implementation of primary care strategy and improvements in primary care provision. • The CCG is committed to addressing the need to improve access to primary care services. • Discussions have taken place in Locality meetings and Executive meetings to identify ways to improving access. • Plans for commuter clinics, telephone triage and the upskilling of Practice Nurses to aid same day consultations are being progressed at a strategic and local level. • Member practices are being actively encouraged to pilot modes of service delivery to enhance accessibility. • As lead Commissioners for NHS 111 the CCG is developing the potential for NHS 111 call handlers to directly book appointments in linked	KMK	

						General Practice Surgeries. • A review of secondary care wound management has revolutionised the way in which A and E works with practices to ensure that unnecessary wound care is delivered in surgeries rather than in the acute care setting at an enhanced tariff price. • Work has been undertaken to promote Access for All with the enhanced provision of LD Healthchecks by supporting being offered by SEPT LD services. The CCG is committed to working with the AT to address identified areas where individual surgeries to improve patient experience of care.		
		Patient experience of GP OOH services (2012/13)	64.04	70.21		• As host CCG for OOH contract monitor improvements in service provision and ensure recovery plans in place where required. • Undertake review of calls to out of hours and NHS 111 to ensure quality of consultation and episode of care.	EH EH	
		Overall experience of GP surgery (2012/13)	TBC	88%		• See local measures relating to implementation of primary care strategy.	KMK	
		Access to NHS dental services	TBC	94.9%		• Work with NHS England to ensure appropriate access to dental provision, following concerns raised through NHS 111.	EH	
		Women's experience of maternity services				• Implement recommendations from CQC arising from CQC report. • Ensure recovery plan in place for post natal care at SUHFT. • Capacity review to be undertaken in relation to maternity services in Essex due to increased birth rate. • The CCG is committed to ensuring that acute, community and Mental Health Providers are committed to the role out of the Friends and Family test and specifically within Maternity Services.	TD TD TD	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 4	Ensuring that people have a positive experience of care; and	Improving children and young people's experience of healthcare (TBC)				• Through commissioning community contestability improve C&YP services • CQUINs in place to improve services locally. • CAMHs review to be undertaken.	SMC	
		Bereaved carers' views on the quality of care in the last 3 months of life				• Support voluntary bereavement services to provide counselling sessions through usage of CCG estates. • Submit bid to secure funding to run dedicated survey of bereaved carers, piloting the Friends and Family test linked to improving the end of life care across the CCG.	TD	
		Patient experience of community mental health services				• Through contract monitor performance at CQRG to improve service provision. • To ensure that information on complaints from service users is collated and shared. • To improve information, advice and guidance on care options and access to relevant services.	MT	

Domain 5: Treating and caring for people in a safe environment; and protecting them from avoidable harm



Period		National	Median	75th Percentile	CCG	% Var (Nat.)	CCG Percentile	Spine Chart (Diff from Median) (Limited to +/-100%)
Incidence of hospital care associated infection -Clostridium Difficile (per 100k population, unstandardised)								
OPA112	Jun 2013		*185*	*2.58*	0.55		13.3	
CCG Operational Planning Atlas #111 | Incidence of hospital care associated infection - MRSA (per 100k population, unstandardisec								
OPA111	Jun 2013		*0.00*	*0.00*	0.00		0.0	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.	Reducing inappropriate prescribing of antipsychotic medication				The community dementia nurses continue to provide training/support to care homes to ensure prescribing is appropriate. Supporting community pharmacists in medication reviews.	SW	
		Reducing premature death in people with a serious mental illness				Develop robust psychiatric liaison pathways Improve crisis response and care planning and management of people with severe and enduring mental illness. Increase the number of physical health checks as part of CPA process that lead to health intervention and make links to personal health plans and be aware of other long term conditions. Development of medication concordance programmes.	MT	
		Incidence of newly acquired grade 2,3,4 pressure ulcers				Through contract management ensure the level of pressure ulcers continues to decline. Supporting the University of Essex to undertake a research project to review the acquisition of pressure ulcers in the CPR locality, causes and potential areas of improvement.	TD	May 2014
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.	Zero cases of MRSA and C. difficile cases are at or below defined thresholds for CCG by March 2014	0 21 (SUHFT) 30 (CCG)		MRSA 0	The CCG IPC Quality Team are working with acute, community and MH providers to ensure that all contracted measures are in place to minimise the risk of a Hospital Acquired Infection. This work is directed and underpinned by tight trajectories 2013/2014/2015. Treatment of all patients in SUFHT to prevent MRSA prior to admission in line with National Best Practice. Screening of all podiatry patients by SEPT. Monthly reporting to CCG Locality Groups as to anti-biotic/ PPI prescribing and the evidence underpinning individual prescribing to reduce the risk for development of CDIFF during an acute care episode. Re-establishment of Non-Medical Prescribing Forum by Chief Nurse for CPR and Southend Practice Nurses. Monthly newsletter distributed by Hosted Medicines Management team to all practices outlining any new evidence with regards to risk prescribing for CDIFF/MRSA. Establishment of South Essex focus group by CCG IPC to tackle levels of CDiff/MRSA bacteraemia in a systematic way.	TD	

Area	Aim	Indicator	2012/13 Baseline	National Avg.	2014/15 Standard	Action Required	Lead	Deadline
		Hospital deaths attributable to problems in care (estimated release April 2014)				SHMI/HSMR reported by exception at CQRG's. CQC rating score monitored regularly and prompt action to be taken with all providers that are judged by the CQC as "require improvement" on "inadequate". CCG to notify the CQC if it is felt that a provider might have quality or risk issues requiring further investigation. Attendance at and alerts to the Quality Surveillance Group re patient concerns and never events. Open reporting of all Serious Incidents and review of RCA's by Chief Nurse. Check, challenge and audit of action plans to ensure lessons are learned. Quality Team developed data base to link themes and trends as reported via the STEIS reporting model.	TD	
		Deaths from Venous thromboembolism (VTE) events (release before March 15)				Monitored via Safety Thermometer and KPI data. Ensure that all patients are assessed and provided with prophylaxis as appropriate to reduce the risk of development of DVT and PE as per contract/CQUIN. Safety Thermometer CQUIN for 2014/2015 as per National guidelines. All deaths subject to SI and RCA processes.	TD	
		Patient safety incidents reported				Commissioning Intentions including measures to encourage 'Just Culture'. We have ensured that all providers have robust DATIX collection measures in place to identify themes and trends. All providers have established links to NPSA/MDA for reporting purposes. Monitoring of this occurs on a monthly basis through the contract. CAS alert system in place.	TD	
		Safety incidents involving severe harm or death				As detailed above with the added assurances around the SI process.	TD	
		Incidents of medication errors causing serious harm				Monitored through environmental audits to CQRG. Recent SI Healthsystem review of Preventable death due to medication omission. Lessons learned will be communicated to the family and the wider healthcare community.	TD	
		Admission to full-term babies to neonatal care	3.4 (SEE PCT)	5.1			TD	
		Incidence of harm to children due to 'failure to monitor'		1.017			TD	

1.2 IMPROVING HEALTH – COMMISSIONING FOR PREVENTION

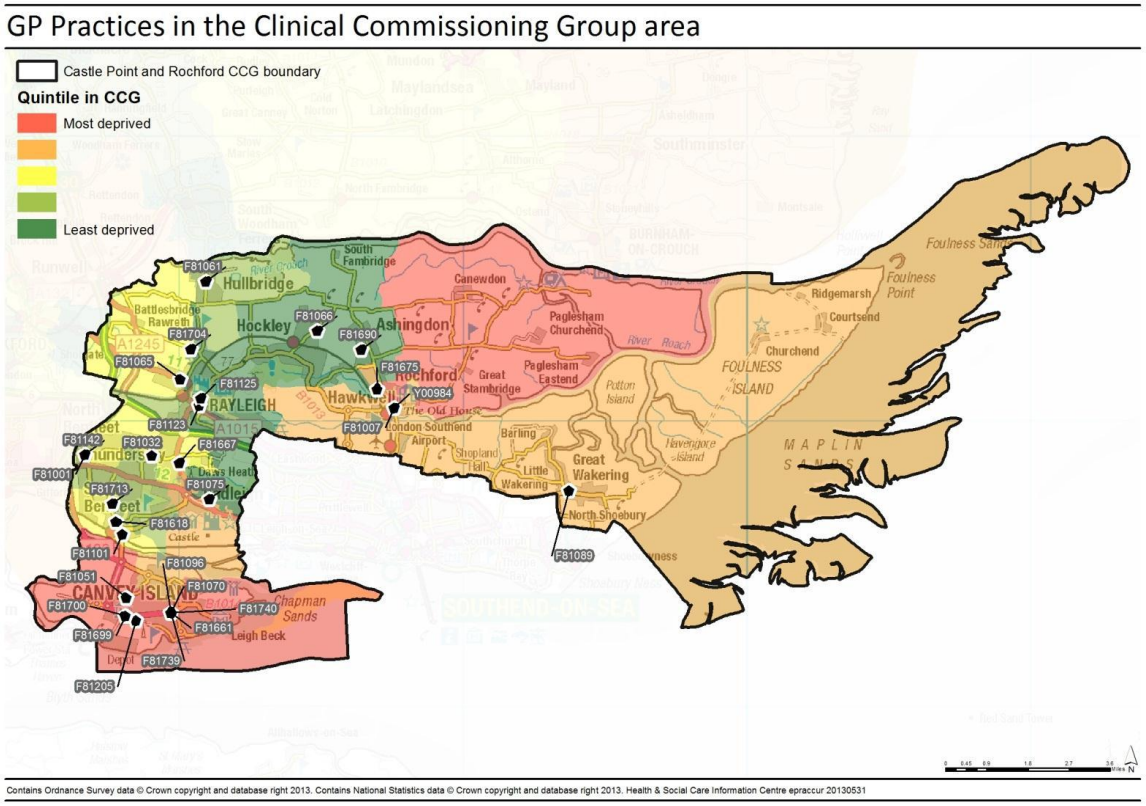
	Aim	Action Required	Lead	Deadline
1	Analyse key health problems	• We will identify and analyse the top health problems for CRP CCG working together with local authority Directors of Public Health.	DS	April 2014
2	Prioritise and set common goals	• The CCG will agree a set of common priorities and goals based on above analysis of epidemiology and current performance. These priorities will be few, highly targeted and shared with key partners such as Health and Wellbeing Boards, local government, providers and others. • They will also be quantifiable so that progress can be regularly tracked.	DS	April 2014
3	Identify high impact programmes	• The CCG will identify evidence-based prevention programmes that can deliver goals. These will encompass a mix of primary prevention, early detection and secondary prevention activities. • Not to pre-empt CCG goals, prevention of mental illness and hypertension screening, to take two examples, appear to be particular gaps in many parts of England given the burden of mental ill health, ischemic heart disease and stroke	DS	June 2014
4	Plan resources	• CCG will consider the full range of resources available across their health economy, including local government, schools, providers, employers and others. • The BCF may also be deployed to fund joint prevention activities. Crucially, in order to be cash releasing for our area as a whole (rather than simply shifting costs) reallocated funds will be linked to reductions in acute activity and capacity over the medium term.	DS	June 2014
5	Measure and experiment	• To ensure that our prevention programmes are delivering results - including reduced acute activity - they will be measured regularly with a mixture of process and outcomes measures. • Innovative approaches will be implemented with an evaluation method in mind from the start. • The CCG will need the intelligence to assess whether prevention programmes are working and will act decisively if they are not.	DS	April 2015

1.3 REDUCING INEQUALITIES

1.3.1 Groups with the worse outcome

In the period 2006 to 2010 in males the difference in life expectance between the most and least deprived individuals was approximately 5 years in Castle Point and approximately 4 years in Rochford. In females the difference was approximately 5 years in Castle Point and approximately 2 years in Rochford.

The areas of increased deprivation within Castle Point and Rochford are shown in the map below taken from the local JSHNA.



Cardiovascular death and deaths from cancer are the biggest causes of death and the greatest contributors to health inequalities. In order to reduce health inequities the risk factors for cardiovascular and cancer deaths need to be addressed. Most important of these is smoking but excessive alcohol consumption, inactivity, obesity, diet and undiagnosed or undertreated blood pressure are also important. In will be necessary to monitor the uptake of services to address these risk to see that those in the most deprived areas are accessing them at least as much as less deprived groups.

As set out in the Essex Health and Wellbeing Strategy 2013-2018 key themes to focus on across our locality are:

- Tackling health inequalities and the wider determinants of health and wellbeing
- Transforming services: developing the health and social care system
- Empowering local communities and community assets
- Prevention and effective interventions
- Safeguarding

Key areas of concern highlighted for Castle Point and Rochford are:

- Castle Point has high levels of children with tooth decay and one of the lowest levels of adults who eat healthily, and the highest number of obese adults in Essex. It also has one of the highest levels of hospital stays for alcohol-related harm.
- Rochford has the second highest level of increasing and higher risk drinking, and a relatively high level of hospital stays due to alcohol-related harm.

Actions to be taken to address health inequalities 2014/15:

Area	Action	Lead	Deadline
Obesity	• The CCG is commissioning a Tier 3 weight management service to bridge the gap between Tier 1 and 2 population wide services and lifestyle interventions and the specialist bariatric surgical services.	EH	April 2014
Obesity	• The CCG is undertaking a detailed review of Community Dietetics Service.	EH	July 2014
Obesity/CVD	• The CCG identified as our local priority for the remote monitoring DES weight gain associated with congestive cardiac failure. This DES will commence from April 2014.	EH	April 2014
Alcohol	• The CCG is fully supporting the Essex County Council Public Health Investment Programme in Alcohol Interventions, actively supporting and facilitating the system-wide developments. This includes investment in: ○ Alcohol Liaison Nurse Services ○ Community Based non medical interventions (psychosocial interventions) ○ Community based care recovery management and rehabilitation ○ Enhanced Justice Services ○ Alcohol Treatment Pathway	DS	April 2014
Alcohol	• Explore joint working with Education Service to deliver education and support into local schools and colleges. This includes linked GPs to local schools.	EH	Oct 2014
CVD	• 24 hour ECG and 24 hour BP monitoring services to be commissioned in the community to increase access and patient choice.	EH	April 2014
Smoking	• Continue to support public health smoking cessation programme through sharing practice level smoking data at Locality Commissioning Group meetings and raising poor performance at practice visits.	KMK	July 2014

1.3.2 Equality and Diversity

The CCG refreshed its Equality and Diversity Strategy recently and this will be submitted to Quality and Governance in February prior to ratification at the Governing Body in March 2014. This new Strategy will reflect the new requirements of EDS2. However a number of steps have already been taken to ensure that the CCG fulfils its public sector equality duty:

- Information about the composition of the CCG's workforce has been published on the dedicated equality and diversity section of the CCG website; Don't know it has been uploaded as of yet. Amanda S please arrange as a matter of urgency – it is in my in box
- Within the Equality and Diversity Strategy, the CCG has published its interim EDS goals;
- Equality and diversity (including the EDS goals) was discussed at the last CCG's patient group known as the Commissioning Reference Group (CRG). The CRG will be a key vehicle for agreeing priorities with the community and assessing progress;
- Equality and Diversity Policy in place;
- Chief Nurse appointed as Board-level lead for equality and diversity;
- Lay Member identified as Equality and Diversity Champion;
- Equality impact assessments are undertaken on all CCG policies, QIPP plans and commissioning cases;

1.4 PARITY OF ESTEEM

As outlined below NHS Castle Point and Rochford CCG supported by the Commissioning Support Unit Mental Health Commissioning Team plans to undertake a number of key actions to deliver the Parity of Esteem agenda locally.

Action	Clinical Lead	Commissioning Lead
Training NHS staff to better identify and respond to the needs of people with mental health needs	TD	JI
All GPs to have had training to recognise signs of risk indicators for suicide and severe mental illness and correct referral paths.	TD	JI
All medical and nursing staff in Basildon Hospital to have received training to identify mental health problems and correct referral paths.	TD	JI
All mental health inpatient and community staff to have received appropriate training in physical health care and the identification of physical health needs.	TD	JI
Integrating Mental and Physical Care •All people with low-level mental health need (clusters 1-3) to be principally cared for by their GP as their Named Accountable Professional. •Community mental health teams to form part of primary care multi-disciplinary teams	Dr Taylor	JI
Integrating mental and physical care cont. •IAPT services to be integrated into primary care federation based health teams, focusing on long-term conditions. •Psychogeriatricians and older people community mental health teams to be integrated into the new care of the elderly community 'step up' teams. •Introduce specified pathway of health prevention work with individuals who suffer from a mental health problem (e.g. obesity / alcohol).	Dr Taylor	JI
Other areas •Introduce audit programme of GP SMI registers and health checks for people with mental health needs. •Cross reference GP and secondary care SMI register to identify unidentified individuals. •Implement formulary for mental health services across primary and secondary care and supporting audit programme. •Implement the 'South Essex Recovery College' •Implement personal health budgets for people in recovery.	TD	JI

1.5 CHILDREN AND YOUNG PEOPLE

Service Re-design

The CCG is working with the other 6 CCGs in Essex and Local Authorities to ensure that there is a whole systems approach to the service redesign for CAMHs.

Maternity Review

The south Essex system is currently undertaken a review of maternity services locally to identify the capacity demands and future model of care required to meet the needs of the local population.

Clinical Leadership

All contestability reviews are undertaken with clinician and parent representation.

Governance

The Paediatric Clinical Executive Group gains whole system clinical feedback and GP leads receive weekly updates in relation to delivery against agreed plans.

The South Essex Network project works closely with parent/carer forums and clinical colleagues receive regular briefings.

Health are holding Integrated Commissioning Strategy Group with Children and Young People Commissioners – South Essex, NHS England / three Local Authorities / four CCGs in South and Commissioning Support Unit (CSU) are in attendance.

To ensure that services are safe and of high quality the Childrens and Young People Commissioning team attend the CCGs Clinical Quality Review Group and ensure that quality impact assessments are undertaken on all commissioning reviews / service redesigns.

Collaboratively Working

The SEN includes:

- Working with Local Authorities
- Attending regional events
- Attending national events
- Incorporating new KPIs and information requirements in line with new guidance
- Include new guidance within all provider contracts.

Patient and Public Engagement

Friends and Family Test in place to receive feedback in relation to the current CAMHs service and exit surveys undertaken. Peer group review of treatment in place and a report is submitted to the CORQ (quality monitoring / benchmarking against other CAMHs services nationally).

Choose Well leaflets have been provided to parents / carers to ensure that they are able to make informed decisions about services, care and treatment.

The CAMHs SEN is chaired by a parent/carer.

The friends and family test results relating to A&E, IPY and maternity services are reported at the monthly CQRG meeting and key themes identified to ensure actions are put in place to improve performance in these areas.

The Children and Young People Commissioning (CYP) Team has held CAMHs and SEN events with our local population to ensure that they have been fully included in all aspects of service design and change.

Mechanisms in Place to Monitor Treatment Outcomes

The following measures are currently being monitored to ensure that there is improvement in patient outcomes and that patients are staying well after treatment has been under taken:

- Asthma Pathway – monitoring frequent flyers
- Diabetes – effective monitoring and keeping the CYP stable and out of acute through BPT.

The SEN MAPIT Tool (audit evaluation tool) has been put in place to identify patients receiving poor care and where poor care is to be found.

Training and Education
SEN key worker training is currently being rolled out and IAPT pilot for children and young people evaluation to be undertaken by March 2014.
The CYP Team ensure that serious case reviews and CDRs are shared appropriately, so that lessons are learnt and actions are identified where necessary to mitigate risks for the future.

Continuing Health Care
The CCG will ensure

Information Sharing and Information Governance Protocols are in place.

ISPs have been signed between ecdp (the delivery partner) and both Essex and Hertfordshire CCGs. Patient sharing information forms and processes have also been developed and agreed and ecdp will be using EGRESS to ensure electronic patient data is stored and shared in line with Information Governance and Information Sharing Protocols. The ISP has been signed by the provider data controller.

Patient consent is required to refer prospective PHB recipients to the delivery partner and a referral form and process have been agreed between ECDP and with both PHB Steering Groups and agreed with the Central Eastern CSU Information Governance lead.

Safeguarding
The CCG will ensure that providers are compliant against the *Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework* through the CQRG providers performance dashboard. The CQRG meet monthly and is chaired by the CCG Chief Nurse. This is also covered within the Section 11 Audit, Children's Act 2004, which is completed 3 yearly but reviewed annually and shared with the LSCB. This can also be reflected in the KPIs and monitored by the CQRG and Contracts.

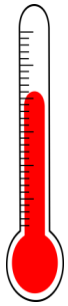
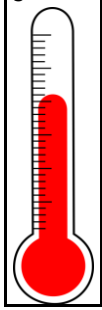
The CCG's plans are aligned with SET priorities.

The CSE is led by all three LSCBs and they have a county wide strategic CSE group. The designate nurses are also the Champions for CSE. The LSCBs are currently putting CSE training together and sharing information intelligence form. This will be rolled out to front line staff. The Champion for Southend (Designate Nurse) has attended training. There is also a Domestic Abuse strategy in place which is led by Adult Safeguarding (Andrea Metcalfe).

There is a Safeguarding KPI/contract and Safeguarding assurance protocol which is being embedded in all contracts with Providers. This will assist providers in demonstrating how safeguarding duties are discharged and reported.

1.6 SPECIFIC CLINICAL OUTCOMES

1.6.1 Key National Clinical Outcome Measures

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
1 	Clostridium difficile reduction	TBC	26 - CCG Target	Explore the options to set up a scrutiny panel with AT to consider how unavoidable cases can be removed from local trajectories. Epidemiology review to be undertaken with Public Health. RCA's to be undertaken on all post 72 hour cases with regards to anti-biotic prescribing. Further work to be developed with GP's for reviewing patients with on-going diarrhoea in the community. SUFHT to re-examine GDH positive cases to see if they have had any previous hospital admissions.	TD/IPC	March 2015
2 	Dementia diagnosis	TBC	58% (Stretch of 65%)	The CCG will be validating the QOF vs SEPT registers - we are expecting the data to be collated by the end of March to enable us to develop an action plan. The Dementia SEPT CQUIN in 13/14 enabled the development with ARU, a training program to enable nurses to independently identify dementia syndrome within the care home population. Through the MH Commissioning Team the CCG are currently reviewing the memory service specification - to ensure that we have capacity in the future increase the diagnosis rates in a timely fashion.	IL	March 2015
3 	IAPT coverage and recovery	TBC	15%	A number of key actions are outlined in the dedicated section on the following page in relation to improving performance in this area.	JI	Mar 2015

1.6.2 IAPT Recovery Plan

As host of the South Essex Partnership NHS Foundation Trust, the CCG is committed to ensuring that the local IAPT standard of 12.6% is achieved during 2013/14, moving to a standard of 15% during 2014/15.

Current Performance
IAPT Performance as at the 12th February 2014 is included within the following table and sets out the numbers of patients to be seen on a weekly basis to ensure that the 12.6% standard for 2013/14 is achieved.

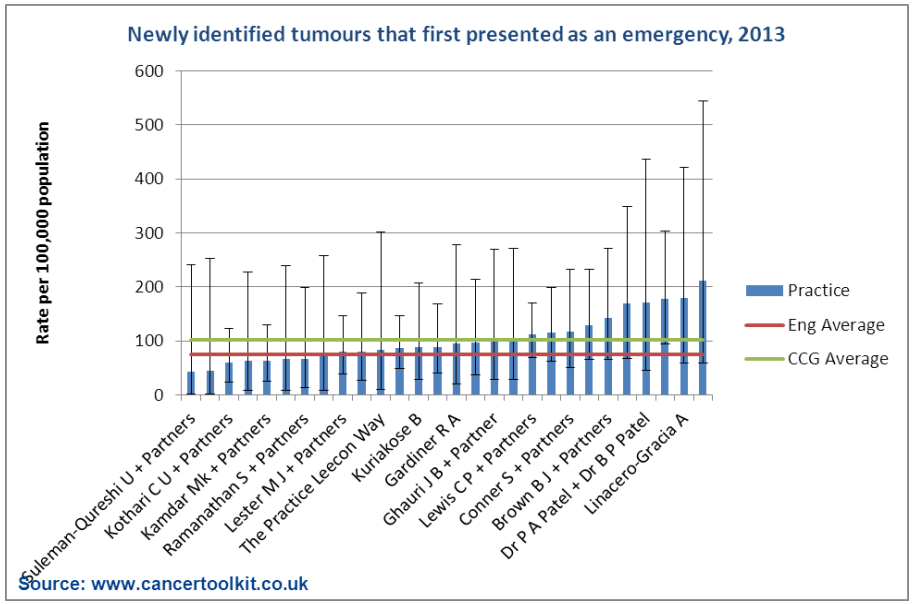
CCG	Population	Target	Currently Achieved	Difference	% previous week	% as at 12.02.14	Weekly Target
B&B CCG	32743	4126	2886	1240	8.6%	8.8%	124
CP&R CCG	21110	2660	2001	659	9.3%	9.5%	66
SCCG	22104	2785	2029	756	8.9%	9.2%	76
TCCG	20240	2550	1346	1204	6.4%	6.7%	120
Total	**96197**	**12121**	**8262**	**3859**	**8.4%**	**8.6%**	**386**

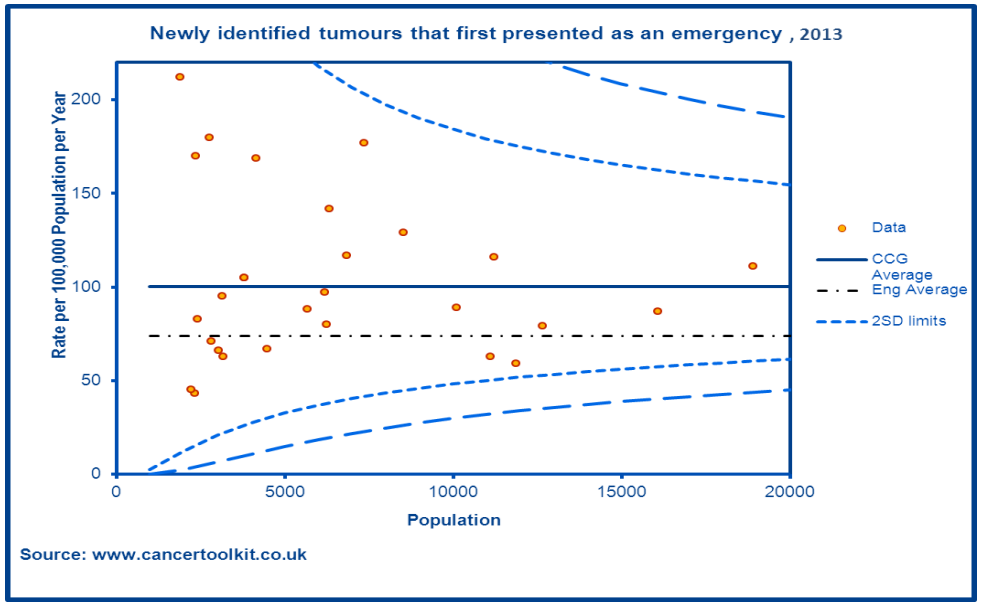
Key actions being taken to ensure delivery of the 12.6% target in 2013/14 and 15% in 2014/15:

- Performance notice accepted and Recovery Action Plan (RAP) agreed.
- Progress against RAP monitored at weekly IAPT performance meeting and milestones on track.
- Intensive Support Visit undertaken and draft report received outlining a number of key recommendations to be implemented.
- Data cleansing undertaken and additional admin support in place to support information reporting requirements.
- Draft self populating Referral form developed for GPs to add onto SystemOne – March 2014.
- Request sent to all south Essex Accountable Officers to agree a specific mental health READ code to assign to IAPT, enabling the service to add a hyperlink to patient notes.
- Pre-paid envelopes provided to support self referrals.
- Additional work taking place with third sector organisations and Public Health to increase referrals from other sources.
- Media campaign being rolled out including stands in Lakeside, and other large stores in the area, four page advert in the local paper, leaflet drops, posters and cards in surgeries etc.
- Additional group sessions arranged and model adapted so that these can be accessed if living outside of the CCG boundaries e.g. Castle Point resident can attend Westcliff group.
- Modelling undertaken to ensure sufficient capacity in place to meet 12.6% by March 2014.
- Executive Director lead assigned by SEPT to IAPT and monitoring performance on a daily basis internally.
- Service user feedback results shared on a monthly basis.
- Internal communications developed for GPs in relation to IAPT and frequently asked questions sheet currently being developed with the support of the service.
- Develop an action plan to roll out IAPT into Long Term Conditions Management
- Transfer of PbR clusters 1-3 from secondary care into IAPT service
- Boost effective partnership working between the Trust and Voluntary Sector Organisations to support and promote coverage.
- Develop a CQUIN to support IAPT in addressing inequalities

1.6.2 Quality Premium Local Priority Measure

NHS Castle Point and Rochford CCG has identified 'Cancer diagnosis via emergency routes' as our local priority indicator. This is because Castle Point and Rochford has a higher number of cancers first presenting as emergencies (due to the age of the population). The data analysis shown below does not identify any one practice within the CCG as a statistical outlier but demonstrates that there is a need to undertake further analysis to identify where additional support and resource in primary care could improve performance in this area.





		2013/14		
	Indicator Definition	**Numerator**	**Denominator**	**Measure**
Local Priority 1	C1. 16 Cancer: Diagnosis via emergency routes	182	749	24.3%
		2014/15		
Growth assumed at 2.4%	**Indicator Definition**	**Numerator**	**Denominator**	**Measure**
Local Priority 1	C1. 16 Cancer: Diagnosis via emergency routes	182	767	23.7%

1.7 IMPROVING OUTCOMES – MEASURES TO REDUCE HARM

	Key areas to make improvements to reduce harm	Success will be delivered through	Lead	Deadline
1	To review CCG governance for Patient Safety and Quality	Review the functionality and Governance of the Quality and Governance Committee, making recommendations for change and implementing agreed Quality Outcome framework	TD	March 2014
		Review the delivery of the functions of the Quality Support Team in view of BB CCG decision to withdraw from hosted arrangement.	TD	March 2014
		Attendance at appropriate meetings internal and externally to the organisation, promoting the PS&Q agenda in all forums	TD	Completed & Ongoing
2	Continue to work with partners to gain the required level of assurance for patient safety and quality of care within SEPT services and SUFHT services	To work with the Trust to drive improvement. Monitoring compliance with recommendations from Francis, and Berwick.	TD	Completed & Ongoing
		To ensure the contract is used to its best effect to provide safety, good quality care that provides a good patient experience	TD	March 2014
		To have a programme of assurance reports as per the CQRG programme to monitor standards of patient safety and quality of care	TD	March 2014
		To work with regulatory partners to share intelligence and drive improvements	TD	Completed & Ongoing
		To work with key stakeholders to enable sound knowledge of standards achieved by the Trust and provide assurance of processes of monitoring	TD	Completed & Ongoing
		To continue programme of announced and unannounced visits to check and challenge service provision and gain instantaneous patient and staff feedbacks	TD	March 2014 & ongoing
3	Continue to work with partners to gain the required level of assurance for patient safety and quality of care within all commissioned services	To work with partner CCGs to ensure Castle Point and Rochford CCG gains assurances of the standards of care with all commissioned providers • SEPT • SUHFT • EEAST • Private hospitals • Hospices • Continuing Health Care • NHS 111	TD	March 2014
		Monitoring compliance with recommendations from Francis, Keogh and Berwick reports.	TD	March 2014

	Key areas to make improvements to reduce harm	Success will be delivered through	Lead	Deadline
4a	Take a strategic lead to ensure responsibilities of the NHS for safeguarding (children and adults)are embedded and delivered	Ensuring appropriate measures are in place to Safeguard Children in the locality and across the South Essex Health system.	TD	Completed and ongoing
		Work collaboratively across Essex to best provide for safeguarding of children through integration and intelligence sharing of best practice.	TD	Completed and ongoing
		Chief Nurse to attend and contribute to the Health Executive Forum for Children's safeguarding as a sub-committee of the Essex Safeguarding Children's Board	TD	Completed and ongoing
		Work with designate staff to hold commissioned organisations to account for processes and systems in place to safe guard children	TD	Completed and ongoing
		Work in partnership with local authority to drive the safeguarding agenda for children	TD	Completed and ongoing
		Ensure the section 11 audit is completed, implemented and improved	TD	July 2014
		Ensuring appropriate measures are in place to Safeguard Vulnerable Adults in the locality and across the South Essex Health System.	TD	Completed and ongoing
		Work collaboratively across Essex to best provide for safeguarding of vulnerable adults	TD	Completed and ongoing
		Chief Nurse to attend the Essex Safeguarding Adults Board	TD	Completed and ongoing
		Work with commissioned organisations to hold to account for processes and systems in place to safe guard vulnerable adults	TD	Completed and ongoing
		Work in partnership with local authority to drive the safeguarding agenda for vulnerable adults	TD	Completed and ongoing
		Ensure the section 11 audit is completed, implemented and improved	TD	September 2014
		Work with partners to implement the Winterbourne recommendations	TD	Completed and ongoing
5	To develop integrated working patterns with the local authority with specific regards to resident safety and quality of care within care homes	To establish a pro-active, collaborative working relationship with the local authority in regards to care homes	TD	Completed and ongoing
		Ensure the sharing of intelligence about standards of care in care homes, to enable the best outcomes to improve standards	TD	Completed and ongoing
		To work in partnership with the local authority, to monitor care homes where health care is delivered, to drive improvement	TD	Completed and ongoing
		To ensure the input of the Continuing health Care Team is appropriate and timely to monitor and improve standards with care homes	TD	Completed and ongoing
		To work with the Individual Placement Team to ensure that the most effective option is available to individuals.	TD	Completed and ongoing
6	To work with partner organisations to re-design services which promote clinical effectiveness, patient safety, quality of care and enhances patients experience	To ensure that there is patient / carer engagement in all re-design projects	TD	Completed and ongoing
		To ensure quality is central to all service re-design initiatives	TD	Completed and ongoing
		To work collaboratively with the local authority and other CCGs on re-design projects and promote innovation at every opportunity.	TD	Completed and ongoing

1.8 INNOVATION

1.8.1 NHS Castle Point and Rochford CCG Innovation Group

CPR CCG acknowledge that we need to find ways to raise the quality of care for all in our communities to the best possible standards while closing a significant funding gap by 2020/21. This calls for creativity, innovation and transformation.

This will require a significant shift in activity and resource from the hospital sector to the community. The funding and implementation of the Better Care Fund has the potential to improve sustainability and raise quality, including by reducing emergency admissions; hospital emergency activity will have to reduce by around 15 per cent for our CCG. Our CCG will need to make significant progress towards this during 2014/15.

CPR CCG is committed to innovation to deliver significant improvements in quality and efficiency across our system. In 2014/15 we intend to access the **Regional Innovation Fund** to support and promote the adoption of innovation and the spread of best practice across South East Essex. We will be looking to facilitate fresh perspectives and partnerships, bringing in different types of expertise or capacity to support the adoption of current innovations or the development of new ideas.

Next Steps

- We have established a CCG dedicated 'Innovation' Group using our clinical leadership tasked to adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS.

1.8.2 High Impart Early Adopter Interventions

The CCG Innovation Group are supporting in a range of recommended interventions for local adoption, namely:

- *Early Diagnosis* - Early detection and diagnosis to improve survival rates and lower overall treatment costs
- *Reducing Variability Within Primary Care by Optimising Medicines Use* - Reducing unwanted variation in primary care referring and prescribing
- *Mental Health – Rapid Assessment Interface and Discharge (RAID)* - Psychiatric liaison services provide mental health care to people being treated for physical health conditions
- *Dementia Pathway* - Fully integrated network model to improve health outcomes and achieve efficiencies in dementia care
- *Palliative Care* - Community based, consultant-led integrated palliative care service
- *Acute Visiting Service* - Reducing demand for emergency care through providing a rapid-access doctor at home
- *Reducing A&E pressure* - Acute GP unit to triage emergency arrivals; occupational therapists in A&E to reduce low-risk admissions
- *Acute Stroke Services* - Creating a hyper-acute stroke unit at SUHFT to optimise acute stroke services and ensure 24/7 access to specialist care
- *Integration of Health and Social Care for Older People* - Integrating care through organisational, procedural and cultural changes

- *Electronic Palliative Care Coordination Systems* - Improving care and helping patients to die in the location of their choice through a shared electronic record (this sees all providers using System1 – acute community and voluntary sector)

1.8.3 Technology

CPR CCG believes that technology is an enabler to meet growing demand in health and social care services in a more timely and effective manner while still providing overall value for money. CPR (working with colleagues in public health have are interested in some technology trends which, if applied at scale, hold the power to significantly impact the way care is delivered over next 5 years. These include: App-Driven Wellness Culture; Self-Care and Proactive Health Management; Assisted-Living Technologies (in partnership with local authority); Remote Consultations; Telemedicine; Case Managers and Patient Navigators; Predictive and Visual Analytics and Evidence-Based Medicine; Technology-Enabled New Work Models, and Seamless End-to-End Health and Social Care Provision.

Specific Innovation where CCG already Engaged

Analytic Tool for prediction of falls: Castle Point and Rochford CCG is working with Anglia Ruskin University, Essex County Council and an external commercial organisation to develop an analytic tool for prediction of falls. The idea is to try to use a large amount of data which is already present in NHS and Social Care records ("big data") and carry out an analytical process to produce a more accurate tool for the prediction of falls in the elderly.

Better Sharing of data between Health and Social Care: Castle Point and Rochford CCG is working with Essex County Council, NHS England, other CCGs in Essex and other organisations on improving the flow of information between Health and Social Care. This should result in improved outcomes and save money while still having appropriate safeguards in place. It will eventually result in a single health and social care record.

1.9 RESEARCH AND EDUCATION

Research and evaluation across the whole patient pathway, including with partners in local government and Public Health England will contribute to improving outcomes and spreading innovation and economic growth. A additional marker of quality within NHS organisations is those with research activity able to demonstrate evidence of improved patient outcomes and health service delivery.

Our CCG our actively seek out research opportunities, understand where research is taking place within the providers with whom they contract and support that activity wherever possible, through their commissioning decisions.

The CCG Research and Education programme is outlined below and lead by the Chief Nurse and Accountable Officer.

Area	Action	Lead	Deadline
Member practices	Encouraging all member practices to be research ready (toolkits completed)	TD	Sept 2014
	Ensure high level support continues through the provision of CCG hosted Clinical Education Service.	TD	
Primary Care Development	To better educate nurses and encourage recruitment and retention into primary care of experienced nurses.	TD	Sept 2014
	Lead Practice Nurse Forum for CPR locality.	TD	Jan 2014
	Establish Non-Medical Prescribing Forum	TD	Jan 2014
	Encourage the number of GP training places by 15%	TD	April 2014
	Review varying models to support the recruitment and retention of salaried sessional and partner GPs into the locality. Ongoing work with LMC to develop local business case which could be delivered across the County.	SG	March 2015
Succession Planning	ST4 commissioning fellow supported to achieve leadership qualification and commissioning experience in healthcare commissioning.	SG	Aug 2014
Academic Research Network	Strengthen membership with ARU Health Partnership through attendance at all partnership meetings and acting as an active stakeholder. Encouraging research where it will benefit health and social care domains.	TD	Jan 2014
Partnership Working	Establishment of CCG Research Network with CLRN	TD	April 2014
	Ongoing membership of LETB Board	SG	Jan 2014
	Ongoing membership of Postgraduate Medical Institute Board of ARU	SG	Jan 2014
	Further collaboration with acute partners to target research initiatives crossing primary and secondary care domains e.g. GCA	SG	Jan 2014
	Building on existing relationships with Higher Education Institutions to strengthen research activity in CPR locality.	TD	July 2014
	Work with County Partnership Group and local Higher Educational Institutions to employ apprenticeships with a view to long term employment opportunities within the healthcare domain.	VG	June 2014
	Deliver Pressure Ulcer Project with University of Essex to improve the incidence of pressure ulcer development in the care homes of CPR.	TD	May 2014
	Linked prescribing incentive scheme and educational CPD for practice nurses at the University of Essex.	TD	Jan 2014

1.10 PERSONAL HEALTH BUDGETS

The CCG are working in collaboration with Basildon & Brentwood CCG to meet the mandate for delivery of PHB from April 2014. There are two options for the CCG, both are required deliver a range of services (Appendix 1):

1 To provide the service internally
2 To commission a PHB service from an external provider.

Options appraisal:

Descriptor	Positives	Negatives
1. Establish an internal team to the CCG to provide this service	• Direct ownership and reporting.	- Cost of establishing team - Ongoing employment liability - Currently the demand for PHBs is unknown and it is possible that there will be significant variation in requests, there will be time delays in recruiting additional staff. - There is limited experience of delivering PHBs and therefore people with the requisite skills are at a premium.
2. To commission a PHB service from an external provider	• The cost per case can be defined • Scalability of response to requests for PHBs • Maximise the limited experience of administering PHBs	- Subject to procurement regulations - There is likely to be a limited market initially.

Recommendation

The recommendation that will be formally considered by our Procurement Committee in by the end of February 2014 is for them to formally accept the preferred option which will recommends the following approach:

1. We will undertake a short pilot for the provision of the service. This will cover the 'optional' provision phase, plus a further period following the mandatory phase (from 1st October). It is suggested that this will require a period of 9 months (April to October, then 3 months from 1 October) **plus** a further 3 month period to allow for a new procurement process to be undertaken. The pilot will, therefore, operate for a total period of around 12 months.
2. The pilot will be used to obtain better commissioning information, to allow for a full procurement of the service to be undertaken at a later date in a more informed manner. Better information will be available regarding take-up of the provision by service users and also of the kind of PHB support service users are requiring. This will also allow time for the provider market to become more mature.
3. We are aware that ECDP are providing a similar service for ECC. They are a local provider of this type of service, with appropriate local connections and it is considered that they are best placed to operate this pilot on behalf of CPR & B&B.

1.11 IMPROVING SUPPORT FOR CARERS

Support for Carers

NHS Castle Point and Rochford CCG understand that Carer breakdown is a main trigger for admission to hospital/residential and nursing care.

We are committed, therefore, to support the implementation of the 'Essex Carers Strategy' and weaving requirements into contracts. This work will be reflected in our Strategic, Operational and Better Care Fund Plans

There is a range of Carer support arrangements in place across the county. These include carer befriending scheme, hospital link worker, Macmillan carer service, carer wellbeing checks (not universal coverage). In Castle point and Rochford CCG and South Essex CCGs we have carer recognition workers in primary care and secondary care settings, 'Who Cares' project and Carer champions.

In 2014/15 we will develop the business case for improved carer support and commission jointly between Essex County Council, for implementation late 2014/15.

Support for professional carers to raise standards in care homes, linking with providers of community services.

It is clear in CPR CCG that there are high numbers of patients present to A & E from residential and nursing homes.

In 2014/15 ECC and CCG partners will work with care homes to reduce falls and improve experience at End of Life through the 'My Home Life' Programme. Benefits would include reducing admissions to acute hospitals from residential and nursing homes.

Other Carer Support Areas

Dementia Support Services within Memory Services. WE will continue to use Voluntary Sector Organisation opportunities to support carers. These are jointly commissioned services provided by specialist voluntary organisations (e.g. Alzheimer's Society and Mind) to provide sensitive, responsive and individualised information, signposting, guidance and support to all people newly diagnosed with dementia, and their families and carers, to enable them to manage the impact of assessment and diagnosis of dementia on their lives.

Assistive Technology - Used wisely, we know that Assistive Technology offers local care partnerships an opportunity for transformational change in the way customers and their carers receive support, and in the types of support that can be offered and providing a more joined up, whole systems approach to health and social care delivery. Working with ECC through better Care Fund we will be looking to maximise opportunities for our patients and carers to avail of Assistive Technology.

1.12 PATIENT AND PUBLIC ENGAGEMENT

Since authorisation the CCG has established our Commissioning Reference Group (CRG), with dedicated GP leadership, and has undertaken a number of mechanisms to obtain patient and public engagement as outlined below:

- CCG launch event with patient survey.
- Two public events in Castle Point and Rochford based on nationwide NHS Call to Action campaign.
- Supported by councillors from both Rochford District Council and Castle Point Borough Council, including Mayor of Castle Point Borough Council, and Leader of Rochford District Council and Healthwatch Essex, demonstrating our commitment to working with our Local Authority partners to improve healthcare.
- CCG's PPI group (Commissioning Reference Group) was an integral part of the 2 events-helped to shape agenda.
- Commissioning Reference Group Urgent Care Survey seeking the views of patients using emergency care services which culminated in informing comprehensive winter planning/111 campaign including production of www.getwellessex.com

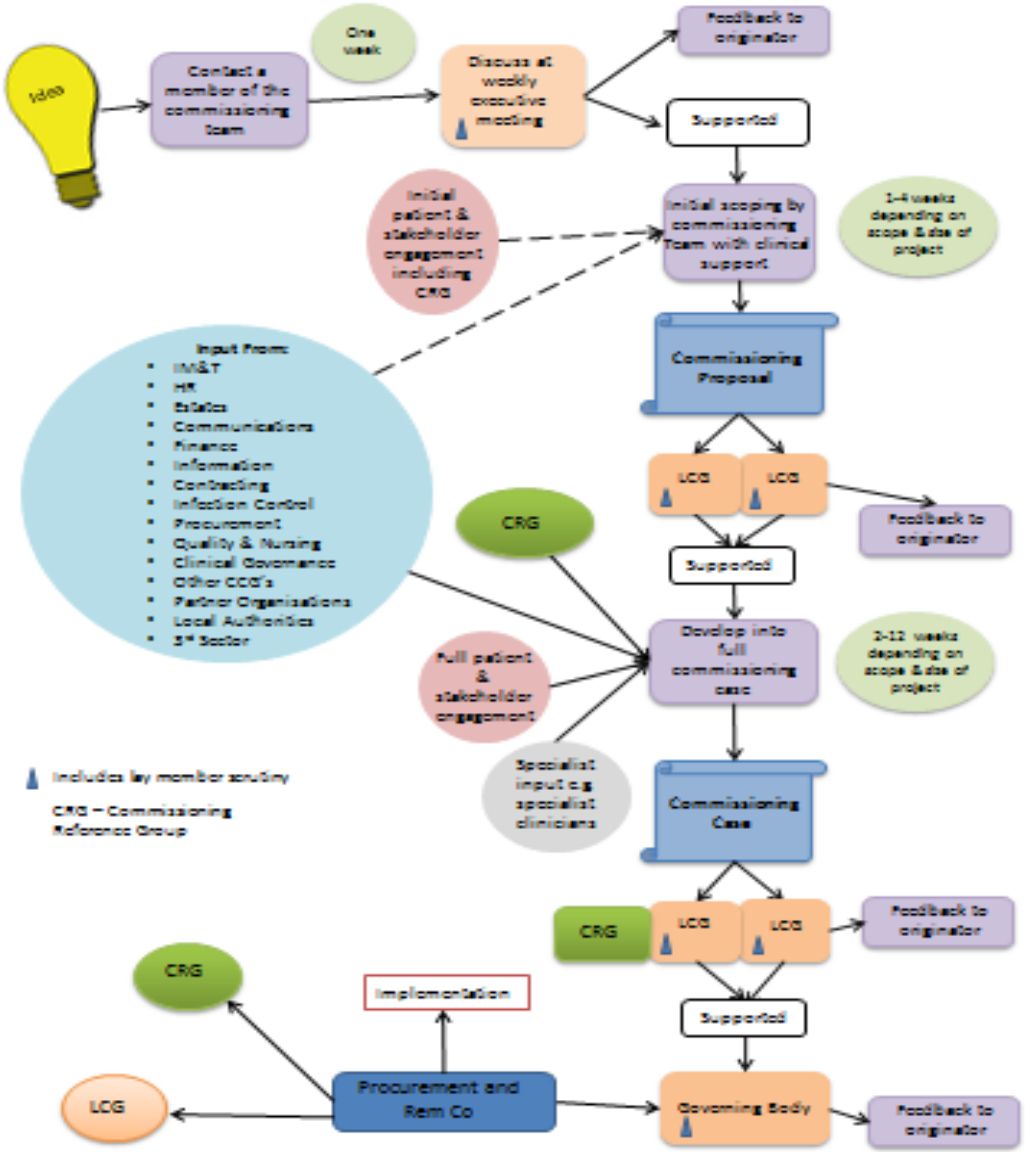
Some being addressed:

- Empowering patients to self care
- A&E communications campaign to run over Winter explaining how to use emergency services appropriately
- Challenges our local NHS faces: ageing demographic, rising cost of drugs, increased demand.

The outcomes of the above events have been pivotal in shaping our longer term planning and noted below are the actions to be taken during 2014/15 to commence the process of community led commissioning.

Action	Lead	Deadline
Distribute children's story book ' the Birthday Bug' through Children's Centres as recommended by the CRG Project Group	EH	May 2014
Liaise with GP practices in relation to running NHS 111 information on practice televisions.	EH	June 2014
Hold follow up call to action events across our locality.	TD	May 2014

Through direct engagement Commissioning Reference Group and CCG leads engagement with local partners and attendance at public events the CCG is building insightful methods that are in turn being used for patients and carers to participate in CCG planning, managing and making decision about their care and treatment through the services that they commission. Our commissioning cycle below sets the varying stages of CRG engagement and involvement in our commissioning processes.



Call to Action

Of particular note is a new requirement to set aside 1% relating to a "Call to Action" fund. The fund has been earmarked nationally to ensure the CCG meets its expectation "to support practices in transforming the care of patients aged 75 or older and reducing avoidable admissions by providing funding for practice plans to do so. They will be expected to provide additional funding to commission additional services which practices, individually or collectively, have identified will further support the accountable GP in improving quality of care for older people. This funding should be at around £5 per head of population for each practice". The CCG are actively working with our local GP Federation to submit a bid in response to the Prime Ministers Challenge Fund in alignment.

1.13 GOVERNANCE ARRANGEMENTS

1.13.1 Governance & Delivery Arrangements for Implementing the Plan

The CCG is a membership organisation with member practices accountable for exercising the organisation's statutory functions (including those it has delegated) and delivering against its responsibilities and objectives.

The CCG Constitution, which includes the Scheme of Reservation and Delegation, sets out the key functions of the CCG and who in the CCG has delegated responsibility for fulfilling these. In summary, the CCG Governing Body and its sub-committees will act under delegation from CCG members with the responsibility for ensuring delivery of the Integrated Plan.

Full details of the CCG Governance arrangements are included in *NHS Castle Point CCG Constitution* and the *NHS Castle Point CCG Organisational Structure & Governance Arrangements* document, with this section highlighting the role of committees in respect of delivering and monitoring progress against the major programmes of work included in this plan.

To deliver the major programmes of change included in the Operational Plan, the following have been established by the CCG.

- Two Locality Commissioning Groups
- CCG Executive Team

To review progress against the implementation of the Operational Plan, the following committees and sub-groups will/have been established by the CCG:

- Quality and Governance Committee
- Engagement and Patient Experience Committee (Commissioning Reference Group)
- Finance & QIPP sub-group

To consider the implementation of the Operational Plan and play a lead role in completing the annual refresh, the following committees have been established by the CCG:

- Commissioning Executive Committee
- Engagement and Patient Experience Committee
- Locality Commissioning Groups (for Integrated Plan engagement and approval)

In each area and across all areas of remit, Committees will be mandated to engage with member practice locality group and with locality patient participation groups.

The Governing Body

This is the body with ultimate responsibility for the delivery of the Integrated Plan. The body will consider Integrated Performance Reports monthly to track the overall position against all aspects of performance, quality, finance and QIPP delivery. The Governing Body will delegate responsibility for implementation of the

Integrated Plan to the Locality Groups and will delegate the responsibility for tracking performance against the Integrated Plan and the oversight of mitigating and remedial actions to the Quality and Governance Committee and its sub-groups.

The Governing Body has appointed the following committees and sub-committees to oversee implementation of the Integrated Plan. All of the committees set out above are accountable to the Governing Body and the Governing Body has approved and keeps under review the terms of reference for the committees.

Two Locality Groups:

Responsibility in relation to Integrated Plan: Multi-disciplinary and multi-organisational groups responsible for the delivery of programmes of work and QIPP in each priority area.

Description: Locality will include every practice member from within locality. The LCGs will act to oversee the implementation of the CCG's key commissioning programmes and QIPP initiatives.

Quality and Governance Committee:

Responsibility in relation to Operational: Oversees the delivery of all aspects of the plan. *Description:* Monitors and provides the Governing Body with assurance on overall progress against the Operational Plan, including all domains of finance, QIPP, performance, quality and safety. The Committee maintains the CCG's assurance framework and risk registers. It will act to shape the management agenda for the locality CCGs.

Commissioning Executive Committee:

Responsibility in relation to Operational Plan: Review implementation of current plans and performance and assume responsibility for annual refresh of Integrated and Strategy Plans.

Description: Oversees the development of the CCG's strategic plans and commissioning intentions, scrutinising the ongoing efficacy of current plans, commissioned services and scopes service developments. The Committee receives reports from locality CCGs and instructs them to undertake designated actions working through the member practices in the localities; receives reports from lead individuals charged with overseeing major commissioning programmes.

Engagement and Patient Experience Committee (Commissioning Reference Group):

Responsibility in relation to Operational Plan: Assuring that plan and work programmes engage with members of the public and patients.

Description: The Committee is responsible for ensuring that a range of patient experience data is captured and acted upon and informs commissioning decisions and to monitor patient engagement and advise the Governing Body on the subject.

Finance and Performance Committee

Responsibility in relation to Operational Plan: Focussed group assuring full delivery of annual QIPP programme and financial responsibilities.

Description: The purpose of the sub-committee is to act as the oversight body with responsibility for CCG financial performance and QIPP delivery. The sub-group will have one over-arching responsibility: to act in an advisory capacity in relation to the CCG Governing Body's delegated finance and QIPP delivery targets, and to recommend corrective action to the Quality and Governance Committee and CCG Governing Body as appropriate

1.14 PRIMARY CARE

1.14.1 Why Our Primary care Services Need to Change?

Our CCG clearly acknowledge that primary care needs to change if it is to cope with future demands and challenges. Some of the key challenges impacting this need to change are:

- Increase in Older Population.
- More Chronic Diseases.
- Rising GP workload exacerbated by recruitment difficulties
- Financial Pressures on NHS.
- Increased Patient Expectations

Our key priorities for primary and community care can be summarised as:

- Reducing variation in the quality of primary care
- Support for preventative care, wellbeing and early diagnosis of health problems
- Improved access to primary care on a 24/7 basis, supported by 111/OOH
- Integrated approaches (linked to Better Care Fund) to care for the elderly and those with long term conditions
- Personalised care-planning and self-management
- Rapid, convenient access to planned & outpatient care, with more care provided out of hospital.

Primary care plays a vital part in the delivery of our Strategic Plan and in improving patient outcomes. One of the five CCG goals included in our plan is to reduce the variability of primary care quality and outcomes so that patients across the localities receive the same high standard of care.

The CCG would like to commission a project looking at primary care quality and their capacity to deliver this Strategic Plan and achieve improvement in the outcome indicators. This work would be completed during 2014/15 to inform a longer-term strategy to improve primary care quality and reduce variation in patient outcomes across the CCG geography.

The intention is that our CCG will support the Area Team to invest in a programme of targeted primary care development to enable delivery of the Strategic Plan and the outcomes included in the High level Ambitions. The purpose of this development programme is to:

- Support high quality care in primary care and community settings (ensuring access for all)
- Improve the identification and management of a range of conditions

- Provide more care closer to the patient and by doing so decreasing reliance on acute hospital care.
- Aim is to shift 5% of resources currently invested in secondary care to primary care with the workload.

The primary care development programme would operate using a variety of different training approaches including - peer-to-peer and specialist-led programmes; formal learning events; clinical protocols and practice-based audits – to achieve targeted improvement in the following areas included in the Integrated Plan:

- Early identification and accurate diagnosis of long-term and other priority high prevalence conditions
- Enhanced ability to manage long term conditions, to avoid hospital referral and support better patient outcomes
- Medicines management knowledge in order to provide quality, cost-effective prescribing and support
- Management of patients in primary care where part of an agreed pathway/shared protocol
- Good understanding of agreed local pathways and local service configuration to enable referrals to be made to the right service for each patient's needs, at the right time

Practice staff training will focus on our strategic priority areas, which include long-term conditions (diabetes, respiratory and CVD) mental health (including dementia care) and planned care aimed at supporting a shift of care setting in specialities like dermatology and ophthalmology.

The scope of the development programme would not include formal GP training, nor is it intended to replace the CPPD programme. The programme is designed to be complementary to other training resources for primary care staff and will operate in alignment with formal training programmes. We would ensure that the wider training and workforce issues emerging from our Strategic Framework and this Integrated Plan are reflected in training plans over the next five years and beyond.

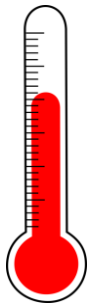
1.14.2 Primary care vision in CCG

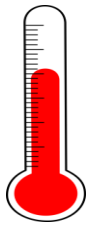
Our CCG vision for primary (and community care) is providing easy access to high quality, responsive primary & community care as the first point of call for people in order to provide a universal service for the whole population and to proactively support people in staying healthy.
The aim is to increase the proportion of episodes of morbidity that are commenced and completed in primary care without recourse to the acute services. Core aspirations linked to emerging Primary Care strategy and local strategic plans are set out in table below.

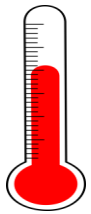
	Headline Aspirations	**Month / Year Complete**
	Core Primary Care Strategy Aspirations supported by our CCG	
1.	Make full use of premises. Endeavour to ensure that any void primary care estate is fully utilised	Dec 14
2.	Encourage Individual GP practices to move towards having a minimum list size of 4,500 patients serviced by the equivalent of 2.5WTE GPs and/or develop close associations with neighbouring practices to share skilled resources.	Mar 16
3.	CPR would support Primary Care Strategy aim to increase number of GPs working in CP&R through the establishment of more training practices and enhanced roles within hubs/localities that attract professionals	Linked to Strategy
4	CPR would support Primary Care Strategy aim to increase number of nurses working in CP&R through the enhancement of nurse practitioner training and enhanced roles within hubs supported by LETB	Linked to Strategy
5.	As per above initiatives to increase quality and reduce variability we will be working with our practices who are currently unable to evidence they are delivering high quality care in line with CQC standards to avoid the risk of potential decommissioned.	Ongoing
6.	Increase the % of CPR GPs using text messaging service to remind patients of their appointments	Apr 15
7.	CPR GP practices aim to create Federated structure forming a virtual hub covering CCG population	Apr 15
8.	CPR has arrangements in place with community provider to ensure HV/District Nurses are aligned to individual practices.	Jan 14
9.	10% shift of activity alongside 5% in resources from acute to primary care.	Apr 18
10.	CPR patients with LTC to have a named clinician/managed by a specialist within a hub or hub created as specialist practice for patients with LTC.	Apr 15
11.	Commuter clinics provided by GP practices / within a hub / hub delivering clinics in evenings and at weekends.	Apr 15
12.	The CCG will support AT initiative that will undertake triage, diagnosis and treatment of minor illness in a pharmacy setting / write prescriptions for a limited list of medications from pharmacy or as part of primary care team in general practice / fully integrated into primary care team delivering consultations, prescribing, immunisations	Apr 15
13.	Pharmacists take on a greater role in managing supplies of repeat medicines enabled by batch prescribing and electronic prescriptions / pharmacists will request or carry out appropriate routine monitoring e.g. blood tests and be able to re-authorise repeat medicines. This will be integrated with face to face discussions with the patient about their medicines / A holistic patient centred medicines service focussed on patient wellbeing, enablement and joint decision making, working closely with the patients GP.	Apr 15
14.	Pharmacists managing straightforward conditions such as allergic rhinitis, hayfever, dry and itchy skin / management of long term conditions such as asthma or chronic pain, in the pharmacy, linked to and supported by GP hubs / specialist pharmacists will be employed within hubs to be part of specialist teams caring for patients with LTC.	Jan 14

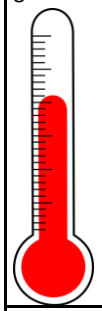
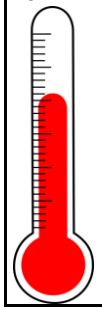
	CPR Specific Aspirations	
15.	CCG Innovation Group agrees approach to reducing variation, including training and development plans, access and productivity initiatives	Dec 14
16.	Secure support to deliver training programme and agree future priorities and funding	Jun 15
17.	Plan and deliver a programme of Practice Visit to present emerging CCG Strategic and Operational Plans so Practices clearly understand their role and responsibility in delivery	Jun 14
18.	Agree and support individual practice to operationalise their development plans	Ongoing
19.	Working with Better Care Fund Programme implement a plan to address gaps in supporting self-management in Long term conditions such as local Diabetes Integration initiative	Apr 15
20.	Further develop risk stratification, linking to Better Care Programme work, care-co-ordination and Community Multi-Disciplinary Team development.	Apr 15
21.	Continue to develop referral support services in particular peer review	Apr 14
22.	Develop diagnostics strategy and implementation programme	Dec 14

2 NHS CONSTITUTION

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
1 	RTT Despite meeting the national standards for admitted and non-admitted in Q3 (unvalidated) SUHFT continue to underperformance in a number of specialties and a recovery plan is in place to address this.	Admitted = 86.10% Non-Admitted = 95.10% Incompletes = 52+ week waits = 0 (Dec 2013)	Admitted = 90% Non-Admitted =95% Incompletes = 92% 52+ week waits = 0	Continue to monitor progress at weekly performance meetings with SUHFT and support host CCG in respect of raising contract queries as required. Speciality level areas currently underperforming: • General Surgery • T&O • Urology • ENT • Oral Surgery Significant issues identified relating to the roll out of the new PAS system and the impact on the Trust's RTT backlog and contract notice raised.	VG	TBC
2 	Diagnostic Waits - Percentage of patients who have waited less than 6 weeks for a diagnostic test	99%	99%	Continue to monitor performance through CQRG.	MA	Ongoing

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
3 	A&E - Percentage of people who have been admitted, transferred or discharged within 4 hours of their arrival at an A&E department	As at 31.01.14 YTD = 93.65 Q1 = 91.04% Q2 = 96.54% Q3 = 94.21% Q4 = 91.14%	95%	• Continue to monitor progress against the Recovery Action Plan at weekly performance meetings with SUHFT and support host CCG in respect of raising contract queries as required. • Implementation of A&E CQUIN to ensure that cancer patients are seen in a more appropriate environment e.g. CAU • Contract notice raised.	KMK	March 2015
4 	Number of people who have had to wait for longer than 12 hours following a decision to admit them in A&E.	0	0	Continue to monitor through weekly performance meetings with the Trust. A&E Recovery Plan in place and Urgent Care Network monitoring progress against the plan as a system.	KMK	Mar 15
5.1 	Cancer waits 2 week waits (patients referred urgently with suspected cancer by a GP) 2 week waits (patients referred urgently with breast symptoms (where cancer was not initially suspected)	 96.9% (Nov 13) 97.8%	 93% 93%	Continue to monitor through weekly performance meetings with the Trust. Regular review of Patient Tracking Lists and early identification of issues arising at Trusts and in Primary Care for resolution. Inter-Trust Cancer Policy developed but not yet agreed. Host CCGs for SUHFT and BTUH working with the Trusts to resolve this.	KMK	Mar 15
5.2 	31 day (wait from diagnosis to first definitive treatment for all cancers) 31 day (wait for subsequent treatment where that treatment is surgery) 31 day (wait for subsequent treatment where that treatment is an anti-cancer drug regimen) 31 day (wait for subsequent treatment where the treatment is a course of radiotherapy)	100% (Nov 13) 94.4% (Nov 13) 100% (Nov 13) 96.2% (Nov 13)	96% 94% 98% 94%	As above	KMK	Mar 15

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
5.3 	62 day (wait from urgent GP referral) 62 day (wait from referral an NHS screening service) 62 day (wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient)	88.1% (Nov 13) 100% (Nov 13) 100% (Nov 13)	85% 90% No operational standard set	Ensure full implementation of the Cancer Waits recovery plan. Performance as at Q3 is showing all cancer waiting time standards achieved at SUHFT. Inter Trust Policy singed between BTUH and SUHFT. Discussions around localisation of site specific "Timed pathways" implemented in Anglia.	KMK TA/MC	March 2014
6 	Category A calls for an ambulance resulting in an emergency response within 8 minutes (R1 / R2) and ambulance arriving in 19 minutes	As at November 2013 Red 1 = 70.37% Red 2 = 61.45% 19 minutes = 98%	Red 1 = 75% Red 2 = 75% 19 minutes = 95%	The concerns around East of England Ambulance Trust's performance have been escalated and support is being provided to the Trust collaboratively to address these issues. Discussions are currently focussing on capacity and recruitment issues and the six key priority areas for EEAST to provide a safe and high quality service are noted below: • EEAST six key priorities to provide a safe and high quality clinical service: • Recruit 400 student paramedics in 2014/15 • Up skill Trust ECA's to Technicians and Technicians to Paramedics • Maximise clinical staff on front line vehicles • Reduce response cars and increase Ambulances • Accelerate fleet and equipment replacement programme • Re-invest corporate spend into front line delivery	EH	March 2014
7 	Number of people who breach mixed sex accommodation requirements	0	0	Governance process in place via the monthly Provider update for the CCG Quality report which goes to the CCG Quality and Governance Committee, Locality Commissioning Groups and the CCG Governing Body meetings. Schedule of planned and unplanned visits in place to monitor compliance.	TD	March 15

	Performance Measure	2013/14 Baseline	2014/15 Standard	Action Required	Lead	Deadline
8 	Cancelled Operations - Number of patients who are not offered another binding date within 28 days > 0	38 YTD as at Dec 13	100% patients to be offered another binding date within 28 days No urgent ops cancelled for the 2nd time		EH	March 2015
9 	The proportion of people under adult mental illness services on CPA who were followed up within 7 days of discharge from inpatient care.		95%	Improving CPA quality standards by addressing care planning and management process weaknesses especially S117.	JI	Mar 2015
10 	Percentage of ambulance handovers completed by 15 minutes of arrival and to be ready to accept a new call by 30 minutes of arrival	No. of handovers >15 minutes = 4178 YTD Of which >30 = 916 YTD	15m: 100% 30m: 100%		EH	March 2015

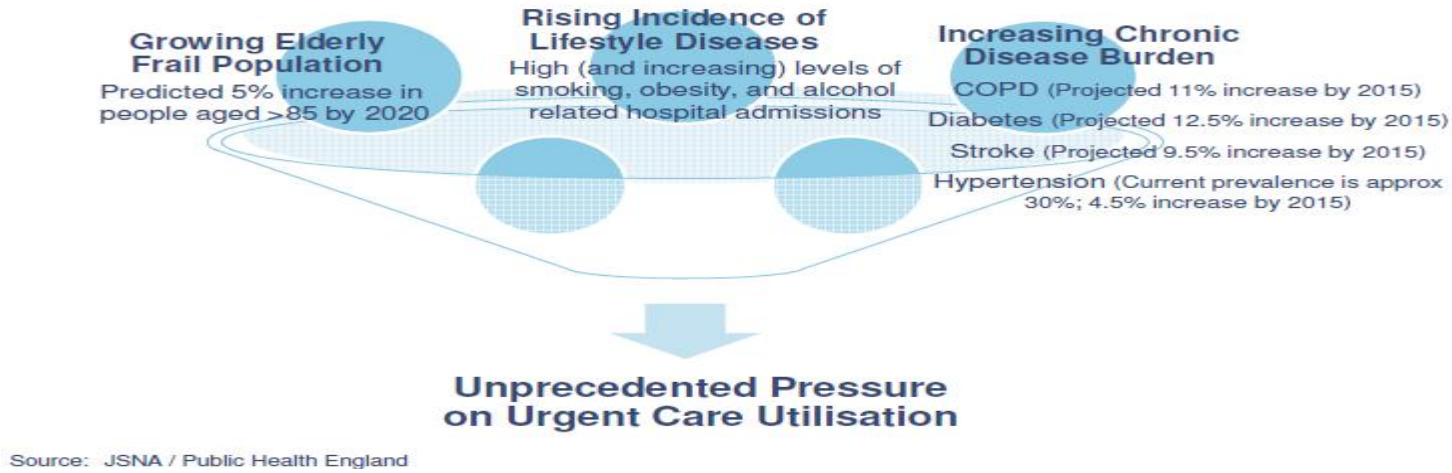
2.1 URGENT CARE

South East Essex Urgent Care System Headlines

- We are a mature and historically well performing health system serving a population of more than 345K
- Current emergency admissions are draining considerable resources. We have recently encountered performance issues which we are addressing aggressively in partnership with SUHFT
- Our efforts have gained traction but we are very mindful of the medium and long term risks we face given our aging population, and the increasing incidence of lifestyle and chronic disease burden
- In order to tackle this critical agenda, we need to ensure that:
    - We deal with problems in non-urgent components of the health and social system which are creating excessive demand for urgent care
    - Reduce clinical practice variation
    - Improve methods of mainstreaming protocols
    - Add capabilities to deliver timely data reporting and insights to support effective decision making
    - Improve whole system engagement and planning

Looking Ahead

We are very mindful of the medium and long term risks we face given our aging population, and increasing incidence of lifestyle and chronic disease burden.



Source: JSNA / Public Health England

The Future of Urgent Care Services in South East Essex

The challenges facing our urgent and emergency care system in South East Essex are clear, as are the opportunities for improvement. Castle Point and Rochford CCG in partnership with Southend CCG will take action. Our plan sets out our key areas of focus for the future of urgent and emergency care services in South East Essex. Based on guidance, there are five key elements, summarised below, which Castle Point and Rochford CCG intend to take forward in collaboration to ensure success:

1. **Firstly, we will provide better support for people to self- care**. To achieve this, we will need to provide better and more easily accessible information about self-treatment options so that people who prefer to can avoid the need to see a healthcare professional. We will also need to accelerate the development of comprehensive and standardised care planning, so that important information about a patient's conditions, their values and future wishes are known to relevant healthcare professionals. This way, patients will be better supported to deal with that condition before it deteriorates, or if additional help is required.

2. **Secondly, we will help people with urgent care needs to get the right advice in the right place, first time**. To achieve this, we will greatly enhance CPR CCG hosted South Essex NHS 111 service so that it becomes the smart call to make, creating a 24 hour, personalised priority contact service. This enhanced service will have knowledge about people's medical problems, and allow them to speak directly to a nurse, doctor or other healthcare professional if that is the most appropriate way to provide the help and advice they need. It will also be able to directly book a call back from, or an appointment with, a GP or at whichever urgent or emergency care facility can best deal with the problem.

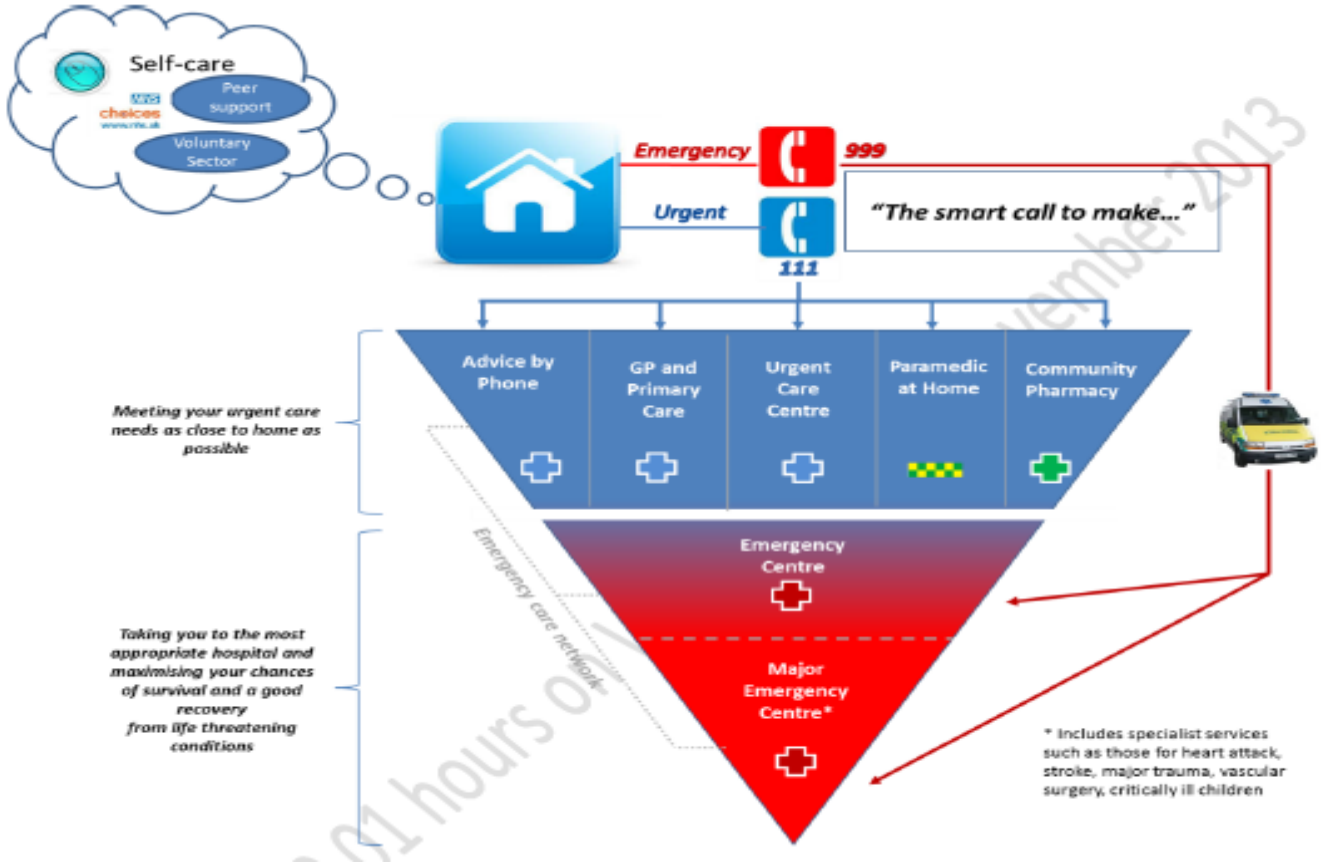
3. **Thirdly, we will provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E.** This will mean providing faster and consistent same-day, every-day access to general practitioners, primary care and community services such as local mental health teams and community nurses for patients with urgent care needs. It will also mean harnessing the skills, experience and accessibility of a range of healthcare professionals including community pharmacists and ambulance paramedics. We will work with our Ambulance service to ensure the extension of paramedic training and skills, and supporting them with GPs and specialists, we will develop our 999 ambulances into mobile urgent treatment services capable of dealing with more people at scene, and avoiding unnecessary journeys to hospital.

4. **Fourthly, we will ensure that those people with more serious or life threatening emergency care needs receive treatment in centres with the right facilities and expertise in order to maximise chances of survival and a good recovery.** Once we have enhanced urgent care services outside hospital, in line with national guidance we will introduce the two levels of hospital emergency department – Emergency Centre and Major Emergency Centre. In time, these will replace the inconsistent levels of service provided by our A&E Department. The presence of senior clinicians seven days a week will be important for ensuring the best decisions are taken, reassuring patients and families and making best use of NHS resources. Emergency Centres will be capable of assessing and initiating treatment for all patients and safely transferring them when necessary. Major Emergency Centres will be much larger unit, capable of not just assessing and initiating treatment for all patients but providing a range of highly specialist services. This centre will have consistent levels of

senior staffing and access to the specialist equipment and expertise needed to deliver the very best outcomes for patients. We envisage there being a Major Emergency Centres in South East Essex.

5. **Fifthly, we will connect all urgent and emergency care services together so the overall system becomes more than just the sum of its parts.** Building on the success of major trauma networks, we will support the emergency care network in South East Essex. The network will dissolve traditional boundaries between our hospital and community based services and support the free flow of information and specialist expertise needed to achieve the delivery of patient care in the most appropriate and convenient setting. The Major Emergency Centres will have a lead responsibility for the quality of care and operational performance of services across the network they support, including linked Emergency Centres. The network will also support the introduction of an efficient critical care transfer and retrieval system so that patients requiring specialist help reach the best possible facility in a timely fashion.

The Proposed Design and Look of New System *(ref NHS England)*



Urgent Care System Emerging Action Plan for 2014/15

We anticipate that it will take 3-5 years to enact the major transformational change set out within this plan. However, we expect to make significant progress over the next 6-12 months:

There were a number of successful actions and initiatives taken during the winter period of 2013/14 which demonstrate the commitment from all partners to deliver a sustainable urgent care system for the population of South Essex. These successes will be embedded into business as usual and built upon as we move into the next phase of change.

- Distinct shift in approach to a system that is working effectively in partnership with improved communication and transparency. Issues seen as being owned by the system, not by one organisation/department
- Dedicated medical outlier ward with robust medical input maintained efficient discharge and reduced length of stay.
- Significant operational improvements to SPOR resulting in increased usage by GPs
- Increased use of admission avoidance and community pathways by EEAST ambulance crews, reducing conveyance rate to A&E
- Increased reablement capacity and implementation of 'holding' care packages
- Social care becoming integrated with hospital teams, and extension to Sunday working.

Following a system wide review in February 2013, a number of key areas of focus were agreed with partners. These are in the process of being fully developed and agreed through the Urgent Care Steering Group. An indicative plan is outlined below, this is subject to further detailed discussions and approval.

This plan reflects the system wide learning and outcomes from the 13/14 winter surge period, with all system partners engaged in the vision and delivery of the emerging action plan. The action plan will be overseen by the Urgent Care Steering Group which will refocus from operational delivery to sustainable transformation and change management.

It is anticipated that a number of these initiative may require non-recurrent investment as the system transfers focus towards the earlier stages of a patients pathway.

Action	Description	Owner	Timescale
Use of Winter Monies	Review of outcomes for each initiative to determine short term success and inform longer term planning	Yvonne Campen (Southend CCG)	March 2014
Non-Emergency Patient Transport	Full review of service to support same day access and discharge processes	Emily Hughes	May 2014
	Short term solutions implemented to support system	Emily Hughes	August 2014
	Service redesign and potential recommissioning/procurement	Emily Hughes	December 2014
Intermediate Care Beds	Reprovision of community based step up and step down model	Liz Paddison (CP&R CCG) and Yvonne Campen (Southend CCG)	September 2014
A&E Recruitment Programme		SUHFT	
Feedback on Poor Discharges	Improved processes to allow timely feedback to enable swift learning and actions to be taken	Amanda Yeates (SEPT)	March 2014
Care Homes	Implementation of new model and pathways to support admission avoidance in nursing and residential homes	Liz Paddison (CP&R CCG) and Yvonne Campen (Southend CCG)	June 2014
Integrated Community Teams	Clarity regarding services available to support the system	Amanda Yeates (SEPT)	March 2014
Continuing Health Care (including Fast Track)		Matt Gillam	August 2014
Primary Care	• Options regarding 7 day working • Messaging from Practices to Patients • GP Admissions Pathways • Education of locums re: community pathways/admission avoidance schemes • Impact of 'batching' of GP admissions	NHS England (Ian Ross) in partnership with CCGs	

Action	Description	Owner	Timescale
Consultant Triage of GP admissions	All GP admissions to be triaged by a consultant, initiative supported by CQUIN scheme	SUHFT	September 2014
System Dashboard	Development of system wide 'live' dashboard to enable swift action and predictive modelling	Yvonne Campen (Southend CCG)	July 2014
Frail Elderly Ambulatory Care	Further development and implementation of Frail Elderly Ambulatory Care model and associated pathways, including: • Redesign of Community Geriatrician service • 'Front End' Pathways within Acute • Expansion of SPOR and DAU	Liz Paddison (CP&R CCG) and Yvonne Campen (Southend CCG)	October 2014
NHS 111	Increase awareness and usage of successful NHS 111 service as the 'first point of call' for urgent care	Emily Hughes	September 2014
7 day Working	Initiating local initiatives (demonstrator site) to trial new models of delivery for 7 day services supported by NHS Improving Quality	Yvonne Campen	
Consultant review in A&E	Early specialist review of patients		
A&E - Front Door	Continued redesign of access and pathways through A&E, consideration of primary care model.		

Measures of success of the above action plan will include:

- Sustained achievement of the A&E 4 hour target
- Reduction in medical outliers during surge periods
- Reduction in emergency admissions for Frail Elderly
- Increased activity of NHS 111
- Reduction in CHC Fast Track applications, to be comparable with peers
- Reduced use of 'ad hoc' patient transport

3.1 ACTIVITY

	Activity	Area	2013/14 Baseline	Growth (2.4%)	QIPP	Plan	Action Required	Lead	Deadline
1	Elective FFCEs	Ordinary	5231	5356	-	5356	Explore opportunities for re-modelling MSK pathways across the system, to reduce specialist activity whilst improving patient outcomes and experience.	EH	Sept 2014
		Daycase	21782	22304	-	22304	Develop bundled pathway for cataracts.		
							Reviewing and updating SRP to reflect latest guidance.	EH	May 2014
								EH	April 2014
2	Non elective FFCEs	Non-elective	15522	15895	- 1795 *Urology* *- 225* *Int care* *- 468* *DAU* *-969* *CAU* *-97* *Care Homes* *-36*	14100	Introduction of new catheter care pathway.	EH	April 2014
							Commission community based intermediate care beds.	EH	Sept 2014
							Redesign DAU to offer same day access to complex geriatric assessment to avoid onward admission into the hospital.	EH	April 2014
							Commission dedicated Cancer Assessment Unit .	EH	April 2014
							Provide additional resource and support to practices in relation to managing patients in care homes.	EH	April 2014

	Activity	Area	2013/14 Baseline	Growth (2.4%)	QIPP	Plan	Action Required	Lead	Deadline
3	Outpatient attendances	All Firsts	51582	52820			Explore opportunities for re-modelling MSK pathways across the system, to reduce specialist activity whilst improving patient outcomes and experience. Develop bundled pathway for cataracts. Reviewing and updating SRP to reflect latest guidance. Continued improvement in outlying areas of GP referral management.	EH EH EH EH	Sept 2014 May 2014 April 2014 April 2014
		All Subsequents	121792	124715	-2100 (glaucoma)	122615	Implementation of stable glaucoma pathway.	EH	June 2014
4	A&E attendances	Type 1	43908	44962	-1278		Attendances avoided through communications and marketing campaign to redirect patients from A&E via NHS 111 onto alternative services.	EH	April 2014
		All attendances	45336	46424	-880 (NHS 111) -398 (A&E impact of Admission Avoidance Schemes)				
5	Referrals	GP Referrals	40391	41360	As above	As above	See outpatients above	EH	As above
		Other Referrals	20222	20454	As above	As above			
		First Op following GP Referral	32924	33302		33302			

3.2 QIPP PLANS 2014/15

3.2.1 Overview

QIPP management is a critical component of our CCG operational arrangements and is considered as part all CCG decision-making. Core themes across our QIPP planning are:

- the development of integrated commissioning in partnership with the Local Authority and neighbouring CCGs;
- clinical ownership and leadership across our localities and member practices, and
- our commitment to improving community health care to reduce reliance on acute services.

The QIPP plans for 2014-15 are still in development as part of the 2014/15 planning round. To support this, the CCG will employ a QIPP lead to work with the project leads and stakeholders to develop robust, deliverable plans. In 2013/14 the CCG developed a robust QIPP activity and financial analysis process for our QIPP programme enabling both detailed planning and strong monitoring processes, supported by key members of the Business Intelligence and Contracting team of the CSU.

The CCG continues to work with local stakeholders to develop QIPP schemes to address the financial gap identified and has in place an clinically led Innovation Forum to generate new ideas, led by the Clinical Accountable Officer.

3.2.2 QIPP Monitoring and Delivery

Delivery of our CCG QIPP plans requires a strong Programme Management Office (PMO) function. The CCG is currently reviewing our PMO arrangements for next year and will confirm these arrangements shortly. Fundamentally the following components will be intrinsic to our consolidated PMO arrangements:

- A member of the CCG Executive will oversee each scheme in order to ensure milestones are met and any blocks to delivery are quickly addressed.
- All schemes will have a detailed project plan with measureable milestones.
- The QIPP schemes will be reviewed at regular intervals with each of the programme leads and then by exception at a monthly QIPP meeting.
- The GP leads and their commissioning managers will be held to account for delivery by our CCG Finance and Performance Committee if scheme slippage occurs.
- QIPP delivery will be reviewed by our Governing Body as part of the monthly finance reporting.
- QIPP will be visible and owned by all areas/localities within the CCG and will be subject to both high level and operational scrutiny within the CCG.
- The attached QIPP checklist evidences how well the PMO processes for QIPP will be embedded within the CCG.

3.2.3 QIPP Plans and Impact

As identified in Finance Plan section the CCG has an £8.4 million funding gap /QIPP challenge for 2014/15. The QIPP plans for 2014-15 are still in development as part of the 2014/15 planning round. The table below details the QIPP schemes for 2014/15. We are confident of meeting our 2014/15 QIPP challenge and we have identified the work streams and services line savings we will be aggressively pursuing to ensure we deliver our financial statutory obligations.

There are three tables below set out how we intend to deliver our QIPP challenge, namely: (a) Legacy Schemes impacting on 2014/15 (b) New schemes in advanced planning/scoping and (c) Remaining Service Lines /workstreams and target savings for each

Summary

Funding Gap/QIPP Target	-8,400,000
Legacy 13/14	929,184
New QIPP Scoped	2,647,415
New QIPP Service Lines targeted for savings	5,214,234
Contingency	**390,833**

It should be noted that all QIPP schemes are currently being rebased to reflect latest delivery and activity profiles and to align with the contract model principles.

The activity implications of QIPP schemes are being reflected in the contract activity models.

(a) 2013/14 Legacy Schemes (impacting on 2014/15

A number of legacy schemes implemented in 2013/14 will deliver an incremental saving in 2014/15. These 'legacy' schemes are fully implemented and require minimal resourcing to monitor.

Workstream	Scheme	Scope	GB Clinical Lead	14/15 Planned Saving (CP&R)*
Legacy Planned Care	Dermatology	CP&R	Dr Siddiqui	£17,215
	Repatriation	CP&R	Vacancy	£21,368
	BPH – Decommissioning	CP&R	Dr Turner	£7,200
Legacy Unplanned Care	DVT	CP&R	Dr Siddiqui	£8,000
	Urology / TWOC	South East Essex	Dr Saad	£117,619
	Minor Injuries	CP&R	Dr Gardiner	£2,340
	NHS 111	South Essex	Dr Gardiner	£73,589
	DAU	South East Essex	Dr Mike Saad	£308,533
	Respiratory	South East Essex	Dr Taylor	£161,320
	SHAARC	CP&R	Dr Gardiner	£212,000
			Total	**£ 929,184**

**subject to rebasing*

(b) 2014/15 QIPP Workstreams - Scoped

Workstream	Scheme	Scope	GB Clinical Lead	14/15 Planned Saving (CP&R)*
New Planned Care	MSK	South East Essex	Dr Saad	TBC
	Ophthalmology	South Essex	Dr Taylor	77,000
	Community Contestability	South Essex	Dr Gupta	107,294
	Diabetes	South East Essex	Dr Kent	TBC
	PR Maintenance Programme	South East Essex	Dr Taylor	5,012
New Unplanned Care	Intermediate Care Beds	South East Essex	Dr Saad	226,718
	Cancer Assessment Unit	South East Essex	Dr Kuriakose	268,216
	Care Homes – Primary Care Federated Model	CP&R		TBC
	Falls	CP&R	Dr Gardiner	40,320
Medicines Management	Gastro Intestinal	South East Essex	Dr Taylor / Dr Grauri / Dr Lester	88,727
	Cario-vascular			293,521
	Respiratory			350,823
	CNS			371,490
	Endocrine			403,001
	Nutrition			310,151
Childrens	High Impact Pathways	CPR	Dr Siddiqui	14,399
	Lighthouse			87,500
	Child Death Review			3,243
	CAMHS Redesign			TBC
			TOTAL	**2,647,415**

(c) 2014/15 Area of Commissioning Spend targeted for QIPP savings

Area of Commissioning Spend targeted for QIPP savings	Budget Holders	QIPP Target
Mental Health Contracts	Kevin McKenny	-614,500
Child & Adolscent	Kevin McKenny	-45,600
Mental Health Other providers (e.g non NHS etc)	Kevin McKenny	-5,800
Acute - Southend Hospital	Kevin McKenny	-2,298,101
Acute – Other NHS	Kevin McKenny	-246,185
Acute – (Private & Other)	Emily Hughes	-185,960
Out of Hours/111	Emily Hughes	-45,791
Oxygen Services	Sunil Gupta	-45,791
Continuing Health Care - Adult	Tricia D'Orsi	-1,408,799
Continuing Health Care - Children	Kevin McKenny	-23,327
Funded Nursing Care	Tricia D'Orsi	-72,733
Community Services	Emily Hughes	-133,630
Hospices and Palliative Care	Kevin McKenny	-26,774
Non Acute Commissioning	Kevin McKenny	-37,888
Patient Transport	Emily Hughes	-23,355
	TOTAL	**-5,214,34**

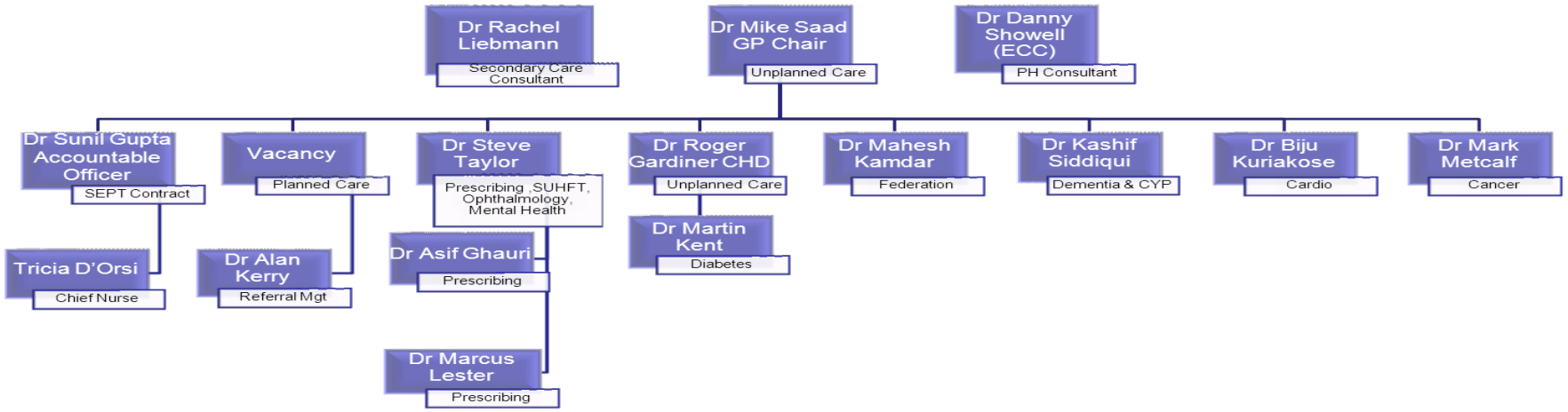
3.2.4 Further QIPP Ideas in Scoping

Our GP leads and member practices have identified a range of ideas that currently also being scoped. These include:

- Cellulitis Pathway
- Dietetics
- SALT (Dementia)
- Non-Emergency Patient Transport Services
- GP Home Visit Car covering localities
- Heart Failure -A work stream to bring about earlier diagnosis and better management of heart failure
- Atrial Fibrillation - A work stream to improve the detection of people who have Atrial Fibrillation.
- GP visits - A work stream to ensure patients who were in hospital due to an emergency admission and discharged on Thursday, Friday, Saturday or a Sunday are visited by a GP the day after they are discharged.
- Experience GP at front door A&E

3.2.4 CCG Clinical Leadership Structure

To ensure that all service redesign / QIPP schemes are clinically led, the CCG has identified clinical leads for all priority areas and CCG QIPP schemes.



4 BETTER CARE FUND

Overview

We are worked very closely with our partners to develop our plans for Better Care Fund (BCF) with Essex County Council, Southend CCG and Basildon and Brentwood CCG, alongside local providers. We have already agreed areas of joint work and are keen to develop new governance arrangements to oversee the implementation of these key programmes. Together Castle Point & Rochford CCG, Basildon and Brentwood CCG and Essex County Council are implementing the Better Care Fund agenda, aligned to key QIPP and JSNA priority areas for 2014/15. It is imperative that we develop our plans in collaboration with our colleagues in Southend CCG (our partners in our shared South East Essex system). Our shared priorities include:

- Focus on frail elderly across health and social care with particular focus given to admissions avoidance and reablement, and in particular in working to shift the balance of care in Castle Point & Rochford.
- Children and Young people's services including safeguarding.
- Mental Health and Learning Disabilities

Developing integrated Care through Better Care Fund is an important part of the CCG's approach to delivering its strategy. In 2013/14 SEE CCG commissioning teams have been working collaboratively on a programme of work focusing on Integrated Care that brings together all key providers and commissioners in the local health system, with focus on the development of integrated care and service models that reduce rising number of acute unplanned admissions across South Essex. Examples include: lead provider now contracted to deliver care using 'integrated team' specifications, and we have commissioning a Single Point of Referral (SPOR) shared health and social care telephone referral service for clinicians.

Our aim for BCF is to deliver sustainable integrated local health and social care models and services. It will being delivered through a partnership between Southend CCG, Castle Point & Rochford CCG, Basildon & Brentwood CCG acute and community providers, local GP practices and partners in Local Authorities. The aim of the programme is to jointly redesign the health and social care system and redefine the way professionals engage with each other around the assessed needs of individuals.

The BCF will fundamentally change the way in which people are supported in taking charge of their own care and conditions. The programme's initial focus, through integration with local authorities, is on caring for older people and its scope will be systematically broadened over the next four years (2014-18) – with Frail Elderly and Long Term Conditions being the focus the first phase of work.

The aim of the collaborative BCF (Integrated Care) Programme is to drive up the quality of care and drive down costs of providing it:

- improving the value of care we provide to local people by joining up care around people, across providers;

- identifying and managing people's care needs better and intervening earlier;

- ensuring care is provided in the most appropriate setting, particularly at times of acute crisis and by ensuring the right incentives exist for providers to work in integrated ways.

Our key objectives of the Better Care Fund (BCF) are:

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services.
- To move care closer to home so that our hospitals have manageable demand
- To work together to ensure people are supported to look after their health and wellbeing.
- To support providers to join up, share information, and make services easier to navigate
- To create an Integrated Commissioning Board or similar to align our work and have a single commissioning process

In 2015/16 the system will be led by a board of health and social care providers with an overarching integrated board structure. The board will work in partnership with clinical commissioners and be responsible for the shared delivery of care along agreed pathways.

During 2014/15 BCF work stream will develop:

- patient-based risk registers and increase reporting in GP practices,

- holistic health assessment (including mental health) and case management for older people through GP practices and
  Urgent access 'hot' geriatric outpatient clinics/Day Assessment Unit for rapid diagnosis of older people.

Metrics

There are a range of core and local metrics that are set out below alongside target levels of achievements at key (pay) point over the next 18 months

		Essex(Total of 5 x CCG & ECC)	CP&R CCG Baseline	CP&R CCG By April 2015	CP&R CCG By Oct 2015
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	583.0	565.0	N/A	503.1
	Numerator	1575	215		204
	Denominator	270160	38055		40600
		(April 2012 - March 2013)	(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	82%	82%	N/A	82%
	Numerator	692	133		169
	Denominator	844	163		207
		(April 2012 - March 2013)	(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	199.3	23.2	22.4	21.7
	Numerator	2212	32	31	30
	Denominator	1109834	138052	139500	140300
		2012-13 outturn		(April - December 2014)	(January - June 2015)
**Avoidable emergency admissions (composite measure)*	*Metric Value*	1674	1636	1635.2	1635.5
	Numerator	5296.4	603.1	612.2	617.1
	Denominator	316466	36864	37437	37731
		(TBC)			(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]					
		(insert time period)			*(insert time period)*
Additional Local Measure - Coverage of reablement	*Metric Value*	1451.0	1842.1	1874.4	2196.4
	Numerator	3920	701	744	892
	Denominator	270160	38055	39700	40600
		2012-13 data			*(insert time period)*

***Please note that these are initial speculative and subject to robust analysis and evaluation before the CCG can confirm that this is the metric we are prepared to measured against*

Financials Implications

We see the implementation of the BCF as a phased programme with 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure to provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

CP&R CCG and ECC are having productive discussions around the sums that should go into the integrated fund, both parties recognise that if we simply deposit the minimum amounts as allocated by DH then it is unlikely that there will be sufficient monies to bring about real transformation of our health and social care systems in Essex. So whilst we still have considerable work to do we are confident that we will collectively be contributing more to the pooled fund than the minimum amounts stipulated.

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for 2014/15 will be considerably different and smaller scale than those transferring in 2015/16. As we have established the size of the BCF will grow from 2014/15's allocation of £4.85M, which is mainly constructed from similar S256 amounts from 2013/14, to approximately £11.0 - £11.5M for 2015/16. Whilst we still have work to do and challenging conversations to have the table below sets out our initial assumptions:

Scheme identifier/Service name	Maximum	
Transfer of social care money	£	2,672,270.00
Reablement Monies	£	904,000.00
Social Care Uplift	£	749,728.00
Integrated Community Teams	£	3,367,013.01
Collaborative Care Team	£	243,037.74
SPOR (Health Element)	£	97,998.44
Intermediate Care Beds	£	350,000.00
Tissue Viability	£	43,414.20
Leg Ulcer	£	92,503.03
Stroke (Community Service)	£	159,950.53
Pressure Relieving Equipment	£	112,980.63
Continence	£	356,832.24
Dementia Intensive Support Team	£	70,118.09
Older People Community Mental Health Teams (inc. Assessment Service)	£	780,107.00
Older People Day Care (Mental Health)	£	169,584.00
Community Geriatricians	£	85,000.00
Wheelchair Services	£	305,600.38
Havens Hospice	£	410,688.80
Rosedale Rehab/Reablement Beds	£	130,314.50
Rosedale Therapy Input	£	154,332.00
Occupational Therapy	£	217,503.57
CAVS Befriending Service	£	18,500.00
Carers	£	50,000.00
Totals	**£**	**11,541,476.16**

Scheme identifier/Service name	Minimum	
Transfer of social care money	£	2,672,270.00
Reablement Monies	£	904,000.00
Social Care Uplift	£	749,728.00
Integrated Community Teams	£	3,367,013.01
Collaborative Care Team	£	243,037.74
SPOR (Health Element)	£	97,998.44
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Rosedale Therapy Input	£	154,332.00
Occupational Therapy	£	217,503.57
CAVS Befriending Service	£	18,500.00
Carers	£	50,000.00
Totals	**£**	**11,096,358.07**

5 LOCAL MEASURES

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline 2013/14	Target 2014/15	Action	Deadline
Local Measures	Quality Premium	Reduction in people with dementia taking anti-psychotic medication	8.1% reduction in people with dementia taking anti-psychotic medication by March 2014 (*12.5% of Quality Premium)*	1625	2442	Build on existing medicines management QIPP scheme relating to reduction in anti-psychotic medication in people with dementia.	April 2013
		Reduction in emergency admissions from care homes	7.1% reduction in emergency admissions from care homes by March 2014 *(12.5% of Quality Premium)*			Implement care homes QIPP scheme GP Federation to submit bid to secure funding through £50M Primary Care Challenge Fund to pilot GP dedicated cover Care Homes Pilot scheme funded through winter monies targeting care homes with highest use of urgent care resources.	April 2013
		Reduction in first appointments for acute dermatology services	20% reduction in first appointments for acute dermatology services *(12.5% of Quality Premium)*			Implement Dermatology QIPP scheme	April 2013
	Primary Care Strategy	Individual GP practices will move towards having a minimum list size of 4,500 patients serviced by the equivalent of 2.5WTE GPs	Quality Indicator still to be defined for CPR CCG	TBC	TBC	Some of our single-handed practices may find it difficult to meet the growing demands of general practice and we wish to support them to work as part of an integrated health care team, through federation, where the practice and its patient participation group agree this is the right model for them.	April 2015
		Number of GPs working in CP&R will increase through the establishment of more training practices and enhanced roles within hubs that attract professionals	Quality Indicator for the number of increased training practices still to be defined for CPR CCG	TBC	TBC	Working with NHSE identify opportunities for additional training practice in CPR CCG	April 2015

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline	Target	Action	Deadline
Local Measures	Primary Care Strategy	Number of nurses working in CP&R will increase through the enhancement of nurse practitioner training and enhanced roles within hubs	Quality Indicator for the number of increase enhancement of nurse training practitioner still to be defined for CPR CCG Ultimately, model will see • Nurse Practitioners taking on increased roles and operating from every hub • Nurse Practitioners managing lists of patients with GP support • Nurse practitioners operating from within hubs	TBC	TBC	Working with NHSE identify opportunities enhanced nurse training in CPR CCG	April 2015
		Practices who are unable to evidence they are delivering high quality care will be decommissioned and patients will be distributed to practices operating in the defined hub.	No CPR practices identified as being unable to evidence they are delivering high quality care	TBC	Nil	• In partnership with NHSE identify if any CPR Practices are operating below standard • CPR Practices identified as being unable to evidence that they are delivering high quality care will be to supported by CCG to improve in the first instance • Through access to training and education programme, support for the QOF and support for individual practices experiencing difficulty we will ensure that we continue to improve services for patients.	April 2015 Sept 2015
		Increase the % of GPs using text messaging service to remind patients of their appointments	Increase the % of CPR GPs using text messaging service to remind patients of their appointments	TBC	100%	• Using Locality Group engagement to support and encourage practices to introduce and use text messaging service that already available on primary care systems (SystemOne)	April 2015
		GP practices Federated forming a virtual hub covering populations of between 20,000 and 70,000 or GP practices merging forming a legal hub covering populations of between 20,000 and 70,000	By 1st April 2014 it is anticipated that there will be one federation in CPR with approx. 14 practices serving circa 80,000 population By 1st April 2015 it anticipated that CPR will have one large (170,000) federation.	Nil federation	Single federation	• CCG will promote the 'federation' model of general practice	April 2014

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline 2013/14	Target 2014/15	Action	Deadline
		Integrated Nursing Hub aligned to individual practices/hubs	Creation of 4 Hubs across CPR	Nil Hubs	4 Hubs	• Working with NHSE the CCG will To facilitate the establishment of hubs and the delivery of consistent high quality primary care services	April 2015
		% shift from acute to primary care.	CPR aspires to see a shift of up to 5% in resources from hospital providers into primary care over next 5 years equating to a transfer of £10m within the SEE system (£5M for CPR)		5% shift	• We will optimise the use of existing primary care estates • We will work to minimise or eliminate empty space and "void" costs and close premises that are not up to standard • We will work with health and wider partners to optimise use of all publically owned (or leased) estate. • Deliver BCF and system plans for reducing elective and non-elective care at acute trust	

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline	Target	Action	Deadline
Local Measures	Primary Care Strategy	Patients with LTC to have a named clinician/managed by a specialist within a hub or hub created as specialist practice for patients with LTC.	To be developed alongside Primary Care Strategy	TBC	TBC		
		Commuter clinics provided by GP practices / within a hub/hub delivering clinics in evenings and at weekends.	To be developed alongside Primary Care Strategy	TBC	TBC		
		Undertake triage, diagnosis and treatment of minor illness in a pharmacy setting / write prescriptions for a limited list of medications from pharmacy or as part of primary care team in general practice / fully integrated into primary care team delivering consultations, prescribing, immunisations	To be developed alongside Primary Care Strategy	TBC	TBC		
		Pharmacists take on a greater role in managing supplies of repeat medicines enabled by batch prescribing and electronic prescriptions / pharmacists will request or carry out appropriate routine monitoring e.g. blood tests and be able to re-authorise repeat medicines. This will be integrated with face to face discussions with the patient about their medicines / A holistic patient centred medicines service focussed on patient wellbeing, enablement and joint decision making, working closely with the patients GP.	To be developed alongside Primary Care Strategy	TBC	TBC		

Outcome Framework Domain	Outcome Framework Improvement Area	Castle Point and Rochford CCG Priority	Quality Indicator	Baseline	Target	Action	Deadline
Local Measures	Primary Care Strategy	Pharmacists managing straightforward conditions such as allergic rhinitis, hayfever, dry and itchy skin / management of long term conditions such as asthma or chronic pain, in the pharmacy, linked to and supported by GP hubs / specialist pharmacists will be employed within hubs to be part of specialist teams caring for patients with LTC.	To be developed alongside Primary Care Strategy	TBC	TBC		
		Establish local primary care network to facilitate integrated working.	To be developed alongside Primary Care Strategy	TBC	TBC		

6.1 SPECIALISED SERVICES

As part of *A Call to Action,* NHS Castle Point and Rochford CCG is to participate in a systematic market review of all services to ensure that the right capacity is available, consolidating services where appropriate, to address clinical or financial sustainability issues.

The CCG has agreed that Basildon and Brentwood CCG is to lead the scoping exercise to review current models of care locally and the potential for developing specialist centres of expertise.

The scoping exercise is to review all appropriate areas prioritising:

- Stroke
- Paediatrics
- Vascular
- Renal
- Cancer

The timeframe for the initial scoping exercise has been identified as May 2014 and the CCG will provide clinical and non clinical support to the lead CCG in this process.

6.2 PUBLIC HEALTH

The CCG will continue to support NHS England Essex Area Team to implement the following ambitions in 2014/15:

- roll out of the Family Nurse Partnership and the Health Visitor Programmes;
- a revised specification for Pneumococcal Vaccination;
- introduction of HPV testing in women with mild/borderline changes in their cervical screening;
- bowel and diabetic eye screening;
- extension of the bowel screening programme for men and women up to 75;
- a minor change to the service specification for seasonal flu;
- a meningitis C catch up programme for university entrants;
- continuation of a time limited MMR campaign for people over 16 and a catch-up campaign for teenagers;
- continuation of the temporary programme for pertussis for pregnant women;
- implementation of DNA testing for sickle cell and thalassemia screening;
- a shingles catch up programme planned for 71-79 year olds, starting with 78 and 79 year olds; and
- a number of developments for Sexual Assault Referral Centres to develop the service and make it more equitable.

6.3 ARMED FORCES COVENANT

The Armed Forces Covenant Commitment sets out the relationship between the national, the state and the armed forces. It recognised that the whole nation has a moral obligation to members of the armed forces and their families and it establishes how they should expect to be treated.

The CCG's identified lead to support the delivery of the Armed Forces Covenant is Kevin McKenny, Chief Operating Officer. Although the CCG does not have any military bases in the locality, it is recognised that the military and veteran community may well be registered with GP practices in south Essex and will be accessing services through providers. To that end, it is recognised that there is a need to build strong mechanisms within services commissioned to ensure access routes into mental health and other health services are available.

- Ensure NHS employers are supportive towards those staff who volunteer for reserve duties.
- Ensure primary care is provided with information and signposting for military and veterans who access services
- To ensure veterans‟ prosthetic needs are met.

We will continue to work with South Essex University Partnership NHS Foundation Trust to implement a plan for managing military and veterans cases referred by GPs or other agencies, this plan will include:

- Follow-up protocols for regulars and reserves leaving the forces.
- Access arrangements for crisis services
- Specification of outreach and early intervention services.

6.4 SERVICES FOR PEOPLE IN THE JUSTICE SYSTEM

NHS Castle Point and Rochford CCG will continue to support our stakeholders in the delivery of the following key priorities for 2014/15:

- to ensure that commissioning is informed by an up-to-date health needs assessment, taking account of the reconfiguration of the custodial estate, including the creation of Resettlement Prisons;
- to support sustainable recovery from addiction to drugs and alcohol and improved mental health services;
- promotion of continuity of care from custody to community and between establishments, working closely with Probation Services, Local Authorities and CCGs;
- development of a full understanding of the healthcare needs of children and young people accommodated in the secure estate and work collaboratively to commission services to meet these needs;
- continued close collaboration with our partners in the successful implementation of the Liaison and Diversion Programme; and
- to ensure timely and effective transition of commissioning responsibility for healthcare in immigration and removal centres.

Mid Essex Clinical Commissioning Group

OPERATIONAL PLAN 2014-16

VERSION 3

DRAFT IN DEVELOPMENT – SUBJECT TO BOARD APPROVAL

Version Control

Version Number	Date Approved	Author	Brief Description
2.3	14 February, 2014	Mid Essex CCG	Multiple changes including, C. Rassell, D. Davey, J. Bullion, A. Mitchell-Baker, R. Hearn, M. Crass, J. West, P. Wilkinson
2.3.1	28 February, 2014	Mid Essex CCG	Update Medicine Optimisation – P. Wilkinson Update Mental Health – M. Crass & J. West
2.3.2	9 March, 2014	Mid Essex CCG	Update Integrated Commissioning – J. Bullion
2.3.3	10 March, 2014	Mid Essex CCG	Update Quality – R. Hearn
2.3.4	11 March, 2014	Mid Essex CCG	Insert Outcomes of Colchester Cancer Review 4.7.1 – Sian Brand Inserted updated version of Building Strategy around phases of life diagram Insert Section on Maldon Service Development 4.6 Insert section on GP Access to IT 5.3
2.4	12 March, 2014	Tricordant	Format document based on text of v2.3.4 Note that page numbers and contents page are yet to be formatted
2.5	12 March, 2014	Tricordant	Page numbers and content page formatted
2.6	12 March, 2014	Tricordant	Update Public Health sections 3.1-3.3 – K. Ramkhelawon Change to MAR activity heading section 9.1
3	12 March, 2014	Tricordant	Update Starting Well, section 4.5 – M. Williamson. Final edit for submission of draft to Essex HWB.

Contents

1. Introduction

This is a draft of the key plans of the CCG and commissioning partner, ECC, for submission to Essex HWB on12/3/14. MECCG and the wider Mid Essex health and social care system faces considerable financial challenges. The draft plan has been developed at a time of organisational transition and critical short-term financial recovery and longer –term transformational planning. The final 2 year operational and 5 year strategic plans will therefore demonstrate significant developments.

Mid Essex CCG and its main acute provider, MEHT are both financially challenged. The size of the recurrent deficits in both organisations are significant and are inextricably linked. In addition Essex CC also needs to make significant financial savings. A recent sustainability review by Capita, concluded that the only chance for the CCG of reaching financial sustainability will be to look at radically reshaping services to reduce cost but maintain quality, rather than using the traditional approaches of slash and burn and/or development of small out of hospital schemes to reduce expenditure. To achieve this transformation change will not only involve time and the testing of new models of care but necessitate working hand in glove with local providers so financial sustainability can be achieved across the economy.

This plan contains the CCG's draft 5 year Plan on a Page, which is still under development, and a high level commentary on the key areas of CCG activity including those outlined in 'Everyone Counts, Planning for Patients 2014/15 to 2018/19'.

As part of the 5 year Strategic Planning process, MECCG is committed to developing a sustainable health and social care environment focussed around clinically led, evidence based services. This process will demonstrate improvement across the 5 domains and 7 key outcome measures, whilst over a period seek to achieve sustainable financial balance across the Mid Essex system.

Current work includes:

- Robust plans for the development of primary care based on the outcomes of current consultation with member practices
- Negotiation and agreement of provider contracts consistent and supportive of this ambition
- Further system planning, working closely with Essex CC, District Councils, our key providers and our vibrant local community and voluntary sector, including ensuring full local ownership, clarity around detailed scheme costs and benefits, detailed mobilisation plans and appropriate governance arrangements
- Establishing an externally supported Transformation Support Unit to drive short term financial stability whilst the longer term Sustainability Programme is developed;

- Stakeholder involvement (which has begun) to ensure full engagement and sign off of plans
- Collaborative action with local partners on improving quality, and finalising use of quality premium
- Liaison with NHSE and CCG colleagues around services where collaborative or lead commissioning arrangements are in place to ensure alignment and integration of plans
- Completing modelling and planning around activity levels, QIPP, tariff and predicted finance position
- Addressing key enablers including use of data and NHS number, and workforce
- Producing a simple and concise internal business plan outlining MECCG and partner plans underpinned by detailed SMART action plans.

From this work a single transformation programme (with identified project streams) is being developed which will enable the CCG to:

- Have a clear plan for "QIPP"/financial savings" for 2014/2015, although both sets of external advisors have already indicated that this will be limited due to savings already achieved
- Have a clear programme approach detailing how the transformation agenda can be delivered
- Have a clear trajectory over which the clinical change and financial sustainability can be achieved
- Ensure alignment of plans and effort with local providers and partners

It should be noted that there is the assumption that QIPP proposals plus the transformation agenda do deliver financial sustainability over a period; if this is indeed not demonstrated by the planning then there will need to be further discussions about how this is addressed. For the CCG and partners to concentrate on the delivery of a sustainability programme, in 2014/2015 the CCG will need acceptance that financial balance will not be delivered and business rules cannot be met. Furthermore alignment with NHSE and NTDA will be required to allow the CCG transformation and financial sustainability plan, and MEHT 5 year plan to be properly aligned. Although the CCG will vigorously continue to identify and pursue QIPP opportunities, the main concentration will be on delivering 2 to 3 transformational whole system projects during 2014/2015.

These build on existing clinically led work, and are likely to be:

- Immediate care (with MEHT)
- Review of CHC assessment and procurement (with Essex County Council and CSU)
- Testing the frailty pathway (with Essex CC and all providers)

The assumption would be that they would all deliver substantial financial benefit in 2015/2016 (yet to be quantified); and that contract agreements for 14/15 will aim to provide stability to allow organisations the opportunity to start to plan and deliver sustainable change.

2. Plan on a Page – Mid Essex CCG 5 Year

VISION: Mid-Essex health and social care economy, comprises of Mid-Essex CCG, Essex County Council, Chelmsford City Council, Maldon Borough Council, Braintree Borough Council plus key providers Mid Essex Hospital Trust, North Essex Partnership Trust, Provide, Essex Cares, East of England Ambulance Service, and a range of smaller providers working together. The CCG vision, which is a shared ambition, is "**Our communities working together to create innovative and sustainable local services delivering integrated first class health and social care for all**"

CONTEXT & CHALLENGES:
- 1 CCG, 3 localities matching district/city councils, with Essex CC and 9 sub localities
- Financially challenged (CCG forecast 13/14 deficit of £8-10m. MEHT underlying deficit of £15M)
- Diverse and multiple providers

JSNA Headlines:
- Ageing population
- Increasing long term conditions and frailty
- Inequality: - mortality gap

SYSTEM OBJECTIVES:
1. Resilient and engaged communities and citizens
2. Person-centred and integrated care
3. Appropriate use of and access to health and social care 7 days per week
4. Improving patient experience and outcomes
5. Whole system financial sustainability

SUCCESS CRITERIA:
- System objectives delivered
- Key outcomes delivered
- Quality and patient experience is good as evidenced by lack of enhanced external regulator monitoring of providers
- Whole system financially stable by 18/19

GOVERNANCE:
- System Leadership Group (SLG) overseeing whole system implementation
- Joint Commissioning Board to oversee Better Care Fund and integrated commissioning
- Workstreams with clear mandates and leadership plus Clinical and Executive Sponsors

CLINICAL PHASES OF LIFE MODEL DRIVES TRANSFOMATION

Starting Well	Fit and Well	Long term conditions	Frail	End of Life
Embedding healthy lifestyles	Developing capacity for self care & community resilience	Integrating 1º, community & specialist care around needs	Integrating health, social care & housing to support independence	Enabling preferred place of care

Transformational Programmes

- Safe and well at home – developing capacity for self-care, community resilience
- House of Care - developing LTC Hubs integrating primary care, community health services & specialist services around needs of people with complex needs and co-morbidities
- Frailty Pathway – proactively identifying frail people and integrating health, social care & housing to support independence, proactive approach to managing CHC.
- End of life – continuing to promote conversations about EOL and preferred place of care choices
- Immediate Care – simplifying and joining up urgent and emergency care services
- Primary care – engaging practices to develop as providers at scale
- Enablers – IT/IG, workforce, pharmacy, estates, PPE, etc

SYSTEM PRINCIPLES & VALUES:

Our patients will be:
- Assessed in the appropriate setting
- Guided to the full range of services; health, social care, voluntary and private sector including promotion of good health opportunities

Our roles and responsibilities will be focused on:
- Outcomes and evidence based commissioning specifications
- Collaboration of Providers in order to deliver
- Sharing the risks and gains

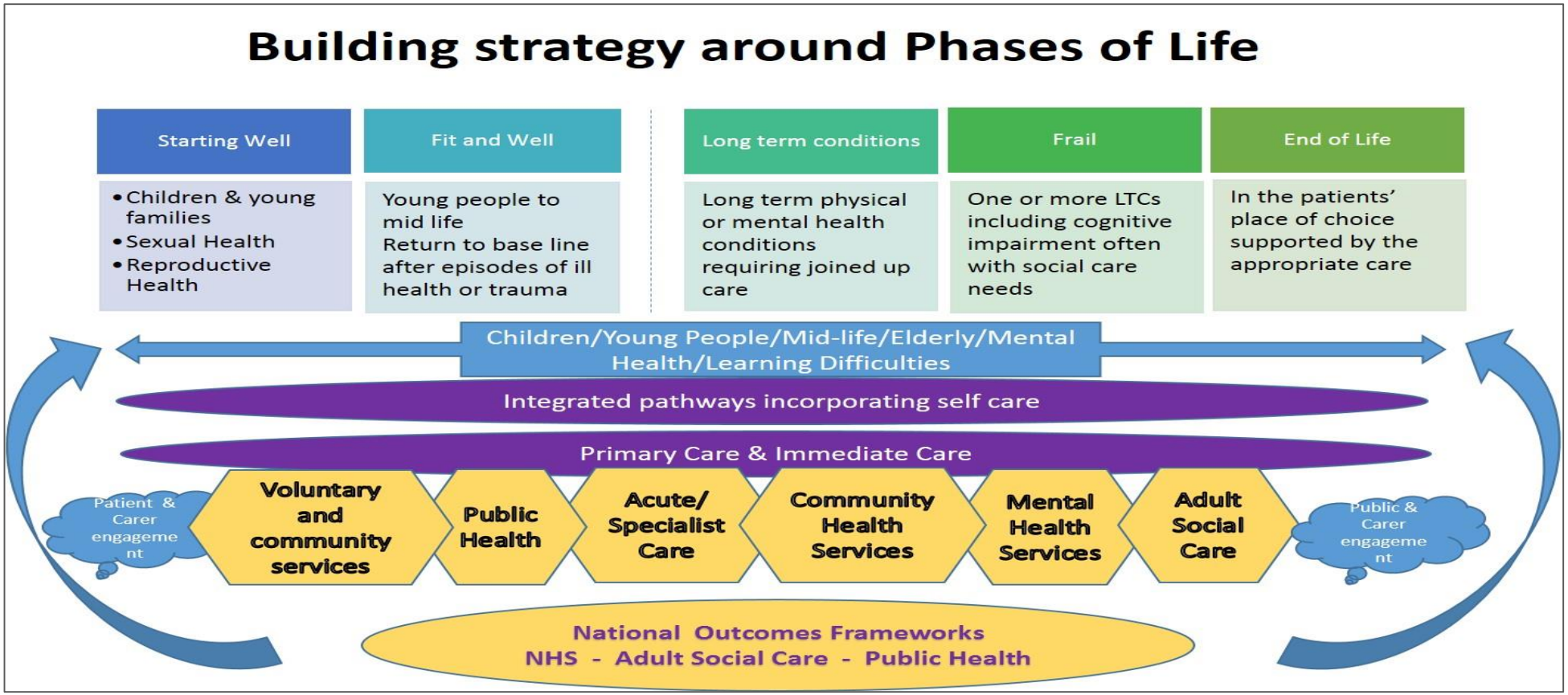
Our working behaviours will demonstrate:
- Quality and safety of services is our first priority
- Courage to ensure we are an effective system leadership
- Openness, trust and collaboration with an attitude of respect for all

Our intention is to:
- Have a shared understanding of financial constraints and opportunities across the system
- Achieve sustainable return on investment
- Support innovation and 'ring-fence' market testing activity
- Harness learning from joint working to inform on-going ways of working

2.1 The CCG Vision

The clinical vision for the CCG concentrates on optimal care being provided in the different "phases of life" as well seeking to reform and improve services which support this (immediate care; primary care) at less than the current cost.

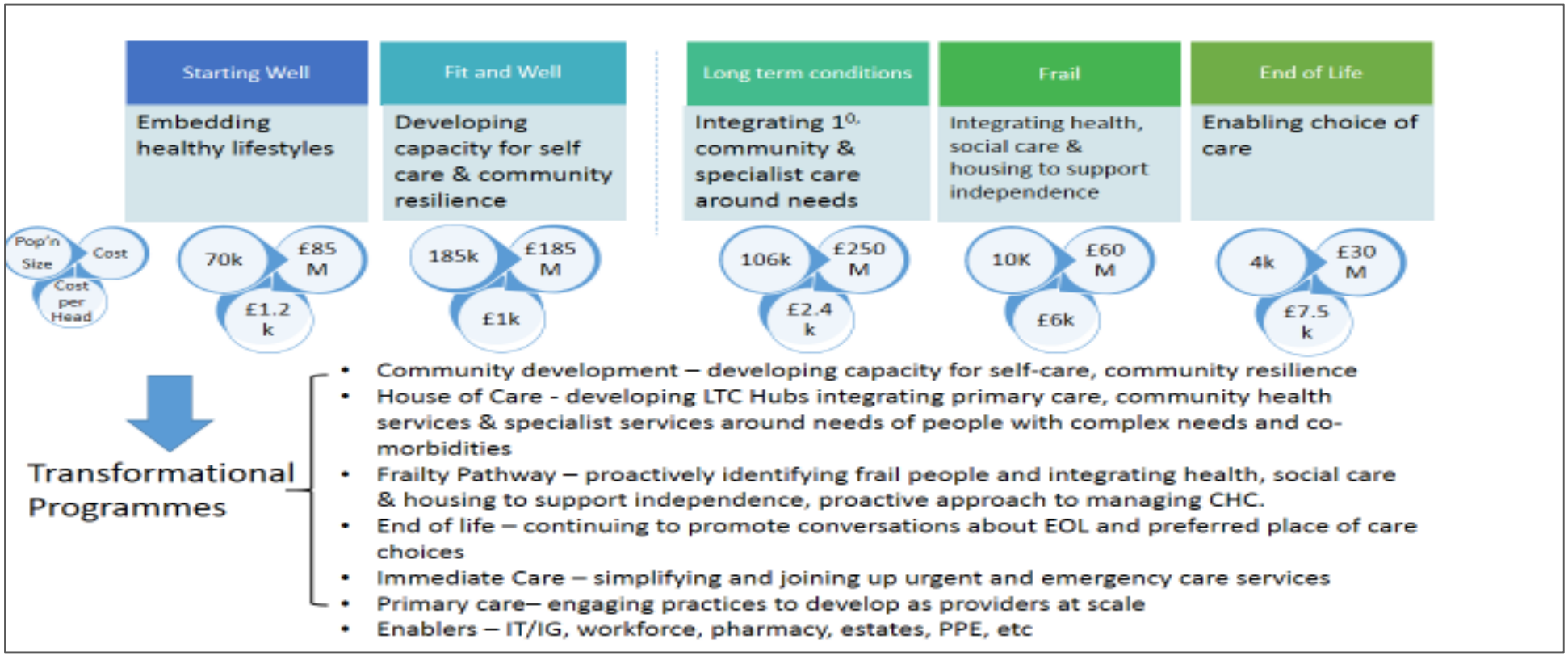
The diagram below reflects the current thinking:



2.2 Quantifying the Phases of Life

The segmentation of the population according to needs allows services to be developed through transformational programmes of work which focus on meeting those needs and thus delivering value. Work is being undertaken to quantify for each phase of life the population; cost and spend per head so that there is a baseline set prior to any service change.

Example of this below (figures are only illustrative):



We recognise that the planning timetable is challenging and the development of this 2 year plan prior to the 5 year plan being produced runs the risk of short terms measures and plans being written to satisfy a timetable rather than address the real issues. We are therefore seeking to try and get as much of the high level 5 year plan completed by the end of March to inform our final 2 year plans.

3. Outcomes

3.1 Delivery across Domains & Outcome Measures

The NHS/CCG Outcomes Framework describes the five main domains of better outcomes that the NHS and partners are expected to secure:

- A reduction in dying prematurely mortality, with an increase in life expectancy for all
- Improved quality of life for those people with long-term conditions and with mental illnesses
- Effective recovery from episodes of ill-health or following an injury
- A good patient experience in accessing all healthcare services
- A safe health service and ensure patients are protected from all avoidable harm

Our ambitions for delivery against the 5 Domains are set out below.

New interventions have been/will be informed by in-depth review of the evidence and where appropriate, well-constructed innovative approaches.

Reduction in potential years of life lost from conditions considered amenable to healthcare:

Causes considered amenable to health care are those from which premature deaths (people under 75 years) should not occur in the presence of timely and effective health care. In 2010, deaths caused from such avoidable conditions represented 24% of all deaths in England and Wales – a reduction of 25 per cent between 2001 and 2010. Some of these conditions include mortality from heart diseases, respiratory illnesses, cancers and smoking-related ill-health as well as the potential role of excluding new technology or innovation plays on quality of care.

Whilst improvements have been made in the provision of stroke care, further development is required to consistently achieve key standards, reduce overall stroke mortality and better long terms outcomes. Current performance is shown in the table below.

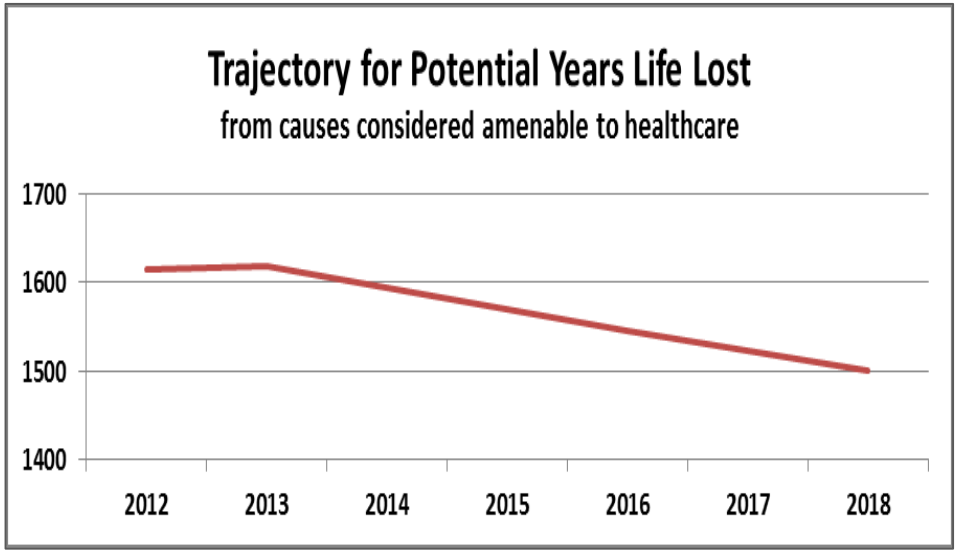
Stroke Metric	Target	Performance Q3 MEHT	Performance Q3 CCG
% non-haemorrhagic stroke patients receiving Thrombolysis within 3 hours of onset	12%	8.3%	6.4%
Proportion of people who spend at least 90% of their time on a stroke unit	80%	79.5%	81.6%
Proportion of people who have a TIA who are scanned and treated within 24 hours but not admitted	60%	73.3%	71.7%
Proportion of patients supported by a stroke skilled Early Supported Discharge team (by Acute Trust - MEHT)	40%	28.8%	34.1%
Proportion of patients admitted to an acute stroke unit within 4 hours of hospital arrival	95%	64.8%	68.8%

In Mid Essex, there is a gender difference in the potential years of life lost (PYLL) from causes considered amenable to healthcare, with a more sustained reduction amongst women. Trend analysis suggests a marginal increase of around 0.2% between 2009-2012, for all people with an overall reduction in PYLL (of 78 years) between 2011 (1,692/100,000) and 2012 (1,614/100,000). MECCG is mid-point in the best quintile in 2012 (Best CCG Surrey Downs, 1,414/100,000). There is a marked gender inequality (F=1,461; M=1,773).

Some of the key interventions that may have contributed to this reduction in PYLL include:

- An increase in the proportion of smokers, including maternal smokers, who are quitting
- Early identification and intervention in people at higher risk of CVD
- Improved uptake of screening programmes and early referral of potential cancer patients
- Better integrated provision for early supported discharge for stroke patients
- Improved advise to patients about healthier choices, including national campaigns
- Improving management of CVD to prevent secondary reoccurrence of CVD events
- Recent introduction of technological improvement

Nationally, all CCGs are expected to plan for an annual reduction of 3.2% in PYLL for their respective population. MECCG feels that having one of the lowest PYLL against all peers and under the current financial challenge that this target is inequitable and unachievable. There is also likely to be a substantial time lag between the introduction of new public health interventions and improved healthcare services and a corresponding reduction in mortality. We are therefore proposing a modest annual reduction in PYLL of 1.5%. This will equate to a reduction of 118 years in PYLL over 5 years.



Proposed plan to achieve this reduction in PYLL include:

- Targeted health messages and smoking cessation service for working-aged men, whilst continuing to improve on ante-natal smoking intervention and in most deprived areas
- Improve early detection and treatment of people at higher risk of CVD in more disadvantaged communities, with a special focus on hypertension case identification and management
- Targeted secondary prevention for CVD including cardiac rehabilitation and reviewing pathways starting with AF
- Finalise and implement new stroke services (based on Essex-wide proposed HASU model) and we will increase the provision of ESD for stroke patients (to 40%) through the BCF Work Plan
- Review of pathways for cancer care (patient transfer between providers), patient tracking through the service to tackle delays and a review of services is also in planning
- New community-led health education schemes to promote healthier lifestyles, including multi-agency development work programme on 'social mobilisation'
- Targeted mental health initiatives (such as MH case workers, health checks) to maximise prevention and improving the physical health of people with mental health conditions
- A complete review of respiratory care with a view to introduce new more cost-effective specification, implement best practice and innovative self-management scheme, and ensure annual patient reviews are undertaken
- Agreement reached with District support and led by ECC, to implement new alcohol treatment pathways
- Targeted falls prevention work in areas with high levels of falls and tackling underlining causes

Improving the health related quality of life of people with one or more long-term condition:

This overarching indicator provides a picture of the NHS contribution to improving the quality of life for people that have a long term condition (LTC). This provides the average health status (EQ-5D is the tool) scores for adults with a LTC. It assesses whether health-related quality of life is increasing over time for this cohort of the population and if people feel supported to manage their conditions.

MECCG was at the bottom of the best quintile in 2012-13 at 76.2% (no change from 2011-12); the score is not significantly different from the best performing CCG (*Surrey Heath, 79.7%*). This information is collated through the national GP Patient Survey.

More interventions have been instigated to support people with a LTC, such as:

- Improved management of respiratory illnesses especially COPD
- Some improvement in the management of people with diabetes
- Overall improvement in some quality outcome measures (as per QOF)
- Some successes with schemes aimed at keeping people with a LTC out of hospital
- Improving the uptake and success of talking therapeutic services (IAPT)
- Implementation of multi-disciplinary team in some areas with pilot step-up locality hub
- Our plans for the development of integrated services for people in the LTC and Frailty phases of life alongside those of ECC are set out in section 4c and will also significantly contribute

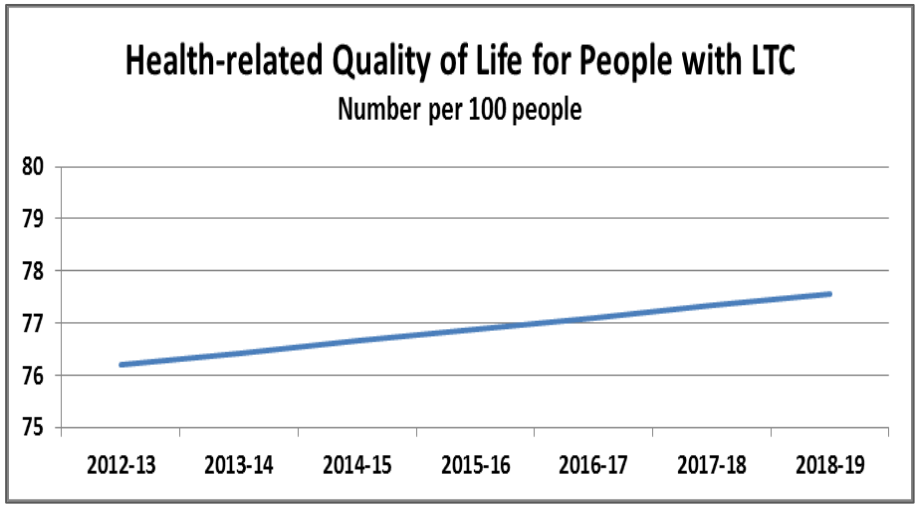
Our ambition is based on the average change between 2011-12 and 2012-13 in the top three quintiles. As this measure is based on qualitative data, it is more challenging to project future outcomes and this methodology reduces the risk of over-estimating the potential change. We will aim for a 0.23% improvement year on year to reach 77.6% in 2018/19.

With an ever-growing proportion of people projected to have a LTC, the CCG will continue to improve disease ascertainment and management by its focus on the LTC phases of life including exploring the longer term development of the 'house of care model.'

Immediate plans include:

- Improve disease ascertainment and develop local initiatives to promote effective self-management of LTC
- Ensure that all people with COPD meeting appropriate criteria are offered an effective, timely and accessible multidisciplinary pulmonary rehabilitation programme

- Ensure that all people with diabetes have received all nine care processes and referred to structured self-care programmes whilst promoting 'Dafne' courses
- Implementation of risk stratification system to prevent people with a LTC needing hospital admission
- Procurement for new IAPT service has been completed to meet local population needs and promote self-referral, with the new service due to begin in April 2014
- Implementation of an all-age Integrated Continence Care service, with clearly defined pathways with a standardised approach to the procurement of products across Essex



- Review the areas of success with MDT and expansion of step-ups beds to support this innovative approach between health and social care
- In collaboration with local providers, the CCG will pilot a 100 day "test and learn" Lead Provider process and pathway review for patients with multiple morbidities.
- Work with ECC to support the expansion of Recovery College to enhance and promote healthy integrated living for people with mental health
- Rolling out the Personal Health budgets and collaborative working with ECC to learn on best approach and maximise outcomes for residents
- Implementation of key recommendations from '*Who will Care?*' report aimed at improving support to people with multiple morbidities
- Work to improve screening and service provision as well as community support for people with dementia

Reducing avoidable emergency admissions (composite measure):

The recent policy drive through *A Call to Action* sets out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. This will require a significant shift in activity and resource from the hospital sector to the community and how the NHS and its partners can reduce unplanned hospital admissions.

This overarching composite indicator is made up of four key measures detailed in the table below. MECCG is near the top of the best quintile at 1,576/100,000 population in 2012/13 (*Best CCG Crawley, 903/100,000*). The trend is a reducing one for MECCG and the CCG has the lowest rate in Essex although this rate is above 8 of the 10 CCGs in our ONS cluster group. The better performing CCGs have been showing little improvement between 09/10 and 12/13, and the worst performing CCGs have typically been showing worsening positions. MECCG has been performing well in the measures making up this indicator (Quintile 1 is best and 'lower' is better):

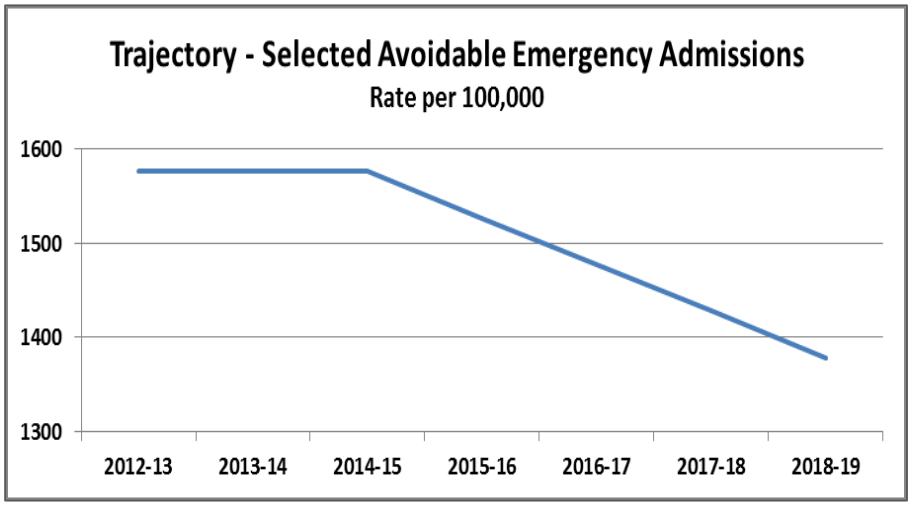
Key Measures for this Indicator	Performance in 2012-13
Unplanned admissions for chronic ambulatory care sensitive conditions (ACSCs)	Lower in Quintile 2
Unplanned admissions for under 19yrs with asthma, diabetes and epilepsy	Higher in Quintile 1
Emergency admissions for acute conditions that should not require hospitalisation	Higher in Quintile 1
Emergency admissions in children with lower respiratory tract infections (LRTI)	Lower in Quintile 1

Some of the key interventions that are and/or may be contributing to a reduction in hospital admissions:

- A variety of hospital admission avoidance schemes
- Provision of rapid response services in partnership with social care reablement services to both prevent hospital admissions and support discharge and avoid readmission.
- Home-from-hospital support scheme in collaboration with social care
- Increasing the proportion of older people living independently at home following discharge from hospital including through the reablement programme. A pilot is being introduced in 2014 to improve the integration of health input into the current ECC commissioned reablement service.
- Further development of multi-disciplinary team work in primary care settings to target patients at risk of admission, including a nominated professional lead for older people.
- Some targeted interventions to support vulnerable groups (e.g. carers, illicit substance users) in preventing unplanned admissions and for better utilisation of healthcare services
- People with diabetes with or at risk of foot ulceration receive regular review and urgent support for foot care to reduce risk of amputations

- Improved access to community mental health services (including IAPT) by people from vulnerable and ethnically diverse groups and promoting self-referrals

MECCG aims to maintain the current rate for 2013-14 and 2014-15 and reduce the rate in future years to achieve the median on this best quintile to 1,379/ 100,000. This will equate to a 12.5% improvement over 5 years to 2018-19.

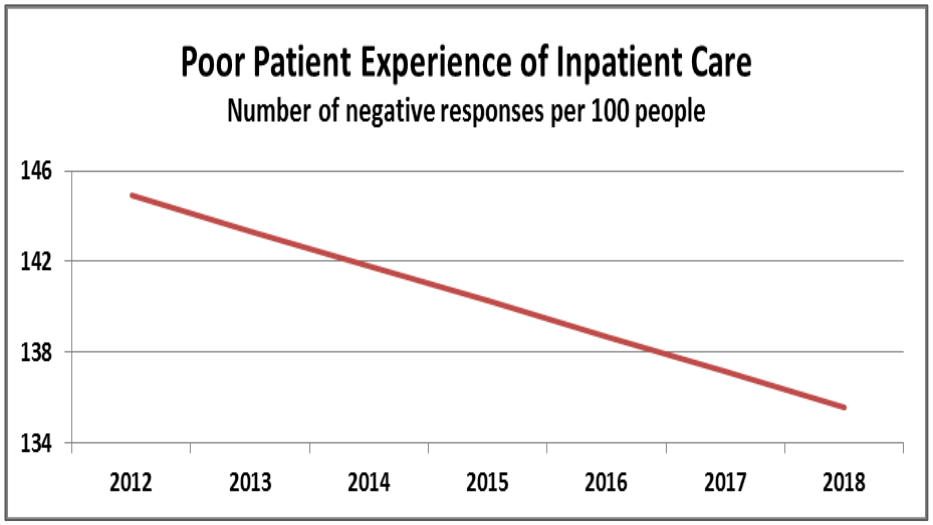


The CCG will ensure new proposals will raise the quality of care whilst diligently managing the financial gap over the next few years, through a programme of innovation and transformation, including the development of the work programme around integrated care. Plans will also provide a defined focus on helping people to recover from episodes of ill health or injury.

These include:

- The funding and implementation of the Better Care Fund to improve sustainability, put in place urgent and unplanned care services, reduce emergency admissions and raise quality
- Implementation of risk stratification system to intervene earlier with people most at risk of needing hospital admission to promote independence and minimise re-admissions
- Support the health of carers to promote independence
- Targeted interventions, including effective prevention, in areas that the CCG is an outlier with unplanned hospitalisation for chronic ambulatory care sensitive conditions in adults and children

- Improving care pathways and prevention work for people at risk of falls, needing support around continence care and who can access care and support closer to home
- Expansion of the reablement care programme whilst evaluating areas with better outcomes to ensure efficient and effective approach
- Development of Frail and Older People register to promote independence, self-care and minimise hospital re-admissions
- Targeted interventions to reduce inequity in access and utilisation of health services to reflect the community demographic profile and in line with the CCG's Equality Duty
- Integrating medicines optimisation into care pathways, supporting people to get the most benefit from their medicines and remain independent
- Implementation of the Paediatric high impact pathway revisions to improve quality and achieve better outcomes
- Improving surgical post-discharge and health outcomes especially where PROMs benchmarking shows that the CCG is an outlier (eg knee replacement)



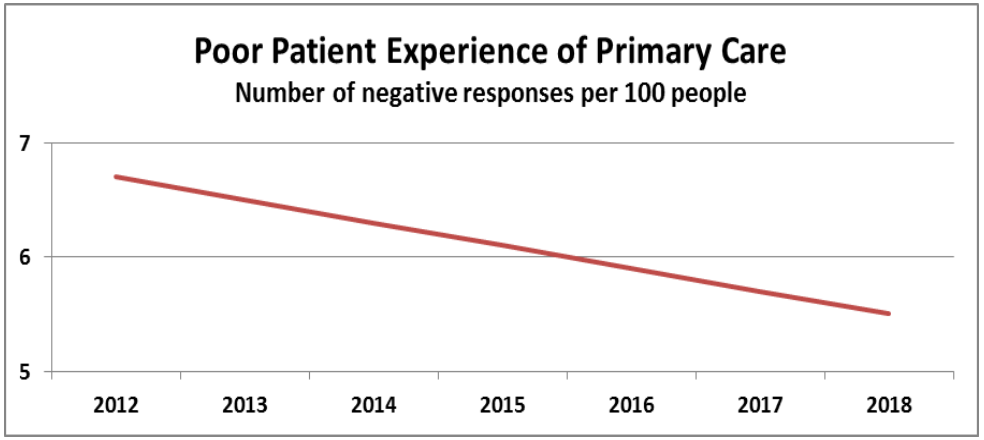
Increasing positive experience of hospital care, general practice and care in the community:

There are two indicators measuring patient experience of [i] hospital care and [ii] GP care, based on the number of negative responses per 100 patients.

In relation to the Family & Friends test MECCG has improved their response rate substantially in A&E (9.8% to 19.2%), maternity and inpatient services with a combined achievement of 25.3% against target of 15% in November.

- MECCG is on 144.9 per 100 patients in 2012 near the bottom the 3rd quintile. MECCG's position is not significantly different from CCGs in this quintile.
- MECCG aims to get to a position equal to the best CCG (*South Lincolnshire, 135.6*) in the 2nd quintile. We have modelled steady improvement over the 14/15 to 18/19.
- MECCG is on 6.7 per 100 patients in 2012; this is near the middle of the second worst performing quintile (4th quintile).
- MECCG aims to get to a position equal to the best CCG (*Tameside and Glossop, 5.5*) in the 3rd quintile. We have modelled steady improvement over the 14/15 to 18/19 and we will continue to monitor improvement through the Net Promoter scorecard and interrogate the data to ensure any issues are identified, addressed and lessons learned to continuously improve patient experience by responding to concerns in a timely manner.

The CCG will need to work with providers to increase the proportion of people who report a positive experience of their inpatient care (for both mental and physical conditions) and of their care outside hospital, in general practice and in the community, including GP out-of-hours services.



Plans are to:

- Plan to expand Family and Friends test to include outpatients and day cases services and rolling out to reach other providers
- Better use of PALS information to improve resolution, reduce reoccurrence and improve outcomes
- Improving access to hospital, primary care and community services through the implementation of the 7-day working principle
- The CCG will work with NHSE, Healthwatch Essex and other key stakeholders to support the development and implementation of a more effective Primary Care Strategy, with active involvement from the CCG's Primary Care Forum and Patient Participation Groups

Eliminating avoidable deaths in hospital:

This overarching indicator has yet to be defined nationally. However, the expectation is that this indicator will gauge the improved readiness of the NHS to report harm and to learn from it. Reporting patient safety incidents, identifying common risks to patients and eliminating hospital-acquired infection risks should aim to increase awareness and provide opportunities to improve patient safety. Acutely ill patients may die suddenly if staff fail to spot or act on changes in their conditions.

Some of the current measures that the CCG has implemented to promote patient safety include (further details in the Quality Section):

- Actively working with providers to implement the zero-tolerance on MRSA and further reducing the spread of *C.difficile*
- Providers supported to ensure that all medication incidents which have caused harm or have the potential to cause harm are reported to the National Reporting and Learning System (NRLS) and to MECCG in a timely manner and using the learning from such incidents to improve safety of care pathways

Following the publication of a number of national recommendations (such as Francis, Berwick & Winterbourne reports) and with the latest contracting round, the CCG has taken further steps to ensure that patient safety is placed at the forefront of service planning and delivery.

MECCG will aim (further details in the Quality section):

- For a zero-tolerance approach with MRSA and a *C. difficile* panel is being instigated to review all cases as part of the Harm Free Care agenda.
- MECCG working with the Essex Area Team in respect of GP practices and community pharmacies, and with Essex County Council in respect of care homes and domiciliary care, will develop processes for sharing and learning from medication incidents and optimise the safe use of medicines.
- Continue the review SHMI rate with local providers and encouraging them to explore and understand the activity which underlies their SHMI from their own data collection sources.
- Work to drive consultant cover for 7-day week in the acute setting.
- \improve the care of deteriorating patients with the introduction of new software for real time escalation (CQUIN driven).
- Improving learning through the introduction of the Global Trigger tool for a monthly random audit of patient care (both deceased and discharged).

3.2 Improving Health

Improving health and wellbeing deserve the same focus we place on treating ill-health. There is a clear understanding that Public Health is everybody's business and everyone must make sure they work with all partners as well as the public so that all the issues which affect the broader determinants of health are addressed to also help reduce inequalities.

At a local level, MECCG will actively engage in partnership with all commissioners, wider stakeholders and the local communities to facilitate and lead the most effective way of delivering against the following joint Health and Wellbeing Board's priorities:

These include:

- Starting and developing well: ensuring every child in Essex has the best start in life
- Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life
- Ageing well: ensuring that older people remain as independent for as long as possible

These priorities map against the CCG's clinical vision around 5 phases of life. We need to ensure that the key elements of Commissioning for Prevention are delivered and that every contact really does count in taking the opportunity to promote a healthy environment and healthy lifestyles.

These are:

- A Mid Essex JSNA was completed following the publication of a high level Essex-wide JSNA to inform the CCG's commissioning intentions. Some of the key issues that have been identified for further interventions:
  - Key issues linked to causes of pre-mature mortality include liver, breast and skin cancers; cardiovascular conditions (including atrial fibrillation - AF), stroke, hypertension, diabetes and respiratory diseases
  - Key causes of chronic ill-health also include musculoskeletal disorders, falls, poor lifestyle choices and mental health problems
- MECCG has been a key stakeholder in the development of the joint Essex HWB Strategy, in developing a common set of principles for the commissioning of Public Health interventions and in developing a common approach to Integrated Commissioning. This collaborative approach continues to provide an opportunity to set common goals and priorities, such as:
  - Ensuring children and young families have a good start in life and are actively supported to lead a healthier life

- Closer working with partner agencies, Healthwatch and local groups to tackle wider health and social issues impacting on health and to ensure high safeguarding standards – some of these areas include domestic abuse, sexual exploitation/violence
- Improving disease ascertainment by implementing national and local screening programmes
- Improving health and wellbeing outcomes for people with mental health
- Improve management of long term conditions including effective self-care and secondary prevention programme
- Improving prevention and developing integrated care around falls and incontinence.
- Improve care for frail and older people to support independence and targeting vulnerable groups (e.g. BME groups, Travellers, Carers,)

- Additionally, the CCG will work to weave in the "*Who Will Care?*" recommendations focused on the five proposals for improved integration, patient centred services and better health outcomes for children and young people, especially for children with who have special educational needs.
- A number of high-impact prevention programmes have been agreed, in collaboration with stakeholders and will be progressed over the next 2 years:
  - Reduce harm from substance misuse and reduce smoking and implementing systematic approach to 'making every contact count'
  - Primary Care screening for early diagnosis and support of mental health conditions, including improving the physical health of these residents
  - Multi-agency approach to the provision of obesity prevention and reduction (including school based, new Tier 2 services and effective Tier 3 services).
  - Implementation of integrated falls prevention and continence care services.
  - Implementation of AF and hypertension screening programmes targeting high-risk groups to reduce CVD.
  - Systematic diagnosis and management of respiratory illnesses, including patient education programme to promote effective self-management.

- To support the development of this work programme, the resource planning includes:
  - A reduce in acute activity and beds with some reinvestment in high-impact prevention programmes.
  - Joint investment and re-engineering with ECC and District/City councils to support social mobilisation, early detection, self-care schemes and promote lifestyle changes.

- Plan the deployment of BCF to maximise agreed outcomes.
- Introduction of lead-provider and risk-sharing approach to contracting to improve quality and access to better prevention and support.

MECCG is keen to promote innovation and will continue to strive in ensuring new interventions are evaluated to demonstrate effectiveness and replicability. Innovative solutions will be co-produced with the patient and communities as the core stakeholders, to ensure these are sustainable and provide value for money.

3.3 Reducing health inequalities & Equality Duty

There is a substantive evidence base that shows the extent of inequalities in the factors that ultimately contribute to a differential in life expectancy. This is more pronounced in some of the Mid Essex communities where there is a high level of material deprivation.

The key communities we will focus more intervention in are (MSOA code in brackets):

- Patching Hall Ward (Chelmsford 006)
- Bocking South Ward (Braintree 008)
- Witham West Ward (Braintree 016)
- Braintree South Ward (Braintree 011)
- Maldon town area (Maldon 004) and Heybridge (Maldon 003)

Moreover, the latest CCG's JSNA has identified that Maldon and Braintree have experienced an increase in the gap in life expectancy in men in the last few years. There has also been a more marked increase in the gap for women over the latest 2 years to 2010 especially in Braintree and Chelmsford. The gap in life expectancy for women living in Braintree and Maldon as well as men living in Chelmsford has narrowed. Despite the local level of affluence in Mid Essex, there are nearly 10,000 children live in poverty; Braintree with 4,500 children, Chelmsford with 3,900 children and Maldon with 1,500 children.

The Mid Essex system's Health & Wellbeing/Integrated planning group which has high level district councils representatives, have pledged to focus their collective effort in tackling inequalities and support local communities to live healthier lives. We are currently developing a strategy and our shared approach in engaging communities through 'social mobilisation'.

The CCG's Board has tasked their Public Health Lead to review areas where the local HWB committee can make a real difference with a collective approach to tackling health inequalities.

Some of the key groups with worst outcomes and experience of care in Mid Essex include:

- Working-aged men and their higher CVD risk
- Older women and the higher incidence of stroke

- Disparity between GP practices in the level of disease ascertainment as well as management of patients on disease registers (some correlations with variation in Patients to GP ratio)
- Disparity between districts in health access and outcomes (e.g. high number of falls, access to surgical interventions) as well as in premature mortality rates
- More deprived communities with over 10,000 children living in poverty
- There is an inequity in emergency hospital admissions between ethnic groups
- Poor lifestyle choices in the most disadvantaged communities as well as between districts

Additionally, the recent publication of the Equality and Diversity System (EDS2) to support the NHS in delivering its Public Sector Equality Duty, has placed more emphasis on the workforce 'health' as well as the expectation that CCGs will use this framework to support local providers (detailed later in this plan). MECCG has completed an EDS review (January 2014) and is currently finalising a local stakeholders' consultation. A robust equality impact assessment system is in place to support decision-making at all levels and the CCG's Board will sign off the revised EDS goals in March 2014.

Working in collaboration with local partners and communities, MECCG is developing a plan to close the inequalities gaps, including the implementation of high impact and cost effective interventions.

These are as follows:

- Optimise the use of drugs to control hypertension and reduce cholesterol with a targeted intervention amongst working-aged men
- Sustained tobacco control measures and increase the number of people supported to quit smoking, including in the disadvantaged communities
- Early identification of people at risk of stroke (including AF-related stroke) and ensure effective management in primary care, with a targeted approach with older women
- Targeted approach to case finding, including defined work programmes to reach vulnerable and BME groups, with targeted health checks and local early detection schemes for CVD, alcohol harm and mental health issues
- Review and re-engineer service configuration to improve access to primary care and reduce inequity in access (such as surgical interventions) or service provision (such as falls prevention)
- Involve the local communities in replicating successful social mobilisation schemes and innovative self-care schemes to

promote healthier lifestyle choices and reduce dependency on local public sector services

- The CCG in collaboration with all local partners will endeavour to promote equality and diversity for service users and the local workforce alike by implementing EDS2

3.4 Mental Health, Learning Disabilities and Parity of Esteem

Resource allocation:

The draft North Essex Joint Mental Health Commissioning Strategy 2014 – 2017 has been subject to a period of wider consultation with service users and stakeholders during 2013/14.

It sets out to describe the vision for the commissioning and delivery of mental health services for North Essex over the next three years and recognises the importance of joint commissioning with social care, developing community well-being, delivering services closer to home in primary and community settings and the need to integrate physical and mental health services more effectively.

The Strategy has been developed in partnership across the three North Essex CCGs and Essex County Council. The principles of the strategy are now being adopted locally in mid/west/north east Essex with implementation underway specifically with regards the development of more community based provision for patients with mild to moderate mental health illness.

Both the Strategy and the local delivery plans for mental health recognise the need to improve parity of esteem. The associated work plans include the need to undertake comprehensive clinical service reviews of community, urgent and older people's pathways to better understand provision, patient outcomes and experience. It will also explore the opportunities of further integration between mental and physical health services to close the 20 year gap and to improve urgent care provision. The outcome of this work will be reported to the three CCGs and The North Essex Partnership Foundation University Trust (NEP) in September 2014, with service changes to be embedded either through contract discussions with NEP or as a consequence of a procurement programme likely to commence April 15.

In terms of additional resources, we are proposing a number of CQUINs and service developments to further strengthen the delivery of parity of esteem. The CQUINs include supporting frail and older people including those at the end of their life, those experiencing urgent care services and the adoption of the national CQUIN 'Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI)'.

Within the proposed Service Development Improvement plan in addition to supporting primary care development, suicide prevention and the safe transition of patients in clusters 1 – 4, we are aiming to establish improved communications by exploring the development of a telephone advice line to provide general advice and guidance including medications and risk. We are also planning to monitor closely and apply contractual leverage with regards Trust communications/documentation following outpatients/admissions etc.

In respect of on-going projects, The Mid Essex Recovery College and Hub pilot is currently underway and will be evaluated during 2014. The Recovery College delivers educational courses to people with mental health problems, their families, carers and staff who work alongside people who experience mental ill health. It is planned that the learning of this project will be rolled out across North East and West Essex CCG localities.

A key feature of recovery-focused mental health services is the adoption of an 'educational' and 'coaching', rather than a 'therapeutic', model of services. Helping people to recognise develop and make the most of their talents and resources in order to become experts in their own care and do the things they want to do in life. Personalisation reinforces this through the idea that people are best placed to know what they need and how those needs can best be met. It means that people have choice and control for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

We are also exploring the opportunities for joint commissioning opportunities with Public Mental Health services. There are plans to explore what has been achieved in Northampton and to consider opportunities as to how this may bring service improvement for North Essex. This may include earlier intervention for children and supporting families.

Improving access to psychological therapies (IAPT) remains a high priority. The local IAPT service has recently been re-procured and the new service goes live on 1st April 2014. Access will be increased to 15% coverage by March 2016. It is envisaged that this new service will support the CCGs proposals to facilitate, where clinically appropriate, the safe transition of patients currently being treated under Mental Health Care Clusters 1 – 4 in secondary care to a primary care setting.

Reduction in gap in life expectancy:

In addition to the proposed CQUINs and the SDIP proposals for our Mental Health Service provider, as noted above, there are further plans underway which include the:

- Development of a primary care mental health education programme

- Development of a North Essex Mental Health Clinical Network and Associated "Think Tank" aimed at clinicians working together to develop new pathways both in mental health and the acute sector, this will concentrate on both the development of Parity of Esteem and the Mental Health Crisis Concordant
- A strategy target that 100% of patients admitted to mental health will receive a health check on admission
- Discussions on-going on possibilities of data sharing – the first area to focus on will be investigation results
- Joint commissioning with public health – including programmes focussing on early intervention and traditional public health screening
- The development suicide prevention across North Essex. The programme of work is to be led by Mid Essex as a consequence of receiving a pathfinder grant but learning will be shared across the three CCGs with joint training being made available where possible.
- The development of a personality disorder strategy which will link to both the health and suicide prevention agenda

Finally MECCG is developing transformation plans for Frailty/Older People which will seek to integrate pathways more effectively involving community, acute and mental health provision.

Young people with mental health problems:

Child and Adolescent Mental Health services (CAMHS) are currently being redesigned and re-commissioned across Essex with a view to improve the emotional health and wellbeing of children and young people from conception to their twenty fifth birthday.

One of the primary aims of the redesign is to address the current gaps identified by the Emotional Health and Wellbeing JSNA in particular behaviour management which transcends both paediatric and adult services through transition. We are also working closely with current CAMHS providers with regards the improvement transition of Adolescents to older peoples' services.

We are exploring the opportunities for joint commissioning opportunities with Public Mental Health services. There are planned to understand what has been achieved in Northampton and to consider opportunities as to how this may bring service improvement for North Essex. This may include earlier intervention for children.

There is an IAPT Children's pilot in North East Essex where we would hope any learning shared and would inform future commissioning opportunities.

Services for People with Learning Disabilities:

Work is actively underway between the three North Essex CCGs and Essex County Council around the future integration of health and

social care Learning Disability commissioning. The project is overseeing the transition of the commissioning function from health to ECC from April 2014.

The CCG will work with NHS England through the Essex Area Team to support the increased uptake of annual health checks for people with learning disabilities. This is being provided by GPs through a Directly Enhanced Service (DES). Clinical Commissioners are negotiating with HPFT, the local specialist LD Provider, to meet the demand for people who have no access to Annual Health Checks funded through the DES.

Work is on-going with MEHT to improve patient pathways in the Acute Hospital for people with LD/Autism.

The improvement plan has the following local priorities and standards:

- There is a clearly identifiable Board and Senior Management engagement in embedding LD strategy
- The Trust has policies in place that meet the specific needs of adults with LD/autism
- Adults with LD/Autism receive high standards of fundamental care
- Adults with LD/Autism are identified prior to admission for elective cases or on admission through emergency departments
- Training and Education on understanding the specific needs of people with LD/Autism is provided to all hospital staff
- Adults with LD /Autism attend A&E appropriately
- Adults with LD/Autism and their Family Carers are fully involved in preadmission planning; care planning and care delivery

4. Patient Services

4.1 Citizen engagement in service design and empowerment in self-care

Patients and Citizens have the opportunity to take control:

The CCG are currently embedding patient and public engagement in the commissioning function through a number of activities including;

- PPE training across the CCG
- PPE embedded in the PMO and commissioning sign off processes
- Maximising the synergy of PPE across a number of providers and stakeholders such as Healthwatch Essex
- Developing more proactive opportunities for PPE through more regular and increased communications; e.g. website, newsletter, Survey Monkey, an ongoing calendar of clinical priority focussed PPE events

- Developing role of PPGs across Mid Essex in PPE and their valuable contribution to the wider local health agenda

The CCG will manage the delivery of these activities through an action plan which will be monitored by the Patient Reference Group.

The CCG also aims to develop a number of commissioned health schemes that would see the emergence of individualised self-management plans in collaboration with the public (patients, communities, voluntary groups) with an approach that provides the resources, skills and community support required for individuals to live and manage their chronic ill-health.

Real time patient and citizen voice at the heart of decision making:

Active patient participation will be vital since the process of planning and implementing individual care programme will essentially rely on negotiating personalised goals within the socio-cultural context – the whole-system self-management model.

In addition to the above model of engagement we will also be developing our Patient Stories presented to the CCG Board. We will also be building on our Patient Experience measures with a mid-Essex picture of themes reported from patients through our PALS and Complaints service. These will combine with our engagement model to ensure real time patient and citizen voice is at the heart of our decision making.

Authentic Citizen Participation at the heart of our plans:

The public engagement approach will underpin the transformational agenda and seek to capture the patient perspective from within the patient life-cycle which is characterised by the following 'phases of life'.

These are:

- ***Starting Well***
- ***Fit and healthy people***
- ***Long Term Conditions***
- ***Frailty***
- ***End of life care***

Engagement and consultation will be an iterative process centred on the clinical priorities of the organisation and starting with the reconfiguration of urgent and immediate care.

This will include consideration of how to:

- Deliver care closer to the patients home
- Provide affordable and sustainable services
- Make it fit for purpose and adaptable

Transparency in local health services:

Our PPE model will promote transparency through being embedded across the CCG throughout the clinical commissioning function. PPE strategy, priorities, activity and developments are reported to the Board via the mid Essex Patient Reference Group (PRG).

The PRG has a membership of a number of external organisations and three volunteer Locality Leads ensuring transparency and delivery against the PPE work plan.

4.2 Wider Primary Care

There is a significant variation in patient to GP ratio across Mid Essex - Chelmsford (1,331/GP), Braintree (1,653/GP) and Maldon (1,849/GP). These compare with Essex and National averages of 1,515/GP and 1,351/GP respectively.

The CCG will work with NHS England through the Essex Area Team to review the level of GP provision to ensure safe and effective practice in primary care and particularly address areas of under-provision.

Within the context of the CCG's development of a transformation and sustainability programme there is a recognition of the critical need to enable and support primary care to play a key role as the 'bed rock' of local community health and social care services.

The CCG is currently out to consultation with Mid Essex Member GP practices to explore what changes and development options they see as a priority within this context. This includes consideration of the NHS Constitution Core service offer for Mid Essex as mandated by member practices and how best to support delivery of primary care at scale.

The CCG will also engage and work with other local primary care providers including community pharmacists, optometrists and dentists around their key roles in the overall CCG transformation programme as it is developed.

Medicines Optimisation;

Medicines optimisation must be placed at the heart of the sustainability agenda-improving quality by better adherence, safer care, and care tailored to individuals' expressed needs thereby freeing up the resources that better use of medicines brings. Working with individuals to set their own goals helps people regain and maintain independence, reduce avoidable readmissions into secondary care, reduce delayed discharge from hospital, improve patient clinical outcomes from prescribed medicines and reduce waste medicines.

Mid-Essex CCG will focus on medicines optimisation rather than cost-reduction, improving clinical engagement and joining up services. GPs will be supported to embed medicines optimisation within general practice, potentially through employment/attachment of clinical medicines optimisation pharmacist prescribers. Pharmacists will work with GPs to drive up the quality of medication reviews, focussing on older people and people with a long term conditions, supporting patients to get the most health benefit from their medication, and work in partnership with community pharmacists to maximise the benefit from the Medication Use Review service. General practice

pharmacists will support medicines reconciliation by secondary care clinical pharmacists, reducing risks around transfer between care settings, and utilising the New Medicines Service provided by community pharmacists.

Mid Essex CCG will work with NHS England-Essex Area Team in respect of GP practices and community pharmacies, and also with Essex County Council in respect of care homes and domiciliary care, to develop processes for sharing and learning from medication incident reports to improve the safety of patient care pathways and optimise the safe use of medicines.

Self-care of minor ailments and self-management of long-terms conditions is an effective means of improving quality of life and reducing dependency on immediate care services. Empowering and educating patients to self-care underpins the CCG's strategy for addressing immediate care needs. Utilising community pharmacy as the first port of call for the public and patients requiring healthcare advice and treatment for minor ailments and other self-limiting conditions can release GP appointments and help meet the unmet need in primary care. The CCG recognises the need to up skill the community pharmacists to support their developing clinical role, and will work with the Essex Workforce Partnership to deliver this.

4.3 A modern model of integrated care – working with partners to integrate commissioning and services to promote independence

The CCG is working closely with Essex County Council, Braintree District Council, Chelmsford City Council and Maldon District Council, to align and integrate commissioning activities particularly around the life phases typically, but not wholly, associated with later life; long term conditions, frailty and end of life care. The Better Care Fund will be used to implement integrated services which support people with health and social care services throughout those phases. Our overall model for integration is for care to be coordinated by lead professionals in multi-disciplinary teams (MDTs), with a joint assessment and agreed authority to arrange services. We will make sure that services are easily accessible with single points of triage and referral and .we will work in partnership with GPs to target support at those at risk of unnecessary admission. We will target preventative interventions to avoid health and care needs escalating. We will implement three specific initiatives over the next two years to bring this about.

Fully Integrated support & care for people with multiple long term conditions & risk factors:

MID Essex CCG, working with health and care providers and the voluntary sector, is developing a Frailty Pathway which is a transformational initiative to wrap services around the individual irrespective of provider, with a view to keeping them out of hospital and maintaining or improving their condition.

The approach being taken is to use a new provider model "The Accountable Lead Provider".
Secondly the CCG is also developing a plan for a clinically led 'House of Care' model of integrated hubs for the management of people with multiple long term conditions which will link with the frailty pathway.

Thirdly the County Council Adult Care Services are being transformed to become more personalised in accordance with the Care and Support Reforms in the Care Act. In addition the Council, to ensure service sustainability, has specific business plans for changing services for older people and people with learning disabilities. This is explain further below in this plan.

Using the Better Care Fund as a key enabler:

These 3 significant transformation schemes will be supported by the Better Care Pooled Fund (BCF) by MECCG and Essex CC.

The focus of our £21.6m pooled fund include joint commissioning and pathway reviews for:

- Supporting people at risk of losing independence with personal care services
- Rapid Response, and Immediate care services
- Reablement services – including residential reablement services and in particular increasing the coverage of reablement and enhancing the capability – see below
- Supported discharge, home from hospital and admission avoidance initiatives
- Continuing healthcare – focused around how joint commissioning will improve the quality and reduce the cost of care.
- Early supported discharge for stroke
- Access to Equipment and Assistive Technology
- Enhanced Support for Carers
- Housing and floating support

The Better Care Fund aims to provide an opportunity to make best use of resources by providing better integrated care and support. The Fund will be an important enabler to take the health and social care integration agenda forward at scale and pace, acting as a significant catalyst for change.

For 15/16 the Mid Essex system will have a pooled budget of at least £21.6m – partially funded by Social Care Sustainability funding but including at least £14.4m from CCG allocated funding.

In Mid Essex, we intend that integrated working will enable economies and efficiencies to be derived from existing expenditure and commitments which will in turn create uncommitted resources which can reinvested in further joint working and integrated services that support patients in the community and reduce/manage the demand upon acute hospital services.,

Integrated health and social care teams will operate seamlessly across the system and with all our providers and partners, in order to improve people's outcomes.

For more details on the Mid Essex BCF please refer to our detailed BCF Plan.

The draft 15/16 plan is as set out overleaf:

Indicative 15/16 BCF Investment	Fund Value £000	Benefits	
Protection of Social Care to Benefit Health:			
Baseline Social Care Sustainability Funding	*4,136*	*TBA*	*(See Note 2)*
Mid Essex Pro Rata share of £5.6m 13/14 Social Care Sustainability Grant increase	*1,550*	*Improved recovery and independence after a stroke, social care resource into MDT case management to promote and support independence including identifying and supporting frail members of the population to prevent episodes of crisis.*	*(See Note 2 - 4)*
New Social Care Sustainability Grant funding - priorities yet to be agreed	*1,595*	*TBA*	*(See Note 2 - 5)*
Community Health Services inc Admission Avoidance:			
Accountable Lead Provider/LTC (ICT & Therapies)	*3,791*		*(See Note 2)*
Reablement:			
Reablement Grant	*887*	*Reablement to support return to independence and reliance on health and social care services*	*(See Note 2)*
Other Reablement funding committed to demand management schemes	*856*	*Equipment, Rapid Response service and other measures to prevent hospital admissions or support discharge.*	*(See Note 2)*
Joint Nursing and Care Home Commissioning Inc CHC:			
Continuing Health Care (Assessment)	*717*	*Faster, comprehensive and integrated needs assessment and care package co-ordination*	*(See Note 2.6)*

Continuing Health Care (Costs)	*6,000*	*Better utilisation of resources to support return to independence and/or provide the necessary level of on-going care.*	*(See Note 1,2 & 7)*
Discharge Support:			
Early Supported Discharge for Stroke	*670*	*Supporting recovery and return to independent living*	*(See Note 2)*
Early Intervention and Prevention:			
Joint Risk Profiling (Fragility Risk Register)	*118*	*Identification of at risk patients as part of admissions avoidance.*	
Carers	*581*	*Support for carers - including carers breaks and respite arrangements to avoid the need to resort to residential care*	*(See Note 2)*
Other			
Equipment	*750*	*Equipment for use in the community to support admissions avoidance and hospital discharge.*	*(See Note 2,8)*
Total	***21,651***		
Capital Funding Including Disabled Facilities Grant	***TBA***		

Notes

1) 2015/16 expenditure by scheme has been estimated. These estimates are subject to change as plans are finalised, in particular Accountable Lead Provider/LTC, Equipment and Continuing Health Care Costs

2) Benefits from BCF expenditure/joint working are being calculated.

3) £7,281k Social Care Sustainability funding in 14/15 is transferred from NHS England to ECC

4) The £5.6m 2013/14 new investment is to support investment in Early Supported Stroke Discharge and other agreed initiatives. Utilisation of the Mid Essex share being confirmed.

5) Plans still under discussion - likely to include increasing the support to patients for maximising health outcomes and independence prior to assessment for CHC requirements.

6) Expect better decision making and more joined up outcomes from a joint assessment process.

7) Reprioritisation of Investment in order to invest in advance of the assessment and do the 3 month review of maximise patient's chance of successful outcome and return home.

8) Improvements to be driven by joint commissioning - also l.a. capital funding and social care equipment budgets?

The contribution of Essex CC to support for people in the LTC House of Care and the Frailty Pathway:

Essex CC's Older People's Services can be described in three elements:

- Early Intervention
- Intermediate Care Services and
- On-going Support Care

All elements interact with NHS services but particular focus in 2014/15 will be on Intermediate Care, where an integrated intermediate care pathway is being developed to ensure that people are able to access services at the right time in the right place. This is a key component of the overall frailty pathway and a key support for people in the LTC and Frailty phase of life.

Within the LTC and Frailty phases, the CCG and ECC share the ambition to enable people to remain safe and independent at home and so will shift their approach to a more preventative, integrated and targeted approach to providing services for older people, expanding jointly commissioned, and reablement and intermediate services. This will minimise the need for on-going support care services, and delay or avoid demand pressures from 2014.

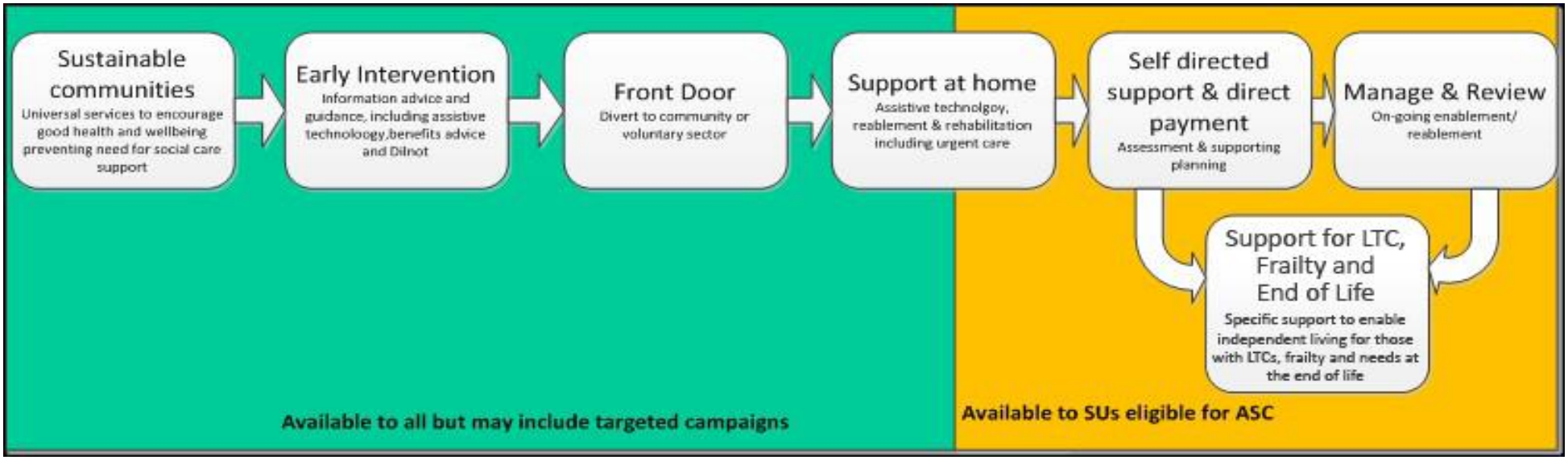
Early intervention	Intermediate care	On-going support

• Information Advice and Guidance (IAG), Self-Serve and Signposting
Strengthening Communities
Targeted approach to prevention and early intervention providing low level services which:
• are community focused
• are community led
• utilise community agents
• encourage voluntary sector development
• prevent social isolation
	Preventative, integrated and targeted approach to expanding jointly commissioned, reablement and intermediate services to:
	• minimise the need for on-going support care services
	• delay or avoid demand pressures from 2014 through:
	  • Rapid Response
	  • Home from Hospital
	  • Domiciliary reablement
	  • Residential reablement
		Long term care
		• Residential / nursing
		• Specialist day care
		• Domiciliary care
		• Continuing Healthcare (CHC)
		• End of Life (EOL)

To deliver this ECC will:

- Move to a proactive model of care that addresses key areas of demand which include the high number of people going through acute care that were not previously known to have an assessed social care need
- Work with its CCG partners to redesign the intermediate care pathway to ensure that the people who use the services are getting the right level of support at the right time and the pathway is joined up to enable people to remain independent in the community
- Deliver its aims and objectives by locating its care and assessment resources and its care services to support people to stay in their homes
- Locate its hospital discharge capacity into the community and intermediate care pathways
- Be looking to benefit from health schemes that allows it to deliver its responsibilities within a cash position 30% lower than its current spend
- Move as much of its resources as possible from residential and domiciliary care into more reablement and proactive case finding to address the issue that most of ECCs demand comes from hospital discharges which is driven by peoples deterioration in heal

Mid Essex CCG will work with ECC and other partners to deliver information, advice and guidance to the citizens of Mid-Essex and develop community resilience for people that do not have eligible assessed needs under the Fair Access to Care criteria, with the aim of avoiding or delaying unnecessary entry into the statutory health and social care systems. Those with eligible needs will be supported to maintain independence or to return to a previous level of independence through communities and reablement support. This approach is underpinned by the principles of personalisation including personal budget



Those individuals with Long Term Conditions may require support specifically designed around their condition. We will be informed by the people who use our services and work closely with our health partners to integrate pathways of care wherever possible (for example, early supported discharge pathways)

Mid Essex CCG and ECC recognise that there will be changes in circumstances for an individual triggered by a range of different situations. Our aim is therefore to develop robust pathways with all partners, including the voluntary sector, that reduce the dependency on statutory services and provide high quality services that promote independence and self-management including the use of Assistive Technology.
The current thinking is that the Systems Leadership Group will be used to oversee implementation of relevant integrated programmes including the proposed BCF schemes, metrics and governance. The SLG includes the CEOs of MEHT, Provide and NEPFT, the Director of Integrated Care as well as our clinician lead and Accountable Officer. We believe that success of the fund will be optimized with this broad input into the programmes from our providers and will signal how we intend partnership working to take place.

4.4 Access to highest quality immediate care

Strategic Plan in line with Urgent & Emergency Care Review Phase One Report – Vision:

The strategic vision of Mid Essex CCG aligns with the Urgent and Emergency Care Review Phase 1 report in that it seeks to deliver a model of care that is person centered, holistic, targeted and cost effective.

It also focuses on prevention of deterioration in function wherever possible and supporting the individual to feel safe and supported in their usual place of residence.

It will provide the ability to intervene rapidly in case of destabilizing events such as infection or illness and to avoid inappropriate admissions to hospital or residential care for conditions that can be safely managed in the community.

The plan will promote service user education and provide support to assist self- management of their long term conditions, increasing independence and self-confidence.

The CCG will work to ensure that carers feel adequately supported in their role. The plan acknowledges that where help is needed for daily functions the approach to care should be based on reablement principles with the cared for person encouraged to become more self-reliant wherever possible rather than a passive recipient of help.

During 2014/15 the Mid Essex urgent and emergency care network, will be working with key partners to develop a detailed understanding of:

Patient flows:

- Based on a comprehensive analysis of activity for 2013/14, adjusted for growth anticipated in 2014/15, QIPP plans, and contract negotiation with providers
- A detailed scorecard will be monitored by the urgent care network at the monthly meetings which will focus on a number of areas including Primary Care Practice variations, A&E activity, Emergency length of stay, readmissions, and delayed transfers of care
- The attendance and membership of the urgent care network will be determined by all of the above

The number and location of emergency and urgent care facilities:

- The intention of Mid Essex CCG is to make this as simple as possible for the people of Mid Essex, providers and commissioners

- Details of emergency and urgent care services are captured in the urgent care recovery and improvement plan and will be updated according to changes in service and future redesign
- A clear and visual representation of the number and location of emergency and urgent care services will be added to the updated urgent care recovery and improvement plan for 2014/15

The services provided:

- This will be clearly highlighted in the service specifications,
- Providers will be asked to feedback to the urgent care network on services provided and comment on exceptions within the urgent care scorecard

The most pressing needs of our population:

- This is determined by the Joint Strategic Needs Assessment (JSNA), the development of a risk stratification tool and tight control of referral management and eligibility criteria in line with the NHS constitution

The CCG and partners are preparing for designation of all facilities within the local network in 2015/16 based on development of a clear strategy within Mid Essex which will determine the future direction and how services will be commissioned in 2015/16 with clear links to the integrated plan. This will align with the overall Transformation and Sustainability programme.

4.5 A Step Change Productivity of Elective Care

Achievement of a 20% productivity improvement in elective care within 5 years with better outcomes and 20% less resource:

Mid Essex CCG are working towards achieving this step change productivity of elective care through a multi-faceted approach.

One feature of achieving these improvements will be the shift of care from acute to community settings. MECCG propose focusing on the shift of low acuity, population targeted specialties, particularly those that are non-profitable for our local acute provider. In some instances, services may transfer from community settings into the acute provider in areas where quality and safety are improved or economies of scale gained.

MECCG also intend to focus on repatriation of acute services from out of area centres. Providing local services is clearly beneficial to our local population and has the added benefit of reducing spend on MFF, as well as supporting our local acute provider.

We will assess whether outcomes evidenced schemes for planned care efficiency such as the Ten High Impact Changes (MDA 2004) are in place and working in Mid Essex to ensure pathway flow is operating at

its optimum levels already. Seven day working will be developed and expanded within existing resource through negotiation with our Providers.

We will be looking to exploit PBR local flexibilities in 14/15 to ensure appropriate tariff pricing is in place to reflect the nature of activity.

4.6 Starting Well – working with partners to maximise opportunities for integrated services for maternity, children and young peoples' services

The CCG are working closely with providers and stakeholders to develop robust effective pathways for all common childhood conditions. The development of the pathways (particularly Bronchiolitis and Diarrhoea & Vomiting) are essential to ensuring that Children & Young People and their families are able to access services/treatment at the right time and in the right place, enabling where possible Children to remain at home and receive care either at home or in their local community, thus ensuring that only those children that need to be treated and cared for in hospital are able to access that facility.

The CCG are committed to working collaboratively with local authorities, school and providers in delivering the obligations and requirements as laid out in the Children and Families Bill and are working with partners to ensure implementation from September 2014. The bill will require substantial change in the way health, education and social care work together to assess, plan and provide services for children with SEND and as such the CCG in collaboration with the Other CCGs in Essex and the Local authority.

They will:

- Continue implementation and development of personal budgets for Children and Young People with Complex Needs
- Work with CCGs and partners to develop "The Local Offer"- Details the services to support children and young people with SEND and their families in a clear and transparent way so that they can understand what is available.

The CCG will clearly articulate through Service Development Improvement Plans improvements and obligations to be embedded into service delivery during 2014/15 and work with Providers to identify appropriate Key performance Indicators and information reporting to ensure compliance with the act, once enacted.

In particular providers will be required:

- To ensure that all services are accessible in line with the Children and Families Bill and SEND reform with extend services to meet the needs of SEN from birth to 25 years
- To work with all services and partners collaboratively thus ensuring an integrated approach to the assessment, care and

treatment of Children, Young People and their families Ensuring through integrated working the embedding of the early support model improving the delivery of services for disabled children, young people and their families and enabling services to coordinate their activity better and provide families with a single point of contact and continuity through key working.

- To ensure that all planning processes are Child and Young Person, outcomes driven, with a holistic understanding of the needs and expectations of the Child or Young Person.
- To work collaboratively and ensure that all relevant information is in one easily accessible place.
- To coordinate and align activities of all agencies via the plan to ensure greater efficiency; responsibilities are clear.
- To ensure that plans are communicated in a shared and easily understood language.
- To enable families to "tell us once", we listen and capture information and utilise it to inform our future engagement.
- To deliver an improved experience of the system for all involved.
- To ensure through delivery of services that all Children and Young People achieve improved and positive outcomes as a result of improvements and changes made.
- To update their own 'local offer' service information in order for the latest information is available for families. Ensuring that details are shared with all relevant LAs (e.g. Essex County Council, Southend Borough Council and Thurrock Council)

4.7. Maldon Health and Well-being Services provision

During 2013 and 14 Mid Essex PCT and more recently the CCG revisited the issue of reprovision of health services at St Peter's Hospital in Maldon. A significant piece of work was completed towards the development of a multi-agency multi-purpose health and wellbeing facility.

This work included a completing a comprehensive JSNA for Maldon, public and partner consultation, developing a NHS England Project Initiation Document (PID) which was given approval for progress to Outline and Final Business case stages,

Current services and activity were mapped against current need and also projected in to the future Local Delivery Plan (LDP) for Maldon District. This highlighted a growing need for Primary Care services particularly in the older population which is growing exponentially.

Delivery of Primary care was a key component of the future plans for local services in the District along with a greater integration of health

and wellbeing services including voluntary sector services, social care and housing.

This work was reported through both the CCGs Board and a formal Project Board hosted by Maldon District Council.

In the context of the CCG's current financial situation and the development of a 5 year, the CCG will review the Maldon Development Project and ensure alignment with the transformational plans.

4.8 Specialised services concentrated in centres of excellence

Specialised services concentrated in centres of excellence:
The CCG is committed to working closely with NHSE, local providers and stakeholders to engage with and support the NHSE-led National Review of Specialised Services. We recognise this is likely to lead to the concentration of specialist expertise in fewer centres with Academic health science centres.

Locally there is currently a consultation across Essex on a review of stroke services with the proposed creation of 3 hyper-acute stroke units including at Broomfield Hospital, which the CCG fully supports. We recognise this trend is likely to continue for services where patient outcomes are significantly improved from the concentration of specialist skills and resources. Furthermore we recognise the need for some specialist services (as well as certain NHSE commissioned specialised services) to also be reviewed in the context of the proposed development of more capable integrated primary and community health and social care services, the continuing financial pressures facing providers and the need to maintain and improve quality standards and patient outcomes.

The CCG will work collaboratively with the other Essex CCGs and acute providers to initiate an appropriate review.

4.8.1 Outcomes of Colchester Cancer Review

Mid Essex CCG acknowledges the Colchester Cancer Review and the recommendations of the review and NHS England team that an in-depth review of urology pathways and a review of anal cancer in undertaken on clinical ground and in terms of moving towards IOG compliant pathways for Essex patients.

The report into the immediate review of Cancer Services at Colchester Hospital was published on 19th December 2013 and can be found on

Incident page: http://www.england.nhs.uk/publications/incident-mng-rep/

News item: http://www.england.nhs.uk/2013/12/19/review-cancer-services/

Several specialist commissioning pathways are not IOG compliant and the East Anglia Specialist Commissioning group is now involved. However changes in the specialist parts of the pathways have implications for general DGH work. The Cancer Network has been approached to help in scoping IOG compliant pathways for anal cancer and for urology.

There is not currently an IOG compliant centre in Essex for urology. Mid Essex CCG and DGH will work with the Cancer Network and other partners to put in place a plan to move to IOG compliance. There will also be work undertaken to ensure that MEHT has sufficient capacity in urology to manage demand.

4.9 Continuing Healthcare and Personal Health Budgets

The CCG recognises both in terms of potential risk to patients and monetary value it is essential to ensure a robust process in place for the provision of Continuing Health Care.

The CCG contracts with the CSU for the provision of assessment and implementation of packages for patients. There is an agreed threshold for CSU staff to approve packages of care, if care costs fall above this Threshold approval is required from either the Director of Nursing or Deputy Director of Nursing.

Performance in relation to CHC has significantly improved over 2013/14. An Essex wide review and recovery action plan has been developed and implemented throughout the year and this has ensured the CCG can continue with robust processes and systems for the management of CHC in 2014/15. In addition the CCG has taken an independent view of the CHC process and has recommendations for further developments in line with the integration agenda throughout 2014/15.

The CCG has been developing systems and processes to support the implementation of personal health budgets from April 2014. The CCG is currently participating in a pilot for personal health budgets and this is being supported by the Essex Coalition of Disabled People. A number of key stakeholder events have been held for patients and clinicians across the health economy. A Personal Health Budgets Peer Support Network has been established and is chaired by a patient. In addition a monthly steering group takes place to monitor the implementation of process and ensure learning from the Pilot is being implemented. The CCG participates in both Regional and National events in relation to CHC and PHB and participates in the Regional "Markers of Progress" process.

The CCG is working in collaboration with all Essex CCGs, Local Authority colleagues and the voluntary sector to ensure the process implemented meets the needs of the local population.

5. Access

5.1 Convenient access for everyone

As the CCG develops its transformation programme we will ensure that good access is delivered to the full range of services including GP and community services, acute and mental health services.

In particular the CCG will ensure:

- That access routes and advice for the public are simplified and streamlined as far as possible through promoting the use of the 111 service locally and ensuring the directory of service is appropriately developed and maintained
- That we work with NHSE to ensure primary care access issues are addressed
- We will develop proposals for immediate / unplanned care in line with the National Review of urgent and emergency care to cover 111, 999, GP access, A&E, GP Out of Hours, mental health crisis services, rapid community services and other urgent care services, including links with social care services
- There is a single point of referral for health professionals in Mid Essex. This has been commissioned from NEPT in 2013.
- Attention in 14/15 will focus on ensuring the realisation of benefits from communicating the service and aligning and coordinating contributing services across providers including in support of the rapid response Crisis Response Service

These actions will be delivered as part of the development of the patient service strategies outlined above particular attention will be given to ensuring equity of access for minority and hard to reach groups.

5.2 Meeting the NHS Constitution standards

The CCG will continue to commission and performance manage contracts to ensure sufficient services are delivered to continue to meet the NHS Constitution rights and pledges including around access and choice.

We will have system wide escalation plans, emergency planning and coordinating mechanisms, managed by the local urgent and emergency care network and overseen by the System Leadership Group, in place to ensure that during busy times such as the winter, local services work in a coordinated and mutually supportive way to ensure patient access is maintained. The effectiveness of these

processes is demonstrated by MEHT having met the A&E 4hr target for Q3.

The CCG will also review any services which do not meet NHS Constitution requirements with a review to their transformation or decommissioning as appropriate.

CCG Performance against the NHS Constitution Standards 18 weeks Pathway:

Although the CCG recognises the achievement of 18 weeks at aggregate level there is still some work to ensure we achieve it at speciality level, mainly around general surgery which was just below target for the non-admitted pathway in December. The Trust has a trajectory to be compliant across all specialities by March 2014.

The Trust has continued to reduce the backlog of patients in 2013/14 of which the majority is Plastics and attributed to patient choice of Consultant. The CCG continues to proactively work with the Trust to ensure compliance across all specialities and ensure equity of service delivery for all patients. Contract penalties are applied to the underperformance.

Cancer standards:

The Trust has been consistently achieving all standards since July 2011. The drop in the 62 standard from October 2013 is mainly due to:

- An increase of 14% in 2 week referrals in 13/14 adding pressure on diagnostic and histology mainly in the urology pathway resulting in patients slipping the timeframe
- The loss of the local Cancer Network to coordinate changes/issues around pathways has resulted in delay in inter provider discussions/resolutions
- More complex patients on shared pathways having delays in inter provider care.
- Early indication of small movement of CHUFT referrals
- The Trust undertook an internal audit and also used the information from the NHS England CHUFT review to produce a comprehensive recovery plan and trajectory. This has provided the CCG Board with assurance that the Trust will be progressing actions which ensure this standard will be met by March 2014.

These actions include:

- Implementation of an Inter-Provider Transfer Policy to ensure a smooth transfer of patient care across South Essex Tertiary Providers minimising delays in the pathway
- Discussions around localisation of site specific “Timed pathways” implemented in Anglia
- Regular review of Patient Tracking Lists and early identification of issues arising at Trusts and in Primary Care for resolution

- Contract queries/penalties to both MEHT and CHUFT

A&E- % of Patients Seen & Treated in four hours:

During 2013/14 the CCG implemented an Urgent Care Recovery and Improvement Plan and significantly revised its Winter Plan. In addition winter schemes implemented by MEHT have enabled the system to manage the pressure across the local health economy. Supporting this approach MEHT has been delivering the A&E performance throughout the year meeting the standard in Q1 & Q2 and whilst missing it in December, good performance in October and November meant they also met Q3. At the time of writing we forecast achievement of the 4 hour standard in Quarter 4 and overall for the year.

Ambulance Trust:

Performance issues with East of England Ambulance Service NHS Trust (EEAST) continue. Whilst there is good working relationships between the Ambulance Crews and handover to Trust staff the handover target is still not met. This is similar for most Trusts in the EoE. The tripartite agreement has yet to be signed. Contract performance penalties are applied The CCG continues to work with the CCG collaborative commissioning arrangement to support EEAST to move to a more sustainable position for all national targets. Key issues of focus on are capacity and recruitment, and the ambulance service transformation.

NHS Constitution	Target 14/15	Current Performance		NHS Constitution	Target 14/15	Current Performance
18 week RTT - admitted % within 18 weeks	90%	Dec-13 95.2%		Ambulance clinical quality – Category A (Red 1) 8 minute response time	75%	Dec-13 71.6%
18 week RTT - non-admitted % within 18 weeks	95%	Dec-13 98.0%		Ambulance clinical quality – Category A (Red 2) 8 minute response time	75%	Dec-13 67.1%
18 week RTT - incomplete % within 18 weeks	92%	Dec-13 97.3%		Ambulance clinical quality - Category A 19 minute transportation time	95%	Dec-13 92.1%
Number of 52 week Referral to Treatment Pathways	0	Dec-13 1		% waiting 6 weeks or more for diagnostic tests	<1%	Dec-13 0.2%
Cancer: Two Week Wait	93%	Dec-13 94.9%		% of patients who spent 4 hours or less in A&E (MEHT)	95%	YTD to 10-Feb-14 95.6%
Cancer: Breast Symptom Two Week Wait	93%	Dec-13 93.5%		Trolley waits in A&E: Patients who have waited over 12 hours in A&E from decision to admit to admission (MEHT)	0	Jan-14 YTD 0
Cancer: 31 Day First Treatment	96%	Dec-13 97.8%		NHS Constitution Support Measures		
Cancer: 31 Day Subsequent Treatment - Surgery	94%	Dec-13 100%		Mixed Sex Accommodation (MSA) Breaches	0	Dec-13 YTD 3
Cancer: 31 Day Subsequent Treatment - Drug Treatments	98%	Dec-13 100%		Urgent operations cancelled for a second time (MEHT)	0	Dec-13 YTD 0
Cancer: 31 Day Subsequent Treatment - Radiotherapy	94%	Dec-13 95.8%		Cancelled Operations - % of patients not treated within 28 days of last minute elective cancellation (MEHT)	Reduce	Q2 2013/14 9.4%
Cancer Plan: 62 Day Standard	85%	Dec-13 80.6%		Mental Health - CPA follow up within 7 days	95%	Q2 2013/14 99.3%
Cancer: 62 Day Screening Standard	90%	Dec-13 92.3%		Ambulance - % of patients handed over within 15 minutes	85%	YTD to Dec-13 54.3%
Cancer: 62 Day Upgrade Standard	No Target	Dec-13 100%				

5.3 Consistent & Appropriate IT Access for GP Surgeries

The responsibility for the day to day management of GP Practice IT systems has been delegated by NHS England to individual CCGs.

Mid Essex CCG is in the process of a review of the strategic objectives for GP IT. The main objectives are to determine the most significant risks within the primary care environment, assess the impact and likelihood of each risk and therefore determine the priority in which those risks should be addressed.

The road-map for tackling the 'priorities will need to be set against a back-drop of financial constraints. All IT solutions that are explored and consequently planned will be prioritised by the CCG and set against other cost pressures

The CCG continues to be in discussion with the CSU and remains fully supportive of GP practices where the biggest concerns have arisen. The outcome of those discussions has resulted in the identification of three primary strategic objectives and a specific process relating to migration / systems upgrade.

Primary strategic objectives:

- Assessing IT equipment (specifically desk-side equipment e.g. PCs, printers, scanners etc.) within GP practices.
- There is a need to audit and assess the current equipment in all GP practices (including other equipment that has been purchased by the practice that is windows XP compatible) to identify any which may need replacing in the foreseeable future – i.e. PCs running Windows XP before official support from Microsoft ends for Windows XP.
- This poses a significant risk for Mid Essex due to obsolete equipment and software. The aim is to start replacing old legacy hardware.
- Review aging servers (old EMIS, Vision or PCT servers) within GP practices. Almost all practices retain a local server on-site, regardless of whether you use a hosted clinical system (e.g. SystmOne).

The likelihood of server failures within Mid Essex is high given that the age of much of the equipment is 7+ years. The impact risk is high considering approximately 75% of practices have a legacy server still in use.

The CCG requested the CSU carried out an urgent and fully comprehensive assessment regarding current server estate which will inform the necessary solutions for managing the GP IT server infrastructure for all practices. This assessment would highlight a solution with a view to all practices being connected to the new solution, circa. End of Q2 2014 (i.e. mid-summer) subject to sufficient capital funding being made available.

Review of ineffective clinical systems.

It is has been identified that there are a number of practices that operate using old legacy clinical systems. These may be perceived to be inefficient and/or drawing towards the end of their supportable live i.e. the software vendor is planning to retire the product. The CCG recognises its obligation to support practices with choosing a suitable alternative to their current ineffective product, and where funds are available the CCG should financially support the practices' decision to change clinical system when the chosen product meets the national criteria (i.e. the GPSoC framework), the local CCG-wide objectives (e.g. CCG cost savings and improved patient care) and the practices own objectives (e.g. improved practice efficiencies).

Mid Essex CGG will therefore monitor the situation with those practices and plan for the inevitable migration/upgrade of those systems. Given that upgrades/migrations can span 4-6 months and attract a price tag of approximately £20k per upgrade/migration it is critical that planning starts early to ensure funds are prioritised appropriately. .

Current Progress

The CCG is developing a 'General Practice Clinical IT Systems Strategy' document outlining the core objectives that the CCG wants to see achieved by the nominated replacement clinical system.

Submission of Templates

The overview of the collated requirements from both practices and the CCG will be made available to viable clinical system providers for them to put forward proposed solutions that cater for all requirements. This will then be followed by discussions with practices regarding individual requirements as we want to support GP practices in reaching appropriate and affordable decisions where IT equipment and systems are concerned.

6. Quality

6.1 Reflecting key findings of Francis, Berwick & Winterbourne View reports

MECCG recognise now is the time to build upon the foundations already laid in Mid Essex and make further advances in the world of safety improvement and quality so the legacy of Francis, Berwick, Keogh and Winterbourne is that of a confident and learning health system that listens to the needs of its patients and staff in order to deliver the safest and best healthcare. There is full commitment to recommendations made and the CCG has pledged to ensure that all contracts include quality performance requirements, expected core standards of care are secured contractually and Providers are challenged to make on-going improvements in the quality of care provided.

MECCG will seek contractual redress when performance does not meet expected quality and safety standards; whilst working with that Provider to improve the quality of services provided for every patient. Specific measures and monitoring processes to improve outcomes for patients with a learning disability will be consistently applied. This will be based upon the outcome of self-assessments of Learning Disability services and in the light of the Serious Case Review into abuse at Winterbourne View. Providers will be required to monitor patterns in A&E attendances from residential units for people with learning disabilities.

The focus on adequate staffing levels, including sickness absence monitoring and ensuring staff appraisal occurs annually in the national contract 2014/15 has been built on further with the development of local key performance indicators devised to assure that there are safe staffing levels reported on and practised in all areas. This has been further strengthened with investment into nursing leadership and competency, aiding assurance that care is delivered by a competent workforce. Such work streams feed directly into and from the Compassion agenda and recommendations from Patients First and Foremost. Cost improvement plans are regularly reviewed by the CQRG and providers are required to share quality impact assessments whereby staffing levels are affected.

Further work presently being undertaken in relation to Nursing Leadership in the secondary care environment, with the Royal College of Nursing (RCN), has been fully supported by the CCG and incentivised further through CQUIN.

The CCG will continue to participate in the Essex Quality Surveillance Group with attendance by the Accountable Officer and Director of Nursing. The surveillance group provides a forum for local partners to

realise the cultures and values of open and honest cooperation, whilst ensuring that supervisory, commissioning and regulatory bodies work in a more coordinated way. Thus enabling MECCG to escalate quality or risk concerns to colleagues such as the Care Quality Commission in a timely and supportive manner.

Whereby it is identified by the Care Quality Commission (CQC) that they are taking enforcement against a provider the CCG will ensure that where the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and any other relevant legislation is not being met that we will use contractual redress and monitoring to ensure the required improvement is achieved and maintained.

6.2 Patient Safety

Patient safety is a key domain of ensuring overall delivery of a quality service and will continue to be formally reviewed monthly via the Clinical Quality Review Groups; provider performance against safety standards will be escalated internally to the Quality and Governance Committee through to Board, to ensure that key safety concerns are always recognised and acted on across all levels in the CCG.

The CCG fully supports the Harm Free Care agenda across all commissioned services and will continue to work with all providers to ultimately ensure that no avoidable harm is caused. To support the Harm Free Care agenda, the CCG collaboratively works with all providers and CCGs in North Essex to hold the Harm free Care Collaborative, which actively shares good practice and lessons learnt across providers on a quarterly basis.

Contracting for quality improvement will continue to be a key objective for the CCG, with a continued commitment to learning from incidents, complaints and near misses, as well as listening to and learning from others experiences. The CCG will ensure:

- We utilise transparent methodology within contracts with respect to on-site visits and inspections of premises, these may be announced or unannounced
- We expect a reasonable timeframe for the implementation of NICE Quality Standards. Where relevant Quality guidance has been identified the CCG will seek assurance that each provider has an implementation strategy
- We continue to work across the system to reduce HCAI and strive towards zero tolerance in relation to existing MRSA and Clostridium *difficile* across the system
- New initiatives will be introduced to address incidents of surgical site infections and catheter associated urinary tract infections. This will include the use of catheter passports and care pathways for managing incontinence and retention of urine

- Providers will be expected to demonstrate effective systems to identify and manage sepsis to reduce the associated mortality and improve overall patient outcomes
- Require all Providers to adopt our Policy in relation to identifying, reporting and investigation of Serious Incidents and incidents. Providers must comply with their duty of candour, being open and transparent with their process and also sharing outcomes with us in a timely manner. Reporting and learning from serious incidents across all Providers working with North Essex CCGs is formalised via the Serious Incident and Never Event Panel
- It will be expected that all Providers demonstrate evidence through the CQRG that they have implemented the National Patient safety Alerting System, which is used to disseminate patient safety information at different stages of development to NHS organisations providing care across all settings. Thus allowing more rapid dissemination of urgent information via the Central Alerting System (CAS), as well as encouraging information sharing between organisations and providing useful education and implementation resources to support providers in reducing risks to patients. Require Providers to share their level of achievement with the NHSLA
- Continue to work with Providers in managing and improving quality Re NQB report – Quality in the New Health System, reviewing the report and the implications for the new health economy
- Work with Essex County Council collaboratively to improve standards of nursing care (where commissioned) within care homes in Mid Essex. This will include a specific focus on Infection Prevention & Control (IP&C) and pressure ulcers.
- Ensure Providers continue to focus on improving safeguarding of adults at risk and children
- The CCG will support Providers to set up falls panels with the aim of recognising and determining avoidability of serious harm falls, identifying trends and intervention strategies
- Continue to promote reporting and in eliminating all avoidable health care acquired grades 3 and 4 pressure damage. This will include robust reporting of incidence and trends to establish avoidability
- Commence new work streams in relation to the identification and intervention for Grade 2 Pressure Ulcers
- All good providers have robust KPIs in place to ensure that the performance for assessment and prophylaxis of VTE is sustained and remains above the national target. Where a hospital acquired thrombosis occurs robust investigation will determine root cause, to enable improvements to be made.
- Continued use by providers of prevalence data collection through the national safety thermometer, using the data to

influence the commissioning of new care pathways. Further developments in safety thermometer methodology will be supported by the CCG including its introduction into Mental Health and Medicines Management

- To seek assurance that the early warning scoring system NEWS is effectively implemented to ensure robust mechanisms are in place to recognise the deteriorating patient
- Promote reporting of medicine management incidents, analysing incidents, identifying trends and ensuring robust action plans are established in response

6.3 Patient Experience

Patient experience is integral to providing quality care to enable understanding of quality from the unique perspective of those receiving care.

MECCG will require Providers to demonstrate that effective systems are in place to respond to patient feedback from surveys, including the Friends and Family Test, complaints and other intelligence, such as patient stories. We will improve responsiveness to complaints, identifying themes and trends to improve patient experience and perception. Alliances with our provider colleagues for PALS and complaints will be developed to ensure a robust mechanism of a timely response to complaints and trends from PALS ensuring a consistent approach for our patients.

This will include some exciting joint working with listening events to capture and utilise a rich source of patient feedback and experience, feeding directly into the executive boards, aiming, to capture information from all priority groups

The CCG recognise supporting and educating partner organisations on the variety of methodology associated with capturing and enhancing patient experience for example, experienced based design and emotional mapping, is a key patient experience objective moving forward. These methodologies will form part of the larger work plan designed to meet the Care and Compassion agenda. A key component of which will be to ensure identified patients are invited to present their story to every CCG Board. This powerful medium will be utilised to ensure as commissioners we understand our services from the unique view of the patient.

The CCG will expect that Providers gather patient experience intelligence from a variety of sources, including real time monitoring, and survey following treatment; enabling understanding of patient wellbeing following care and timely responsiveness to areas of concern. The continued requirement of providers to ensure PROMS

are used in the determination of patient experience remains with consideration of using this data to influence future decision making.

There is a continued expectation that all providers meet single sex accommodation guidance (EMSA) including reporting of any EMSA breaches, with the completion of an RCA. All patients attending hospital services will receive the same level of service regardless of age, sex, race, sexuality or disability and will require providers to comply with all existing national legislation with regard to the provision of services and for reasonable adjustments to be made to support their access to acute services. Providers will also need to meet the requirements of the Equality Act 2010 and the NHS Equality Delivery System (EDS).

Providers will also be required to maintain the EDS (or in the case on non-NHS providers) and to have in place similar arrangements that will help to progress the EDS goals.

MECCG will seek to improve services and service outcomes for people with mental health problems, working with North East Essex as lead commissioner, ensuring services are commissioned and delivered from a basis of humanity, dignity and respect. This includes measuring, assessing and improving service user and carer experience. We expect the 'No Health without Mental Health, a cross-government mental health outcomes strategy for people of all ages, February 2011 to be implemented.

The Clinical Quality Specialist Lead will work together with the CCG Engagement Lead to further establish key working partnerships with stakeholders to develop strategy and networks to ensure that patient experience is at the heart of commissioning. This will of course include enhanced working with Healthwatch and other local carer forums, to ensure the voice of all patient groups is heard.

6.4 Compassion in Practice

MECCG expect providers to respond to National Patient Safety and Quality Initiatives such as the CNO vision for Nursing and Midwifery, Compassion in Practice. This work will be supported by the Clinical Quality Specialist Lead within the CCG, whose role is to work with Providers to achieve and embed Compassion in Practice. As well as the clear focus on developing and communicating the 6Cs, MECCG is actively engaged in the six areas of action where we can concentrate our effort and create impact for our patients and the people we support.

The action areas are:

- Helping people to stay independent, maximising well-being and improving health outcomes
- Working with people to provide a positive experience of care
- Delivering high quality care and measuring the impact of care
- Building and strengthening leadership

- Ensuring we have the right staff, with the right skills, in the right place
- Supporting positive staff experience

MECCG has ensured that all contracts have embedded the requirements of the 6C's in practice. The unique role of the Quality clinical specialist lead is to continuously engage with Providers and develop exciting work streams and projects to demonstrate not only implementation in practice, but improved outcomes and experience of our patients. Supporting the competency drive within nursing, capturing rich and meaningful patient experience and the ongoing health and wellbeing of staff groups are expected reportable outcome measures from this work stream.

6.5 Staff Satisfaction

Evidence suggests that engaged staff will undoubtedly enhance quality of services and despite there being no question that patients have to be at the very heart of all service delivery, leaders must identify projects wisely and ensure that staff are protected and also fully engaged.

Moving forward MECCG will continue to monitor staff satisfaction as measured via Staff surveys, in particular the staff element for the Friends and Family Test and the National Staff survey. We will work with providers to ensure that safer staffing levels are achieved across all services, enabling staff to meet the needs of patients and that those staff are appropriately trained, competent, have supervision and are appraised– all in line with the compassion in practice action area 5.

6.6 Seven Day Services

As part of the contract round for 14/15 the CCG will be requiring all providers of acute services within their SDIP to document actions that they will take during 2014/15 to commence implementation of the recommendations of the review into 7-day services.

Confidence in delivery and progress made for 7 day working and its implications will be aligned to the strategic planning process of the CCG and a working group set up to oversee implementation.

For non-acute based urgent and emergency services outside of the hospital, implications for 7 day working is being picked up as part of the Emergency and Urgent Care Strategy (and aligns with the Urgent and Emergency Care Review Phase 1 report) with the majority of these services already operating 7 days a week.

The local Better Care Fund proposals will also support development of 7 day health and social care services including to support 7 day hospital discharge and admission avoidance.

6.7 Safeguarding

Mid Essex CCG (MECCG) is committed to delivering safe and effective safeguarding services and to strengthening arrangements for safeguarding children and adults at risk across Essex.

Our vision is to provide services to promote and protect individual human rights, independence and well-being. Everyone requiring our services will be treated with dignity and respect.

Safeguarding children, young people & adults at risk and promoting their well-being is essential for Mid Essex Clinical Commissioning Group (MECCG). MECCG will ensure safeguarding, protection and promoting well-being in all its activities with children, young people and their parents, adults at risk, carers, families and staff.

Our vision:

Children and young people and adults at risk are considered in all interactions with service users and carers. A 'Think Family' approach across adult and children's services will enhance safeguarding practice, service provision and commissioning.

Safeguarding and protecting the vulnerable will be realised as a role for all services and all staff across Mid Essex regardless of their position.

A strategy helps us reach this vision. It describes our main aims and what we will need to achieve to get there.

We will:

- Seek the views of children, young people, adults at risk and their carers to influence the commissioning of services
- Comply with statutory requirements nationally and locally including quality standards set by the Care Quality Commission and NHS England
- Provide leadership for safeguarding across NHS and partner organisations
- Have sound reporting, monitoring and accountability arrangements for safeguarding across the organisation ensuring Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework 2013 continues to be used to monitor commissioned services
- Have executive level membership of the Essex Safeguarding Children Board & Essex Safeguarding Adults Board
- Work in collaboration with Essex County Council and other partner organisations to provide where appropriate integrated services for the local population, including specialist services for disabled people, looked after children and other vulnerable groups

- Commission services which reduce the effects of domestic abuse which includes Honour Based Abuse, Forced Marriage and Female Genital Mutilation
- Promote the PREVENT anti-terrorist strategy to reduce the risks of vulnerable people becoming radicalised
- Have safeguarding children (including those who are Looked After) and adult at risk policies in place, which includes safe recruitment of staff, whistle-blowing policies
- Have a positive influence on safeguarding arrangements
- Across the NHS and partner organisations
- Make sure that all staff know how to recognise and respond to safeguarding concerns
- Take account of the views and experiences of the most vulnerable members of our communities to inform service planning
- Review serious incidents to identify lessons learned and to cascade learning across organisations
- Improve and develop safeguarding practice through learning from experience, review, research, evidence and guidance
- Continually monitor and review the quality of services to vulnerable groups through our quality assurance and governance processes to achieve the best outcomes

7. Research

7.1 Research & innovation

How we fulfil our statutory responsibility to support research:

Mid Essex CCG believes that research and innovation are important to the future of shaping local clinical services in Mid Essex. The CCG are a member of the Comprehensive Local Research Network (CLRN) and we also have a number of members of the East of England Clinical Senate including a GP Chair.

The CCG fund a Research Nurse at our local acute provider to facilitate primary care engagement in clinical research and we are actively involved in the ethical evaluation of research proposals within our acute trust.

We are exploring partnership opportunities with our local higher education institute. In particular, Anglia Ruskin University (ARU) are developing a MedTech campus within Chelmsford and the CCG are in discussion with ARU as to how a partnership could be mutually beneficial in promoting clinical research and innovation within Mid Essex.

How we will use the Academic Health Science Networks to promote research:

We are establishing links with our local HEIs as described above and we also actively engage with the Local Education & Training Board (LETB) in terms of planning and research promotion

How we will adopt innovative approaches using the delivery agenda set out in Innovation Health and Wealth: accelerating adoption and diffusion in the NHS:

In addition to the above, we adopt the Invention, Adoption, Diffusion approach set out in Innovation Health and Wealth with the Innovation Pipeline approach to business case development we have adopted in partnership with our local acute trust.

8. Organisational Development

Mid Essex CCG has, in its short life, already made a considerable impact in terms of ensuring it can fulfil its role as the commissioner of the health care for its population. An early vision laid out the following goals:

- For individuals in mid Essex to be healthy and supported to look after themselves as far as possible
- Healthcare in mid Essex will be a beacon of excellence
- As leaders of healthcare commissioning we will be respected and trusted by our peers and the communities we serve whilst demonstrating respect, care and dignity towards all
- People will feel valued, encouraged and supported to make the right choices and use services appropriately
- Services we commission will focus on quality, innovation, productivity and prevention and deliver the best possible care to communities and individuals and reduce health inequalities

The delivery of these goals is both challenging and exciting and with the leadership provided by our clinicians the CCG is aiming to achieve a sustainable and forward looking health system which operates within the resources available.

Over recent months the CCG has been working to develop a long term sustainable vision for the Mid Essex health system.

The emerging vision focuses on 5 "phases of life":

- Long Term Conditions
- Frailty
- Self-Care
- Immediate Care
- End of Life

These need to be of a high quality and affordable. In order to ensure that this can be delivered the CCG needs to be structured in such a way to support this change process while balancing both the quality and the cost agendas whilst ensuring "business as usual" continues.

As a result the CCG is currently restructuring its organisation to better and more effectively meets the needs identified as above.

The new structure is anticipated to be in place by the end of the financial year 2013/14. In addition the CCG has also secured new premises and the move to these is also anticipated during the same timescale.

The CCG has spent significant time and resource in organisational development during 2013/14 both for the CCG Board members, clinical leads and all staff. Development has been focussed primarily on achieving mandatory training levels across the organisation as well as a defined programme of core commissioning and support skills delivered through workshops. This will continue into 2014/15 and beyond

The CCG's Organisational Development Plan is due to be refreshed and will reflect the outstanding needs identified in the two Staff Away Days held in 2013/14 as well as a programme for development across the organisation, reflecting the new sustainable vision for the CCG.

9. Monthly Activity Return

MAR Submissions are based on FOT at Month 9 using contract profiles, adjusted working days for electives and outpatients and calendar days for non- elective.

14/15	15/16	16/17	17/18	18/19	Schemes/policies which will/should impact on growth % reductions
Emergency (+2%)	Emergency (0%) Flat	Emergency (-1%)	Emergency (-1%)	Emergency (-1%)	Changes to front door, RAU/EAU frailty pathway , BCF
NEL - Non emergency (+1%)	NEL Non-emergency (-1%)	NEL Non-emergency (-2%)	NEL Non-emergency (-2%)	NEL Non-emergency (-2%)	Frailty , EOL, BCF
Elective (-0.5%)	Elective (-1%)	Elective (-1%)	Elective (-1%)	Elective (-1%)	QP+ , SRP
Referrals & Outpatients (-0.5%)	Referrals & Outpatients (-1%)	Referrals & Outpatients (-1%)	Referrals & Outpatients (-1%)	Referrals & Outpatients (-1%)	QP+ , SRP

CCG's are expected to deliver challenging activity reductions over the life of the medium term plan. The CCG is working closely with system partners to identify the service delivery pathways which offer the best use of scarce resources and avoids undermining provider sustainability where possible.

The forecast activity assumptions do not yet reflect the impact of any service transformation which may be agreed as part of the System Sustainability review.

10. Delivering Value

10.1 Financial resilience, & delivering value for money

Meeting rules on business plans:

The CCG is required to meet its national and local priorities and to deliver the NHS Constitution within allocated resources. National planning assumptions identify a potential funding gap of around £30 billion by 2020/21 and CCG plans are required to demonstrate how services can be maintained in that context.

The Mid Essex system has been a historically financially challenged health economy. Assessed need to spend is low due to the relatively affluent population with relatively good health outcomes and life expectancy.

For 14/15 onwards, NHS England has adopted a revised funding formula recommended by the Advisory Committee on Resource Allocation. The new formula reduces the CCG's assessed target funding requirement (now assessed as £1,079 per head of population by 15/16 compared to £1,084 in 2013/14 using the 13/14 formula).

Whilst service quality and outcomes are good, Mid Essex Hospital Services Trust has reported a significant underlying financial deficit for a number of years and the combination of low CCG funding and the financial pressures experienced by the main acute provider means that the financial challenge for Mid Essex is escalating.

The CCG's 14/15 allocation is £1,014 per head which is in the bottom 20% of funding per head for England and 4.88% below target.

The CCG is likely to incur a deficit of £9.2m in 13/14. A number of non-recurrent resources were used to deliver that position e.g. £2.5m surplus brought forward, £1.3m Winter Pressure funding and dispensation from delivering the required target 1% surplus or holding 2% of funding for non-recurrent expenditure. These factors contribute to an opening underlying deficit in the order of £13m.

Funding allocations have been announced for 14/15 and 15/16 as follows:

	2013/14 £000	2014/15 £000	2015/16 £000
Confirmed Programme Funding	368,029	379,825	390,642
Agreed RL Adjustments	558	11,324	8,802
Return of Specialist Top-Slice	10,631	(507)	(507)
GP IT	1,223		
Winter Pressure	2,869		
Surplus Brought Forward	2,509		
Additional Better Care Funding			7,281
Total Programme Funding	385,819	390,642	406,218
Running Cost Funding	9,430	8,753	8,753
Total Funding	395,249	399,395	414,971

Meeting rules on business plans:

The following Business Plan rules have been set nationally:

2014/15	2015/16-2018/19
• Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2.5% non-recurrent spend (including 1% for transformation)	• Minimum 0.5% contingency • 1% cumulative surplus carry forward • 2% non-recurrent spend • Better Care Fund spend as notified separately

The 14/15 funding increase was disappointing and is more than offset by expected new cost pressures. The CCG is not going to be able to achieve the Business Rules nor deliver a balanced financial plan in the short term.

Note: Further tables and commentary to be added once the Medium Term Financial Plan/Sustainability information is firmer. Data to be added includes 5 year overview, commentary upon the planning assumptions, sustainability plan etc

Clear & Credible plans for QIPP:

The CCG is working closely with NHSE Essex Area Team and system partners on a System Sustainability project. Timings are such that plans are not yet available to include in the plan submission.

Service transformation plans are in development but require greater granularity and assumptions require validation.

Clear link between service plans, financial and activity plans:

The CCG is in early discussion with the MEHT regarding possibility of agreeing block payments in the short term in order to create the headroom to test and implement service transformation that will enable both MEHT and MECCG to achieve financial sustainability. As a part of these discussions we are working with MEHT, NHSE Essex AT and NTDA in order to support the financial viability of MEHT.

There are key work streams are in progress to model planned acute activity and will align with service and financial plans. At this stage in the process, the modelling is still work in progress.

North East Essex CCG

2 Year Operational Plan

2014/15 – 2015/16

V12

VERSION CONTROL

Draft V6	14.02.14	Submitted to LAT 14.02.14
Draft V7		
Draft V8		
Draft V9	05.03.14	Incorporates feedback from LAT quarterly meeting on 04.03.14
Draft V10	10.03.14	Submitted to NEE CCG Board March 25th 2014
Draft V11	13.03.14	Submitted to NEE CCG Board Meeting 25th March 2014 and to Essex HWB Meeting 27th March 2014
Draft v12	18.03.14	Submitted to HWB and shared with Providers

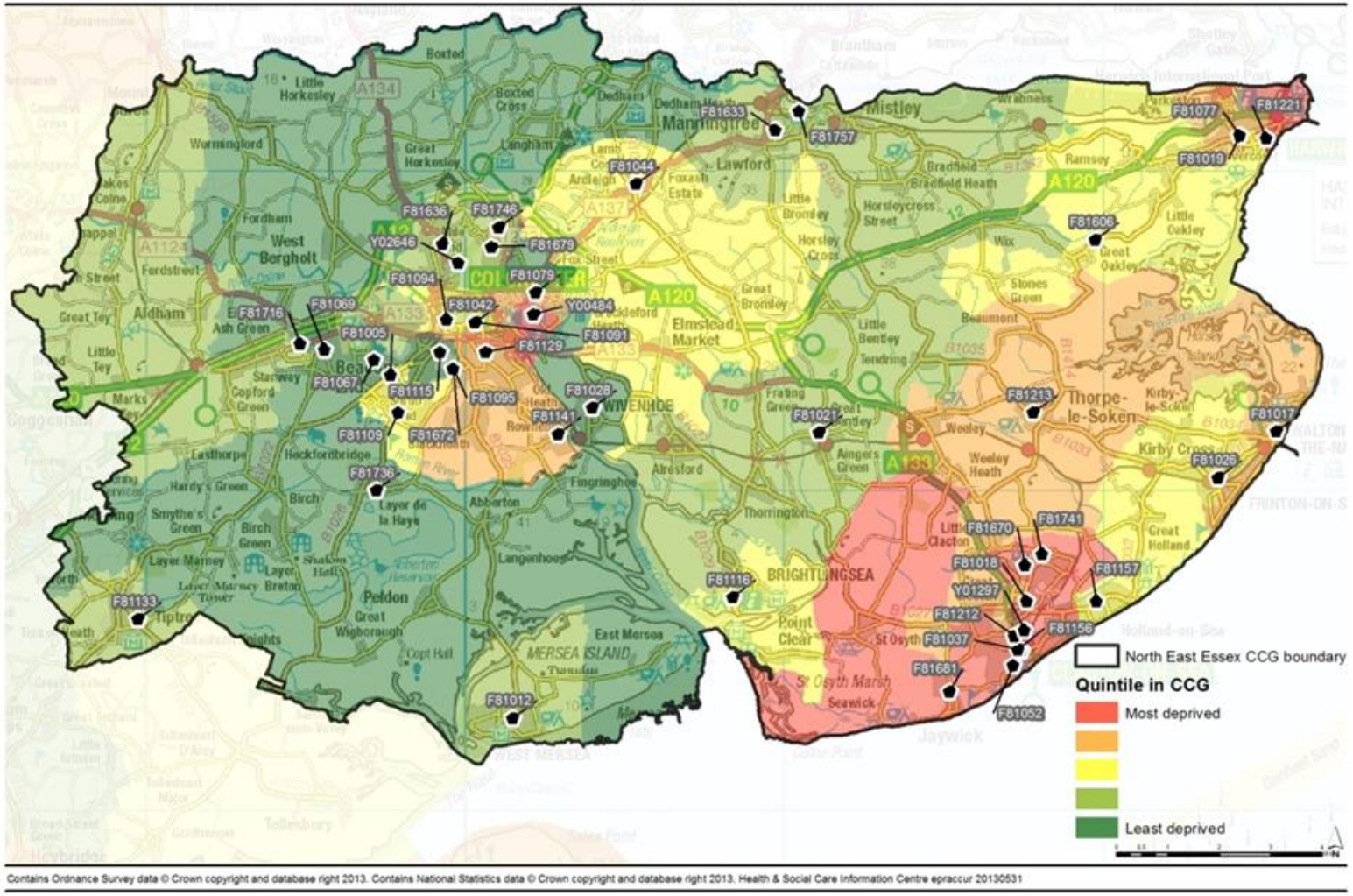
SECTION 1 INTRODUCTION

This section gives an overview of the health and social care system in North East Essex and how it will evolve over the next five years. It highlights the key strategic issues, our vision and values, and the approach we will take to ensure the delivery of high quality, cost-effective and integrated health and social care. North East Essex Clinical Commissioning Group will continue to work very closely with Essex County Council to jointly commission integrated services

North East Essex CCG is responsible for commissioning the majority of health services for the people who live in the areas covered by Colchester Borough Council and Tendring District Council. The CCG is made up of the 43 GP practices in Colchester and Tendring. The CCG is led by clinicians and there is a clinical majority on its Board and committees.

The CCG and Essex County Council (ECC) started working together before the CCG became a statutory body. The ECC representative on the CCG Board has full voting rights and has been actively involved in the production of this plan, along with key members of the ECC team. The CCG Chair and Clinical Chief Officer are active members of the Essex Health and Wellbeing Board and the Business Managers Group. The CCG Chair worked with Sir Thomas Hughes-Hallett as part of the Who Will Care? Commission into health and social care strategy.

GP Practices in the Clinical Commissioning Group area



Essex Health and Wellbeing Strategy

NEE CCG and ECC affirm their commitment to the Essex Health and Wellbeing Strategy with the 3 priorities of:

- Starting and developing well – every child has the best start in life.
- Living and working well – residents make better lifestyle choices and have the opportunities needed to enjoy a healthy life.
- Ageing well – older people remain as independent for as long as possible.

We will:-

- promote a shift from acute services to the prevention of ill health, to primary health care, and to community-based provision;
- support investment in early intervention and the prevention of risks to health and wellbeing to deliver long-term improvements in overall health and wellbeing;
- support individuals in exercising personal choice and control, and influence over the commissioning of relevant services;
- enable local communities to influence and direct local priorities for better health and wellbeing strengthening their resilience and using community assets to reduce demand;
- promote integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way where it is beneficial to do so;
- ensure resources are allocated consistent with the needs within and between the communities in Essex; and
- support individuals in making informed lifestyle choices and promoting the importance of individuals taking responsibility for their own health and wellbeing.

SECTION 2 VALUES AND PRINCIPLES

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We want to work in partnership with public, patients and carers in North East Essex to help them have greater choice, control and responsibility for health and wellbeing services:-

- People will be encouraged and supported to look after their own health and social care needs
- Carers will receive the support they need.
- Patients, public and community groups will take up opportunities to be involved in planning and developing services
- Services will be centred around the patient and will be high quality, evidence-based, cost effective and sustainable
- People will receive seamless and joined up services across their health and social care needs

We are committed to commissioning services which are equitable, inclusive and sustainable.

The values that lie at the heart of the work of the CCG are:-

- **Integrity** – We will work in the spirit of public service, professionalism and selflessness to serve our local population.
- **Inclusiveness** - Our commissioning will be driven by the health needs of the whole population. We will prioritise our commissioning towards work which delivers the greatest improvements in health and the best possible experience for all people throughout their care and treatment.
- **Improvement** - Our communities require high-quality services. This means services which are safe, personalised and deliver good clinical outcomes. We will seek to continually improve quality wherever possible and to embrace innovation to achieve this.
- **Patient-centred** – We will ensure that services respond to people as individuals, involving them in their individual care decisions and also in the planning of services.

We are committed to delivering the pledges of the NHS Constitution and upholding its values

SECTION 3 VISION AND TRANSFORMATION

Our vision is “Embracing better health and wellbeing for all.” We will focus on improving outcomes for the four priority populations we have identified with Essex County Council: the frail and elderly, people with mental health care needs, people with learning disabilities and children,. We will also focus on vulnerable and marginalised groups. Even though we will focus on priority groups within North East Essex, everybody should be able to expect an improved level of health and wellbeing from the services we commission, delivered through a simpler system. People will have greater choice, involvement and control regarding their health and wellbeing.
Our vision is based around 4 overarching principles of care:-

1. Care focused around people, not services
2. Seamless, harm free care
3. People have a large part to play in staying healthy
4. Efficient advice and care

We want to work in partnership with public, patients and carers in North East Essex to help them have greater choice, control and responsibility for health and wellbeing services. We are also committed to engaging in Essex-wide transformation where this improves the quality of services for our population. We are committed to commissioning services which are equitable, inclusive and sustainable. We will achieve this over the next five years through commissioning integrated physical and mental health and social services. A series of planned commissioning steps will deliver for patients a system where they can choose between end to end service providers offering seamless care.

This is likely to include up-skilling staff and maximising the use of technology, so that service users’ needs are met by a smaller core team and so that service users are supported by technology to remain in their own homes. Services will be commissioned for specific geographical populations so that we can focus on the different needs in different areas. This means that the improvement in outcomes we require may be greater in areas, or groups of people where outcomes are poorer at present.

SECTION 4 Joint Strategic Needs Assessment

The CCG has worked with ECC Public Health colleagues to produce a health need-focused JSNA to inform strategic planning by commissioners and providers, and to support the CCG's Values of *Inclusiveness* and *Improvement.* The JSNA uses benchmarking of local data on need, spend and outcomes to identify areas where either quality or value for money could be improved.

Demographic Challenges in NE Essex

- In Oct 2013, the GP registered population of NE Essex was 331,866 (male 162,480; female 169,386). The resident population of NE Essex CCG is expected to rise from 314,293 in 2012 to 357,121 in 2021 – a 43,000 (13%) increase. The greatest increases are expected to be in ages 56-75 years (13,300 increase) and 76+ years (9,700 increase). Integrated Planning by health and social care should take account of the anticipated additional demand for older people's services over the next 5-10 years. This includes the absolute increase in the number of older adults, but also the increased burden of multiple physical and mental conditions among older people.
- Service planning should take account of the needs of minority and marginalised communities including BME, Gypsy and Traveller, and Migrant communities, particularly in relation to services providing LTC, sexual health, maternity and children's services, where need is often higher in these communities. These communities can also experience lack of awareness of services, lack of knowledge about how to access services, and the need for translation services.
- In assessing the needs of patients, the needs and views of any carers, who may not self-identify as such, should also be taken into account and addressed. There are approximately 30,000 carers in NE Essex. How to improve the identification of carers, including young carers, should be considered further. Service planning should consider options for including carers in decision-making, and for increasing access to respite care, plus advice, practice and emotional support for carers. 30,000 care4rs in nee
- Integrated planning and QIPP planning should take account of the specific needs of high health need groups (including older people, BME and migrant communities, more deprived communities, people with mental health conditions). Commissioners

should consider alternative models of service delivery to target particularly high need communities, in order to maximise gains in health status and in system efficiency.

Health Inequalities

Inequalities in life expectancy are experienced in NE Essex by more deprived communities and by males. Deprivation is associated with a higher burden of ill health and worse health outcomes. Premature mortality (death under 75) is similar to England average in Tendring, but is lower in Colchester. NE Essex has the highest proportion of Disability Living Allowance (DLA) claimants in Essex.

There is considerable variation in the socioeconomic profiles of different communities in NE Essex:

- Out of 326 Local Authority areas, Tendring is ranked 86th most deprived in England[1] (a slight increase in relative deprivation, moving from 29th percentile in 2004 to 26th percentile in 2010[2])
- Out of 326 Local Authority areas, Colchester is ranked 205th most deprived in England (a slight reduction in relative deprivation, moving from 61st to 63rd percentile)
- The *most* deprived small area (LSOA; approximately 1,500 people) in England is in Tendring (LSOA E01021988). For comparison, the *least* deprived LSOA in NE Essex (LSOA E01021728) is ranked 32,169 out of 32,482 LSOAs in England i.e. is the 315th *least* deprived small area in England. Although Colchester is less deprived overall than Tendring, pockets of deprivation exist in both, and include both rural and urban areas.
- Health need varies considerably by practice in NE Essex. The need score for each NEE practice is compared to registered population in the graph below. Five practices on the coast have a particularly high patient needs relative to their practice size and funding. The CCG is working with NHS England to develop a joint strategy for health care in the worst affected area.

[1] IMD 2010
[2] IMD 2004 and IMD 2010

Quality and Patient Outcome Improvements

The table below summarises the areas where NE Essex CCG is an outlier or could make improvements in terms of clinical quality and patient outcomes. The issues identified are being taken forwards through outcome-based commissioning approaches, for example: delivery of the 8 key care processes for diabetes is a KPI subject to risk-share arrangements in the Integrated Diabetes Service contract which will start in April 2014; and Maternity services are to start CO2 screening all pregnant women in order to reduce smoking in pregnancy and resultant health complications such as low birth weight.

Programme	Issue
Healthy Lifestyles	NE Essex GP practices and other services should continue to focus on addressing under-diagnosis of long term conditions and increasing diagnosis rates (including of hypertension and other cardiovascular conditions, diabetes and respiratory conditions), in order to ensure people receive the treatment they need and to prevent future complications.
	Improvements in healthy eating should continue to be built on to increase the proportion of residents eating 5 portions of fruit and vegetables a day. Urgent co-ordinated action to reduce obesity in pre-school, primary and secondary school children is required through integrated children's commissioning processes.
	Levels of physical activity are difficult to assess, but increases are associated with reduced mortality and morbidity, so keeping active should be promoted across all age ranges.
	As the single greatest cause of avoidable death and ill-health, reducing smoking rates should continue to be a primary focus of all public services. Smoking cessation services should continue to have targets for quitting among more deprived communities, and services should ensure they are accessible to individuals from these communities. Commissioners and front line health staff should consider how to maximise Making Every Contact Count in respect of smoking status, despite personal objections that can be raised. Public services need to work together to take a multi-pronged approach to reducing people taking up smoking, for example through: working with youth health trainers, schools and other young people's services; working with the media; enhancing trading standards activity to target under-age sales; cutting access to contraband cigarettes etc. In order to reduce low birth weight births and future poor health, reducing smoking in pregnancy should be a priority for all services, and a variety of support should be available to expectant mothers.
	With increasing hospital admissions and over 40% of adults estimated to be at increasing or worse risk of problems from alcohol, commissioning and provision of all appropriate services should include Making Every Contact Count or Intervention and Brief Advice (IBA) regarding alcohol misuse. Patients report that the GP is their preferred point of contact for alcohol support, so ensuring that IBA coverage and awareness of alcohol services by GPs is maximised should be a priority for primary care commissioners.

Programme	Issue
Secondary Care	The observed SHMI level is higher than expected at Colchester Hospitals (CHUFT). There has however been a longstanding discrepancy between HSMR (Hospital Standardised Mortality Ratio; which has been within expected range for some time), and on-going detailed monitoring of mortality data is indicated.
	Patient feedback suggests that information-giving to patients could be more consistent in CHUFT.
Infectious Diseases	Uptake of flu vaccination in the over 65s is significantly lower than the England average. Uptake rates also remain low in other at risk groups. This may be partly responsible for the NEE CCG's high non-elective admission rates for influenza and pneumonia, and should be actively addressed in order to increase uptake.
Cancer & Tumours	Mortality data suggests that: Breast, Cervical and Lung cancer pathways should be reviewed to identify quality improvements; the two week wait pathway should be reviewed and improved to ensure rapid diagnosis and entry to treatment; access to palliative care for cancer patients should be assessed to ensure it reflects local need; and audit of non-elective Cancer admissions should be undertaken to identify tumour pathways where quality improvements may be possible.
	Patient feedback highlights that respect for, and communication of cancer clinical staff with, patients could be improved.
Endocrine, Metabolic and Nutritional	It is estimated that diabetes is around 20% under-diagnosed in NE Essex. How to improve timely diagnosis, in order to prevent future complications, should be considered.
	Basic care for diabetes (e.g. delivery of the 8 key care processes) still requires improvement across all providers, and all age ranges. Young people and younger adults with Type 1 diabetes require particular focus to prevent complications in later years, and quality of management of risk factors remains low compared to other areas of the country.
Mental Health	Mental health care should be integrated with routine physical health care wherever possible. This is particularly important for patients with diagnosed long term conditions (LTCs) who are at higher risk of poor mental health as well as having physical health problems.
	Improvements could be made in both primary care monitoring of physical health risks for patients with mental health problems, and access to mental health treatments (e.g. IAPT) for those with physical health conditions. Future commissioning of services should seek to integrate physical and mental health care.
	Commissioners should ensure that mental health care providers are commissioned to provide patients with support for activities of daily living such as securing stable accommodation and claiming benefits, in line with patient feedback.
	Commissioners, providers and public health should work together to address the need, expressed by young people supported by CAMHS and their parents, to raise awareness of mental health services available and to develop awareness/understanding of mental health issues.
Learning	People with Learning Disabilities experience substantial health inequalities. Commissioners and Service Providers should work together and with people with learning disabilities to ensure reasonable adjustments are made to enable access to mainstream services, and to ensure that specific targeted services are provided in a manner

Programme	Issue
Disabilities	acceptable to patients.
	Uptake of annual health checks remains low. All GP practices should ensure that all their patients with learning disabilities receive an annual health check. Feedback from service clients suggests that practices may need to make *reasonable adjustments* and be *thoughtful* in the way the service is delivered in order to maximise uptake.
Neurology	The Epilepsy Specialist Nurse service should address the gaps in service identified by patients, including availability of specialist advice to patients and carers, and conception advice.
	CCG should work with NHS England AT and local GPs to address gaps in knowledge and service in Primary Care, focusing on improving routine care such as provision of at least annual review including medication concordance, as recommended by NICE (2012).
	The high rate of A&E admission for children with epilepsy, compared to national rates, might suggest a lack of access to routine care, which should be investigated.
Circulatory Disease	Cardiovascular patient outcomes are relatively good in NE Essex, however variability in primary care quality could be reduced across pathways, particularly CHD and HF.
	42% of hypertension and 27% of CHD remains undiagnosed. Under-diagnosis of CVD should be systematically addressed, to ensure that people are getting effective treatment for their conditions, and to reduce future complications.
Respiratory	30% of COPD remains undiagnosed. Under-diagnosis of respiratory conditions should be systematically addressed, to ensure that people are getting effective treatment for their condition, and to reduce future complications.
	Patient feedback suggests that not all COPD patients have the knowledge and confidence to manage exacerbations of their COPD at home, and services should consider how this can be improved.
	Prescribing practice around respiratory disease should be reviewed to identify possible savings, including considering COPD patient feedback that having the necessary treatments available at home to manage exacerbations (e.g. a nebuliser or a basic stock of steroids) might reduce acute admissions out of hours.
Gastro Intestinal	GI mortality and underlying quality data should be reviewed to identify areas for improvement, in order to reduce avoidable morbidity and mortality. Commissioning for Value data suggests that up to 17 lives could be saved per year.
Musculo-Skeletal	Patient musculo-skeletal and trauma-related outcomes are outcomes generally good, however benchmarking suggests that patient outcomes could be improved even further in e.g. joint replacement. Data analysis should be undertaken to identify specific areas of hospital over-activity, to improve prevention of complications and of avoidable injuries.
Genito-Urinary	A review of renal risk identification and management pathways should be carried out to reduce functional deterioration and avoidable AKI (which is significantly high in NEE) and other complications.
Maternity	Agencies should continue to work together to further reduce teenage conceptions in NE Essex, with a particular focus on Tendring.
	Antenatal services should focus on supporting smoking cessation, good nutrition and exercise among pregnant women, especially in Tendring, in order to reduce the

Programme	Issue
	prevalence of low weight births, and give children the best start in life.
Children	Breastfeeding and immunisation rates are similar to or higher than the comparable national rates, but NHS England, the CCG, GPs and other service providers should work together to improve further in order to maximise health status for children. Urgent co-ordinated action to reduce obesity in pre-school, primary and secondary school children is required through integrated children's commissioning processes.
Social Care Needs	The substantial level of unmet need for social care in NE Essex should be addressed. This includes some people with high and very high needs. Improving access to social care overall may require additional provision and targeting of services by social care agencies, and enhancing the knowledge of health and other care professionals about how to refer to social care. Projects such as the Reach Out project could also be extended to support this. Access to reablement in NE Essex should be maximised, in order to enhance independence in old age. Given the high percentage of older people with health and care needs in Tendring, particular focus should be given to improving access in Tendring. Client feedback suggests that experience of social care could be improved in Essex.
Dental	Tendring has the highest prevalence of tooth decay among 5 year olds in Essex. NHS England, NEE CCG, and children's services should work together to improve preventative dental care and education, particularly in Tendring, in order to reduce avoidable dental health problems.

Opportunities for Cost and Productivity Savings at a Glance

The table below summarises areas where NE Essex CCG is an outlier in terms of cost and productivity. Please note that the total potential financial opportunity is not the sum of each of items listed in the table because items are derived from a range of data sources that may partly duplicate savings. For example, potential high spend listed in the Endocrine, Nutritional and Metabolic Problems programme will be partly a function of high diabetes prescribing costs. In addition, the savings are forecast at full PbR tariff rate, whereas they may only be realised at the 30% (marginal) rate. The areas identified have fed into QIPP and Integration planning for 14/15 and beyond.

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
Secondary Care	High rates of procedures of low or limited clinical value, including hysterectomy, D&C/hysteroscopy, tonsillectomy, lumbar spinal procedures and myringotomy.	£226,484	If operation rate per 100,000 population reduced to 25th percentile nationally
	Ambulatory Care Sensitive (ACS) admissions for the nineteen listed conditions could be reduced. Areas where over £50k p.a. could be saved are: Influenza and pneumonia;	£1,402,246	If admission rate per 100,000 population reduced to 25th percentile nationally

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
	COPD; Cellulitis; Heart failure; Asthma; Diabetes.		NB These conditions are mostly age-related, and NE Essex's high proportion of older people will potentially reduce the savings that can realistically be achieved compared to the 25th percentile areas, which have a lower percentage of older people.
	NE Essex has a significantly higher GP referral rate than average for England. When compared to the 9 most demographically similar CCGs in England, it is estimated that 26,799 1st OP attendances could be saved a year.	£2,519,000	If outpatient appointment rate per 100,000 population reduced to the performance of the top 5 most similar CCGs.
Healthy Lifestyles	Evaluation of the impact of the Tier 3 weight management service in NE Essex should include consideration of wider usage of services, including community services.	TBD	
Infectious Disease	In 2012/13, flu vaccination uptake among over 65s was significantly lower than average for England, and emergency admissions for Influenza were higher in NE Essex than average for England or the CCG's peer group of similar CCGs.	£637,528	Reduction of Influenza and Pneumonia acute admissions in NE Essex from 2012/13 levels to the rate seen in the lowest quartile (a reduction of 235 admissions).
Cancer & Tumours	Commissioning for Value pack (2013) states that non-elective admissions could be reduced by 305 p.a. and emergency bed days by 3,377.	£842,000	If the performance of the best 5 similar CCGs to NEE was replicated. Given that cancer pathways are usually planned elective pathways, audit of these non-elective admissions might be useful in identifying pathways where improvements could be made.
Endocrine, Nutritional and Metabolic	Spend on diabetes prescribing is higher than average (although overall spend is lower than cluster average). This is particularly marked in the spend on blood glucose testing strips.	£600,000	Spend on testing strips reduced to the level of the lowest 25% of CCGs nationally.
	Commissioning for Value data suggests further diabetes prescribing savings could be made over and above testing strip reductions.	£1,400,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs.
Mental Health	Commissioning for Value data suggests that mental health prescribing savings could be made.	£1,600,000	Spend reduced to that of the lowest similar CCG.

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
Neurological	Commissioning for Value data suggests that neurological prescribing costs could be reduced. Neurological spend overall is lower than cluster average however.	£1,325,000	Prescribing costs reduced to those of the lowest spending 5 CCGs in the CCG cluster.
Circulatory	Hypertension registers are significantly incomplete (by 40%) and CHD register also under-populated (by 27%). Potential for improvement in CHD and HF QOF indicators.	TBD	From strokes prevented if H/T QOF register completeness increased to 70%. Improvement in QOF scores to top quartile.
	Commissioning for Value data suggests that a saving could be made on cardiovascular prescribing in NE Essex.	£1,317,000	Prescribing costs reduced to those of the lowest spending 5 CCGs in the CCG cluster.
Respiratory	Commissioning for Value data suggests that savings. could be made on respiratory prescribing in NE Essex.	£1,333,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs.
Gastro Intestinal	Commissioning for Value data suggests that elective and non-elective admissions for GI conditions could be reduced.	£1,094,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs.
Skin	NEE CCG is in the highest spend quartile nationally for this category.	£2,925,000	Spend reduced to CCG cluster average.
Musculo-Skeletal	Commissioning for Value data suggests that NE Essex could make savings from elective and non-elective musculo-skeletal admissions It also identifies potential prescribing savings of £195k p.a. Reductions in Trauma and Injury emergency admissions.	£727,000 £195,000 £549,000	Spend reduced to the best 5 of the CCG's 10 most similar CCGs. Spend on this category should be reviewed carefully, and in line with quality of care. Trauma admissions are higher than in CCGs with a similar demographic profile.

Programme	Issue	Financial Opportunity	Criterion to deliver financial opportunity
Genito-urinary	Commissioning for Value data suggests that savings could be made by reducing elective and day case activity. It also suggests that savings of up to £285k p.a. could be made from prescribing.	£434,000 £285,000	Elective, day case and prescribing spend reduced to the best 5 of the CCG's 10 most similar CCGs. The impact of this reduction on quality and patient outcomes would need to be carefully considered however.
Prescribing	Prescribing spend should be benchmarked and reviewed in more detail in the following areas: cancer & tumours; circulation; endocrine (including diabetes); genitourinary; infectious disease; maternity & reproductive health; mental health; musculoskeletal; neurological; and respiratory.	£6,350,000	Prescribing spend reduced to the best 5 of the CCG's 10 most similar CCGs.

SECTION 5 OUTCOMES

5.1 The seven outcome ambitions and how we plan to achieve them

It should be noted that the seven outcomes ambitions are based on the five high level ambitions of the National Outcomes Framework (NOF), the only difference being that two of the NOF outcomes have been sub-divided into two parts.

See chart below

Outcome ambition	Measure to be used	Quality Premium measure	Support measure(s)	Action in 14/15	Additional Action in 15/16
1.Securing additional years of life for the people of England with treatable mental and physical health conditions.	Potential years of life lost from conditions considered amenable to healthcare – a rate generated by number of amenable deaths divided by the population of the area.	Improvement to be locally set and no less than 3.2%. CCGs should focus on improving in areas of deprivation in developing their plans for reducing mortality.	None	**Public Health** will commission a range of services to address this, including Senior Health Checks for over 75s, NHS Health Checks for 40-74 year olds, obesity management and smoking cessation services. All these services incentivise a focus on more deprived populations. NEE CCG will offer a contract for **enhanced primary care services**, including Anti-Coagulation Monitoring, DVT, Minor Injuries, Wound Care and Suture Removal, Learning Disabilities and IUCD. The contract will look at commissioning a single provider to offer safe, high quality and equitable services to all patients within North East Essex, reducing fragmentation and variation in accessibility that we current see …. **Integrated Diabetes Pathway** implemented from April 2014	The integration of physical and mental health care will be enhanced through the commissioning of the integrated **Care Closer to Home** community service, including implementing the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services. Specific higher need sub-populations will enjoy targeted services.
2.Improving the health related quality of life of the 15 million+ people with one or more long-	Health related quality of life for people with long-term conditions (measured using the EQ5D tool in the GP Patient Survey).	IAPT roll-out: i. achieve 15% for CCGs below that level ii Additional locally set improvement	Increase dementia diagnosis rate to 67 per cent by March 2015. Achieve the	**Enhanced IAPT model** to be implemented from April 2014, including focus on those with LTCs **Promotion of self-care** agreed as a priority with providers, and a CQUIN on Behaviour Change training for clinicians proposed. **Dementia diagnosis**	Commissioning of the integrated **Care Closer to Home** community service should enhance holistic LTC care, including implementing the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental

term condition, including mental health conditions.		for those over 15% or near 15%.	IAPT recovery rate of 50%.	Continued development of Memory Service will increase number of people being diagnosed with dementia and direct them to appropriate support. **Integrated Diabetes Pathway** implemented from April 2014 Consulting with GPs on **supporting case management of >75s** through a range of services aligned with the BCF, including MDTs, diagnosis and prevention services etc	health services" to achieve parity between mental and physical health services.
3.Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital.	A rate comprised of: • Unplanned hospitalisation for chronic ambulatory care sensitive conditions. • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. • Emergency admissions for acute conditions that should not usually require hospital admission. • Emergency admissions for children with lower respiratory tract infections.	As per outcome measure	None	Avoidable emergency admissions will be monitored monthly by the CCG, allowing intervention if the metric is off-target. The CCG has commissioning bundles focusing on each of the composite measures in the metric: **Care Closer to Home** impacts on avoidable ACS admissions among older people, and a number of services to be included in this bundle are already in place including risk stratification and multi-disciplinary case management through virtual wards and other services to support case management of >75s in primary care; **Urgent Care** impacts on avoidable acute admissions among older people and children. In 14/15, 7 day working and admission avoidance through a new Rapid Assessment Unit in Clacton will be implemented; **End of Life** impacts on avoidable acute admissions among older people, through single point of access to care and support,	**Care Closer to Home** impacts on avoidable ACS admissions among older people will be enhanced through introduction of a **Community Gateway** and enhanced use of **risk stratification**.

				enhanced palliative care in non-acute settings etc; **Children's services** impact on avoidable chronic condition admissions among children.	
4.Increasing the proportion of older people living independently at home following discharge from hospital.	No indicator available at CCG level. CCGs and Area Teams will not be expected to set a quantitative level of ambition for this outcome. However, they will be expected to set out how they will improve outcomes on this ambition in their five year strategic plans.	None	A level of ambition needs to be established at Health and Wellbeing Board level on the *Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.*	NEE CCG has one of the highest performing **stroke rehabilitation** services in the country, with 55% of patients receiving Early Supported Discharge. **Essex Social Care Services** and CHUFT will continue to work together and with ACE Community Health providers to ensure effective discharge support. ECC will use BCF investment in **reablement** to promote ward led discharge, development of rapid response services and to ensure assessment is taking place at the appropriate time in the appropriate environment. The nature of reablement cases will shift with short stays being replaced with more complex cases, which may impact on independent living rates. BCF funds to be used to increase the number of people to be offered reablement.	**Care Closer to Home** aims to provide seamless, simpler care for patients, wrapped around GP practices, providing holistic support to people in their own homes.
5.Increasing the number of people having a positive experience of hospital care.	Patient experience of inpatient care.	Friends and Family Test: specific actions to improve low scores.	None	F&F Test action plans – see Section 8 7 day working impacts – see Section 8 Cancer Action Plan - see Section 6	**Urgent care** system development
6.Increasing the number of	Composite indicator comprised of (i) GP services, (ii) GP Out of	None	None	Almost 1,000 people were reached with our Big Care Debate engagement over the productivity challenge. The key theme were	**Care Closer to Home** aims to provide seamless, simpler care for patients, wrapped

people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Hours.			:- • Self care People overwhelmingly understood that personal responsibility for their health is important. Diet, exercise and mental well-being were recurrent sub themes. • The role of family, friends and the voluntary sector in providing support mechanisms, care and social contact were also vital in helping people to avoid isolation and to remain independent, fit and healthy. Friends and Family test Use of technology and personal health budgets were supported as was better training of staff to help individuals become more independent in managing long term conditions **Access to information and services** Access to information and signposting to services was viewed as important. Use of plain English and guides to services were felt to be important. People felt this was crucial to self-care and to ensuring services were not used inappropriately when people needed support and/or advice for minor ailments and to reduce demand on other services. Appointments with GPs, dentists and professions allied to medicine such as physiotherapy or audiology, as well as	around GP practices.

				access through the walk in centre, were recurrent themes with some mixed commentary about the 111 service which has only recently gone live. Overwhelmingly, however, access to GPs for appointments was the single biggest point of satisfaction or concern dependent on how easy participants found it. There was an overwhelming view that GPs are the gateway to prevent other services being overloaded. **Prevention** The theme of access to information also extended to health promotion and education for individuals about to stay well and healthy and how to manage a long term condition so the individual remains in control. **Integration of services** There was a level of frustration with lack of integration of services, particularly around discharge from hospital but also with support services such as appliances or equipment when bereaved families found it difficult to return of items that were no longer needed. Suggestions included creating one budget for services and gateways/single point of contact for services that provided more clarity and removed barriers. Care closer to home and home visits for the vulnerable were key comments throughout the engagement whilst others felt centres where a range of services that could be accessed together were a good idea.	

				<u>Culture and Patient Centred Services</u> People felt there was still some way to go to develop the right culture in the NHS and Social Care, improving the way professionals speak to patients and carers creating a partnership rather than a dependency. Some BME community representatives felt that there were communication issues even when the use of English was not a barrier but that cultural values were not always understood. The engagement included meetings with BME communities including Chinese, Middle Eastern and Turkish representatives. Working families were reached through an online survey and young mothers were reached through children's centres Convergence between CCG strategies and NHS England **Primary Care Strategy** **Joint North Essex Mental Health Strategy** includes: • Developing and supporting community well-being, encouraging people to maintain healthy lifestyles that help keep themselves and their families mentally well. • Improving access and the gateway into services – more effective direction. • Ensuring smooth transition between services (CAMHS/Adult/Older People). • Ensuring a more holistic and integrated approach to mental health and physical health services. • Developing broader primary care and community based models of care for people across the spectrum of mental health	

				conditions. • Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs.	
7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care	Hospital deaths attributable to problems in care. This indicator is in development.	Improving the reporting of medication errors	MRSA zero tolerance *Clostridium difficile* reduction	Mortality Working Group Cancer Action Plan Regular Review by CCG Board and Quality Committees, including SI reporting, mortality rates, MRSA and *C.diff* rates, safety thermometer etc Participating in Child Death Review Panels	

5.2 Improving health - Commissioning for Prevention

Through its Organisational Development work, the CCG is developing a commissioning approach for delivery of its strategic priorities with partners. This approach will reflect the principles of "Call to Action: Commissioning for Prevention". The table below summarises how NE Essex CCG is already addressing each step in the framework to focus on prevention:

Framework Step	**Action in NEE CCG**
1. Analyse Key Health Problems	The CCG's Commissioning priorities and QIPP plans have been informed by the NEE CCG JSNA (summarised above and available at: Joint Strategic Needs Assessment (JSNA) Resources - Essex Insight). This document collates and analyses key national (e.g. Commissioning for Value) and local (e.g. local patient experience surveys) health and care need information, benchmarking it and highlighting priorities for service development and improvement work, and high need population groups. The JSNA has been presented to the CCG's Board and Transformation & Delivery Committee, and shared with staff and partners. It will continue to be used to identify priority areas for QIPP and service transformation, as well as informing the CCG's Commissioning Intentions. 'Deep Dives' are also undertaken into priority clinical areas to inform future commissioning, for example, urgent care, and cancer mortality and care quality. The CCG's QIPP planning is including more in-depth reviews into clinical pathways highlighted in the JSNA as potentially requiring quality and/or productivity improvements.
2. Prioritise & Set Common Goals	<u>Prioritisation</u> The CCG has developed a prioritisation framework that it uses to assess the priority of commissioning proposals against current services and other proposals. This framework was developed with input from patients, CCG staff and members,

	and partner agencies, in order to reflect the views of the whole system. The framework has also been adapted for use in prioritisation of voluntary sector grant bids and CQUIN proposals for 14/15 contracts. This framework allows every proposal to be scored against a weighted set of benefits, and for this benefit to be plotted against total annual cost and annual cost per patient, in order to allow the relative priority of services to be assessed for both commissioning and decommissioning decisions. <u>Setting Common Goals</u> The CCG has undertaken extensive consultation with the local population through the Big Care Debate. This has informed the CCG's draft Strategic Objectives, which were developed by the Board and elected clinical members, and with key partners: **Strategic objective 1: Holistic Approach** - Achieve our vision through an inclusive, holistic approach to patient and service user- centred commissioning, embedding personalisation of care through integrated health and social care services. **Strategic objective 2: Quality and Safety -** To transform care and drive continuous improvement in quality and safety. Achieve the best possible outcomes from our service users through high quality care **Strategic Objective 3: Best use of resources –** To use commissioning resources effectively and responsibly. To develop our organisation, teams and individual staff to be trusted, competent, well trained, talented, enthusiastic and dedicated. **Strategic Objective 4: Priority Health Goals -** To tackle the biggest health challenges in North East Essex reducing health inequalities

	The CCG's Vision, outlined above, reflects the Strategic Objectives, and has been refreshed as part of the 14/15 planning process to ensure it is fit for purpose. The CCG's commissioning priorities have been assessed against the Vision to ensure commissioning focus is in the right areas. A further planning workshop will be held in April/May to inform the economy's five year plan. Commissioning priorities are also escalated down into individual job plans. The CCG has developed organisation-wide objectives aligned with its vision, so that staff personal objectives set for 14/15 demonstrably support the delivery of the CCG's vision.
3. Identify High Impact Programmes	High impact programmes which address the CCG's priority areas have been identified through identification of best practice from elsewhere, local innovation, and use of evidence, including but not limited to: • Essex Annual Public Health Report 2013; • Reducing Unplanned Admissions: a review of the literature, Central Midlands Commissioning Support Unit (Knowledge and Evidence Team); • Key Success Factors in delivering great emergency care in Essex (slides) by Stephen J Duncan, National Head of Intensive Support, Emergency Care Intensive Support Team, NHS IMAS. The CCG has used this evidence, plus insight from local clinical members and others, to identify novel and/or innovative ways to improve quality and efficiency through the QIPP planning process. The CCG's current plans include action on prevention at several levels. Examples include:

	Primary Prevention Although responsibility for primary prevention now rests with public health teams in local authorities, the CCG's commissioning intentions include commissioning prevention of complications, such as through a Tier 3 weight management service and an AQP chronic back pain service. The CCG has agreed with ECC PH commissioners that commissioning of community services will be aligned, so that providers must ensure seamless access to primary prevention services. **Improving Diagnosis Rates** The CCG has a rolling programme of biannual Atrial Fibrillation screening trough pulse checks at flu vaccination clinics, focusing on high risk groups. **Secondary prevention** The CCG has commissioned a new integrated managed pathway for diabetes to start in April 2014. This has been commissioned in a way which incentivises risk factor management (such as HbA1c, hypertension etc) and reducing poor outcomes (such as diabetic foot disease) through contractual performance-related mechanisms.
4. Plan Resources	In order to deliver effectively, the CCG needs to consider the full range of resources available across the economy, and work with partners as appropriate to deliver our shared goals. The CCG has developed their medium term financial strategy which considers the:

	• Effective management arrangements that will ensure financial balance and stability • Ensures that the governing body is kept aware of the planning assumptions used and any deviations • Supports the delivery of the integrated operational plan through effective use of available resources • Secures value for money and efficiency in the CCGs commissioning responsibilities • Ensures robust arrangements are in place for investment and disinvestment decision which are aligned with investment and disinvestment. The CCG is currently developing a model of the whole system's activity and finances which will be used to map the impact of different service models and proposed changes. The impact can then be considered from a population, organisation and whole system perspective.
5. Measure & Experiment	<u>Measurement</u> The CCG is introducing enhanced programme management arrangements which will include enhanced monitoring of the delivery portfolio of the CCG. This will be supported by a number of tools including a portfolio management dashboard, how to guides, programme management support software and benefits trackers. Key components of the CCG portfolio, programme and project management include initiating and managing: • Governance • Programme and project briefing and initiation • Quality assurance and risk management • **Financial (QIPP)** and KPI development and monitoring • Programme and project engagement and communications • Programme and project delivery • Performance management, benefits capture and evaluation • Transition from project to business as usual – moving from pilot status

	<u>Experiment</u> NEE CCG has affiliated to Eastern Academic Health Science Network, and is a member of the Essex Node of the Network. The CCG is also making links with local academic institutions and actively supporting research locally in order to benefit from local innovation.

5.3 Equality Delivery System

- The Equality Delivery System (EDS) is managed by staff within our CCG. Over the last year our CCG has been working towards grading the outcomes of the EDS framework and developing objectives. These will then be delivered so our organisation can support the ongoing programme.
- The CCG agreed with the Quality Committee at the beginning of the year a plan to achieve this.
- In shaping the objectives staff from the CCG have met with, and gathered views from, over 100 individuals, groups and organisations. A set of controlled questions were asked to establish the issues that people from the protected groups face. The objectives that have been produced come from the themes expressed during this period. We then tested the proposed objectives with the protected groups. Our CCG shall be reporting and monitoring against these through the Quality Committee, our public Health Forum Committee and finally the board at the end of the year.
- The grading for the outcomes was produced by a publically held event. People and organisations representing the protected groups graded our CCG after being presented with a range of examples and evidence from staff. Benchmarked against previous grading our CCG has improved but can still do more.

5.4 Parity of esteem

- Details of how the CCG aims to achieve parity of esteem for people with mental health needs are in section 6.5

SECTION 6 PATIENT SERVICES

6.1 Patient engagement and empowerment

Our consultation and engagement strategy (refreshed in November 2013) sets out the following principles for engagement:

- Promoting the NHS constitution to our communities
- Working with our stakeholders to make sure we are effective, efficient and display financial prudence
- Using our stakeholders to tell us how the quality of services should improve
- Using our stakeholders to tell us how the quality of primary care services should improve
- Working in partnership with our communities to reduce inequalities
- Involving patients at all stages of what we do
- Working closely with all clinicians and healthcare professionals
- Developing partnerships
- Promoting equality
- Being innovative and forward thinking

<u>Patient, public, service user engagement</u>

The CCG has built on the previous work of health commissioners to establish relationships with local communities to identify needs and gaps and to ensure we have robust patient involvement in how health services and patient care are planned and delivered

When we took over the role of Public, Patient and Carer Engagement (PPCE) we produced a discussion document for our stakeholders to help us understand how we should improve the way we engage. We put together a working group of stakeholders that represented different backgrounds out of which was born the North East Essex Health Forum with the following features:-

- A greater voice is given to our local residents
- Largely owned by the people who use our services;
- Accountable for stakeholder engagement by having a GP lead whose portfolio is PPCE;
- An independent and democratically elected group (North East Essex Health Forum Committee) which sets the agenda for raising issues with commissioners. This committee has inclusive representation from patients/service users, carers, voluntary sector and Healthwatch
- The committee can make recommendations to the CCG Board
- A member from the Health Forum Committee sits on the CCG Board and members sit CCG sub- committees as well as commissioning working groups
- Locality Engagement Forums which set their own agendas with commissioners held to account for actions arising from Forums meetings.
- A coordinated relationship between Practice Patient Groups;
- The structure is shaped around stakeholders rather than for Commissioners;

Prior to authorisation we held a stakeholder event “Involving Local People in Health Decisions” where we presented our plans and priorities and invited feedback from the 100 strong audience. The outcomes of our stakeholder event were shared with the Health Forum (which has a membership of approximately 300) who monitor our progress on the priorities that were identified.

Local Engagement Forum meetings take place bi-monthly in Colchester, Harwich and Clacton, chaired by Health Forum representatives: the agendas reflect local issues and concerns and the CCG reports back to the next meeting on the actions taken. Minutes are posted on our website and emailed to all forum members.

To date, 85% of our member practices have Patient Participation Groups. The Health Forum Committee has set up a working group to find out how the work of the PPGs can be used on a systematic basis to influence commissioning decisions, including their views and experience of being offered and exercising choice. The CCG is also working with GP practices to develop these groups further and to ensure that they are well advertised.

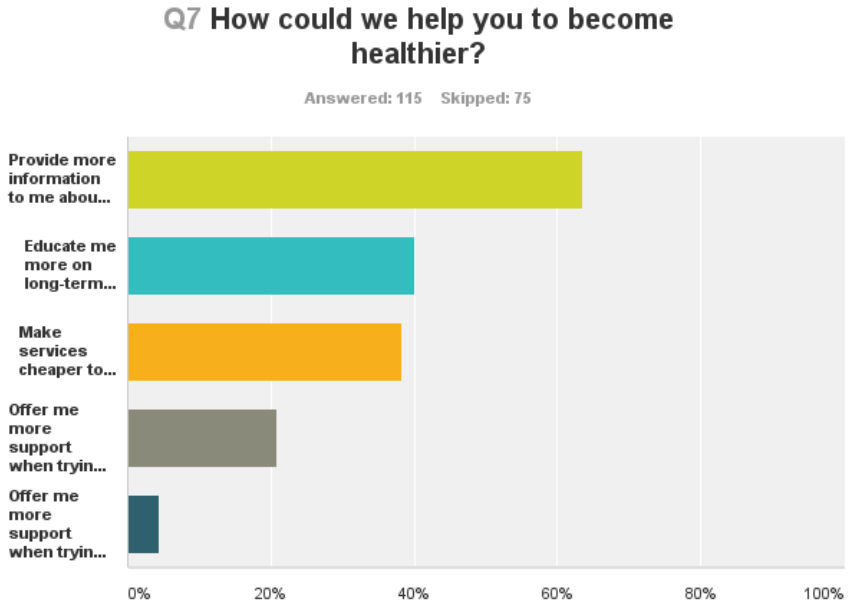
In addition to using the Health Forum to embed public and service user representation into our work, we also work with Healthwatch Essex and speciality service user groups such as Diabetes UK and our local Maternity Services Liaison Committee (to

name but two) to ensure we have strong user representation in our planning and commissioning work as well as in implementation to ensure there is strong service user involvement in how health services and patient care are delivered. As we recommission services inherited from the PCT we are systematically using this approach to ensure service users are involved in the service design and change specifying this as a requirement in our contracts.

We have taken a robust approach to patient and public engagement. In November 2013 we used the opportunity of NHS England's Call to Action to raise awareness of our local productivity challenges and how we propose to address them. The Big Care Debate has engaged with over 1,000 members of the public in two large set piece events, an online survey and outreach events where the community already gather such as Children's Centres, Older People's luncheon groups and PPGs.

The first phase qualitative survey was about identifying public priorities for care as well as raising awareness. A secondary benefit has been a rich stream of feedback which provides soft intelligence for our quality teams. It is clear from the Big Care Debate that our citizens want to be empowered and actively be involved in determining their future health and social care in partnership with an appetite for patient centred care, personalised budgets and signposting

Extract from Big Care Debate on line survey:-



The second phase is about feeding back how the public priorities map against our commissioning intentions and have influenced them – closing the loop. This engagement has also allowed us to identify service users and carers with specific patient experience that will assist in developing our strategies from intentions through to procurement.

Next steps will be a full 12 week consultation on our commissioning intentions to sense check that we have understood what the public has told us and integrated their ideas and concerns into our Care Closer to Home and Urgent Care Strategies.

We have sought to benchmark and verify our approach by commissioning Jeremy Taylor CEO of National Voices to undertake a review of our work to date.

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Patient, public, service user communication

In the last year we have further refined our website to make it simpler to navigate as well as being content rich (particularly featuring information about choice, managing illness and where treatment options are available as well has how to access friends and family test information) and have increased our use of social media to reach younger audiences and those who 'hard to reach' because they are working.

Our Facebook user involvement has doubled and our Twitter engagement has trebled. These digital media have been at the heart of multi-media campaigns to help patients stay well and to manage illness. Get Well Essex was developed in partnership with neighbouring CCGs using bus, radio, ambient advertising and PR stunts to raise awareness of the most appropriate urgent care services during the Winter.

Our Health Forum has also been actively involved in developing a service user led patient choice leaflet.

The CCG has a monthly column in the East Anglian Daily Times and is regularly featured in other local media with key messages around choice, quality, transparency (particularly in respect of recent issues at Colchester hospital)

Engagement with our practice members

The CCG consists of its member practices and has close and on-going engagement with them. The CCG Constitution was produced with the active participation of the practices and the Memorandum of Understanding sets out the mutual responsibilities of the CCG governing body and the practices, as well as between the practices themselves

Our 43 member practices are grouped into six Practice Forums. Each practice sends a clinician and a practice manager to the forum meetings, which are supported by an elected CCG member and a manager.

Engagement with providers

The CCG holds regular meetings throughout the year with the main providers of acute, community, mental health and learning disability services. These meetings include commissioning intentions, contestability plans and contract monitoring. The CCG makes

sure that providers are aware of the whole patient pathway, for example diabetes. Where pathways are being redesigned, the CCG ensures that the relevant providers are included in the reference groups.

Engagement with local authority partners and elected members

The CCG Chair is a member of the Essex Health and Wellbeing Board (HWB) and was a member of the task and finish group which established the governance arrangements for the HWB. The CCG Chair also worked with Sir Thomas Hughes-Hallett as part of the Who Will Care? Commission into health and social care strategy. The CCG Clinical Chief Officer is a member of the Business Management Group. The CCG regularly meets with Essex HWB, the Overview Scrutiny Committee (HOSC) and Tendring District Council Health and Colchester Borough Councils. Officers from Essex and Colchester council are also on the CCG board.

The ECC representative on the CCG Board has full voting rights and has been actively involved in the production of this plan, along with key members of the ECC team. ECC representatives also sit on the Integrated Commissioning Programme Board and project groups.

Regular meetings are held with elected members at local government and national level.

Engagement with system partners

The CCG chairs a system wide partnership group which brings together the strategic partners of the NE Essex health and social care system. Sectors represented include the voluntary sector, the local acute hospital, both upper and lower tier local authorities, the local provider for community services and mental health.

6.2 Wider primary care, at scale

Primary Care Development in North East Essex CCG

The CCG is not responsible for commissioning primary care: NHS England hold the contracts for General Practice, Dental Practices, Opticians and Pharmacies. However, the services provided by these organisations are key to the delivery of the strategy of the CCG. Patients often start their treatment pathway within primary care and therefore their experience at this stage is vital in ensuring their safe and effective treatment going forward. Good access to general medical services at their GP surgery is so important as otherwise people will use other services, which are not always appropriate, to access support, assurance and treatment.

During the CCGs Big Care Debate engagement with public, patients and their families there has been a consistent and overwhelming message that general practice services are valued and necessary to maintaining the health of the population. However, there is a real perception that there is not enough capacity within these services to meet the needs of the population and that access to these services needs to improve.

The CCG and NHS England are committed to supporting primary care in North East Essex to provide the best possible services to their patients The CCG recognise that it is in our patient's interest to work collaboratively and responsively with NHS England to ensure that collectively the services provided by primary care to our population does meet their needs in a timely and responsive way. Within the 'Transforming Primary Care in Essex' strategy there is an acknowledgement that across Essex there is an inconsistency in the quality and outcomes of care provided by primary care. Within North East Essex there is a need to reduce the unacceptable level of variability in quality outcomes to ensure that all patients receive the optimum level of care for their condition. Another key issue is the struggle of some practices, especially in Tendring, to recruit GPs and other staff, which is resulting in them now spending less time with each patient due to the demand for their services. There is a recognition that in North East Essex there are not enough GPs to provide a comprehensive service and the CCG will work actively with NHS England to improve the numbers of GPs for every 1500 people.

North East Essex CCG is leading the work, with NHS England, Essex LMC and Health Educate England on Primary Care Workforce across Essex. This includes considering short, medium and longer term workforce planning, for GPs, Practice Nurses and Practice Managers, different models of primary care, the role of primary care in urgent care and organisational development support to enable the primary care community to respond positively and actively to opportunities to play a much stronger role in improving health outcomes. The CCG and NHS England recognise the need to move from a reactive model to a more proactive and supportive model in 14/15. This work has started and will link with the workforce and capacity planning

The CCG is keen to work with NHS England on ensuring that resources from both organisations are invested in the most effective way, this includes both financial and non-financial resources. The CCG will work with NHS England to ensure that all investment the CCG makes into the infrastructure and workforce within primary care can be sustained through the funding available within the NHS England budget.

There is recognition from both organisations that there may be the need to consider different models of delivery of primary care in North East Essex, thus supporting the CCG's vision of creating services around patients rather than organisations. There is a need to acknowledge and respond to the diverse needs of patients within different sections of the community and move away from the one model fits all.

Within the next year the joint working group, which will include patient groups as well as other stakeholders, will produce a small number of different models of delivery of primary care services that will provide opportunities for NHS England and the CCG to commission services that meet the needs of different populations.

In North East Essex we will work with GP Primary Choice – a group of 41 local practices that have come together to form a company to encourage the collaboration and joint working opportunities that the new commissioning approach could offer. This gives the CCG an opportunity to work with a group of practices under one umbrella in a co-ordinated and consistent way to the benefit of our population. It will provide the practices with a vehicle to drive out efficiencies and productivity without damaging the underlying values of each individual practice.

We will also work with NHS England to explore the opportunities for practices to collaborate and possibly merge to further support primary care sustainability in NEE. The CCG has commissioned a piece of work from primary care which will provide guidance to practices who are considering this action as a way of spreading lessons identified.

Within the "Everyone Counts" planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

There is an expectation within this document that CCGs will support practices in transforming the care of patients aged 75 or older by commissioning services from primary care to support the reduction of avoidable admissions.

North East Essex CCG will work with NHS England to ensure that this additional investment in services meets the following principles:

- Meets the needs of our local over 75 year old population
- Does not commission services that are already commissioned through core contracts or enhanced services
- That are developed in partnership with patients and practices
- That all plans are aligned and complementary to the Better Care Fund
- Reduces the number of emergency avoidable admissions
- Supports and contributes towards the overarching Primary Care Strategy

The additional investment could be used to:

- Reduce the number of falls resulting in an ambulance conveyance and a subsequent admission
- Work with NHS England to improve the uptake of flu vaccinations in the over 75s and care home residents
- Enhance the end of life services available to North East Essex patients
- Enhance the use of prescribing to reduce the numbers of emergency respiratory admissions
- Commission the range of enablement service to enable people to remain at home without having to get to a crisis in order to receive reablement services.
- Worke with social care commissioners to reach out to people over 75 to support them to access services across health and social care
- Work with Public Health and social care commissioners to commission services to encourage patients over 75 to undertake regular appropriate exercise.
- Encourage providers of health and social care to maximise Making Every Contact Count
- Support primary care to deliver annual health checks on all over 75 year old patients
- Reduce the number of requests for ambulances to attend the over 75's who have not received the assurance that they needed to stay at home and therefore result in a conveyance to hospital
- Support primary care to identify an accountable lead professional for integrated packages of care – though the delivery of the virtual ward model and case management

The CCG will continue to work with stakeholders including our local acute Trust, Colchester Hospital, to improve communication and joint working across different sectors of health and social care in North East Essex. Colchester Hospital have recently recruited a GP to help them to do this which has resulted in the development of a virtual GP office within the hospital, which is going to support the communication between the hospital and GP practices.

6.3 Modern integrated care

As set out in our vision, the CCG is committed to commissioning joined up health and social care for local people. The Care Closer to Home project will

- improve the quality of and experience of care for patients and their carers
- commission integrated, both mental and physical health and social care pathways
- combine and streamline commissioning and procurement across health and social care
- reduce the complexity of care making it seamless at the point of delivery
- promote self-care for patients and support for family and carers
- promote prevention, early diagnosis and early intervention
- deliver more care in the home and community - with care in hospital only where it adds value
- ensure that delivery of health and social care remains sustainable in the context of financial and demographic challenges – QIPP

The final product will be a fully commissioned integrated community service across North East Essex. The model of care will be based on a community gateway service that will co-ordinate the long term management of all patients within the community who require health and social care input to maintain their wellbeing in a community setting. The community gateway will work in collaboration with other community functions such as reablement and virtual ward, which are time limited services designed to assess, treat and improve a patient's wellbeing in the community. The community services will maximise the patients outcomes, identify the continued long term needs and handover the patients to the community gateway and care co-ordinating team. This team will reassess patients on a regular basis to ensure their long term care package addresses the needs identified to manage risk and optimise health.

It is anticipated that the community gateway will be supported by a consultant led MDT to provide support and advice to care co-ordinators when a patients risk categorisation has changed significantly and a revised package of care is required. The referral and assessment route will be supported by a single referral and assessment process, including a decision support tool, which will include documentation and definitive information flows. Agreed response timeframes in the management of referrals will be defined by clinical urgency and outcomes, as specified by the Department of Health 18 week referral to treatment targets.

The service will also include a rapid response service with a response timeframe of 2 hours, linking directly with the Rapid Assessment Unit (RAU) service identified within the Urgent Care Strategy. The rapid assessment unit will be defined as a rapid response to support patients continue their care in the community, preferably at their usual place of residence, however the model does include a step-up bed provision in Harwich and Clacton Hospitals. The rapid assessment/response service is not a clinical emergency service provider; clinical emergencies will be managed through the pathways defined within the urgent care strategy.

The model is based on predictive modelling which will focus on identifying those patient/clients at risk and the pro-active actions that can be provided to avoid deterioration and the requirement for acute care. The model appreciates that health needs are seldom in isolation therefore the integrated assessment and service provision model will provide the holistic approach required to prevent delays and maximise effectiveness.

Older People's Services

Essex CC's Older People's Services can be described in three elements:

- Early Intervention
- Intermediate Care Services and
- On-going Support Care

All elements interact with NHS services but particular focus in 2014/15 will be on Intermediate Care, where an integrated intermediate care pathway is being developed to ensure that people are able to access services at the right time in the right place. This is a key component of the overall frailty pathway and a key support for people in the LTC and Frailty phase of life.

Early intervention	Intermediate care	On-going support

• Information Advice and Guidance (IAG), Self-Serve and Signposting
Strengthening Communities
Targeted approach to prevention and early intervention providing low level services which:
• are community focused
• are community led
• utilise community agents
• encourage voluntary sector development
• prevent social isolation
	Preventative, integrated and targeted approach to expanding jointly commissioned, reablement and intermediate services to:
	• minimise the need for on-going support care services
	• delay or avoid demand pressures from 2014 through:
	  • Rapid Response
	  • Home from Hospital
	  • Domiciliary reablement
	  • Residential reablement
		Long term care
		• Residential / nursing
		• Specialist day care
		• Domiciliary care
		• Continuing Healthcare (CHC)
		• End of Life (EOL)

Within the LTC and Frailty phases, the CCG and ECC share the ambition to enable people to remain safe and independent at home and so will shift their approach to a more preventative, integrated and targeted approach to providing services for older

people, expanding jointly commissioned, reablement and intermediate services. This will minimise the need for on-going support care services, and delay or avoid demand pressures from 2014.

To deliver this ECC will:

- Move to a proactive model of care that addresses key areas of demand which include the high number of people going through acute care that were not previously known to have an assessed social care need

- Work with the CCG to redesign the intermediate care pathway to ensure that the people who use the services are getting the right level of support at the right time and the pathway is joined up to enable people to remain independent in the community
- Deliver its aims and objectives by locating its care and assessment resources and its care services to support people to stay in their homes
- Locate its hospital discharge capacity into the community and intermediate care pathways
- Work with independent and voluntary sector partners to ensure that care services are available 7 days per week to facilitate discharge and avoid unnecessary admission.

- Be looking to benefit from health schemes that allows it to deliver its responsibilities within a cash position 30% lower than its current spend
- Move as much of its resources as possible from residential and domiciliary care into more reablement and proactive case finding to address the issue that most of ECCs demand comes from hospital discharges which is driven by peoples deterioration in health.

End of Life Care Services

The EoL Strategy has been approved by CCG Board. This document is a 5 year strategy detailing the future commissioning of end of life services across the health and social care economy. The document identifies the importance of raising the profile of achieving ‘a good death’ and putting mechanisms in place to achieve this

The focus will be an integrated approach, co-ordinated through a single point of access and determined by the end of life register and advance care planning. The elements of the model to be commissioned include:

- End of life register
- Advance Care Planning
- Single Point of Access
- Key workers/care co-ordinators
- Rapid response
- Specialist Nursing and community teams
- Improving Access to Psychological Therapies
- Hospice Care
- Transport
- Social care

There is a high prevalence of undiagnosed dementia across north east Essex and people with dementia who are dying should have the same access to end of life care services as those without dementia. The Care Closer to Home Strategy will commission services to improve early diagnosis and care for people with dementia, and this strategy identifies action across the economy to support end of life planning for patients, their family and carers and the health and social care workers providing care and support specific to the needs of people with dementia.

6.4 Urgent and emergency care access including winter plans

NEE CCG strategy on Urgent Care, in line with the vision and proposals set out in the Urgent and Emergency Care Review Phase One Report aims to ensure;

- We reduce complexity in the system to enable patients and clinicians to make an informed choice
- There is consistency of provision across the services regardless of what time of day or day of the week the patient presents
- Services are provided by people with the right skills, in the right place and at the right time.
- Utilises the resources available in an efficient way and is sustainable to deliver the requirements through periods of peak demand.

We need to be ambitious and demonstrate to our patients that we have a clear vision of how services will be delivered during the next 5 years. We will commission services that provide the same level of service irrespective of the time of presentation by the patient.

We have identified a number of key enablers to achieve this, including;

- Information Sharing
- Training and development
- Primary care development
- Agreed core hours of delivery on a 7 day basis across the system to reduce complexity where appropriate.
- Commissioned PTS to try and avoid ambulances arriving at ED in waves creating additional pressures,
- Use of QP to improve data collection from Primary Care.
- Working closely with ECIST to explore a system wide 'perfect week' exercise to quickly identify improvements that could be made in the system.
- Redesign of supporting services e.g. reablement, intermediate care, admission avoidance schemes etc. in to one service that is inclusive, responsive and meet the needs of the individual. Services could range from be-friending to double handed care.

NHS IQ

The NEE local health system has also signed up to working with NHS Improving Quality to undertake a series of system wide bespoke workshops (including patients and carers), to identify the requirements from the system in the future. We will be looking to agree a joint vision with all Partners with each organisation being held to account in achieving this aim through aligned incentives. This will include undertaking detailed data analysis of current patient pathways and flows and how future demand is likely to impact on these in future years.

The workshops take place monthly from March to September 2014 and will include commissioning for transformation and improving the whole patient journey. The CCG recognises that the cost envelope will reduce over the coming 5 years and therefore we need to commission services that will provide value for money maximise efficiency.

Additional work which has either started or is scheduled includes:-

- Review of high intensity users in order to develop a multidisciplinary approach
- Wound closure training for ambulance crew to enable patients to stay at home
- Supporting our Acute provider in redesigning their discharge processes for short stay patients.
- A review of the current use of community beds, to move to a model which is focused on the 'step-up' of patients and increased community support. This will include a rapid assessment unit where a holistic assessment of the patients' needs will be undertaken, in order to promote independence and rehabilitation.
- Analyse the benefits of an urgent care centre compared with other models for simplifying and improving urgent care system across the local economy

Our aim is to implement a simplified urgent care system, which effectively channels patients to the right place at the right time rather than expecting patients to choose from a wide range of similar but slightly different services.

A&E Performance

The annual performance for the 95% 4 hour standard is currently below the required standard. Considerable work has been undertaken within our Urgent Care recovery group to recover the target after performance significantly dropped from October 2013. Although this has been a large area of focus across the economy and a number of changes and improvements have been made, it remains a significant challenge to deliver against the year end position.
A number of lessons have been learnt across the system and we are continuing to meet on a weekly basis to ensure the improvements in performance being seen are sustainable and the 4 hour standard is maintained with the increased demands in 14/15.

Clinical Decision Making

The focus continues to be that all patients attending ED will be seen and treated by a senior doctor within 60 minutes of arrival. Patients requiring a specialist doctor should be seen within 30 minutes of referral. Performances against these standards are monitored at the weekly Urgent Care recovery meetings and are accountable to the Clinical Director for Urgent Care.

Ambulatory Care Pilot

This pilot commenced in January 2014, in order to reduce the number of short stay admissions in the hospital and to improve the overall bed flow within the hospital. Initial stages of the pilot have proved successful and therefore this has been expanded to operate 4 days a week.

Staffing Levels

10 additional nurses have been appointed to work in ED and are due to start within the next quarter, with a further 10 nursing posts appointed for Paediatric ED. Recruitment to substantive posts for medical staff is ongoing with temporary staff supporting rota gaps. CHUFT acknowledge that currently there is high medical locum cover and are implementing an acute physician to work the late shift in ED in order to effectively meet the periods of high demand.

Leadership

The change of leadership at CHUFT has inevitably caused some challenges, however it has also provided some opportunities for increased collaboration and we have agreed an integrated approach to the redesign of urgent care with the support of NHS IQ.

A&E Re-design

The A&E redesign is due to be completed by April. It has been acknowledged that this has caused some significant challenges to performance, however, assurance has been provided that the new design should increase capacity to the required levels and contribute to sustained performance against the 4 hour standard.

Process for Winter Planning

The CCG has undertaken an evaluation of the winter schemes implemented for 13/14 in order to fully understand which elements of the system have had the most impact. This will inform our strategy and contract negotiations for 14/15.

The CCG, building on the lessons we have learnt from 13/14 and the outcomes from our winter funding evaluation, the CCG is currently designing a specification for the delivery of community based services. The intention is to use winter resources to increase admission avoidance, accelerate discharge and support patients to be cared for out of hospital. This will take the form of a mini procurement and will require integrated working from all Providers to support the system during 14/15.
An initial draft of this specification will be available by May 2014.

6.5 Mental health services

NEE CCG is committed to lead in developing mental health services to ensure that:

- everyone who needs mental health care should get the right support at the right time,
- people are offered services that encourage recovery,
- those who could benefit from psychological therapy will be able to access suitable therapies and
- physical care and mental health care will work in an integrated way.

In the past five years NEE CCG has invested in Improving Access to Psychological Therapies, with over 30,000 people referred to the service in that period, and has recently procured a new service provider to continue to build on that success.

NEE CCG has worked together with other CCG in North Essex to form a mental health strategy which is out lined below

Joint Health and Social Care North Essex Mental Health Strategy 2013-2017

Our Vision

- People will have good mental health
- People with mental health problems will recover
- People with mental health problems will have good physical health, and people with physical health problems will have good mental health
- People with mental health problems will have the best possible quality of life

We Will Achieve Our Vision By

- Developing and supporting community well-being, encouraging people to maintain healthy lifestyles and keep themselves and their families mentally well
- Improving access and the gateway into services – more effective direction
- Ensuring smooth transition between services (CAMHS/Adult/Older People)
- Ensuring a more holistic and integrated approach to mental health and physical health services
- Developing broader primary and community based models of care for people across the spectrum of mental health conditions
- Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs

The Challenges

- Currently 1 in 6 people will experience mental health problems at any one time in their lives
- Prevalence of mental illness is predicted to increase with population growth (a predicted increase in demand of 2.7% by 2020). Predicted increase in prevalence of dementia as a consequence of the increase in elderly people in North Essex
- There is a strong relationship between physical health and mental health
- Inequity and variance of provision across the three North Essex CCGs
- Disaggregation of mental health budgets (CCG/Specialised)

- Insufficient housing and reablement currently for people with mental health conditions leading to delayed discharges
- Effective decommissioning of health services as a consequence of service redesign and roll out of personal health budgets

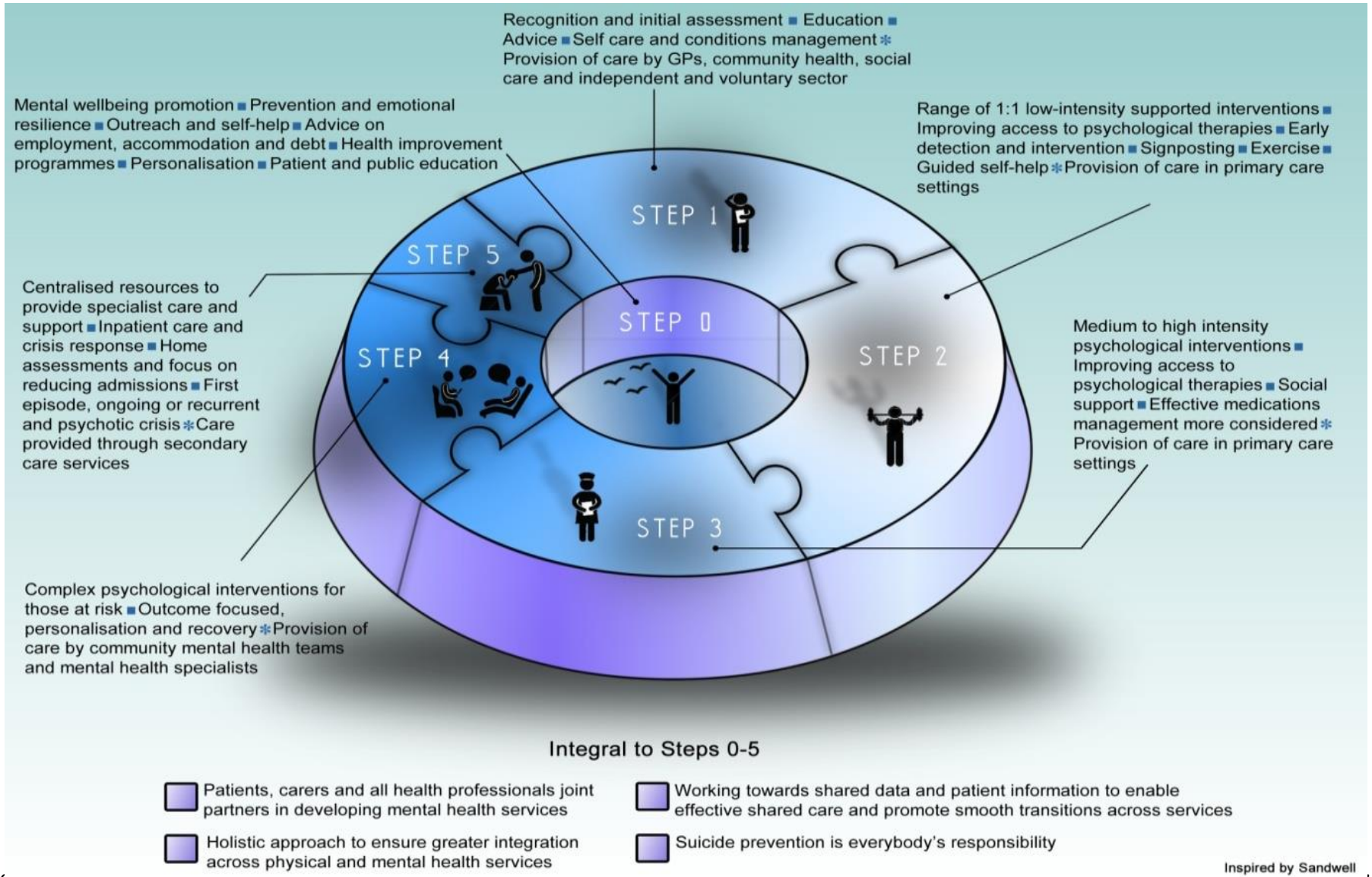
Recent Achievements

- Delivery of comprehensive IAPT programmes across three CCGs
- Development of Recovery College in Mid Essex
- Improving dementia pathways
- Joint Commissioning with social care (section 256)
- ECC development of Community Dementia Service, Accommodation Strategy and Procurement
- Individual Placements
- Veterans First Pilot
- Mother and Baby Psychotherapy
- Personality Disorder Service, joint initiative with Probation service
- Edward House
- Good CQC inspections and reports

Key Messages

- The model will support the wellbeing agenda
- There is recognition that suicide prevention is a responsibility for all.
- All people with mental health condition will receive care in the most appropriate place for their treatment and experience a smooth transition through services
- There is a need to ensure there is a holistic approach with true integration of mental health services with physical health provision
- There is a need to transfer low intensity services into the community to develop greater provision in primary care
- We will maximise our impact by commissioning services through jointly agreed strategies; such as Children and Adolescent Mental Health, learning disabilities, older people and the recently produce mental health clinical outcomes framework
- There is a need to work more closely and collaboratively with voluntary and community services to support local populations

North Essex: A New Model of Care for Mental Health



A New Model of Care

The proposed ambitions and models of delivery have been developed in conjunction with the North Essex Mental Health Strategy.

- No Health Without Mental Health (DH 2011)
- Building resilient communities – making every contact count for public mental health (MIND/Mental Health Foundation Aug 2013)
- Joint Commissioning Panel for Mental Health (series of papers updated August 2013)
- Kings Fund: Long Term conditions and mental health (Feb 2012)
- NHS Confederation: A primary care approach to mental health and wellbeing (2013)

Our local ambitions:

- To develop community wellbeing, supporting and empowering individuals to manage their own mental health
- To develop integrated primary/community based care for the delivery of mental health services and the management of long term conditions
- To establish improved crisis pathways to reduce A&E attendances, admissions and the time people stay in acute beds
- To improve access to services and reduce waiting times for assessments, diagnosis and treatment, including 7 day working and the transition from CAMHS to Adult Services and Adult to Older People's Services
- To improve provision of urgent care pathways, in-patient provision and specialist services

We will achieve this by:

Year 1

- Explore opportunities of joint commissioning with public health colleagues to support early intervention and community wellbeing, including families and carers
- Suicide prevention – commencing with pathfinder application led by Mid Essex – learning to be shared across North
- Establish North Essex Mental Health Clinical Network (likely locality forums) input into service and pathway redesign
- Development of a series of "Think Tanks" to explore across all providers opportunities for improvement. Suggestions to date: Urgent Care, Management of Long Term Conditions, Stroke and Pain
- Further development of IAPT, primary and community mental health services. National Funding/project management support sourced
- Development and roll out of Primary Care (General Practice), Mental Health Education Programme. Link to EQUIP and establishment of North Essex Mental Health Clinical Network

- Commence Development of single point of access (primary care) based. Business case to be produced for individual CCG/North Essex Pilot (6 months)

Year 1 (2014/2015)

- Development of Personality Disorder Strategy for North Essex
- Preparation for joint procurement of new CAMHS tier 2 and 3 service
- Repatriation programme for out of area placements
- Proposed collaborative working with specialised commissioning for Personality Disorders and Locked Rehabilitation Services
- Section 12 Procurement
- Effective contract discussions with NEP to support:
  - Development of proposals to integrate service provision for patients with mental health and long term conditions
  - Improve access to consultant psychiatrists
  - Establishing effective KPIs to improve quality, provision of data and clinical effectiveness
- Development of a comprehensive service review programme to explore and fully understand the provision of NEP services (community, CRHT/inpatient and dementia services), exploring opportunities for integration and to make recommendation for future delivery of the North Essex Mental Health Strategy and CCG locality plans via collaboration and contestability
- Review of Mid Essex Recovery Pilot with potential roll out to other North Essex CCGs

Our local delivery plan:

Year 2/3 (2015/2017)

- Further development of primary care mental health including establishment of “hub” model. Roll out based on early implementers across North Essex. Need to incorporate second level education programme to support new function (required in-practice presence from secondary care and assignment of care workers)
- Development and implementation of GPwSI role – suggestion is to start with dementia. Proposal to work through Strategic Network to understand national practice and build on existing service models
- Implement Mental Health Redesign Programme – based on the finding of the 2014/2015 review programme to enable the delivery of the strategy and local plans focusing on early intervention, community well-being, integration of physical and mental health services, rehabilitation pathways/recovery models and the provision of high quality specialist in patient serviceS

Parity of Esteem

Resources allocation:

The draft North Essex Joint Mental Health Commissioning Strategy 2014 – 2017 has been subject to a period of wider consultation with service users and stakeholders during 2013/14. It sets out to describe the vision for the commissioning and delivery of mental health services for North Essex over the next three years and recognises the importance of joint commissioning with social care, developing community well-being, delivering services closer to home in primary and community settings and the need to integrate physical and mental health services more effectively.

The Strategy has been developed in partnership across the three North Essex CCGs and Essex County Council. The principles of the strategy are now being adopted locally in Mid, West and North East Essex with implementation underway specifically with regards the development of more community based provision for patients with mild to moderate mental health illness.

Both the Strategy and the local delivery plans for mental health recognise the need to improve parity of esteem. The associated work plans include the need to undertake comprehensive clinical service reviews of community, urgent and older people's pathways to better understand provision, patient outcomes and experience. It will also explore the opportunities of further integration between mental and physical health services to close the 20 year gap and to improve urgent care provision. The outcome of this work will be reported to the three CCGs and The North Essex Partnership Foundation University Trust (NEP) in September 2014, with service changes to be embedded either through contract discussions with NEP or as a consequence of a procurement programme likely to commence April 15.

In terms of additional resources, we are proposing a number of CQUINs and service developments to further strengthen the delivery of parity of esteem. The CQUINs include supporting frail and older people including those at the end of their life, those experiencing urgent care services and the adoption of the national CQUIN 'Improving physical healthcare to reduce premature mortality in people with severe mental illness (SMI)'.

Within the proposed Service Development Improvement plan in addition to supporting primary care development, suicide prevention and the safe transition of patients in clusters 1 – 4, we are aiming to establish improved communications by exploring the development of a telephone advice line to provide general advice and guidance including medications and risk. We are also

planning to monitor closely and apply contractual leverage with regards Trust communications/documentation following outpatients/admissions etc.

In respect of on-going projects, The Mid Essex Recovery College and Hub pilot is currently underway and will be evaluated during 2014. The Recovery College delivers educational courses to people with mental health problems, their families, carers and staff who work alongside people who experience mental ill health. It is planned that the learning of this project will be rolled out across North East and West Essex CCG localities.

A key feature of recovery-focused mental health services is the adoption of an 'educational' and 'coaching', rather than a 'therapeutic', model of services. Helping people to recognise develop and make the most of their talents and resources in order to become experts in their own care and do the things they want to do in life. Personalisation reinforces this through the idea that people are best placed to know what they need and how those needs can best be met. It means that people have choice and control for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

We are also exploring the opportunities for joint commissioning opportunities with Public Mental Health services. There are plans to explore what has been achieved in Northampton and to consider opportunities as to how this may bring service improvement for North Essex. This may include earlier intervention for children and supporting families.

Improving access to psychological therapies (IAPT) remains a high priority. The local IAPT service has recently been re-procured and the new service goes live on 1st April 2014. Access will be increased to 15% coverage by March 2016. It is envisaged that this new service will support the CCGs proposals to facilitate, where clinically appropriate, the safe transition of patients currently being treated under Mental Health Care Clusters 1 – 4 in secondary care to a primary care setting.

There is an IAPT Children's pilot in North East Essex where we would hope any learning shared and would inform future commissioning opportunities.

Reduction in gap in life expectancy:

In addition to the proposed CQUINs and the SDIP proposals for our Mental Health Service provider, as noted above, there are further plans underway which include the;

- Development of a primary care mental health education programme
- Development of a North Essex Mental Health Clinical Network and Associated "Think Tank" aimed at clinicians working together to develop new pathways both in mental health and the acute sector, this will concentrate on both the development of Parity of Esteem and the Mental Health Crisis Concordant
- A strategy target that 100% of patients admitted to mental health will receive a health check on admission
- Discussions on-going on possibilities of data sharing – the first area to focus on will be investigation results
- Joint commissioning with public health – including programmes focussing on early intervention and traditional public health screening
- The development suicide prevention across North Essex. The programme of work is to be led by Mid Essex as a consequence of receiving a pathfinder grant but learning will be shared across the three CCGs with joint training being made available where possible.
- The development of a personality disorder strategy which will link to both the health and suicide prevention agenda

Finally as part of their longer term strategic plans it is noted that MECCG/WECCG/NEECCG are developing transformation plans for Frailty/Older People which will seek to integrate pathways more effectively involving community, acute and mental health provision.

Young people with mental health problems:

Child and Adolescent Mental Health services (CAMHS) are currently being redesigned and re-commissioned across Essex with a view to improve the emotional health and wellbeing of children and young people from conception to their twenty fifth birthday. One of the primary aims of the redesign is to address the current gaps identified by the Emotional Health and Wellbeing JSNA in particular behaviour management which transcends both paediatric and adult services through transition.

We are also working closely with current CAMHS providers with regards the improvement transition of adolescents to adult services.

6.6 Elective care and productivity

The Care Closer to Home plans include transfer of certain elective pathways into that contract, in clinical areas including: dermatology, ENT, ophthalmology, lymphoedema, tissue viability, musculoskeletal, pain, spinal, rheumatology, urology, ENT.

The CCG is undertaking modelling of the impact of its strategic commissioning plans. This will enable to the CCG to assess whether we can achieve a 20% productivity improvement within 5 years, so that existing activity levels can be delivered with better outcomes and 20% less resource.

These findings will be discussed with providers as part of development of the 5 year plan for the NE Essex care economy. We will work collaboratively with providers and other stakeholders to address any gap between the national aspiration and the CCG's current plans.

6.7 Specialised services

The report into the immediate review of Cancer Services at Colchester Hospital was published on 19th December 2013 and can be found on

Incident page: http://www.england.nhs.uk/publications/incident-mng-rep/

News item: http://www.england.nhs.uk/2013/12/19/review-cancer-services/

Seventeen cancer pathways were visited by teams comprising cancer experts, local GPs, Area Team clinicians and members of the cancer network administration. Six pathways were placed under intensive or enhanced monitoring. These pathways will be re-visited in April 2014 and a second report generated.

The Colchester Hospital cancer action plan is embedded here

CHUFT Cancer Action Plan_28_01_1

The CCG will work with specialist commissioning and NHS England to ensure that the urology and anal cancer are IOG compliant.

The CCG also will work with the 5 Rivers Vascular Network, specialist commissioning and NHS England to ensure that the vascular pathway is compliant.

6.8 Children's services

The requirement to work in an integrated manner between Health and ECC presents opportunities to re-consider the entire CYP structure of delivery and to consider the options for fully integrated services delivering both improved outcomes for service users and cost benefits.

Alongside these fundamentals are significant projects currently being worked up to deliver change/implementation in the following areas;

- Child and Adolescent Mental Health Services (CAMHS)
- The Local Offer delivering centralised access to available services for Social Care, Health, Education and other agencies (**Children and Families Bill 2013**)
- The 'One Plan' the ECC name for the single assessment requirement and data sharing across (EHC) Education, Health and Social Care (**Children and Families Bill 2013**)
- Centralised / shared Equipment services
- Transition to adult services
- Re-commissioning / consideration of Children's Centres and expansion of usage
- Personal Budgets

The project is scoping existing services and aims to deliver the following:-

- Delivery of seamless care pathways for young service users reflecting best practice and NICE guidance
- Equity of access and delivery for all children regardless of disability or disadvantage
- Clear ownership of care pathways but with expanded multidisciplinary team (MDT) opportunities and multi-agency integrated working
- Meeting of all requirements of the **Children and Families Bill 2013**
- Integration between Education, Health and Social Care (EHC) to deliver best outcomes, reduce inefficiencies and generate cost savings
- Delivery of unique early intervention services within Emotional Health & Wellbeing (EHWB) to radically reduce escalation (with accompanying costs and stress) and to work with ECC Family Solutions team to deliver a whole family approach to Children's mental health
- Movement closer to home of activity from secondary and urgent care
- The meeting of NICE and additional clinical standards
- The reflection in all services of the input from service users
- Fully integrated Looked After Children (LAC) and Safeguarding requirements

6.8 Maternity Services

NHS North East Essex (NEE) Clinical Commissioning Group (CCG) and Colchester Hospital University Foundation NHS Trust (the Trust) working in close collaboration with the NEE Maternity Services Liaison Committee (MSLC) are planning changes in the way that community maternity services are currently delivered. This will facilitate the development of the existing service and deliver a less variable service across the district for women and their families with increased local access, support and continuity of maternity care available in the community. There will continue to be provision of a safe service which is clinically and financially sustainable whilst maintaining choice for women in the future.

- The ambition is to continue to provide a high quality, safe service that is equitable and clinically and financially sustainable for the future and provides one-to-one care in established labour whilst continuing to offer a choice of where to give birth and providing increased access and continuity of care in the community. A PID and related documentation including action plan is currently in place

6.9 Intellectual disability services

NHS CCG is committed to offering equal access to service for all the population. People who have an intellectual disability (previously called learning disability) or who suffer with Autistic Spectrum Conditions will be offered reasonable adjustments by all provider services to ensure they can access the same quality of services as the general population. Until March 2014, intellectual disability services were commissioned by West Essex CCG on behalf of CCG s in North Essex but responsibility for services currently offered by health services to people with intellectual disabilities will be transferring to the Local Authority from 1st April 2014. This will include community services and assessment and treatment services currently provided by Hertfordshire Partnership Foundation Trust at the Lexden Hospital site. The key challenges and plans are shown below.

The Michael Report: *Healthcare for All* (2008) and the Mencap report: *74 Lives and Counting* (2012) provide clear evidence that people with an intellectual disability have unequal access to health services and are often at risk through failures to make reasonable adjustments to meet their needs.

The impact of these greater health needs and unequal access to general health services is that people with an intellectual disability are likely to die prematurely. The recently published *Confidential Inquiry into Premature Deaths of People with a Learning Disability*: 2013 (University of Bristol; Improving Health and Lives Learning Disability Public Health Observatory) identifies from the cohort they studied that men with intellectual disabilities died on average 13 years sooner than men in the general population; and women with intellectual disabilities died 20 years sooner than women in the general population. Overall, 22% were under the age of 50 when they died; 43% of the deaths investigated were identified as ‘unexpected’ and 42% ‘premature’ whilst fewer deaths of people with intellectual disabilities (38%) were reported to the coroner compared with the general population (46%).

The view is that an integrated health and social care team is best placed to take responsibility for the end-to-end health and social care experiences of people with intellectual disabilities. This will support an improvement in safeguarding and access to services, enhancing the experiences and outcomes from both health and social care.

Key Patient Benefits
• Experience will improve and better outcomes will be achieved for people with learning disabilities.
• People will no longer become "stuck" in hospital assessment and treatment services (this happens currently because the current pathway between health and social care services is disjointed and managed separately);
• Funding disputes between CCGs and ECC (which can cause delays to people receiving the services they need) will no longer occur; • Social care services will be enabled to work with health services to ensure that people's health needs are being met effectively and that people are being supported to live healthy lifestyles;
• The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex.

- The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex. - **April 2014**
- Formal Pan Essex integration of commissioning resource (North and South Essex). - **April 2015**
- Service design - Integrated pathways for all cohorts – **throughout 2015**
- Joined-up care management and assessment **– April 2016**

A Modern Model of Integration – Intellectual Disabilities

Principles

- Increasing pressure on the health and social care system is potentially best mitigated through integration.
- There is a pressing requirement to respond to the national Winterbourne View action plan, which requires us to demonstrate that we are delivering joined-up services for people with learning disabilities.
- Integrating LD will act as a key "early adopter" project to test and evidence the impact that can be delivered. The lessons can be translated across other areas

- Integrating LD commissioning will safeguard the benefits defined in the WAA Increasing Independence programme, through ensuring contractual buy-in to solutions that are best for the total combined expenditure
- There is some evidence that demand is a factor not only of demography, but also of the design of the system; an integrated approach to management and design of the system will mitigate the potential negative impacts
- The market continues to innovate and develop solutions for the separate budget and procurement processes. The market will only provide the innovative joined-up community-based solutions when the integrated budget puts those out to tender. Similarly the stand-alone nature of current performance and contract management makes it more difficult to hold suppliers to account for performance across the whole system;

Outcomes

- To improve customer experience and outcomes for people with learning disabilities through integrated pathways
- To create organisational capacity to address the impact of the projected demographic pressures
- To deliver the requirements of the Government response to Winterbourne View
- To bring the commissioning budgets together to drive greater value from the market with an increased focus on avoiding the poor experiences and outcomes which the cohort can suffer
- To drive value as well as managing increasing demand by developing integrated specifications
- To reduce the potential risk of systemic failure by creating integrated care pathways that improve experiences
- The development of integrated care and support pathways, to deliver the integrated specifications to deliver the *"Behaviours that Challenge"* work stream within the "*Increasing Independence for Working Age Adults"* programme*
- To address the issue that people with learning disabilities continue to have lower life expectancy and experience poorer health outcomes than the general population, despite increasing levels of funding over recent years

Priorities

- The approach to commissioning will have changed to enable people with learning disabilities to have improved customer experience and outcomes.
- Commissioning teams for Health and Social Care will be co-located, with commissioners working as a single team to define integrated specifications
- Commissioning of services will be carried out as a joint activity between Health and Social Care, with budgets jointly managed
- There will be an approach to governance in place which enables and operationally manages joint commissioning and provides delegated authority to make commissioning decisions
- Commissioners will commission services which are delivered via integrated pathways between Health and Social Care, with seamless service and minimal hand offs
- People with learning disabilities will be supported to live healthy and fulfilling lives, with health and social care services working together to enable this to happen.

SECTION 7 ACCESS

7.1 Access to all services especially Mental Health services and tailored to minority groups

Alongside the CCG's engagement model (see section 6) our CCG will be relying heavily on what people from the protected groups within the equality act told us when we undertook the Equality Delivery System. We have developed objectives that will address reducing inequality and improving health outcomes, experience and access. Underneath these objectives will be outcomes and measures which we hope to report on to our stakeholder groups so we are held to account for delivering good access to services for minority groups.

7.2 NHS Constitution standards

The CCG monitors monthly performance against the NHS Constitution standards, below, ensuring that local providers uphold patients' rights within the agreed thresholds. Where individuals do not receive their treatment within this framework; the CCG ensure that patient safety has not been impacted in a negative way. Where providers fall below expected standards contractual mechanisms are used to ensure that performance is improved and where appropriate a remedial action plan is formed to manage sustained improvement to the measure.

The CCG monitors on a daily basis the health care systems performance against the standards expected in the NHS Constitution. Whilst local urgent care services have worked hard to ensure their performance remains above the established thresholds during periods of peak demands, unfortunately this has not been consistent in terms of the 4 hour A&E standard. The CCG are currently holding weekly recovery meeting with all system partners to troubleshoot where any issues lie and implement mitigation plans to overcome these. These meetings are focusing on sustainable improvements which have

resulted in improvements to performance and we will continue to closely monitor and support organisations in maintaining these standards

Cancer standards have fallen below thresholds on a number of occasions in 2013-14 this initially came to light after the Keogh review, subsequently Colchester hospital has been placed in special measures whilst cancer services are investigated. The CCG has worked with cancer leads at the hospital to monitor cancer waiting lists to ensure that patient safety has not been affected by any delays in their pathways. As a result of the investigation and this work a number of cancer tumour site pathways are being reviewed and plans are in place to improve the effectiveness of these pathways. Monitor is working with the trust to improve cancer standards and subsequent CCG plans will reflect the outcomes of the agreed action plan.

The CCG is part of a commissioning consortium working with the East of England ambulance service, which has not been able to uphold the NHS constitution pledges for ambulance response times. The lead commissioner had agreed a remedial action plan with the ambulance service which has not produced the expected results. A recent risk summit has been held to identify what can be done to improve ambulance responses and the results of this summit will be reflected in subsequent CCG plans.

NHS Constitution Standards can be found in full in Appendix D and are explained further in the NHS Constitution handbook which can be found online

The CCG monitors performance against the 3 pathways for referral to treatment where 90% of patients should be treated within 18 weeks if their treatment requires an hospital admission, 95% if treatment can be provided in an outpatient setting and 92% of patients still waiting for treatment have not exceeded 18 weeks. These thresholds apply to both aggregate and specialty level, Colchester Hospital are currently underperforming in a number of specialties and have invited the intensive support team in to provide guidance, their review is expected to report in March. At the present time several specialties including dermatology and ENT are not expecting to have reached the required threshold until June 2014. The CCG are working with CHUFT colleagues on a weekly basis to identify issues with long waiters on their outstanding patient waiting list. As soon as the Trust's remedial action plan is received this will be closely monitored by the CCG, with the intention of ensuring that these standards are recovered in a timely fashion.

7.3 Digital access and data – to be added

Through its website, the CCG provides links to NHS Choices and other websites offering information and signposting, which help patients to make informed choices.

Telehealth and telecare can be effective ways of helping patients to maintain independence. We will expect providers to include these in their models of care, but in line with our outcomes-based commissioning approach we will not be prescriptive, but rather devolve decisions on how best to use these to the providers.

Community voluntary services provide training in health literacy but the CCG will explore further ways of supporting this work?

The CCG receives assurance from CHUFT that all patients undergoing procedures for hip and knee replacements, groin hernias and varicose veins are offered the pre-operative questionnaire as part of the national survey on Patient Reported Outcome Measures. These are followed up nationally, asking patients to complete the second part of the survey.

The CCG has not been able to use the NHS number for a prolonged period due to national restrictions. Having been granted Accredited Safe Haven (ASH) status and having put DSCRO arrangements in place, the CCG is now in a position to begin receiving patient identifiable data. Ongoing restrictions apply, but the CCG will be in a position to use NHS number, or a pseudonymised version of, for 2014/15 reporting.

In line with ECC, our strategic ambitions for data management, systems development and performance/financial reporting have the NHS number as a single consistent patient identifier. This is crucial for us in terms of understanding patient pathways and end-to-end commissioning of these – and providing quality data to GP Practices to support patient care. As noted there will be restrictions on the CCGs ability to receive process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

SECTION 8 QUALITY

The CCG quality team have integrated into the bundles structure of the organisation with quality leads for mental health, care closer to home, urgent care, maternity and children's care and end of life. The quality team provide clinical input into the development of the strategic plans through the bundles work with specific input into;

- Developing new pathways/models of care
- Resource modelling in relation to beds and staffing
- Risk management and safety
- KPIs
- CQUINs

The clinical quality agenda is part of the overall contract monitoring agenda with monthly (or more frequent) meetings with all providers through the Clinical Quality Review Groups.

The team take a multi-faceted approach to assuring quality across the organisation and across providers;

- Contracts; developing KPIs, CQUINs, safeguarding and infection prevention and control, producing quality accounts. The CQRG is now part of the overall contract monitoring agenda.
- Walkarounds; a schedule of multi-practitioner walkarounds across all providers is undertaken against specific quality checklists with lay members attending to capture patient experience direct feedback. The outcome of the workarounds forms part of the overall performance monitoring.

- Procurement; the quality team provide specific information and PPQ standards to inform all procurement processes and participate in tender evaluations.
- Patient safety; working both strategically and locally processes are in place for the management of SINE
- Complaints management and PALs; overall co-ordination and reporting and review.
- Monthly Quality Committees; addresses all elements of quality across all disciplines and provides action and mitigation for the corporate risk register.

8.1 Response to Francis, Berwick and Winterbourne View

A focus for the CCG has been the outcomes of the recommendations of the Keogh review; The Keogh Review into the quality of care and treatment provided by Colchester Hospital University Foundation Trust (CHUFT) identified the need for further joint working across the economy to find solutions for patients who could appropriately be at home, or in their normal place of residence to receive end of life care.

The CCG have worked collectively with all providers to produce a North East Essex End of Life Strategy which clarifies the economy wide approach to the provision of the best practice model of care supported by the commissioning intentions for the delivery of this best practice model. The model includes; my care choices, a single point of access, improved training across all service providers to support the Gold Standards Framework, improved carer and family support including care after death.

The model identifies the economy wide approach to single point for all patients and service providers and the success of this is qualified by the activity reports, patient feedback and provider feedback. An example is the very successful work undertaken between St Helena's Hospice and the East of England Ambulance Service Trust to provide the education and training for ambulance staff attending patients who are at end of life and how to access the single point and the best support for the patients through the rapid response service, avoiding patients experiencing unnecessary A&E attendances in the end of life.

The Keogh review found that the Summary Level Hospital Mortality Index (SHMI) at CHUFT was higher than expected and concluded that this was in part a consequence of the lack of genuine choice and support for patients and their families in identifying their preferred place of care.

Much work has gone on across the economy to implement ‘my care choices’ empowering patients and their families to plan for their end of life with the care and support appropriate to them and identification of the preferred place of care. Activity figures across NEE identify that 37 of the 43 practices are participating in my care choices. Quarter 3 reports identify 65% of patient deaths were on the end of life register and 49% of these patients died at their preferred place of care.

The community have also faced challenges as a result of the outcome of Monitor’s review of cancer services at CHUFT. The CCG have worked jointly with Monitor and the acute provider to review all processes and implement changes in many aspects of the care provision to assure the quality and safety of cancer services at CHUFT. The quality team have been working to support the review of complaints and incidences raised by patients and or their relatives as a follow-on to the release of the Monitor report.

The Report on Winterbourne View came about as a result of BBC Panorama programme, which exposed abuse at this private hospital in Gloucestershire for people with intellectual disabilities and challenging behaviour. The abuse was criminal and management allowed a culture of abuse to flourish. The key recommendations of the report were to:-

- Commission the right model of care, focusing on individual needs
- Commission flexible, community based services
- Listen to people and their families
- Spot and act on early warning signs
- Only local action can guarantee good practice, stop abuse and transform local services.
- Minimise number of people requiring hospital admission due to lack of early support
- Plan for transition from children to adult services to avoid crisis.

The following action points form part of the delivery plan for services for people with intellectual disabilities which is now in place:-

- Implement Winterbourne and DH requirements including local registers and person centred support/move on plans for everyone in health funded in-patient services.
- Implement integrated model of care, joint commissioning and procurement including pooled budget
- Introduce a single birth to 25 years assessment process and individual birth to 25 years Education, Health and Care Plans through the Children and Families Bill.

8.2 Patient safety

Patient Safety is a key domain of ensuring overall delivery of a quality service and will continue to be reviewed monthly via the Clinical Quality Review Group; concerns with provider performance against safety standards are escalated internally to the Quality Committee and through to Board, to ensure that key safety concerns are always recognised and acted upon in all levels within the CCG.

The CCG fully support the Harm Free Care agenda across all commissioned services and will continue to work with all providers to ultimately ensure that no avoidable harm is caused. To support the Harm Free Care agenda, the CCG collaboratively works will all providers and other CCGs in North Essex to hold the Harm Free Care Collaborative, which actively shares good practice and lessons learnt across all providers on a quarterly basis.

The CCG work collaboratively with providers in the management of health care acquired infections and strive towards zero tolerance in relation to existing MRSA and Clostridium Difficile across the systems.

New initiative and CQUINS will be used to address incidents of surgical site infections and catheter associated urinary tract infections. This has included the revision of surgical prep and the use of catheter passports.

The Quality Team, on behalf of the NEE CCG manage and co-ordinate the processes for the management of serious incidents. The systems and processes are consistent with and aligned to the NHS Commissioning Board Serious Incidents Framework.

The CCG Serious Incident Management Policy (July 2013) provides guidance to the local health economy providers and managers to take appropriate steps in the best interest of their patients/clients/service users, staff and the NHS as a whole. It details the minimum reporting requirements expected in North East Essex.

The CCG is responsible for holding to account NHS funded acute, community, mental health and other commissioned providers for their compliance with this policy and where appropriate to co-ordinate serious incident investigations.

The role of the CCG is to ensure that serious incidents are robustly investigated, that action has been taken to improve clinical safety and that lessons have been learned and widely disseminated in order to minimise the risk of similar incidents occurring in the future.

As part of the North Essex Quality Collaborative, NEE CCG Quality Team review serious incident reports across North Essex as part of a panel review and internally review serious incident and never events at a weekly assurance meeting. The north Essex SINE panel ensure peer review of local processes, and shared learning across north Essex.

Reports are produced by the Quality Team and shared internally with commissioning teams and externally with provider organisations at the Clinical Quality Review Groups and providers are held to account for any themes that are occurring and Learning from Experience Action Plans (LEAPs).

All providers are required to demonstrate evidence that they have robust systems in place for the dissemination, management and monitoring of all safety alerts.

The Quality team have had a key role working with Monitor and Keogh in providing assurance to the safety of the cancer pathways locally.

The Quality Team have been in discussion with NHS England to request information by practice of any serious incident or never events to ensure the CCG are aware of any safety issues across the economy.

Several indicators are monitored for each provider through the Clinical Quality Review Groups focussed specifically on national safety triggers; VTE risk assessment and treatment, MUST nutritional assessment, intentional rounding, falls, duty of candour, think glucose assessment tool, reporting of grades 2, 3 and 4 pressure ulcers, safeguarding training, children and adults, HSMR.

Issue logs from the CQRG meetings are reported to the CCG Quality Committee for review, advice, actions or escalation to the CCG Board.

8.3 Patient Engagement

The CCG engaged with over 800 people face-to-face and 200 people completed online surveys regarding patient experience and views from November 2013 to February 2014 at a series of meetings, some specially arranged, some joining pre-existing groups and societies. Specially convened meetings for ethnic, age and gender groups were also included. All comments were recorded, analysed and used to inform planning strategies and commissioning projects. The three key themes from the engagement exercise were;

People voted at the meeting to say that the best way to stop the NHS going bust is early help and advice so that people can be treated in the community rather than in hospital.

- People voted to say the best way to get better access to your GP surgery was a guarantee to see a health professional, such as a nurse, within 24 hours;
- People voted to say the best way to look after yourself and help the NHS was to develop ways to support people better who live with long-term conditions
- Patients have been involved in designing service, such as the engagement re diabetes mobilisation, and involvement in procurement, such as diabetes procurement process with Diabetes UK reps.

The public were also engaged in the work of the Maternity Services Liaison Committee regarding the Maternity Services Review and the patients and public meetings held for people interested in the Community Beds Project at Clacton Hospital. From the Big Care Debate, patients and public have made their priorities and views very clear, with support for self-care, easy and quick access to services, prevention work, integration and avoiding waste. The Big Care debate targeted a range of vulnerable groups where the agenda was tailored specifically for the audience. We also shall be acting upon the feedback provided at a recent Equality and diversity event where vulnerable groups helped shaped the objectives for our organisation going forward. The ambition is to incorporate carer feedback as part of our integrated agenda with Essex County Council. Future commissioning plans, including improving the experience of carers, have been developed with carer's groups where suitable and relevant outcomes are expected to be in place to measure this.

8.4 Patient experience

The CCG PALs and Complaints service monitor the issues, complaints and platitudes received from patients with regard to commissioned services and where multiple providers are involved in a complaint.

If the PALS contact is an informal concern they will follow up with the provider of the service, or the commissioner of the service, to find answers for the person contacting

Answers are fed back to the person contacting, by the same method used to contact initially, which is usually telephone or email. If they are happy with the explanation or the PALS team have been able to resolve or put right what has gone wrong it will be closed and information recorded on the PALS module. Patients are kept up to date with progress throughout the enquiry.

If the issue is not resolved the person will be advised how to make a formal complaint and who that can be made to. In straightforward cases this will always be the provider. CCG complaints only deal with those relating to commissioning decisions or where more than one provider is involved and the providers cannot agree who should lead on the complaint.

Information about the contact is recorded on Datix and is used in bi-monthly PALS and Complaints reports to the CCG Quality Committee (anonymised). The Quality Team also uses data from the provider monthly reports to CQRG's in the reports to identify any trends emerging about particular services. If a trend is identified before a report the team will raise this as an issue within Quality Team Management Structure and action taken to raise this within the CCG or appropriate service.

The PALS and Complaints team provide monthly reports to the Quality Committee as a measure of the patient experience across commissioned services and to ensure these issues are being addressed and escalated when required. The Team also provide commissioning teams with reports to support improvements required within contract management and to inform commissioning processes when new services are being commissioned.

The CCG take part in the Essex wide Patient Experience Forum and the feedback from this meeting is reported through the CCG Quality Committee.

Within the development of all service specifications, key performance indicators are identified specifically in relation to patient experience. All providers are expected to capture patient experience information and this information is reported at the CQRGs on a monthly basis. Our acute and community providers use a combination of patient experience trackers and questionnaires. The Friends and Family test has been implemented by both our acute and community providers; through the minor injury units and A&E, through the inpatient units and across community and inpatient maternity care. The inpatient capture has remained fairly consistent at 15 % however maternity capture is proving difficult due to the subdivision of the care pathway across antenatal and post natal as well as across the two care settings, acute and community. A&E and Minor Injuries units are now piloting various data capture methodologies in an attempt to encourage patients to provide a response to the F&FT. This will be reviewed in the spring to determine how effective the various methods have been and if this would be suitable for use across the maternity service.

The Children's Commissioning team within the CCG have been working jointly with Essex County Council Children's Leads as well as working pan Essex with health care and education to identify areas for improved joint commissioning and the implementation of national guidance.

The CCG are part of a collaborative commissioning group that commission the CSU to manage the provision of Personal Health Budgets, working jointly with the centrally commissioned Continuing Health Care Team at the CSU.

Working jointly with ECC and the Public Health Team, the CCG are guided by the joint strategic needs assessment (JSNA) to identify particular areas of need and the type of services to be commissioned. The JSNA, national directives (NHS Mandate, Winterbourne View, Francis Report) and local directives (Keogh Review) have been used to inform the commissioning strategies for the CCG; Care Closer to Home, End of Life and Urgent Care.

8.5 Compassion in practice

The CCG is in the process of developing its Quality Strategy. This strategy is aligned with the Governments Compassion in Practice campaign, underpinned by 6 Cs. These are:

- Care
- Compassion
- Competence
- Communication
- Courage
- Commitment

The Government launched an implementation plan to ensure that the 6Cs are embedded in practice. The CCG vision and strategic direction relates directly to the six action areas were identified:

Number	Action	CCG Strategic Agenda
1	Helping people to stay independent, maximizing well-being and improving health outcomes	Care Closer to Home Strategy focusing on ensuring the appropriate care and support is available where and when patients need this. Developments such as risk stratification, virtual ward, reablement, handy man services, hospital to home have been put in place to support patients and their carers to remain at home safely for as long as possible. End of Life strategy – ensuring patients are supported in their preferred place of care

		The Care Closer to Home Strategy ensures care co-ordination in the long term management of patients with care co-ordinators for all patients experience sustained disruption to their wellbeing as a result of one or more long term conditions. The care co-ordinators are supported by a community multi-disciplinary team.
2	Working with people to provide a positive experience of care	The CCG and Essex County Council have undertaken a consultation with the NEE population to identify what the people across NEE want from their health and social care commissioners. This information has been collated and used to inform the strategic direction for integrated commissioning. The CCG have a PALS and Complaints Policy and this is managed by the PALS and Complaints Team. The team provide weekly complaints reports, monthly PALS and Complaints reports by themes, attend PALS meetings with provider organisations and provide patient stories information to commissioning teams to inform commissioning and performance management processes.
3	Delivering high quality care and measuring impact	All working groups across the CCG have representation from Patient Forum members.
4	Building and strengthening leadership	The CCG are working jointly with the Local Education and Training Board to identify training and development requirements across the economy in the realisation of the commissioning strategies.
5	Ensuring we have the right staff, with the right skills, in the right place	The CCG have commissioned an external company to provide organisational development across the CCG workforce to assess the capabilities of the teams against the organisational needs and to address the development gap to support the delivery of the strategy. Staffing resources for commissioned services are outlined within service specifications in relation to levels of

		qualifications/professional registrations and experience. Some staffing levels are reportable through the CQRG for example maternity services. All strategic developments for example the care Closer to Home Strategy, Urgent Care Strategy and End of Life strategy are shared with LETB and they in turn provide an advisory and intermediary role in the workforce planning. Joint funding has been identified with the CCG and ECC to recruit a project lead for the role out of 7 day working across the health and social care economy in NEE.
6	Supporting Positive Staff Experience	Staff surveys are used to inform the management team of how people in the organisation feel about their roles and contribution. Action plans have been put in place to address areas identified for improvement; Investment in staff with regards to training budgets, training sessions in-house on a variety of strategic issues, support and counselling offered for staff affected by the outcomes of the recent CQC cancer review at CHUFT. The Organisation's Whistleblowing Policy is currently being reviewed to incorporate whistleblowing within the CCG as well as within provider organisations.

The Quality Team have lead advisor roles within each commissioning bundle and have the responsibility for assuring the level of quality in the care commissioned. Using the Quality Impact Assessment Tool, each service to be commissioned is RAG related to provide the level of quality assurance from the proposed service plan. This process also provides information on areas within the service proposal that need further clarification and improvement actions in order to ensure the service is safe, effective and value for money. The QIA tool measures the level of compliance against; clinical effectiveness, patient experience, patient safety, governance and value for money.

Quality Leads take responsibility for working with providers in relation to any CQC reports and actions required, providing assurance or recommendation to the CCG Board through the monthly Quality Committee. The Quality Team triangulate information received through the CQRG, SI Reports, Complaints and issues identified during walk arounds, to identify any areas of concerns. These are raised with the providers and with the CCG Programme Board. Failure to receive assurance within specified timeframes results in escalation to Executive Board level and decisions are then made of further escalation.

8.6 Staff satisfaction

As a new statutory body, the CCG held its first annual staff survey in autumn 2013. The survey was designed by a focus group of staff and the topics included development opportunities, job satisfaction and health and wellbeing. Outcomes were shared with staff and are being used in the refresh of the CCG's Organisational Development Plan. The first in a series of follow up surveys has already been carried out and will be repeated at regular intervals.

8.7 Seven day services across Health and Social Care in North East Essex

Introduction

The North East Essex Health and Social Care system are keen to explore further the benefits for our population on providing a range of services across a seven day week.

North East Essex CCG have, as part of the call to action and to meet their statutory responsibilities, participated and hosted a number of events during the past 6 months to capture the views and thoughts of our local population. There have been a number of themes that have emerged from this work which we are including in our planning processes.

One of the key messages from the public was the need to use the resources we have across 7 days a week to maximise efficiencies of estate and workforce. There was a clear message that services, especially those in the community and primary care were often not available during out of hours when required, resulting in patients reaching crisis point and then accessing emergency services.

NHS England have stated in their Everyone Counts: planning for patients 2014/15 to 2018/19 that the seven day a week services is an essential component for the NHS to focus on. There is no 'one size fits all' answer to introducing seven day services and therefore local solutions need to be found. However, NHS England did commission a forum, chaired by the National Medical Director, to consider how NHS services could be improved to provide a more responsive and patient centred service across the seven day week. http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf

This forum has made a number of recommendations which the CCG plan to consider with system partners – these include:

- The forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends and that these should be adopted in every community in England by the end of 2016/17
- That NHS England and other commissioners use incentives, rewards and sanctions through the contract to support the scale of change required.
- That the Better Care Fund (BCF) is identified as a key enabler for change and that CCGs and Local Authorities utilise this resource to support seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at the weekend.

The 2014/15 GMS contract changes also support this by introducing a new enhanced service to avoid unplanned admissions and proactive case management and continuing to commission the extended hour access enhanced service

As financial and service pressures intensify within health and social care, the need to accelerate integrated care to improve patient's outcomes and experience have never been greater.

In June 2013 the Chancellor announced in his spending round that there would be a £3.8 billion Integration Transformation Fund created (this is now called the Better Care Fund) which would enable the pooling of budgets for health and social care services to enable closer working in local areas. In NEE Essex we have specifically indicated that during 2-14/15 we will utilise the BCF as one of our enablers for moving towards routine health and social care services being available across 7 days a week.

Key Points to Note:

- North East Essex health and social care system need to develop an approach to 7 day a week working, from both a commissioner and provider perspective. This approach needs to be developed with the local population.
- Seven day a week working is not just about the hospital – it is about the whole system, which includes health and social care. It does not just mean NHS providers either, NEE will need to co-develop a strategy that covers all providers if appropriate.
- The strategy will need to consider a range of issues and challenges including workforce planning.
- The NHS England, NHS Services Seven Days a week forum, have produced a set of clinical standards describing the standard of urgent and emergency care that all patients should expect to receive seven days a week. These should be used in NEE as basis for developing plans.
- The Better Care Fund should be used to enable the health and social care system in North East Essex to develop a comprehensive action plan to deliver the clinical standards.
- Opportunities need to be explored and tested out with primary care to provide general medical services across a 7 day a week period using the current contractual arrangements and by working with the GP Provider company to maximise resources efficiently.

Actions

- North East Essex in partnership with Essex County Council and Health Educate England recruit a fixed term programme manager to work across the system to develop:
    - Seven day a week service strategy for NEE
    - A system wide action on how to deliver the clinical standards as defined by the forum
    - A system wide workforce strategy on how the system will deliver 7 day a week services in an environment that needs to deliver consider financial efficiencies
- The development of the strategy feeds into overall commissioning strategy for North East Essex CCG
- Progress against this programme of work reports into the Integrated Commissioning Programme Board
- That any learning is shared with the wider Essex community

8.8 Safeguarding

The CCG safeguarding monitoring is in line with Section 11 of the safeguarding audit tool. This provides the CCG with the assurance that providers are meeting the safequarding regulation and contract requirements. Providers are required to evidence;

- Senior management leadership and commitment to safeguarding
- Lines of accountability
- Embedded safeguarding policy
- Interagency working
- Information sharing
- Learning and improvement
- Service development and emerging issues
- Safe recruitment, vetting and allegations management

The expectation is that providers will attend the Health Education Forum where the attendance is monitored and this forum reports to the ESCB. External assurance is provided by CQC and Ofsted.

Identification of domestic abuse is implicit in all training packages and an expectation that all practitioners will demonstrate an awareness of domestic abuse and how to escalate these concerns. Further joint working will be undertaken with ECC in progressing the planned provision of services.

8.9 Medicines management

The main elements of the medicines management policy are:-

- Working across the health system in NE Essex to optimise patient's medicines and obtain value for money
- Targeting antibiotic prescribing - supporting practices with reduction of prescribing and ensuring that appropriate drug choices and treatment length are made for each infection
- Optimising respiratory care across the health system – to include ensuring appropriate lifestyle interventions have been made e.g. stop smoking, reduced exposure to allergens, appropriate referral to pulmonary rehabilitation, improved patient inhaler technique, training for practice nurses, cost-effective drug choice and appropriate use of BTS guidelines for asthmatics. Engaging with secondary care, patients, practices and community pharmacies to deliver the agenda
- QIPP will be implemented using pharmacy technicians to support practices and the Prescribing Incentive Scheme as an enabler
- Supporting practices with optimising prescribing in angina
- Continuing to promote safety in prescribing across the health system e.g. appropriate use and review of drugs, prescribing in the appropriate sector of care, regular review is taking place, shared care agreements are in place and up to date
- Supporting medicines management and medication review for residents of care homes
- Medication review for patients with dementia taking antipsychotic medication
- Supporting service redesign to ensure that they incorporate appropriate medicines management principles
- Managing the introduction of new drugs
- Ensuring that Nice TAs and guidance are implemented
- Ensure the safe and appropriate use of anticoagulant therapy in the management of non-valvular atrial fibrillation
- Encourage effective joint working across the health economy to ensure safe and effective use of medication particularly in the management of long term conditions.
- Promote effective communication at transfer of care (secondary to primary care, transfer to residential care) to ensure medication safety and continuity of care.

SECTION 9 PUBLIC HEALTH IMPROVEMENT IN NORTH EAST ESSEX

Public Health Commissioning

The Public Health vision for Essex is for the people of Essex to enjoy long, healthy, disease free lives and for this to be possible wherever they live and whoever they are.

Essex County Council's Public Health spend in the NEE CCG area is £8.6m. The Public Health commissioning strategy is informed by the Essex Health and Wellbeing Strategy, the Essex County Council Corporate Plan, the National Public Health Outcomes Framework, centrally mandated areas for public health action and locally assessed needs.

ECC's strategic approach to public health was informed by a member's reference group that defined four key principles. These are in line with the CCG's commissioning approach:

- We recognise a broad definition of health and public health interventions
- Our approach will be locality focused and led
- Addressing health inequalities is a priority
- We will commission what evidence tells us is needed locally and what works

Mandatory Deliverables for ECC Public Health:

- Sexual health services – STI Testing and treatment
- Sexual health services – Contraception
- NHS Health Check programme
- Local Authority role in Health Protection
- Public Health advice to the NHS
- National Child Measurement Programme

ECC Public Health Spend in NE Essex

Other services commissioned include priority areas from the JSNA, and services that deliver system productivity. Evidence shows that improvements can particularly be made from new, enhanced and/or targeted spend in the following areas:

- Falls prevention
- Alcohol harm reduction
- Enhanced diagnosis of cardiovascular disease in older people
- Diagnosis and treatment of depression in older people
- Smoking cessation support
- Improved public mental health
- Improved physical activity rates
- Reducing obesity rates
- Child health services
- Drug and alcohol treatment
- Gypsy and Traveller health
- Domestic violence advocacy
- Workplace health

ECC Public Health Spend in NE Essex by Clinical Area

Service Area	**Spend (£000s)**
Alcohol/Substance Misuse	£169
Breastfeeding Support	£167
Community Wellbeing / Health Improvement	£458
Falls	£570
Grant - Alcohol/Substance Misuse	£145
Grant - Community Health Services	£519
Grant - Other	£140
Grant - Targeted Parenting	£18
Health advice, prevention & promotion	£436
Health Checks	£943
Health Trainers	£543
Obesity/Weight Management	£487
Other Public Health	£122
Physical Activity	£55
School Health Improvement	£898
Sexual Health - chlamydia screening	£319
Sexual Health - GUM	£1,560
Sexual Health advice, prevention, promotion	£504
Stop Smoking Services	£572

TOTAL	**£8,624**

The CCG has agreed with ECC colleagues that public health services that support Care Closer to Home service bundle will be commissioned in an aligned way, ensuring public health and CCG-commissioned services provide an integrated and seamless service.

NHS England / PH England Local Area Team Public Health Deliverables

- The number of Health Visitors will increase to 383fte by 31 March 2015.
- Family Nurse Partnership will be rolled out across all of Essex.
- Improved child health information services (CHIS) resulting in better outcomes for children and families.
- Commissioning responsibilities for the 0-5 Healthy Child Programme will be successfully transitioned to local authorities.
- Increases in immunisation coverage, particularly in respect of MMR at both 2 and 5 years and Influenza amongst clinical risk groups.
- Implementation of a Meningitis C catch up programme for university entrants.
- Continuation of our childhood flu vaccination pilot in South East Essex for primary school children. Pilots of childhood flu vaccination for secondary school children will be developed.
- A review of the commissioning arrangements for vaccination programmes will be complete and outcomes actioned.
- All Diabetic Eye Screening providers will be implementing the Common Surveillance Pathway.
- All Breast Screening providers will have implemented age extension.
- Introduction of flexible sigmoidoscopy into bowel screening programmes.

- Improved outcome measures across all screening programmes.
- Improved quality within Sexual Assault Services Pathways, and new contract for SARC.

SECTION 10 RESEARCH AND INNOVATION

In line with the NHS Constitution, NEE CCG is required to:-

- Be Research Active, including promoting patient participation in research
- Ensure research and management governance arrangements in place
- Ensure knowledge management and evidence based commissioning is practised

We will:-

- Make patients aware of opportunities to take part in research.
- Promote research :-
    - There is a section on the our website about research and innovation, with links to the National Institute for Health Research website, which lists all portfolio studies eligible for support in NHS;
    - Work with Essex &Herts Comprehensive Local Research Network (CLRN) to promote research via display screens in waiting areas etc;
    - Work with NE Essex Health Forum to promote research;
    - Work with NHS England to promote primary care research and cascade information, e.g. on Research Incentive Support Scheme, to practices.
- Share membership of CLRN Board between the three North Essex CCGs.
- Encourage participation in Primary care research projects and Local Specialty Groups funded by the E&H CLRN. These groups consider local feasibility matters for studies to proceed locally.
- Ensure providers have in place arrangements for Research Governance and issuing NHS Permission for Research.

- Ensure CSU Medicines Management support for the Designated Signatory role for covering excess treatment costs of NIHR Portfolio research undertaken by Providers
- Promote evidence-based commissioning
- Ensure through our Memorandum of Understanding with Public Health and contract with CSU that appropriate support for evidence-based commissioning and innovation is in place.

Work with local Academic Health Sciences Network (AHSN) to promote best practice and innovation. AHSNs are local partnerships between the NHS, academia and industry to lead and support innovation and improvement

The following draft strategy has been produced with input from representatives from the following groups:-

GPs, North Essex Partnership Foundation Trust, Colchester Hospital University Foundation Trust, Mid Essex Hospital Trust, Essex and Hertfordshire Comprehensive Local Research Network, NEE CCG, ECC

Draft research and innovation strategy

AIMS

1. **Promotion of patient access to participating in research, as per the CCG Constitution**
   This will primarily be achieved through increasing opportunities for participation in research in NE Essex through practice participation in NIHR research studies.

2. **Developing research capacity in NE Essex**
   This will include capacity to participate in NIHR portfolio studies, but also ultimately capacity to generate research proposals locally. It will also include development of links between interested organisations and promotion of proportionate governance and delivery of research.

3. **Supporting CCG strategic priorities through research**

A longer term aim will be to support addressing high priority health needs through the local research strategy. This will initially start with mapping high priority patient needs, and priority strategic development areas against current open NIHR projects. Ultimately the aim would be to support robust evaluation of strategic innovations.

Actions
Increase visibility of primary and secondary care research in NE Essex through: • Produce annual research report for CCG Board • Require contracted providers to ensure their Boards receive at least an annual update on research activity (e.g. in line with Southend dashboard) • Produce summary of active research for local circulation • Use CCG and other communications channels to increase circulation of updates on local research
Address barriers to practices participating in research: • Research mapping by Primary Care Research Facilitator/Nurses and CCG quarterly updates to be circulated to identify barriers • Address perceived barriers through provision of information to practices via communications, primary care research nurse roles etc • Include session on how practices can participate in research at GP Educational Event • Publicise Research Site Initiative and other support e.g. 'Buddying', GCP training, to support research in primary care • Support full staffing of primary care research support team
Enhance research capacity and capability locally through partnership: • Establish virtual Research Network for information sharing • Open up Primary Care Research Group to all interested practices • Establish links into the Research Network for EAHSN, University of Essex, NIHR Research Design Service, GP Trainers workshop etc • Agree 2-5 year targets for enhanced participation in research by both NEE providers including primary care and patients
Alignment of research activity to local need and priorities: • Open Primary Care research projects to be mapped to local needs and strategic priorities • Open secondary care research projects to be mapped to local needs and strategic priorities • Consider how local research capability can support evaluation of transformational change

Innovation Health and Wealth, accelerating adoption and diffusion in the NHS

The areas within this are:

The 6 High Impact Innovations

- **Child in a chair in a day**;
- **3 million lives** (add reference to CC2H strategy re managing LTCs);
- **Digital First** (Think we could mention the bid going off today for the Prime minister Challenge Fund, This is a pilot that incorporates weekend opening which will also include appointments by Skype and Telephone, training for GPs is to run alongside this with regard to diagnosis and understanding from in non face to face contact . In addition to this there is a proposal to put in a Medical Interoperability Gateway which will allow GPs to see a patients record from another GP practice where the patient gives authority, allowing GPs to work effectively in a Cluster, this should also cross reference to “Primary Care wider and at Scale”)
- **Intra-operative Fluid Management**
- **Support for Carers for people with dementia** (add reference to CC2H, carers and MH)
- **International and commercial** - is the High Impact Innovation that calls for the NHS to look at the economic and industrial role it has, both with respect to health and care related industries and the wider economy.

Academic Health Science Networks
NICE compliance to ensure rapid implementation of NICE Technology Appraisals
Clinical Practice Research Data Link

SECTION 11 DELIVERING FINANCIAL VALUE AND SUSTAINABILITY

The CCG has developed a 5 year Medium Term Financial Strategy which will be added as an appendix. This includes the detailed 2 year financial plan and high level 5 year plan.

SECTION 12 SUSTAINABLIITY

Sustainability means meeting the needs of the present without compromising the ability of future generations to meet their own needs. It has three main inter-related strands – social, economic and environmental. The CCG has duties to promote sustainability, both as a commissioner and as a corporate body.

We are committed to tackling sustainability in the widest possible terms and to ensuring that this approach is part of our everyday work. We will work with all our partners to commission sustainable healthcare and help ensure that the people of North East Essex receive the highest quality services both now and into the future.

The CCG has a Sustainable Development Management Plan (SDMP) which is available on our website. The CCG undertakes the Good Corporate Citizen online assessment at six monthly intervals and uses the results to update the SDMP. The assessment covers travel, procurement, facilities management, workforce, community engagement, buildings, adaptation and models of care. In April 2013 the CCG scored 70% and in October 2013 this had risen to 75%.

In 2014/15 and 2015/16 the CCG will continue to focus on ensuring that the services commissioned are sustainable and contribute to the wider NHS targets around carbon reduction in England.

It will continue to work with the other CCGs in Essex on adaptation and resilience

SECTION 13 GOVERNANCE

NEECCG has established clear and robust governance arrangements to ensure the organisation fulfils its overall purpose, achieves its intended outcomes and operates in an effective, efficient and ethical manner.

The NEECCG Constitution and the NEECCG Governance Assurance Framework clearly sets out the principles and methods NEE CCG will adhere to in delivering its roles and functions. It also sets out the procedures by which our Governing Body and statutory committees will operate, be governed and held to account on how we conduct our business, how we embed our commitment to openness and how we make ourselves accountable to the people and communities we serve.

NEE CCG has developed and adopted a Performance Management Process Framework which clearly sets out how the organisation will monitor, measure and track performance against its strategic objectives, commissioning intentions and two year operational plan to ensure delivery and allow pro-active planning and forecasting.

Operational Plan success will be championed and ultimately evaluated by the Governing Body to provide assurance that NEECCG have delivered the plan objectives and are commissioning high quality, cost effective, sustainable healthcare that improves the health and life expectancy of the NEE population.


NEE CCG
Governance Assuran


Draft NEE CCG
Performance Process

SECTION 14 Appendices

Appendix A NEE CCG Better Care Fund Parts 1 and 2 – to be added

Appendix B Essex-wide Better Care Fund Essex Parts 1 and 2 – to be added

Appendix C CCG Governance structure – to be added

Appendix D NHS Constitution Measures – to be added

Appendix E NEE Plan on a Page

APPENDIX E **North East Essex CCG Integrated Commissioning Plan on a Page**

Vision	A simpler system for patients. People have greater choice, involvement and control regarding their health and wellbeing. A series of planned commissioning steps will deliver for patients a system where they can choose between end to end service providers offering seamless care.		
Commissioning principles/ approach	Patient centred care; improving the patient/service user experience; patient choice; experienced based commissioning (using NEE Big Care Debate outcomes to inform). Evidence-based pathways (CCG JSNA and ECC Annual PH Report will inform); commissioning to NICE guidelines. Integrated commissioning and provision of health and social care; sustainable system; continual quality improvement; equality of outcomes; collaborative; using contractual/procurement levers; release money to frontline care. Initial procurement of 3 care bundles: End of Life; Care Closer to Home; Urgent Care		
Integration principles/approach	Reduce complexity in the system, with integration of services driven by contracts and partnership. Integration focused on Care Closer to Home and End of Life Care Bundles. Improved integration of community services will reduce dependence on acute services and avoid admissions		
Strategic context and challenges	Everyone Counts – Essex Health & Wellbeing Strategy – Essex Joint Strategic Needs Assessment –– collaborative working across North Essex Large increase in over 70s – inequalities in life expectancy – low levels of non-elective admissions – variations in primary care		
Developing integration/enablers	Shared vision with ECC and providers – ECC membership of CCG projects and programme board – developing joint approach by ECC and CCG on HR/IT/IG/Estates – Care Bundles and Better Care Fund are first steps on pathway to fully integrated care – Management of interdependencies between care bundles will form integral part of specifications and contracts.		
Budget Position/Savings	Financial balance – delivery of 1% surplus and 2% transformation monies - £15 – 20m QIPP challenges in 2014/15		
Key Risks	Continued clinical engagement, provider engagement, delivering transformation in primary care without levers, alignment of national and local priorities, shared information systems, acknowledgment that public health changes take time to deliver, integrated commissioning; ensuring commitment, alignment different cultures, timelines and priorities; financial balance, risk and benefit share agreement for pooled monies, funding increased activity in acute services if BCF doesn't deliver required outcomes; risk of CCG paying for empty premises if new providers don't use them?		
Priority areas	Priorities 2014/15	Priorities 2015/16	5 Year Ambition
Children	• Education Health & Care Plans • CAMHS specification • Directory of Health Services to support the Local Offer • Personal Health Budgets	Commissioning of Children's services	Full range of integrated children's services delivered from a community facility. Seamless transition between child and adult services. Integrated CAMHS and behavioural services tier 1-3.
Frail, Elderly & Vulnerable	End of Life Bundle implementation Commissioning of Care Closer to Home Bundle Commissioning of Urgent Care Bundle Equity of access for vulnerable & marginalised groups	Care Closer to Home contract in place Urgent Care contract in place	Client feels safe and in control. Rapid access to most appropriate care through Community Gateway. Client received least complex and least intrusive care. Client had good quality of life and good death. Co-location of health and social care.
Mental Health	Commissioning of Care Closer to Home Bundle	Care Closer to Home contract in place	Focus on prevention and early intervention. Integrated care delivered in home and community. Specialists services only where they add value.
Learning Disabilities	North system wide approach - commissioning	North system wide contract in place	People with learning disabilities: adopt health lifestyles; have equal access to services; learn to manage and improve their own physical and mental health.
Other	Voluntary sector grants alignment Urgent care centre planning QIPP	Urgent care centre operational QIPP	Service users received integrated care, delivered with minimum interventions. Service users are supported to self-care. System efficiency and stability.
BCF Schemes	2014/15 onwards: 7 day working, Reablement, Carers, Sustainability Fund Services		
	2015/16 onwards: As above plus Care Closer to Home health and social care elements		

NHS
West Essex
Clinical Commissioning Group

Operational Plan

2014/15 - 2015/16

DRAFT Subject to CCG Board Approval

Contents

This Operational Plan brings together the priorities for the West Essex Health and social care system over the next two years and in some cases beyond. At the core of this plan are our Transformation Programmes that we have developed with our partner commissioners Essex County Council and our local health and social care providers. In particular we have worked closely with ECC , in the development of our proposals for application of the Better Care Fund (BCF) and our broader integrated Commissioning agenda. ECC and providers South Essex Partnership Foundation Trust, Princess Alexandra Hospital Trust , Essex Cares and North Essex Partnership Foundation Trust have contributed significantly to the unplanned care programmes of work encompassing Frailty and Urgent Care.

Any enquiries about the plan should be directed to West Essex CCG, Spencer Close, St Margaret's Hospital, The Plain, Epping, CM16 5TN

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Version	Reviewed by	Date
Draft 0	CCG Workshop on Planning Guidance and Requirements	6 /1/14
Draft 0 and BCF Proposals	CCG Executive Clinical Commissioning Committee	16/1/14
Draft 0	West Essex Systems Briefing Session	17/1/14
Draft 0	Patient Reference Group	28/1/14
Draft 0	CCG Board	30/1/14
Draft 1	CCG Executive Committee	13/2/14

Executive Summary

This plan sets out the work plan for West Essex CCG over the next two years April 2014 to 31 March 2016.

During the last year we undertook a major engagement exercise with our patients, residents and wider stakeholders in partnership with Essex County Council and our providers. The outcome of this engagement has informed our short, medium and longer term vision for transforming our services , *"My health, My future, My say – A vision for the west Essex health and care system 2014-2014"* The discussions that took place through this programme have contributed directly to how we plan to design and shape our services for the next 3, 5 and 10 years. Seven principles have guided the development of our vision:

1) Quality first - Patient safety, clinical effectiveness, better outcomes and care for people as people
2) Significantly shifting the point of care - the right care is provided at the right time and in the right place
3) Integration between health and social care
4) Connected transition of care and support between professionals and organisations
5) Provision built around and **responsive to the different needs** of our communities and localities
6) Maximise **productivity and efficiency** where appropriate
7) Allow individuals to **take responsibility for their own health and retain independence** where appropriate.

These principles underpin the aspirations that we have set out in this plan. Having established our vision we are now setting out on a major "transformation Journey" It is through our **transformation programmes** that we have set our trajectories to for improvement against the **CCG Outcome Indicators** and the **7 measurable ambitions**. In most case we have set our ambitions against the highest performers.

The CCGs transformation programmes include:

- Transforming **urgent and emergency care** services to ensure that timely care is available when required but also reduce unnecessary use of emergency hospital services.
- Improving care for **frail and older people** to avoid unnecessary admission to hospital
- Making care more accessible and local for people with **ambulatory care sensitive conditions,** including support to prevent worsening of condition and improvement in self management
- Implementing new high impact pathways for **Children** to support avoidance of unnecessary time in hospital, Ensuring early intervention and prevention through integrated approaches to care
- Ensuring high quality care for people with **mental health** conditions ensuring parity of esteem across all health and social care services including physical health. Shifting point of care for lower acuity conditions into primary care setting.
- A step change in **elective care:,** improving how we contract with our providers to ensure the most effective and efficient pathways for our citizens

We have high ambition for these programmes of work. They will form the basis of how we will drive forward an improvement in quality but also offer opportunity to improve productivity and as such have financial savings attached to them. **Section 5 Improvement Interventions** summarises these opportunities 14/15:

Frailty	£1.2m
Ambulatory Care	£0.2m
Children	£0.5m
Mental Health	£1.3m
Elective Care	£5.6m

Our ambitious work programme relies on a number of key enablers that will support the improvement in care that we want to achieve.

These include:

- Development of a model of **integrated commissioning (Better Care Fund supports)**
- Commissioning for **integrated provision of care** and delivery of improved outcomes for patients.
- Improving how we **contract** including alignment of CQUINS to improving patient outcomes , ambitions and quality premium and introduction of new contracting arrangements such as **Accountable Lead Provider**
- Supporting the development of our providers including primary care to respond to our ambitious plans, supported by a **contestability plan**
- **Community Mobilisation** working with our communities to increase the role that they play in their own community to support personal empowerment and responsibiliy.
- Ensuring that the right infrastructure is in place , developing **estates and IT strategies**
- Ensuring appropriately trained, developed and availably **workforce**
- Developing our organisations supported by an **Organisational Development Plan**

Patient Engagement

Most importantly we outline how we will engage and work with our patients and communities. We are developing our patient groups (that feed to board) to ensure a broader demographic is represented and will work with us, together, to test ideas, gather information and influence commissioning decisions and in doing so aligning patient engagement to be at the heart of service transformation and delivery.

Quality and Patient Safety

The CCG is responsible for ensuring that health care services are of a high quality and continuously improving. To improve the quality of care we will promote a culture of quality and ensure that it is central to everything that we do.

To achieve this we require strong and measurable mechanisms for reporting quality issues, such as early warning indicators including patient feedback, staff surveys and clinical outcome data. The quality section of this plan demonstrates how we will ensure that the recommendations of the Francis review will be assured and how we routinely work with our providers to ensure that quality of care is continually improving.

Changing how we work

For the CCG to transform the health and social care system we must work with patients, professionals, service providers and local partners such as the County Council and the District Councils but we need to do this in a different way than we have in the past. This means that we will need to commission differently moving to joint commissioning with the County Council. This will support the commissioning of care that is integrated across providers both in the health system and social care. To support this we are proposing different models of contracting, including Accountable Lead Provider whereby we contract with one provider who in turn will manage the wider supply. We also see a new and expanded role for primary care that is a key component of our plans. The CCG and its partner practice have over the last 12 months been exploring a different approach to provider care to our population. From July 2014 our two locality business units, Epping Forest and Harlow as one and Uttlesford will start providing what will be the beginning of a range of ambulatory care services within a primary care environment.

Sustainability (financial plans)

The CCGs Financial Plan demonstrates achievment a 1% surplus in all financial years of the planning cycle. In 2014/15 the CCG transformation and efficiency target is set at £12.9m . The plans are transformational and are limited to just 8 core schemes (under the 4 transformation work streams. Additionally there are benchmarked efficiencies which are to be delivered via contract management.

1.0 Our Vision for High Quality Sustainable Care

This section summarises the CCG Vision resulting from an extensive series of engagement events that took place over the summer in 2013 and forms the basis of out Operational Plan together with the local context from the West Essex JSNA

1.1 Local Context

1.2 Our Vision

1.0 Our Vision for High Quality Sustainable Care

1.1 Local Context

In setting out our Vision, transformation priorities and ultimately this plan the CCG has been guided by health and well being and social care needs, changing demographics and economic challenges within the system as follows:

- Higher than average premature mortality rates in Harlow with Harlow having the highest rate of deaths as a result of smoking in Essex
- Worsening premature mortality rates for circulatory disease, cancer and respiratory disease relative to our peers
- Survival from cancer is lower than the national average
- Higher than average prevalence of depression
- Under ascertainment of diagnosed COPD
- Increase in alcohol related admissions to hospital
- Increasing life expectancy yet variation of life expectancy across our communities
- Proportionately more people aged over 65 in west Essex than the rest of the country
- Total population of west Essex is expected to grow by 12.1% in next 10 years as compared to a national average of 8.7%

If people carry on using health care services in the way that they currently use health services, this would put enormous pressure on our local health system. For example, there would be a 14 per cent increase in the number of hospital admissions per year from 62,000, to 71,000, and an increase in the number of attendances at A&E from 83,000 to 92,000. Along with the pressure on health services the aging population in particular puts increasing demands on social care including residential home places and re-ablement packages. This plan sets out how we plan to manage this challenge over the next two years.

1.2 Our Vision

"My Health, My Future, My Say" sets a vision for the west Essex health and care system over the next 10 years. The development of our vision was informed by two major engagement programmes undertook by the CCG with patients, clinicians and service providers in west Essex during 2013. Listening to our patients and stakeholders we have identified the following key interventions as the basics that we need to right

- Identifying high users of health and care services through **risk stratification**
- Planned and coordinated management of individuals health and care needs by **multi disciplinary teams**
- When care is needed it is **coordinated** by an individual best placed to know the patient's needs
- **Personal health plans** are in place
- **Shared patient records/information available** across providers
- Patients are empowered to **manage their own care**
- Supported **independent living**
- Managing **mental and physical health** together
- **Proactive disease management** including early intervention

1.3 Our Providers

Our hospitals have an important and unique role to play in supporting people when they are seriously ill, but many people use hospitals in other circumstances. We will be working with our hospitals to establish a clear definition of their role. We see The Princess Alexandra Hospital in particular supporting delivery of a whole system model of integrated care pathways in partnership with our primary care , community and mental health providers to reduce the fragmentation of care that currently exist within our system.

2.0 Working with our Citizens

This section describes how we will be working with our citizens in the planning and delivery of care, ensuring that they are at the heart of everything that we do

2.1 Ensuring our Citizens are fully involved

2.2 Ensuring Patient Voices are heard

2.3 Mobilising our Communities

2.0 Working with our Citizens
2.1 Ensuring our Citizens are involved

Working with our Citizens Timelines……

.

Joint approach to citizen engagement, District Councils and ECC by **July 2014**

Systematic approach to citizen involvement in commissioning in place by **April 2014**

Enhanced routes for patients' and citizens to:

- influence decision making at all levels
- ensure their voices to be heard at board level

Despite having an established PPE model, WECCG wanted to explore how we could engage with more people in more innovative ways. After months of research, discussion, extensive channel testing and consultation with a wide range of internal and external partners, the WECCG board approved enhancements to its PPE model. The enhancements to the model mean there is a **fivefold increase** in opportunities for **local peoples' voices to be heard at board level.** Citizens will personally and collectively, have a richer range of ways to be involved with the CCG's decision making and ways to connect with our clinical and non-clinical senior decision makers. This increase in the opportunities for people to influence our work and decision making will allow us to connect with people in a more targeted way. We will work with a wider range of people - giving voice to people that might not normally engage. Our plans have been endorsed by **HealthWatch a**nd will see the CCG co-producing work with local people representing, for example: carers, children and young people, older people, people with long term conditions, people with disabilities, colleagues from the voluntary sector, migrant and ethnic minorities.

2.0 Working with our Citizens
2.2 Ensuring Patient Voices are Heard

Opportunities will include:

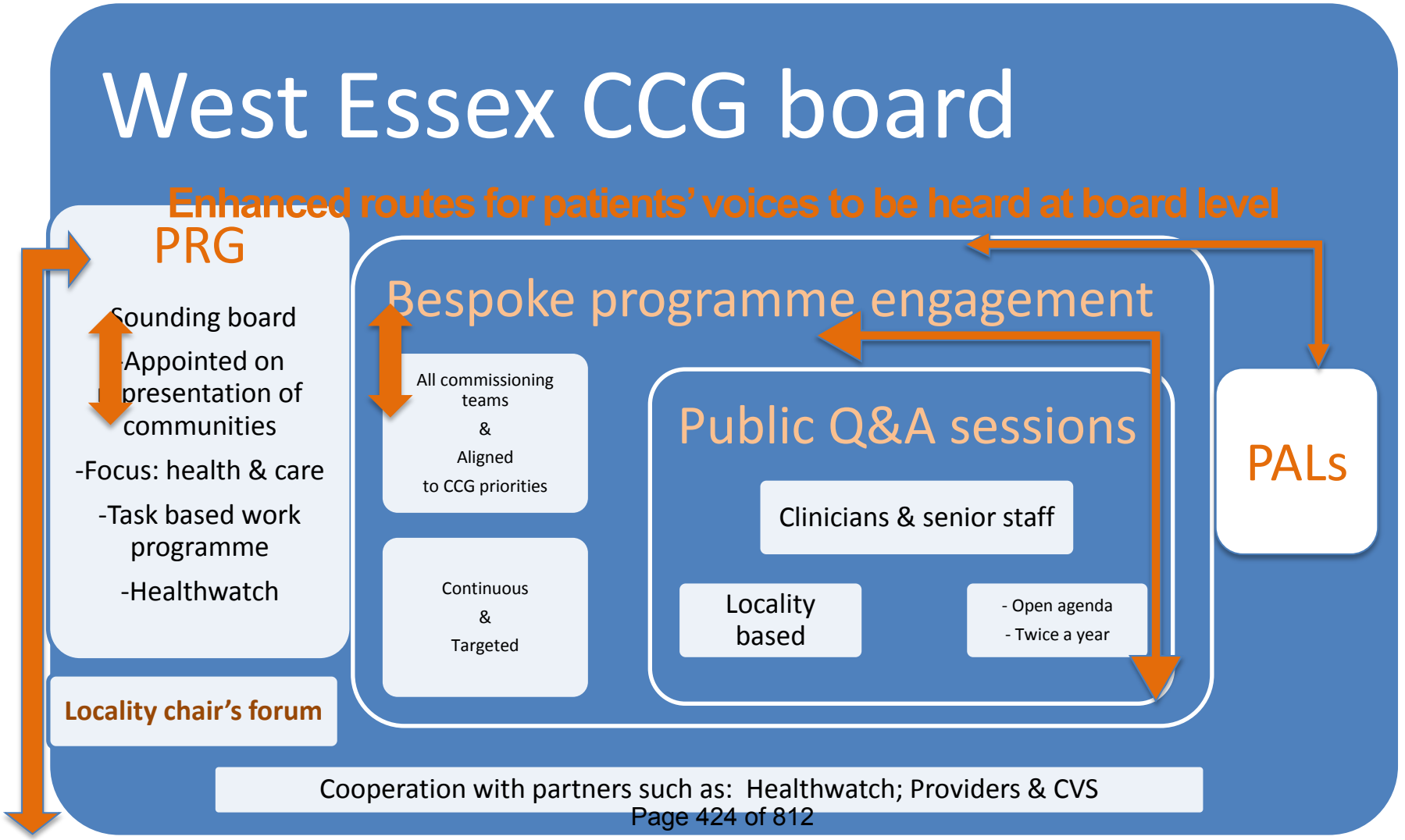
Patient Reference Group (PRG): Our PRG has been with us since the CCG inception and its member's views, support and feedback has been invaluable in our journey to becoming a fully-fledged CCG. The PRG had itself, identified the need to, in time, create a membership that was more representative of the broader demographics in our communities and the new approach for this group will allow many more people to be involved in the CCG's decision making. We will be increasing the size of this group and opening membership of it up to anyone in our community who has experience or insight to share. In order to ensure we give as many different voices the opportunity to get involved, we will shortly be inviting people to express an interest in joining, by filling out an application form. We will offer assistance in completing the form to people who need it and the point of the form is to help us identify the different strengths people might bring to make the group as broad as possible. We hope to achieve a membership that will include representation of;

Carers , Children and young people, Older people People with long term conditions People with disabilities People with mental health need, Voluntary sector , Migrant and ethnic minorities

This will be a democratic group that will respect all voices and points of view, so the hope is also that those who feel a formal 'committee' style of meeting isn't for them, will also be enticed to get involved. The PRG will also have a working aspect, which will see it undertake projects that report back to our board and therefore members should expect to get lots of satisfaction from seeing their input come to life in the CCG's future work.

Public Question & Answer sessions: When statutory organisations engage, it is normally within the constraints of a set topic. We identified an appetite for a space where citizens could engage with us without the constraints of a specific agenda. Twice a year, in each of our three localities we will hold open Q&A sessions. The sessions won't have a set agenda, so members of the public will be able to quiz, comment and make suggestions to our GPs and senior managers on any subject they wish.

Engaging with individual commissioning teams on specific topics: We are working with individual clinicians, commissioners and their teams to support them to develop their own tools to involve local people who are relevant to their service areas. Each team will connect with their relevant stakeholders in different ways (for example, be it: long terms conditions, mental health or women's and children's), but we will be encouraging them to develop their own, bespoke ways to involve local people with experience or insight in to their areas. Local people might want to input via formal meetings, or more informal routes, such as focus groups and workshops. They might even want to input remotely (by telephone, correspondence – or even via the internet). The idea is that we tailor the engagement style to suit the relevant audience and make it easier for people to access the CCG.


West Essex CCG board
Enhanced routes for patients' voices to be heard at board level
PRG
Sounding board
Appointed on presentation of communities
-Focus: health & care
-Task based work programme
-Healthwatch
Locality chair's forum
Bespoke programme engagement
All commissioning teams & Aligned to CCG priorities
Continuous & Targeted
Public Q&A sessions
Clinicians & senior staff
Locality based
- Open agenda
- Twice a year
PALs
Cooperation with partners such as: Healthwatch; Providers & CVS

2.0 Working with our Citizens

2.3 Mobilising our Communities

Along with the "*Who will Care ?* Commission" the CCG sees our communities having a powerful contribution in complementing health and care services to deliver improved outcomes for individuals and communities as a whole. We see the voluntary sector having an increased role in implementing our vision and being part of an integrated system working more closely with general practices. In addition to this we want to work with our partners in ECC and District Councils to promote and develop the role of volunteers, building on the existing concepts such as health champions, neighbourhood watch and village agents.

The CCG has a strong ambition to develop and mobilise the voluntary sector to:

- gather data and intelligence from our communities on what is important in health and care provision;
- deliver services as part of an integrated system that will empower individuals to either prevent ill health and support people to maintain good; and
- help local people navigate the system supporting individuals to access the right care in the right place.

Empowering communities – Key Milestones	By When	Key Outcomes
Mobilising communities event	**April 2014**	Establish the scope of opportunity and programme of work
Increasing investment in the third sector	**2014/15 - 15/16**	Unique services offered by organisations that have a real understanding often through own experience will enrich the range of services that we commission in a cost effective manner.
Care navigators/ community agents	**2014/15**	Support citizens to make informed choices about their health and well being and support citizen empowerment
Pooled budgets commencing	**April 2014**	Health and social care joint commissioning of voluntary sector

3.0 Quality and Patient Safety

This section demonstrates how the CCG are ensuring a relentless focus on the provision of high quality care, that is safe, clinically effective and provides as good an experience for the patient as is possible. In this section we outline trajectories that the CCG has set against the 7 deliverable ambitions . We will achieve these ambitions through delivery of our Quality and Transformation agenda

3.1 Improving Quality
- Response to Francis, Berwick and Winterbourne
- Compassion in Practice
- Systems and Processes

3.2 Governance and Reporting to support Quality
3.3 Healthcare Associated Infection
3.4 Patient Experience in our Services
3.5 Quality Contractual Standards
3.6 Quality Premium
3.7 7 Measurable Ambitions
3.8 Constitutional Rights and Pledges

3.1 Improving Quality

Improving quality

Francis, Berwick and Winterbourne

The CCG has prepared a response to the Francis Review. Many of the recommendations in the review focus on strengthening relationships with the CCG, the action plan identifies specific actions and timescales for implementing this. There are 5 themes to the review:

- High quality, patient-focused and compassionate care must be the central value
- Consistent culture of Openness and Candour:
- Values and Standards – patient at the centre
- Leadership in staff at all levels of the healthcare system must be encouraged
- Use of information to improve patient and staff experience

Microsoft Excel Worksheet

Along with our action plan for Francis we will be agreeing actions from Berwick and Winterbourne reviews by end of March.

Compassion in Practice
Compassion
Communication
Commitment
Courage
Competence
Care

The CCG is contracting with providers to deliver the six Cs initiative which ensures delivery of compassionate care. We expect our providers to present action plans to us that will be agreed and monitored throughout the year. We are also working with Health Education East of England and the Essex Workforce Partnership Steering Group to support development of this initiative.

We are in the process of recruiting a senior nurse whose specific role will be to work with providers to ensure that this is delivered.

The actions identified in the Francis review also contribute to the delivery of this initiative.

Systems, Process and Standards

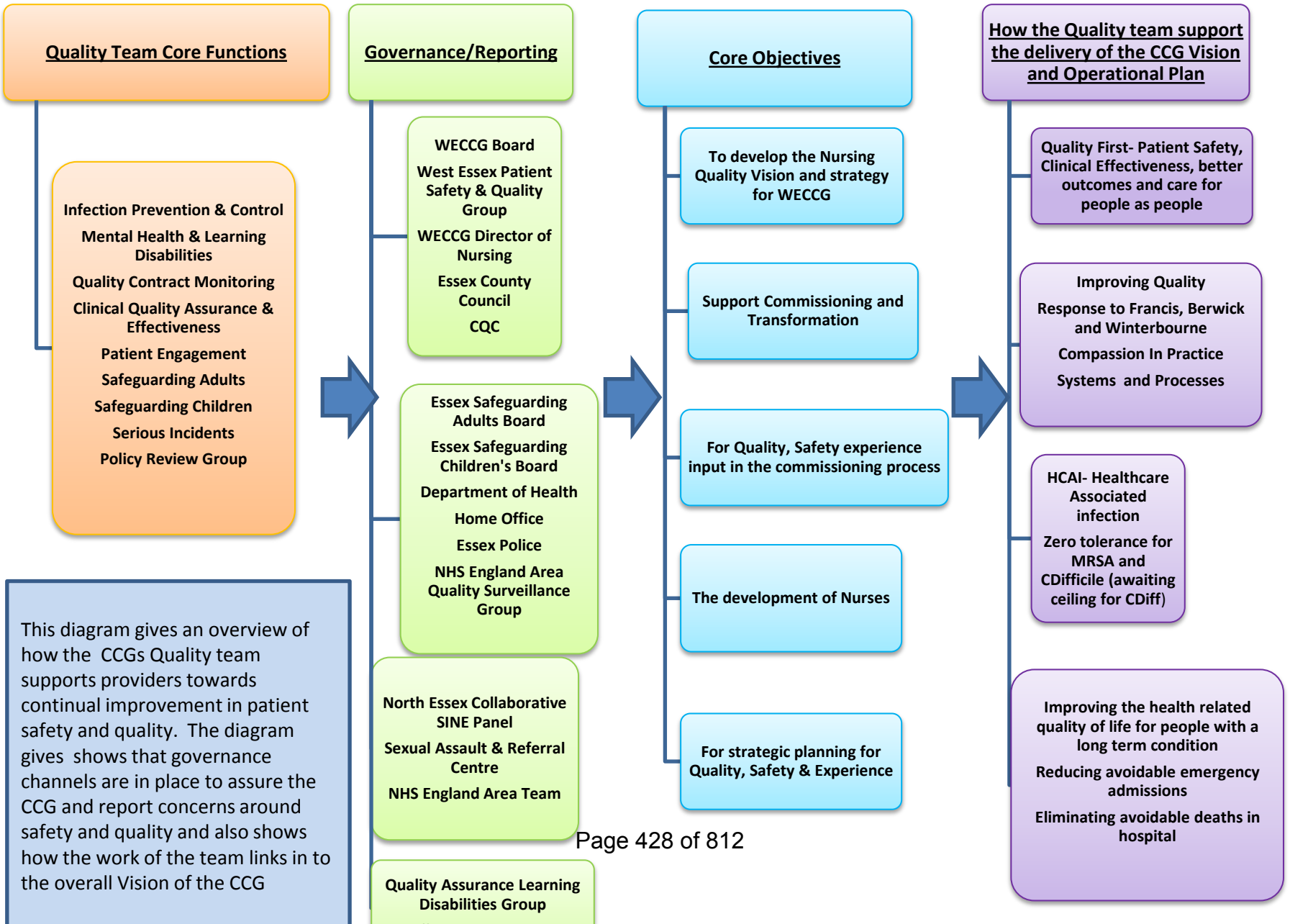
The CCG operates a rigorous assurance framework (imbedded document describes). This supports performance management across all performance standards and is overseen by Service Performance Quality Review Group (SPQRG) and Patient Safety and Quality Committee ((PS&Q) covering:

Microsoft Word Document

- Quality
- NHS Constitution. Essentially this is National Standards
- Outcomes and Supplementary Indicators including local priorities, Quality Premium, Potential Years of Life Lost (PYLL) and the Friends & Family Test.
- Finance

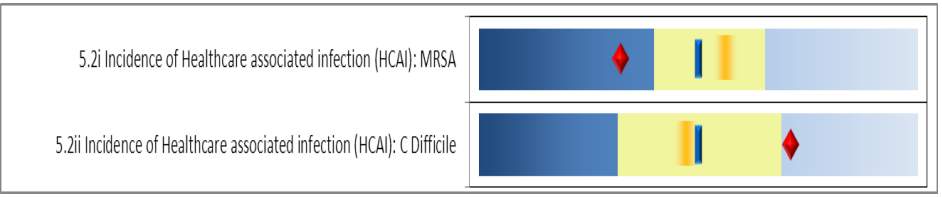
The SPQRG meetings take place with each provider on a monthly basis . The PS&Q meeting takes place monthly and is chaired by a lay member of the CCG Board with representatives including, Director of Nursing, Medical Director, and Vice Chair of the CCG. This committee will oversee the CCGs responsibilities to ensure that the recommendations of the Francis, Berwick and Winterbourne Reviews are implemented.

3.2 Governance and Reporting to Support Quality



This diagram gives an overview of how the CCGs Quality team supports providers towards continual improvement in patient safety and quality. The diagram gives shows that governance channels are in place to assure the CCG and report concerns around safety and quality and also shows how the work of the team links in to the overall Vision of the CCG

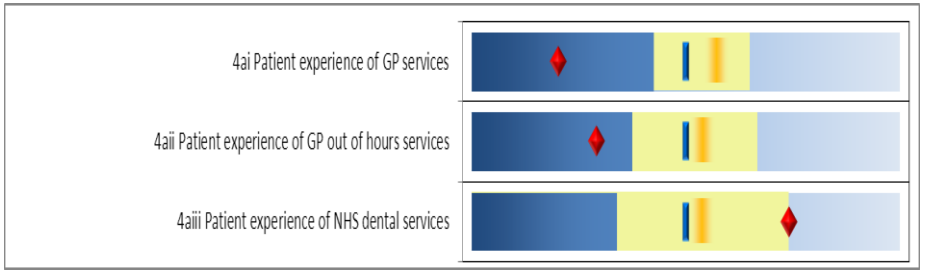
3.3 Healthcare Associated Infection



The CCG will contract for zero tolerance for MRSA and Cdifficile (awaiting ceiling for Cdiff) in 14/15 and 15/16 contracts. These targets are performance managed through the Service Performance and Quality Review Group on a monthly basis.

Through contracting negotiations we will be reviewing the latest performance against outcome indicators and will be sharing this with providers. Our monthly performance for 13/14 indicates an improved position for MRSA. We will be seeking to maintain this during 14/15 and beyond.

3.4a Patient Experience (Primary care)



Working in partnership with NHS England……

- Further work to be undertaken with individual practices, building on the work undertaken by Primary care foundation and NHS England in 2013/14.
- Improvement plans to be developed for each practice in the bottom 10%.
- Implementation of 7 day working in each locality.
- Improvement in GP access in Stansted from Autumn 2015 as a result of the new practice premises development.

3.4b Patient Experience – Acute and Community Care

The CCG receives monthly assurance from main providers, PAH (acute provider), SEPT (community Provider) and the CCG Patient Experience Team as below.

PAH

A monthly dashboard showing : Type, Item, trend, month

Complaints: (Number per month)

Combined Friends & Family Test numbers

Friends & Family individual numbers from :

Emergency Dept., Inpatient Ward & Maternity

All PALS

PALS- which are compliments

Web – Choices/Ratings

An Executive Summary which covers:

Complaints

Friends & Family Test

PALS

Complaints

NHS Choices

National Patient Survey

Elimination of Mixed Sex Accommodation

CQUINS

A&E Service Experience

PLACE

PROMS

SEPT

Patient Experience:

Complaints (broken down by directorate & Location)

Compliments

PALS broken down by source rec'd :

Survey,Email,Letter & Telephone

Resolution Time

Outcome

Friends & Family Test via the Patient Experience Indicator(which has been implemented as part of a CQUIN target)

How did we do surveys – trust wide patient satisfaction survey

Elimination of Mixed Sex Accommodation

CQUINS

PROMS

DIGNITY

WECCG

Tabular data for the previous month which includes:

PALS Contacts

Complaints

Compliments

Table and Graphs showing PALS by subject and organisation

Subject/Service Area trend analysis for all of the above

Learning/Actions for all of the above

3.5 Quality Contractual Standards – Patient Safety

In addition to the specific performance indicators that are referred to in other parts of this chapter, the CCG works closely with providers via SPQRG meetings to ensure that standards are being met and where improvements are required that action plans are put in place .

Indicator	Assurances
VTE	Contract with providers to identify all patients at risk and number of patients requiring prophylaxis. Good identification and prescribing. Monitored through SPQRG meetings on a monthly basis. In the event of an avoidable VTE occurring RCA is requested with lessons learnt and action plans
Pressure Ulcers	Contract with providers monitor occurrence of avoidable pressure ulcers and treatment of unavoidable. Good performance but when an avoidable incident occurs RCA is requested with lessons learnt and action plans. Monitored through SPQRG meetings on a monthly basis..
Mortality	HSMR and SHMI monitored through PS&Q and SPQRG on a monthly basis and attendance at hospital mortality group. West Essex providers not an outlier.
Serious Incidents	Monitored through PS&Q and SPQRG on a monthly basis. Reporting levels good. Occurrence always followed with RCA, lessons learnt and action plans
Provider Staffing levels	Contract with providers to provide workforce plans and methodology for staffing levels, monitor on a monthly basis through SPQRG with providers
Staff Satisfaction	Providers expected to undertake NHS Staff Survey, results reviewed on an annual basis through SPQRG
Patient Safety Alerts	NHSE provide service from 1 April 2013 and cascade to all providers
Continual learning on patient safety improvement within providers including serious incidents	As seen above continual improvement is sought. Where poor performance and/or serious incidents occur RCA takes place with lessons learnt followed with action plans to improve. We are also members of the North Essex Collaborative Group that reviews serious incidents to ensure continual improvement in safety
NHS Safety thermometers MH, medicines safety, maternity	Contract with providers to measure safety of services through safety thermometers. Also form part of a national CQUIN. Good performance

3.5 Quality Contractual Standards – Patient Safety cont……

In addition to the specific performance indicators that are referred to in other parts of this chapter, the CCG works closely with providers via SPQRG meetings to ensure that standards are being met and where improvements are required that action plans are put in place .

Indicator	Assurances
Safeguarding Vulnerable People in the Reformed NHS  Microsoft Word 97 - 2003 Document	Contracts reflect standards outlined in the Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework (2012) Providers submit annual ESAB/ESCB audit to the CCG with action plans. Monitoring of the action plans takes place via SPQRG meetings. Named GPs are funded by the CCG to continue supporting GPs and practices in their safeguarding work. Partner agencies work and engagement with Essex Safeguarding Adults Board/Essex Safeguarding Children Board is evidenced at both operational and strategic level through specialist Doctor and nurse roles in provider and designated leads for safeguarding in CCG- these roles allow for internal oversight of safeguarding within the organisation and offer expertise and safeguarding prioritises to be taken forward in organisations i.e. Child Sexual Exploitation, MHA. The SCCN provides a collegiate approach to deliver the safeguarding agenda across Essex as identified within NHS England document (4.1) The CCG has a Strategy for Safeguarding Children and Adults (2013-15). The priorities outlined in the Strategy are reflected in contracts with our providers.
Safeguarding to address key priorities of child sexual exploitation, female genital mutilation, sexual violence and domestic abuse	children's contract sets out an expectation on provider to develop these areas of work. An initial scoping exercise has been undertaken and workshop has been set with safeguarding specialist in provider for discussion on FGM and meeting intercollegiate guidance. Outcomes will be taken back to CQRG. The CCG continues to commission a community domestic abuse nurse specialist, an aligned KPI requires a practitioner to review all domestic incidents. Practitioners work with clients and children to empower them to recognise the dynamics of domestic abuse supporting them to protect themselves and their children. Providers and CCG are engaged with the ESCB CSE strategy with CSE champions nominated in all organisations Training on Domestic Abuse and CSE is planned for GP shutdowns during 2014. The CCG works closely with local Domestic Abuse organisations to facilitate engagement in Primary Care.
s**afeguarding** duties d to be reflected in all local plans and NHS England will seek continuous assurance on this important issue	Governance arrangements with reporting schedules are in place within CCG and provider organisations. The CCG Vision 2014/16 document and the adult and children's safeguarding strategy outlines the organisations commitment to safeguarding.
provision for improvement and sustainability of domestic abuse services	CCG works closely with local Domestic Abuse organisations currently providing domestic abuse specialist workers in Maternity Department, A&E and Primary Care to help facilitate partnership working with our providers and local GPs.

3.6 Quality Premium

The CCG has set improvement trajectories for each mandatory quality indicator to support achievement of the quality premium in 14/15 below.

Measure	13/14 Baseline	14/15 Target	Aligned to Transformation Programme	Interventions to support improvement
Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and Young People	1905 YLL per 100,000 in 2012	Reduction by at least 3.2% on 13/14	Working Age Adults, Frailty, Children,	
Improving access to psychological therapies (IAPT)	10%	15%	Mental Health	Additional investment in IAPT services
Avoiding emergency admissions, composite measure of: a) Unplanned hospitalisation for chronic ACSC (adults) b) Unplanned hospitalisation for asthma, diabetes and epilepsy in children c) Emergency admissions for acute conditions that should not usually require hospital admission (adults) d) Emergency admissions for children with lower respiratory tract infection	1,669 per 1000,000 population	Reduction or 0% change	Working Age Adults, Frailty, Children,	Frailty, ACS and children's transformation programmes with targets for reduced avoidable admissions

3.6 Quality Premium cont…….

Measure	13/14 Baseline	14/15 Target	Aligned to Transformation Programme	Interventions to support improvement
Addressing issues in 2013/14 FFT, supporting roll out of FFT in local economy in 2014/15, support local providers to roll out, evidence to be provided Patient Experience Survey Indicator	Patient Experience Survey results available in February	Improved average score between 13/14 and 14/15, agree target	Quality Team	Action plans to reduce negative responses monitored by quality team at SPQRGs
Improved reporting of medication-related safety incidents - Increased level of reporting of medication errors	No reporting by PAH, SEPT report numbers but not nature	PAH contracted to report numbers and nature of incidents and SEPT to report nature of incidents and see an increase in reporting	Quality Team	Improved reporting in place from 1 April 2014
Local measure - Improved identification of people with undiagnosed COPD – supports longer term outcome of preventing people from dying prematurely and enhancing quality of life for people with long term conditions	1.6%	1.8%	Working Age Adults and Frailty	Increase in patients diagnosed and placed on register (next slide)

3.6 Local Quality Measure – Improved Identification of People with Undiagnosed COPD

Links with CCG Outcome Indicators	***Preventing people from dying prematurely*** **Reducing premature mortality from the major causes of death:** **Under 75 mortality from respiratory disease (NHS OF 1.2).** ***Enhancing quality of life for people with long term conditions*** **Reducing time spent in hospital by people with long term conditions:** **Unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults) (NHS OF 2.3.i)**
Rationale	Evidence suggests that between 10 to 34 percent of the NELs for an acute exacerbation of COPD are in patients with previously undiagnosed COPD. Proactive early diagnosis and treatment could reduce need for emergency admission. The NICE Quality Standard for COPD (QS 10: Statement 1 – diagnosis) and the Outcomes Strategy for COPD and Asthma recommend targeted case finding in those at higher risk of COPD. The JSNA identifies that COPD mortality is significantly worse in the Harlow locality as shown overleaf. This figure is significantly worse that the England average.
Improvement Target and Investment	The CCG proposes that the number of patients registered on West Essex GP COPD registers will increase by a minimum of 700 between 31st March 2014 and 31st March 2015, across West Essex. This has been calculated using the current percentage registered of 1.6%, with the aim of reaching 1.8%. In order to identify 700 confirmed cases of COPD, NICE Guidance states that approximately 2800 at risk patients need to be screened in the first instance. NICE guidance also proposes a specific definition of patients to be screened; however, local proposals include the testing of FEV1 levels, in-conjunction with a COPD Assessment Tool (CAT) which measures the impact of the condition on a person's life. GP Practices will need to be funded to undertake this extra work load and prevalence targets will be set for each practice to ensure this premium is met. Additional investment may also be required to ensure Primary Care

3.7 7 Measurable Ambitions

Our transformation programmes and improvement interventions outlined in Section 5.0 are underpinned by opportunities to improve against local outcome indicators. The transformation programmes and part of the quality work programme detailed in this plan highlights our position against the outcome indicators where they relate to that particular programme. The table on slide 3.5 shows the ambition that we have set for these outcomes over the next 5 years. The transformation programmes will be the main contributor to achieving this improvement. The summary below shows how the ambitions align to each programme

Ambition 1 Securing Additional years life from conditions amenable to healthcare	All programmes
Ambition 2 Improving the health related quality of life for people with a LTC	Frailty, Adult and Mental Health programmes
Ambition 3 Reducing avoidable emergency admissions	Frailty, Adult and Mental Health programmes
Ambition 4 Increasing proportion of older people living independently following discharge	Frailty programme
Ambition 5 Increasing positive experience of hospital care	All programmes
Ambition 6 Increasing positive experience of general practice and care in the community	All programmes
Ambition 7 Eliminating avoidable deaths in hospital	Quality work programme

3.7 7 Measurable Ambitions

Per 100,000	Domain 1 Securing Additional years life from conditions amenable to healthcare	Domain2 Improving the health related quality of life for people with a LTC	Domain3 Reducing avoidable emergency admissions	Domain3 Increasing proportion of older people living independently following discharge	Domain4 Increasing positive experience of hospital care	Domain 4 Increasing positive experience of general practice and care in the community	Domain 5 Eliminating avoidable deaths in hospital
Baseline	1905 YLL per 100,000 in 2012	74.2 (12/13)	1,669 per 100,000 pop (12/13)	Awaiting indicator	165.9 (2012)	7.2 (2012)	Awaiting indicator
2014/15	1785	75	1208	Awaiting indicator	155.8	7.1	Awaiting indicator
2015/16	1728	76	808	Awaiting indicator	150.7	6.9	Awaiting indicator
2016/17	1673	77	803	Awaiting indicator	145.7	6.7	Awaiting indicator
2017/18	1619	78	788	Awaiting indicator	140.6	6.4	Awaiting indicator
2018/19	1517	79	773	Awaiting indicator	135.6	6.0	Awaiting indicator

3.7 Measurable Ambitions

Indicator	Methodology	Supporting interventions
Securing Additional years life from conditions amenable to healthcare (where intervention can impact on mortality lung cancer excluded from measure).	Baseline 1844/100,000 (middle of 2nd best quintile, Continuing at 3.2% decrease per annum would take us to 1517 per 100,000 by 2018. This is slightly higher than the best CCG in 2012	The CCG is an outlier for premature mortality for CVD, breast cancer and respiratory disease . Work programmes to Improve local cancer standards and diagnosis and treatment of respiratory disease (ACS programme) will support this trajectory.
Improving the health related quality of life for people with a LTC	Baseline 74.2% (bottom of the second best quintile) to 79% in 18/19, Our expectation is to reverse the decline seen between 11/12 and 12/13, consolidate over 14/15 and make progress from 15.16 as our primary care initiatives start having impact. 1% improvement year on year, steady rise, discussion around this being survey based and inherent risks	**Frailty , ACS and children's programmes** early diagnosis of conditions, increasing ability to manage and reduce exacerbations, self management tools, management of more conditions at home and in primary care, better follow up care, social care and care support all delivered through improved integration of care.
Reducing avoidable emergency admissions	Baseline is 1,669 per 100,000 population in 12/13. WECCG is near the top of the 2nd best quintile. WECCG has only just returned to its 09/10 position. Through the ACS and frailty programmes the CCG has ambitions to reduce avoidable admissions significantly with a 54% reduction against the 4 composite measures over a 5 year period.	**Frailty, ACS and Children's programmes** more prevention and reablement in the community, improved management of exacerbations, management of more conditions at home and in primary care, better follow up care, social care and care support all delivered through improved integration of care.
Increasing positive experience of hospital care	165.9 per 100,000 in 2012, (based on a large number of survey questions) in worst performing quintile. Aim to move to top quintile by 2018 to 135.6	Quality team developing action plans for improvement with providers
Increasing positive experience of general practice and care in the community	7.2 per 100 patients in 2012, this is in the second worst performing quintile. Aim to get to a position equal to the current middle quintile. We have modelled more improvement towards the end of the period 14/15 – 18/19.	Working in partnership with NHS England to implement improvement plans with worst performing practices.

3.8 Constitutional Rights and Pledges

The CCG is contracting to hit all targets in 14/15 where failing in 13/14 we will work with providers to ensure clear action plans are in place to achieve this. The standards detailed below are those for which performance is variable. Action plans are either in place or in developments and will be closely monitored through monthly SPQRG meetings with providers

Standard	Key Actions and Interventions
18 Weeks • Achievement of 95% / 90% standards at a speciality level – focus on T&O and Urology • 52 week breaches – aim for achievement of 10 case "lower threshold" as a minimum	Princess Alexandra are consistently achieving the national RTT standards at an aggregate level. We have established weekly RTT meetings and are working closely with the Trust to ensure delivery at a specialty level in 2014/15. PAH aim to be specialty level compliant in April 2014 and we are currently working with the Trust to agree trajectories. Currently 24 completed cases Year to Date at month 8. The CCG has implemented processes to routinely monitor +40 week waits and to proactively seek assurance from Trusts that these will not breach 52 weeks. With PAH we are reviewing all pathways that exceed 35 weeks at the weekly RTT meeting.
A&E • Achievement of 95% 4 hour standard on a daily basis	Resilience against the 4hr standard will follow on from lessons learnt during the 2013/14 winter planning and surge management process. 2014/15 will be based around fully integrated and sustainable working across all system providers and partners. This will be underpinned by a revised and strengthened Urgent and Emergency Care Governance framework . Daily performance monitoring, shared organisational operational standards and effective escalation processes will be introduced to deliver sustainable service delivery.
Cancer • Consistently achieve all monthly cancer standards Microsoft Excel Worksheet	PAH are currently failing against the Breast Cancer 14 Day Standard and are producing an urgent recovery plan. Month 9 data shows issues in a number of other standards and this is being escalated via the West Essex Cancer Board and PAH SPQRG. All breaches are analysed on a case by case basis. Detailed contractual standards, KPIs and SDPs (as attached) are being negotiated for inclusion in 14/15 contracts:

Standard	Key Actions and Interventions
Ambulance • Move to a position of compliance against all Category A Call standards • Regional solution	The CCG is actively engaged in the East of England Ambulance regional management process. The regional Risk Summit took place on 28 January 2014 where the following key actions were agreed: • The Trust will develop a new recovery plan by the end of March 2014 • This recovery plan will require transitional funding which all CCGs will be asked to support • The Trust is looking to appoint Locality Directors for Essex, HBL and Suffolk/Norfolk • The Trust is beginning to recruit 400 paramedic trainees • 2013/14 financial penalties identified will not be applied by CCGs
Stroke • Consistently achieve all monthly stroke standards	PAH have breached a number of standards throughout 2013/14 and the CCG has agreed recovery trajectories in respect of: 1. % of high risk TIA patients scanned and treated < 24 hours 2. % of stroke patients admitted to a ward < 4 hours 3. % of patients receiving thrombolysis < 3 hours Trajectories are being delivered with the exception of number 2. Current achievement is 70% against the 95% standard. Recovery plans are monitored through the West Essex Stroke Board and SPQRG meetings and will continue to be driven in 2014/15.
IAPT % of people that have entered psychological therapies Achieve 15% by end of 2014/15	We are working closely with the West Essex IAPT Provider, MIND, to ensure delivery of the 2013/14 intermediate target of 10%. Meetings are scheduled with MIND in February 2014 to review and agree budgets and detailed plans to ensure delivery of the 2014/15 standard. Additional funding has been set aside by the CCG to underpin delivery.
Dementia Achieve the 90% "Find / Assess / Refer" standards	Princess Alexandra Hospital are currently non-compliant in respect of the "Find" and "Refer" standards. The CCG's Director of Quality has agreed a detailed action plan and trajectory with the Trust to deliver compliance by May 2014. Delivery of the plan and on-going compliance through 2014/15 will be monitored through the monthly SPQRG meetings with the Trust.

4.0 Changing How We Work

In this section we outline how we plan to work differently to support our transformation agenda.

4.1 Integrated Commissioning
4.2 Integrated Provision (inc BCF)
4.3 Primary Care at Scale
4.4 7 Day Working
4.5 Commissioning for Prevention
4.6 Commissioning Continuing Health Care

4.0 Changing How We Work

4.1 A Modern Model of Integrated Care – Integrated Commissioning

Providing integrated services is dependant on integrated commissioning between health and social care. We are therefore committed to integrated commissioning with Essex County Council. We aim to operate in a shadow form from April 2014 whereby we commission through pooled budgets, shared commissioning resources and joint governance between ECC and WECCG, achieving shared outcomes through the joint commissioning of health and social care services. Plans are progressing for integrated commissioning for our frail elderly population and also for Learning Disabilities. **The Better Care Fund will act as an enabler for integrated commissioning for frailty.** Beyond this we will be exploring integration opportunities for children and mental health.

Outline governance arrangements

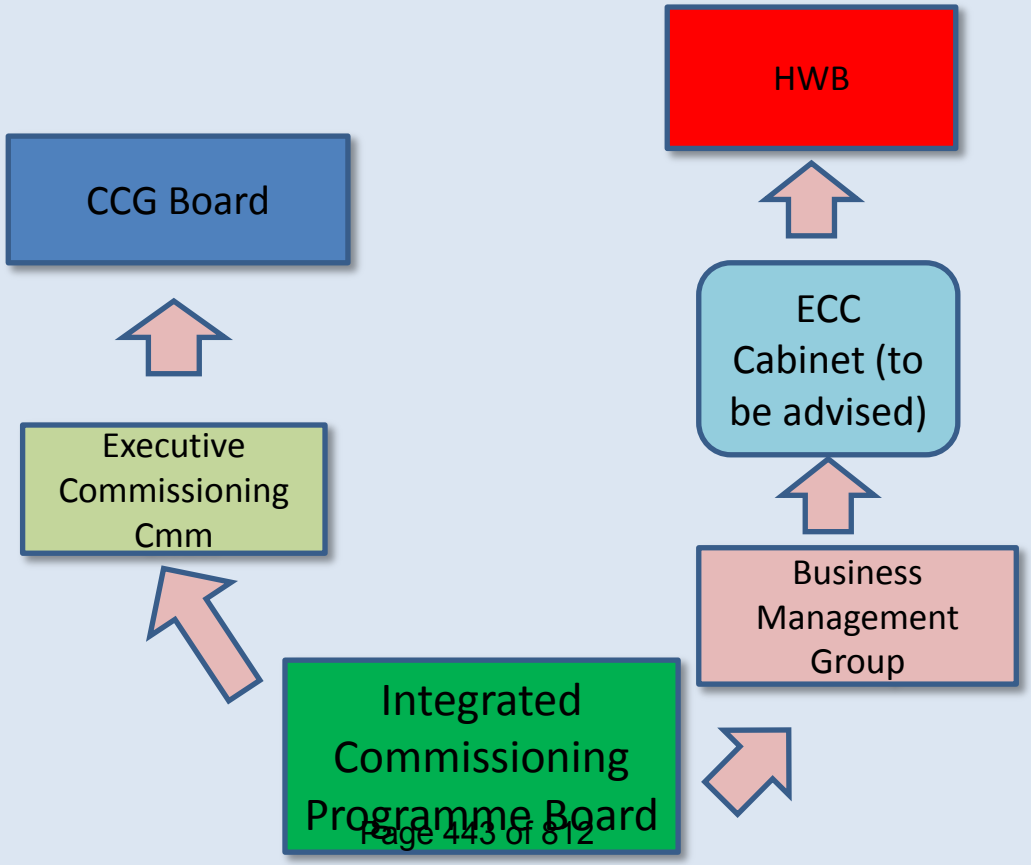
During 14/15 we will explore further what our preferred organisational form will be to work as a Accountable Care organisation with the aim of a clear conclusion on a preferred option by September 2014 for implementation by April 2015.

- **From April 2014** working under the principles of an Accountable Care Organisation for Older People, shadowing shared outcomes, budgets, governance, resources
- **From April 2015/16** working closely with ECC as **an** Accountable Care Organisation for commissioning of Older People , Children, Learning Disabilities, Mental Health

4.0 Changing How We Work

4.1 A Modern Model of Integrated Care – Integrated Commissioning

The governance structure through which the CCG and ECC are working to take forward our plans to develop integrated commissioning are shown below:



4.0 Changing How We Work

4.2 A Modern Model of Integration – Learning Disabilities

The Michael Report: *Healthcare for All* (2008) and the Mencap report: *74 Lives and Counting* (2012) provide clear evidence that people with a learning disability have unequal access to health services and are often at risk through failures to make reasonable adjustments to meet their needs.

The impact of these greater health needs and unequal access to general health services is that people with a learning disability are likely to die prematurely. The recently published *Confidential Inquiry into Premature Deaths of People with a Learning Disability*: 2013 (University of Bristol; Improving Health and Lives Learning Disability Public Health Observatory) identifies from the cohort they studied that men with learning disabilities died on average 13 years sooner than men in the general population; and women with learning disabilities died 20 years sooner than women in the general population. Overall, 22% were under the age of 50 when they died; 43% of the deaths investigated were identified as 'unexpected' and 42% 'premature' whilst fewer deaths of people with learning disabilities (38%) were reported to the coroner compared with the general population (46%).

The view is that an integrated health and social care team is best placed to take responsibility for the end-to-end health and social care experiences of people with LD. This will support an improvement in safeguarding and access to services, enhancing the experiences and outcomes from both health and social care.

Key Patient Benefits

- **Experience will improve and better outcomes will be achieved for people with learning disabilities.**
- **People will no longer become "stuck" in hospital assessment and treatment services (this happens currently because the current pathway between health and social care services is disjointed and managed separately);**
- **Funding disputes between CCGs and ECC (which can cause delays to people receiving the services they need) will no longer occur;**
- **Social care services will be enabled to work with health services to ensure that people's health needs are being met effectively and that people are being supported to live healthy lifestyles;**

- **The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex.**

- The same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex. - **April 2014**
- Formal Pan Essex integration of commissioning resource (North and South Essex). **- April 2015**
- Service design - Integrated pathways for all cohorts – **throughout 2015**
- Joined-up care management and assessment **– April 2016**

4.0 Changing How we Work

4.2 A Modern Model of Integration – Learning Disabilities

Improving quality

Principles

Increasing pressure on the health and social care system is potentially best mitigated through integration.
There is a pressing requirement to respond to the national Winterbourne View action plan, which requires us to demonstrate that we are delivering joined-up services for people with learning disabilities.
Integrating LD will act as a key "early adopter" project to test and evidence the impact that can be delivered. The lessons can be translated across other areas
Integrating LD commissioning will safeguard the benefits defined in the WAA Increasing Independence programme, through ensuring contractual buy-in to solutions that are best for the total combined expenditure
There is some evidence that demand is a factor not only of demography, but also of the design of the system; an integrated approach to management and design of the system will mitigate the potential negative impacts
The market continues to innovate and develop solutions for the separate budget and procurement processes. The market will only provide the innovative joined-up community-based solutions when the integrated budget puts those out to tender. Similarly the stand-alone nature of current performance and contract management makes it more difficult to hold suppliers to account for performance across the whole system;

Outcomes

To improve customer experience and outcomes for people with learning disabilities through integrated pathways
To create organisational capacity to address the impact of the projected demographic pressures
To deliver the requirements of the Government response to Winterbourne View
To bring the commissioning budgets together to drive greater value from the market with an increased focus on avoiding the poor experiences and outcomes which the cohort can suffer
To drive value as well as managing increasing demand by developing integrated specifications
To reduce the potential risk of systemic failure by creating integrated care pathways that improve experiences
The development of integrated care and support pathways, to deliver the integrated specifications to deliver the *"Behaviours that Challenge"* work stream within the "*Increasing Independence for Working Age Adults*" programme*
To address the issue that people with learning disabilities continue to have lower life expectancy and experience poorer health outcomes than the general population, despite increasing levels of funding over recent years.

Priorities

The approach to commissioning will have changed to enable people with learning disabilities to have improved customer experience and outcomes.
Commissioning teams for Health and Social Care will be co-located, with commissioners working as a single team to define integrated specifications
Commissioning of services will be carried out as a joint activity between Health and Social Care, with budgets jointly managed
There will be an approach to governance in place which enables and operationally manages joint commissioning and provides delegated authority to make commissioning decisions
Commissioners will commission services which are delivered via integrated pathways between Health and Social Care, with seamless service and minimal hand offs
People with learning disabilities will be supported to live healthy and fulfilling lives, with health and social care services working together to enable this to happen.

4.0 Changing How We Work

4.2 A Modern Model of Integrated Care – Integrated Provision

We strongly believe that integration is the answer to ensuring people get the best possible care and outcomes for their individual conditions. It is one of the underlying principles to our vision. We will be supporting integration where we can use it as a key enabler to:

- Bring together the organisations involved in patient care to deliver consistent and coordinated care
- Offer patients higher quality and more efficient care that better meets their individual needs
- Improved efficiency in how patient's conditions are managed and supported

The CCG is leading the way in developing an "Accountable Lead Provider"(ALP) approach to contracting and commissioning for a targeted population. We are working towards a role out of this approach for our frail elderly population in the first instance. Rather than commission separately for all the different health and social care services that this population needs, we will contract with one lead provider, who will be accountable for ensuring that the population achieve the outcomes that we have jointly commissioned with ECC. The plan is have an ALP operational in 2015/16, and to 'shadow' this arrangement in 2014/15

In this approach the ALP will manage and be responsible for a supply chain of care providers including themselves to deliver these outcomes. By commissioning these services in this way we want to free providers to innovate and work together to deliver improved care for frail people. The specific approach to frail elderly is explored further within the Transformation section of this plan.

The Better Care Fund is an enabler to facilitate phase 4 of the frailty programme. The CCG will contribute a sum of circa £18m into a pooled budget with ECC via a S75 Agreement from 2015/16. Further detail can be seen on slide 5.2 – Transformation of Frailty Services

4.0 Changing How We Work

4.2 A Modern Model of Integrated Care – Integrated Provision for Frailty

Our timeline for rolling out this out is shown as follows:

Year 1 2014/15	Year 2 2015/16	Year 3 2016/17
Shadow form	Single contract	Review and improve Transform services
Transform services	Transform services	Expand chain
Some incentives	Some incentives	

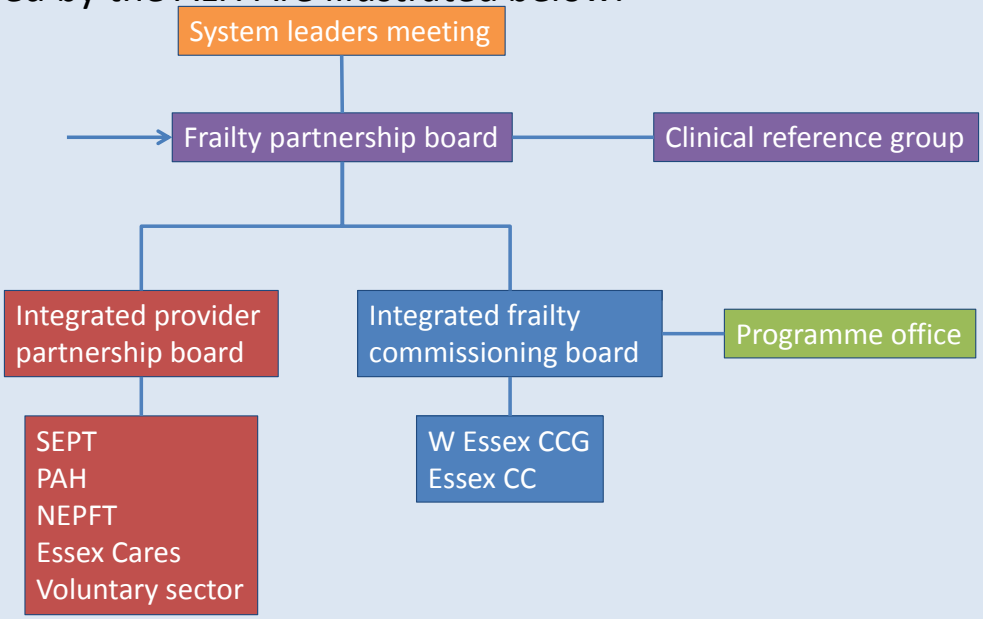
We are currently working with our providers to develop the year 1 and year two ambitions and will shortly be specifying within contract what will be expected. Typically for year two this is likely to include the following:

- the total budget available to meet the health and social care need
- the required health and social care combined, outcomes for the population group and the basis on which these outcomes will be measured;
- the incentivisation model by which benefits and risks will be shared between the CCG, ECC and the ALP for over or under-achievement of health gains for the population;
- details of the governance structures and reporting mechanisms through which the ALP will enable the CCG and ECC commissioners to have confidence in, and be publicly accountable for the integrity of all aspects of the care services provided by the ALP.
- Year 1 will see significant reductions in non-elective settings, with more effective community alternatives.

4.0 Changing How We Work

4.2 A Modern Model of Integrated Care – Integrated Provision for Frailty

Proposed governance structures and reporting mechanisms through which the ALP will enable the CCG to have confidence in, and be publicly accountable for the integrity of all aspects of the care services provided by the ALP. Are illustrated below:



4.3 Providing Primary Care at Scale

The CCG and its partner practices have over the last 12 months been exploring how a programme of transformation within primary care can support a different approach to providing care to our population. Our primary care localities, Harlow, Uttlesford and Epping are proposing to establish themselves business entities to facilitate their ability to act as lead coordinators for the management of care for a number of conditions over and above core services. Uttlesford will form one entity and Harlow and Epping will join to create a second. This will involve practices taking responsibility for a total budget for a group of patients. Plans are being developed as follows:

- Localities to form business entities by 1 April 2014 including the managed transfer of a range of services into primary care.
- Extended range of provision of ACSC (Plus) commencing **July 2014** including use of technology including TeleDiagnosis, TeleFundus Screening, TeleOphthalmology and initially focussing on diabetes, respiratory and cardiology to aid diagnosis and treatment.
- Extended provision- 7 day working **June 2014** including use of technology offering more flexible ways for patients to access general practice
- Locally Enhanced Services to be commissioned through localities rather than individual practices, reducing variation in care, sharing skills and improving efficiency
- Commence co-location of services /community based hubs from **Sept 2014** providing an extended range of wider out of hospital services including consultant led and specialist nurse led services tailored to locality needs. This will ensure people get the best possible care and will bring together multidisciplinary teams in a meaningful and directed way.

NB Expansion of Primary Care is a key enabler to the Adult Transformation Programme refer 5.3.

Benefits
• Reducing variation in GP referrals through rolling out good practice for managing demand and reprovision
• Practices working together to provide efficient services through services being shared across a wider base including sharing responsibility for patient care more efficiently and effectively across the week.
• shift to prevention and early intervention through person-centred care
• Caring for people as individuals with closer professional-patient relationships
• Practices providing a front door to a wider range of services
• A more integrated approach to providing general practice and wider out of hospital services
• Driving up quality in primary care generally
• More care delivered at home, in primary care and in the community
• Services delivered via a single point of contact with primary care as the coordinator

4.4 7 Day Working

Improving quality and access

10 Clinical Standards

Urgent Care | **Frailty** | **Children** | **Adults**

- Health and Social care commissioners in west Essex will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge.
- In the meantime the CCG is developing an Urgent Care Strategy, in response to associated 'winter pressures' in the acute hospital setting . There is a clear expectation that 7 day support for hospital discharge on a WECCG 'whole system' basis. Priorities including 7 day discharge from PAH, health and social care in-hospital capacity and activity and Health and social care support and reablememt services for community discharge are being piloted this winter., supported by rapid assessment, and CARS,
- The accountable lead provider for frailty will be commissioned to develop a set of services that 'wrap around' patients and operate flexibly across a 7 day service arrangement.
- Early diagnosis of ACS conditions is highly dependent on improved and direct access to diagnostics, with urgent reports being provided to GP's within 24 hours. The CCG therefore expects the ACS service model to be available 7 days per week where appropriate. We will be commissioning for outcomes and these outcomes will be the same regardless of day of the week and expect primary care providers to be provider extended 7 day a week services from July of 2014
- We are working with all of our providers to develop action plans to support their response to the 10 clinical standards for 7 day working. This will be a key component of SDIPS over the next two years.

4.5 Commissioning for Prevention

There is a clear understanding that Public Health is everybody's business and working in partnership with all commissioners, wider stakeholders and the communities of Essex is seen as the most effective way of delivering against the outcomes nationally and locally. Essex County Council is responsible for the public health of Essex residents and has been given a grant of £50 million - that was historically National Health Service money – to improve the population's health. Of this approximately £7½ million is spent in the West Essex CCG area. The strategic context around agreeing optimal use of public health resources includes the Essex Health and Wellbeing Strategy, the Essex County Council Corporate Plan, the National Public Health Outcomes Framework, centrally mandated areas for public health action and locally assessed needs.

PH area	Spend	Transformation area
Falls prevention	£450,000*	Frailty
Senior Health Checks	£40,000	Frailty
Health Checks	£367,000	Adults
Health Trainers	£110,000	Adults
Stop Smoking services and interventions	£395,000	Adults
Sexual Health - GUM	£1,093,950	Adults
Sexual Health - Young People Service	£368,359	Adults
Sexual Health - CASH service	£524,570	Adults
Obesity	£300,000*	Adults, Children
Drugs and alcohol	£2,612,586	Mental Health
Depression and OP	£48,498*	Mental Health
Healthy Schools	£15,000	Children
5-19 Health Child Programme	£1,179,462	Children
VCS grants	£58,220	any
* New or proposed for 14/15		
N.B Some figures are approximate as not all contracts have a specific PH basis		

We will use the resource to commission a comprehensive range of public health services. Key strands of commissioning next year will include

- Mandated must do's: healthchecks, national child measurement programme, sexual health services, & health protection
- System productivity eg falls prevention, alcohol,
- Priority areas from JSNA etc: depression in older people, obesity and physical activity, domestic abuse

4.5 Commissioning for Prevention
Examples of working together to achieve shared outcomes

Integrated Public Health Commissioning Programme
Aimed at: Reducing harm caused by alcohol misuse, reducing falls in older people, improving recovery from stroke and improving continence care
Delivery start date: April 2014.
Resourced through: ECC and CCG
Description: Our JSNA Lifestyles Deep dive identified significant harm being caused to our population through alcohol misuse, and in the over 65s by falls. The programme, jointly commissioned between ECC and the CCG and forming part of our integrated commissioning programme, provides a substantial increase in investment of alcohol brief screening and intervention and treatment programmes, and in integrated falls clinics locally by ECC in return for the CCG increasing investment in stroke early supported discharge and continence services

Reducing Health Inequalities through stop smoking services
Aimed at: Smokers in deprivation quintiles 4 and 5
Delivery start date: April 2014.
Resourced through: ECC
Description: A health equity audit on smoking has identified that differences in access to stop smoking services and quit rates between affluent and deprived communities across the CCG are resulting in a failure of smoking cessation to address health inequalities. The project aims to increase referral rates of smokers from GP practices serving our 40% most deprived communities to levels that address this.
This fits with WECCG Local Quality Premium intervention to improve COPD case finding and management

Improving the mental health of vulnerable people and groups
Aimed at: Older people, people accessing IAPT and secondary mental health services
Delivery date: July 2014
Resourced through: ECC
Description: Research shows that there is a high prevalence of undiagnosed depression in older people and that patients of all ages who access mental health services have poorer physical health outcomes. This scheme will commission a suite of initiatives aimed at improving the mental health of older people and vulnerable groups, including screening and treating older people for depression, social prescribing to address loneliness and isolation in older people, floating support to assist patients with mental health problems to deal with housing problems and debt, and providing health trainers to people accessing secondary care mental health services to assist them to address health damaging behaviour such as smoking and alcohol misuse.

4.6 Continuing Health Care

CHC Governance

- SLA and service specification in place with Central Eastern CSU to deliver against the National Framework for CHC (2012 Revised), Responsible Commissioner Guidance and key quality markers. The CSU deliver on behalf of the CCG both the core CHC service and the retrospective claims. The CSU employs specialist practitioners who are subject matter experts in this field of practice.

    - The performance of the service is reported to the CCG and monitored by the CCG in a number of ways including:
    - Reporting of Monthly KPI's
    - Monthly reporting of activity, cost and performance via a dashboard, and narrative identifying key areas
    - Bi Monthly reports to the CCG Quality Committee presented by key CHC leads
    - Monthly finance report and forecast of CHC spend
    - Quarterly National benchmarking reports
    - Weekly reporting on the clearing of backlog reviews
    - Monthly reporting of performance of the retrospective reviews against trajectory
    - Fortnightly Essex wide meetings with the AT across Essex
    - Meetings with CCG DON and Finance Director
    - Provision of ad hoc requests for information
    - Close links with the CCG quality team and CHC staff in the CSU

Personal Health Budgets

- On schedule to be in place by September 2014 as per national programme.
- In our own engagement programme there was keen interest from citizens to the concept of personal budgets.
- We intend to maximise opportunities presented by the national rollout of the programme . With evidence of the greatest benefit attributable to areas of spend that impact on the amount of control that people have over their lives we see the management of LTCs as a key area for development in the use of personal budgets going forward.

NHS
West Essex
Clinical Commissioning Group

5.0 Transformation Programme and QIPP

In this section we describe the transformation interventions that we see as the key to delivery of our ambitions to improve quality and productivity of health and care services.

5.1 Transformation Programme and QIPP - Introduction

Transformation Programme (QIPP)

The CCG has developed a transformation programme with ambition to deliver real change and improvement in how health and social care services are delivered to the population of west Essex. The aims of the programme are to:

- **Improve quality.** *Patient safety, clinical effectiveness, better outcomes and care for people as people.*
- **Significantly shift the point of care**, *the right care is provided at the right time and in the right place*
- **Integration between health and social care**, *for both commissioning and providing of care*
- **Connected transition of care**, *and support between professionals and organisations*
- **Maximise productivity and efficiency**.

My Health, My Future, My Say – A vision for the west Essex health and care system 2014-2014 was the result of a major engagement exercise that the CCG undertook in partnership with ECC and providers during Summer 2013. This process has informed the transformation programmes that we are taking forward. These are:

- Frailty and Older people
- Adults (ambulatory care sensitive conditions
- Children and Maternity
- Mental Health and Vulnerable Adults

Our transformation programme incorporates our wider business as usual reform programme which includes the following:

- Urgent and emergency care
- Stroke
- Productivity in elective care
- Concentrated centres for specialist care

This chapter of our plan describes each of the programmes. In particular how they each contribute to improvements in patient care, how they contribute to the 7 ambitions and how they support a step change in productivity.

The programme will be overseen through the governance arrangements shown at 5.2. The programme itself is unpinned by the following gateway principles:

1) Outline project mandate

2) Business case to demonstrate
    - Innovation, CCG using tools such as The Advisory Board Company, The Kings Fund, Better Care.
    - A thorough review of best practice sought through evidence based research
    - Clinical engagement
    - Patient engagement
    - Improvement in quality and positive impact against CCG outcomes and 7 ambitions
    - Opportunity for productivity

3) Project Implementation
    - Detail project planning
    - Risk management
    - Progress reporting
    - Reporting against project milestones
    - Reporting against planned savings

The CCG operates a PMO function that will oversee the transformation programme. QIPP Assurance checklist imbedded.

Microsoft Excel Worksheet

5.2 Transformation Programme and QIPP - Governance

MONITORING ARRANGEMENTS FOR TRANSFORMATION/QIPP 2014/2015

MEETINGS	WORKSTREAM TEAM MEETINGS WEEKLY: MONDAY	WORKSTREAM / TASK & FINISH	PROGRAMME BOARD MONTHLY / QUARTERLY	FORMAL EXECUTIVE COMMITTEE MONTHLY: WEEK 2	→	• CLINICAL COMMISSIONING COMMITTEE • FINANCE & PERFORMANCE COMMITTEE MONTHLY: WEEK 3	WEST ESSEX CCG BOARD MONTHLY: WEEK 4
REPORTS	Weekly Milestone Tracker Risk logs	PROGRAMME SUITE (produced monthly)	PROGRAMME SUITE (produced monthly)	2 Part QIPP report ((produced monthly)	→	2 Part QIPP report (produced monthly	ACCOUNTABLE OFFICERS REPORT
DETAILS	**Attendees:** Delivery leads & PMO **Owner:** PMO **Purpose:** To holds the Delivery team to account on their actions and ensure that milestones are met.	**Attendees:** Delivery leads / PMO/ Exec Lead **Owner:** Executive lead **Purpose:** Review Programme plans – and progress against these plans Identification of areas of slippage & to address them. Identify additional actions required Assurance - Escalation	**Attendees:** Delivery leads / PMO/ Stakeholderc / Exec Lead / Clinical lead / Providers / Voluntary Services / Social Care /Patient Reps **Owner:** Designated Chairman of the Programme Board **Purpose:** Responsible for the delivery of QIPP programmes, developing initiatives, overseeing projects and monitoring progress.	**Attendees:** Executive Board Members **Owner:** PMO **Purpose:** Copy what we have put in Clinical Commissioning Committee + Overall – Assurance + ESCALATION OF RISK.	→	**Attendees:** CCG Chair / CCG Vice-chairs / Assos Medical Director/ Clinical leads / Exec team /Social Services/ **Owner:** PMO **Purpose:** Part 1:Provide detailed financial performance of the QIPP schemes with the financial forecast for the year end. Part 2: Provide written document that details the current position highlighting where there has been significant change. Details of any actions that will impact the QIPP delivery.	
OUTCOMES	**ACTION REQUIRED:** PMO to maintain log of weekly actions to be delivered and their status. Escalation to Senior management around slippage and roadblocks. Ensure the Risk Log is updated.	**ACTION REQUIRED:** SITREP Review Programme plans – and progress against these plans Identification of areas of slippage Give direction to manage risk and close potential shortfall of the programme	**ACTION REQUIRED** Programme boards to take stock on project performance, risks and issues and be clear on deliverables for next period.	**ACTION REQUIRED** Confirm assurance and give directions where risks to programme delivery.	→	**ACTION REQUIRED** Assurances for the board around the QIPP programme.	
Example	**Risk Log / Action Log** Risk Severity Mitigating Actions / Owners. Action – Owner Status Impact				+		

5.0 Improvement Interventions – Transformation Programme

5.3 Access to Highest Quality Urgent and Emergency Care

5.3.1 Urgent and Emergency Care – Plan on a Page
5.3.2 Governance Overview
5.3.3 Winter/Operational Approach
5.3.4 Strategic Development

5.3.1Urgent and Emergency Care – Plan on a Page

Governance Overview

Urgent Care Strategy Board (monthly) - Development of longer term U & E Strategy and service integration agenda from 2015 to 2018 – stakeholder and increased clinical involvement linked to national plans (Keogh review) - ***ongoing with overall strategy agreed by end of Q1 of 2014/15***

Urgent Care Working Group (weekly/bi-weekly dependent on requirements) - senior operational membership from all providers and development of 14/15 action plans for delivery of system capacity and resilience – ***plans agreed by end of March 2014***

Operational system network (daily via on site meetings and teleconferences) – day to day operational interface between providers – ***continuous process building on successes of winter initiatives13/14***

Three Phase approach to Urgent Care Provision

Pre Hospital phase (attendance avoidance)

- GP in car to support EEAST ambulance reduction in conveyances
- Increased GP urgent appointment slots
- Focus on minor injury and ailment treated in Primary Care environment
- SPA alternatives to hospital
- NHS 111 patient navigation to Pharmacy & self-care options
- Care homes initiatives

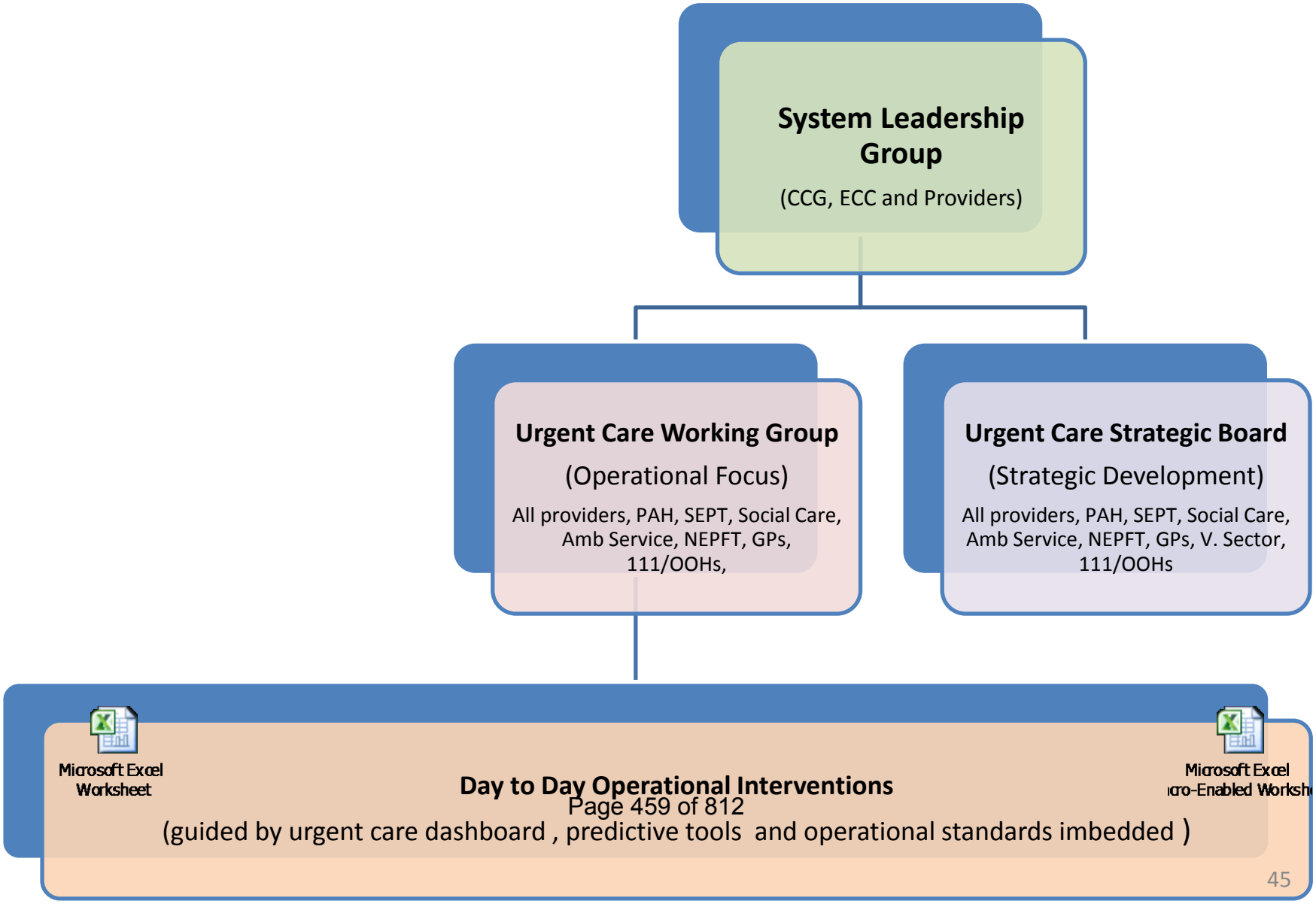
Hospital arrivals phase (admission avoidance)

- Enhanced streaming to OOH service
- CARS nurse initiative
- Co-location of agencies
- Frailty Pathway development
- C&YP initiatives
- Mental Health support
- Reablement initiatives
- Joint Health and Social care ownership and approach

Discharge phase (post hospital recovery & readmission avoidance)

- Enhanced streaming to OOH service
- CARS nurse initiative
- Co-location of agencies
- Frailty Pathway development
- C&YP initiatives
- Mental Health support
- Reablement initiatives
- Joint Health and Social care ownership and approach

5.3.2 Providing High Quality Urgent and Emergency Care Pan System Governance



5.3.3 Providing High Quality Urgent and Emergency Care

5.3 Winter /Operational Approach

Improving quality

Overview of Approach	•CCG has the role of system manager with oversight of performance and delivery of all providers and system partners •Governance of winter pressures management is via the Winter System Programme Board chaired by the CCG accountable officer •The system wide performance dashboard has been used to monitor and develop system KPIs . This will continue to developed with local predictive decision support tools and increased use of CAMS system. •Increased scrutiny from both NHS England and Trust Development Authority with focus on A&E 4 hour target and Ambulance handover times •Health economy received £5m to support winter pressures in the community and at Princess Alexandra Hospital •Sustainable plans for use of 70% marginal rate have been agreed and will be monitored going forward by the UCWG •Significant underperformance during November and December with PAH failure against 4 hour target in Q3 •McKinsey intervention commissioned to give external view of system challenges and opportunities to improve
Recovery Measures	•Increased focus and pace in system led by Winter Programme Board meeting weekly •Additional interim executive level CCG support to ensure high level engagement across urgent and emergency care •McKinsey inputs added to overall system recovery plan and increased monitoring of performance against agreed actions •Adoption of 7 day working arrangements across all system partners •Co-location of providers at PAH to ensure effective escalation and communication •Decision support framework strengthened to include: •System wide urgent care dashboard •More effective and frequent teleconference arrangements •Increased engagement from Ambulance and OOH providers •Urgent care Working Group review of existing plans, escalation processes and triggers for improved system responsiveness at times of increased activity •CCG leading the advanced development and implementation of cross system operational standards and joint working to reinforce the escalation process.
Recovery, Resilience and sustainability	•20 bed modular ward (SSEAU) opened at PAH on 20th Jan •Additional Community and Social Care capacity now online •Developing relationships across all partners remains key to delivery of quality patient care •Winter Programme Board focus on remaining weeks of 13/14 period and ensuring ongoing sustainability throughout 2014/15 •Planned revision of Urgent and Emergency Care governance arrangements to support future 5 year strategy •Awareness of national Urgent Care guidance and clinical models from Keogh review •UC mobilisation event planned for March to begin strategy process •The CCG through the CSU commissioning mechanism is fully engaged in the process of ensuring ambulance services are at the heart of sustainable delivery of urgent and emergency care. Building on improving relationships and joint schemes developed during this winter period the CCG and its partners are focussed on delivery of the enhanced role of the ambulance service as defined by the Keogh review.

5.3.4 Providing High Quality Urgent and Emergency Care

Strategic Development

What are we trying to achieve through the Urgent Care Strategy ? …*Following the Urgent and Emergency Care Review we will create an integrated urgent care system, that will improve value for money & reduce spend to reinvest in proactive care and to ensure people with urgent or emergency care needs get to the right person / service as quickly as possible aligned to the recommendations and clinical models as follows:*

To ensure minor injury and minor illness are treated outside of the acute hospital setting

To ensure patients with mental health issues are treated outside of the acute hospital where appropriate when their clinical needs have been met

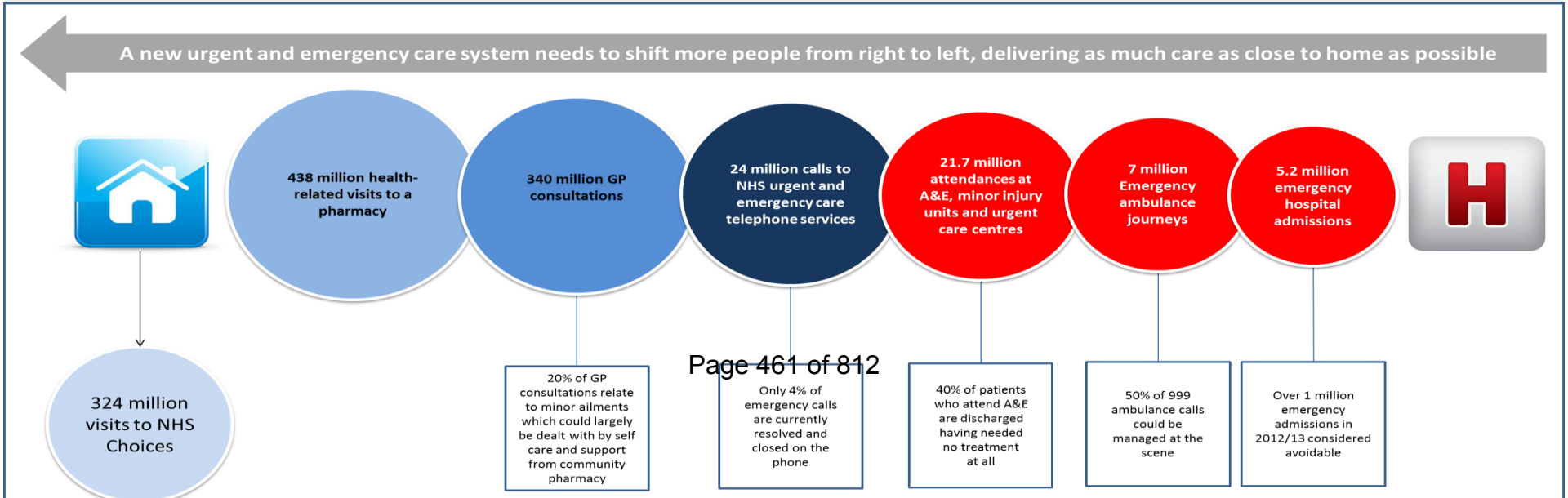
To ensure patients with ambulatory care conditions are treated as quickly as possible and not admitted into hospital unnecessarily

To ensure patients with multiple chronic health needs have access to timely assessment by appropriately skilled clinicians and have an appropriate care plan delivered

To improve access to and responsiveness of urgent community support services

To ensure that patients do not stay in hospital longer than they need to

To ensure people with specialist emergency needs are fast-tracked to the appropriate specialist service, e.g. stroke



5.3 High Quality Urgent and Emergency Care Strategic Development cont……

Key Milestones	14/15	15/16	16/17	17/18
"Phone First" (inc 111, OOH, SPA) service spec development	√			
Integrated UCC &OOH service planning	√			
Review crisis services	√			
Self care and pharmacy strategy	√			
Workforce strategy development	√			
"Phone First" (inc 111, OOH, SPA) procurement		√		
Integrated UCC &OOH service specification development		√		
Continued development of mobile assessment services		√		
"Phone First" (inc 111, OOH, SPA) hub launched			√	
Integrated UCC &OOH service procurement			√	
Mobile services implementation			√	
Integrated UCC & OOH service launched				√
Workforce Strategy	√	√	√	√
Engagement and Communications	√	√	√	√

14/15 & 15/16 – Building resilience

16/17 & 17/18 – Implementing Strategy

Key Opportunities 2014/15

- tender OOH & 111 service
- align with single point of access (SPA)
- Influence ambulance service contract to improve emergency response and improve integration with GPs and providers – imbedded diagram illustrates

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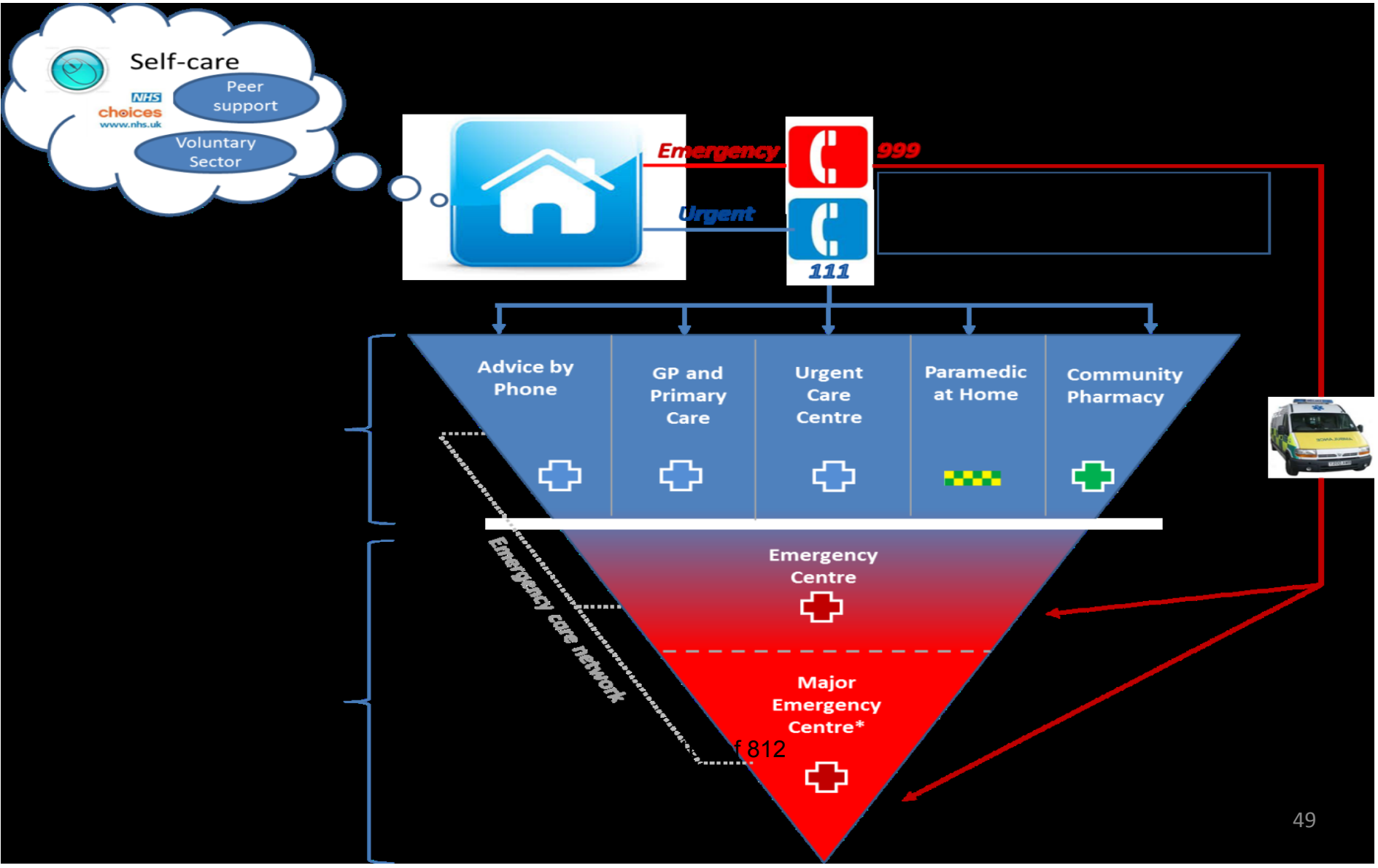
5.3.4 High Quality Urgent and Emergency Care Strategic Development cont……..

The diagram below illustrates the vision for urgent care in the west Essex system over the next two years. This shows a reduction in reliance on hospital care except in the case of a major emergency. Access will be improved in community and primary care settings supported by self care and advice from 111 services



5.0 Improvement Interventions – Transformation Programme

5.4 Frailty Programme

5.4 Improvement Interventions – Transformation Programme Frailty

Summary of Programme

- The West Essex system is proposing a fundamentally different approach to the provision of care for the frail population in West Essex. This approach will facilitate improved co-ordination of care involving all agencies, including third sector, across health and social care working more closely together, to ensure that they combine efforts to achieve the very best outcome for those who use services. The overarching benefits will be:
    - potential to share resources,
    - improving efficiencies by eliminating unnecessary duplication.
    - improve quality of care by reducing the barriers between different parts of the care pathway
- The Integrated Frailty Programme will be commissioned jointly by CCG and Social Care and provided by SEPT as accountable lead provider with an integrated supply chain including Essex County Council, Princess Alexandra Hospital, Essex Cares, Primary Care, Ambulance Service, North Essex Mental Health Trust and voluntary sector, with aspirations to develop the supply chain further and expand the role of the social care sector.

Aims and Objectives	Goals for Patients
Demonstrate a marked improvement in patient experience and quality of care, which is centred on the needs of the individual Share risk and gain appropriately through the West Essex care system	Increasing the length of time known conditions are maintained in a stable condition, and therefore reducing the frequency of acute exacerbations
Work through organisational boundaries and promote inter-organisational working	Decreasing the severity of acute exacerbations when they cannot be prevented, by early detection and rapid response
Develop a commissioning landscape that supports prevention of crisis	Reducing the impact of acute exacerbations by shortening the duration of the episode through rapid response and effective re-ablement
Develop a commissioning landscape that supports prevention of crisis	Reducing the levels of vulnerability/ frailty by managing the risk of developing/ worsening additional co-morbidities
Invest in infrastructure that will improve sharing of patient information across organisations involved in care; and also support performance management	Fewer ‘crises’ requiring acute admission
Improve productivity and make better use of resources.	A slower transition to frailty for those at risk of becoming frail

5.4 Improvement Interventions – Frailty Transformation Programme

Improving quality

Principles

- designed around the needs of the frail and those likely to become frail;
- reductions in acute admissions and readmissions, A&E attendances and outpatient follow-ups; replaced by preventive and re-ablement services in community setting.
- joint commissioning of health and social care; and will develop an integrated supply chain
- localised models of care
- Self-care and carer support are integral to the programme;

Outcomes

- to improve independence and reduce crisis by ensuring individuals have access to reactive support, and multidisciplinary advanced care planning, to empower patients to feel confident in managing their condition(s) and prevent causes for health decline.
- through education, advanced care planning, better access to support services and family and carer support and education services to improve the quality of life for people over the age of 75, or with dementia or living in a care home.
- prevent avoidable admissions will use information shared between the acute providers and community providers to ensure follow up care for those discharged from hospital have the social and health support which mean the risk of readmissions is significantly reduced. Integrated intervention following discharge includes; reablement, therapy, social support, and carer support and education.

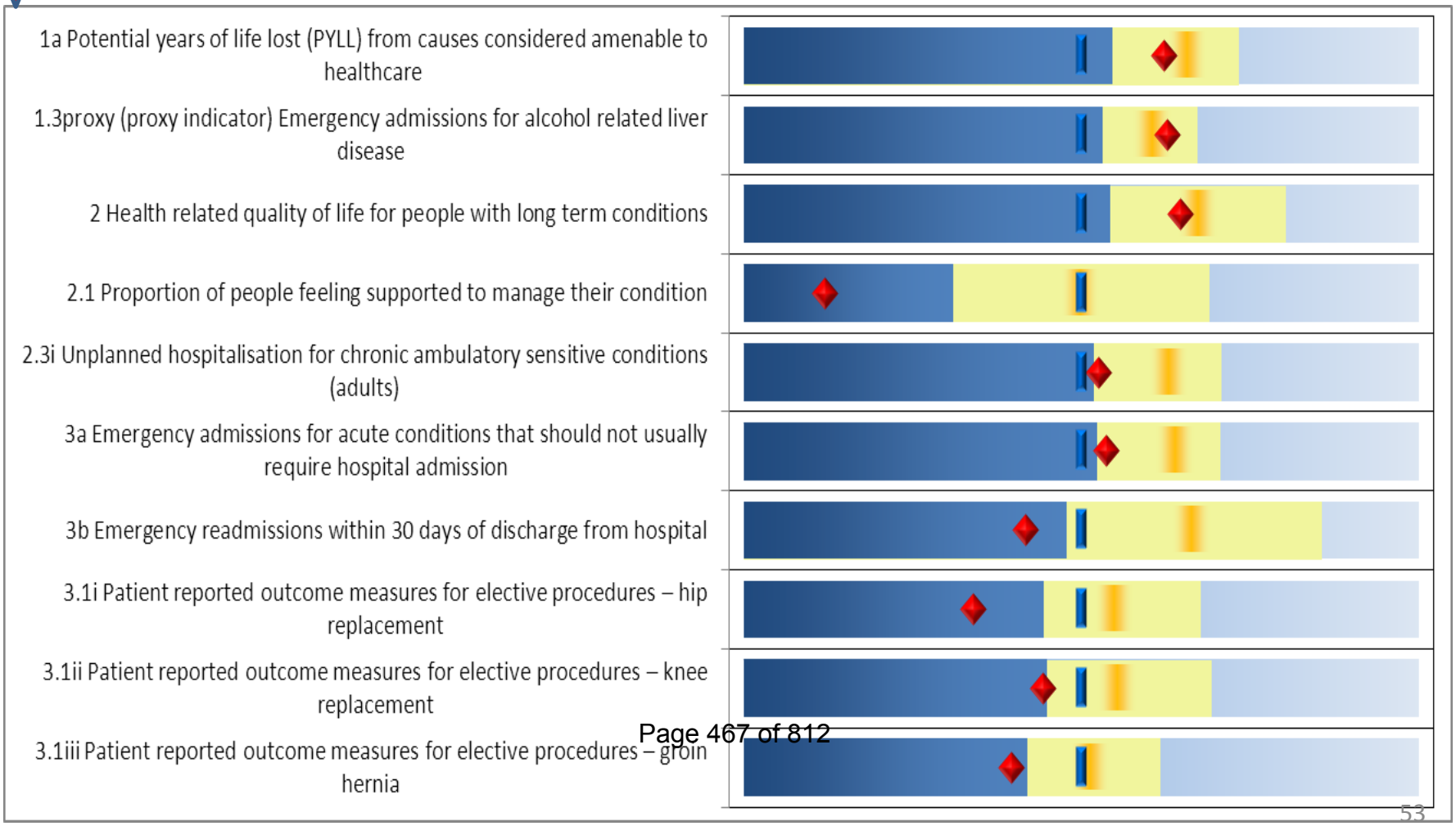
Priorities

- Designing integrated care around the needs of the frail and those likely to become frail means designing services 'around' the needs of the patient; the programme will include activities focused on changing professional 'culture' .
- Preventative care will necessarily include a focus on more minor problems.
- A single point of contact for services is included in the integrated care model
- Integrated care is the main plank of the programme

5.4 Improvement Interventions – Frailty Transformation Programme

The frailty programme is a key intervention that will contribute to an improvement in the outcome indicators below:

National Average Peer Group Average CCG Position



5.4 Improvement Interventions – Frailty Transformation Programme

Key outputs that will support improvement in outcomes

Year 1 2014/15	Year 2 2015/16	Year 3 2016/17
integrate health and social care: access to social care information & access to rapid response social care via SPA for A & E & RAC	Fully integrated health and social care access via a Care Co-ordination centre to all piloted services	Establish full capability of care co-ordination centre
Improve access to reablement for hospital discharge	Extend access to rapid response to community	Embedding and roll – out of all successful pilot schemes
Front end of PAH changes to support admission avoidance activity	Improve rates of community based rehab at home	Re-design and re-pilot unsuccessful schemes
Improve access to RAC	Set up specialist MDT's	Establish full MDT working
Working towards dedicated step up beds in focussed units.	Increase capacity for step up intermediate care	
Focus on admission avoidance from care homes	Ambulance trust changes to support admission avoidance	
Extension to mental health crisis support for AA	Revised focus on community dementia support and liaison	
Pilot MDT's in willing and able GP practices, developing risk stratification tool	Delivery of supportive end of life pathways, revise integrated community team working including falls pathway	

5.4 Improvement Interventions – Frailty Transformation Programme

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
Frailty (Older People)	**Frailty**	13/14 start	1		1,608	2,390,000	(1,224,000)	1,166,000
	Hospice at Home	13/14 start	1			432,000	(310,000)	122,000

5.0 Improvement Interventions – Transformation Programme

5.5 Adult Programme

5.5 Improvement interventions – Transformation Programme - Adults

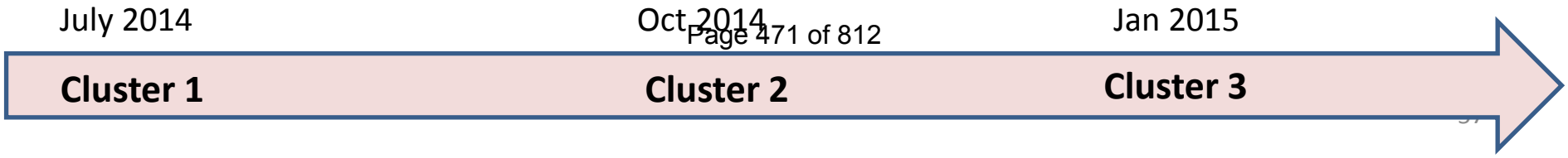
The CCG currently provides care for patients with an ACS Condition through a number of pathways, across primary, community and secondary care settings. The business case imbedded outlines West Essex CCG's commissioning intentions to improve the care provided for adults living with an ACS condition.

It is evident that current ACS care is provided across numerous complex pathways and with limited formal integration, resulting therefore in the absence of shared management of patients in west Essex and delays in diagnosing chronic health conditions. There is currently a gap of specialist support within primary and community care settings, which results in patients not being treated within the correct environments.

West Essex CCG aim to commission a model of care, which can be tailored based on individual need. This model of care will result in integrated, co-ordinated services along with specialist level management of complex patients within a Primary/Community based setting. The majority of patients will be diagnosed earlier, receive on-going management in Primary Care and be given the tools to self-manage their condition. In commissioning this pathway of care West Essex CCG aim to improve the experience and outcomes for patients within the west Essex health economy, living with an ACS Condition.

Aims and Objectives	Goals for Patients
Improved quality and equality of care across West Essex through earlier diagnosis and holistic support for patients through multi-disciplinary clinics.	Quicker response to early signs of ill health.
Ensuring improved provision and quality of care for patients in a primary care setting where clinically appropriate.	Allow people with ACS conditions to live (with support) independently for longer at home or in the community.
Promote self-management to enable patients to self-care more effectively and maintain independence.	Improved responses to crisis and acute episodes of ill-health.
Avoid unplanned hospital admissions by proactive identification of patients at risk, creating efficiencies.	Improved support for families and carers

Implementation Timeline



5.5 Improvement Interventions – Adults Transformation Programme

Improving quality

Principles

- Improved quality and equality of care across West Essex through earlier diagnosis and holistic support for patients through multi-disciplinary clinics.
- Ensuring improved provision and quality of care for patients in primary care where clinically appropriate.
- Promote healthy lifestyles and self management to enable patients to self care more effectively and maintain independence and/or increased years of life through promotion of healthy lifestyles and earlier diagnosis across all ACS conditions.
- Promote self-management to enable patients to self-care more effectively and maintain independence.
- Avoid unplanned hospital admissions by proactive identification of patients at risk, creating efficiencies.

Outcomes

- Increased years of life through earlier diagnosis across all ACS conditions.
- Holistic support for patients with co-morbidities through multi-disciplinary clinics.
- Improved health related quality of life through the provision of innovative self-management tools, primary care based specialist clinicians and enhanced rehabilitation programmes.
- Proactive identification of patients at risk of crisis to avoid emergency admissions.
- Preventing patients suffering exacerbations through enhanced education programmes, thus avoiding emergency hospital admissions.

Priorities

- Quicker response to early signs of ill health.
- Allow people with ACS conditions to live (with support) independently for longer at home or in the community.
- Improved responses to crisis and acute episodes of ill-health.
- Improved support for families and carers.

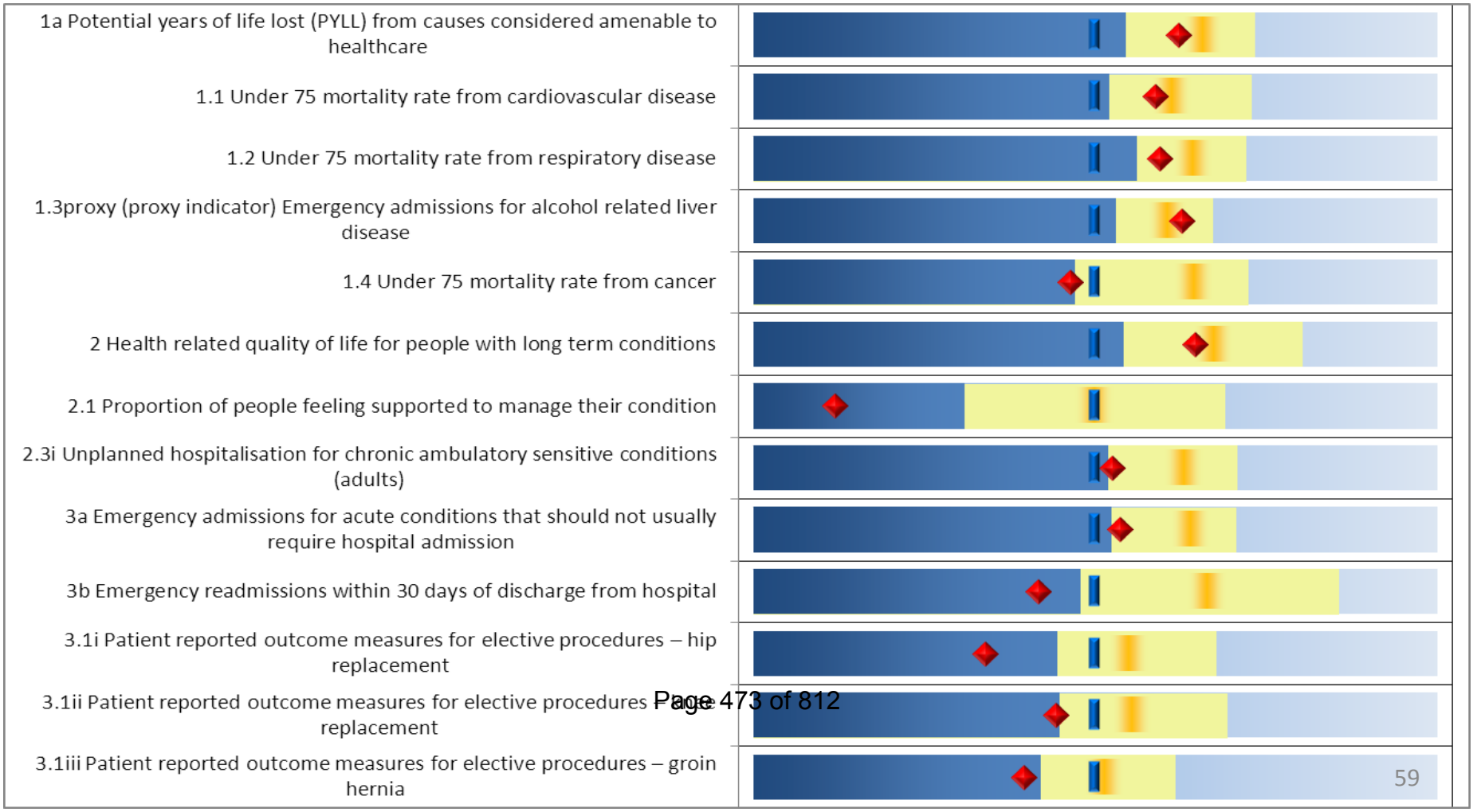
5.5 Improvement Interventions – Adults Transformation Programme

The adult programme is a key intervention that will contribute to an improvement in the outcome indicators below:

National Average

Peer Group Average

CCG Position



5.5 Improvement Interventions – Adult Transformation Programme – Productivity Opportunities

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
Working Age Adults	**ACS priorities (Under 75 only)**	Staggered implementation	2		585	401,000	(201,000)	200,000

5.0 Improvement Interventions – Transformation Programme

5.6 Children and Maternity Programme

5.6 Children's Health and Social Care Transformation framework

Principles

- Significant shift away from a hospital setting to home.
- Reviewing primary care to deliver consistent high quality care
- Connected transition of care between primary & community care
- Collaborative commissioning across the 0-19 pathway. Integrated pathways, shared outcomes.
- Ensuring early intervention and prevention through integrated approaches to pathway re-design and commissioning
- Ensuring safe and effective practice across all services
- Parent education materials and community care in the home to promote independence

Outcomes

- Children with LTCs such as asthma, diabetes & epilepsy will benefit from better management of care via community nursing & clearer clinical pathways.
- Reducing unplanned hospital stays, through provision of care closer to home where clinically appropriate.
- Preventing unplanned admissions from lower respiratory tract infections, which become serious.
- Improving the experience within maternity services and the patient experience in healthcare settings.
- Delivering safe care to children in acute settings.
- Children and young people are safe from harm and abuse

Priorities

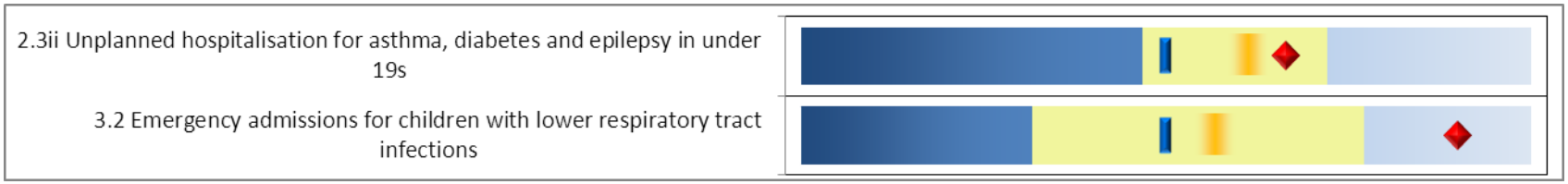
Provision of quicker responses to early indicators of risk through better provision of primary care.

- Better management of low level illness & LTCs in non-hospital settings.
- Better responses to crisis & acute episodes through more proactive primary & community care.
- Community safety - high rates of domestic abuse and social behaviour and the effects of crime on health.
- CAMHS – improving experience for young people and their families and thresholds for decision making
- Transitional care from children to adult services – forward planning with specialist skill from an early stage to support
- Strengthening Integrated Working, coordination of services and information sharing

5.6 Children's Services (Health and Social Care) Priorities

Priority	Key work-streams	Key dates
Paediatrics	Sustainable services incorporating Quality Review (Paediatric plan as part of Acute Strategy) Paediatric re-design (reducing down hospital admissions) – High impact pathways Reconfiguring services closer to home (integrated pathways of care)	June 2014
SEND reforms	To develop a Local Offer that is holistic and covers 0-25 education (provide clarity around how school based local offers will link to over-arching local offer for the area), training, transport, social care, health and support for employment and independent living. EHC Plans, joint assessment and provision Short Breaks/ Aiming High / provision of range of activities Short Breaks overnight residential review	September 2014 September 2014 Review 2014-15 re-commissioned 2016-17
Early Years Health visiting and FNP 5-19 Child Health	Review of Childrens Centres leading to re-commissioning 2016 Contract review for 2014/16. West Essex Early Years redesign. Transition plan agreed for HV & FNP to ECC Agreed approach to shared health and social care dashboard Agreed 5-19 plan and inter-dependencies	Re-commissioned April 2016 April 2015 September 2014 September 2014
Maternity	3 year sustainable maternity strategy Maternity review (incorporating quality and capacity review)	
CAMHS	Re-design of CAMHS Tier 2-3 services as part of Essex Wide re-procurement Define work – streams as per the project plan Integrate new design into local area services	To March 2014 March 2014-May April 2015
Safeguarding and domestic abuse	Identified joint priorities across safeguarding and domestic abuse	September 2014
Early Help offer	Focus on early intervention activities and approaches to prevent escalation of issues. Promotion of Essex Support for Children and Families in Essex Document and Shared Family Assessment	On going during 2014-15

5.6 Improvement Interventions – paediatric high impact pathways (indicators and measures)



WECCG are above national average and good within peer group for the < 19 unplanned hospitalisation for asthma, diabetes and epilepsy and for emergency admissions for children with lower respiratory tract infections, so there is limited improvement to be gained here.

Significant numbers of children access urgent care services within West Essex Hospitals when alternatives are available. Ensuring appropriate pathways for care are in place will facilitate timely and appropriate access to services.

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- The paediatric high impact pathways (HIP) workstream will focus on a small number of common conditions (including asthma and respiratory tract infections) which can be appropriately managed within the community and at home thus avoiding admission to hospital. Their use will embed a consistent approach throughout the clinical community, reducing inequalities within West Essex and promoting evidence-based practice.
- GP practices will be provided with p02 saturation monitors. This is following advice from consultation paediatricians stressing the importance of an accurate p02 reading when diagnosing respiratory conditions.
- A GP launch event and attendance at GP stakeholder meetings will build confidence and strengthen engagement to the HIP
- Parent education materials for HIP will be revised and circulated and a wider parental engagement programme, working with ECC Citizenship Programme, will be developed and form a winter 14/15 communication plan
- A workshop will take place between acute and community providers and commissioners to strengthen the pathways and clinical decision making at the front door and at discharge.
- Community nursing staff have attended Children's Assessment Knowledge Examination Skills (CAKES) training to enhanced quality of service delivery and ensure the child is seen in the appropriate location.

The diabetes best practice tariff will be reviewed to be included in the paediatric specification for 14/15 acute contract.

5.6 Improvement Interventions – cost opportunities

					2014/15	2014/15		
					Activity	**Financial Gross Savings £**	**Investment / reprovision £**	**Financial Net Savings £**
Childrens and Mat	High Impact Pathways	13/14 start	1		39	13,628	0	13,628
	Other childrens pathways	14/15 start	2		2,041	520,405	8	520,397

5.0 Improvement Interventions – Transformation Programme

5.7 Mental Health and Vulnerable Adults Programme

5.7 Improvement Interventions – Transformation Mental Health and Vulnerable Adults – Productivity Opportunity

Improving quality

Principles

- Improved outcomes through high quality evidence & practise based interventions.
- Build primary & community care resilience to prevent ill health.
- Ensure parity of esteem with physical health via public health & care services.
- Free up block contract payments to reinvest in primary care MH education & pathway development.
- Improved understanding of primary care referral patterns to support any further local commissioning decisions
- Ensuring patients treated in the right place at the right time in the most cost effective provision
- Develop integrated approach to addiction services in line with identified needs
- Agree practices that ensure "Parity of Esteem" for all services for citizens with mental health conditions

Outcomes

- Improved early intervention, with better patient experience.
- Reducing unnecessary bed use in acute & secure psychiatric wards.
- Maximising the potential of primary care MH services to maintain independence & quality of life.
- Strengthening the interface between mental & physical healthcare.
-

Priorities

- Better prevention of mental health through early intervention.
- More responsive to early signs of mental health through early intervention.
- Lower acuity mental health conditions to be treated in primary care setting
- Reduction in bed use wherever possible allowing more people to live independently.
- Better co-ordination of social & MH needs through strengthened interfaces between health & care providers.
- Better physical health for those with MH through strengthened interfaces between health & care providers.

5.7 Improvement Interventions – Transformation -Transformation Mental Health and Vulnerable Adults

Year 1 2014/15	Years 2 & 3 2015 - 17
Explore opportunities of joint commissioning with public health colleagues to support early intervention and community well being including families and carers.	Further development of primary care mental health including establishment of "hub" model. Roll out based on early implementers across North Essex. Need to incorporate second level education programme to support new function (required in-practice presence from secondary care & assignment of care workers).
Suicide prevention – commencing with pathfinder application led by Mid Essex – learning to be shared across North.	Development and implementation of GPwSI role – suggestion is to start with dementia. Proposal to work through Strategic Network to understand national practice and build on existing service models.
Establish North Essex Mental Health Clinical Network (likely locality forums) input into service and pathway redesign.	Implement Mental Health Redesign Programme - based on the findings of the 2014/15 review programme to enable the delivery of the strategy and local plans focussing on early intervention, community well-being, integration of physical and mental health services, rehabilitation pathways/recovery models and the provision of high quality specialist in patient services.
Development of a series of "Think Tanks" to explore across all providers opportunities for improvement. Suggestions to date: Urgent Care, Management of Long Term Conditions & Pain.	
Further development of IAPT, primary and community mental health services. National Funding/project management support sourced	
Development and roll out of Primary Care (General Practice) Mental Health Education Programme. Link to EQUIP and establishment of North Essex Mental Health Clinical Network.	
Commence Development of single point of access (primary care based). Business case to be produced for individual CCG/North Essex Pilot (6 months).	
Development of Personality Disorder Strategy for North Essex	
Preparation for joint procurement of new CAMHS tier 2 and 3 service.	
Repatriation programme for out of area placements	
Collaborative working with specialised commissioning for Personality Disorders and Locked Rehabilitation Services.	
Section 12 Procurement	
Contract discussions with NEP to support: ▪ Development of proposals to integrate service provision for patients with mental health and long term conditions. ▪ Improve access to consultant psychiatrists ▪ Establishing effective KPIs to improve quality, provision of data and clinical effectiveness	
Development of a comprehensive service review programme to explore and fully understand the provision of NEP services (community, CRHT/inpatient and dementia services), exploring opportunities for integration and to make recommendation for future delivery of the North Essex Mental Health Strategy and CCG locality plans via collaboration and contestability.	
Review of Mid Essex Recovery Pilot with potential roll out to other North Essex CCGs	

5.7 Improvement Interventions – Transformation Mental Health and Vulnerable Adults – Productivity Opportunity

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
MH & Vulnerable Adults	**Clusters 1-4**		2			1,696,919	(443,317)	1,253,602
	SPoA		2			99,000	(22,000)	77,000

5.0 Improvement Interventions – Transformation Programme

5.8 A Step Change in Elective Care

5.8 Improvement Interventions – A Step Change in Elective Care

We have recently undertaken a benchmarking exercise to review how productive we are across a number of areas of acute activity in comparison with better performing CCGs. Opportunities to improve productivity in elective care have been identified as follows:

Activity	14/15	15/16
Elective inpatient conversions from 1st outpatient attendances	√	
Follow up to first outpatient attendance	√	
First outpatient attendances referred by GP	√	
Day case procedure to outpatient procedure	√	
Reduction in MFF by shifting activity from London providers		√

The first phase of the working age adults work programme (ACS) has identified a number of procedures that can be carried out in a more accessible and lower cost setting than currently available in secondary care. A phased shift of this activity into a primary care setting will start in July of this year. The second phase will involve a review of ENT urology and MSK procedures.

A significant amount of west Essex elective activity currently goes into London Hospitals. The CCG will support PAH to repatriate some of this work over the coming years

	14/15	15/16 and beyond
ACS procedures, shifts to primary care	√	
ENT, Urology, MSK		√

5.8 Improvement Interventions – A Step Change in Elective Care

					2014/15	2014/15		
					Activity	Financial Gross Savings £	Investment / reprovision £	Financial Net Savings £
Primary Care	**Referral Management**	13/14 start	1		2,792	411,984	(24,000)	387,984
Contract Management	**Invoice Validation**		3		na	1,594,664	0	1,594,664
	Elective IP conversions from 1st outpatient led attendances		3			1,174,902	0	1,174,902
	Follow Up to First OP		3		18,303	1,435,431	0	1,435,431

5.0 Improvement Interventions – Transformation Programme

5.9 Review of Stroke Services

5.9 Improvement Interventions - Stroke

Current Position

The National Stroke Strategy 2007 outlines what is needed to create the most effective stroke services in England. The strategy identifies major stages in the stroke patient's pathway and stresses a need to reorganise the way in which stroke services are delivered. A whole pathway approach to the provision of stroke services is essential to maximising clinical outcomes, resultant quality of life and experience of stroke services. The first 72 hours of care is vital to ensure the optimum clinical outcome for stroke survivors, underpinned by an effective whole system pathway for assessment, discharge and repatriation to local stroke services, subsequent rehabilitation and longer term support.

The CCG is committed to delivering high quality stroke services to all of our population. Citizens in the south of our patch currently access high quality acute care within London Hyper Acute Stroke Units (HASU). Patients in the centre of our patch access care from Princess Alexandra Hospital and in the North of our patch from Addenbrookes. Although performance at PAH is improving, sustainable high quality care is always going to be challenging to provide from a relatively small DGH. Consistent good performance at Addenbrookes also seems challenging although with a larger footfall of patients it is likely that Addenbrookes will be able to achieve high standards of care 24/7 going forward.

The CCG has recognised the need to provide acute care (HASU) at scale, but also recognises the need to improve all components of stroke care. We are therefore about to conduct a local review of all stroke services across the pathway

Stroke Pathway Review	14/15				15/16			
	Qtr 1	Qtr2	Qtr3	Qtr4	Qtr 1	Qtr2	Qtr3	Qtr4
Conclude review for HASU inc consultation/engagement								
Conclude review of ASU capacity and performance and rehabilitation services								
HASU mobilisation and implementation								
New ASU/rehabilitation model mobilisation and implementation								

5.0 Improvement Interventions – Transformation Programme

5.10 Concentrated Centres of Excellence

5.10 Concentrated Care in Centres of Excellence

Our Vision, *" My Health, My Future, My Say"* 2014-2024 outlines how we plan to work with our acute sector and what we expect from them.

For patients with rare and complex health needs we want them to be able access the right clinical expertise from specialist centres of excellence such as cases for major trauma, severe stroke, rare cancers or complex child health care

Improving quality

Stroke	• The CCG is undertaking a review of all stroke services having acknowledged the need for immediate acute care to be provided from Hyper Acute Stroke Stroke Units (HASU)
Children	• The CCG commissions complex acute care for children from specialist centres of excellence at Cambridge and London hospitals
Trauma	• The CCG commissions major trauma care from specialist centres of excellence at Cambridge and London hospitals
Cancer	• The CCG commissions specialist cancer services in the main from London Hospital. Cancer services are under review in London and the CCG is contributing to this. Princess Alexandra Hospital is a specialist centre for cancer services.
Cardiac	• The CCG commissions specialist cardiac care from specialist centres of excellence at Basildon and London Hospitals

5.0 Improvement Interventions – Transformation Programme

5.9 Enablers

5.9 Enablers

To transform the local health and social care system we have acknowledged that we will have to work differently. Integrated commissioning and provision of services is key and our plans for this are described earlier in this plan. We also recognise certain enablers that are key to support our transformation. These are described below:

Supporting Transformation

Contracting	• Better sharing of risk within our provider supply chain to incentivise behaviours that are conducive to seamless integrated care • Aligning our CQUINs to improving patient outcomes • New methods og contracting including Accountable Lead Provider model • Longer contract to give time and commitment to transform • Contracting with primary care for a wider range of services	On-going
Contestability	• Supporting primary care to develop as a competitive provider in the market place • Encouraging acute, community and primary care providers to integrate as providers at scale • Growing the proportion of services that we commission from the voluntary sector • Use competition where it demonstratively helps us improve quality and outcomes for patients	June 2014
estate	• During 14/15 we will review the capability of the estate within each locality covering both community and primary care estate to support the demands that will be placed on it to deliver transformation. We will also work with Princess Alexandra Hospital to consider any impacts that our developments in our communities might have on the hospital estate.	Sept 2014
Workforce	• System workforce development strategy to support staff development and workforce planning to ensure that staff are available and trained to work in new ways and potentially at new points of care.	Sept 2015
IT	• Macro-System information strategy	Sept 2014
Organisational Development	• System leadership • Embracing CCG values • Staff development	On-going

5.9 Enablers - Digital/Data Assurance

The CCG is about to embark on a range of enabler programmes to support transformation (slide 5.11 outlines) On of these is the development of a system information strategy to be developed by September 2014. In the meantime key lines of enquiry are responded to as follows:

Line of Enquiry	Response
Patient reported outcome measurement – giving patients and carers the ability to manage and share data on their own care (what does this look like)	We will be reviewing this as part of the digital strategy that will be concluded in September 2014
care plans for patients with LTC are electronically linked to the GP health record	Patients will have an electronic coordinated care plan within GP records with a platform for other providers to access and input information. This is a key component of the ACS and Primary Care transformation programmes.
patients 'digital front door', NHS choices and information for empowerment of patients (who provides this?)	Provided via website and all public literature. Website refresh planned for 2014 to improve navigation for patients.
provision of Telehealth and telecare	This will be a key enabler to support expansion of primary care and the scope of services that they can offer.
implementation of health literacy (with Tinder Foundation) training people to use the internet and Care Connect.	We are working with NHSE with a view to becoming a pilot site for Care Connect
Has assurance been provided for data sharing protocols being implemented successfully or are planned to for sharing patient data.	This is a key component to our programme of work for provision of integrated care. Across our provider organisations. Our providers routinely implement data sharing protocols in line with PID governance to support delivery
Has assurance been provided for providers to comply with data standards for provision (care.data)	The CCG expects its providers to have Patient Data Governance Policies and will assure itself that these are in place through contract management processes
Has assurance been provided for 100% of GP practices to be linked to hospital data	Believe this programme has been put on hold
providers to be NHS number compliant through the Clinical Digital Maturity Index (CDMI) showing the scale of digitisation for each provider. Improvement must be shown for providers in the bottom quartile.	Data quality meetings take place routinely with providers to ensure that they are meeting the 90% target.

6.0 Financial Sustainability

In this section we give assurance that our plans are sustainable and affordable.

1. Financial Governance
2. Finance – the 5 year plan
3. Planning Assumptions
4. Running Costs
5. Transformation & Efficiencies
6. Contracts – Activity Plan
7. Contracts Summary
8. Contracts – Key points
9. Key Financial Risks

6.1 Financial Governance

The Director of Finance, Contracting and Performance has overall fiscal responsibility in the CCG and is responsible for ensuring that the organisation carries out its business within sound financial governance and that risk management arrangements are controlled and monitored through robust accounting mechanisms that are open to public scrutiny on an annual basis.

Assurance and scrutiny for financial performance and strategy, commissioning and contracting activities is within the remit of the Finance and Performance Committee, where monthly meetings provide the forum for highlighting existing and emerging risks to achievement of the financial position. Financial risks are escalated to the CCG Board via the Finance and Performance Committee.

The CCG's prime financial policies (Standing Financial Instructions) describe financial management arrangements for all areas of CCG expenditure, creditors, debtors, cash and capital assets. Financial performance reports are produced for internal and external stakeholders over the course of the financial year; these aim to ensure that the CCG is working within the resources available and to demonstrate the appropriate use of resources.

Financial risks of an operational nature are entered onto the CCG's risk register and reviewed monthly. Financial risks to the CCG's strategic objectives are managed through the assurance framework, these are reviewed bi-monthly. The most significant (red) risks and the assurance framework are reported to the CCG Board.

6.2 Financial Plan

The table on the right shows the summary of the CCGs' Financial Plan which demonstrates that the CCG is planning to achieve a 1% surplus in all financial years of the planning cycle.

The plan has been developed using the agreed national and local planning assumptions reflecting the expected changes in population, provider efficiencies and the impact of the Transformation and Efficiencies (T&E) programme assumptions as set out in the next slide.

In 2014/15 the CCG T&E target is set at £12.9m in order to achieve the required surplus. The plans are transformational and are limited to just 8 schemes (reduced from the 20+ schemes in place for 2013/14) under the 4 transformation work streams. Additionally there are benchmarked efficiencies which are to be delivered via contract management.

The CCG is planning to hold a 1% contingency (minimum national requirement is 0.5%) in each of the 5 years of the planning cycle. This will be used to address any potential financial risks as they arise in year. In addition, the CCG is planning to hold a 1% Transformation Fund in all financial years of the planning cycle.

The CCG has set aside 2.5% of the RRL in 2014/15 for non-recurring investments. In the CCG Plan The 2.5% investment fund is made up of the 1% transformation fund, the new investments reserve and the T&E headroom reserve.

NHS West Essex CCG	07H					
Financial Position						
Revenue Resource Limit						
£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Recurrent	318,299	329,814	342,959	351,887	361,010	370,366
Non-Recurrent	9,923	(1)	3,339	3,464	3,566	3,648
Total	328,222	329,813	346,298	355,351	364,575	374,014
Income and Expenditure						
Acute	186,345	177,401	165,995	158,198	151,017	143,882
Mental Health	31,653	30,238	30,168	30,062	29,984	29,910
Community	34,168	34,454	44,137	53,147	62,555	71,755
Continuing Care	16,061	17,915	24,437	25,521	26,673	27,723
Primary Care	43,237	43,915	45,712	47,206	48,794	50,437
Other Programme	9,517	11,305	20,841	25,845	29,848	34,223
Total Programme Costs	**320,981**	**315,228**	**331,290**	**339,979**	**348,871**	**357,929**
Running Costs	7,241	7,912	8,078	8,240	8,408	8,603
Contingency	-	3,334	3,465	3,566	3,648	3,739
Total Costs	**328,222**	**326,474**	**342,834**	**351,785**	**360,927**	**370,272**

£ 000	**2013/14**	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Surplus/(Deficit) In-Year Movement	(719)	3,339	125	101	82	94
Surplus/(Deficit) Cumulative	-	3,339	3,464	3,566	3,648	3,742
Surplus/(Deficit) %	0.00%	1.01%	1.00%	1.00%	1.00%	1.00%
Surplus (RAG)	AMBER	GREEN	GREEN	GREEN	GREEN	GREEN
Net Risk/Headroom		6,429	2,674	531	1,090	1,763
Risk Adjusted Surplus/(Deficit) Cumulative		9,768	6,139	4,096	4,738	5,505
Risk Adjusted Surplus/(Deficit) %		2.96%	1.77%	1.15%	1.30%	1.47%
Risk Adjusted Surplus/(Deficit) (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN
Contingency	-	3,334	3,465	3,566	3,648	3,739
Contingency %	0.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Contingency (RAG)		GREEN	GREEN	GREEN	GREEN	GREEN

6.3 Planning Assumptions

The table on the right details the planning assumptions that have been made by the CCG in developing the financial plan.

The plan has been developed using the agreed national and local planning assumptions reflecting the expected changes in population, provider efficiencies and the impact of the Transformation and Efficiencies (T&E) programme assumptions as set out within the plan.

The CCG is planning to achieve a 1% surplus in all financial years of the planning cycle.

The CCG has taken a prudent view on population growth and has planned for a rise of 1.54%, in contrast to the ONS forecasts which predicts a rise of just over 1% per year.

For Running Costs, the Target Cost per Head (excluding costs of NHS Property Services) for 2014/15 has reduced to £24.73 (from £25.00 in 2013/14) and from 2015/16 there will be a 10% reduction to decrease the indicative target to £22.07 per head.

Planning Assumptions

		2014/15	2015/16	2016/17	2017/18	2018/19
Allocation Growth (+%)	Programme	3.43%	2.57%	2.65%	2.63%	2.63%
	Running Costs	13.05%	-9.75%	0.28%	0.31%	0.33%
	Weighted Average	3.62%	2.31%	2.60%	2.59%	2.59%
Gross Provider Efficiency (-%)	Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
	Non Acute	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Provider Inflation (+%)	Acute	2.80%	2.50%	3.30%	3.70%	3.70%
	Non Acute	2.20%	2.30%	2.20%	2.20%	2.20%
Demographic Growth (+/- %)		1.54%	1.47%	1.45%	1.54%	1.55%
Non-Demographic Growth (+/- %)	Acute	0.00%	0.00%	0.00%	0.00%	0.00%
	CHC	0.00%	0.00%	0.00%	0.00%	0.00%
	Prescribing	0.00%	0.00%	0.00%	0.00%	0.00%
	Other Non Acute	0.00%	0.00%	0.00%	0.00%	0.00%
Contingency (%)		1.01%	1.00%	1.00%	1.00%	1.00%
Non-Recurrent Headroom (%)		2.50%	1.02%	1.02%	1.02%	1.02%
Running Cost (spend per head (£)		26.29	26.54	26.77	27.01	27.33

6.4 Running Costs

For Running Costs, the CCG has been notified that the Target Cost per Head for 2014/15 has reduced to £24.73 (from £25.00 in 2013/14)

From 2015/16 there will be a 10% reduction to reduce the indicative target to £22.07 per head.

On current spending plans the CCG will be exceeding its running cost allowance from 2015/16.

The table below outlines the CCG running costs position over the planning cycle.

Running Cost Allowance	2013/14 £'000	2014/15 £'000	2015/16 £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000
Notified Running Cost Allocation	7,000	7,016	6,332	6,350	6,370	6,391
Target Cost per Head (£/h)	25.00	24.73	22.07	22.07	22.07	22.07
Plan Estimated Running Cost	7,241	7,912	8,078	8,240	8,408	8,603
less: NHS Property Services	(1,060)	(1,080)	(1,099)	(1,119)	(1,137)	(1,160)
Revised Running Cost Expenditure	6,181	6,832	6,979	7,121	7,271	7,443
Under / (Overspend)	(819)	(184)	647	771	901	1,052
Population Size (000)	298	301	304	308	311	315
Spend per head (£)	20.74	22.70	22.93	23.13	23.36	23.64
Running Costs (RAG)		GREEN	RED	RED	RED	RED

6.5 Transformation & Efficiencies

The 2014/15 funding settlement has improved the plan position such that the T&E targets have reduced to 4.00% of the 2014/15 resource limit, from the 6.44% target in 2013/14.

Based on initial planning assumptions and subject to the outcome of the detailed contracting discussions, the T&E target for 2014\15 is set at £12.9m of which £0.95m is unidentified.

In 2014/15, the plans are transformational and are limited to just 8 schemes (reduced from the 20+ schemes in place for 2013/14) under the 4 transformation work streams. Additionally there are benchmarked efficiencies which are to be delivered via contract management. All schemes are subject to a business case review mechanism.

Delivery of the T&E is taken forward by Programme Boards and subject to scrutiny via the Finance & Performance Committee which holds the GP leads and commissioning managers to account if slippage occurs.

The T&E plan for 2015/16 is £12.37m and will be closely linked with the introduction of the Better Care Fund.

				2014/15 Activity	2014/15 Financial Gross Savings £	2014/15 Investment / reprovision £	Financial Net Savings £
Frailty (Older People)	Frailty - PAH Savings	13/14 start	1	1,222	1,834,002	(1,223,555)	610,447
	Frailty - Other Acute	13/14 start	1	386	555,941	0	555,941
	Hospice at Home	13/14 start	1	180	432,000	(278,407)	153,594
Childrens and Mat	High Impact Pathways	13/14 start	1	39	13,628	0	13,628
	Other childrens pathways	14/15 start	2	2,041	520,405	(8,500)	511,905
MH & Vulnerable Adults	Clusters 1-4		2		1,696,919	(443,317)	1,253,602
	SPoA		2		99,000	(22,000)	77,000
Working Age Adults	ACS priorities (Under 75 only)excludes OP procedures. (Gross scope includes estimate of OP procs.)	Staggered implement ation	2	585	401,330	(200,665)	200,665
Primary Care	Referral Management (Gross scope assumes 20% greater activity reduction	13/14 start	1	2,792	411,984	(24,000)	387,984
Medicines Management		13/14 start	1	na	300,000	0	300,000
Contract Management	Invoice Validation		3	na	1,594,664	0	1,594,664
	Elective IP conversions from 1st outpatient led attendances		3		1,174,902	0	1,174,902
	Follow Up to First OP		3	18,303	1,435,431	0	1,435,431
Productivity			4				
Unidentified			4		2,441,793		2,441,793
					12,912,000	**(2,200,443)**	**10,711,556**

6.6 Contracts – Activity Plan

Activity Plan - taken from CCG ProvComm First Submission (14th Feb 2014)

The activity plan is based on the forecast outturn activity for 2013-14 and then adjusted across the five years for:

- Predicted growth levels based on demographic change
- Activity reductions associated with transformation schemes not yet included

Activity Plan	2013/14 Baseline	2014/15 Plan	2014/15 Plan	2014/15 Plan	2014/15 Plan	2014/15 Plan
Elective						
Ordinary	7,516	7,632	7,744	7,856	7,977	8,101
Day Case	29,215	29,665	30,101	30,538	31,008	31,489
Non Elective	26,585	26,995	27,392	27,789	28,217	28,654
Outpatients						
Firsts	82,905	84,182	85,419	86,658	87,992	89,356
Follow Ups	239,538	243,227	246,802	250,381	254,237	258,177
A&E (All Attendances)	93,667	95,109	96,508	97,907	99,415	100,956
Referrals						
GP Referrals	58,784	59,690	60,567	61,445	62,392	63,359
Other Referrals	34,330	34,859	35,371	35,884	36,437	37,002
First OP following GP Referral	53,840	54,669	55,473	56,277	57,144	58,030

6.7 Contracts - summary

The CCG is the lead commissioner for the Princess Alexandra NHS Trust contract and also leads for Essex on the Barts Health NHS Trust contract.

The CCG is working towards 2014/15 contracts to be signed within the agreed timetable. This involves regular meetings on all aspects of the contract and strict timetables are in place.

The tariff for acute services has been adjusted to deliver a 4% efficiency requirement .

Pay and price inflation is assessed at 2.8% giving a net decrease adjustment of 1.2%.

The overview of contract values is detailed in the table on the right.

Contract value 2014/15		Total
		£000
Code	Trust	
RQW	The Princess Alexandra Hospital NHS Trust	97,705
R1H	Barts Health NHS Trust	20,446
RGT	Cambridge University Hospitals NHS Foundation Trust	20,471
RQ8	Mid Essex Hospital Services NHS Trust	10,521
RYC	East Of England Ambulance Service NHS Trust	9,530
RRD	North Essex Partnership University NHS Foundation Trust	24,019
RWN	South Essex Partnership University NHS Foundation Trust	30,450
		-
XXX	Other Contracts (less than £5m)	11,630
	Total	224,772
	Non NHS Contracts	11,311
	Total NHS & Non NHS Contracts	236,083

6.8 Contracts – Key Points

For **Elective Inpatients and Outpatients**, there are currently no planning expectations that an 18 week backlog clearance will be required in 2014/15.

Growth in **planned care** activity in non NHS providers is broadly flat against prior year. Essex CCGs have commissioned the services of a consultant in order to negotiate lower than PBR tariffs for activity where it can be shown that providers are primarily undertaking work of a lower case mix complexity compared to average

Current trends in **A&E** show an overall increase of A&E attendances through 2013/14, the CCG has factored in changes in counting due to changes in the redirection of patients at the front door of the PAH A&E department.

The current trends in **emergency inpatients** show a circa 8% year over year overall growth against prior year activity. The current expectation is that this growth in activity will be factored into activity plans plus an additional 1.54% before adjusting out for transformation programmes.

In setting out the **national tariff for 2014/15** NHSE have gone for a position of stability and consolidation, as a result there are very few amendments to tariff structures or risk shares. It is anticipated that there will be some significant amendments to national tariff for 2015/16, including the increased use of pathway payments as well as material changes to current rules on emergency thresholds and readmissions. At the time of writing, the details of these changes have not been notified to commissioners

6.9 Key Financial Risks

The principle financial risks facing the CCG in 2014\15 are:

1. **Allocations**

   There are a series of programme allocations for the CCG that are yet to be actioned recurrently by the Local Area Team, although the LAT CFO has confirmed that the Barts transfer will be recurring. These allocations total £3.57m and are incorporated within the financial plan and therefore provide a material risk if not forthcoming.

2. **Transformation & Efficiency Targets**

   The CCG's efficiency target in 2014/15 is set at £12.9 million of which £2.4m is unidentified.

   This represents a significant challenge and risk to the organisation and will require focussed implementation and monitoring throughout the year to ensure any risks to delivery are mitigated.

   Delivery will be monitored by the Finance and Performance committee as well as the Executive committee and clinically led programme boards.

3. **Prescribing**

   There exists price inflation risk in 2014/15 because the national guidance for prescribing price inflation was set considerably lower at 1.9% due to the PPRS agreement with the pharmaceutical industry on medicines prices. This figure has been used within the plan however, historically prescribing price inflation has been higher. In mitigation, the Medicines Management Programme Board will monitor the prescribing patterns throughout the year to oversee achievement of efficiency targets.

4. **Continuing Healthcare**

   The Continuing Care run rate associated with new care packages has grown very significantly over the past few years. It is anticipated that this will continue during 2014/15 and there is still a high risk that this area will overspend despite the substantial level of new funding that has been targeted in this area.

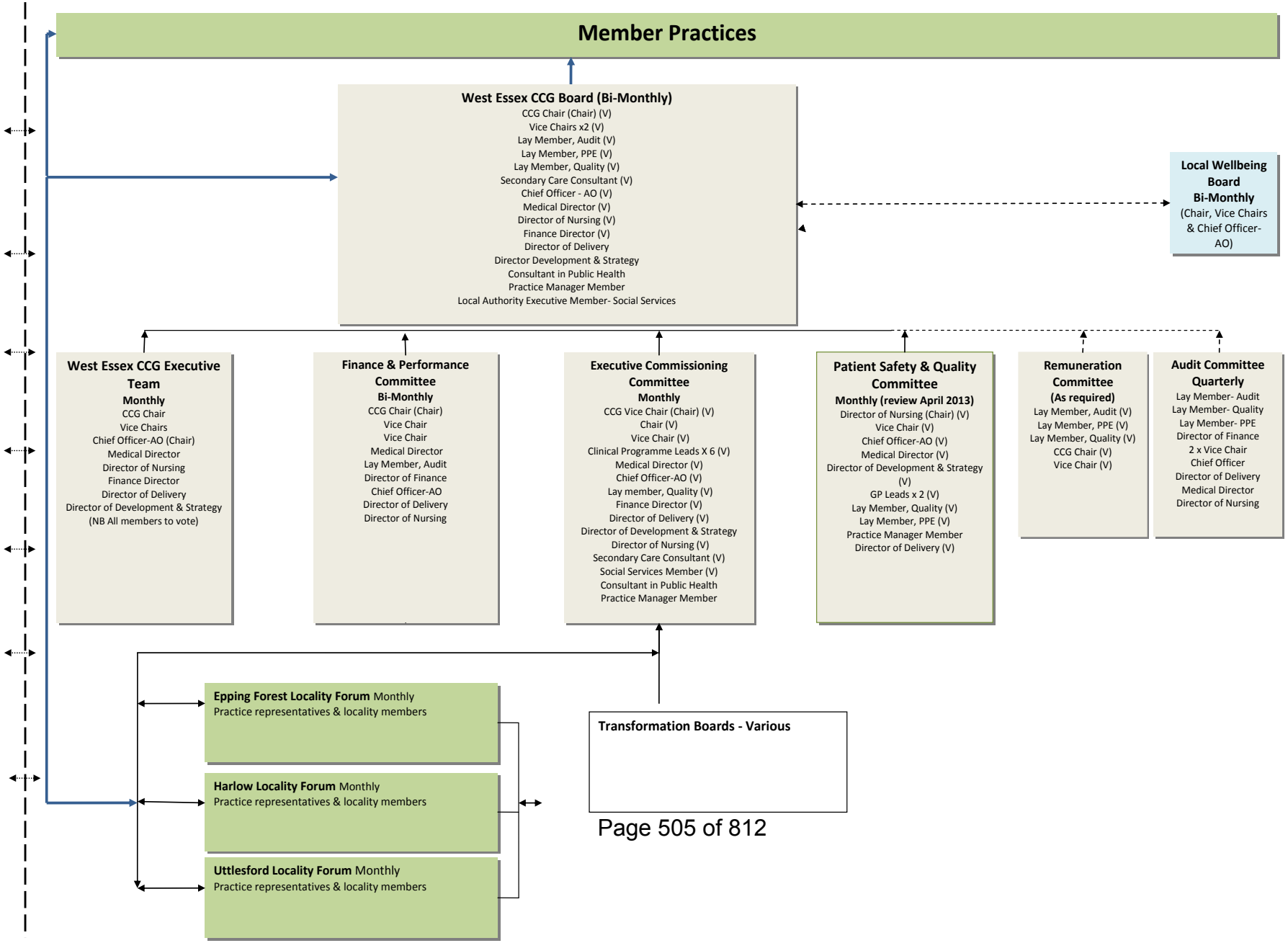
   The CCG has been recently notified by the NHS England Director of Financial Control that it will be required to contribute £1.254m to a risk share pool held centrally by NHS England to fund payments against historical CHC claims. This has been done on the premise that the CCG allocations for 2014/15 include the costs of settling legacy CHC provisions.

   The CGG has been notified that this contribution can counted against the 2.5% non-recurrent investment requirement.

8.0 Governance Overview

In this section we show the governance arrangements that we are proposing to ensure corporate decision making and assurance is given

8.0 Governance Overview (under review)



Essex County Council

AGENDA ITEM 5B

Report to Health & Wellbeing Board	**HWB/10/14**
Date of meeting 27th March 2014	**County Divisions affected by the decision** *All Divisions*
Title of report: Better Care Fund	
Report by Dave Hill – ECC Director for People Commissioning	
Enquiries to Sheila Norris, Director for Integrated Commissioning, ECC email Sheila.norris@essex.gov.uk telephone 01245 436269	

1. Purpose of report

1.1. To seek the Health and Wellbeing Board's (HWB) agreement to submit the attached Better Care Fund (BCF) templates to NHS England as required under NHS Planning Guidance by 4th April 2014.

2. Recommendations

2.1. Endorse the BCF (attached as appendices 2 & 3) for submission to NHS England by 4 April 2014.

2.2. Endorse the proposal contained within the BCF templates that ECC will hold the pooled budget

3. Background and proposal

3.1. The Government's intention is for NHS and local government services to become fully integrated. This was set out in ***Integrated Care and Support; Our Shared Commitment*** and recent guidance (December 2013 and February 2014) on the BCF, formerly Integration Transformation Fund. The shared commitment requires HWB areas to achieve integration within 5 years.

3.2. The BCF is intended by the government to help take forward health and social care integration at scale and pace, and to act as a catalyst for change. It should support better care for vulnerable people through greater integration of services and expansion of care in community settings. The BCF from 2015/16 is to be a single pooled budget for health and social care services to work closely together in local areas, based on a plan agreed between NHS organisations and local authorities. The BCF is a pooled fund consisting of NHS and local authority resources "already committed to existing core activity". NHS England has commissioned the development of a simplified control statement for use by both local government s151 officers and CCGs but this has not yet been received. Locally a finance officer technical sub group of the HWB BMG has been established to provide advice on the s75 arrangements including determining the hosting of the pool. The recommendation of this Technical Group is that ECC host the pooled fund. The BCF submission has a requirement to identify who will host the pool from 2015/16; there is a HWB BMG work programme to ensure implementation of the arrangements by 1 April 2015.

3.3. **Requirements**

3.3.1. HWBs need to agree 2 year BCF plans by 4th April 2014. In considering the BCF plans the HWB is required to consider whether "they are sufficiently challenging and will deliver tangible benefits to the local population (linked to the Joint Strategic Needs Assessment and Health and Wellbeing Strategy)"[1]

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3.3.2. The BCF plan is required to identify which organisation will hold the pooled fund. It has been agreed, in principle, to establish a pooled Better Care Fund from 1st April 2015 under section 75 of the National Health Service Act 2006 and for Essex County Council to host on behalf of all partners.

3.3.3. The plans are required to meet 6 national conditions:

- Jointly agreed plans
- Protection for social care services
- 7 days services (discharge and avoidance of unnecessary weekend admissions)
- Data sharing (based on NHS number)
- Joint assessments and care planning with accountable named professional
- Agreement on consequential impact of changes on the acute sector.

3.3.4. The table below sets out the BCF allocations for 2014/15 both nationally and for Essex HWB. It also demonstrates the value of the 2015/16 pool that is subject to achievement of performance.

[1] Annex to the NHS Planning Guidance, December 2013

Better Care Fund

	2014/15		2015/16 - Minimum		2015/16
	National	Essex HWB	National	Essex HWB	Actual Contribution
	£000's	£000's	£000's	£000's	£000's
NHS Transfer to Social Care (£859m 13/14)	900,000	22,199	900,000		
Better Care Fund allocation (14/15)	200,000	4,932	200,000		
DH & other Government Department					
Transfers (Capital Grants)			134,000	3,296	3,296
Disabled Facilities Grant			220,000	4,713	4,713
- reablement funding			300,000		
- carers' break funding			130,000		
- core CCG funding			1,916,000	86,947	91,228
Total	**1,100,000**	**4,932**	**3,800,000**	**94,956**	**99,237**
Total BCF revenue funding potentially subject to pay for performance measures				**25,129**	**25,129**

Notes re pay for performance:

1. 50% pay for performance will be paid April 2015 based on achievement of the following metrics:
   - delayed transfers for care from hospital per 100,000 population
   - avoidable emergency admissions
   - local metric (Essex=coverage of reablement)

   plus 4 of the national conditions:
   - protection for adult social care services
   - providing 7 day services to support patients being discharges/prevent unnecessary admissions
   -agreement on impact on acute sector
   - ensuring there is an accountable lead professional for integrated packages
2. 50% paid in October 2015 against all national and local metrics
3. Pay for performance monies only relate to the **minimum** contribution into the BCF

3.3.5. The BCF plans are part of the wider NHS planning framework which includes

- 2 year operational plans which are also due to be submitted in final form by 4th April 2014 following HWB endorsement (a separate item on this agenda), and
- 5 year strategic plans to be submitted in draft by 4th April 2014 and in final form by 20th June 2014.

CCGs are required to involve ECC in the development of both sets of plans.

3.3.6. The BCF submission involves the completion of a template covering the HWB area. There is a narrative section covering vision, aims and objectives and sections showing how Essex has met the BCF requirements including provider and service user engagement; fulfilment of the national conditions set out above; planned changes to services covering the BCF schemes; implications for the acute sector of these changes; governance and risks. The rest of the submission covers metrics: baselines and targets proposed against the required and local agreed measures; and details of BCF investment with expected financial benefits.

3.3.7. The BCF Plan is necessarily high level. Each CCG has therefore produced its own plan for BCF. These have informed the Essex submission and set out details of how each CCG has developed its plans locally with providers and

service users, the schemes in which investment is planned and the benefits these will deliver.

3.4. Essex BCF template

3.4.1. The final versions of the BCF template Part 1 and Part 2 are attached for the HWB to endorse for submission to NHS England. Progress in completing the template has been driven and monitored by the Business Management Group (BMG) of the HWB. It was agreed that the broad headings for schemes that should be included in Essex's BCF were:

Protection of Social Care Services with a health benefit
The local authority and NHS commissioners will work together to bring sustainability to the health and social care system.

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Community Health services including admission avoidance
Development of new provider models between community health, community care and primary care providers.

Reablement
Over the two years of the BCF we intend to;

- Continue to fund reablement and intermediate care services
- Expand reablement and intermediate care capacity in each CCG area to meet demand and increase community-led referrals.
- Vary existing social care reablement arrangements during the current contract to commence integrated health and social care reablement in each CCG area during 2014/15.

Joint Nursing and Care Home commissioning (Including Continuing Health Care)
We will review commissioning for Nursing and Residential Care Commissioning in each CCG area with a view to shifting the pattern of care towards a reablement model of service, which seeks to improve independence and functioning and which minimises inappropriate admission to service.

Discharge support
Essex Social Care Services and Acute Hospital providers in Essex will continue to work together and with Community Health providers to ensure effective discharge support. We will use our investment in reablement to promote ward led discharge, development of rapid response services and to ensure assessment is taking place at the appropriate time in the appropriate environment.

Acute Mental Health and Dementia
Mental health is a key priority with rising demand for mental health services.

We are seeking to implement the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services.

Primary Care (Including the requirement for GPs to be accountable for improving quality of care in older people)
We expect Primary Care to form the basis of care coordination for Health and Social Care services.
We will establish Multi-Disciplinary Teams where GPs will be at the centre of organising and coordinating people's care alongside social care and other health professionals and the service users themselves.

Investment to meet requirements of the Care Bill
We will work together as a system to define the requirements of the Care Bill using a joint programme management approach during 2014/15 to prepare for the changes required in 2015/16.

Early intervention and prevention
We aim to identify needs early and intervene to prevent escalation of problems and crises.

Community resilience:
We want to strengthen and mobilise communities to take on a greater role in caring for vulnerable people.

Carers
Carers will receive support at the right time and in the right place to enable them to maintain their caring role and their own health and wellbeing.

Disabled Facilities Grant (DFG)
The DFG is included in the capital element of the fund which comes into play in 2015/16. While no changes are planned immediately, BCF provides an opportunity to explore a holistic approach to improve the process from Occupational Therapist assessment through to DFG in the medium term.

The Plan includes details of how Essex complies with national conditions or sets out how we will ensure that we can do so before the commencement of the BCF in April 2015.

3.5. The Essex Better Care Fund Plan has been written taking account of feedback from service providers and consultation with patients / service users following a series of engagement events. This has included:

- Essex Health and Social Care Integration Accelerated Design Event in June 2013 involving ECC, the CCGs, providers and voluntary sector organisations.
- The consultation undertaken by the ‘Who Will Care?’ commission in 2013

- CCG provider engagement events throughout December 2013 and January 2014
- NEECCG Big Care Debates held throughout December 2013 and January 2014 involving patients and service users.
- CCG public engagement events under the “Call to Action” in December 2013

The draft BCF Plan has been revised following feedback from HWB in February and following the dual assurance process governed by NHSE through the Local Area Team and by the Local Government Association (LGA). The feedback Essex received through the assurance process was largely positive. The Essex submission was rated “green” in 20 of the 27 sections assessed, “amber” in 4 and “red” in the remaining 3.

The 7 areas of the BCF plan that needed improvement have been revised to address the points raised. The most significant of these relate to:

- the implications of BCF plans for the acute sector
- the scale of ambition for the BCF targets on reduction of emergency admissions and the effectiveness of reablement.

We believe that further work is needed to model the impact of BCF schemes on the Essex population and health and wellbeing system. This will enable us to estimate and describe with more confidence the likely impact of BCF plans and the scale of ambition we can aim to achieve from 2015. This work is now being scoped and timescales for delivery are set out in the BCF submission. The Plan also includes actions and timescales to agree the most appropriate and effective governance for the BCF. We will report back to the HWB on the progress of this work and its implications for our BCF plans.

The inclusion of action plans to address outstanding issues is in line with the latest BCF guidance from NHS England issued on 24th February 2014. This states that further refinement and development of the BCF may take place after 4th April 2014 submission.

3.6. **Conclusions**

Having revised the BCF draft plan and taken account of feedback from NHS England (Local Area Team and local government peers) through the assurance process, we recommend this is now endorsed by HWB. In doing so we recognise that there are aspects of our BCF plans which, in common with other areas, require further work and refinement. In these instances action plans with clear timescales have been included in the template. There will be further reporting to HWB on progress in implementing these plans and preparation for the pooled fund in 2015/16.

4. Policy context

4.1. The plans and BCF submission are aligned with the Joint Health and Wellbeing strategy. The Health and Wellbeing Vision for Essex is “By 2018 residents and local communities in Essex will have greater choice, control, and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.” The priorities for achieving this vision are:

- Starting and developing well: ensuring every child in Essex has the best start in life.
- Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life.
- Ageing well: ensuring that older people remain as independent for as long as possible.

The BCF plan supports the achievement of these priorities through schemes that support individuals to be more independent, for as long as possible, and by supporting timely discharge from hospitals with appropriate care and support packages.

4.2. The plans and BCF submission also have direct relevance to the whole system leadership role of the Board and the challenge of integrating health and social care commissioning.

4.3. Revised arrangements for community health and community care will form a core part of the implementation of revised assessment and case management arrangements for people entitled to a service from social care services. In particular the implementation of the Care Bill will entail the development of a ‘Care Coordinator’ role across health and social care organisations dealing with community care. This may require additional resources during a period of transition whilst integrated approaches are developed.

4.4. Nationally £185m (£50m capital and £135m revenue) has been made available in the 2015/16 BCF to invest in the development of capacity to manage information between organisations including case management systems and the development of mechanism to give access to virtual or actual patient records between organisations. This funding also covers the requirements for better information and advice, advocacy and safeguarding and other Care Bill duties. For ECC the national funding translates to £1.1m capital and £3.3m revenue.

5. Financial Implications

5.1. The BCF was announced in June 2013 providing an opportunity to transform local services so that people are provided with better integrated care and

support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The fund provides for £3.8bn of funding in 2015/16 to be spent locally on health and care to drive closer integration, to improve outcomes for patients, service users and carers.

In 2015/16 the fund will be created from:

- £1.9bn of NHS funding,
- £354m of capital funding (including £220m DFG, currently allocated to second tier authorities)
- £1.1bn existing transfer from Health to Adult Social Care,
- £300m CCG Reablement funding
- £130m Carers' break funding.

5.2. Detailed guidance in respect of the BCF was issued on 19 December 2013 alongside the CCG allocations for 2014/15 and 2015/16.

5.3. In 2014/15 an additional £200m will be added to the nationally available funding for transfer from Health to Adult Social Care. This additional funding is to enable localities to prepare for the BCF in 2015/16 (for ECC this totals £4.932m and will be transferred via a s256 agreement from NHS England Local Area Team). There are no extra conditions attached to this money but it will only be paid when local authorities have jointly agreed and signed off two-year plans for the BCF. It must be used to make early progress against the national conditions and performance measures set out in the locally agreed plan in order to secure the performance element of the 2015/16 BCF.

5.4. In 2015/16 the BCF will be a pooled budget under s75 joint governance arrangements between CCGs and ECC. NHS England has commissioned the development of a simplified control statement for use by both local government s151 officers and CCGs but this has not yet been received. Locally a finance officer technical sub group of the BMG was established to provide advice on the s75 arrangements including determining the holding of the pool, taking into account factors such as tax advantages/disadvantages of the local authority or a CCG. The technical group's recommendation that ECC be the pooled fund host was agreed by the BMG on 5th March and is included in the BCF final submission.

5.5. The guidance highlights some areas within the BCF national allocation against which there should be clear plans to ensure no deterioration of existing services (Essex figures in brackets).

- £130m NHS funding for Carers' breaks (£3.267m).
- £300m NHS funding for Reablement services (£7.539m).
- The DFG has been included to ensure that the provision of adaptations/equipment to properties can be incorporated into strategic plans. But the statutory duty to provide DFG to those who qualify for it remains with local housing authorities, and funding will have to be allocated from the BCF to the district councils to enable them to continue to meet their statutory duty.

There will be other conditions around the DFG, including timely payment, spending the grant within the year and minimum allocation levels (£4.713m).

- £50m of the capital and £135m revenue funding has been earmarked for a range of new duties coming in from April 2015 as a result of the Care Bill, including ensuring an appropriate IT system is in place £4.398m.

5.6. From 2015/16 an annual financial benefit of £1m has been identified from functions that transfer into the BCF.

5.7. Further work will be undertaken to identify the level of financial benefit. As part of this work the financial risks and contingency arrangements will be finalised.

5.8. Three of the CCG's have identified financial contingency values if there is a failure to deliver the financial benefits associated with the BCF. Two of these values relate to a QIPP saving which sits outside the BCF and therefore any failure to deliver would need to be addressed by that specific CCG. The other is an element of the benefit relating to a scheme within the BCF, should this failure to deliver the identified benefit the consequence would be that element of the total benefit would not be available for re investment in the pool.

5.9. The risk of 'penalties' for failure to deliver on BCF targets in 2015/16 has been removed. It has not yet been decided whether to hold cash back based on performance from 2016-17 and beyond.

6. Legal Implications

6.1. The BCF represents additional central government funding. For 2015/16 the conditions of entitlement for funding require the Council and clinical commissioning groups to establish partnership arrangements including a pooled fund under section 75 of the National Health Service Act 2006. This fund is to be spent jointly by the Council and clinical commissioning groups in accordance with the agreed partnership arrangement. Such arrangements can only be established by negotiation and agreement, and agreement in this case is likely to be reached. It will be necessary to have a formal legal agreement which sets out the purposes of the fund and how it will be governed and administered. Approval of theS.75 agreement will need to be considered in accordance with the decision making processes of the Council and each clinical commissioning group.

6.2. NHS England view the HWB as having a crucial role in ensuring that the BCF is set up in the best way possible to meet local needs. Although the decision recommended in this report relates only to a proposal which is draft and, to some extent, incomplete, it is clear that this endorsement is also regarded by NHS England as key. The Board will be invited to endorse the final proposals in March 2014.

6.3. Some of the funding is conditional upon performance measures being attained and the parties need to assess the prospects of receiving this money and ensure

that there are arrangements in place for performance monitoring and the management of risk.

7. Staffing and other resource implications

7.1. Any staffing and resource implications for CCGs will be addressed in their operational plans.

7.2. The staffing implications for ECC will be assessed during the design and development of individual BCF schemes. It is expected that, in order to meet the BCF National Condition of 7 day working, assessment staff working arrangements may need to be modified.

8. Equality and Diversity implications

8.1. There are no equality and diversity implications relating to the BCF template and plans.

8.2. Appropriate assessments will be carried out as and when schemes and services are set up to deploy the BCF funding.

Attached papers

Appendices:

- ✓ Appendix 1 - BCF High Level Action Plan
- ✓ Appendix 2 - Better Care Fund Part 1 Template
- ✓ Appendix 3 – Better Care Fund Part 2 Template

Other Supporting Documents:

- ✓ Outcomes and Metrics - CCG Details
- ✓ NEECCG BCF Template – Part 1
- ✓ NEECCG BCF Template Part 2
- ✓ WECCG BCF Template – Part 1
- ✓ WECCG BCF Template Part 2
- ✓ MECCG BCF Template – Part 1
- ✓ MECCG BCF Template Part 2
- ✓ BBCCG BCF Template – Part 1
- ✓ BBCCG BCF Template Part 2
- ✓ CP&RCCG BCF Template – Part 1
- ✓ CP&RCCG BCF Template Part 2
- ✓ Health and Social Care Integration (Accelerated Design Event)
- ✓ The Seven Day Services Improvement Programme
- ✓ “Who Will Care” Report

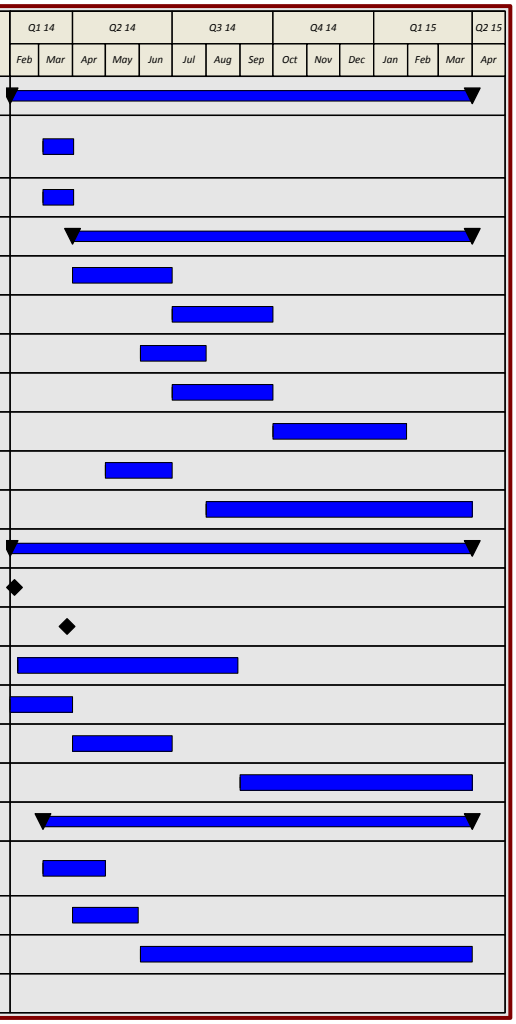
Appendix 1- BCF High Level Action Plan

High Level Action Plan to Support Essex BCF Planning Activity

ID	Task Name	Start	Finish	Duration
1	**Impact on Acute Sector**	**03/02/2014**	**31/12/2014**	**238d**
2	Complete Acute Contract Negotiations	03/02/2014	31/03/2014	41d
3	Identification of functions that impact on Acute Sector	01/04/2014	30/04/2014	22d
4	Modelling of BCF Functions to Acute Activity	03/02/2014	30/06/2014	106d
5	Define Contingency Plans based on outcomes of Acute Sector Modelling / BCF Schemes	01/07/2014	30/09/2014	66d
6	Evaluation of 2013/14 s256 Demand Management Schemes	02/06/2014	31/12/2014	153d
7	**Governance and Pooled Budgets**	**03/02/2014**	**27/11/2014**	**214d**
8	Creation of Governance & Pooled Budgets Task & Finish Group	03/02/2014	28/02/2014	20d
9	Scoping of Partnership Agreements and Functions to be Delegated	01/04/2014	30/04/2014	22d
10	Financial Arrangements and Legal Protocols	01/05/2014	30/09/2014	109d
11	Agree and set up quarterly BCF Monitoring arrangements	01/04/2014	30/06/2014	65d
12	Agree and set up HWB Programme Board twice yearly BCF review	01/04/2014	30/06/2014	65d
13	Review TORs of existing HWB to take account of Programme Board role	01/04/2014	30/06/2014	65d
14	Review TORs of HWB following proposed legislation changes	01/09/2014	27/11/2014	64d
15	**Service User and Provider Engagement**	**05/03/2014**	**29/04/2015**	**301d**
16	Further CCG led engagement throughout 2014/15	01/04/2014	29/04/2015	282d
17	ECC Community Resliience Engagement Event	01/04/2014	30/04/2014	22d
18	Further ECC engagement Events	01/05/2014	31/03/2015	239d
19	**Healthwatch Engagement**	**05/03/2014**	**31/03/2015**	**280d**
20	Agree scope of Essex Healthwatch in future Engagement with Service Users	05/03/2014	01/05/2014	42d
21	Develop Service User Engagement Plan	01/05/2014	30/05/2014	22d
22	BCF Focussed Engagement	02/06/2014	31/03/2015	217d
23	Healthwatch Hospital Discharge research	01/04/2014	31/03/2015	261d
24	Healthwatch Carers Experience Research	01/04/2014	31/03/2015	261d

High Level Action Plan to Support Essex BCF Planning Activity

ID	Task Name	Start	Finish	Duration
1	**BCF National Conditions**	**03/02/2014**	**31/03/2015**	**302d**
2	Define scope for Task & Finish Group for County Wide approach to National Conditions	05/03/2014	01/04/2014	20d
3	Agree resources for Task & Finish Group	05/03/2014	01/04/2014	20d
4	**7 Day Working**	**01/04/2014**	**31/03/2015**	**261d**
5	Identify functions and services that will be affected	01/04/2014	30/06/2014	65d
6	Negotiate contract variations where required	01/07/2014	30/09/2014	66d
7	Create Project Teams in each Service Affected	02/06/2014	31/07/2014	44d
8	Create Action Plan to Implement 7 Day Working	01/07/2014	30/09/2014	66d
9	Identify skill gaps / training requirements	01/10/2014	30/01/2015	88d
10	Create communications plan	01/05/2014	30/06/2014	43d
11	Employee and Trade Union Consultations	01/08/2014	31/03/2015	173d
12	**Data Sharing / IG / NHS Number**	**03/02/2014**	**31/03/2015**	**302d**
13	County Wide Task and Finish Group Created	07/02/2014	07/02/2014	0d
14	Information Sharing Protocol Launch Date	27/03/2014	27/03/2014	0d
15	Create County wide Project Teams as required	10/02/2014	29/08/2014	145d
16	Create High Level IS Plan	03/02/2014	31/03/2014	41d
17	Create Detailed Action Plan for Data Sharing National Conditions	01/04/2014	30/06/2014	65d
18	IS Implementation	01/09/2014	31/03/2015	152d
19	**Disabled Facilities Grant**	**05/03/2014**	**31/03/2015**	**280d**
20	Agree County wide Task & Finish group to develop enhanced DFG services(including tier 2 councils)	05/03/2014	30/04/2014	41d
21	Define Scope for Task and Finish group for DFG	01/04/2014	30/05/2014	44d
22	Develop DFG proposals	02/06/2014	31/03/2015	217d
23				



Appendix 2 Better Case Fund Part 1 Template

Essex - Better Care Fund planning template – Part 1

CONTEXT

Essex Health and Wellbeing Board is committed to ensuring the people of Essex experience high quality and consistent health and care outcomes. We aim to commission and deliver integrated care that is person centred, closer to home and leaves people in-control. We want residents and local communities to have greater choice, control and responsibility for health and wellbeing services. As far as possible we seek to prevent problems occurring and to intervene before these escalate, or become entrenched. To help achieve this aim we are committed to developing more effective community based services and helping communities to play a greater role in supporting those with health and care needs.

The Essex Health and Wellbeing Board covers an area with a population of 1.41 million. Essex has a two tier local authority system with ECC responsible for social care services and five CCGs for the health economy.

The Clinical Commissioning Groups are:

- North East Essex CCG (NEECCG) covering the second tier local authorities of Colchester and Tendring;
- Mid Essex CCG (MECCG) covering the local authorities of Chelmsford, Maldon and Braintree;
- West Essex CCG (WECCG) covering the local authority areas of Harlow, Epping Forrest and Uttlesford;
- Basildon & Brentwood CCG (BBCCG) covering the local authorities of Basildon and Brentwood; and
- Castle Point & Rochford CCG (CP&R CCG) covering the local authority areas of Castle Point and Rochford.

The second tier local authorities are responsible for Housing in their areas and also for discharging the legal responsibilities relating to the Disabled Facilities Grant (DFG).

The county is serviced by five acute hospitals, these are:

- Colchester University Foundation Trust Hospital (CHUFT);
- Mid Essex Hospital Services NHS Trust, Chelmsford;
- The Princess Alexander Hospital NHS Trust, Harlow;
- Basildon and Thurrock University Hospital NHS Trust, Basildon (BTUH); and
- Southend University Hospital NHS Trust, Southend (SUHFT).

BTUH is located in the BBCCG area and serves both BBCCG and Thurrock CCG (TCCG). SUHFT is located in the Southend CCG (SCCG) area and services both SCCG and CP&R CCG.

Our plans have been made in a challenging financial climate. Funding received from central government for both social care and health will continue to reduce in real terms as demand for services increases due to population growth and demographic change.

Health and Adult Social Care services in Essex collectively spend around £2.5bn each year. Essex County Council's net revenue budget for 2014/15 is £931.8m, of which £378.0m is spent on Adult Social Care (41%). With pressure from an increasing population amounting to £13.4m and inflation of £11.2m in 2014/15 there is a need to maximise savings through joining up services with health partners and through working closely with the care providers to develop services which focus on early intervention, enablement (to ensure vulnerable adults can maintain their independence for as long as possible in the community) and rehabilitation to reduce the need for long term care. Over the next three years £73.2m of savings are currently planned to be delivered across Adult Social Care to mitigate demand and inflation pressures; this will necessitate working very differently[2]. The five CCG's under the Essex Health & Wellbeing Board have a combined budget of £1,631.0m for 2014/15[3], but in order to make the budget balance have to make savings in the region of £84.0m[4] (5%) next year.

We recognise that the only way to ensure financial sustainability within the Essex care system is for health and social care to work together in a more integrated way.

[2] ECC Budget Book 2014/15
[3] Source: NHSE Total CCG Programme Budget Allocations 2014/15.
[4] Health and Social Care Integration Workshop 18-19 June 2013, page 7

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**North East Essex CCG**
	West Essex CCG
	Mid Essex CCG
	Basildon & Brentwood CCG
	Castle Point & Rochford CCG
Date agreed at Health and Well-Being Board:	**Final version 27/03/2014**
Date submitted:	**Final version 04/04/2014**
Minimum required value of BCF pooled budget: 2014/15	**£4,932,000**
2015/16	**£94,956,000**
Total agreed value of pooled budget: 2014/15	**£4,932,000**
2015/16	**£99,237,000**

Boundary Differences:

Our plans have been formed taking full account of the boundary differences set out below. Where there are differences, we have collaborative arrangements in place to ensure that the people of Essex experience consistent and high quality services and outcomes. Significant progress has already been made towards the integration of commissioning arrangements across the seven Essex CCGs and Southend, Essex and Thurrock Local Authorities. For example, Learning Disabilities and Mental Health Services are making gains in service improvement through joint commissioning.

Whilst the focus of our plan is the Essex HWB footprint, we are actively working with other stakeholders outside our HWB's borders on broader initiatives and the local arrangements we have put in place support this process.

South West Essex/South East Essex sub economies
Neither Basildon & Brentwood CCG nor Castle Point & Rochford CCG is the sole commissioner for its main acute provider. In the South East Essex health system, CPR and Southend CCGs share lead acute, mental health community and voluntary providers. It is crucial therefore that the CCGs continue to collaborate and jointly plan to deliver shared system priorities for inclusion in their respective Operational and

Strategic Plans. All parties are seeking to achieve similar outcomes and recognise that there will need to be continuous collaboration and shared planning between South Essex, Thurrock and Southend.

They recognise the importance of giving clear direction to providers and the market place. Existing forums (i.e. Unplanned Care Boards that operate in both sub economies) provide a mechanism to ensure that there is consistency in the operational delivery of commissioned services.

The planning footprint for CPRCCG and BBCCG is aligned with ECC to support and ensure our health and social care services work closely together in our local areas. ECC are interested in working to a South Essex (County Council) planning model creating close working alliances between the two CCGs and ECC in the development of our health and social care BCF integrated plans.

b) Authorisation and signoff

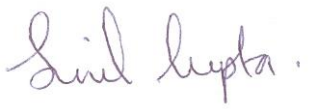
Signed on behalf of the Clinical Commissioning Group	**North East Essex CCG**
By	Will not sign until after the CCG Board meeting on 25th March 2014
Position	
Date	

Signed on behalf of the Clinical Commissioning Group	**West Essex CCG**
By	Clare Morris 
Position	Chief Officer
Date	17th March 2014

Signed on behalf of the Clinical Commissioning Group	**Mid Essex CCG**
By	Caroline Rassell (by email)
Position	Interim Accountable Officer
Date	17th March 2014

Signed on behalf of the Clinical Commissioning Group	**Basildon & Brentwood CCG**
By	Tom Abell 
Position	Chief Accountable Officer

Date	14th March 2014

Signed on behalf of the Clinical Commissioning Group	**Castle Point & Rochford CCG**
By	Dr Sunil Gupta 
Position	Chief Clinical Officer
Date	18th March 2014

Signed on behalf of the Council	**Essex County Council**
By	Dave Hill (by email)
Position	Executive Director for People Commissioning
Date	14th March 2014

Signed on behalf of the Health and Wellbeing Board	**Essex Health & Wellbeing Board**
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We recognise that it is only by tackling the challenges we face as a health and social care economy on a system-wide basis that we will achieve transformational change. We have therefore developed our plans for BCF with local health and care providers and will work closely with our providers to implement our transformation programmes, making effective use of clinical networks and system leadership groups.

This strategic engagement with our providers is well-established. For example, a whole system engagement event was held in June 2013 involving voluntary sector, health and social care providers, local authorities and CCGs to define our vision for what integration could look like in Essex. Details can be found *in "Health and Social Care Integration"* (see Related Documentation section). We have continued to develop our plans with providers over recent months. In particular engagement events took place to develop BCF plans during December 2013 and January 2014 and work will continue in the year ahead.

On a locality basis extensive and on-going engagement has taken place with service providers to create local visions for jointly commissioned services. These are set out in detail in individual CCG plans. Examples include:

- South Essex Partnership University NHS Foundation Trust (SEPT) is lead provider with an integrated supply chain which will include other health and social care providers including Princess Alexandra Hospital, Essex Cares Ltd, and North Essex Mental Health Trust. Aspirations for the accountable lead provider

programme are to develop the supply chain further and expand the role of the voluntary sector.

- In West Essex, health and social care organisations have agreed to develop and test a new way of working that delivers integrated commissioning and provision of services. The West Essex BCF plan focuses on the Integrated Frailty Programme as this is the first pathway to be developed. As this pathway is in its early stages of development it is likely that scope will extend beyond the detail and funding of the BCF plan. The Integrated Frailty Programme will be commissioned jointly by WECCG and ECC and be provided by SEPT as accountable lead provider with an integrated supply chain including Essex County Council, Princess Alexandra Hospital, Essex Cares, Primary Care, Ambulance Service, North Essex Mental Health Trust and voluntary sector, with aspirations to develop the supply chain further and expand the role of the social care sector. All organisations have been involved in the development of this plan
- In North East Essex the CCG has discussed its vision and commissioning intentions with all main providers at Board and Leadership Team level. This includes acute, community and mental health service providers (eg meetings held 8th, 23rd and January and 27th February 2014). Provider representatives sit on the Care Closer To Home clinical reference group and the Urgent Care Working Group, both of which meet regularly. In addition, all providers have been invited to the Big Care Debate events and the further events that were held in February 2014. A workshop on five year plans, including BCF impact, is planned for May 2014.

Further engagement with acute providers will be undertaken as part of the contract agreement process through CCGs and as BCF plans are developed.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

A critical part of our vision for Essex is that residents and local communities will have greater choice, control and responsibility for health and wellbeing services. We believe that engagement, involvement and co-production have the potential radically to improve and transform services. We have therefore been determined to engage patients, service users and the wider public in developing our plans for BCF. In doing so we have drawn on the wealth of information we already hold at a local and county level: for example the evidence gathered by the 'Who Will Care? commission in 2013. Across the county and as individual CCGs we routinely engage with patient and public forums and service user representative groups as part of our planning for commissioning and service development. The outputs from this activity have been used to develop schemes within this BCF plan. In addition, over the last year, Healthwatch Essex, ECC and the CCGs have put in place new arrangements for ensuring that people's voice and lived experience inform our plans.

Some examples include:

- A Call to Action – CCGs undertook a number of consultation and engagement events to enable patients and the community to shape the commissioning and

planning of local services. These events allowed CCGs to set out the challenges and opportunities facing the NHS and social care. For example, the “Big Care Debate” engaged patient groups and representative organisations, and over 1000 people responded to or were involved with the debate. The message from the public was that primary care services and GPs in particular, are key to bringing about person centred healthcare over the next five years.

- CCGs continue to support Patient Engagement Groups, which provided the opportunity for patient views to be heard and considered, and which function as an information exchange conduit. In addition new Patient and Community Reference Groups are acting as formal reference sources for CCGs to discuss broad strategy and integration, and allow outreach to extend into the voluntary and community sector. These groups link to the localities through lay members of CCG Governing Bodies.

Some of the key messages that we have heard from patients and service users are the need for:

- Accepting personal responsibility for their health and social care.
- Access to information and services.
- Prevention and early intervention schemes in their health care
- A change in the culture – being patient centred and caring for people as individuals
- An acceptance that minor problems are important to our citizens
- Access to primary care as gateway to all care that should then be integrated.

These themes have helped to shape our planning.

Over 2014/15, Healthwatch Essex will help to develop BCF plans through its programmes of applied social research and outreach and engagement. Two scheduled pieces of research, on hospital discharge and the lived experience of carers, will be completed over 2014/15, In addition, Healthwatch will use its Voice Network and Community Ambassadors (i.e. community-based volunteers) to gather so-called ‘Stories of Integration and Disintegration’: the provisional title for a year-long programme of outreach to gather people’s experiences of navigating health and social care in the county.

Further engagement focussed specifically on the BCF will involve voluntary and community sector (VCS) organisations, as well as focus groups obtaining feedback from service users and patients as we refine and develop our plans.

e) Related documentation

Document or information title	**Synopsis and links**
Health and Social Care Integration (Accelerated Design Event)	This sets out our shared vision for service users and commissioners, our collective ambition and strategy for commissioning and priority areas for service redesign

Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities the Essex locality (excluding Thurrock and Southend localities) http://www.essexinsight.org.uk/Resource.aspx?ResourceID=299
Joint Health & Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the Essex localities (excluding Thurrock and Southend localities) http://www.essexpartnership.org/content/health-and-wellbeing-board
"Who Will Care" commission report	This report sets out the Who Will Care? commission's 5 high impact solutions to meet the challenges faced in Essex by health and social care services
Appendix 1 Essex BCF High Level Action Plan	A high level plan indicating the activity to be undertaken during 2014/15 to meet the conditions of the Better Care Fund in 2015/16
BBCCG BCF Template	The BBCCG locality Better Care Fund Planning Template Part 1 & 2
CPR CCG BCF template	The CPRCCG locality Better Care Fund Planning Template Part 1 & 2
MECCG BCF Template	The MECCG locality Better Care Fund Planning Template Part 1 & 2
WECCG BCF Template	The WECCG locality Better Care Fund Planning Template Part 1 & 2
NEECCG BCF Template	The NEECCG locality Better Care Fund Planning Template Part 1 & 2
Essex Metrics by CCG	The Essex outcomes and metrics table broken down by CCG
The Seven Day Services Improvement Programme	The Seven Day Services Improvement Programme expressions of interest

2)VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

Our vision is that by 2018 residents and local communities will have greater choice, control and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.

For people with care needs in Essex:

- We will commission and deliver integrated care that is person centred, closer to home and which leaves people in-control.
- The care we deliver will be consistent in quality with an appropriate response across the whole of the County
- Service delivery will be integrated with lead providers coordinating care on our collective behalf.
- We will better understand demographic need and be more able to predict and prevent increasing demand, including proactively identifying long term needs ;
- Services will be available 7 days a week
- Vulnerable and frail people will have a named professional working with them
- We will be fair in the delivery of care. This means being consistent across our patients and service user groups;
- Primary Care Services will proactively support people with long term conditions with preventative interventions
- There will be viable alternative to prevent avoidable admissions
- We will provide more intensive community-based reablement services to promote independence and lessen the need for ongoing health and social care services
- Our care will take account of the wider determinants of people's lives including their families, carers and communities

- Communities will be stronger, through a new partnership about ‘Who Will Care?’

This vision has informed the development of our BCF plans. Our approach to for commissioning in Essex and planning our BCF is to:

- use outcomes based commissioning on the basis of robust evidence and detailed analysis, that will identify clear triggers for interventions;
- be commissioning-led and have a strategy to provide care that is sustainable and is based on local, joint commissioning arrangements
- share data in a safe and timely way enabling us to better understand our population so that we can design and commission the services they need and will need in the future;
- consistently engage with providers to manage markets to streamline our provider arm to deliver efficient and effective pathways;
- align and pool budgets and finances to deliver the most effective impact, integrating resources where possible;
- work with providers to develop behaviours which align to our overall strategy and let our providers innovate.

We have identified our key enablers for change:

- Joint Commissioning at CCG and District level to oversee BCF Schemes and impact.
- Simple access to information;
- Earlier intervention;
- Community engagement and community-based services which reduce demand on health and social care services;
- Continuous innovation in all areas of the system;
- Showing dignity and respect, people are treated as individuals with a choice, and their information follows them wherever they go in the system;
- Services, which are joined up, delivered in a timely fashion, and are easy to navigate.

These enablers are reflected in our BCF plans.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

There is a shared commitment in Essex to integrate commissioning and to develop integrated health and social care provision based on integrated pathways in particular for frailty, people with long terms conditions, admission avoidance and discharge support.

We share an understanding that no one can plan, commission or deliver services in isolation, so if we wish to provide high quality services and make efficient use of diminishing resources we must work collaboratively.

We aim therefore to develop provider models which lead and coordinate health and social care, and which support Primary Care. A strong theme in these models is access to enhanced reablement and intensive support which promote independence and minimises the need for continuing health or social care.

The JSNA and the Essex's Joint Health & Wellbeing Strategy have informed the outcomes that ECC and the CCGs will commission.

Aim/Objective	**Measured by**
Reduction in total demand for acute care (not simply a shift from acute to community settings)	• Reduced admissions; reduced emergency admissions, shorter length of stay
Reduction in emergencies and other unplanned activity	• Reduced emergency and unplanned admissions, reduced A&E attendances
Improved quality of life and greater independence for the frail and vulnerable group that supports optimum self-care and has a primary purpose to improve outcomes at its core	• Patient reported outcomes • Patient reported experience
Improved clinical information	• Evidence of sharing data / use of shared systems use of NHS number/ clinician-reported evidence
Increased levels of education and awareness of self-care	• Patient reported engagement in care planning
Better diagnostic monitoring, community and reablement services	• Activity setting shifts
Improved financial performance	• Savings targets realised
Simplified contract monitoring processes	• Reduced time in contract discussions

	• Feedback from providers
Improved working across health and social care services	• Proportion of people with a joint assessment, use of the NHS number, Greater confidence in partners; greater transparency
A new approach to commissioning that focuses and incentivises the whole system to achieve outcomes that meet the needs of service users in their teams	• Evaluation of risk share contract with Providers and integrated care supply chain; evaluation of outcome measures in use

Individual JSNA's have highlighted that there is disparity between the level of deprivation and the provision of prevention services. Inequity of access to services and inadequate support for self-care as well as a rapidly ageing population, are contributing to an increasing gap in health inequalities and life expectancy.

The overall health gains to the population of Essex to be gained from these aims and objectives will be manifest in:

- People maintaining their independence for longer through lower admission rates to residential care
- Reduced rate of acute hospital admissions by age
- Reduced admissions to hospitals as a result of falls and stroke

We want to see improvements against the metrics set for BCF and our locally chosen metric on the coverage of reablement. The targets we have set and the assumptions behind those targets are explained below:

1. **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population:** Essex proposes to achieve a 5% reduction in the number of admissions to residential care (equating to a reduction of 63 people per 100,000 of the over 65 population). This is based on 6.1% of current residential admissions occurring directly following a new client assessment at hospital. It is intended that BCF schemes will be developed to prevent these people going into crisis and divert them along different care pathways.

2. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**: The Metric target is to "maintain" current performance across four of the five CCG areas and to increase performance in NEECCG are to the average for Essex which will lift the overall Essex performance to 84%. We expect, over the 2014/15 period, that the nature of reablement cases will shift with short stays being replaced with more complex cases. However, our data is inconclusive on whether this will affect the results after 91 days. We will be investing BCF funds into increasing the number of people being offered reablement in Essex thus making in the target to "maintain" performance a stretching one. Essex's current performance compares favourably with both its geographic and its statistical

neighbours, currently achieving 82% against this metric: above the Eastern Region average of 81.5% and shire councils of 80.8%.

3. **Delayed transfers of care from hospital per 100,000 population (average per month):** Current performance is in the top quartile of our statistical neighbours. The proposal is a maximum target reduction of 2.5% (7 people per 100,000 total population) for the April 2015 performance period and a further 2.5% (a further 7 people per 100,000 total population) for the October 2015 performance period. We believe that this is a stretching target as the Essex performance is currently in the top quartile of its statistical neighbours and that the trend has been reducing and is now generally level. However, in the first part of 2014 delays have increased.

4. **Avoidable emergency admissions (composite measure)** NHSE CSU has provided the composite measures to calculate this baseline. This metric will be driven by local CCG admission avoidance schemes particularly around paediatric admissions. The suggested target is to maintain current levels of avoidable emergency admissions (1676) whilst the population increases by 2% in the first performance period.

5. **Patient / service user experience** As ECC and the CCGs do not use comparative methods of measuring this metric it is proposed not to include this metric until the national metric has been developed

6. **Additional Local Metric - the coverage of reablement.** This metric will measure an expansion in the number of referrals from community into reablement. We have taken the 2012/13 baseline and reduced it to take account of inappropriate referrals to reablement. We have identified the number of community referrals we expect in the first target period, increasing these for the October 2015 payment. This reflects schemes that will be put in place to develop additional referrals in the first half of the 2014/15 financial year. The target shows an increase of 99 people per 100,000 population referred for reablement between April 2014 - March 2015 and a further 324 people per 100,000 between October 2014 – September 2015

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- *The key success factors including an outline of processes, end points and time frames for delivery*
- *How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care*

Agreed Better Care Fund Schemes

Within the “Everyone Counts” planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over

and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

Each CCG has created its own timelines for the implementation of activity that supports the BCF schemes (see the Related Documentation section). All schemes will commence implementation through 2014/15 with the aim to be fully functional by 2015/16. Provider contracts are either being varied or new contracts are being arranged to support implementation of the schemes accordingly.

1. Protection of Social Care Services with a health benefit

We want to ensure that those in need in Essex continue to receive the support they require, against a backdrop of pressure on service capacity and resources. We know that to achieve this we have to work in partnership with individuals, carers and communities to help people stay healthy and independent for as long as they can, reducing pressure on services and helping them enjoy better health and wellbeing.

£22.1m in 2014/15 will be used to mitigate reductions in purchasing budgets and a further £4.932m will be used to develop our preventative early intervention and reablement services. These figures have now been apportioned across the other typologies in the BCF Part 2 template.

Through this investment we will also ensure that we build the capacity to deliver 7 day working and integrated services with CCGs. The local authority and NHS commissioners will work together throughout 2014/15 and into 2015/16 to bring sustainability to the health and social care system by:

- investing in preventative health and social care services which will avoid future demand and help people remain safe and independent at home for longer;
- targeting funding at system reform to bring together health and social care provision and avoiding duplication of process through re-designed pathways;
- enhancing services to carers;
- locating care and assessment resources and care services to support people to stay in their homes;
- targeting frail and vulnerable older people to minimise, delay and avoid inappropriate demand;
- Moving as much of resource as possible from residential and domiciliary care into more reablement and proactive case finding.

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2. Community Health services including admission avoidance

We will develop lead provider models of health and social care integration involving community health, admissions and discharge, community social care and primary care services. These providers will be responsible for ensuring access to services, for

effective coordination of multi-disciplinary approaches, and for case management. These lead provider approaches will enable people at risk of frailty or loss of independence to maintain their independence. The models will focus upon risk stratification of vulnerable people and support for people with long-term conditions. They will develop common referral and brokerage arrangements, care pathway review, and asset based community capacity building by community groups. We will work inclusively with acute care providers to invest in admission avoidance and supported discharge. We will pilot arrangements in Essex for the first year of the BCF and will co-produce the models with user-led organisations in Essex.

3. Reablement

We have jointly commissioned community based and residential reablement services with CCGs in Essex. Building on our current joint spending on community based services we will roll out a new integrated health and social care reablement service in each CCG area using existing BCF funds. We consider that reablement is critical enabler to a shift towards care closer to home and a demand management approach for health and social care. This will provide in each area community based reablement to avoid admission and facilitate discharge, it will provide intensive residential and nursing based services to minimise the need for ongoing health or social care, and it will provide an unplanned or rapid response.

Over the two years of the BCF we will;

- Continue to fund reablement and intermediate care services using NHS and Social Care reablement grant funds in 2014/15, allowing for significant growth.
- Roll out additional integrated reablement and intermediate care capacity in each CCG area to meet demand and increase community-led referrals using remaining 2013-14 s256 Sustainability Funds and utilising from 2014-15 s256 NHS Transfer money uplift funding to make that expansion sustainable.
- Pool all NHS and social care reablement funding in 2015/16 and ensure that there are sufficient funds for a significant growth in capacity and reach.
- Agree with CCG's a revised specification and procurement process to replace the existing provision when the contract expires in autumn 2015.

4. Joint Nursing and Residential Care Home commissioning (including Continuing Health Care)

We will review commissioning for Nursing and Residential Care Services in each CCG area with a view to shifting the pattern of care towards a rehabilitation and reablement model of service, which seeks to improve independence and functioning and which minimises inappropriate admission to the CHC service.

We will, in collaboration with the CCG's and the Central Eastern Commissioning Support Unit (CSU), develop a single specification and joint procurement of Nursing Care and Continuing Health Care in 2014/15 with a view to shared management of the market and reduced costs and recognised quality standards.

As part of this work we will work in partnership with the Care Home Market, local housing commissioners and Registered Social Landlords to shift the pattern of services towards greater levels of dementia care support including greater levels of extra-care housing; and as a consequence reduced levels of residential care services. We estimate the need for an additional 2500 places with extra care support of which we would expect to commission 360. We expect a reduction in admission to residential care from social services recipients of 5%.

5. Discharge support

Essex social care services and hospital providers in Essex will continue to work together and with community health providers to ensure effective admission avoidance and discharge support. We will use our BCF schemes for reablement to promote ward led discharge, rapid response services development and ensure that assessment is taking place at the appropriate time in the appropriate environment.

In developing Accountable Lead Provider Models we will ensure that there is a clear accountability for coordinating the care of people in the community who receive in-patient services.

ECC and individual CCGs will continue to build on the development of the integrated discharge team approach to facilitate 7 day discharge and will put in place the relevant infrastructure (community services, transport services etc.) to support this.

6. Acute mental health and dementia

Mental health is a key priority driven by rising demand for mental health services. Our plans are based on the factors that are known to facilitate good integrated care including: information sharing systems; shared protocols; the ability to pool funds from different funding streams into a single integrated care budget; improvements in existing multidisciplinary teams; and the development of new models of liaison services that bring improved outcomes and efficiency savings through reduced admissions to acute hospital care.

The evidence is unequivocal that accommodation plays a key role in mental health recovery pathways and therefore it is important that we are able to implement new accommodation pathways that support discharge from hospital and promote recovery and independent living.

As part of our strategy we will implement the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services.

The three CCGs in North Essex and Essex County Council have produced a Joint North Essex Mental Health Strategy. It is expected that this will be delivered by:

- Developing and supporting community well-being, encouraging people to maintain healthy lifestyles that help keep themselves and their families mentally well;

- Improving access and the gateway into services – more effective direction;
- Ensuring smooth transition between services (CAMHS/Adult/Older People);
- Ensuring a more holistic and integrated approach to mental health and physical health services;
- Developing broader primary care and community based models of care for people across the spectrum of mental health conditions;
- Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs.

Driven by this strategy, a joint approach has been undertaken with ECC and across the North Essex CCGs that will lead to the development of a new integrated model of care for adult mental health services.

Dementia: This plan will continue to support and develop the Essex, Southend and Thurrock Dementia Strategy which was developed during 2011. The strategy was agreed and signed off by NHS commissioners the two Mental Health Trusts and Essex, Southend and Thurrock local authorities in January 2013.

The focus of the strategy is to increase uptake of early intervention services that support independence, ensure service pathways incorporate the appropriate range of interventions including commissioning the voluntary sector to provide support to people in the community and at first diagnosis within Memory Clinics.

The strategy recognises the contribution that the NHS QIPP agenda will make in ensuring that the Dementia Strategy can deliver services that meet demographic demands, that services are cost effective and that planning is integrated. Implementation plans are being developed with partners to improve outcomes for people with Dementia and manage demand on statutory services.

- Early progress to date includes ECC awarding a £700,000 contract to the Alzheimer's Society to provide support by Dementia Care Advisors - supporting people following diagnosis in Memory Services.
- Jointly commissioned services provided by the Alzheimer's Society raising awareness and providing information about support to enable people living with dementia & their carers on how they can remain independent.

7. Primary care (including the requirement for GPs to be accountable for improving quality of care in older people)

We expect primary care to take a lead role in the care coordination for Health and Social Care services in Essex.
We will establish Multi-Disciplinary Teams (MDT's) with GPs at the centre of organising and coordinating people's care in conjunction with social care and other health professionals and service users themselves.
The risk assessment process to identify the care needs of vulnerable people and identify opportunities for early intervention will be led by primary care. We will use BCF schemes to respond and co-ordinate the resultant needs and interventions.

We will work closely with primary care to ensure information is shared appropriately so that as well as receiving Primary and Secondary Care services, people are also supported by appropriate voluntary sector organisations.
Our primary care support for Long Term Conditions will link services for Frail / Older People with community based prevention services for people with specific conditions e.g. continence, diabetes, falls prevention.
Essex GPs are taking a positive approach to their role in care coordination and we will continue to support them to do so.

We will work with our local councils to determine the levels of population growth and the impact on housing requirements to determine the level of Primary Care required in each locality within CCG areas and the requirements for Primary Care practice locations. For example in BBCCG it is expected that over a five year period there will be an increase in our primary care workforce by approximately 1 whole time GP for every 1,800-2,000 new residents.

8. Investment to meet requirements of the Care Bill

Revised arrangements for community health and community care are fundamental to the implementation of revised assessment and case management arrangements for people entitled to services from social services. In particular the implementation of the Care Bill will entail the development of a 'Care Coordinator' role across health and social care organisations dealing with community care. This may require additional resources during a period of transition whilst integrated approaches are developed.

We will work together as a system to define the requirements of the Care Bill using a joint programme management approach to implement change during 2014/15. This will identify the full investment requirements of implementing the Care Bill. However, we expect to invest in excess of £3.39m in new entitlements for carers, introduction of a national minimum eligibility threshold, funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

In addition, we expect to use in excess of £1.13m capital costs to invest in the development of systems, protocols and capacity to manage information between the various organisations, including case management systems and the development of mechanism to give access to virtual or actual patient records between organisations.

9. Early intervention and prevention

We are determined to identify the needs of people earlier and intervene to prevent the escalation of problems and crises. Improved support for people in their communities is at the heart of our approach. Individuals and communities value their independence and the ability to make their own decisions and choices. We will work to equip vulnerable people with the support and skills they need to live independently for longer and to help themselves. Improved management of demand will support the sustainability of the system as well as improve outcomes for individuals and their families.

We will look to enable as much health and care support as possible to be delivered safely in the community and in people's homes.

We will also develop communities' capability to support vulnerable people. An example of this is the community agents model which aims to establish a network of community agents and volunteers that leads to a reduction in the whole cost of care by:

- changing existing patterns of presentation to health and social care services and offering an alternative to those traditional services;
- re-directing from the social care front door and GP practices towards a community-based response - for information, advice, practical solutions, appropriate level care and support enabling vulnerable older people and their carers to find, own and implement the solutions to the issues which affect them

10. Community resilience

Essex is committed to strengthening and mobilising communities and increasing their resilience. The 'Who Will Care?' commission led by Sir Thomas Hughes Hallett recommended five high impact solutions in Essex. These included mobilising communities to play a greater role in supporting vulnerable people. This means engaging people in understanding the challenges facing the health and social care system and the important role that can be played by communities and volunteers. Work is underway to identify successful local schemes and determine how they can be developed as models to provide support county-wide. This will build on initiatives for community building, time and care banking and the creation of a Community Resilience Fund under the Whole Essex Community Budgets programme. We will build capacity within and across Essex communities to utilise community assets and support communities to provide care to vulnerable people.

We are currently discussing with Healthwatch their proposals to develop integrated information and signposting services that are likely to set up in 2014/15. These are designed to provide appropriate and relevant information to help people navigate health and social care, and so improve access to services as well as facilitate better self-management and community-based schemes.

11. Carers

Carers will receive support at the right time and in the right place to enable them to maintain their caring role and their own health and wellbeing. We will achieve this through:

a) Community based & community led activities which support those people who take on a caring role, whether or not they define themselves as carers, helping them to find solutions to issues and support from within their communities and natural networks.
b) An improved early offer reducing the need for formal assessment through:
   - Information & advice;
   - Practical support to sustain a caring role;

•Access to time away from the caring role;
•Carer training.

c) Targeted specialist support – for example at end of life; at hospital discharge; alongside reablement.

12. Disabled Facilities Grant

The DFG is included in the capital element of the fund which comes into play in 2015/16.
In Essex we have taken the view that the BCF provides an opportunity to explore a holistic approach to improve the process from OT assessment through to DFG in the medium term. Due to timescales we are not proposing changes to the DFG in 2015/16 but are engaging with local housing authorities to explore improved approaches. This includes the creation of a "Task & Finish" group during 2014/15 that will include representation from District, Borough and City councils to develop enhanced DFG services going forward from 2015/16 (see Action Plan Appendix 1).

13. Other schemes and enablers

13.1. Local councils are advising CCGs of a number of proposed housing developments which may have significant impact on the population across the Council area within the next 5 years. The BCF will take account of the implications that this may have on services across Essex. An example from BBCCG of the impact of housing and primary care premises in the Basildon area is shown below.

13.1.1. Pitsea–proposed 5,788 dwellings @ estimated 2.5 occupants each = total of c15,000 new residents; it is likely that new primary care premises would be required. Estimated requirement of 1200msq premises to accommodate a practice of this size.

13.1.2. Wickford – potential c1,200 new dwellings, estimated @ 2.5 occupants = 3,000 new residents; this may require redevelopment of existing premises, or progressing proposals for new Wickford Health Centre to include expansion. Capacity may also be created or found within existing GP practices, depending on the location of the developments.

13.1.3. Central/West Basildon – various schemes are currently underway and included in the 1% growth built in to 2014/15 contracts. Further developments are proposed to a maximum of c3,350 dwellings, estimate c8,500 new residents which would require additional capacity. Options include redeveloping an existing practice and relocate to a new site or a new standalone practice. For either option, assumption is that a minimum of further c500msq of primary care estate would be required.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The BCF plan will have a significant impact on non-elective admissions. This impact will be achieved through a more integrated health and social care approach to hospital discharge and better access to services closer to home which prevent the need for emergency admission/re-admission. For example, faster access to urgent social care services including night carers and reablement services, as well as improving the support network in the community which means that patients are less likely to reach a crisis point. The establishment of an integrated community workforce made up of social care, mental health and community services will allow for a more patient centred proactive service.

Examples of the impact on the acute sector are:

- In West Essex the frailty programme aims to avoid approximately 930 inappropriate admissions across the acute sector serving the west Essex patients in 2015/16. Furthermore, a reduction in excess bed days of 475 is also targeted. This will have a positive impact on the acute sector by releasing capacity to deliver more elective capacity and reduce outsourcing.
- In south east Essex, CPRCCG are working in conjunction with the lead commissioner, Southend CCG. Contracts are currently being negotiated with particular emphasis on non-elective activity reductions through QIPP and BCF work programmes. In south east Essex CCGs are looking for systems that incentivise primary care and community providers to see more people for longer and to keep people out of hospital. By making this agreement, we seek to offer stability to the acute system to allow for focus on service redesign to create a longer term sustainable health and social care system. We have submitted estimated reductions in non-elective activity in line with planning requirements.

Modelling of Impact on Acute Providers

The detailed impact of BCF plans on our population and on acute providers is complex and requires further detailed planning and modelling following. This is planned to take place in the next few months.

For instance NEECCG has commissioned modelling work, currently underway, which includes:-

- Benchmarking their current provider with peers/best in class to understand achievability
- Considering any best practice/national reference data based on local pilot data/knowledge
- Taking into account current contract planning rounds/negotiation
- analysing costs of providing the service in acute as opposed to other care settings
- modelling the potential impact on emergency thresholds

- Modelling the impact by service Bundle, and amalgamating to a whole system impact
- Triangulating with work modelling outcomes to be achieved
- assessing our ability to deliver national targets for reduction of elective and non-elective activity through our current plans and identify any gaps
- assessing impact of the plans on the sustainability of the system in the longer term

This work is being done in conjunction with provider conversations and to inform impact assessments by providers.

The Action Plan (appendix 1) shows the high level activities that will be undertaken across Essex throughout 2014/15 to evaluate the impact of the current contract negotiations with the acute sector once concluded and the effect that the BCF schemes will have on acute activity. The outcomes of this modelling and evaluation work will also inform the contingency plans that will be required to support essential services if the schemes do not release the expected benefits. In summary the actions will include:

- Finalising the acute contracts
- Specifying the functions that the BCF schemes will affect
- Modelling of the BCF functions against acute activity
- Evaluating existing demand management schemes.
- Revising contingency plans in light of the modelling undertaken.

- Workforce implications of the local economy.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

ECC and the CCG's have already built strong and effective working relationships at both officer and elected member levels. ECC has also appointed Integrated Commissioning Directors linked to each CCG.

The Health and Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across Essex covering all relevant CCGs and ECC.

The HWB is supported by regular meetings between the ECC Commissioning Directors and CCG Accountable Officers within the Business Management Group. The transformational plans and programmes are formally discussed and approved at local authority governance levels and within each CCG's governing bodies.

However, to deliver the ambition we have set out in our BCF plans, we recognise the need to develop our strategic and operational governance arrangements. We want to ensure these are effective in leading the health and social care system in Essex. We are also designing governance arrangements for the BCF to ensure we are effective in driving delivery of our plans locally, monitoring performance and problem-solving as necessary. Our aim in doing so is to achieve an appropriate balance between county-wide and local decision-making and monitoring.

The HWB is supported by regular meetings between the ECC Commissioning Directors and CCG Accountable Officers within the Business Management Group. The transformational plans and programmes are formally discussed and approved at local authority governance levels and within each CCG's governing bodies.

A technical group (ECC, CCG and NHSE Finance Directors) has been formed to identifying the delegated functions to be included in the section 75 Agreement(s) that will describe the use of the BCF and the arrangements to facilitate and manage the pooled fund.

This group has recommended that ECC should act as the host partner to the pooled fund.

ECC Integrated Directors and the CCGs will agree use of all pooled budgets in a joint and transparent manner, through jointly agreed Governance routes. Decisions about use of funding will be based on a clear and shared understanding of the allocation of resources across different areas of Essex, how this relates to population need, the services that will be supported and the outcomes that will be delivered.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

We will protect social care services in Essex by ensuring that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. Our ambition is to maintain current service levels and develop integrated care pathways that enable individuals to remain as independent and healthy as they are able. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Please explain how local social care services will be protected within your plans.

The local authority has engaged in a transformation programme that has led it to become an outcomes based commissioner with a strong locality focus and has released efficiencies enabling it to maintain its current Fair Access to Care Services (FACS) eligibility criteria. This allows the local authority to ensure that it can allocate additional spending for local social care services to the same financial level in 2014/15 as for 2013/14 using the Social Care Sustainability grant. This will enable the purchasing of community based social services within each CCG locality. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principal mechanism for this is the ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained in 2015/16 and 2016/17 to allow for contract procurements.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

ECC and each of the CCGs are committed to meeting this national condition of the BCF. Within appendix 1 there is a high level action plan that describes the activities to achieve this condition by 2015/16. These include:

- identifying all functions and work groups affected by7 day working,
- identifying skills gaps and training requirements for staff groups affected by 7 day working,
- identifying and negotiating any contractual changes with providers not already covered in the 2014/15 contact negotiations,
- commence and complete employee consultations with representative bodies and individuals affected.

- Communicate with stakeholders, providers and the public

ECC operates a 6 day hospital discharge service which is flexed to a 7 day operation during periods of increased pressure and is committed to support 7 day services to support discharge. We intend to fund community health and social care reablement services and social worker support to operate 7 days per week during the lifetime of the BCF. We will introduce this with immediate effect for reablement and will continue our weekend social care assessment services. We will introduce 7 day working generally as part of the implementation of the Care Bill.

CCGs have specific plans to support the achievement of this national condition. Health and social care commissioners across Essex will expect providers to ensure the same standards of services are provided across seven days. We will be moving towards commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge. CCGs will be working with their acute and other providers throughout 2014/15 to facilitate development of 7 day working. This is likely to include the development of the trusted assessor model and enhancement of community and transport services to facilitate discharge to care homes and normal places of residence at weekends.

Some CCGs in Essex have been successful in becoming early adopters for the Seven Days Services Improvement Programme. The aims of this programme are to:

- work with patients, carers and all partners in the health care system, to create a shared vision of our future seven day services;
- implement a shared vision working collaboratively with patients and all partners;
- establish clinically led care pathways which will include services provided by acute, primary, social care and the third sector.

Outcomes will be improved for:

- Individuals: being able to access treatment as appropriate to them and not limited by the availability services;
- Families: access to better support to cope with family members with ill health;
- Carers: with improved support from relevant organisations to help them provide better, sustainable care;
- Communities: with access to local health care services will be improved to the level where day of the week is not a limitation;
- Staff: their working hours and rotas will be improved to ensure that seven day working patterns are sustainable and rewarding

The CCGs in Essex are working with all NHS providers to develop action plans to support their response to the 10 clinical standards for 7 day working. This will be a key component of Service Development and Improvement Plans (SDIP) over the next two years and beyond. We will engage closely with our providers to ensure, once action plans are developed, that they are rolled out across the system over the plan period in line with contract commitments.

Health and Social care commissioners in Essex will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge.

This vision is aligned with the NHS Outcomes Framework

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

A county wide programme has been created to ensure that all organisations are in a position to share data using the NHS Number with appropriate Information Governance controls in place by 2015/16. This programme is being led by the Chair of the Health and Wellbeing Board and includes representatives from all partners. The high level action plan is shown in appendix 1 and includes:

- The creation of a county wide task and finish group and the launching of Information Sharing Protocols. This has already been completed
- Creation of a detailed action plan for identifying the key issues to be resolved by the group.
- Identification of the current ability to use NHS Numbers amongst all partners.
- Implementing solutions to issues by March 2015

NHS Number: Currently, not all organisations use the NHS number as the primary identifier in correspondence. However, all are committed to doing so during 2015.

The use of the NHS number is to a large extent governed by the rules around Information Governance and until some of these issues are resolved all organisations will continue to work with NHSE to ensure that we are ready and able to implement the use of the NHS number as soon as it is possible following authorisation to do so.

However, we are committed to developing interoperability between all health and social care systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the locality are integrated around the NHS number, and individual information shared in an appropriate and timely way.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

NHS Number in use by: ECC will be implementing a new social care case management IT system that uses the NHS Number during 2015. Within the existing social care recording systems NHS numbers are recorded for the majority of current cases. In the event of a delay implementing its new IT system ECC will develop the facility within existing systems to use NHS numbers in correspondence.

Those CCGs that do not currently use the NHS number have plans to do so and expect to be in a position to implement use of the NHS number by Quarter 3 of the 2014/15 Financial year.

However it should be noted that there will be restrictions on the CCG's ability to receive, process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Open API Systems: All organisations are committed to adopting APIs. ECC will be implementing a new social care IT system that uses Open API's and Open Standards. This system will be implemented in during 2015.
Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

IG Controls:
ECC is committed to appropriate IG Controls and to meeting the requirements of Caldicott2. A Data Sharing project, led by the Leader of the council, is currently underway within ECC with the objective of creating protocols that will enable the council to meet its requirements under the Care Bill as well as the BCF national conditions.

Several CCGs have been granted Accredited Safe Haven (ASH) status which will allow them to receive patient identifiable data in the future.
All CCGs have adopted appropriate IG Controls which cover NHS Standard contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

People at high risk of hospital admission have an agreed accountable lead professional:

ECC works closely with the CCGs jointly planning care for those individuals identified by health professionals as being at high risk of hospital admission. The accountable lead professional model is developing in Essex and varies according to location. The general approach is that all patients at high risk of hospital admission will have their care managed by GP led health teams or by accountable lead providers with an identified accountable lead professional. The care packages for individuals are managed

adopting the Multi-Disciplinary Team (MDT) / Single Point of Referral (SPOR) / Virtual Ward type models of cross social and health care.

Health and social care use a joint process to assess risk, plan care and allocate a lead professional:

ECC and CCGs are developing the accountable lead professional concept through their MDT, SPOR and Virtual Ward activity.

In some CCG areas, individuals are assessed by the GP led MDT against the Rockwood Frailty categories. Those who fall into categories 5, 6 or 7 will be referred onto the Frailty Pathway and be case managed by an accountable lead professional and supported by a care co-ordinator, employed by the Lead Provider.

In other areas risk stratification tools such as the Combined Predictive Mechanism (CPM) is used to identify individuals at high risk of hospital admission. The CPM algorithms are used to predict emergency hospital admission in the next year. The algorithm draws on information from primary and acute care, as well as patients' ages, to make its predictions. The risk is further stratified into patients who have (a) diabetes; (b) chronic obstruction pulmonary disorder (COPD); (c) coronary heart disease (CHD); or (d) if they are over 75.

In west Essex where an Approved Lead Provider (ALP) model is being developed, the responsibility for identifying those at risk of hospital admission and risk stratification will belong to the ALP who will be charged with identifying and sharing a suitable risk assessment tool and methodology and applying this to the west Essex population. This future modelling will then be able to identify the proportion of the population who are at "High" and "Very High" risk of hospital admission. The ALP will be responsible for constructing a supply chain around this population that is capable of ensuring early identification and prevention. The ALP will also be responsible for the development of demand management schemes which, via early intervention and the adoption of early identifier risk stratification models, will be able to offer community based support to prevent crises occurring.

Proportion of the adult population identified as at high risk of hospital admission,

Although risk stratification tools are not universally adopted around Essex we have estimated that in those areas that do currently use risk assessment tools 0.5% of the population are at "Very High" risk of hospital admission for a chronic condition in the next 2 years, and that 5% are at "High" risk.

4) RISKS

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

Risk	Risk rating	Mitigating Actions
In a Health and Wellbeing region that consists of five CCGs and five acute hospitals there is an inherent complexity and a risk that a system failure in one organisation affects the overall performance measures of the HWB Board region which results in the underperformance of the BCF against the metrics which subsequently results in the non-eligibility to receive the health premium	High	ECC Integration Directors and CCG leads are working together to ensure that the programmes nominated for inclusion in the BCF have SMART targets and that providers are appropriately performance managed to ensure that they are sustainable. The BCF metrics will be disaggregated to CCG level to ensure that individual CCG's are not measured in a detrimental way. Modelling work that is planned will help to refine BCF plans based on a better understanding of the impact on the acute sector
Factors outside the control of CCGs and the local authority have an adverse effect on Urgent and Acute care services (i.e. Flu epidemic etc.)	Medium	CCGs will continue to monitor all significant changes to demand for Urgent and Acute services. ECC, CCG's and Providers will maintain and update as necessary their emergency response plans and business continuity plans and by carrying out regular joint exercises will ensure that they are able to respond appropriately.
There is a risk that if there is any lack of clarity of system cost and investment coming from the centre it may inhibit accurate reporting and progress	High	Develop positive and transparent relationships with NHSE to ensure that lines of communication and challenge are maintained and where necessary escalation processes are in place that help to minimise the risk
The pace of change required does not allow safe commissioning of high quality appropriate services	High	Deploy the necessary resources with the right skills and competencies to ensure that we continue to commission legally and within the required timescales, costs and quality standards
There is a risk that the lack of robust and appropriate governance processes resulting in poor and	High	We have plans to review our governance arrangements. We will implement locally approved

slow decision-making across the system delay the integration of services and reduce the effective ness of BCF		governance structures across Essex at the earliest opportunity – by September 2014 at the latest
There is a risk that if we implement new models of care we could destabilise existing providers	Medium	Through a process of communication and engagement with providers and by making sure that we plan the implementation carefully and collaboratively – moving activity before we execute capacity reductions we will deliver stable and sustainable change. Modelling work that is planned will help to refine BCF plans based on a better understanding of the impact on the acute sector.
There is a risk that new and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity	Medium	As with the previous risk mitigation plan we will deliver phased and planned capacity movement
Financial –There is a risk that failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing financial pressure as an ageing population increases demand	High	At the outset of the programme, being clear on: • Clear and achievable financial objectives • Well planned phased service model changes to deliver greater efficiency • Close financial performance management • Early identification of issues and contingency plans in place to mitigate slippages or unexpected demand • Rigorous financial governance to ensure robust due diligence is part of BCF S75 Agreement sign-off
Shorter term financial stability actions by CCGs or Essex County Council could inadvertently undermine BCF schemes	High	• Regular communication with finance leads/Accountable Officers to enable early identification of any issues. • Incorporate BCF S75 reporting into financial management business as usual. • Recognition of particular providers/commissioners

		already in fragile financial status Robust risk sharing arrangements built into S75 arrangements for the pooled budget.
Increase in transaction costs incurred by host partner	Low	Clear understanding of requirements of host organisation
BCF overspend/financial liability – role of host partner	Medium	Clear arrangements agreed as part of the S75 agreement
Clinical and quality – there is a risk that the planned changes do not improve quality but worsen it, resulting in a poorer outcomes and patient experience	Medium	Service model changes will be designed and reviewed throughout the programme process, with contract mechanisms and measures established to evaluate all proposed changes, and where appropriate pilots will be run and evaluated
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits	Medium	The programme will be properly planned, with agreed timescales and dependencies identified at an early stage. Progress will be reviewed through the programme management process, including exception reporting, highlight reports and project status reports, contingencies will be developed where necessary
Commitment and engagement – failure of the local health and social care community to remain committed to the programme and its objectives	Medium	The governance structure formalises senior level commitment to the programme; throughout the programme on-going support will be reviewed and expanded as necessary
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining contracts and the evaluation of results	Low	We will design and implement a thorough intelligence process to put in place processes, checks and balances that will help us to capture and analyse our patient cohorts in a way the minimises potential gaps in our knowledge.
Shorter term financial stability actions by CCGs or ECC could inadvertently undermine BCF schemes	High	Regular communication by finance leads / Accountable Officers to enable early identification of any issues. Recognition of particular providers / commissioners already in a fragile status.

		Robust risk sharing arrangements built into the section 75 arrangements for the pooled budget
Functions are not clearly defined so to be able to articulate how services will be integrated and therefore what the clear delegation of responsibilities are from health to social care or social care to health in. The implication being that benefits cannot be defined or quantified	High	Clear articulation of roles and responsibilities as part of s75 agreement

Appendix 3 Better Care Fund Part 2 Template

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1. Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Essex County Council	Y	£4,932,000	£8,009,000	£8,009,000
NE Essex CCG	N	£0	£20,987,000	£20,987,000
Mid Essex CCG	N	£0	£21,651,000	£21,651,000
West Essex CCG	N	£0	£17,435,000	£18,980,000
Basildon & Brentwood CCG	N	£0	£16,041,000	£18,444,000
Castlepoint & Rochford CCG	N	£0	£10,833,000	£11,166,400
BCF Total		**£ 4,932,000**	**£ 94,956,000**	**£ 99,237,400**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

An action plan has been created detailing the high level activities that will be undertaken across Essex throughout 2014/15 to evaluate the impact of the current contract negotiations with the acute sector and the effect that the BCF schemes will have on acute activity. The outcomes of this modelling and evaluation work will inform the contingency plans that will be required to support essential services if the schemes do not release the expected benefits. In summary the actions will include:
• Finalisation of the acute contracts
• Specifying the functions that the BCF schemes will affect
• Modelling of the BCF functions against acute activity
• Establish in-year monthly monitoring to ensure meeting 14/15 Avoidable Emergency Admissions target in year, allowing intervention with Providers in year, in line with BCF plans, if off-target
• Evaluation of existing demand management schemes.
• Creation of contingency plans based on the outcomes of the modelling work.
The BCF investment in 2015/16 is directly lifted from existing budgets and liabilities within contracts. The CCGs are working on the basis that funding input to the BCF is not new funding and are seeking further guidance on the mechanics of the performance related aspect of the BCF.
Should improvements not be achieved within the system CCGs will:
• Mitigate through acute contract negotiations in 14/15 and beyond. Impact of 2014/15 performance will be felt in 2015/16 with limited impact for the 2014/15 contract with the exception of starting target reductions in NEL and Elective activity in some CCG areas.
• Mitigate through contract negotiations in 2015/16 and beyond. High level contracting strategy for 2015/16 to be developed including the assumption that the BCF will continue beyond second payment in October 2015.
Agree risk sharing arrangements and contingency allocations across the metrics for Essex CCGs and ECC via BCF Technical Group during 2014/15.

Contingency plan:		2015/16	Ongoing
NEECCG Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	Increasing rate of admissions stopped; capped at 1,863 p.a.	Increasing rate of admissions stopped; capped at 1,863 p.a.
	Maximum support needed for other services (if targets not achieved)	Dependant on acute NEL activity rate, increased capacity in CHUFT; enhanced rapid discharge arrangements	Dependant on acute NEL activity rate, increased capacity in CHUFT; enhanced rapid discharge arrangements
BBCCG (CCG QIPP Saving)	Planned savings (if targets fully	£ 723,000	
	Maximum support needed for other	£ 723,000	
WECCG Outcome 1 (ref benefit from the OP Fraility Programme)	Planned savings (if targets fully achieved)	£ 300,000	£ 300,000
	Maximum support needed for other services (if targets not achieved)	£ 300,000	£ 300,000
WECCG Outcome 2 (better case of 1 above)	Planned savings (if targets fully achieved)	£ 150,000	£ 150,000
	Maximum support needed for other services (if targets not achieved)	£ 150,000	£ 150,000
	Planned savings (if targets fully achieved)	£ 371,000	

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
1) Protection of Social Care Services		£0	£0	£0	£0	£0	£0	£360,414	£0
2) Community Health services & Admission Avoidance		£0	£0	£0	£0	£42,595,300	£0	£0	£0
3) Reablement		£0	£0	£0	£0	£16,362,200	£0	£517,608	£0
4) Joint Nursing & Care Home Commissioning		£0	£0	£0	£0	£7,127,700	£0	£0	£0
5) Discharge Support		£0	£0	£0	£0	£4,129,900	£0	£0	£0
6) Acute Mental Health & Dementia		£0	£0	£0	£0	£3,219,800	£0	£0	£0
7) Primary Care		£0	£0	£0	£0	£0	£0	£38,254	£0
8)Care Bill Investment		£0	£0	£0	£0	£4,521,000	£0	£0	£0
9)Early Intervention & Prevention		£0	£0	£0	£0	£7,773,000	£0	£10,691	£0
10) Community Resilience		£0	£0	£0	£0	£1,263,500	£0	£26,289	£0
11) Carers		£0	£0	£0	£0	£3,107,000	£0	£39,878	£0
12) DFG		£0	£0	£0	£0	£4,713,000	£0	£0	£0
13) Others		£4,932,000	£0	£0	£0	£4,425,000	£0	£0	£0
Total		£ 4,932,000	£ -	£ -	£ -	£ 99,237,400	£ -	£ 993,135	£ -

Association

Essex

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

The Essex BCF schemes are designed to provide care earlier in our patients and service users care pathways through early intervention and prevention schemes and to keep people as independent as possible in their normal place of residency for as long as possible. The metrics will demonstrate the achievements of these outcomes by:-
• Showing a reduction in the number of permanent admissions to residential and nursing homes through targeted early intervention and prevention schemes.
• Demonstrating an increase in the number of people being presented to reablement services (local additional measure) and maintaining the outcomes of those receiving reablement packages.
• By investing in additional reablement services including home from hospital schemes we will demonstrate a reduction in delayed transfers of care from hospital.
• Individual CCGs will be investing in BCF schemes that reduce avoidable emergency admissions. Jointly, investment in risk stratification and identification of individuals at risk of hospital admission will support the early intervention and prevention schemes identified in this plan and the CCG Operational plans

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Not Applicable

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance plans that will support these Outcomes and Metrics will be assured across the County and by each CCG. These arrangements will include assurance by the Executive Director for People Commissioning in the local authority and the CCG boards.
The score cards demonstrating progress against the metrics will be reviewed at the Business Management Group of the Health and Wellbeing Board. The Health and Wellbeing Board will also review performance against these metrics regularly

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not Applicable

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	583.0	N/A	520.0
	Numerator	1575		1496
	Denominator	270160		287900
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	82.00	N/A	84.00
	Numerator	692		915
	Denominator	844		1092
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	199.0	192.0	185.0
	Numerator	26545	19410	12617
	Denominator	1109834	1123800	1135200
		April 2012 - March 2013 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	1676	1676	1676
	Numerator	24199	24690	24690
	Denominator	1443757	1472981	1472981
		April 2012 - March 2013 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Local measure *The coverage of reablement. This metric will measure an expansion in the number of referrals from community into reablement. We have taken the 2012-13 baseline and reduced it to take account of inappropriate referrals to reablement. We have the number of community referrals we expect in the first target period, increasing these for the October 2015 payment. This means that schemes need to be in place to be getting the additional referrals in the first half of the 14-15 financial year.*	*Metric Value*	1451.0	1540.2	1864.3
	Numerator	3920	4317	5367
	Denominator	270160	280300	287900
		April 2012 - March 2013 12	*(April 2014 to March 2015)* 12	*(October 14 to Sept 15)* 12

Essex Outcomes and Metrics by CCG

Metrics		Current Baseline (as at....)					
		Essex(Total of 5 x CCG & ECC)	NEE CCG	ME CCG	WE CCG	B&B CCG	CP&R CCG
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	583	644	560	553	577	565
	Numerator	1575	436	388	282	254	215
	Denominator	270160	67739	69314	51011	44041	38055
		(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	82%	76%	88%	82%	82%	82%
	Numerator	692	152	187	90	130	133
	Denominator	844	201	212	110	158	163
		(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)	(April 2012 - March 2013)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	199	120	308	168	203	23
	Numerator	26545	3636	11052	4560	4740	384
	Denominator	1109834	251948	299213	225837	194784	138052
		2012-13 outturn					
Avoidable emergency admissions (composite measure)	*Metric Value*	1676	1864	1576	1669	1621	1636
	Numerator	24199	6125	5997	4898	4263	2916
	Denominator	1443757	328594	380525	293431	262969	178238
		2012- 2013					
Patient / service user experience		n/a	n/a	n/a	n/a	n/a	n/a
		(insert time period)					
Additional Local Measure - Coverage of reablement	*Metric Value*	1451	1463	1158	1123	1935	1842
	Numerator	3920	991	803	573	852	701
	Denominator	270160	67739	69314	51011	44041	38055
		2012-13 data					

Metrics		Performance underpinning April 2015 payment					
		Essex(Total of 5 x CCG & ECC)	NEE CCG	ME CCG	WE CCG	B&B CCG	CP&R CCG
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	N/A	N/A	N/A	N/A	N/A	N/A
	Numerator						
	Denominator						
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	N/A	N/A	N/A	N/A	N/A	N/A
	Numerator						
	Denominator						
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	192	114	298	163	196	22
	Numerator	19410	2659	8082	3335	3466	281
	Denominator	1123800	258200	301800	227900	196200	139500
		(April - December 2014)	(April - December 2014)	(April - December 2014)	(April - December 2014)	(April - December 2014)	(April - December 2014)
Avoidable emergency admissions (composite measure)	*Metric Value*	1676	1863	1575	1669	1621	1635
	Numerator	24690	6302	6093	5005	4327	2963
	Denominator	1472981	338311	386766	299948	266950	181006
		(April - September 2014)					
Patient / service user experience		N/A	n/a	n/a	n/a	n/a	n/a
Additional Local Measure - Coverage of reablement	*Metric Value*	1540	1427	1280	1266	1972	1874
	Numerator	4317	1091	924	661	897	744
	Denominator	280300	70700	72200	52200	45500	39700
		Apr 2014 - Mar 2015	*Apr 2014 - Mar 2015*	*Apr 2014 - Mar 2015*	*Apr 2014 - Mar 2015*	*Apr 2014 - Mar 2015*	*Apr 2014 - Mar 2015*

Metrics		Performance underpinning October 2015 payment					
		Essex(Total of 5 x CCG & ECC)	NEE CCG	ME CCG	WE CCG	B&B CCG	CP&R CCG
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	520	568	494	503	521	503
	Numerator	1496	414	369	268	241	204
	Denominator	287900	72900	74600	53300	46300	40600
		(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	84%	82%	88%	82%	82%	82%
	Numerator	915	170	279	134	162	169
	Denominator	1092	207	316	164	197	207
		(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)	(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	185	110	288	157	190	22
	Numerator	12617	1728	5253	2167	2253	183
	Denominator	1135200	262100	304200	230300	197500	140300
		(January - June 2015)	(January - June 2015)	(January - June 2015)	(January - June 2015)	(January - June 2015)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*	1676	1861	1576	1668	1620	1636
	Numerator	24690	6302	6093	5005	4327	2963
	Denominator	1472981	338311	386766	299948	266950	181006
		(October 2014 - March 2015)	(October 2014 - March 2015)	(October 2014 - March 2015)	(October 2014 - March 2015)	(October 2014 - March 2015)	(October 2014 - March 2015)
Patient / service user experience		n/a	n/a	n/a	n/a	n/a	n/a
		(insert time period)	*(insert time period)*	*(insert time period)*	*(insert time period)*	*(insert time period)*	*(insert time period)*
Additional Local Measure - Coverage of reablement	*Metric Value*	1864	1750	1605	1604	2300	2196
	Numerator	5367	1359	1197	855	1065	892
	Denominator	287900	72900	74600	53300	46300	40600
		October 2014 - September 2015	*October 2014 - September 2015*	*October 2014 - September 2015*	*October 2014 - September 2015*	*October 2014 - September 2015*	*October 2014 - September 2015*

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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	**Essex County Council**
Clinical Commissioning Groups	**North East Essex CCG**
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**07/03/2014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£20.987**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£20.987**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**North East Essex CCG**
By	Dr Gary Sweeney
Position	Chair
Date	**07/03/2014**

Signed on behalf of the Council	<Name of Council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

The main providers commissioned by North East Essex Clinical Commissioning Group (NEE CCG) are Colchester Hospital University Foundation Trust (CHUFT), Anglian Community Enterprise (ACE) and North Essex Partnership Foundation Trust (NEPFT).

The CCG has discussed its vision and commissioning intentions with all main providers at Board and Leadership Team level. This includes acute, community and mental health service providers (e.g. meetings held 8th and 23rd January 2014 with CHUFT, ACE and NEPFT and meeting held on 27 February 2014 with CHUFT). Provider representatives sit on the Care Closer To Home clinical reference group and the Urgent Care working group, both of which meet regularly. In addition, all providers have been invited to the Big Care Debate events and will be invited to the events planned for February. It has been agreed with Providers that a workshop including all stakeholders will be held to further develop the NEE economy 5 year plan in April/May 2014.

Further meetings with individual Providers to triangulate their plans with CCG plans are being organised. An Educational Day for Primary Care staff is to be held in April and will focus on integrated planning, incorporating NHS England Essex Area Team's Primary Care Strategy.

The NEE CCG Chief Officer met with senior colleagues from Health Education East of England to discuss the CCG vision and strategy and those colleagues will be attending Care Closer to Home and Urgent Care project groups in February, March and beyond. A Primary Care workforce action group is underway involving Health Education and NHS England.

d) Patient, service user and public engagement

The schemes that the CCG is putting into the Better Care Fund (BCF) are part of our strategic plans for integrated care as set out in the NE Essex Integrated Plan 2013-18. The Integrated Plan was drawn up with input from a range of stakeholders including the NE Essex Health Forum (a public member organisation consisting of 300+ members, which plays a key role at all levels in the CCG). We have patient representation on the Care Closer to Home and Urgent Care project groups, which are taking forward key parts of the Plan, including reablement, carer support, vulnerable groups and 7 day working.
The Care Closer to Home Strategy has been revised following engagement via The Big Care Debate which has engaged over 1,000 local residents, using a series of "You said"… "We will" statements, highlighted by speech bubbles throughout the document. Engagement on that strategy is ongoing.

The Big Care Debate started on 8th November 2013 with a large event at Colchester's Weston Homes Community Stadium and an online survey was opened at the same time. The key engagement dates for the CCG vision of high quality, integrated care are shown below with number of attendees in brackets:-
Oct 26th – Tendring Community Voluntary Services Health and Wellbeing Fair (40)
Nov 5th – Drop in and meet the Board session in Colchester (30)
Nov 12th - Drop in and meet the Board session in Clacton (25)
Nov 12th – Big Care Debate event in Colchester (100+ attendees)
Nov 14th - Big Care Debate event in Clacton (80+)
Feb 20th – Big Care Debate events in Colchester (94)
Feb 27th – Big Care Debate events in Clacton (109)

The online survey closed on 14th February with a total of 216 respondents. In addition to the large events detailed above, CCG staff have carried out a series of visits to local groups in the community to talk about the CCG's plans and get feedback. Groups have included children's centres, BME groups, Carers' Support Groups and luncheon clubs.,

The main feedback themes from The Big Care Debate to date are:-

Self care

People overwhelmingly understood that personal responsibility for their health is important. Diet, exercise and mental well-being were recurrent themes. The role of family, friends and the voluntary sector in providing support mechanisms, care and social contact were also vital in helping people to avoid isolation and to remain independent, fit and healthy.
Use of technology and personal health budgets were supported, as was better training of staff to help individuals become more independent in managing long term conditions.

Access to information and services

Access to information and signposting to services was viewed as important. Use of plain English and guides to services were felt to be important. People felt this was crucial to self-care and to ensuring services were not used inappropriately when people needed support and/or advice for minor ailments and to reduce the demand on other services.

Appointments with GPs, dentists and professions allied to medicine, such as physiotherapy or audiology, as well as access through the walk in centre, were recurrent themes, with some mixed commentary about the 111 service which has only recently gone live.

Overwhelmingly, however, access to GPs for appointments was the single biggest point of satisfaction or concern dependent on how easy participants found it. There was an overwhelming view that GPs are the gateway to prevent other services being overloaded.

Prevention

The theme of access to information also extended to health promotion and education for individuals about how to stay well and healthy and how to manage a long term condition so that the individual remains in control.

Integration of services

There was a level of frustration with the lack of integration of services, particularly around discharge from hospital, but also with support services such as appliances or equipment when bereaved families found it difficult to organise the return of items that were no longer needed.

Suggestions included creating one budget for services and gateways/single point of contact for services that provided more clarity and removed barriers.

Care closer to home and home visits for the vulnerable were key comments throughout the engagement, whilst others felt that centres where a range of services could be accessed together were a good idea.

Culture and Patient Centred Services

People felt there was still some way to go to develop the right culture in the NHS and Social Care - improving the way professionals speak to patients and carers, creating a partnership rather than a dependency. Some black, minority and ethnic community representatives felt that there were communication issues; even when the use of English was not a barrier, cultural values were not always understood.

Duplication/Waste

There was strong support for improving medicines management and a number of participants felt that GPs should not prescribe medicines that are available over the counter to people who do not pay for prescriptions. Some participants felt the challenge facing NHS and social care was too big and that more money should be made available. Some were strongly opposed to the most recent reforms whilst others felt there was still duplication and waste (see integration of services above).

Methods of communication from the hospital was a cause of frustration with respondents who felt that multiple letters to confirm, cancel and then rearrange appointments added additional cost and could be confusing for patients.

A sub theme was the cost of locum staff in hospital and primary care/out of hours – reflecting recent media coverage of the topic. Respondents expressed concern about the ability to plan training ahead of demand, with the resultant additional cost to services as well as a potential lack of continuity of care/knowledge of the patients.

e) Related documentation

Document or information title	Synopsis and links
NE Essex Integrated Plan 2013-2018	This document sets out the vision and strategy for the local health and social care economy. It was co-produced with Essex County Council (ECC). It sets out the vision for delivering high quality, integrated services which are responsive to the needs of the individual, with a focus on keeping people independent. Where care is needed, it will be delivered in the home and community, with hospital used only where it adds value.
NE Essex End of Life Strategy	This document is a 5 year strategy detailing the

	future commissioning of end of life services across the health and social care economy. The document identifies the importance of raising the profile of achieving 'a good death' and putting mechanisms in place to achieve this.
NE Essex Care Closer to Home Strategy	This strategy outlines the integrated approach to services required to meet the health and social care needs for the people of North East Essex. By putting care packages together as bundles we will break down the traditional barriers between different care providers. Integrated planning will focus on actual needs and avoid duplication. We will use a rigorous procurement process based on achievement of improved outcomes for patients.
NE Essex Urgent Care Strategy	This is a system-wide strategy setting out how we will:- • Reduce complexity in the system to enable patients and clinicians to make an informed choice • Ensure consistency of provision across the services regardless of what time of day or day of the week the patient presents • Ensure services are provided by people with the right skills, in the right place and at the right time • Utilise the resources available in an efficient way
NEE Quality Strategy	The NEE CCG Quality Strategy defines quality as the 'organising principle' which will provide the CCG Board with the assurance that the systems and processes across the organisational disciplines are coherent and robust in the delivery of clinically effective and safe health care, provide positive patient experience and the financial efficiencies required to deliver the quality and productivity challenge, and at the same time deliver the 5 domains of the NHS Outcomes Framework. The strategy is a draft document and will shortly go out to consultation across the health and social care economy, ready for implementation in 2014.
JSNA	Joint assessment of health and social needs of the local population, focusing on areas where improvement in services is most needed, including reduction of health inequalities.
Essex Health and Wellbeing Strategy	A 5 year strategy, based on the JSNA, for improving the health and wellbeing of Essex residents within overarching framework of Starting Well, Developing Well, Living Well, Working Well and Ageing Well.
Annual Public Health Report	Review of published evidence of what impacts

	on health and social care demand.

2) VISION AND SCHEMES

a) Vision for health and care services

Our vision

As a CCG led by its clinical members, our vision is "Embracing better health and wellbeing for all." Even though we will focus on priority groups within North East Essex, everybody should be able to expect an improved level of health and wellbeing from the services we commission, delivered through a simpler system. People will have greater choice, involvement and control regarding their health and wellbeing.
Our vision is based around 4 overarching principles of care:-

1. Care focused around people, not services
2. Seamless, harm free care
3. Individuals have a large part to play in staying healthy
4. Efficient advice and care

We want to work in partnership with the public, patients and carers in North East Essex to help them have greater choice, control and responsibility for health and wellbeing services.
We are committed to commissioning services which are equitable, inclusive and sustainable

Reconfiguration of services

We will achieve this over the next five years through the joint commissioning with ECC of integrated physical and mental health and social services. Currently services are commissioned around providers, with community physical health services and community mental health services being procured from separate providers. Social care is commissioned by ECC. We are planning to commission services based around the needs of patients and service users and are drawing up outcome-based service specifications in order to procure care which is integrated, seamless and wrapped around the needs of the individual.

Integrated health and social care services will be wrapped around clusters of GP practices, with GPs playing the lead role, supported by a local multi-disciplinary team so that the patient's needs are met by a smaller team, who work together to meet all the individual's care needs. Patients will receive joined up care and will no longer have to repeat their details to a range of different staff who work for a range of different organisations.

We are calling this approach "Care Closer to Home". It will focus on supporting people in their homes and in their local community to care for themselves, signposting them where necessary to a range of support available in the community and focusing on prevention and early diagnosis in order to reduce avoidable admissions to acute hospitals or to care and nursing homes. Where people do require admission to hospital or care/nursing homes, rapid access to reablement and other support services will facilitate their recovery and return to independent living wherever possible.

Support for carers is a vital part of this and the Care Closer to Home incorporates all the relevant elements of the Essex-wide Carers' Strategy.

Feedback to date from the Big Care Debate (see Section 1d above) strongly supports what we are aiming to achieve and the feedback has been incorporated into the draft Care Closer to Home Strategy, using a series of "You said…..We did" statements and quotes.

Delivery of Care Closer to Home is likely to include the up-skilling of staff and maximising the

use of technology so that service users' needs are met by a smaller core team, and so that service users are supported by technology to remain in their own homes.

Services will be commissioned for specific geographical populations so that we can focus on the different needs in different areas. This means that the improvement in outcomes we require may be greater in areas, or groups of people where outcomes are poorer at present.

We will focus on improving outcomes for the four priority populations we have identified with Essex County Council: the frail and elderly, people with mental health care needs, people with learning disabilities and children. However, a focus on vulnerable and marginalised groups will also be included.

a) 7 Day Working (2014/15 onwards)

NEE has a well-established Urgent Care Working Group, which includes all local Providers and Commissioners, and this group will facilitate 7 day discharges as a priority in 2014/15, identifying community resources required to support this, and utilising part of the £1.08m funding available for this from 2014/15.

2014/15 priorities include:

- 7 day discharges from CHUFT (Social Care 7 day working required in 2014/15 to achieve this)
- Community discharge support and rehabilitation services
- 7 day working at the proposed Rapid Assessment Unit at Clacton Hospital

2014/15 – 2015/16 priorities include:

- 7 day admission avoidance via A&E and OOHs services
- Diagnostics to support admission avoidance

b) Reablement (2014/15 onwards)

It is proposed that access to reablement is maximised in NEE as well as quality, as NEE CCG JSNA shows rates of provision are low in NEE, but will need to be balanced against % with successful outcomes. This will include both Domiciliary and Residential, with provision of residential reablement.

c) Carers' Support (2014/15 onwards)

Carers will receive support at the right time and in the right place to enable them to maintain their caring role and their own health and wellbeing. We will achieve this through:

i. Community based & community led activities which support those people who take on a caring role, whether or not they define themselves as carers, helping them to find solutions to issues and support from within their communities and natural networks.

ii. An improved early offer reducing the need for formal assessment through:
   - Information & advice;
   - Practical support to sustain a caring role;
   - Access to time away from the caring role;
   - Carer training.

iii. Targeted specialist support – for example at end of life; at hospital discharge; alongside reablement.

d) Care Closer to Home service bundle (2015/16 onwards)

In line with the procurement timetable for Care Closer to Home (see Appendix A), the 2015/16 BCF will additionally encompass some integrated aspects of health & social care delivery in the

community that form part of this service bundle. These are designed to support people to stay in their own homes, avoid unnecessary admissions, and support the national requirement for case management of over 75s by GPs. Schemes cover a range of sectors, including:

- NHS Community Schemes
- Voluntary Sector Schemes
- Joint Commissioning Continuing Health Care
- Marginalised groups e.g. homeless people
- Primary Care Local Enhanced Services (Patient centred care)
- Housing Schemes
- Diabetes Integrated Pathway

Support for vulnerable groups includes voluntary sector grant funding. NEE is rolling over some high priority grants and opening up bids for the remainder of grant funding in 2014/15. It is proposed that an integrated bid process be used to align with ECC grants.

The difference for patients and care outcomes

• People will be encouraged and supported to look after their own health and social care needs
• Carers will receive the support they need
• Patients, public and community groups will take up opportunities to be involved in planning and developing services
• Services will be centred around the patient and will be high quality, evidence-based, cost effective and sustainable
• People will receive seamless and joined up services across their health and social care needs
With regard to specific outcomes to be commissioned against, we are aligning the vision with national outcome framework targets and identifying specific local priority outcomes in order to secure quality improvements in line with national guidance. This will be detailed in the 5 year plan.

b) Aims and objectives

Our aim is to commission integrated care and support, based in people's homes and local community, using acute services only where they add value (see Appendix B). We will commission services which:-

- Are wrapped around the needs of the individual, giving them maximum choice and control
- Deliver an excellent experience of care – right care, right place, right time – where people are treated as partners not patients
- Support people to be and remain independent and to manage their own health and wellbeing
- Are proactive and well planned, using risk stratification
- Reduce unplanned hospital admissions
- Enable services to be sustainable into the future – ensuring services are fit for

purpose at a time when elderly population/health needs are growing and budgets flat-lining.

We will measure :-

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient / service user experience via patient surveys and other engagement methods
- Measures of health gain, including those in the CCG Outcomes Framework, such as Potential Years of Life Lost.

These will be monitored through CCG processes and fed into Integrated Governance processes as necessary.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The details of the specific schemes included in the BCF are being developed through a series of joint workshops between NEE CCG and ECC. Once the modelling work on acute services is completed 9see section 2d), it will be linked with social care modelling.

2014/15

The Fund will consist mostly of existing funding streams in 2014/15, totalling about £8.2m, including:

- Core Baseline Funding
- Reablement Funding
- Sustainability Funding
- Carers Allocation

2015/16

2015/16 will see an increased transfer of funding from CCGs to upper tier local authorities. In NEE, the BCF pooled budget will total around £21m, including the £8.2m outlined above. The schemes funded through this pooled budget will include some pre-existing integrated schemes and new schemes as outlined below:

Proposed NEE BCF Schemes by Year

In BCF from 2014/15 onwards	In BCF from 2015/16 onwards
7 Day Working • 7 day discharges from CHUFT • 7 day working at Rapid Assessment Unit at Clacton Hospital • Community discharge support & rehab services	**7 Day Working** • 7 day admission avoidance via A&E and OOHs services • Diagnostics to support admission avoidance • And/or other elements as required
Reablement • Domiciliary reablement • Residential reablement	**Care Closer to Home** • NHS Community Schemes • Voluntary Sector Schemes

	• Joint Commissioning Continuing Health Care • Marginalised groups e.g. homeless people • Primary Care Local Enhanced Services (Patient centred care)
Carers **Sustainability Fund Services** • Including social care input into virtual ward	

The BCF will be used to:-

- Support people with multiple and complex needs to remain in their own homes and reduce their risk of health or social crisis, through integrated care from health, social care and other agencies. Through our Care Closer to Home plans, GPs will be at the centre of co-ordinating the care of people with long term conditions and will be able to refer people into a virtual ward, to enable them to receive the level of support they need whilst staying in their own homes, thus reducing the risk of decompensation. This includes a single assessment and single point of access. All providers of the Care Closer to Home contract will be required to deliver integrated care. Contracts will be aligned with Public Health contracts to ensure a seamless service.
- Support the development and implementation of 7 day working, including 7 day discharge from acute care, supported by social care, community and reablement services and including 7 day avoidance of admission supported by simplified and integrated urgent care system

The BCF planning is being integrated into the wider planning for the care economy, and as such will be aligned with 2 and 5 year planning. Strategic planning has started with consideration of the JSNA, and commissioning plans are being jointly developed across health and social care.

The Disabled Facilities Grant funding is also included, but no changes to services are currently planned. Further discussions with local authorities will be held.

Within the “Everyone Counts” planning guidance, NHS England has determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

The £5 per head funding has been included in the BCF to support closer integration between primary and social care.

d) Implications for the acute sector

The NEE health economy is aiming to hold the rate of avoidable hospital admissions level at 1,863 p.a., stemming the increase seen over recent years. This equates to 6,302 admissions during 2014/15. Ambulatory Care Sensitive (ACS) admissions are a major component of the composite indicator. Between 2010/11 and 2012/13, the quarterly cost of ACS admissions in NE Essex was on average 17% below expected levels based on national data (NHS Comparators, 2014). This means that it is relatively harder for NE Essex to make large reductions in admission rates compared to other CCG areas. The CCG JSNA shows that achievable reductions in admissions are likely to be marginal, and will result from targeted rather than generic improvements.

Although being lower than national and regional averages, avoidable admission rates in NEE are steadily increasing in line with national trends: standardised ACS admission rates increased 1.6% in 2011/12 and 0.9% in 2012/13. The NE Essex population is forecast to grow 1.6% over 2014/15, with relatively higher increases in the very young (under 5s) and the very old (over 75s), the specific age groups that form the bulk of the avoidable admissions measured by the BCF metric. Aiming to keep the avoidable admission rate level in 2014/15 and beyond (ie achieve a 0% increase) therefore represents a real, but achievable, improvement in performance.
The impact of the BCF and the likely impact on avoidable acute admissions were discussed with CHUFT, NEE CCG's main acute provider, on 27th February 2014. These discussions indicated an agreement between the CCG and CHUFT on the general level of likely achievable change in the BCF avoidable admissions metric, which will be further explored with providers before final submission on 4th April

Avoidable emergency admissions will be monitored monthly by the CCG, allowing intervention if the metric is off-target. The CCG has commissioning bundles focusing on each of the four measures in the composite metric.

Care Closer to Home impacts on the number of avoidable admissions of older people with Ambulatory Care Sensitive (ACS) conditions. A number of services to be included in this bundle are already in place including risk stratification and multi-disciplinary case management through virtual wards and other services to support case management of >75s in primary care.

The aim for the Care Closer to Home element of the BCF will be to reduce avoidable unplanned ACS admissions to the Acute Hospital setting, enabling funding to be released to commission more efficient and effective integrated services across our Primary and Community settings, and contribute towards the overall Quality, Innovation, Productivity and Prevention (QIPP) challenge.

Care Closer to Home impacts on avoidable ACS admissions among older people will be enhanced from 2015/16 through the introduction of a Community Gateway and enhanced use of risk stratification.

In addition to releasing financial savings to the commissioner, our local evaluation of data from

the Virtual Ward pilots indicates that the acute sector should also see a reduced Length of Stay (LOS) of approximately 40 bed days per 100 patients admitted per annum, contributing to improved patient flow through the system.

Urgent Care impacts on avoidable acute admissions among older people and children. From 2014/15, 7 day working and admission avoidance through a new Rapid Assessment Unit in Clacton will be implemented.

End of Life Care impacts on avoidable acute admissions among older people. A single point of access to care and support has been implemented in 2013/14 and includes enhanced palliative care in non-acute settings.

Children's Services impact on avoidable chronic condition admissions among children.

Best practice tariffs facilitate a preventative approach which stabilises the condition and allows management in the community, with acute specialist care when clinically required. This approach demonstrably reduces the number of unplanned admissions and A & E attendances and reinforces service user 'ownership' of their condition

A Children's Epilepsy Nurse has been in post for 2 years and a best practice tariff will be implemented in 2014/15. A best practice tariff is already in place for children's diabetes services. Asthma is subject to revised NICE guidance.

Modelling of Impact on Acute Providers

The detailed impact to our providers is complex and requires detailed planning and modelling to understand the full effect of this and other pathway changes. The CCG has commissioned modelling work, currently underway, which includes:-

a) Benchmarking our current provider with peers/best in class to understand achievability
b) Considering any best practice/national reference data based on local pilot data/knowledge
c) Taking into account current contract planning rounds/negotiation
d) Cost analysis of providing the service in acute as opposed to other care settings
e) Potential impact on emergency thresholds
f) Modelling the impact by service Bundle, and amalgamate to a whole system impact
g) Triangulating with work modelling outcomes to be achieved
h) Assessing our ability to deliver national targets for reduction of elective and non-elective activity **(by 20% and 15% respectively)** through our current plans and identifying any gaps
i) Assessing the impact of the plans on the sustainability of the system in the longer term
j) Assessing the impact of 7 day working including how it will facilitate discharge and patient flow through the system

The systems modelling will cover 5 care areas:-

- Acute activity
- Care closer to home
- Urgent care
- End of life care
- Children's services

The project will take an approach which will include:

1. Aggregating baseline data into a back-end database;

2. Forecasting data over 5 years;

3. Applying modelling assumptions to derive the impact of outcomes-based initiatives on forecast activities and finances. This will include an analysis of acute activity that could either be stopped altogether or moved into a community setting;

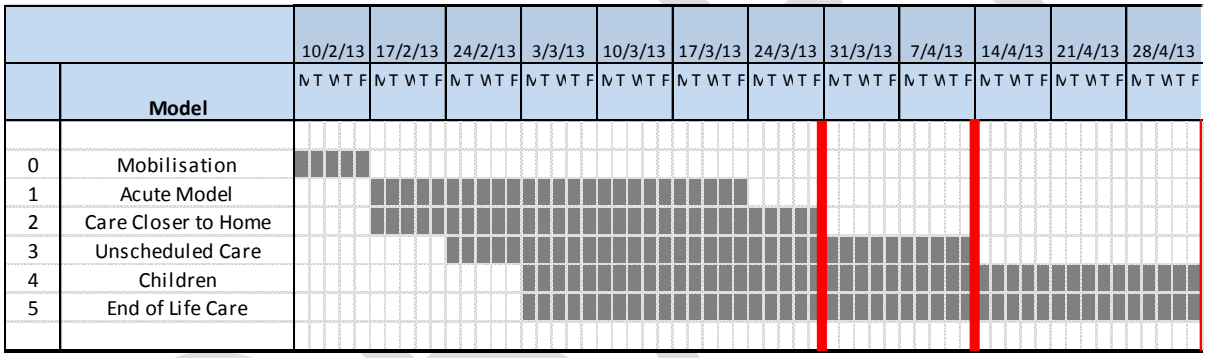
The same phases will be followed for each of the five care areas. However, rather than having five separate models, the project will build incrementally on the same model, adding on the impacts of initiatives in each bundle to the same dataset. This will mitigate the risk of double-counting benefits, because for each HRG (Healthcare Resource Group) it will be explicit which activity and cost assumptions have been applied in each bundle. HRGs which have been impacted by initiatives in more than one bundle will require a review at the end of each phase to ensure that there has been no double counting.

A summary of the project plan for the modelling work is shown below. The key milestones are:-

28 March 2014: Completion and delivery of acute and care closer to home bundles

14 April 2014: Completion and delivery of the unscheduled care bundles

5 May 2014: Completion and delivery of the children and end of life care bundles



In order to model future changes to the health system as set out in the project blueprint, we will first need to generate an activity forecast for the planned care services delivered in the acute setting. We will then determine which services (at a HRG level) will be reduced in the future (e.g. avoidable non-elective readmissions) and which will be moved to other, more appropriate, areas of the health system.

A linear trend forecast based on historical SUS (Secondary Uses Service) activity will be produced. The model will forecast activity forward five years. It should be pointed out here that the relatively short period of historical data may create larger margins of error in the forecast output.

The forecast can include the projected impact of a range of events, including:

- Changes to demand
  - Population increase.
  - Impact of increase of diagnosis across various conditions (The JSNA reports that under-diagnosis is a problem in a range of long term conditions).

- Changes to activity

    - Reducing/stopping services - Admission avoidance: The new service design is intended to bring efficiency gains and so result in reduction of activity over time. Attain can model estimates of admission reduction in addition to the financial impact of moving acute services into the community. For example, an estimate of the reduction in non-elective readmissions brought about by the planned changes to the system can also be incorporated into the model. This will allow the CCG to assess how close it will be to achieving the required 15% reduction in non-elective admissions

    - Moving services to more appropriate settings: A list of current activity better suited to delivery in other settings will be agreed with the team. Attain has already done some work in this area but will ensure that the list is appropriate for the local environment. This list will include ambulatory care sensitive conditions (ACSC) as well as a range of other condition.

    - We will then model the shift of this activity over time into the appropriate setting (there may be a reduction in activity volume at the same time as it is shifted). The model will allow different start dates for the shift and different rates of shift to allow for different scenarios.

- The forecast, with all the events described above, will be at a HRG level, which will be aggregated to POD (place of delivery) level and specialty level to give bundle level analysis, then to an overall system level.

The modelling work is in phases, so by the middle of March we will have some idea of the potential activity that could either stop or transfer. There then needs to be an internal discussion to see how much of that is appropriate/desirable, and we then need to have the conversations with the providers. Alongside this the modelling work will also link the possible stop/transfer to actual schemes. The modelling is being carried out in conjunction with conversations with providers and is taking into account the providers' own impact assessments.

The CCG is also undertaking work to ensure that the BCF plans and QIPP schemes are not being double counted.

The modelling outcomes will enable an assessment of workforce implications of the local economy, to be carried out in conjunction with Health Education East of England.

The CCG is also liaising with providers on the BCF, 2 and 5 year plans through a series of planned meetings.

e) Governance

Within Essex, the Health and Wellbeing Board has delegated the HWB Business Management Group (BMG) to act as a Programme Board. The BMG meets monthly and will be responsible for oversight and governance of progress and outcomes.

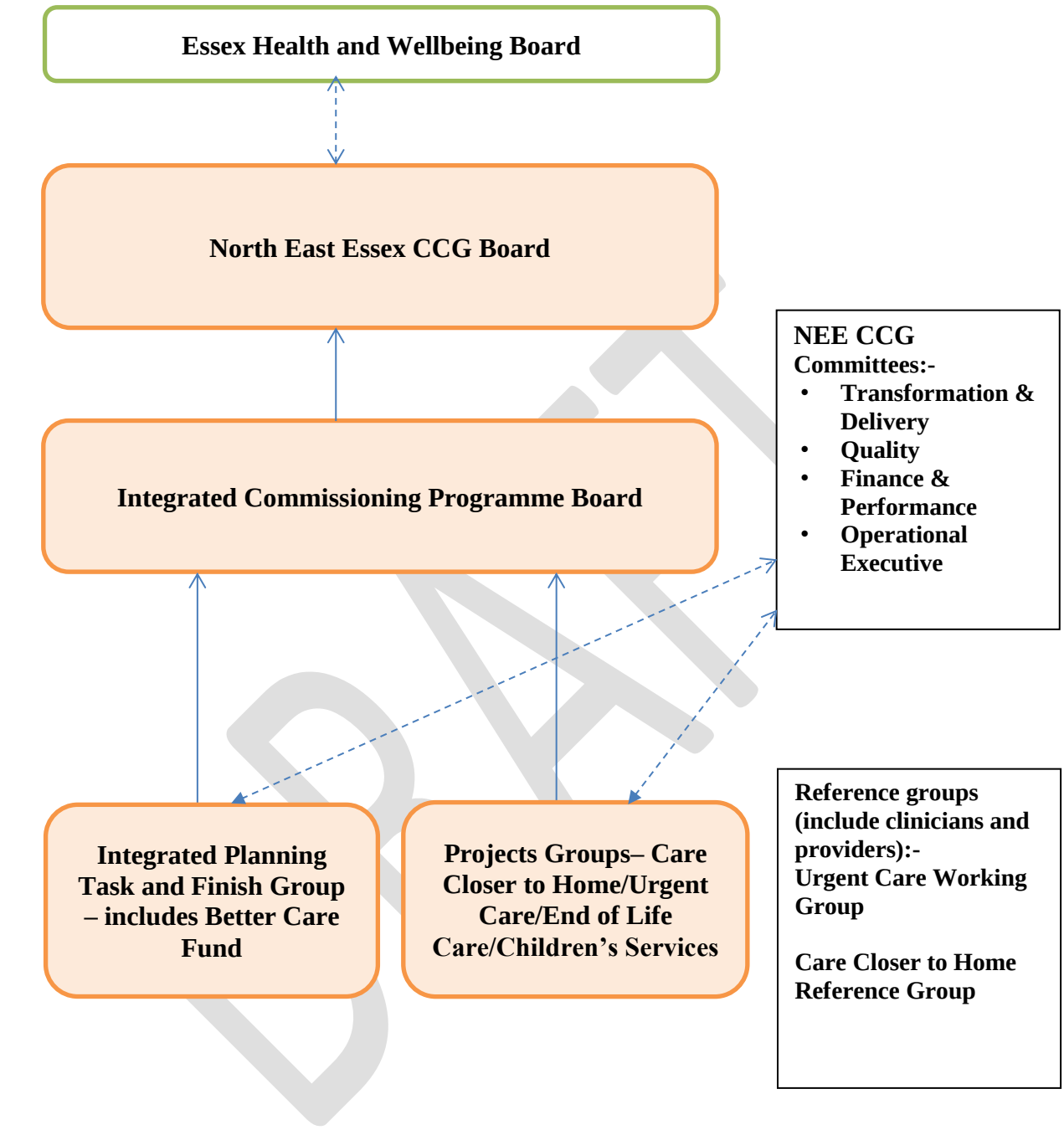
NEE CCG uses programme management structures and processes to manage the production and implementation of plans to support the delivery of their vision, including the production of the Better care Fund Templates, 2 year operational and 5 year strategic plans.

The sponsoring organisation is the CCG Board, with an Integrated Commissioning Programme Board (ICPB) which reports directly to the CCG Board. The ICPB is chaired by the Clinical Chief Officer and includes Elected Members (GPs and a Practice Manager), members of the CCG Leadership Team, senior ECC colleagues and patient representatives. The ICPB oversees all work on the delivery of the CCG vision and has delegated responsibility for the day to day work of producing the plans to the Integrated Planning Task and Finish Group. All plans, including the BCF, are also reviewed by key CCG committees – Transformation and Delivery Committee (clinical scrutiny), Quality Committee (quality scrutiny) and Finance & Performance (financial and activity scrutiny).

A chart showing the NEE CCG governance structure for the BCF and transformation projects is shown on the next page.

Essex County Council has agreed a way forward to accelerate integration, to include a proposal for councillors to sit on CCG Board as invited attendees with speaking (but not voting) rights. Once fully formulated, this proposal will be presented to NEE CCG Board for discussion and approval.

North East Essex CCG Governance and Programme Management Structure



KEY

Essex County Council representatives sit on these boards/groups

Accountable to

Reports to

3) NATIONAL CONDITIONS

a) Protecting social care services

The CCG and ECC will protect social care services in Essex by ensuring that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. Our ambition is to maintain current service level and to develop integrated care pathways that enable individuals to remain as independent and healthy as they are able. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well and are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services.

Social Care Sustainability
Part of the s256 sustainability monies in 2014/15 will be used to fund Essex-wide modelling of flows out of hospital and into social care and community care including reablement and residential/nursing homes, to inform how to intervene to reduce demand.

2014/15 Proposed Allocation NHS Transfer to Social Care and 2014/15 BCF Allocation	
2014/15 Social care base budget areas of spend	**2014/15 BCF spend to be agreed**
Reablement (in addition to s75 Reablement Agreements)	
Hospital Teams	
Carers' Services	
Dementia Services	
Older Adult Mental Health Teams	
Prevention Services including Third Sector Funding, Extra Care Schemes and Virtual Ward	
Telecare Services	
Floating Support	
	Preparation for Care Bill and BCF National Conditions

The local authority has engaged in a transformation programme that has led it to become an outcomes based commissioner with a strong locality focus and has released efficiencies enabling it to maintain its current eligibility criteria. Discussion on local social care spending is ongoing to enable local social care services to be maintained. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principal mechanism for this is the ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained

in 2015/16 and 2016/17 to allow for contract procurements.

b) 7 day services to support discharge

Social Care
ECC operates a 6 day hospital discharge service which is flexed to a 7 day operation during periods of increased pressure and is committed to support 7 day services to support discharge. ECC intends to fund community health and social care reablement services and social worker support to operate 7 days per week during the lifetime of the BCF. ECC will introduce this with immediate effect for reablement and will continue their weekend social care assessment services. ECC will introduce 7 day working generally as part of the implementation of the Care Bill.

Health Economy
NEE has a well-established Urgent Care Working Group, which includes all local Providers and Commissioners, and this group will facilitate 7 day discharges as a priority in 14/15, identifying community resources required to support this, and utilising part of the £1.08m funding available for this from 14/15.

The work programme will include:

- 7 day discharges from CHUFT (Social Care 7 day working required in 14/15 to achieve this)
- Community discharge support and rehabilitation services
- 7 day working at the proposed Rapid Assessment Unit at Clacton Hospital
- 7 day admission avoidance via A&E and OOHs services
- Diagnostics to support admission avoidance

Delivering the Programme
North East Essex in partnership with Essex County Council and Health Education England will recruit a fixed term programme manager to work across the system to develop:

- 7 day a week service strategy for NE Essex
- A system wide action on how to deliver the clinical standards as defined by the National Medical Directors forum
- A system wide workforce strategy on how the system will deliver 7 day a week services in an environment that needs to deliver consider financial efficiencies
- A strategy that feeds into the overall commissioning strategy for North East Essex CCG
- Progress against this programme of work reports for the Integrated Commissioning Programme Board
- Learning to be shared with the wider Essex community

The North East Essex Health and Social Care system are keen to explore further the benefits for our population on providing a range of services across a 7 day week.
North East Essex CCG have, as part of the call to action and to meet their statutory responsibilities, participated and hosted a number of events (The Big Care Debate) during the past 6 months to capture the views and thoughts of our local population. There have been a number of themes that have emerged from this work which we are including in our planning processes.
One of the key messages from the public was the need to use the resources we have across 7 days a week to maximise efficiencies of estate and workforce. There was a clear message that services, especially those in the community and primary care were often not available during out of hours when required, resulting in patients reaching crisis point and then accessing emergency services.
NHS England have stated in their "Everyone Counts: planning for patients 2014/15 to 2018/19" that 7 day a week services are an essential component for the NHS to focus on. There is no 'one size fits all' answer to introducing seven day services and therefore local solutions need to

be found. However, NHS England did commission a forum, chaired by the National Medical Director, to consider how NHS services could be improved to provide a more responsive and patient centred service across the seven day week. http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf

This forum has made a number of recommendations which the CCG plan to consider with system partners – these include:

- The forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends and that these should be adopted in every community in England by the end of 2016/17
- That NHS England and other commissioners use incentives, rewards and sanctions through the contract to support the scale of change required.
- That the BCF is identified as a key enabler for change and that CCGs and Local Authorities utilise this resource to support 7 day services in health and social care to support patients being discharged and to prevent unnecessary admissions at the weekend.

The 2014/15 GMS contract changes also support this by introducing a new enhanced service to avoid unplanned admissions and proactive case management and continuing to commission the extended hour access enhanced service

As financial and service pressures intensify within health and social care, the need to accelerate integrated care to improve patient's outcomes and experience have never been greater.

Primary Care

Opportunities need to be explored and tested out with primary care to provide general medical services across a 7 day a week period using the current contractual arrangements and by working with the GP Provider company to maximise resources efficiently. 7 day working is part of the emerging Essex Primary Care Strategy being developed by NHS England Essex Area Team. The CCG is encouraging all GPs in NE Essex to take part in a pilot being run until April 2014 to see if weekend opening of surgeries reduces the pressure on Colchester Hospital's Accident and Emergency Department. Monies from the national Winter Pressure budget is being used to fund the extended opening hours.

Key Points to Note:

- North East Essex health and social care system need to develop an approach to 7 day a week working, from both a commissioner and provider perspective. This approach needs to be developed with the local population.
- 7 day a week working is not just about the hospital – it is about the whole system, which includes health and social care. It does not just mean NHS providers either, NEE will need to co-develop a strategy that covers all providers if appropriate.
- The strategy will need to consider a range of issues and challenges including workforce planning.
- NHS England's "NHS Services Seven Days a Week Forum" has produced a set of clinical standards describing the standard of urgent and emergency care that all patients should expect to receive seven days a week. These should be used in NEE as a basis for developing plans.
- The BCF should be used to enable the health and social care system in North East Essex to develop a comprehensive action plan to deliver the clinical standards.

Actions taken

- North East Essex in partnership with Essex County Council and Health Education England is recruiting a fixed term programme manager to work across the system to develop:
    - 7 day a week service strategy for NEE
    - A system wide action on how to deliver the clinical standards as defined by the forum
    - A system wide workforce strategy on how the system will deliver 7 day a week services in an environment that needs to deliver consider financial efficiencies
- The development of the strategy feeds into overall commissioning strategy for North East Essex CCG
- Progress against this programme of work reports into the Integrated Commissioning Programme Board
- That any learning is shared with the wider Essex community

c) Data sharing

ECC have been working towards using the NHS number, currently we have linked the NHS number to the social care personal ID, which can enable care records to be used in a pseudonymised way, further work is taking place to enable us to share data on the basis of the NHS number

The CCG has not been able to use the NHS number for a prolonged period due to national restrictions. Having been granted Accredited Safe Haven (ASH) status and having put DSCRO arrangements in place, the CCG is now in a position to begin receiving patient identifiable data. Ongoing restrictions apply, but the CCG will be in a position to use NHS number, or a pseudonymised version of, for 2014/15 reporting.

In line with ECC, our strategic ambitions for data management, systems development and performance/financial reporting have the NHS number as a single consistent patient identifier. This is crucial for us in terms of understanding patient pathways and end-to-end commissioning of these – and providing quality data to GP Practices to support patient care. As noted there will be restrictions on the CCGs ability to receive, process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

ECC will be implementing a new social care case management IT system that uses the NHS Number during 2015. Within the current social care recording systems NHS numbers are recorded for the majority of current cases. In the event of delays implementing its new IT system ECC will develop the facility within existing systems to use NHS numbers in correspondence.

ECC is committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)). ECC will be implementing a new social care IT system that uses Open API's and Open Standards. This system will be implemented during 2015.

ECC is committed to appropriate IG Controls and to meeting the requirements of Caldicott2. A Data Sharing project, led by the Leader of the council, is currently underway within ECC with the objective of creating protocols that will enable the council to meet its requirements under the Care Bill as well as the BCF national conditions.

The CCG confirms adoption of appropriate IG Controls which cover NHS Standard contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional

NEE CCG has commissioned a Risk Stratification tool for two years, formerly provided by Sussex Health Informatics Service (HIS), now part of the Health and Social Care Information Service (HSCIC). This service is able to extract and receive data from the Exeter Spine, SUS and local service providers, including community mental health and primary care practices. This tool is a bespoke model that is based on actual activity and risk factors in the NEE population. As part of current contract negotiations, the CCG is requesting that providers directly share data with HIS for purposes of risk stratification.

Restrictions on sharing patient identifiable information (PII) have limited its use in 2013/14, however, now that Government guidance on sharing PII for risk stratification purposes has been received, this tool is ready to be used to identify people for joint review and interventions including holistic case management. The CCG is currently working with all Providers, under revised IG guidelines, to get Information Sharing Agreements signed.

This tool identifies that 0.5% of the population (1,603) are at Very High risk of hospital admission for a chronic condition in the next 2 years, and that 5% (14,428) are at High risk. The CCG is therefore planning that elements of Care Closer to Home will need to review around 15,000 adults over the first few years to identify those who could benefit from a joint care plan. Planning 4 care data suggests that around 8,500 people in NEE have a High or Very High need for social care. Adults over 75 will have a named person in charge of their assessments and care.

The NEE Virtual Ward service has developed a single Health & Social care assessment tool that can be used as a basis for the further development of tools for the Community Gateway, prior to the commencement of the Care Closer to Home service bundle in April 2015/16. The Care Closer to Home plan includes development of joint planning processes as part of this service. The service will provide support for GP case management of people over 75 years old..

Within the “Everyone Counts” planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs such as dementia. This is further supported by the new GP contract securing specific arrangements for patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs

The risk stratification tool will identify people at high risk of hospital admission who will benefit from care planning. From 2016/15, Care Closer to Home will enable this to happen.

4) RISKS

Risk	Risk rating	Mitigating Actions
1. New models of care will destabilise existing providers	Medium	Mapping all commissioned services, provider by provider, to assess potential impact of procurement and putting in plans to ensure services are protected where necessary. Whole system approach to planning and development, supported by a MOU between CCG and providers.
2. New and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity by 2015/16	Medium	Use of withheld monies to fund unmet need / increased hospital to residential care activity
3. CCG is not able to agree a risk and benefit share with providers of Care Closer to Home. Contract values will be fixed, resulting in CCG carrying all the risk of not achieving the outcome measures.	Medium	CCG contracts team exploring models of risk and benefit share with providers.
4. Balancing demands of business as usual and transformational change	Medium	CCG commissioned external organisation to review its OD in Nov-Dec 2013 and is now working with them to ensure CCG work teams aligned to CCG objectives and to map potential "pinch points" during the annual work cycle. Use of additional support will be commissioned as required.
5. A lack of access to baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards may not be achieved	Medium	The two year allocation enables greater certainty around forecasts. Forecasts are continually monitored and refined where necessary and the CCG is required to carry a contingency.
6.The Care Bill will lead to a significant, but as yet unknown, increase in the cost of care provision from April 2016. This will impact the sustainability of current social care funding and plans.	High	Working with ECC to carry out impact assessment and develop a contingency plan.
7. CCG and provider financial plans will not triangulate in this version of the BCF	High	Ongoing contract negotiations with providers. Strategic alignment with specialist commissioning. Working closely with LAT and other commissioning partners

The general risk of the BCF to the system has been added to the CCG Risk Register as a Red Risk.

Contingency Planning

1. Mitigation through acute contract negotiations in 2014/15 and beyond. Impact of 2014/15 performance felt in 2015/16, limited impact for 2014/15 contract, except for starting target reductions in NEL and Elective activity.

ACTIONS

- Establish in-year monthly monitoring to ensure meeting 2014/15 Avoidable Emergency Admissions target in year, allowing intervention with Providers in year, in line with BCF plans, if off-target
- 2 year plan workshops being held with CHUFT, ACE and NEPFT to align plans
- Contract negotiation strategies to be considered.

2. Mitigation through contract negotiations in 2015/16 and beyond. Risk of contingency loss in 2015/16 from underperformance in 2014/15 = c.£3.2m of CC2H / BCF value. High level contracting strategy for 2015/16 to be developed – including assumption that the BCF will continue beyond second payment in October 2015.

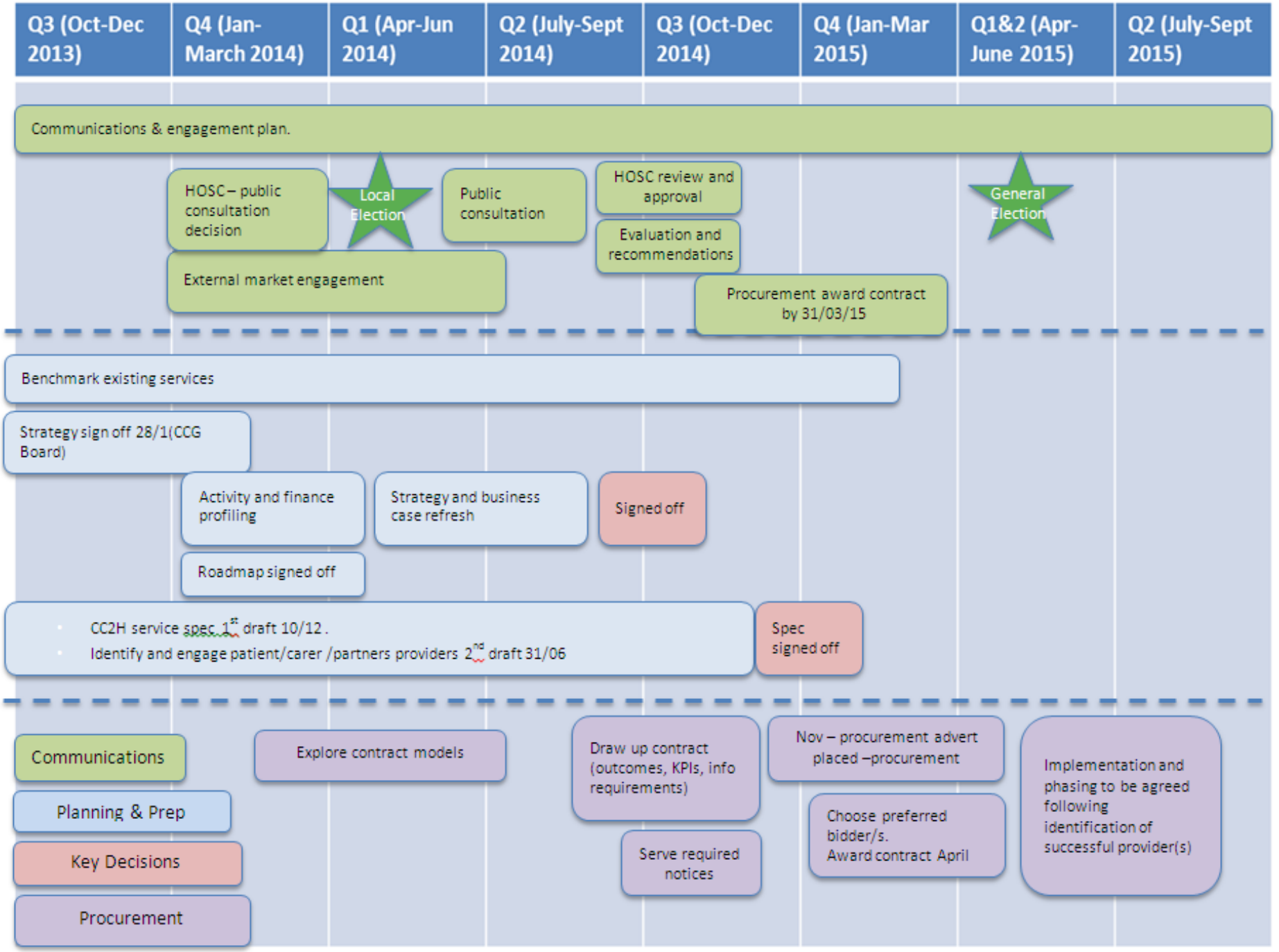
ACTIONS

- Ensure Care Closer to Home contract value includes risk share to appropriate % linked to BCF outcome achievement to mitigate against BCF contingency risk 2015/16 onwards. Being modelled by Attain for inclusion in CC2H procurement.
- Principles around risk-share should be agreed for all Bundles contracting.
- High level contracting strategy for 2015/16 to be developed.

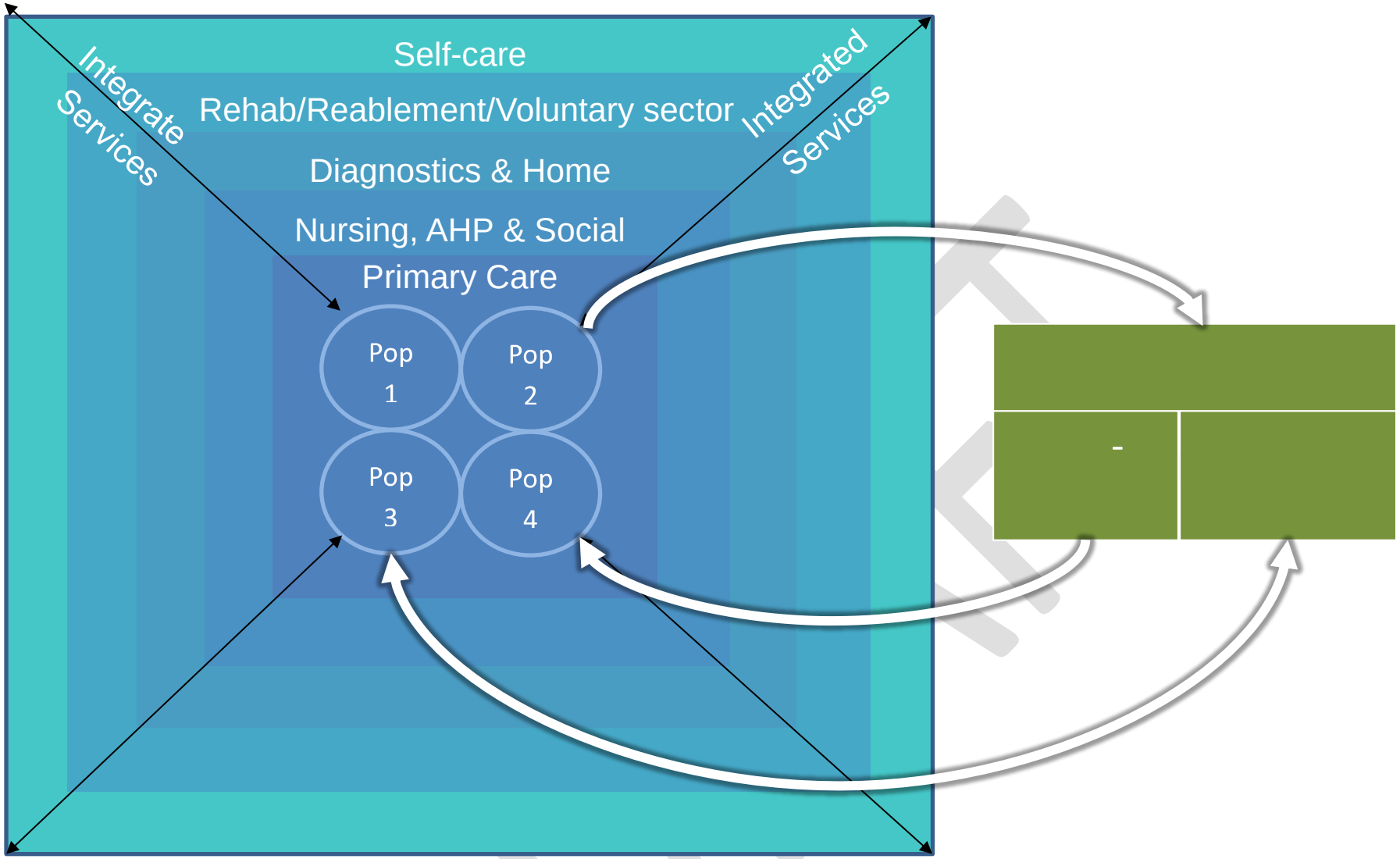
3. Contingency allocation to be agreed through HWB BMG re allocation of contingency in April and October 2015 should targets not be met.

ACTIONS

- Agree risk-share arrangements across Essex CCGs and ECC, and contingency allocations across the metrics


Q3 (Oct-Dec 2013)
Q4 (Jan-March 2014)
Q1 (Apr-Jun 2014)
Q2 (July-Sept 2014)
Q3 (Oct-Dec 2014)
Q4 (Jan-Mar 2015)
Q1&2 (Apr-June 2015)
Q2 (July-Sept 2015)
Communications & engagement plan.
HOSC– public consultation decision
Local Election
Public consultation
HOSC review and approval
Evaluation and recommendations
General Election
External market engagement
Procurement award contract by 31/03/15
Benchmark existing services
Strategy sign off 28/1(CCG Board)
Activity and finance profiling
Strategy and business case refresh
Signed off
Roadmap signed off
CC2H service spec 1st draft 10/12 .
Identify and engage patient/carer /partners providers 2nd draft 31/06
Spec signed off
Communications
Explore contract models
Draw up contract (outcomes, KPIs, info requirements)
Nov – procurement advert placed –procurement
Implementation and phasing to be agreed following identification of successful provider(s)
Planning & Prep
Choose preferred bidder/s. Award contract April
Key Decisions
Serve required notices
Procurement

Appendix A



Appendix B

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Essex County Council	Y			
NEE CCG	N			
CCG #2				
Local Authority #2				
etc				
BCF Total		8,196	20,987	20,987

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency Planning

1. Mitigation through acute contract negotiations in 14/15 and beyond. Impact of 14/15 performance fell in 15/16, limited impact for 14/15 contract, except for starting target reductions in NEL and Elective activity.
ACTIONS
- Establish in-year monthly monitoring to ensure meeting 14/15 Avoidable Emergency Admissions target in year, allowing intervention with Providers in year, in line with BCF plans, if off-target
- 2 year plan workshops being held with CHUFT, ACE and NEPFT to align plans
- Contract negotiation strategies to be considered.

2. Mitigation through contract negotiations in 15/16 and beyond. Risk of contingency loss in 15/16 from underperformance in 14/15 = c.£3.2m of CC2H / BCF value. High level contracting strategy for 15/16 to be developed – including assumption that the BCF will continue beyond second payment in October 2015.
ACTIONS
- Ensure Care Closer to Home contract value includes risk share to appropriate % linked to BCF outcome achievement to mitigate against BCF contingency risk15/16 onwards. Being modelled by Attain for inclusion in CC2H procurement.
- Principles around risk-share should be agreed for all Bundles contracting.
- High level contracting strategy for 15/16 to be developed.

3. Contingency allocation to be agreed through HWB BMG allocation of contingency in April and October 15 should targets not be met
ACTIONS
- Agree risk-share arrangements and contingency allocations across the metrics across Essex CCGs and ECC via BCF Technical Group during 2014/15.

		2015/16	Ongoing
Outcome 4 Avoidable emergency admissions (composite measure)	Planned savings (if targets fully achieved)	Increasing rate of admissions stopped; capped at 1,883 p.a.	Increasing rate of admissions stopped; capped at 1,883 p.a.
	Maximum support needed for other services (if targets not achieved)	Dependent on acute NEL activity rate, increased capacity in CHUFT; enhanced rapid discharge arrangements	Dependent on acute NEL activity rate, increased capacity in CHUFT; enhanced rapid discharge arrangements
Outcomes 1,2,3,6 - ECC to complete	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

BCF Planning Template

Finance - Schemes

Millions

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Core Baseline Funding (1)		3.636				3.636			
Sustainability Funding Uncommitted to be jointly agreed (13)			1.206			1.149			
Sustainability Funding to continue Social Care Virtual Ward investment (1)		0.116				0			
Increase 7 Day Working in Social Care and Health (5)		1.06				1.06			
Reablement (3)		0.976				0.976			
Local CCG Commissioned Reablement Schemes (3)		0.976				0.976			
Carers (11)		0.21				0.21			
Care Closer to Home (2)		0				12.963			
Total		6.99	1.206			20.987	0		
		8.196				20.987			

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The Essex BCF schemes are designed to provide care earlier in our patients and service users care pathways through early intervention and prevention schemes and to keep our service users as independent as possible in their normal place of residency for as long as possible. The metrics will demonstrate the achievements of these outcomes by:-
- Showing a reduction in the number of permanent admissions to residential and nursing homes
- Demonstrating an increase in the number of people being presented to reablement services (local additional measure) and improving the outcomes of those going through reablement
- By investing in additional reablement services including home from hospital schemes we will demonstrate a reduction in delayed transfers of care from hospital
- Avoidable emergency admissions will be monitored monthly by the CCG, allowing intervention if the metric is off-target. The CCG has commissioning bundles focusing on each of the composoite measures in the metric: Care Closer to Home impacts on avoidable ACS admissions among older people; Urgent Care impacts on avoidable acute admissions among older people and children; End of Life impacts on avoidable acute admissions among older people; and Children's services impact on avoidable chronic condition admissions among children.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Not applicable

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance plans that will support these Outcomes and Metrics will be assured across the County and by each CCG. These arrangements will include assurance by the Executive Director for People Commissioning in the local authority and the CCG Board. It is intended that the Integrated Programme Board, with both CCG and ECC membership, will be the formal governance route for the BCF, reporting into the CCG Board and ECC.
The score cards demonstrating progress against the metrics will be reviewed at the Business Management Group of the Health and Wellbeing Board on a quarterly basis and by the Health and Wellbeing Board twice per year.

If planning is being undertaken at multiple HWB level please include details of which HWBs that covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population Proposal is 6% reduction in the number of admissions to residential care. This is based on just over 5% (5.1%) of current residential admissions being directly following a new client assessment at hospital. It is intended for BCF schemes to be set up to prevent these people going into crisis and to divert them down different pathways.	Metric Value	643.6	N/A	584
	Numerator	436		414
	Denominator	67749		68744
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services The proposal is for the Metric target to be to "maintain" current performance. We expect, over the 14-15 period, the nature of reablement cases will shift with short stays being replaced with more complex cases. However, our data is inconclusive on whether this will affect the results after 91 days We have obtained the national results for the ASCOF measure. It shows that Essex, at 83%, is above the Eastern Region average (81.5%) and slim councils (80.8%).	Metric Value	76%	N/A	83%
	Numerator	151		170
	Denominator	201		207
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month) Current performance is in the top quartile of our statistical neighbours. The proposal is a maximum target reduction of 2.5% for the April 15 performance period and a further 2.5% for the Oct 15 Performance period. This is on the basis that the Essex performance is in the top quartile of its statistical neighbours and that the trend has reduced and is now generally level. However, in the first part of this year, delays increased. We believe a 2.5% decrease from 2012/13 levels will be a stretching target.	Metric Value	120.8	114.4	109.9
	Numerator	304	322	218
	Denominator	251948	258300	262100
		2012-13 outturn	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure) The suggested target is to maintain the current rate of avoidable emergency admissions (1863 p.a.) whilst the population increases 1.8% between 2013 and 2014.	Metric Value	1864	1863	1863
	Numerator	6125	3151	3151
	Denominator	328544	338311	338311
		(2012-13)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience (for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used)			N/A	
		(insert time period)		(insert time period)
ADDITIONAL LOCAL METRIC: The coverage of reablement. This metric will measure an expansion in the number of referrals from community into reablement. We have taken the 2012-13 baseline and reduced it to take account of inappropriate referrals to reablement. We have the number of community referrals we expect in the first target period, increasing these for the October 2015 payment. This means that schemes need to be in place to be getting the additional referrals in the first half of the 14-15 financial year.	Metric Value	1680.1	1427	1750
	Numerator	901	915	1454
	Denominator	67749	72900	72900
		2013-14	Apr 2014 - Mar 2015	October 2014 - September 2015

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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	**Essex County Council**
Clinical Commissioning Groups	**West Essex CCG**
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**7 March 20014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£17.43m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£18.98m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	<Name of ccg>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	<Name of council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

"My Health, My Future, My Say" sets a vision for the West Essex health and care system over the next 10 years. The development of our vision was informed by two major engagement programmes undertook by the CCG with patients, clinicians and service providers in west Essex during 2013. The discussions that took place through this programme have contributed directly to how we plan to design and shape our services for the next 3, 5 and 10 years.

Health and social care organisations in West Essex have agreed to develop and test a new way of working that delivers integrated commissioning and provision of services. The West Essex BCF plan focuses this activity within the Integrated Frailty Programme as this is the first pathway to be developed. As this pathway is in its early stages of development it is likely that scope will extend beyond the detail and funding of the BCF plan.

The Integrated Frailty Programme will be commissioned jointly by CCG and Social Care and provided by SEPT as accountable lead provider with an integrated supply chain including Essex County Council, Princess Alexandra Hospital, Essex Cares, Primary Care, Ambulance Service, North Essex Mental Health Trust and voluntary sector, with aspirations to develop the supply chain further and expand the role of the social care sector.

System wide clinicians and social care commissioners and providers are already part of the established clinical reference group governance process, and SEPT has established a Frailty Programme Integrated provider partnership board. Current membership includes:

- Essex County Council
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Princess Alexandra Hospital NHS Trust (PAH)
- North Essex Partnership University NHS Foundation Trust (NEPFT)
- Essex Cares
- Voluntary Sector
- Primary Care
- Ambulance Service

Plans and progress are discussed at monthly system leadership meetings, along with

one off meetings including a stakeholder business event on 17 January and a Lead Provider and Commissioners Workshop on 31 January 2014.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

What our citizens told us they wanted when we engaged with them over the summer:

- Personal responsibility
- Prevention and early intervention
- Changing culture – caring for people as individuals
- Minor problems are important
- Access to primary care as gateway to all care
- Integrated care.

Patients have been involved throughout the service design for the Integrated Frailty Programme for 2013/14 and 2014/15.

An outcomes framework has been developed with patients and carers for the frailty programme.

A workstream has been established as part of the Frailty Programme for patients and carers that will focus on ensuring:

- We understand patient and carer needs and wants
- Patients and carers understand programme goals and how these will be achieved
- Service changes are widely understood and do not result in public concern or opposition

e) 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
Frailty Mandate	West Frail Mandate D1 131024.doc
Frailty Business Case	Draft Frailty Programme Business (
West Essex CCG Planning for Transformation 2014/15	Transformation and redesign event 17th J
West Essex JSNA	**tba**

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Health and social care organisations in West Essex have agreed to develop and test new way of working that delivers integrated commissioning and provision of services to realise the vision of the West Essex Clinical Commissioning Group (CCG):

The population of West Essex is enabled to maximise their health and live fulfilled lives, and, those in need of support receive the most appropriate and well-co-ordinated high quality care that restores their health and promotes their continued independence, at best value to the tax-payer.

This will be achieved through:

1) Establishing a joint commissioning system for improved outcomes and efficiency, not inputs (ECC and WECCG)
2) Appointing an accountable lead provider to manage an integrated care supply chain

This work is already underway and is not limited to activity defined within this plan.

The focus of the programme is the frail population and those who are at risk of becoming frail.

The programme scope runs across the whole health and social care economy in West Essex. The work of the programme spans the roles of key local organisations, responsible for both the commissioning of services and their provision:

- West Essex CCG
- Essex County Council
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Princess Alexandra Hospital NHS Trust (PAH)
- North Essex Partnership University NHS Foundation Trust (NEPFT)
- Essex Cares
- East of England Ambulance Service NHS Trust
- Voluntary sector.

The organisations listed above will form a supply chain, with SEPT as accountable lead provider (ALP). The scope of the programme is however wider than the supply chain, encompassing primary care and other important providers such as Barts Health NHS Trust and Cambridge University Hospitals NHS Foundation Trust.

The supply chain will engage closely with primary care to design services will specifically to the needs of each primary care led locality.

The programme is timetabled for three years (2014/15 to 2016/17), plus a preparatory period in 2013/14:

Year	Work undertaken
2013/14	Preparation for the implementation of change in the commissioning and provision of services
2014/15	Year one – piloting of new models of care and 'shadow' new accountable lead contracting arrangements; early wins
2015/16	Year two – analysis of year one and roll-up of successful pilot / shadow arrangements into core ways of working; further agreed improvement and change
2016/17	Year three – full embedding of successful change; significant and sustained changes to the model of care, including significant and enduring shifts of activity to community settings
2017-19	Years four and five – continued realisation of the benefits of change; all financial targets met

From a patient perspective, the goals of the frailty programme can be summarised as:

- Increasing the length of time known conditions are maintained in a stable condition, and therefore reducing the frequency of acute exacerbations
- Decreasing the severity of acute exacerbations when they cannot be prevented, by early detection and rapid response
- Reducing the impact of acute exacerbations by shortening the duration of the episode through rapid response and effective reablement
- Reducing the levels of vulnerability/ frailty by managing the risk of developing/ worsening additional co-morbidities.

Patients will see the difference through:

- Care closer to home
- Fewer 'crises' requiring acute admission
- A slower transition to frailty for those at risk of becoming frail
- Fewer organisations delivering care

The CCG and its partner practices have over the last 12 months been exploring how a programme of transformation within primary care can support a different approach to providing care to our population. Each of our 3 primary care localities, Harlow, Uttlesford and Epping are proposing to establish themselves business entities to facilitate their ability to act as lead coordinators for the management of care for a number of conditions over and above core services. This could involve practices taking responsibility for a total budget for a group of patients. Plans are being developed as follows:

- Localities to form business entities by 1 April 2014
- Extended range of provision of ACSC (Plus) commencing **July 2014**
- Extended provision- 7 day working **June 2014**
- Commence co-location of services /community based hubs from **Sept 2014**

From a financial perspective, the goal is to ensure that the health and social care economy is able to meet rising demand (due to an ageing population) within available resources.

b) Aims and objectives (should this be dumped and just embed the outcomes document?

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Our overall aims and objectives for integrated care within the frailty programme are to:

- Demonstrate a marked improvement in patient experience and quality of care, which is centred on the needs of the individual
- Work through organisational boundaries and promote inter-organisational working
- Develop a commissioning landscape that supports prevention of crisis
- Share risk and gain appropriately through the West Essex care system
- Invest in infrastructure that will improve sharing of patient information across organisations involved in care; and also support performance management
- Improve productivity and make better use of resources.

The basic assumptions underpinning the programme are:

- That the quality of patient care can be improved by integrating services
- That integration can be facilitated by the appointment of an ALP with a supporting supply chain, covering acute, community and social care
- That ALP arrangements and integration can in turn be facilitated by a new form of contract – where risk and gain are shared between commissioner and provider
- That joint commissioning between health and social care will support an integrated provider response
- That integrated care will remove inefficiencies from the care process and make better use of resources
- That better use of resources will help the health economy to manage demand pressure and, over time, establish a secure financial position.

The programme also assumes that the local health and social care community can work together to deliver the programme in a co-operative and transparent way.

The ALP will be commissioned to deliver a change in outcomes – work is underway to agree how the change will be measured. A draft copy of the outcomes framework is provided:

Frailty Outcomes framework - social ca

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Within the scope of the programme is the development of new service models and commissioning arrangements for those defined as frail or likely to become frail. Most of these patients will be elderly, though not all. The wider patient population within scope is defined as:

- Anyone over the age of 75
- Anyone under 75 years with conditions that are amenable to frailty
- Anyone with dementia or in a long term care home.

This definition is being refined to produce an identified and 'sized' population cohort, on which the programme will focus.

The key criterion is frailty – defined as a patient who has or is likely to have a set of health conditions and/or social circumstances that mean they can readily fall into a crisis resulting in (for example) unplanned acute hospital admission. The scope of the frailty programme population includes services for those who are very ill or at the end of their lives, but importantly it includes services for those who are at risk of becoming frail.

The boundaries of the programme are wide, but will be bounded in order to ensure that it is manageable; the population cohort is capable of being robustly commissioned for; and success can be properly evaluated.

A summary of proposed changes in the service model is given below. This will be refined in early 2014.

Pre-shadow & Year 1	Year 2	Year 3
Start to integrate health and social care: access to social care information & access to rapid response social care via SPA for A & E & RAC	Fully integrated health and social care access via a Care Co-ordination centre to all piloted services	Establish full capability of care co-ordination centre
Improve access to reablement for hospital discharge	Extend access to rapid response to community	Embedding and roll – out of all successful pilot schemes
Front end of PAH changes to support admission avoidance activity	Improve rates of community based rehab at home	Re-design and re-pilot unsuccessful schemes
Improve access to RAC	Set up specialist MDT's	Establish full MDT working
Working towards dedicated step up beds in focussed units.	Increase capacity for step up intermediate care	
Focus on admission avoidance from care homes	Ambulance trust changes to support admission avoidance	
Extension to mental health crisis support for AA	Revised focus on community dementia support and liaison	
Pilot MDT's in willing and able GP practices, developing risk stratification tool	Delivery of supportive end of life pathways, revise integrated community team working including falls pathway	

The key interfaces between this programme and other work are:

- The CCG's other transformational programmes with complementary aims; including -
    - Working age adults with ambulatory care sensitive (ACS) conditions – linked in terms of caring for patients with long term conditions
    - Primary care - where changes in the service model are complemented by changes in primary care provision
    - Non-supply chain providers – contracting with (for example) tertiary hospitals must complement the main frailty programme
    - Within the CCG, there are clear linkages to the work to commission improvements in urgent care, NHS 111, stroke care and end of life care.
- Alignment with ECC transformational programme

d) Implications for the acute sector

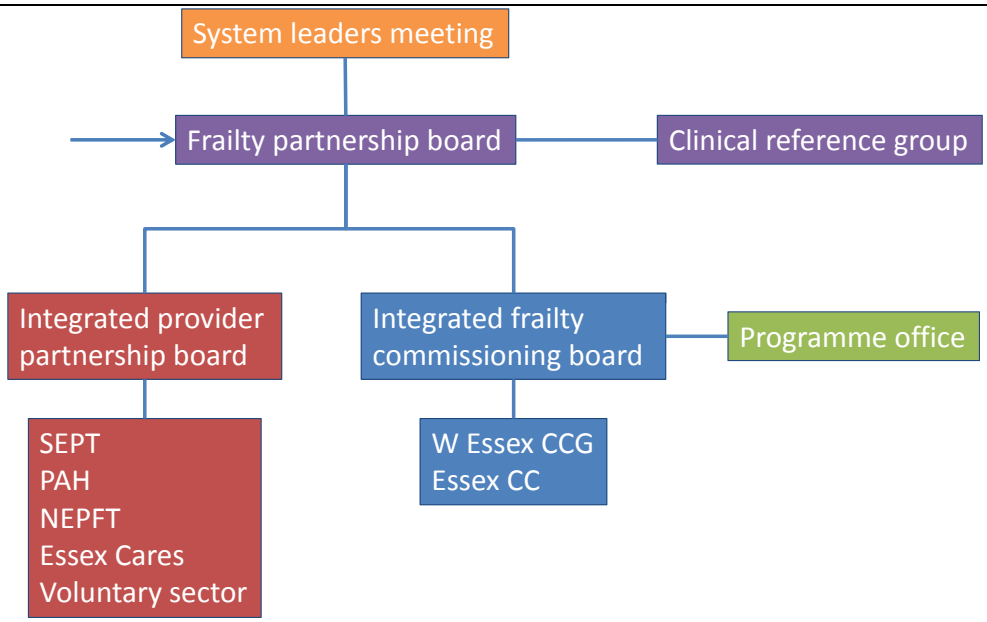
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The BCF fund spending plan will have a significant impact on non-elective admissions. This impact will be achieved through a more integrated health and social care approach to hospital discharge and better access to services closer to home which prevent the need for emergency admission/re-admission. For example, faster access to urgent social care services including night carers and reablement services, as well as improving the support network in the community which means that patients are less likely to reach a crisis point. The establishment of an integrated community workforce made up of social care, mental health and community services will allow for a more patient centred proactive service.

During 15/16 the programme aims to avoid inappropriate admissions across the acute sector that serves west Essex patients. The exact numbers are still in development This should have a positive impact on the acute sector by releasing capacity to deliver more elective capacity and reduce outsourcing.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



Each named organisation is accountable through its own governance structures and to national structures. The nature of this programme is one of collaboration between independent organisations.

The governance roles of each body are set out below:

Body	**Role**
Integrated partnership board	Authorisation of the programme, including changes in provision and commissioning arrangements
Clinical reference group	Agreement of the service model for integrated care; required outcome measures; etc
Joint frailty commissioning board	Forum for the CCG and ECC to agree their commissioning approach and requirements for frailty
Integrated provider partnership board	Forum for SEPT and the supply chain to agree the frailty provider approach and manage delivery

Terms of reference will be agreed for each of the bodies listed.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

We will protect social care services in Essex by ensuring that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. Our ambition is to maintain current service level and to develop integrated care pathways that enable individuals to remain as independent and healthy as they are able, that maximises resilience and builds upon personal capacity and existing support networks. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

Please explain how local social care services will be protected within your plans.

The local authority has engaged in a transformation programme that has led it to become an outcomes based commissioner with a strong locality focus and has released efficiencies enabling it to maintain its current eligibility criteria. This allows the local authority to ensure that it can allocate additional spending for local social care services to the same financial level in 2014/15 as we did for 2013/14 using the Social Care Sustainability grant. This will enable the purchasing of community based social services within each CCG locality. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principle mechanism for this is ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained in 15/16 and 16/17 to allow for contract procurements. In particular for the West Essex health and social care system this will take the form of further investment in an integrated community based reablement model following our test and learn reablement pilot in West. It is our intention that the identification of such citizens and scheme development will in future be the responsibility of the Approved Lead Provider, using existing metrics and data.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

- We are working with all of our providers to develop action plans to support their response to the 10 clinical standards for 7 day working. This will be a key component of SDIPS over the next two years and beyond. We will engage closely with our providers to ensure once action plans are developed to ensure roll out across the system over the plan period in line with contract commitments

- Health and Social care commissioners in west Essex will expect providers to ensure the same standards of services are provided across seven days. We will

be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge.

- In the meantime the CCG is developing an Urgent Care Strategy, in response to associated 'winter pressures' in the acute hospital setting. There is a clear expectation that 7 day support for hospital discharge on a WECCG 'whole system' basis. Priorities including 7 day discharge from PAH, health and social care in-hospital capacity and activity and Health and social care support and reablement services for community discharge are being piloted this winter., supported by rapid assessment, and CARS, improved access to primary care services 7 days a week.
- The accountable lead provider for frailty will be commissioned to develop a set of services that 'wrap around' patients and operate flexibly across a 7 day service arrangement.
- Early diagnosis of ACS conditions is highly dependent on improved and direct access to diagnostics, with urgent reports being provided to GP's within 24 hours. The CCG therefore expects the ACS service model to be available 7 days per week where appropriate. We will be commissioning for outcomes and these outcomes will be the same regardless of day of the week and expect primary care providers to provide extended 7 day a week services from July of 2014

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

It is our intention to use the NHS number as the primary identifier in the future. Improved IT systems within ECC to be commissioned later in 2014 will have the ability to enter and use the NHS number. WECCG are currently unable to use the NHS number due to national restrictions which impact upon all CCG's. However, the CCG has been granted Accredited Safe Haven status and will potentially be able to receive patient identifiable data at some point in 2014/15. We already have a data sharing protocol in place between ECC, PAH and SEPT to support the SPOA.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

As above

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

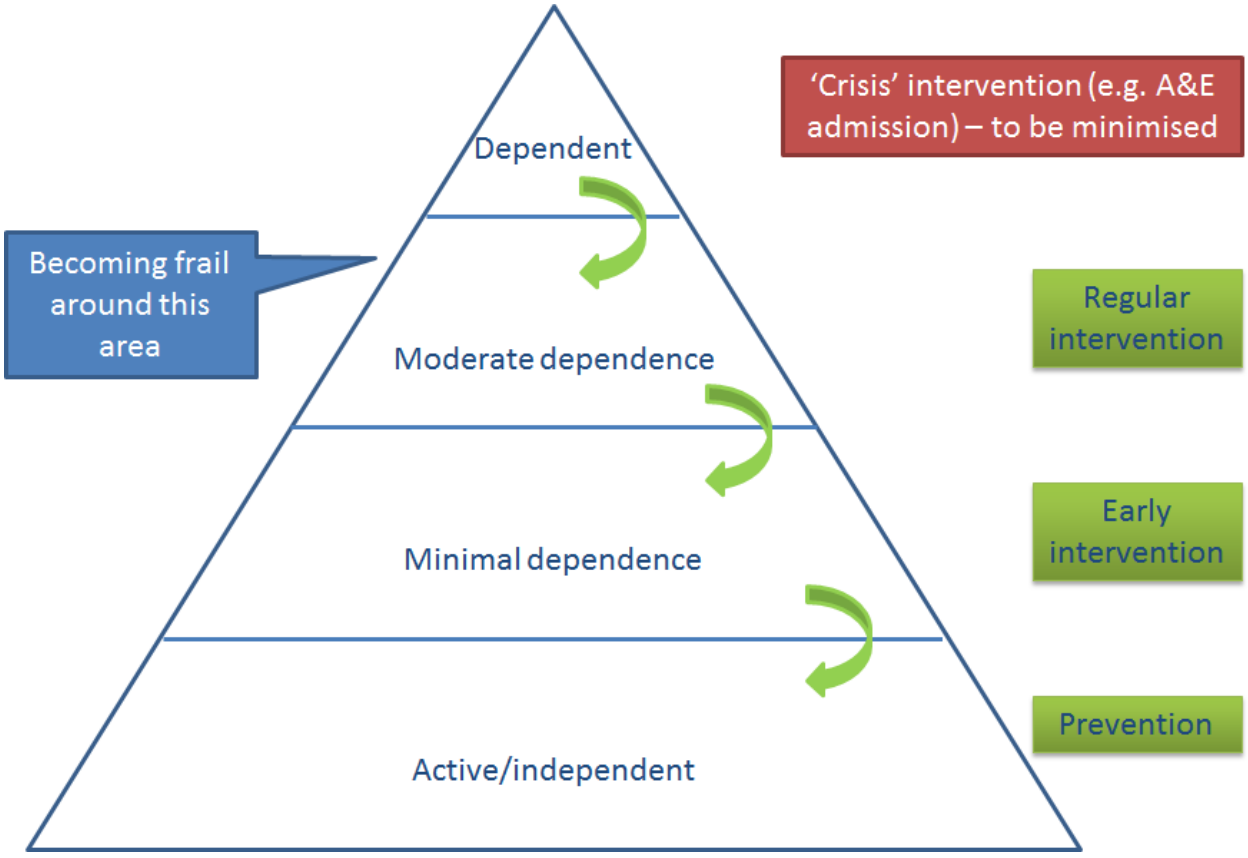
Yes

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Local people deemed to be at high risk of hospital admission will be allocated an accountable lead professional via primary care. At present a jointly agreed risk stratification tool, between CCG and social care has not been agreed or identified. The future approach to risk stratification will be by the Approved Lead Provider for the WECCG area, which will commence in shadow form from April 2014. The ALP will then be charged with the responsibility of a) identifying and sharing a suitable risk assessment tool and methodology b) apply this to the WECCG population. This future modelling will then be able to identify the proportion of the population who at High and Very High risk of hospital Armed with this information, more importantly the ALP will then begin to construct a supply chain around this relevant population that is able ensure early identification and prevent and where possible, reverse frailty and maximise resilience and capacity. The ALP will also be responsible for the development of demand management schemes which, via early intervention and the adoption of early identifier risk stratification models will be able to offer community based support, to prevent crises occurring.



We will put in place a service model that will slow down and where possible reverse the

rise of patients up the pyramid. We will design and commission a model of care that reduces the risk of crisis and reduces dependence.

4) RISKS

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

Risk	Risk rating	Mitigating Actions
Financial – failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing pressure as an ageing population increases demand	High	At the outset of the programme, being clear on: • Financial objectives • Service model changes to deliver greater efficiency
Clinical and quality – that changes do not improve quality or worsen it, resulting in a poorer patient experience	Low	Service model changes will be reviewed throughout the programme, with contract mechanisms and measures in place to evaluate all changes
Contracting process – inability to set an agreed baseline and assumptions for the contract; for example, relating to funding for transformational schemes during 14/15	Medium	Contract negotiations and clarifications have begun, with an agreement to make all financial baseline issues transparent
Competition rules – inability to set a contract length long enough to facilitate transformational change while conforming to market testing requirements	Medium to High	Market testing policy to be drafted as part of the contract, to facilitate competition within the supply chain
Objectives / expectations – failure to adhere to agreed programme scope, objectives, etc. and to 'drift'; risk of overlap or conflict with other transformational schemes	Low	The PID and subsequent documents will formally record the scope and nature of the programme, for formal sign-off and review
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits	Medium	The programme will be properly planned, with agreed timescales, dependencies, etc.; progress will be reviewed and contingencies developed where necessary

External environment, including politics – challenges to the programme from important external stakeholders or influencers, opposing programme objectives or the means of achieving them	Medium	A stakeholder management exercise will be undertaken to (inter alia) assess any potential challenges, their impact on the programme and how they should be managed
Commitment and engagement – failure of the local health and social care community to remain committed to the programme and its objectives	Low	The governance structure is intended to formalise senior level commitment to the programme; throughout the programme ongoing support will be assessed
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining the contract and the evaluation of results	Low	Early prioritising of a pragmatic population cohort that can be identified and measured

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority #1				
West Essex CCG	Y	0	*17.435*	*18.98*
CCG #2				
Local Authority #2				
etc				
BCF Total				

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

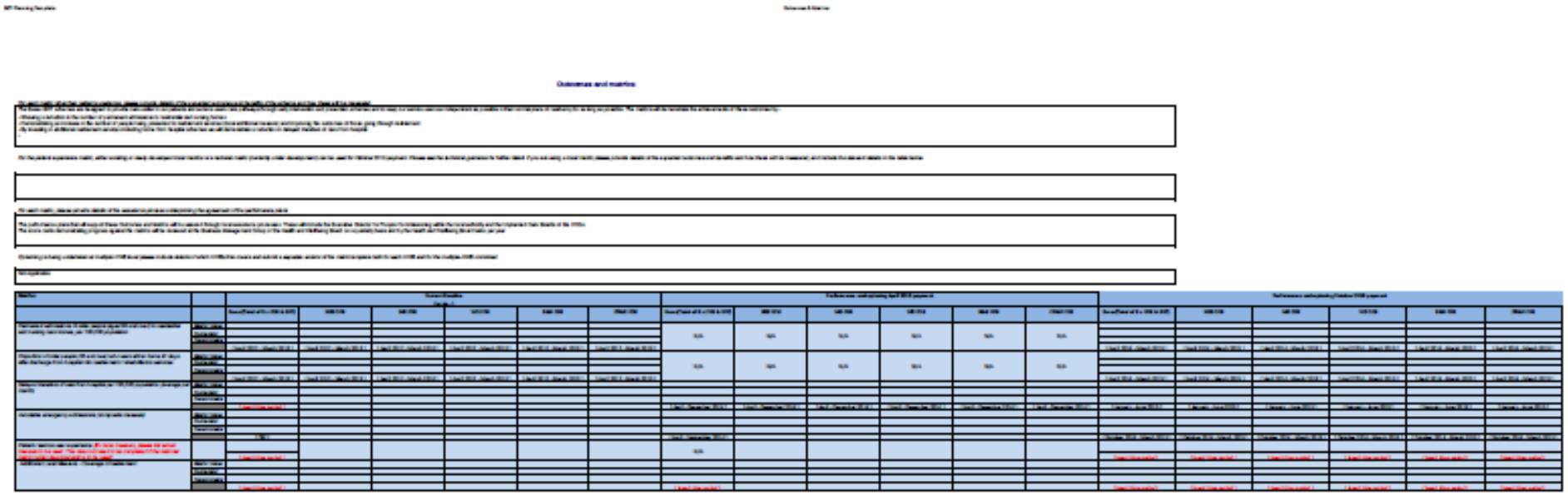
CCG: The £18.98m invested in 2015/16 is directly lifted from existing budgets and liabilities within contracts (predominantly community). The CCG is working on the basis that funding input to the BCF is not new funding and is seeking further guidance on the mechanics of the performance related aspect of the BCF.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	0.3	0.3
	Maximum support needed for other services (if targets not achieved)	0.3	0.3
Outcome 2	Planned savings (if targets 50% achieved)	0.15	0.15
	Maximum support needed for other services (if targets50% achieved)	0.15	0.15

BCF Planning Template | Finance - Schemes | DRAFT

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

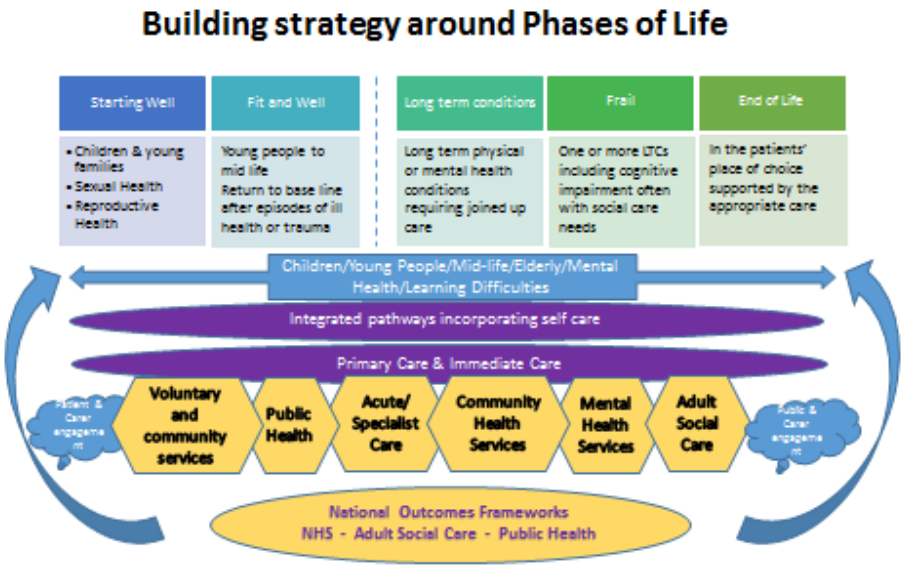
BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Scheme 1: Protection of social care fund to benefit health	ECC					*5.538*		*0.09*	
Scheme 2 : Community Health services incl admission avoidance	SEPT					*11.604*		*0.18*	
Scheme 3: Reablement	ECL					*1.464*		*0.02*	
Scheme 9: Early intervention and prevention	SEPT & VCS					*0.1*		*0.00*	
Scheme 11: Carers	SEPT					*0.184*		*0.00*	
Total						**18.98**		**0.3**	



Mid Essex - Better Care Fund planning template – Part 1

CONTEXT

Our aim is to use BCF to improve outcomes for Mid Essex residents by transforming services through greater integration and earlier intervention. Our vision is of our communities working together to create sustainable and local services delivering integrated first class health and social care services for all. The Council and the CCG are working together on an integrated approach to the 'phases of life';



The Better Care Fund will be used to implement integrated services which support people with health and social care services throughout those phases.

Our overall model for integration is for care to be coordinated by lead professionals in multi-disciplinary teams (MDTs) , with a joint assessment and agreed authority to arrange services. We will make sure that services are easily accessible with single points of triage and referral and .we will work in partnership with GPs to target support at those at risk of unnecessary admission. We will target preventative interventions to avoid health and care needs escalating.

This planning document reflects the planning intentions of the Mid Essex Clinical Commissioning Group (MECCGs), Essex County Council (ECC) and partners to the Essex Health and Well-Being Board for the use of the Better Care Fund (BCF) in Mid Essex. It is an appendix to the main Essex Better Care Fund template, and its actions form part of the Mid Essex Two-Year Operational Plan 2014-16.

This document has been informed by the Joint Strategic Need's Assessment's (JSNA), the Health and Wellbeing Strategy (HWBS) for Mid Essex, and by discussions with providers and service users It has been endorsed by the Essex Health and Wellbeing Board (HWB) on 27th March 2014.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**Mid Essex CCG**
Date agreed at Health and Well-Being Board:	**Draft version 12/02/2014** **Final version 27/03/2014**
Date submitted:	**Draft version 10/03/2014** **Final version 04/04/2014**
Minimum required value of BCF pooled budget: 2014/15	**£4,932,000 (County Figure)**
2015/16	**£21,651,000**
Total agreed value of pooled budget: 2014/15	**£4,932,000 (County Figure)**
2015/16	**£21,651,00**

The Plan covers the Mid Essex area of the County, including the Districts of Braintree, Malden and Chelmsford. The CCG and ECC schemes cover these areas, and form a contribution to the Essex-wide Health and Well-Being Board BCF Plans.

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**Mid Essex CCG**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Council	**Essex County Council**
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

c) Service provider engagement

We have developed our plans for BCF Schemes with local health and care providers and we expect their shared leadership for implementation of transformation programmes, in particular using clinical networks and system leadership groups. This submission therefore reflects a number of existing transformation programmes developed with providers, including the recent reviews undertaken within the CCG as part of its sustainability review. More details of that are contained within the Two-year Operational Plan.

A whole system engagement event was held in June 2013 involving voluntary sector, health and social care providers, local authorities and CCGs to define what integration

could look like in Essex. Details of this consultation work can be found *in "Health and Social Care Integration"* (see Related Documentation section).

Further engagement events took place during December 2013 and January 2014. Working together, ECC and individual CCG's have jointly developed the vision, aims and objectives for health and wellbeing in their localities.
The joint integration programmes/schemes that the BCF will include were discussed and provisionally agreed at these events, subject to further planning and validation.

d) Patient, service user and public engagement

The Business Management Group, (a subcommittee of the Health and Wellbeing Board), has led the development of this submission and includes representation from Healthwatch to help ensure that this plan reflects a patient and service user perspective.

ECC and the CCGs routinely engage with a number of patient and public forums and service user representative groups as part of their planning for future commissioning and service development. The outputs from these sessions have been used to develop schemes within this BCF plan.

A number of consultation and engagement events have taken place to enable patients and the community to shape the commissioning and planning of local services. ME CCG is in the process of embedding its refreshed PPE structure and strategy across its organisation and work which will facilitate a comprehensive engagement programme across its services and the integration agenda.
We will work in partnership to use all existing engagement routes to maximise opportunities to engage with the public including Healthwatch Essex. Patient Engagement Groups events that took place during 2013 which provided the opportunity for patient views to be heard and considered, i.e. to act as an information exchange conduit. Patient and Community Reference Groups act as formal reference sources for CCGs and forums to discuss broad strategy and integration. These groups link to the localities through lay members of CCG Governing Bodies.

- CCG locality managers ensure local views and connections are maintained. CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients and the public. Each CCG publishes a prospectus each year.

In summary, whilst developing this plan, the key messages that we have heard from patients and service users are the need for:
:

- Personal responsibility for their health and social care.
- Prevention and early intervention schemes in their health care
- A change in the culture – caring for people as individuals
- An acceptance that minor problems are important to our citizens
- Access to primary care as gateway to all care that should then be integrated.

These themes have helped to shape our planning.

Further engagement with voluntary and community sector (VCS) organisations will include the facilitation of focus groups to obtain further feedback from service users and patients as we refine and develop these plans. Healthwatch Essex will work with us to develop user engagement and feedback forums specifically focussed on the BCF.

e) Related documentation

Document or information title	Synopsis and links
Health and Social Care Integration (Accelerated Design Event)	The vision for service users and commissioners, the collective ambition and strategy for commissioning, priority areas for service redesign  1372316_Essex Accelerated Event AS
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities the Essex locality (excluding Thurrock and Southend localities) http://www.essexinsight.org.uk/Resource.aspx?ResourceID=299
Joint Health & Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the Essex localities (excluding Thurrock and Southend localities) http://www.essexpartnership.org/content/health-and-wellbeing-board
"Who Will Care" commission report	
ECC BCF Template	The ECC Better Care Fund Planning Template Parts 1 & 2
The Seven Day Services Improvement Programme	The Seven Day Services Improvement Programme expressions of interest

2) VISION AND SCHEMES

a) Vision for health and care services

Our vision is of our communities working together to create sustainable and local services delivering integrated first class health and social care services for all. This means that by 2018 residents and local communities will have greater choice, control and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced. Every child and adult will be given more opportunities to enjoy better health and wellbeing.

For people with health and care needs in Mid Essex:

- We will commission and deliver integrated care that is person centred, closer to home and which leaves people in-control.
- The care we deliver will be consistent in quality with an appropriate response 7 days a week.
- Service delivery will be integrated with lead providers coordinating care on our collective behalf.
- Vulnerable and frail people will have a named professional working with them
- We will be fair in the delivery of care. This means being consistent across our patients and service user groups;
- Primary Care Services will proactively support people with long term conditions with preventative interventions
- There will be viable alternative to prevent avoidable admissions
- We will provide more intensive community-based reablement services to promote independence and lessen the need for ongoing health and social care services
- Our approach will take account of the wider determinants of people's lives including their families, carers and communities
- Communities will be resilient and sustainable, with a new partnership about 'Who Will Care?'

For commissioning in Mid Essex:

- We will use outcomes-based commissioning on the basis of robust evidence and detailed analysis, that will identify clear triggers for interventions;
- We will be commissioning-led and have whole systems sustainability based on local, joint commissioning arrangements
- We will share data in a safe and timely way enabling us to better understand our population so that we can design and commission the services they need and will need in the future;
- We will consistently engage with providers to encourage innovation, manage markets to streamline and deliver efficient and effective pathways;
- We will align and pool budgets and finances to deliver the most effective impact, integrating resources where possible.

The key enablers for change are;

- A joint commissioning approach that oversees BCF Schemes.
- Leadership at a system-wide level
- Simple access to information;
- Earlier intervention;
- Community engagement and community-based services which reduce demand on health and social care services;

- Dignity and respect, people are treated as individuals with a choice, and their information follows them wherever they go in the system;
- Services, which are joined up, delivered in a timely fashion, and are easy to navigate.

Aims and objectives

In Mid-Essex we have developed a strong clinically-led Phases of Life model which seeks to support people to be strong fit and well, and to intervene when people need support with long term conditions, frailty or end of life care. Essex Social Care Services provide services and personal budgets to enable people with long term needs to remain independent.

There is a shared commitment to integrate commissioning and to develop integrated health and social provision based on integrated pathways in particular for frailty, people with long terms conditions, admission avoidance, immediate care needs, and discharge support.

We share an understanding that no one can plan, commission or deliver services in isolation, so if we wish to provide high quality services and make efficient use of diminishing resources we must work collaboratively.

We aim therefore to develop provider models which lead and coordinate health and social care, and which support Primary Care development. A strong theme in these models is access to enhanced reablement and intensive support to promote independence and minimise the need for continuing health or social care.

The JSNA and the Essex's Joint Health & Wellbeing Strategy have informed our outcomes.

Aim/Objective	Measured by
Improved quality of life and greater independence for the frail and vulnerable group that supports optimum self-care and has a primary purpose to improve outcomes at its core	• Patient reported outcomes • Patient reported experience
Reduction in total demand for acute care (not simply a shift from acute to community settings)	• Reduced admissions; reduced emergency admissions, shorter length of stay
Reduction in emergencies and other unplanned activity	• Reduced emergency and unplanned admissions, reduced A&E attendances
Improved clinical information	• Evidence of sharing data / use of shared systems use of NHS number/ clinician-reported evidence
Increased levels of education and awareness of self-care	• Patient reported engagement in care planning
Better diagnostic monitoring, community and reablement services	• Activity setting shifts

Improved financial performance	• Savings targets realised
Simplified contract monitoring processes	• Reduced time in contract discussions
Improved working across health and social care services	• Proportion of people with a joint assessment, use of the NHS number, Greater confidence in partners; greater transparency
A new approach to commissioning that focuses and incentivises the whole system to achieve outcomes that meet the needs of service users in their teams	• Evaluation of risk share contract with Providers and integrated care supply chain; evaluation of outcome measures in use

The JSNA highlights inequity of access to services and inadequate support for self-care as well as a rapidly ageing population, is contributing to an increasing gap in health inequalities and life expectancy.

Work on the BCF schemes, and wider Transformation Programme in the CCG and Essex County Council should result in:

- People maintaining their independence for longer through lower admission rates to residential care
- Reduced rate of acute hospital admissions by age
- Reduced admissions to hospitals as a result of falls and stroke

We have identified the Metrics identified in BCF Template 2. The targets we have set and the assumptions behind those targets have been developed for Essex as a whole and are explained below:

1. **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population:** Essex proposes to achieve a 5% reduction in the number of admissions to residential care (equating to a reduction of 63 people per 100,000 of the over 65 population). This is based on 6.1% of current residential admissions occurring directly following a new client assessment at hospital. It is intended that BCF schemes will be developed to prevent these people going into crisis and divert them along different care pathways.
2. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**: The Metric target is to "maintain" current performance. We expect, over the 2014/15 period, that the nature of reablement cases will shift with short stays being replaced with more complex cases. However, our data is inconclusive on whether this will affect the results after 91 days. We will be investing BCF funds into increasing the number of people being offered reablement in Essex thus making in the target to “maintain” performance a stretching one. Essex’s current performance compares favourably with both its geographic and its statistical neighbours, currently achieving 82% against this metric: above the Eastern Region average of 81.5% and shire councils of 80.8%. To maintain 82% requires an increase in 256 people to achieve the reablement target during 2014/15
3. **Delayed transfers of care from hospital per 100,000 population (average per month):** Current performance is in the top quartile of our statistical neighbours. The proposal is a maximum target reduction of 2.5% (7 people per 100,000 total population) for the April 2015 performance period and a further 2.5% (a further 7 people per 100,000 total population) for the October 2015 performance period. We believe that this is a stretching target as the Essex performance is currently in the

top quartile of its statistical neighbours and that the trend has been reducing and is now generally level. However, in the first part of 2014 delays have increased.

4. **Avoidable emergency admissions (composite measure)** NHSE CSU has provided the composite measures to calculate this baseline. This metric will be driven by local CCG admission avoidance schemes particularly around paediatric admissions. The suggested target is to maintain current levels of avoidable emergency admissions (1676) whilst the population increases 2% in the first performance period.
5. **Patient / service user experience** As ECC and the CCGs do not use comparative methods of measuring this metric it is proposed not to include this metric until the national metric has been developed
6. **Additional Local Metric - the coverage of reablement.** This metric will measure an expansion in the number of referrals from community into reablement. We have taken the 2012/13 baseline and reduced it to take account of inappropriate referrals to reablement. We have identified the number of community referrals we expect in the first target period, increasing these for the October 2015 payment. This reflects schemes that will be put in place to develop additional referrals in the first half of the 2014/15 financial year. The target shows an increase of 99 people per 100,000 population referred for reablement between April 2014 - March 2015 and a further 324 people per 100,000 between October 2014 – September 2015

b) Description of planned changes

Agreed Better Care Fund Schemes

Within the “Everyone Counts” planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

Mid Essex CCG has developed, in partnership with the Council, a Transformation Programme based on its vision for support during life phases, to deliver system-wide change and sustainability. We will take action in 2014-15 on the following programme of work to deliver change and to create sustainable funding for the health and social care system. These schemes are designed to enable the CCG to return to sustainability, and for the County Council to achieve savings required by its Transformation Programme:

Programme	Life phase
Safe and well at home - developing capacity for self-care, community resilience	All
Long Term Conditions - House of Care, developing LTC Hubs integrating primary care, community health services & specialist services around needs of people with complex needs and co-morbidities - Integrated care MDTs and risk stratification - Supported self-management - primary and secondary prevention	LTC
Mental health and dementia Continuing the support community-based facilities delivered through community-based organisations	LTC and frailty
Frailty - Pathway; proactively identifying frail people and integrating health, social care & housing to support independence	Frailty
Frailty - Continuing Health Care - Working with ECC and cross-Essex group to redesign early intervention and prevention, assessment and review and joint procurement	Frailty
End of life - continuing to promote conversations about EOL and preferred place of care choices - joining up EOLC services, working with Hospice	EOL
Immediate Care - simplifying and joining up urgent and emergency care services	All
Primary care - bedrock for (nearly) all programmes - engaging practices to develop as providers at scale - advice and guidance/CRS - extended/enhanced primary care - using changes in QOF - community pharmacy	All
Enablers – IT/IG, workforce, pharmacy, estates, PPE, etc	all

This programme then contributes to the following Better Care Fund Schemes which are grouped according to headings across all CCG BCF schemes.

1. Continued Protection of Social Care Services with a health benefit

We want to ensure that those in need in Essex continue to receive the support they require, against a backdrop of pressure on service capacity and resources. We know that to achieve this we have to work in partnership with individuals, carers and communities to help people stay healthy and independent for as long as they can, reducing pressure on services and helping them enjoy better health and wellbeing.

£4.136min 2014/15 will be used to mitigate reductions in purchasing budgets and a further £1.550m will be used to continue our preventative early intervention and reablement services. £1.595m will be used to develop additional capacity for reablement services and preparation to implement the Care Act.

Through this investment we will also ensure that we build the capacity to deliver 7 day working and integrated services with CCGs. The local authority and NHS commissioners will work together to bring sustainability to the health and social care system by:

- investing in preventative health and social care services which will avoid future demand and help people remain safe and independent at home for longer;
- targeting funding at system reform to bring together health and social care provision and avoiding duplication of process through re-designed pathways;
- enhancing services to carers;
- locating care and assessment resources and care services to support people to stay in their homes;
- targeting frail and vulnerable older people to minimise, delay and avoid inappropriate demand;
- Moving as much of its resources as possible from residential and domiciliary care into more reablement and proactive case finding.

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2. Community Health services including admission avoidance

<u>Integrated Community Health and Social Care</u>

We will develop a lead provider model for health and social care integration involving community health services, admissions and discharge pathways, adult social care and primary care services. These providers will be responsible for ensuring access to services, for effective coordination of multi-disciplinary approaches, and for case management. These lead provider approaches will enable people at risk of frailty or loss of independence to maintain their independence. The models will focus upon risk stratification of vulnerable people and support for people with long-term conditions. They will develop common referral and brokerage arrangements, care pathway review, and asset based community capacity building by community groups. We will work inclusively with acute care providers to invest in admission avoidance and supported discharge. We will develop arrangements in Mid Essex for the first two years of the BCF before further implementation in line with 2 Year and 5 Year operational plans. We will co-produce the models with user-led organisations in Mid Essex. A further description of work with Primary Care is outlined in part 7 below.

3. Reablement

We have jointly commissioned community based and residential reablement services with CCGs in Essex. Building on our current joint spending on community based services we will roll out a new integrated health and social care reablement service in each CCG area using existing BCF funds. We consider that reablement is critical enabler to a shift towards care closer to home and a demand management approach for health and social care. This will provide in each area community based reablement to avoid admission and facilitate discharge, it will provide intensive residential and nursing based services to minimise the need for ongoing health or social care, and it will provide an unplanned or rapid response.

Over the two years of the BCF we will;

- Continue to fund reablement and intermediate care services using NHS and Social Care reablement grant funds in 2014/15, allowing for significant growth.

- Roll out additional integrated reablement and intermediate care capacity in each CCG area to meet demand and increase community-led referrals using remaining 2013-14 s256 Sustainability Funds and utilising from 2014-15 s256 NHS Transfer money uplift funding to make that expansion sustainable.
- Pool all NHS and social care reablement funding in 2015/16 and ensure that there are sufficient funds for a significant growth in capacity and reach.
- Agree with CCG's a revised specification and procurement process to replace the existing provision when the contract expires in Autumn 2015.

4. Joint Nursing and Residential Care Home commissioning (inc. Continuing Health Care)

We will review commissioning for Nursing and Residential Care Services in each CCG area with a view to shifting the pattern of care towards a rehabilitation and reablement model of service, which seeks to improve independence and functioning and which minimises inappropriate admission to the CHC service.

We will, in collaboration with the other CCG's and the Central Eastern Commissioning Support Unit (CSU), develop a single specification and joint procurement of Nursing Care and Continuing Health Care in 2014/15 with a view to shared management of the market and reduced costs and recognised quality standards.

As part of this work we will work in partnership with the Care Home Market, local housing commissioners and Registered Social Landlords to shift the pattern of services towards greater levels of dementia care support including greater levels of extra-care housing; and as a consequence reduced levels of residential care services. We estimate the need for an additional 2500 places with extra care support of which we would expect to commission 360. We expect a reduction in admission to residential care from social services recipients of 5%.

5. Discharge support

Essex social care services and hospital providers in Essex will continue to work together and with community health providers to ensure effective admission avoidance and discharge support. We will use our BCF schemes for reablement to promote ward led

discharge, rapid response services development and ensure that assessment is taking place at the appropriate time in the appropriate environment.

In developing an Accountable Lead Provider Models we will ensure that there is a clear accountability for coordinating the care of people in the community who receive in-patient services.

ECC and individual CCGs will continue to build on the development of the integrated discharge team approach to facilitate 7 day discharge and will put in place the relevant infrastructure (community services, transport services etc.) to support this.

6. Acute mental health and dementia

Mental health is a key priority driven by rising demand for mental health services. Our plans are based on the factors that are known to facilitate good integrated care including: information sharing systems; shared protocols; the ability to pool funds from different funding streams into a single integrated care budget; improvements in existing multidisciplinary teams; and the development of new models of liaison services that bring improved outcomes and efficiency savings through reduced admissions to acute hospital care.

The evidence is unequivocal that accommodation plays a key role in mental health recovery pathways and therefore it is important that we are able to implement new accommodation pathways that support discharge from hospital and promote recovery and independent living.

As part of our strategy we will implement the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services.

The three CCGs in North Essex and Essex County Council have produced a Joint North Essex Mental Health Strategy. It is expected that this will be delivered by:

- Developing and supporting community well-being, encouraging people to maintain healthy lifestyles that help keep themselves and their families mentally well;
- Improving access and the gateway into services – more effective direction;
- Ensuring smooth transition between services (CAMHS/Adult/Older People);
- Ensuring a more holistic and integrated approach to mental health and physical health services;
- Developing broader primary care and community based models of care for people across the spectrum of mental health conditions;
- Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs.

Driven by this strategy, a joint approach has been undertaken with ECC and across the North Essex CCGs that will lead to the development of a new integrated model of care for adult mental health services.

Dementia: This plan will continue to support and develop the Essex, Southend and Thurrock Dementia Strategy which was developed during 2011. The strategy was agreed

and signed off by NHS commissioners the two Mental Health Trusts and Essex, Southend and Thurrock local authorities in January 2013.

The focus of the strategy is to increase uptake of early intervention services that support independence, ensure service pathways incorporate the appropriate range of interventions including commissioning the voluntary sector to provide support to people in the community and at first diagnosis within Memory Clinics.

The strategy recognises the contribution that the NHS QIPP agenda will make in ensuring that the Dementia Strategy can deliver services that meet demographic demands, that services are cost effective and that planning is integrated. Implementation plans are being developed with partners to improve outcomes for people with Dementia and manage demand on statutory services.

- Early progress to date includes ECC awarding a £700,000 contract to the Alzheimer's Society to provide support by Dementia Care Advisors - supporting people following diagnosis in Memory Services.
- Jointly commissioned services provided by the Alzheimer's Society raising awareness and providing information about support to enable people living with dementia & their carers on how they can remain independent.

7. Primary care (including the requirement for GPs to be accountable for improving quality of care in older people)

We expect primary care to play a lead role in the care coordination for Health and Social Care services in Essex. We will establish Multi-Disciplinary Teams (MDT's) where GPs will be at the centre of organising and coordinating people's care in conjunction with social care and other health professionals and the service users themselves.

The risk assessment process used to identify the care needs of vulnerable people and identify opportunities for early intervention, will be led by primary care We will use BCF schemes to respond and co-ordinate the resultant needs and interventions.

We will work closely with primary care to ensure information is shared appropriately so that as well as receiving Primary and Secondary Care services, people are also supported by appropriate voluntary sector organisations.

Our primary care support for Long Term Conditions will link services for Frail / Older People with community based prevention services for people with specific conditions e.g. continence, diabetes, falls prevention. Essex GPs are taking a positive approach to their role in care coordination and we will continue to support them to do so.

We will work with our local councils to determine the levels of population growth and the impact on housing requirements to determine the level of Primary Care required in each locality within CCG areas and the requirements for Primary Care practice locations. For example in BBCCG it is expected that over a five year period there will be an increase in our primary care workforce by approximately 1 whole time GP for every 1,800-2,000 new residents.

8. Investment to meet requirements of the Care Bill

Revised arrangements for community health and community care are fundamental to the implementation of revised assessment and case management arrangements for people entitled to services from social services. In particular the implementation of the Care Bill will entail the development of a 'Care Coordinator' role across health and social care organisations dealing with community care. This may require additional resources during a period of transition whilst integrated approaches are developed.

We will work together as a system to define the requirements of the Care Bill using a joint programme management approach to implement change during 2014/15. This will identify the full investment requirements of implementing the Care Bill, however, we expect to invest in excess of £3.39m in new entitlements for carers, introduction of a national minimum eligibility threshold, funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

In addition, we expect to use in excess of £1.13m capital costs to invest in the development of systems, protocols and capacity to manage information between the various organisations, including case management systems and the development of mechanism to give access to virtual or actual patient records between organisations.

9. Early intervention and prevention

We are determined to identify the needs of people earlier and intervene to prevent the escalation of problems and crises. Improved support for people in their communities is at the heart of our approach. Individuals and communities value their independence and the ability to make their own decisions and choices. We will work to equip vulnerable people with the support and skills they need to live independently for longer and to help themselves. Improved management of demand will support the sustainability of the system as well as improve outcomes for individuals and their families.

We will look to enable as much health and care support as possible to be delivered safely in the community and in people's homes.

We will also develop communities' capability to support vulnerable people. An example of this is the community agents model which aims to establish a network of community agents and volunteers that leads to a reduction in the whole cost of care by:

- changing existing patterns of presentation to health and social care services and offering an alternative to those traditional services;
- re-directing from the social care front door and GP practices towards a community-based response - for information, advice, practical solutions, appropriate level care and support enabling vulnerable older people and their carers to find, own and implement the solutions to the issues which affect them

10. Community resilience

Essex is committed to strengthening and mobilising communities and increasing their resilience. The 'Who Will Care?' commission led by Sir Thomas Hughes Hallet recommended five high impact solutions in Essex. These included mobilising communities to play a greater role in supporting vulnerable people. This means engaging people in understanding the challenges facing the health and social care system and the important role that can be played by communities and volunteers. Work

is underway to identify successful local schemes and determine how they can be developed as models to provide support county-wide. This will build on initiatives for community building, time and care banking and the creation of a Community Resilience Fund under the Whole Essex Community Budgets programme. We will build capacity within and across Essex communities to utilise community assets and support communities to provide care to vulnerable people.

11. Carers

Carers will receive support at the right time and in the right place to enable them to maintain their caring role and their own health and wellbeing. We will achieve this through:

a) Community based & community led activities which support those people who take on a caring role, whether or not they define themselves as carers, helping them to find solutions to issues and support from within their communities and natural networks.
b) An improved early offer reducing the need for formal assessment through:
    - Information & advice;
    - Practical support to sustain a caring role;
    - Access to time away from the caring role;
    - Carer training.
c) Targeted specialist support – for example at end of life; at hospital discharge; alongside reablement

12. Disabled Facilities Grant

The DFG is included in the capital element of the fund which comes into play in 2015/16. In Essex we have taken the view that the BCF provides an opportunity to explore a holistic approach to improve the process from OT assessment through to DFG in the medium term. Due to timescales we are not proposing changes to the DFG in 2015/16 but are engaging with local housing authorities to explore improved approaches.

13. Other schemes and enablers

Local councils are advising CCGs of a number of proposed housing developments which may have significant impact on the population across the Council area within the next 5 years. The BCF will take account of the implications that this may have on services across Essex..

c) Implications for the acute sector

Our BCF plans will have a significant impact on avoidable admissions. This impact will be achieved through a more integrated health and social care approach to admissions avoidance, immediate care, hospital discharge and better access to services closer to home which prevent the need for emergency admission/re-admission. For example, faster access to urgent health and social care services including rapid response services, night carers and reablement services, as well as improving the support network in the community which means that patients are less likely to reach a crisis point. The

establishment of an integrated community workforce made up of social care, mental health and community services will allow for a more patient centred proactive service.

Modelling of Impact on Acute Providers

The detailed impact to our providers is complex and detailed planning and modelling will continue in the period ahead of the formal pooled fund to understand the full effect of this and other pathway changes. Modelling has included

a) Benchmarking our current provider with peers/best in class to understand achievability
b) Considering any best practice/national reference data based on local pilot data/knowledge
c) Reviewing current contract arrangements
d) Cost analysis of providing the service in acute as opposed to other care settings
e) Piloting a frailty approach designed to reduce admissions to the local EAU
f) Assessing impact of the plans on the sustainability of the system in the longer term

The modelling outcomes will also enable an assessment of workforce implications of the local economy.

d) Governance

The Health and Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across Essex covering all relevant CCGs and ECC. To deliver the ambition we have for our BCF, we recognise the need to develop further strategic and operational governance arrangements. We are reviewing our governance arrangements to ensure these are effective in managing the BCF and there is an appropriate balance between county-wide and local decision-making.

The HWB is supported by regular meetings between the ECC Commissioning Directors and CCG Accountable Officers within the Business Management Group. The transformational plans and programmes are formally discussed and approved at local authority governance levels and within each CCG's governing bodies.

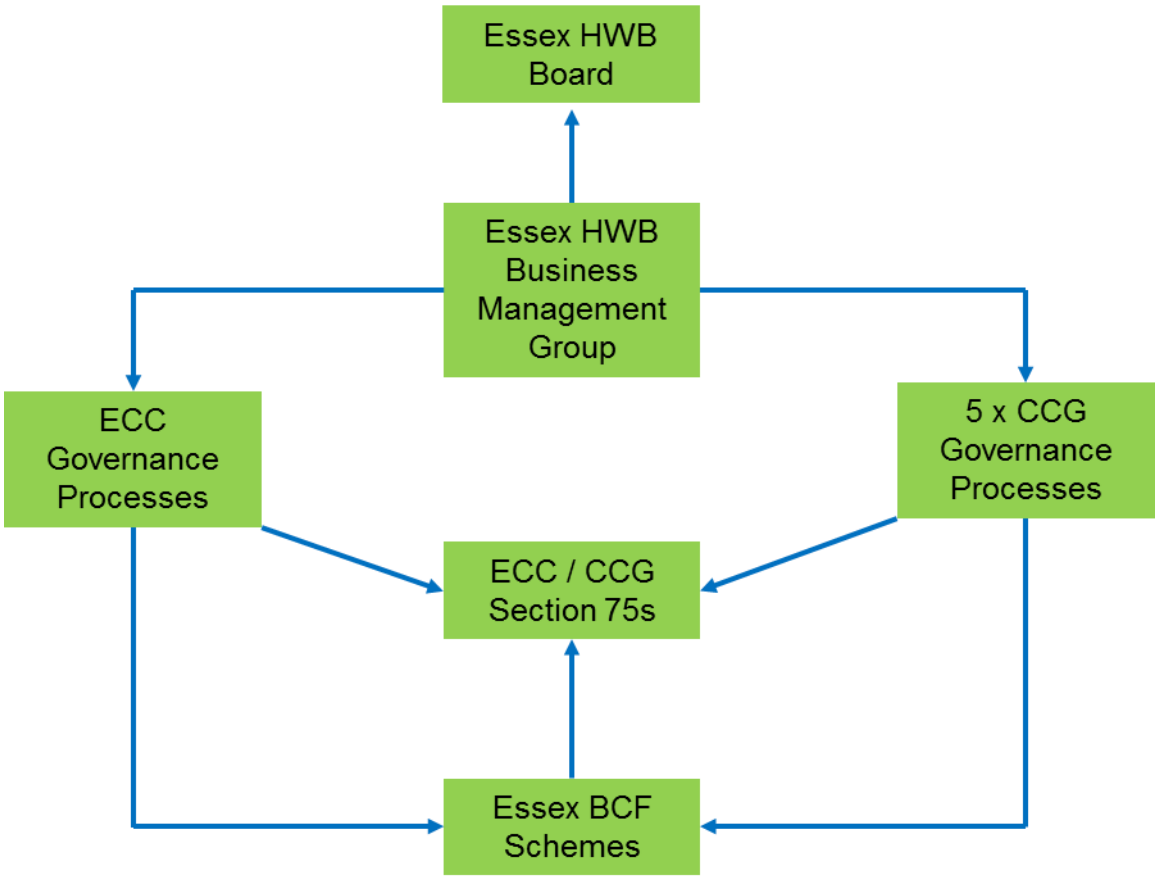
A governance and contractual risk sharing work group has been established to finalise governance arrangements including financial governance by September 2014. This group will also review the Terms of Reference of the Health and Wellbeing Board in light of any legislation changes that may be forth coming as a result of the Better Care Fund.

Additionally a technical group (ECC, CCG and NHSE Finance Directors) has been formed to identifying the delegated functions to be included in the section 75 Agreement(s) that will describe the use of the BCF and the arrangements to facilitate and manage the pooled fund. This group has recommended that ECC should act as the host partner to the pooled fund.

The future management teams responsible for the commissioning of integrated care will be accountable through the Health and Wellbeing Board, and through local authority governance arrangements and CCG's governance arrangements.

At the level of Mid Essex CCG we have agreed the development of a joint commissioning approach, as part of our CCG Transformation Programme Board to oversee the progress

of BCF Schemes, the pooled fund, and other transformation programmes. The arrangement will be joint with the Council.



3) NATIONAL CONDITIONS

a) Protecting social care services

We will protect social care services in Essex by ensuring that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. Our ambition is to maintain current service levels and develop integrated care pathways that enable individuals to remain as independent and healthy as they are able. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well, are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focussing on the supply of services.

The local authority has engaged in a transformation programme that has led it to become an outcomes based commissioner with a strong locality focus and has released efficiencies enabling it to maintain its current Fair Access to Care Services (FACS) eligibility criteria. This allows the local authority to ensure that it can allocate additional spending for local social care services to the same financial level in 2014/15 as for 2013/14 using the Social Care Sustainability grant. This will enable the purchasing of community based social services within each CCG locality. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principal mechanism for this is the ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained in 2015/16 and 2016/17 to allow for contract procurements.

b) 7 day services to support discharge

ECC operates a 6 day hospital discharge service which is flexed to a 7 day operation during periods of increased pressure and is committed to support 7 day services to support discharge. We intend to fund community health and social care reablement services and social worker support to operate 7 days per week during the lifetime of the BCF. We will introduce this with immediate effect for reablement and will continue our weekend social care assessment services. We will introduce 7 day working generally as part of the implementation of the Care Bill.

As part of the contract round for 14/15 the ME CCG will be requiring all providers of acute services within their SDIP to document actions that they will take during 2014/15 to commence implementation of the recommendations of the review into 7-day services.

Confidence in delivery and progress made for 7 day working and its implications will be aligned to the strategic planning process of the CCG and a working group set up to oversee implementation.

For non-acute based urgent and emergency services outside of the hospital, implications for 7 day working is being picked up as part of the Emergency and Urgent Care Strategy (and aligns with the Urgent and Emergency Care Review Phase 1 report) with the majority of these services already operating 7 days a week.

The local Better Care Fund proposals will also support development of 7 day health and social care services including to support 7 day hospital discharge and admission avoidance

c) Data sharing

NHS Number: Currently, not all organisations use the NHS number as the primary identifier in correspondence. However, all are committed to doing so during 2015.

The use of the NHS number is to a large extent governed by the rules around Information Governance and until some of these issues are resolved all organisations will continue to work with NHSE to ensure that we are ready and able to implement the use of the NHS number as soon as it is possible following authorisation to do so.

However, we are committed to developing interoperability between all health and social care systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the locality are integrated around the NHS number, and individual information shared in an appropriate and timely way.

NHS Number in use by: ECC will be implementing a new social care case management IT system that uses the NHS Number during 2015. Within the existing social care recording systems NHS numbers are recorded for the majority of current cases. In the event of a delay implementing its new IT system ECC will develop the facility within existing systems to use NHS numbers in correspondence.

Those CCGs that do not currently use the NHS number have plans to do so and expect to be in a position to implement use of the NHS number by Quarter 3 of the 2014/15 Financial year.

However it should be noted that there will be restrictions on the CCG's ability to receive, process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

Open API Systems: All organisations are committed to adopting APIs. ECC will be implementing a new social care IT system that uses Open API's and Open Standards. This system will be implemented in during 2015.

IG Controls:
ECC is committed to appropriate IG Controls and to meeting the requirements of Caldicott2. A Data Sharing project, led by the Leader of the council, is currently underway within ECC with the objective of creating protocols that will enable the council to meet its requirements under the Care Bill as well as the BCF national conditions.

Several CCGs have been granted Accredited Safe Haven (ASH) status which will allow them to receive patient identifiable data in the future.
All CCGs have adopted appropriate IG Controls which cover NHS Standard contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2

d) Joint assessment and accountable lead professional

People at high risk of hospital admission have an agreed accountable lead professional:

ECC works closely with the CCGs jointly planning care for those individuals identified by health professionals as being at high risk of hospital admission. The accountable lead professional model is developing in Essex and varies according to location. The general approach is that all patients at high risk of hospital admission will have their care managed by GP led health teams or by accountable lead providers with an identified accountable lead professional. The care packages for individuals are managed adopting the Multi-Disciplinary Team (MDT) type models of cross social and health care.

Health and social care use a joint process to assess risk, plan care and allocate a lead professional:

ECC and the ME CCG is developing the accountable lead professional concept utilising the MDT, frailty pathway and primary care development activity.

Individuals are assessed by the GP led MDT against the Rockwood Frailty categories. Those who fall into categories 5, 6 or 7 will be referred onto the Frailty Pathway and be case managed by an accountable lead professional and supported by a care co-ordinator, employed by the Lead Provider.

Proportion of the adult population identified as at high risk of hospital admission,

Although risk stratification tools are not universally adopted around Essex we have estimated that in those areas that do currently use risk assessment tools 0.5% of the population are at “Very High” risk of hospital admission for a chronic condition in the next 2 years, and that 5% are at “High” risk.

4) RISKS

The following Risks are agreed at an Essex-wide level for the whole BCF.

Risk	Risk rating	Mitigating Actions
In a Health and Wellbeing region that consists of five CCGs and five acute hospitals there is a risk that a system failure in one organisation affects the overall performance measures of the HWB Board region which results in the underperformance of the BCF against the metrics which subsequently results in the non-eligibility to receive the health premium	High	ECC Integration Directors and CCG leads are working together to ensure that the programmes nominated for inclusion in the BCF have SMART targets and that providers are appropriately performance managed to ensure that they are sustainable. The BCF metrics will be disaggregated to CCG level to ensure that individual CCG’s are not measured in a detrimental way.

Risk	Risk rating	Mitigating Actions
Factors outside the control of CCGs and the local authority have an adverse effect on Urgent and Acute care services (i.e. Flu epidemic etc.)	Medium	CCGs will continue to monitor all significant changes to demand for Urgent and Acute services. ECC, CCG's and Providers will maintain and update as necessary their emergency response plans and business continuity plans and by carrying out regular joint exercises will ensure that they are able to respond appropriately.
There is a risk that if there is any lack of clarity of system cost and investment coming from the centre it may inhibit accurate reporting and progress	High	Develop positive and transparent relationships with NHSE to ensure that lines of communication and challenge are maintained and where necessary escalation processes are in place that help to minimise the risk
The pace of change required does not allow safe commissioning of high quality appropriate services	High	Deploy the necessary resources with the right skills and competencies to ensure that we continue to commission legally and within the required timescales, costs and quality standards
There is a risk that the lack of robust and appropriate Governance processes delay the integration of services resulting in poor and slow decision-making across the system	High	We will implement locally approved governance structures across Essex at the earliest opportunity – by September 2014 at the latest
There is a risk that if we implement new models of care we could destabilise existing providers		Through a process of communication and engagement with providers and by making sure that we plan the implementation carefully and collaboratively – moving activity before we execute capacity reductions we will deliver stable and sustainable change
There is a risk that new and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity	Medium	As with the previous risk mitigation plan we will deliver phased and planned capacity movement
Financial –There is a risk that failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing financial pressure as an ageing population increases demand		At the outset of the programme, being clear on: • Clear and achievable financial objectives • Well planned phased service model changes to deliver greater efficiency • Close financial performance management

Risk	Risk rating	Mitigating Actions
		• Early identification of issues and contingency plans in place to mitigate slippages or unexpected demand
Clinical and quality – there is a risk that the planned changes do not improve quality but worsen it, resulting in a poorer outcomes and patient experience		Service model changes will be designed and reviewed throughout the programme process, with contract mechanisms and measures established to evaluate all proposed changes, and where appropriate pilots will be run and evaluated
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits		The programme will be properly planned, with agreed timescales and dependencies identified at an early stage. Progress will be reviewed through the programme management process, including exception reporting, highlight reports and project status reports, contingencies will be developed where necessary
Commitment and engagement – failure of the local health and social care community to remain committed to the programme and its objectives		The governance structure formalises senior level commitment to the programme; throughout the programme on-going support will be reviewed and expanded as necessary
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining contracts and the evaluation of results		We will design and implement a thorough intelligence process to put in place processes, checks and balances that will help us to capture and analyse our patient cohorts in a way the minimises potential gaps in our knowledge.
Shorter term financial stability actions by CCGs or ECC could inadvertently undermine BCF schemes	High	Regular communication by finance leads / Accountable Officers to enable early identification of any issues. Recognition of particular providers / commissioners already in a fragile status. Robust risk sharing arrangements built into the section 75 arrangements for the pooled budget
Functions are not clearly defined so to be able to articulate how services		

Risk	Risk rating	Mitigating Actions
will be integrated and therefore what the clear delegation of responsibilities are from health to social care or social care to health in. The implication being that benefits cannot be defined or quantified		

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 (£000's)	Minimum contribution (15/16) (£000's)	Actual contribution (15/16) (£000's)
Essex County Council		£4,932	£8,009	£8,009
NE Essex CCG		£0	£20,987	£20,987
Mid Essex CCG		£0	£21,651	£21,651
West Essex CCG		£0	£17,435	£18,980
Basildon & Brentwood CCG		£0	£16,041	£18,444
Castlepoint & Rochford CCG		£0	£10,833	£11,166
BCF Total		**£4,932**	**£94,956**	**£99,237**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

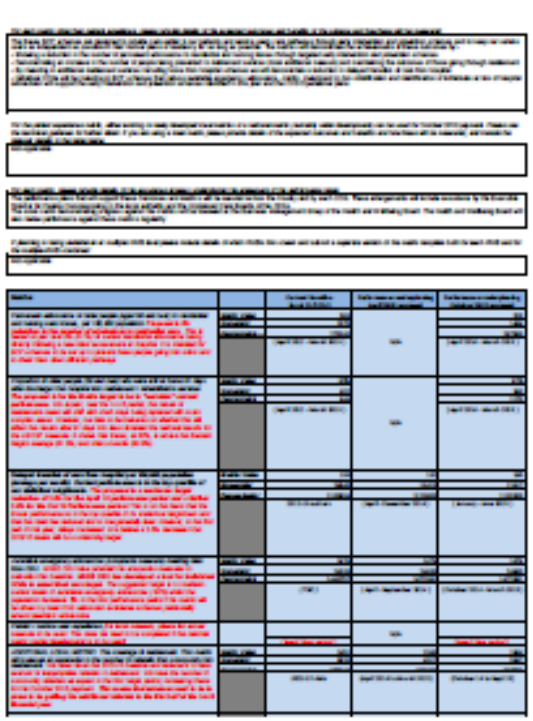
BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Protection of Social Care to Benefit Health:									
Baseline Social Care Sustainability Funding						4,136,000		TBA	(See Note 2)
Mid Essex Pro Rata share of £5.6m 13/14 Social Care Sustainability Grant Increase						1,550,000		TBA	(See Note 2)
New Social Care Sustainability Grant funding - priorities yet to be agreed						1,595,000		TBA	(See Note 2)
Community Health Services Inc Admission Avoidance:									
Accountable Lead Provider/LTC (ICT & Therapies)	Provide					3,791,000	(See Note 1)	TBA	(See Note 2)
Reablement:									
Reablement Grant				TBA	(See Note 2)	887,000		TBA	(See Note 2)
Other Reablement funding committed to demand management schemes						856,000		TBA	(See Note 2)
Joint Nursing and Care Home Commissioning Inc CHC:									
Continuing Health Care (Assessment)						717,000		TBA	(See Note 2)
Continuing Health Care (Costs)						6,000,000	(See Note 1)	TBA	(See Note 2)
Discharge Support:									
Early Supported Discharge for Stroke	Provide					670,000		TBA - benefit largely to social care expenditure	(See Note 2)
Early Intervention and Prevention:									
Joint Risk Profiling (Frailty Risk Register)						118,000			
Carers						581,000		TBA	(See Note 2)
Other:		4,032,000							
Equipment	Provide					750,000		TBA	(See Note 2)
Total		**4,832,000**				**21,651,000**			

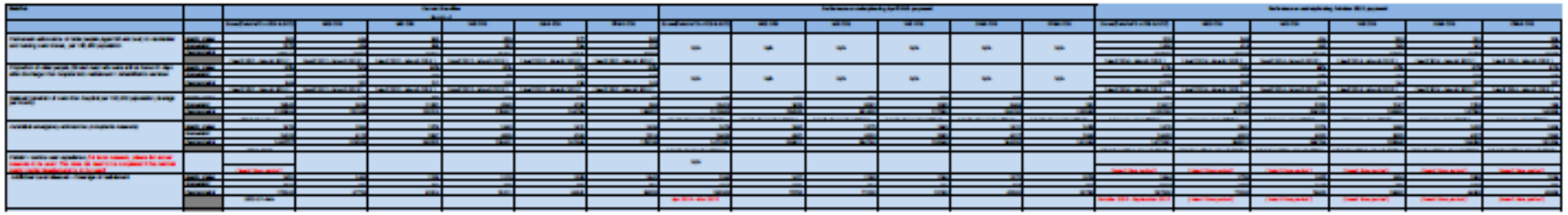
Notes

1) 2015/16 expenditure by scheme has been estimated. These estimates are subject to change as plans are finalised, in particular Accountable Lead Provider/LTC, Equipment and Continuing Health Care Costs

2) Benefits from BCF expenditure are being calculated - "TBA" indicates which schemes are expected to have financial benefits

3) £7,281k Social Care Sustainability funding in 14/15 is transferred from NHS England to ECC





BASILDON AND BRENTWOOD CLINICAL COMMISSIONING GROUP BETTER CARE FUND PLANNING

Document Control

Change history

Version	Reason/Summary of Changes	Date	Author
V0.1 & V0.2	1st Drafts for review	10/01/14	Stuart A Brown
V0.3	3rd Draft incorporating Risks and Finance	30/01/2014	Stuart A Brown
V0.4	4th Draft incorporating new guidance	25/02/2014	Stuart A Brown
V0.5	Comments incorporated	27/02 2014	Stuart A Brown
V0.6	Comments incorporated	03/03/2014	Stuart A Brown

Document approvals - this document requires the following approvals

Name	Title	Version and Date
Dr Anil Chopra	CCG Chairman	V0.5 - March 2014
Tom Abell	Chief Officer	V0.6 -March 2014
Tracey Easton	Chief Finance Office	V0.6 - March 2014
Tonia Parsons	Chief Operating Officer	V0.6 - March 2014
CCG Governing Body	All	V0.6 - March 2014
Nick Presmeg	Director of Integration - ECC	V0.6 - March 2014

Distribution

Name	Title	Date of issue	Version

Table of Contents

Better Care Fund planning template – Part 1

There are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts have been completed as part of the Better Care Fund Submission.

Plans have been submitted to the NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

1.EXECUTIVE SUMMARY

1.1.Vision and ambition

Basildon and Brentwood Clinical Commissioning Group (BBCCG) and our partners have ambitious plans to radically transform our health and care economy. Our ambition centres around being able to deliver person centric services that meet the needs of all our population, services that are delivered in the most appropriate setting that benefits both the patient and the service provider(s) in terms of affordability and operational effectiveness.

We will take immediate steps to reduce health inequalities in our local communities through the implementation of 8 high impact pathways, and the work we intend to undertake to achieve parity of esteem for people with mental health conditions and to break the silos in our current services between physical and mental health services. Our aim is that in 5 years we have significantly closed or narrowed the gap in health outcomes for people with long term mental illness.

This document, whilst describing BBCCG's approach to planning for the development and implementation of the Better Care Fund (BCF) is an integral part of the CCG's two year Operational plan (recently submitted) and the CCG's five year strategic plan which will be submitted on the 6th of June 2014.

Our vision is to create a clinically led organisation that delivers the outcomes and quality that we would want for our own families. We know we must live within our means and we also know that the best way of achieving that is to commission efficient and effective treatments which patients are happy and proud to use. We accept that some parts of the system will take time to change and resources can sometimes be slow to move around the system as new priorities emerge.

Whilst this document is focussed predominantly on our plans for the BCF we feel it is important to identify the links to our overall strategy and plans that we have in train to transform Basildon and Brentwood's health and social care economy.

During our first year of authorisation we have made good progress in identifying where our biggest challenges are and what needs to change. We have begun to formulate tangible detailed plans for designing and delivering that change. This process has included engagement with providers, partners and our own member practices.

BBCCG has, working with our partners and providers, developed strategic plans that identify initiatives designed to tackle the root causes of poor health and health inequalities.

BBCCG's "Care Conversation" is the vehicle we are currently using to convey our vision and ideas to our key stakeholders and the public. It sets out some of our initial ideas for the future of the NHS in Basildon and Brentwood for discussion with members, localities and stakeholders.

The purpose of the Care Conversation document is to test and refine these ideas so they can be developed further and incorporated within the CCGs' 5 year plan for the transformation of local services.

These ideas have been built from our understanding of the national policy direction and draw on recent announcements from the department of health. Notably "Everyone Counts: Planning for Patients 2014/15 to 2018/19. The key elements of the proposed transformation centre around four key themes:

- The BCF;
- GP Federations;
- Excellent Primary Care; and
- Specialist pathways.

Notwithstanding these key elements, our planning and commissioning intentions for the coming years are based on a fully inclusive approach to health and social care provision. We recognise the need to address Mental Health and Dementia issues in a manner that is at least equal to the way in which we provide other mainstream health services.

1.2.Transforming outcomes for older people and joint focus

Across England in order to meet the current and future needs of older people for health, housing and social care services, local and regional partnerships must plan and deliver services differently. Jointly commissioned services are essential if sustainable solutions to the complex problems facing local partners, such as the growth in numbers of older people and delayed transfers of care from hospital, are to be achieved.

Older people themselves are quite clear about the outcomes they want from health and social services. They want:

- to be helped to be more independent;
- to have choice and control over how they manage their lives; and
- to stay in their own homes whenever it is possible, with customised support.

And they do not particularly mind who provides the service. As their expectations of a better quality of life increase, they and their carers should be involved more effectively in designing and delivering joint services.

A joint service is one that has shared decision-making by health, housing and social care partners over one or more of the following:

- service design;
- commissioning;
- resourcing;
- delivery; and
- performance management and evaluation.

Joint services offer many advantages over single agency services in helping older people to cope better. They combine the strengths and skills of staff from many different professions and agencies, so they can respond faster and more effectively. And with the added benefit in that they can be more cost-effective.

It is not necessary for all health, housing and social care services to be jointly commissioned or joint ventures- joint services should be put in place wherever it is clear there are or will be benefits for people who use services and their carers. BBCCG and ECC are working collaboratively to design the new pathways and develop the necessary frameworks for commissioning, contracting and procuring those services that we are planning to jointly commission to produce better outcomes for our older people.

1.3.Delivering parity of esteem

A report produced by the Royal College of Psychiatrists - *Whole-Person Care: From Rhetoric to Reality* highlights the potential inequalities that exist between physical and mental health care, including preventable premature deaths, lower treatment rates for mental health conditions and some instances of underfunding of mental healthcare relative to the scale and impact of mental health problems.

The report makes key recommendations for how parity for mental health might be achieved in practice and includes a set of commitments to actions they will be taking to help achieve parity of esteem[1].

- equal access to the most effective and safest care and treatment;
- equal efforts to improve the quality of care;
- the allocation of time, effort and resources on a basis commensurate with need;
- equal status within healthcare education and practice;
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.

Current contract negotiations with our shared Mental Health provider, South Essex Partnership University NHS Foundation Trust (SEPT) include requirements to meet the

1 More detail is contained in the main body of the document about how we will deliver this.

timely access[2] requirements for 15% of adults with relevant disorders to be delivered in 2014/15

Dementia, with an ageing population and the prevalence of Dementia increasing nationally BBCCG have already commissioned an extension to the specialist dementia rehabilitation and reablement service at Mountnessing Court following an initial pilot.

Whilst the pilot has not yet demonstrated significant financial savings the patient outcomes are demonstrably improved and a number of potential admissions to CHC would appear to have been avoided.

1.4.Providers

As mentioned previously whole system transformation is what is our vision is about, and this cannot be achieved without engagement, alignment and the willing collaboration of our providers. We are already working with our providers to develop joint planning approaches via a number of provider engagement events, some of which have already been delivered and some of which will be delivered in the coming months.

Our main acute provider, Basildon and Thurrock University Hospitals Trust (BTUH) has worked closely with the CCG to jointly develop a new contracting model which recognises the financial challenges that both CCG's and Providers face and recognises the need to reduce activity going into acute settings and move it to community based settings.

We recently brought together, at a South Essex provider engagement event all our main service providers along with the County Council and representatives of the Voluntary Sector and Essex Cares to articulate our vision for the future as one of a number of steps designed to continue our move toward integrated planning.

One of our primary transformation programmes is "Excellent Primary Care" included within the work stream and also within some of our other "business as usual" activities is work that we will undertake to support our GP's to become the accountable lead healthcare professionals, coordinating patient centric care provision. This programme will initiate in April 2014.

As mentioned previously our focus for the BCF is primarily the Frail and Elderly pathway and other carefully selected community services that have been selected because of their close alignment to the mainstream requirements of the frail and elderly. The BCF programme, a joint approach with Essex County Council, is a structured programme that has already initiated[3].

2 Increased Access to Psychiatric Therapies IAPT

3 A structural diagram of the programme can be found in the main body of the document

What we want to achieve is better quality of life for those patients and service users that come into contact with our services, helping people to remain independent for longer. To provide them with support when they need it and help them to access services where and when they need them.

The details of the specific sub programmes of work that make up our BCF programme for 2015/16 are still in the development stage, whilst 2014/15 will be focussed on the protection of social services as in 2013/14.

We will develop a primary care service that takes the lead role in patient management and care, a primary care system that will be the focal point for integrated multi-disciplinary working putting the patient at the centre.

Our vision is based on the creation of a clinically led organisation that delivers the outcomes and quality we would want for our own families. We know we must live within our means and we know too that the best way of achieving that is to commission efficient and effective treatments which patients are happy and proud to use. We accept that some parts of the system will take time to change and resources can sometimes be slow to move around the system as new priorities emerge.

We must work with others in the system, especially Essex County Council as commissioner of social care services, but also our own service providers, large and small.

Dr Anil Chopra

Chair

Tom Abell

Chief Officer

2. PLAN DETAILS

a)Summary of Plan

Local Authority	**Essex County Council (ECC)**
Clinical Commissioning Groups	**Basildon and Brentwood CCG**
Boundary Differences	**One of five CCG's co-terminus with ECC**
Date agreed at Health and Well-Being Board:	**<dd/02/2014**
Date submitted:	**<dd/02/2014**
Minimum required value of BCF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

b)Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	Basildon and Brentwood CCG
By	Tom Abell
Position	Chief Officer
Date	<date>
By	Anil Chopra
Position	Chair of the CCG
Signed on behalf of the Council	Essex County Council
By	Nick Presmeg
Position	Director of Integrated Commissioning & Vulnerable People
Date	<date>
Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	<Name of Signatory>
Date	<date>

3. Introduction

3.1.Context

BBCCG is responsible for the area of Basildon, Billericay, Brentwood and Wickford, which has a total population of 264,630. As a CCG we work with four locality groups for Basildon, Billericay, Brentwood and Wickford. This enables us, as a CCG; to work more closely with the populations we serve and allows us to have insight into the diversity of our population.

There is expected growth of up to circa 25,000 new residents in the Basildon and Billericay areas if proposed housing developments proceed as planned over the coming 2-5 years.

Our current primary care workforce and estate will not meet the expected demand without us taking action now. We must also recognise existing workforce shortages as we are already experiencing difficulty in recruiting GPs . Essex has one of the lowest levels of GPs/1000 population in the country. Essex average number of GPs is 0.66 GPs/ 1000 population compared to 0.74 GPs across England. In order to reach the England average, Essex needs to attract and retain another 143 full time GPs.

We were authorised as a statutory commissioning body in April 2013, with a number of conditions and directions we had to meet before we could take on full commissioning responsibilities. We have worked hard to address these and have now assumed full responsibility for our statutory functions.

We will take immediate steps to reduce health inequalities in our local communities through the implementation of 8 high impact pathways, and the work we intend to undertake to achieve parity of esteem for people with mental health conditions and to break the silos in our current services between physical and mental health services. Our aim is such that in 5 years we will have significantly closed or narrowed the gap in health outcomes for people with long term mental illness.

3.2.Objectives

We recognise that we still need to describe and provide more specific details about how and when we will deliver the planned system change envisioned for not just the BCF but the wider health and social care system in Basildon and Brentwood. This is currently constrained to a certain extent by the planning that we are doing and contractual arrangements we are in the process of concluding with our providers for 2014/15.

Our key objectives of the Better Care Fund (BCF) are:

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence. The newly developed integrated community

services teams will ensure a multidisciplinary approach that is targeted and risk based. One of our most immediate priorities it so procure and implement a risk stratification tool.

- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services;
- To move care closer to home so that our hospitals have manageable demand, one of the enablers for this will be the newly commissioned integrated health and social care rehabilitation and reablement service;
- To work together to ensure people are supported to look after their health and wellbeing;
- To support providers to join up, share information, and make services easier to navigate;
- To work with the District Councils to ensure that the Disabled Facilities Grant continues to be used appropriately to support the rehabilitation of people back to their home environments and to prolong their independence
- To create Integrated Commissioning arrangements with ECC and other local authorities as appropriate, to align our work and have a single commissioning process, services and work.

3.3.Strategy

The CCG's draft 5 year strategy outlines three care concepts underpinning the future of Healthcare in Basildon and Brentwood:

I. The establishment of Excellent Primary Care consistently across Basildon and Brentwood;

II. The creation of Named GP Teams, working as Lead Professionals for people at risk providing GPs with the responsibility and authority to ensure the provision of integrated and co-ordinated evidence based care to each individual. These teams will be built from geographic Primary Care Federations, with an opportunity to consider differing integration forms and models;

III. The development of Specialist Pathways of Care, integrating existing community, acute and specialist service provision for designated indications. Such pathways will be evidence based and time limited.

Whilst we have some high performing services, our healthcare system is complicated involving too many hand overs between organisations and services. For example, our management of long term conditions and services to the frail and elderly require much

greater integration particularly focussing on who is in charge, or who is responsible for their health and care.

This situation provides a clear driver for integration across health and social care. This document describes our high level plan for the implementation of the integration agenda in Essex and Basildon and Brentwood in particular - and specifically the implementation of the first tranch of the Better Care Fund (BCF) in 2014/15.

Basildon & Brentwood CCG will work in collaboration with Essex County Council; striving to achieve seamless provision of health and social care where integration can work in the best interests of the local people of Basildon and Brentwood.

4.SERVICE PROVIDER ENGAGEMENT

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

4.1.Basildon and Brentwood CCG and the South Essex sub-economies

BBCCG is not the sole commissioner for our main acute hospital provider - Basildon and Thurrock University Hospital. It is a shared provider with Thurrock CCG, this means there will be overlaps between the BBCCG part of the Integrated Plan and the Integrated Plan of Thurrock.

All parties are seeking very similar outcomes and recognise the importance of giving clear direction to providers and the market place that will only come through close working. We will utilise existing forums such as the Unplanned Care Working Group to ensure that there is consistency in appropriate levels of strategic and operational commissioning intentions.

This latest draft reflects a number of existing programmes that are designed to include health and social care providers as active participants; together with a range of GP locality groups, and our voluntary and community sector as a whole. Our intention is to actively encourage our providers to take an active role in developing future plans.

We held a major provider engagement event jointly with Castle Point and Rochford CCG planned for the end of January 2014, and further events are planned. It is also worth noting that as part of a fresh approach to the contracting round regular Executive to Executive meetings have been established and it is planned for these to continue as a matter of course as we develop and implement our transformational plans.

As the programme gathers momentum it is also our intention to invite representatives from key providers to join the various forums of the South Essex BCF Programme Group. This will ensure that the design of future services and clinical pathways is jointly driven and jointly owned.

We recognise that there will be difficult and challenging conversations to be had across the provider landscape as there will be both winners and losers as we move to the new ways of working, particularly when it comes to moving activity from one provider to another and the inevitable movement of revenues.

The following figure (fig 1) describes the key stakeholders (Providers and Commissioners) that make up the South Essex Integrated Commissioning landscape

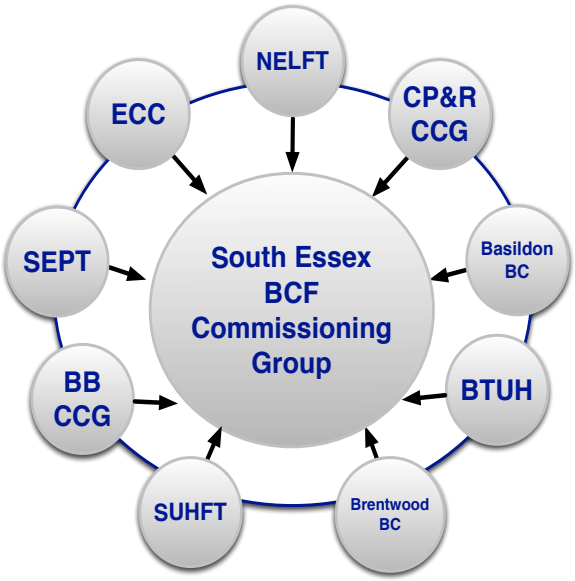


Fig 1 - South Essex BCF Commissioning Landscape

Not unusually our providers as in many other areas of the NHS and Local Authorities, have budgets which are are under considerable stress and challenge. There is also considerable pressure from the public, in the wake of the Francis report and Winterbourne, to demonstrate that our services are adequately staffed with the right skill mix and with a high level of experienced staff. Clearly this presents a challenge to the finances, which providers and commissioners need to work closely together to manage - to strike the right balance between safe levels of staffing and affordability. The CCG and ECC are engaged with our providers to develop safe staffing models and alternative care pathways to move activity away from Acute settings and relieve the pressure on Acute Hospital staff.

Our wider system transformation plans, as described earlier, are focussed around moving activity and capacity out of an acute setting if and when it can be delivered more effectively and efficiently - without any deterioration in quality, in a community setting. A key element that will lead to the realisation of this ambition will be effective workforce planning, realignment and in some cases up-skilling of that workforce. The CCG is working with providers, ECC and the Local Education and Training Boards (LETB's) to

develop detailed plans that will lead to safe and effective transition. This results of this work will be published in quarters 2 and 3 of 2014.

4.2. Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Our vision is based on the implementation of an integrated care system that our resident population needs, that need will be articulated by the residents themselves via the various citizen engagement forums that we have already established and a number of additional groups that we are planning to establish over the coming weeks.

The CCG has implemented a wide range of activities to help ensure that our patients and community feel fully engaged with the planning and quality monitoring of local services:

All 4 locality groups have Patient Engagement Groups (PEGs) which meet monthly to hear patient views and act as an information exchange.

The CCG has a formal Patient and Community Reference Group (PCRG) in place, acting as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc.

Membership of the PCRG includes 9 lay reps, 2 x CVS, 3 local authorities, Healthwatch Essex and GP chair of the CCG. Key roles of the group include receiving reports from the Patient Leaders for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year, etc

The PCRG links to the locality PEGs through lay members and CCG locality managers to ensure local views and connections are maintained. The workplan of the PCRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval. http://www.basildonandbrentwoodccg.nhs.uk/patient-and-community-reference-group

As well as being the CCGs representative on the Essex Health and Wellbeing Board, the GP Chair of the CCG is a member of the Basildon Health Partnership and a Brentwood GP is a member of the Brentwood Council health forum.

CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients,.

Board meetings are held in public, with questions invited, and some GP locality groups have patient representatives as members.

The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.

The CCG has its own website where all plans (including the Integrated Plan), policies and documents are published and accessible to the public www.basildonandbrentwoodccg.nhs.uk

Contact details for the CCG and a general enquiry email account has been set up to receive comments and messages from the public.. Bbccg.contacts@nhs.net

Our current engagement map is described below in Fig 2:

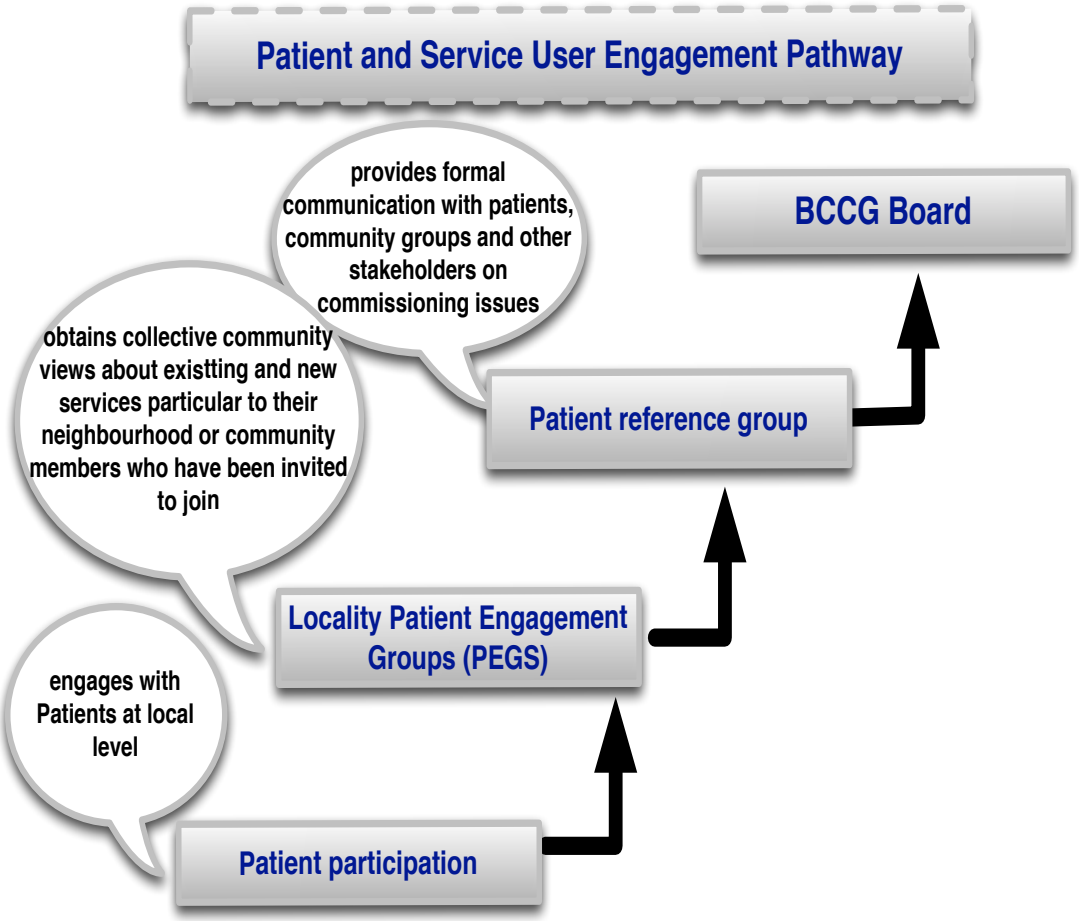


Fig 2 - Patient and public engagement process

4.3. Residency versus GP Registration

All residents within the geography of Essex County Council are covered by ECC's social services. Access to health services is dependent on the address of the GP that the individual is registered with. This can lead to ECC residents receiving their healthcare from CCG areas outside of ECC's geography and some residents from neighbouring local authorities receiving their healthcare from within the Essex Health and Wellbeing geography.

4.4. 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
BBCCG Integrated Commissioning Plan	Describes the five year plan for Basildon and Brentwood Clinical Commissioning Group - setting out in detail the services we intend to commission, the services we intend to reform and improve and the services we may wish to de-commission.
BBCCG Strategic Plan	This document sets out the challenges and the issues we face as a CCG and defines the strategy we will adopt to address those challenges in the coming years as we strive to reform and modernise the local health economy
BBCCG Operational Plan 2014-2016	Provides the specific detail that describes how and what we will measure in relation to such things as improving Patient Safety, Safeguarding, Standards of Care in our providers.
Citadel Healthcare Future State V0.2	A mindmap translation of the Citadel Workshop held in November 2013 and attached as an appendix to this document
Citadel Healthcare Workshop Scan - Graphic	A graphic representation of the Citadel workshop held in November 2013, a copy of which is attached as an appendix to this document
The Care Conversation	is the vehicle we are using to convey our vision and ideas to our key stakeholders and the public. It sets out some of our initial ideas for the future of the NHS in Basildon and Brentwood for discussion with members, localities and stakeholders.

5.VISION AND SCHEMES

5.1. Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

The current provision of health and social care services is not sustainable from either a quality or capacity perspective or a financial perspective in the long term. Therefore we are committed to significant radical reform to design and build a health and social care system that is: based on quality and safety, is accessible, affordable, responsive, agile, person centric and delivers the levels of quality that our residents demand and rightly deserve.

Our vision for the future requires whole system change; in terms of how we commission work from providers, how our providers interact with citizens and with each other. Working together across the local government and health landscapes we are committed to driving behavioural change in partnerships in all areas of the health & social care system, which will include a much more prominent role for the voluntary, community sectors, and not least our residents themselves.

NHS Basildon and Brentwood CCG (BBCCG) is commencing a process to undertake significant reform of the local NHS and wider care system. The objectives of these reforms are to:

- Design, develop and implement a patient centric integrated health and social care system that delivers the right care in the right place at the right time;
- Improve the quality and safety of local services;
- Improve outcomes for our local populations and reduce health inequalities;
- Move to a local health and care system that is financially sustainable.

The system reform proposed focuses on three core work elements:

- The establishment of 'Excellent General Practice' consistently across the area;
- The creation of integrated 'Named Accountable Professional Teams' who will be responsible for managing the health and care of people with long term complex needs;
- The creation of integrated 'Specialist Pathways of Care' for people with specialist needs.

What changes will have been delivered in the pattern and configuration of services over the next five years?

Citizens, Service Users and Carers will be empowered to direct and manage their care and support, and to receive the care they need in their homes or local community and:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;

People will have a named GP and someone from the surgery who co-ordinates all the different services within a joint Care plan. A single patient and care record which can be accessed and controlled by the clinicians and care workers who are involved in their

care. Which gives them the assurance that they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell. The GP will , using teams consisting of Community nurses, OT's, Social Workers and Geriatricians, co-ordinate the patients care ensuring a fully integrated delivery model.

5.2. GP Estates

For each new GP required, we estimate that a further 80-100msq of space to accommodate each GP and supporting/utility services will be required, either in existing or new premises (on the lower side if expansion of existing premises is possible).

BBCCG is working with the Strategic Partnership Board recently established across Essex to identify and prioritise these estate developments for primary care.

5.3. Housing

Housing is a factor in peoples Health and Wellbeing, identified as one of the primary wider determinants of Health, Basildon Council has also notified the CCG of a number of proposed housing developments which may have a significant and positive impact on the population across the Council area within the next 5 years, with our estimates as follows:

Subject to formal planning and approvals processes the following proposals have also been put forward:

Pitsea–proposed 5,788 dwellings x estimated at 2.5 occupants each = total of circa15,000 new residents; it is likely that new primary care premises would be required4.

Wickford – potential c1,200 new dwellings, estimated @ 2.5 occupants = circa 3,000 new residents; this may require redevelopment of existing premises, or progressing proposals for a new Wickford Health Centre to include expansion (which has been in the planning stages for some time). Capacity may also be created or found within existing GP practices, depending on the location of the developments.

Central/west Basildon – various schemes are currently underway and included in the 1% growth built in to 2014/15 contracts. Further developments are proposed to a maximum of circa 3,350 dwellings, estimated circa 8,500 new residents which would require additional GP capacity. Options include redeveloping an existing practice or relocation to a new site or a new standalone practice. For either option, the assumption is that a minimum of a further 500 msq of primary care estate would be required.

Billericay – maximum of a possible circa 5,500 new dwellings, but Basildon Council has advised that this scale of development is a longer term prospect and unlikely to be within the next 5 years.

4 Estimated requirement to accommodate a practice of this size would be 1200 Msq

5.4. Systems will enable and not hinder the provision of integrated care;

People have a single care plan and where appropriate have been provided with simple devices and support that allows them to self-manage as much of their conditions as possible on a daily basis. With clearer information and advice, and knowing that professional support will be provided if they need it.

- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy.

Frail and Elderly are linked into local voluntary schemes for older people, which facilitates the sharing of experiences for mutual support.Care coordinators are proactive in ensuring that support is available to them within their communities, through difficult times. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

5.5. Clinical pathways will be designed around the needs of patients, carers and their families

This work starts and ends with individuals experience of care. Through mapping the current experiences, capabilities and needs of our citizens and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas.

This is about not simply looking at people in terms of the cost of their care under the current service model of provision,or the types of interactions with those services that they currently have, but looking further to the root cause of the challenges many of our citizens and their families experience today, and how these can be converted into more positive experiences and outcomes in the future.

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

As a result of these changes:

In line with the NHS Outcomes Framework and the five domains of:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm

and the four domains of the Adult Social Care Outcomes Framework of:

- Enhancing quality of life for people with care and support needs;
- Delaying and reducing the need for care and support;
- Ensuring that people have a positive experience of care;
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

We aim to help people to feel confident about the quality and level of care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including local A&E departments, is significantly reduced. If they do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission.

People routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

Overall pressures on Essex hospitals and health budgets will have reduced, as we shift from high-cost reactive services to lower cost preventative services, supporting greater self management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved care at home which in turn reduces the need for high-cost nursing and care home placements.

To achieve this we will engage with local health and social care providers, and associated public, private and voluntary and community sector groups, to "co-design" models of care that will engage with and meet people's aspirations and needs.

People will be empowered to direct their care and support, and to receive the care they need in their homes or other appropriate community setting.

Over the next 2 to 5 years we will enable community healthcare and social care teams to work closely together in an increasingly integrated way, with single health and social care assessments providing for rapid and effective joint responses to identified needs, provided in and closer to home.

Our teams will also increasingly work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring a level of health or social care support, so that we help them to remain healthy, independent and well. We will make considerable investment available to empower local people through effective care signposting, peer support, mentoring, self-management and personal healthcare budgets to maximise their independence and wellbeing.

We will design and implement integrated Community Independence teams tasked with providing a rapid response service to support individuals in crisis and help them to remain at home.

Community Independence Teams will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication.

We will also seek to introduce individuals to the potential of assistive technologies and, where these can be employed, we will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and social care systems, through earlier and better engagement and intervention;
- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

In doing so our plan is to go far beyond using BCF funding to back-fill existing social care budgets, instead working in a truly integrated fashion to reduce long-term dependency across the health and social care systems, promote independence and drive improvement in peoples overall health and wellbeing.

As a result of the planned changes we expect the volume of emergency activity in hospitals to reduce and we also expect planned care activity in hospitals to also reduce because we will have developed alternative community-based services.

A managed admissions and discharge process, fully integrated into local specialist provision and Community Independence provision, will mean we will be able to eliminate delays in transfers of care,reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

Mental health is a key priority, with rising demand on mental health service provision will be given consideration alongside frail and elderly which is the main thrust of our integration planning. Our plans therefore are designed to ensure that the work of community mental health teams is seamlessly integrated with community health services and social care teams, thereby superseding traditional CMHT's; they will be organised

around groups of practices; and enables mental health specialists to support GPs and their citizens in a similar way to physical health specialists.

By improving the way we work with people to manage their conditions, we expect to reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

5.6.Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

The overarching objective for the CCG is to improve health outcomes, reduce health inequalities and develop a sustainable affordable health and social care system.These aims will be achieved by proactive case management, by stratifying the risk and needs of the patients and service users - through responsive provision of local and regional services channelled through an effective community, social and primary care offer with a single point of access. Integrated Care through a lead professional and using a multi-disciplinary team approach focused on early intervention and prevention.

We have already agreed and implemented work in five specific areas with ECC which are:

- Commitment to jointly procure an effective risk stratification tool and share the data;
- To jointly specify and procure an enhanced reablement and rehabilitation service (this will include all current hospital discharge, intermediate care and continuing healthcare pathways);
- To develop and implement an integrated community services specification that will bring together social care assessment and care management services and community health provision;
- A joint programme approach to the implementation of the BCF;
- To ensure effective governance though the Joint Programme Board that we have established.

What are the aims and objectives of your integrated system?

We see the implementation of the BCF as a two phased programme, the initial phase being that which we will deliver in 2014/15 and phase two which will go forward from April 2015.

The BCF is also a key enabler for the long term strategy that we are looking to deliver in Basildon and Brentwood which is a large scale modernisation programme that will transform the health economy landscape for the area. This programme of modernisation and reform, which we have named Citadel, is an integral part of our planning activities for 2014/15.

BBCCG is basing the approach to the BCF as part of an opportunity to transform the health and social care system for our population, to make it person centric with the system being responsive, sufficient and necessary to meet their needs.

Based on this proviso we have structured the services/pathways that will form part of the BCF in order to meet that criteria. A full list of the current proposed schemes/service lines that we are considering is detailed in Part II of this submission with relevant values where we have clarity at this point in time.

Essentially we are focussing on areas that :

I. There are very clear synergies with ECC ;

II. There are opportunities to prevent admissions to secondary care;

III.The are obvious health deterioration prevention opportunities;

IV.There will be a reduction in Health Inequalities ;

V. There are financial economies of scale to benefit from;

VI.Joint commissioning is driven by the needs identified in the JSNA and the HWBS.

How will you measure these aims and objectives?

Using the NHSOF and the ASCOF as our guide, we will measure specific nationally mandated and local metrics, the specific details of which will be covered in the Outcomes and Metrics tab of the excel submission template. The success factors will include such things as reductions in hospital attendance and admissions.The advances in IT capability will help us to drill down deeper into the data held which in turn will lead to more information on specific reasons for admissions and by doing so will present opportunities to develop additional preventative measures.

In order to manage and track outcomes, we will be developing business cases to enhance developments in data warehousing, that will help us to work with all available care data, information and intelligence, getting as close to “real time analysis” as we can to allow us to make rapid and accurate decisions - including total activity and cost data across health and social care for individuals and whole segments of our local populations. Our vision is to develop interoperability between all systems to provide this “real time” information and managerial analytics capability.

Our GP practices all use the same IT system,SystmOne providing the opportunity for our care providers to all use the same patient record5; the BCF will help ensure this happens by joining up Health and Social Care data across the County provider landscape, all linked together via the NHS number.

5 Subject to Information Governance constraints

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow effective identification and management of need and outcomes across our health and care economy as a whole.

What measures of health gain will you apply to your population?

We will be using the nationally mandated indicators6 and we will be using locally developed indicators and KPI's that will use the JSNA and the JHWS as the key drivers and sources of intelligence that informs them.

A key measure of success for our CCG will be the impact that the changes we set in motion have on our Acute providers and specifically our A&E departments - how quickly does demand begin to reduce in A&E departments, how quickly do emergency admissions of frail and elderly start to reduce and how much can we reduce our Continuing Health Care bill because we are seeing more people going through a rehabilitation and reablement model that actually works for them and allows/facilitates them to lead a relatively independent lifestyle for longer.

5.7. Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including: The key success factors including an outline of processes, end points and time frames for delivery

As mentioned previously these are the key changes we will be implementing:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy;
- Clinical pathways will be designed around the needs of patients, carers and their families.

Working closely with ECC, and using a programatic approach based on Managing Successful Programme (MSP). The following diagram (Fig 3) describes the three main stages of the MSP process which we will be following.

6 As driven by the NHSOF & ASCOF

At the time of submission we can say with a degree of confidence that we7 are in the Development phase of the programme. A description of phase 1 - Define can be found in Appendix III of this document

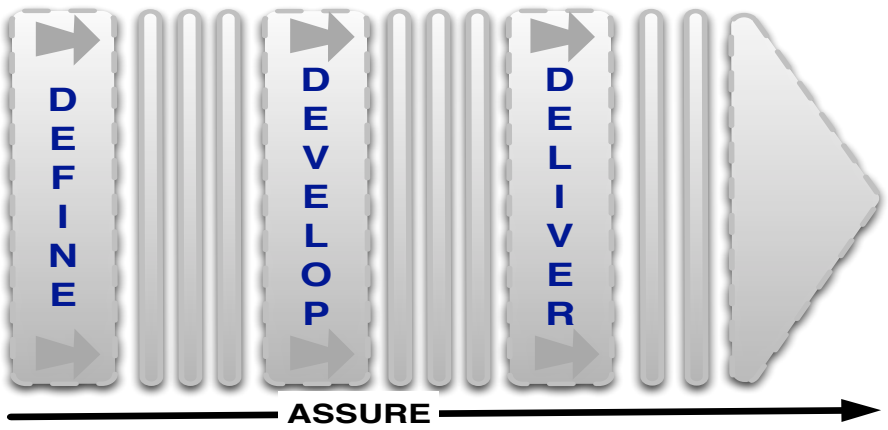


Fig 3 - MSP Programme phases

The programme level weekly meetings that take place with ECC have ensured that we have gained momentum in planning terms and the membership of the group has meant that we have had executive decision making capability and authority in the room at all times which has ensured that we have not been unnecessarily delayed whilst we wait for decisions.

In line with the guidance issued on the 20th of December 2013 we submitted our initial plans to NHSE and ECC in February 2014 , albeit that they may not have gone through our desired full approvals process of ECC Cabinet and HWB.

A fully detailed programme plan is being developed in collaboration with ECC and with Castle Point and Rochford CCG as well as NHSE and local district councils. The detailed plan was not ready for the initial submission date of 14th of February 2014, but is expected to be complete by the end of March 2014.

7 South Essex Commissioning Programme Group

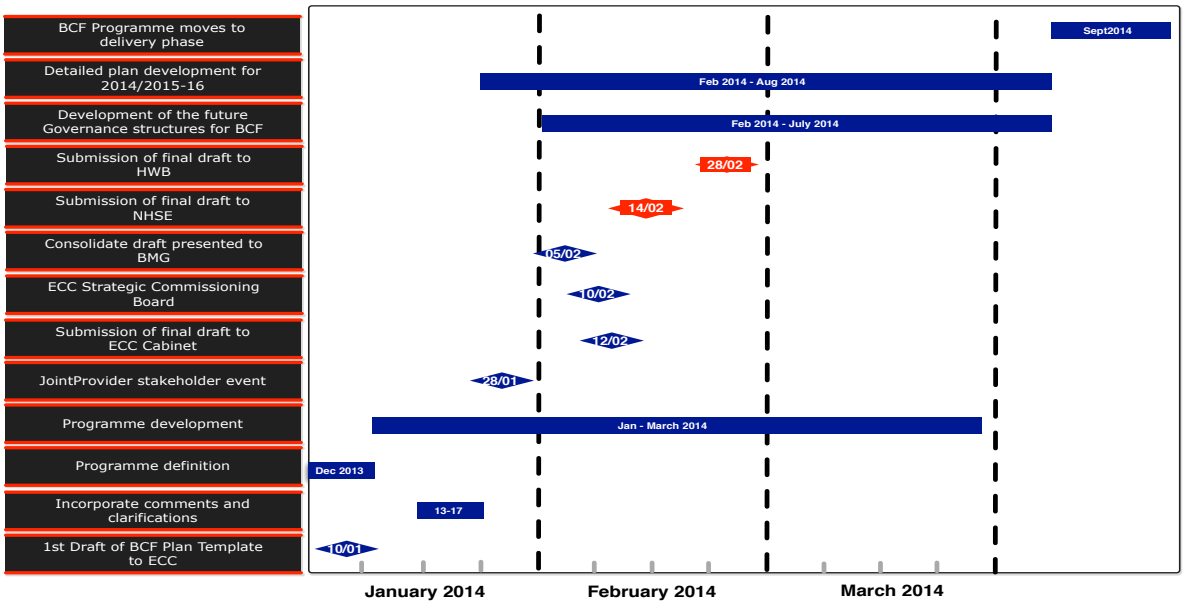


Fig 4 - Short term high level BCF programme plan

How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The JSNA will be used to provide the evidence to support our commissioning intentions as it does for the Health and Wellbeing Strategy.

5.8. Implications for the acute sector

Implications of the plan on the delivery of NHS services

Not dissimilar to many other parts of England our Acute providers are continuing to feel the strain of excessive demand, particularly in the Unplanned Care pathway(s). Clearly the level of demand being placed on our Acute Trusts is not sustainable so something has to change. This is recognised by both Commissioners and Provider. The CCG has a productive dialogue with Basildon and Thurrock University Trust Hospital, a dialogue that has already started to explore and agree new approaches to commissioning and payment models which are reflected in the 2014/15 contracts recently agreed.

Heads of Agreement were signed on the 28th of February 2014 with contract documentation now being finalised which is expected to be formally signed off by the 31st of March.

5.9. Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Governance around BCF is considered to be two distinct work streams that apply to separate phases of the implementation and delivery of the BCF programme :

a. The programme definition and development stage which encompasses 2014/15

b. The programme delivery and move to “business as usual” stage which will manage the delivery of BCF from April 2015 going forward.

The diagram below (Fig 5) describes the current Governance structure that we have developed to manage Phase 1.

ECC has a strong history of collaborative working with health commissioners and providers across the county. This has continued under the new structure for Health with the authorisation of multiple CCG’s in Essex, of the seven CCG’s in Essex only two of which are not aligned to ECC’s health and wellbeing board.

Under this current structure the South Essex Commissioning Programme Board meets monthly and the Business Management Group, whose membership includes the Accountable Officers from the five CCG’s, ECC and NHSE, meets fortnightly.

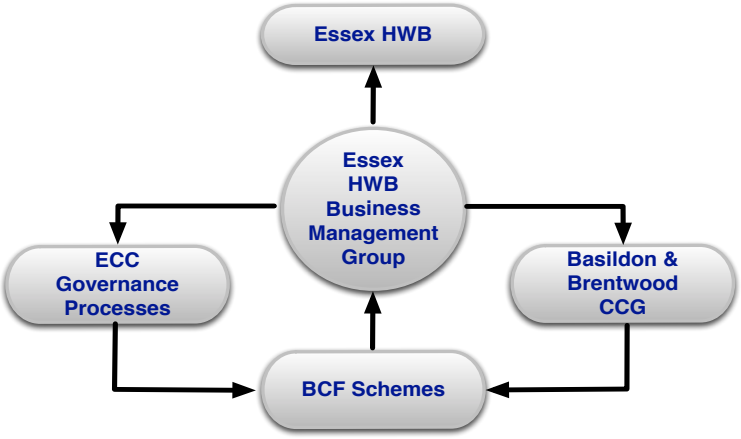


Fig 5 - BCF Phase 1 Governance structure

To deliver the ambition that the establishment of the BCF offers, we recognise that we need to develop robust yet agile strategic and operational governance arrangements that will stand the test of both internal and external scrutiny and possibly public scrutiny. We therefore propose to consider, as part of this process, what are the specific arrangements that will work best in order to discharge our management responsibilities and accountability across social care and health services, whilst at the same time ensuring that we deliver the services our citizens require.

We are still in the process of developing potential commissioning scenarios which will form part of our options appraisal that will determine which is the most appropriate vehicle to deliver the joint commissioning functions - be this a jointly resourced commissioning team or a legally constituted Commissioning Trust. Whichever the model we select we would see our future commissioning management team for the commissioning of integrated care, accountable through the Health and Wellbeing Board, to both the Local Authorities and the CCGs.

In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

As stated previously we are in the process of developing detailed programme plans for the implementation of the BCF programme in collaboration with ECC, Providers and other key stakeholders.

6. BCF Programme structure

The development and delivery of the BCF programme is expected to be complex and challenging, particularly the communications, engagement and governance elements of the programme. Therefore based on this we have adopted a working group and task and finish group approach to programme management. The following diagram overleaf (Fig 6) describes the main standing groups that will sit during the development and early stages of delivery. These will be complimented, when and where necessary by task and finish groups which will be convened for a time limited task specific period.

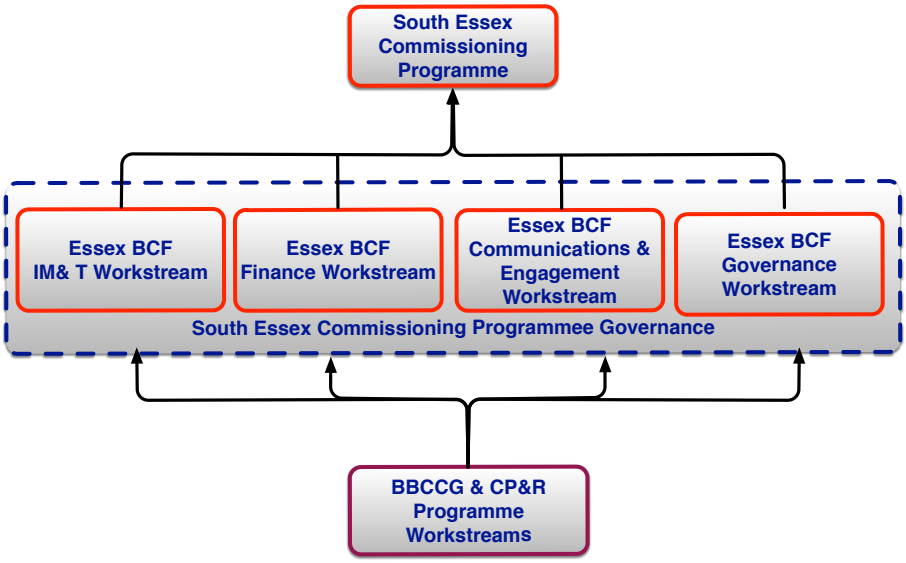


Fig 6- BCF Programme Structure

6.1. Working Groups

Each of the programme working groups has representation from the two CCG's and from ECC. Terms of reference (ToR's) and meeting schedules have been drawn up for each group and published. The groups are in the process of developing their scopes of work which will inform the development of the overall programme of work for the South East Integrated Commissioning Programme. The detailed programme plan will be presented to the programme board for approval at the end of March with implementation initiating following approval.

6.2. Financial Implications

We see the implementation of the BCF as a phased programme in 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure we provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

BBCCG and ECC are having productive discussions around the sums that should go into the integrated fund, both parties recognise that if we simply deposit the minimum amounts as allocated by NHSE then it is unlikely that there will be sufficient monies to bring about real transformation of our health and social care systems in Essex. So whilst we still have considerable work to do8 we are confident that we will collectively be contributing more to the pooled fund than the minimum amounts stipulated.

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for 2014/15 will be considerably different and smaller scale than those transferring in 2015/16.

6.3. 2014/15 BBCCG Investment

Following a recent meeting of the Business Management Group it was agreed that consistency of terminology would make ongoing development easier and reduce potential confusion between the various collaborating organisations. Based on the agreement the tables overleaf for 2014/15 will be identical in terms of structure to that for 2015/16 although the numbers will obviously differ.

8 this work will be taking placduring quarters 1 7 2 of the 2014/15 financial year

Function/Service Identifier	Description	Min	Max	Total Investment
Protection of Social care to benefit health		£3.7M	£4.854 M	
Community Health Services (including admission avoidance)				
Reablement	Residential step-up/step down Community Beds Home from Hospital High Intensity Rehabilitation Hospital In reach Rapid Response SPOR	£773K	£1.546 M	
Joint nursing and care home commissioning including CHC				
Discharge support				
Acute mental health and dementia				
Care Bill				
Early intervention and prevention				
Community resilience				
Carers				

Function/Service Identifier	Description	Min	Max	Total Investment
Disabled Facilities Grant				
Other and enablers				

Table 1 - 2014/15 Proposed investment

6.4. 2015/16

As we have established the size of the BCF will grow from 2014/15's allocation of £4.85M, which is mainly constructed from similar S256 amounts from 2013/14, to approximately £18.44M for 2015/16. Whilst we still have work to do and challenging conversations to have the table overleaf describes and sets out our ambition for 2015/16.

Function/ Service Identifier	Description	Min	Max	Total Investment
Protection of Social care to benefit health		£4.853M	£4.853M	
Community Health Services (including admission avoidance)		£9.809M	£14.834M	
Reablement	Residential step-up/step down Community Stats Home from Hospital High Intensity Rehabilitation Hospital In reach R&R SPOR	£3.700M	£1.850M	
Joint nursing and care home commissioning including CHC				
Discharge support			£507K	
Acute mental health and dementia			£71K	
Care Bill				
Early intervention and prevention				
Community resilience				

Function/ Service Identifier	Description	Min	Max	Total Investment
Carers		£82K	£82K	
Disabled Facilities Grant				
Other and enablers			£1.8M	
	Totals	£18.444M	£24.077M	

Table 2 - 2015/16 proposed investment

7.NATIONAL CONDITIONS

BBCCG will align with the national requirements as mandated by NHSE and those that are contained in the planning guidance that was issued on the 20th of December 2013. Specifically in relation to BCF we are developing plans that meet the following preconditions:

- Plans that are jointly agreed;
- Protection for Social Care services (not spending);
- 7 day services in H&SC to support patients being discharged and prevent unnecessary admissions at weekends;
- Better data sharing between health and social care, based on NHS number;
- Ensure joint approach to assessments and care planning and ensure an accountable professional where integrated care package is funded;
- Agree on consequential impact of changes in the acute sector.

We also recognise that there will be a significant performance linked payment(s) which CCG's and the Integrated commissioning functions will need to deliver against.

7.1.Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

The objective of integration is to develop a more effective, efficient and affordable health and social care economy. Integral to this will be the continued development and enhancement of social care services. Our stated ambition is to move more activity out of an acute setting and into a community based setting, this will require a stable and accessible social care system in order to make the changes sustainable.

ECC will continue to allocate additional spending for local social care services to the same financial level in 2014/15 as they did for 2013/14. This will enable the purchasing of community based social services within each CCG locality. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principle mechanism for this is ECC social care resource allocation system (RAS) and support planning.

7.2.Carers (Care Bill)

We have ring fenced an amount of money for both 2014/15 and 2015/16 to support the requirements of the Care Bill and supporting Carers.

Whilst we still have work to do with ECC in this area we are fully aware that the care and support planning process is there to help decide the best way to meet a person's needs.

It considers a number of different things, such as what needs the person has, what they want to achieve, what they can do by themselves or with the support they already have, and what types of care and support might be available to help them.

The planning process takes place with the local authority and the individual, any carer they have and any other person they ask the authority to involve. Where the person lacks the capacity to ask, any person who appears to the authority to be interested in the adult's welfare should be involved. This process will decide how to meet the needs of the person and the local authority must do everything it reasonably can to reach agreement.

A carer is someone who helps another person, usually a relative or friend, in their day-to-day life. This is not the same as someone who provides care professionally, or through a voluntary organisation.

The Bill relates mainly to adult carers - i.e people over 18 who are caring for another adult. This is because young carers (aged under 18) and adults who care for disabled children can be assessed and supported under children's law.

The local authority and the carer need to think about what type of support the carer might benefit from. This might include help with housework or gardening, buying a laptop to keep in touch with family and friends, or becoming a member of a gym so that the carer can also look after their own health and wellbeing.

It may be that the best way to meet a carer's needs is to provide care and support directly to the person that they care for, for example, by providing replacement care to allow the carer to take a break. It is possible to do this as long as the person needing care agrees.

Our short term plans (for 14/14) will focus on the needs assessment of our carers and putting in place tangible support mechanisms, which may include some or all of the suggestions mentioned above as well as other initiatives yet to be defined.

7.3. 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)

ECC already operate a six day discharge support service and in line with national guidance, BBCCG is working with ECC and our providers to deliver a seven day access to health services programme.

This work is being undertaken: Locally, across multiple providers and regionally across the County. The programme includes a number of clinical pathways including Social care discharge, Reablement, Step down and Rapid response via an out of hours emergency duty team. Care homes are working with us to ensure they are able to accept 7 day planned admissions.

> seven day care is about having a service that gives me care, any day of the week, that meets my needs to maximise my recovery and well-being whilst keeping me safe.

BBCCG has implemented a collaborative working arrangement with key providers across the borough, see Fig 7 below, to develop the necessary support and infrastructure that will facilitate a sustainable response to the requirements for 7 day working in the NHS.

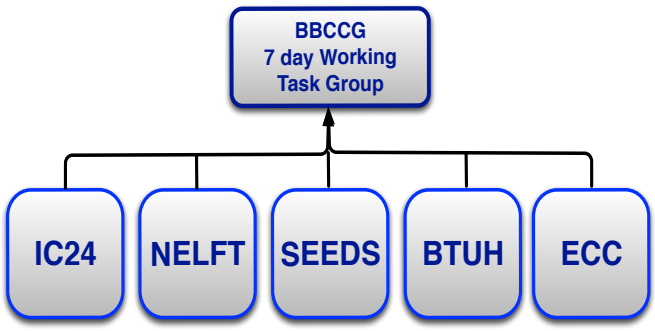


Fig 7 - BBCCG 7 day working task force

The following are some of the initiatives that are being developed :

- Paediatrician cover has shown a marked increase since the Paediatric review;
- McKinsey reviewed 10 specialties and validated job plans. Three workshops in September, October and December 2013 have driven this work at pace the success of which has been manifest in increased attendance rates. The consultants are working to agree the standards and plug existing gaps;
- A pilot started on the 16th November for acute physicians, DMPO and general medicine to increase consultant cover. Improvements have been seen at the weekend, analysis is now underway to assess the impact of the upturn in discharge rates;
- January 2014 sees the implementation of a new model for Trauma & Orthopaedic (T&O) consultants;
- Additional locums have been brought in to increase from half to full days at weekends. Respiratory coverage is increasing to 6 days per week;
- Discussions with anaesthetics, gastro and diabetes are ongoing to identify improvements that will be made. (This is managed through right place right time in what is known as work stream 3).
- ECC's pilot programme has been extended (moving from their previous 6 day supported discharge team's working window to 7 days). A further evaluation of the success and outcomes of this will be carried out at the end of the financial year.

In conclusion we will prioritise delivery of the requirements set out in the NHS Constitution, that focus on the introduction the 7 day working arrangements , strengthening our urgent care system and improving cancer waiting times.

By 2019 we expect that the majority of primary care services will be accessible to patients over the 7 day period, with smaller organisations being supported by centralised facilities. Continuity of care will be ensured through a single care record so citizens will know that any contact they have with services will be available to their named primary care clinical lead.

7.4. Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We are currently able to use the NHS number in a limited fashion, due to Information Governance, but our clinicians have Approved Safe Haven (ASH) status, and along with ECC, we have plans to broaden usage in the future.

ECC also have plans in place to adopt the use of the NHS number as the default identifier, as indicated below.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

It is our expectation that we will be in a position to implement usage of the NHS number by Quarter 3 of the 2014/15 Financial year.

Because the use of the NHS number is governed by the rules around Information Governance, and until some of these issues are resolved, we cannot put a specific date against this item.

We will continue to work with NHSE and the Local Authority, ECC, to ensure that we are ready and able to implement the appropriate use of the NHS number as soon as it is possible following authorisation to do so.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Implementation will be subject to both organizations evaluating various issues in order to maximize the rewards, as well as manage the implications associated with an open API model and of course the requirements and constraints of the Information Governance arrangements for the NHS and CCG's in particular.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The changes that integration effects and the impacts it has will take place with due regard and compliance with our Information Governance framework, and we are

committed to maintaining five rules in health and social care to ensure that patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully;
- Members of care teams should share confidential information only when it is needed for the safe and effective care of an individual ;
- Information that is shared for the benefit of the community should be anonymised;
- An individual's right to object to the sharing of confidential information about them must be respected;
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed.

7.5. Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. professional.

Following the announcement by the Secretary of State for Health in December 2013 that everyone over the age of 75 would have a named GP lead who would monitor and manage their health BBCCG is in the process of working towards the implementation of this directive, we currently do not have full implementation.

One of the key benefits of a commissioning organisation led by local GPs is we know our citizens and routinely interact with them as they move through each stage of their life.

In 2013 we made extra efforts to make sure that we also heard from other people in our communities, both citizens who don't regularly use services and organisations who see and hear from people in different ways.

The aim is that geographic, federation configured, 'Named GP Teams' would be the sole deliverer of front line care to people with complex needs and long term conditions, this would include existing generic community, social care and mental health resources.

As part of the BCF in practice, this **will** mean that every citizen who is covered within these teams has a named GP who is responsible and accountable for their care and outcomes. Our plans for integrated community services within the BCF will ensure that Social Care resources are fully aligned on a multi-disciplinary basis.

Our plans to develop a fully integrated approach to reablement and rehabilitation will strengthen our existing arrangements and ensure we use a joint process to assess risk, plan care and allocate a lead professional.

A step up approach to this could see the mobilisation of services that provide specialist intensive management of individuals. BBCCG is in the process of trialling this along with other models of care in the community.

3 categories are being considered to help us define the level of health and social care that will be expected to be available to each individual who is 75 years or older:

- 'Well' – those individuals with a relatively non-complex health profile, who are able to maintain an appropriate level of wellbeing and independence, with minimal recourse to primary, community or secondary health care, and do not require social care. Care co-ordination will be via routine GP practice or patient initiated contact with relevant health services as required.
- 'Moderate complexity' – those individuals with a more complex health profile, including co-morbidities and/or frailty, and increasing social care needs, requiring frequent monitoring and intervention within primary and community environments, and close co-operation with secondary care consultants within the relevant medical specialties. The Lead Professional Care Co-ordinator for individuals within this category will be a named GP, and the care co-ordination vehicle will be the GP Practice-level MDT, on an ongoing basis.
- 'Significant complexity' – those individuals identified, either through the GP Practice level MDT, or following presentation at the ED/admission to an acute bed, as experiencing significant exacerbation in the complexity of their health needs and/or significant increase in their social care needs. Requiring intensive specialist intervention within a community environment, with a view to transferring the individual back to the care of the GP Practice-level MDT once their condition has been stabilised. The Lead Professional Care Co-ordinator for individuals in this category will be a Consultant Geriatrician, and the vehicle for assessment/planning and implementation of required care will be the Geriatric Case Management Team.

In order to take this model forward further it will be necessary to develop an effective risk stratification tool that will allow professionals across the health and social care system to apply a common approach to identifying individuals that fit within the 'moderate complexity' and 'significant complexity' categories. The CCG in partnership with ECC are fully committed to working together to evaluate and procure an appropriate risk stratification tool within 6-9 months, appropriately aligned to other BCF procurements.

7.6. Supporting GP Development to Lead Accountable Professional

A key part of our GP strategy development is through supporting general practice to strengthen and develop their core primary care service and to align the focus on primary care to the commissioning work of the CCG. We are working with our practices to clearly define what "excellent" means in primary care delivery, with specific success factors aligned to the shift in resources that this will mean.

8.RISKS

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

Risk	Risk rating	Mitigating Actions
There is a risk that moving funding from existing pathway provision will destabilise providers	Medium	We will work closely with providers, social care and partner organisations to ensure that when capacity is moved providers are supported and that when the capacity moves the patients move with it.
There is a risk that when services and capacity are moved from an Acute setting into a community or home based setting that patients will not be fully informed or engaged with the changes	Medium	The CCG will lead a programme of communication and engagement in partnership with GP's, Providers, Essex County Council and other partner organisations to provide consultation and educational programmes to support the implementation of the changes.
There is a risk that the current level of ambition for system change is not matched by available CCG resources which will impact on the ability of the partnership to deliver the full impact of the BCF on time	High	The CCG will need to consider the use of non recurrent transformational funding to deploy additional external and/or seconded resources to support the change agenda. Plans are currently being finalised to present to the governing body and to NHSE for assurance prior to implementation.
There is a risk that politicians if not feel fully briefed on the implications, advantages and benefits of the pooled funding arrangements and are therefore unable to fully support the plans in the first instance	Medium	The CCG (s) are working closely with ECC, and will continue to do so during 2014 to ensure that Elected members are fully engaged and briefed on progress towards to implementation of the BCF and the impact of implementation on their constituencies.

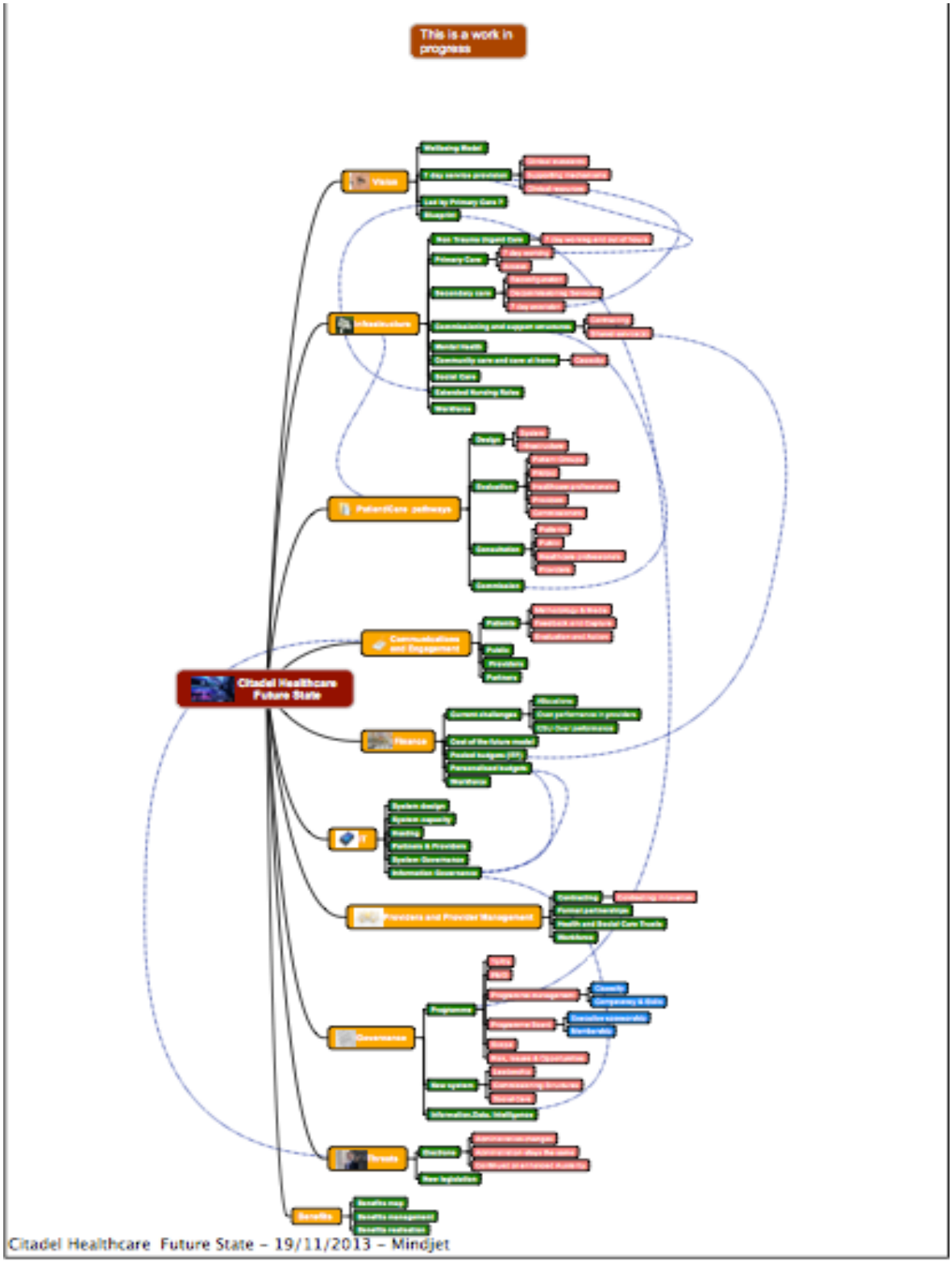
There is a risk that if the use of the NHS number by all parties to the pooled funding arrangement is not facilitated by the end of Quarter 2 of 2014 it will have a significant delaying effect on the full implementation of the BCF	High	CCG's have limited ability or scope to mitigate against this risk, the ownership of the risk in reality transfers to NHSE

6.Appendices

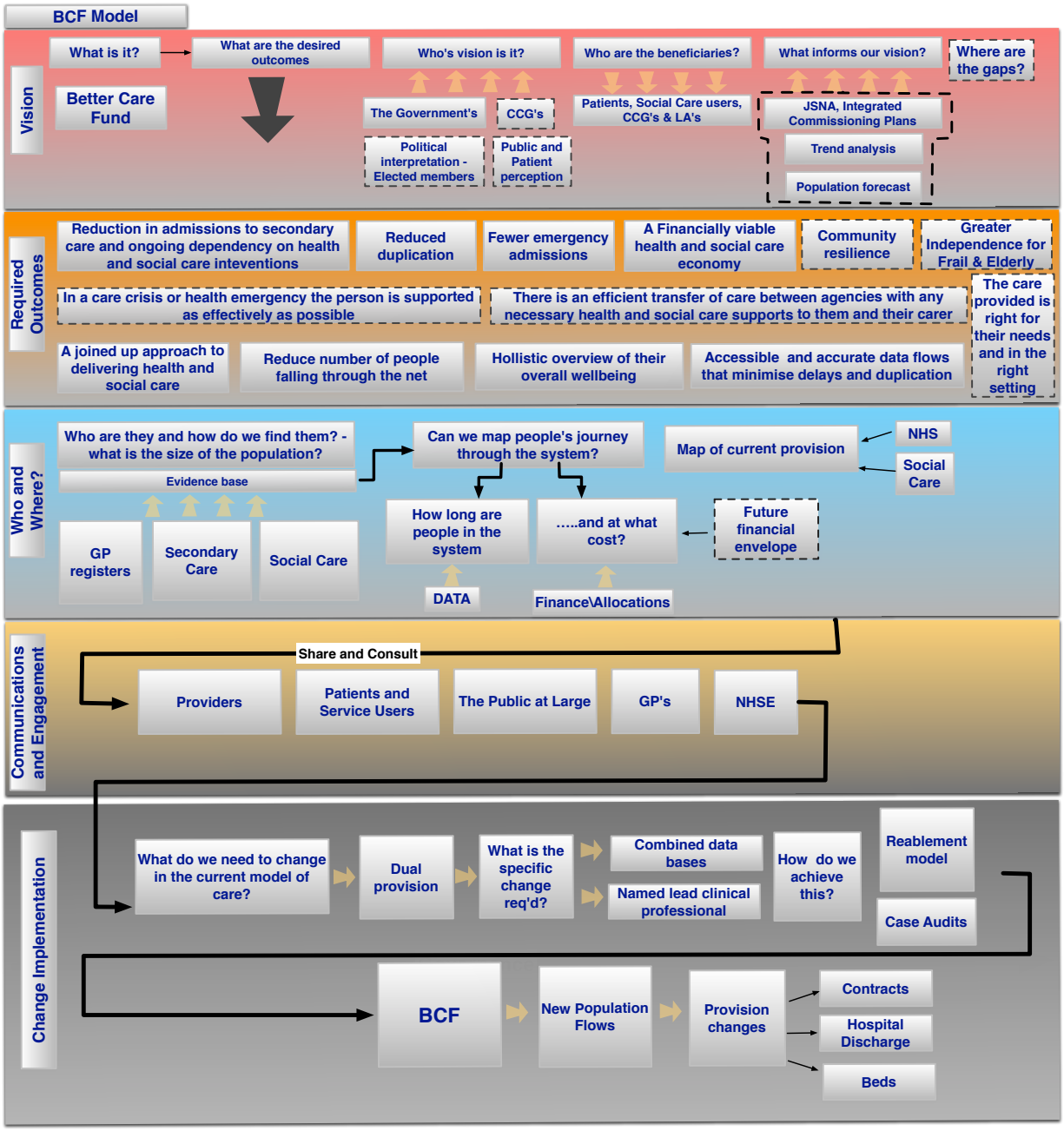
(I)Appendix 1 - Citadel

Fig x - Citadel Graphic representation

(II)Appendix II - Programme definition & build



(III)Appendix III - BCF Programme definition and initial build



Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Local Authority #1	Y	£ 6,400,000.00		
CCG #1			£ 16,041,000.00	£ 18,444,500.00
CCG #2				
Local Authority #2				
etc				
BCF Total		£ 6,400,000.00	£ 16,041,000.00	£ 18,444,500.00

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The functions and services that will go into the BCF are based on service redesign and moving activity away from an Acute setting wherever possible. The service redesign work will be taking place during 2014/15 and it very important that as commissioners we do not close down capacity in the Acute Trusts until we are sure that the activity really has been moved and that the patients are familiar and comfortable with the revised pathways.

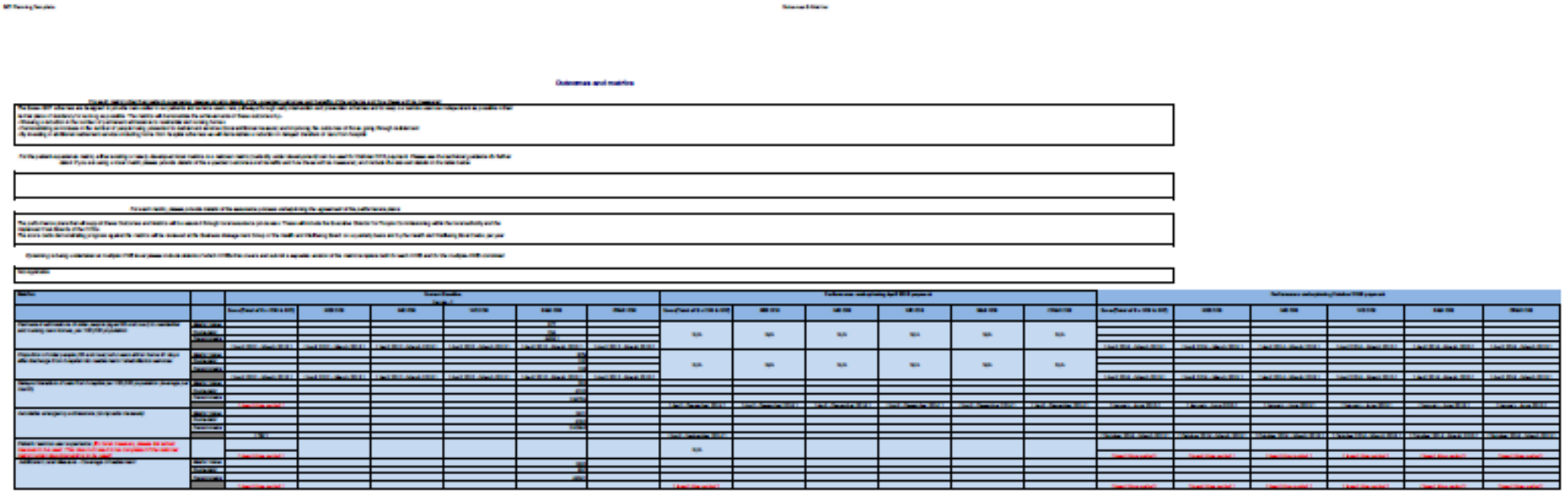
Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	£723,000	
	Maximum support needed for other services (if targets not achieved)	£723,000	
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

BCF Planning Template | Finance - Schemes | DRAFT

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
SW Reablement / Intermediate care									
SW Integrated Community Services									
SE reablement / Intermediate care									
SE Integrated Community Services									
Scheme 5									
Total									

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend Max		2015/16 Spend Min	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
(3) Reablement / Intermediate Care including recommissioning existing contract, Home from Hospital, Residential Beds, High Intensity Pathway, Hospital Inreach, Rapid Response, SPOR									
Protection of social Care (uplift)						£1,063,500	£0	£1,063,500	£0
Reablement Contract						£1,400,000	£0	£1,400,000	£0



NHS
Castle Point and Rochford
Clinical Commissioning Group

Better Care Fund Plan

Part 1

Castle Point and Rochford Clinical Commissioning Group

(developed in partnership with Essex County Council)

DRAFT 1.1

March 2014

Table of Contents

Authorisation and Sign Off

Local Authority	Essex County Council (ECC)
Clinical Commissioning Groups	Castle Point and Rochford CCG
Boundary Differences	One of five CCG's co-terminus with ECC
Date agreed at Health and Well-Being Board:	<dd/02/2014
Date submitted:	<dd/02/2014
Minimum required value of ITF pooled budget: 2014/15	£0.00
2015/16	£0.00
Total agreed value of pooled budget: 2014/15	£0.00
2015/16	£0.00

Sign on behalf of Castle Point & Rochford Clinical Commissioning Group	
By	
Position	
Date	

Sign on behalf of Essex County Council	
By	
Position	
Date	

Sign on behalf of Essex Health and Well Being Board	
By	
Position	
Date	

1. Castle Point & Rochford CCG – Context & Executive Summary

1.1 Geography & Population

Castle Point and Rochford localities make up a large swathe of land surrounding the Southend Borough Council boundaries in South East Essex. Each locality is served by its own borough council. The CCG is made up of 28 practices. Their total registered population (taken from the Attribution Data Set in April 2011) is 177,000. This compares to an average for all 212 CCGs in England of 261,000.

Castle Point and Rochford CCG (CPR CCG) is responsible for the area of the populations consisting of Rayleigh, Hockley, Rochford, Great Wakering, Hadleigh, Benfleet and Canvey Island. As a CCG we operate across two core locality groups based on our local borough council boundaries: Castle Point and; Rochford. This enables us, as a CCG; to work more closely with the populations we serve and allows us to have insight into the diversity of our population.

We were fully authorised as a statutory commissioning body in April 2013, with a small number of conditions.

Our Population

15.9% of Castle Point and Rochford CCG registered population are under age 15 (England average 17.1%) and 9.3% are age 75 or over (England average 7.5%). 50.6% are female (England average 50.2%). Table 1 below shows how the CCG population is expected to grow by 2015, 2020, and 2025. This is based on applying weighted averages of ONS population projections by age and Local Authority to the CCG's population.

Year	Population	population 75+
Current (2011)	177,091	16,536
2015	181,491	18,817
2020	188,006	22,445
2025	194,855	27,492
Average annual growth rate 2011 to 2020	0.7%	3.5%
England average annual growth rate 2011 to 2020	0.7%	2.3%

Table 1: CPR CCG Population Growth

By 2030, the number of older people with care needs, such as requiring help with washing or dressing, is predicted to rise by 61 per cent and by 2032, more than 40 per cent of households are expected to be people living on their own. The number of people with dementia is expected to more than double over the next 30 years. This increasing ageing population could put significant pressure on our hospitals

1.2 CPR CCG - Overview of Better Care Fund

We are worked very closely with our partners to develop our plans for Better Care Fund (BCF) with Essex County Council, Southend CCG and Basildon and Brentwood CCG, alongside our local providers (namely Southend University Hospital Foundation Trust [SUHFT] and South Essex Partnership Trust [SEPT])

We have already agreed areas of joint work and are keen to develop new governance arrangements to oversee the implementation of these key programmes. Together Castle Point & Rochford CCG, Basildon and Brentwood CCG and Essex County Council are implementing the Better Care Fund agenda, aligned to key QIPP and JSNA priority areas for 2014/15.

For CPR CCG, it is imperative that we develop our plans in collaboration with our colleagues in Southend CCG our partners in a shared (acute, community and mental health) South East Essex health system. Our BCF priorities include:

- **Focus on frail elderly across health and social care with particular focus given to admissions avoidance and reablement, and in particular in working to shift the balance of care in Castle Point & Rochford.**
- **Children and Young people's services including safeguarding.**
- **Mental Health and Learning Disabilities**

Developing integrated care through BCF is an important part of our CCG's approach to delivering our strategic plan. Since authorisation in April 2013 our CCG commissioning team has been working collaboratively on a programme of work focusing on Integrated Care that brings together all key providers and commissioners in the local health system, with focus on the development of integrated care and service models that reduce rising number of acute unplanned admissions across South Essex. Examples include:

- Our lead community provider (SEPT) has been contracted to deliver care using 'integrated team' specifications,
- We have commissioning a Single Point of Referral (SPOR) shared health and social care telephone referral service for clinicians.
- Commissioned 'befriending service' from local voluntary organisation

The BCF has been implemented in the context of an ageing population and an increasing number of people who have one or more long-term conditions. These two factors mean that the needs of patients and service users increasingly cut across multiple health and social care services.

Increasing demand and financial pressures mean there for us to focus on prevention, reducing the demand for services and making the most efficient and effective use of health and social care resources. It is vital that our CCG and local authority understand the population we serve and how the use of services is distributed within our population in order to target interventions where they can have the most impact. Our Local Joint Strategic Needs Assessment is helpful information in this regard.

1.3 CPR CCG Core Aims for BCF

Our aim is to use the substantial opportunity offered by BCF to bring sources together to address immediate pressures on services and lay foundations for a much more integrated system of heath and care delivered at scale and pace.

This sustainable integrated system will being delivered through a partnership between Basildon & Brentwood CCG, Southend CCG, acute and community providers, local GP practices and partners in Essex County Council and Southend Borough Council. The aim of the programme is to jointly redesign the health and social care system and redefine the way professionals engage with each other around the assessed needs of individuals.

The BCF will fundamentally change the way in which people are supported in taking charge of their own care and conditions. The programme's initial focus, through integration with local authorities, is on caring for older people and its scope will be systematically broadened over the next four years (2014-18) – with Frail Elderly and Long Term Conditions being the focus the first phase of work.

The aim of the collaborative BCF (Integrated Care) Programme is to drive up the quality of care and drive down costs of providing it:

- improving the value of care we provide to local people by joining up care around people, across providers;
- identifying and managing people's care needs better and intervening earlier;
- ensuring care is provided in the most appropriate setting, particularly at times of acute crisis and by ensuring the right incentives exist for providers to work in integrated ways.

Our key objectives of the Better Care Fund (BCF) are:

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services.
- To move care closer to home so that our hospitals have manageable demand
- To work together to ensure people are supported to look after their health and wellbeing.
- To support providers to join up, share information, and make services easier to navigate

To create an Integrated Commissioning Board or similar to align our work and have a single commissioning process

There are over-arching themes that CPR CCG has set out in our Strategic and Operational Plans that play into our emerging BCF plan, namely:

A. Primary Prevention

B. Self-care

C. Managing Ambulatory-sensitive conditions

D. Risk Stratification or Predictive Modelling

E. Falls Prevention

F. Care-Coordination

G. Case Management

H. Intermediate Care, reablement and rehabilitation

I. Managing emergency activity, discharge planning and post-discharge support

J. Medicine Management

K. Mental and Physical Health Needs

L. Improving Management of End of Life Care

M. Delivering Integrated Care

Delivery of BCF programme requires the building of collaborative leadership across health and social care organisations.

1.4 Service provider engagement

CP&R CCG share a main acute and community providers with Southend CCG within a South East Essex health system. Southend CCG is host commissioner for the acute contract with CPR CCG operating as an associate. CPR CCG is host commissioner for the mental health and community contracts with Southend CCG acting as an associate. As a consequence; all parties acknowledge that there will be significant overlaps between the CP&R CCG and Southend CCG Strategic and BCF Plans.

A strong working relationship with the local Acute and Mental Health / Community Foundation Trusts based upon clinician to clinician engagement has been a priority for the CCG in 2013/14 and will be actively developed further during 2014/15 as part of the CCG's organisational evolution.

All parties are seeking very similar outcomes and recognise the importance of giving clear direction to providers and the market place that will only come through close working. We will utilise existing collaborative forums such as Urgent Care Steering Group (that operate in both Health sub- economies) to ensure that there is some consistency in the strategic and operational delivery of commissioning intentions.

This first draft reflects a number of existing programmes that are designed to include health and social care providers as active participants; together with our GP locality groups, and our voluntary and community sector as a whole. Our intention is to encourage providers to take an active role in developing future plans. We had a major provider engagement event jointly with Basildon and Brentwood CCG, acute and community providers and ECC on the 28th January 2014.

It is our intention, as the programme gathers momentum, to invite representatives from key providers to join the appropriate Essex BCF Programme work stream project group. This will ensure that the design of future services and clinical pathways is jointly driven and jointly owned.

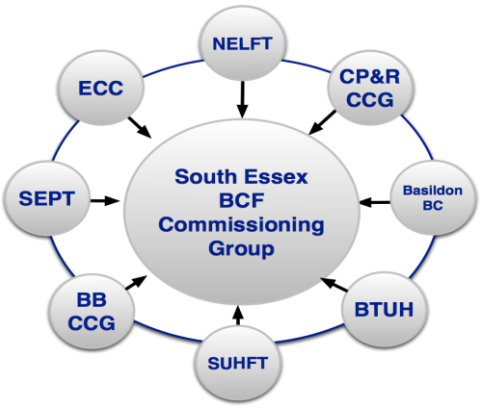


Fig 1 - South Essex BCF Commissioning Group

We recognise that there will be difficult and challenging conversations to be had across the provider landscape as there will be both winners and losers as we move to the new ways of working, particularly when it comes to moving activity from one provider to another and the inevitable movement of revenues.

1.5 Patient, service user and public engagement

Our vision is to design and implement an integrated care system based on our resident population needs, that will be articulated by the residents themselves via the various patient and service user engagement forums that we have already established and a number of additional groups that we are planning to establish over the coming weeks and months. The CCG has implemented a wide range of activities to help ensure that our patients and community feel fully engaged with the planning and quality monitoring of local services.

Commissioning Reference Group

We will be using our established Patient Involvement Forum (Commissioning Reference Group) to engage directly with our patient and public representative on this agenda. We have a single Patient Engagement Group (Commissioning Reference Group [CRG]) which meets monthly to hear patient views and acts as an information exchange.

The CRG acts as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc. Members include our CCG lay representative, 2 x CVS, local authority, Healthwatch Essex and GP lead for PPI. Key roles of the group include receiving reports from the CCG Leaders responsible for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year etc.

The CRG links to the GP practice Patient Participation Groups to ensure local views and connections are maintained. The work plan of the CRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval.

CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients.

Other Patient Engagement Activities

- CCG Communication and Engagement Strategy (will be updated to include BCF)
- A prospectus for patients is published each year (due for review)
- Two 'Call to Action' events in Oct 2013
- Board meetings are held in public, who are invited to become actively involved.
- The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.
- The CCG has its own website where all plans (including the Integrated Plan), policies and documents are published and accessible to the public

www.castlepointandrochfordccg.nhs.uk

- Contact details for the CCG and a general enquiry email account has been set up to receive comments and messages from the public. CP&R CCG.contacts@nhs.net

1.6 Related documentation

The below documents relate to BCF

Ref	Document	Synopsis
1	Joint Health and Wellbeing Strategy	A partnership document detailing the vision and aims for improving health and wellbeing in Essex.
2	CCG Operational Plan (2014-16)	CPR CCG's two year operational plan
3	CCG Strategic Plan (2014 – 19)	CPRCCG's five-year strategic plan
4	Joint Strategic Needs Assessment	Analysis of the health needs of Essex's residents to inform planning and commissioning.
5	Draft Primary Care Strategy	The Strategy outlines the vision for Primary Care in Essex and identifies how the vision will be delivered.
6	Delivering Seven Day Services	Describes how seven day services across health and social care will be delivered.
7	Strategic Housing Market Assessment	This is a study of current and future housing requirements and housing need across south Essex. It provides evidence to support development of local housing strategies and also the planning of other services such as health, education and transport.

2. VISION AND SCHEMES

2.1 Our Vision for Health and Care Services

Our CCG has a vision for integrated commissioning that sees health and social care services working together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

Our Vision: To enable the people of Castle Point and Rayleigh Rochford localities to live longer, healthier and with improved quality of life through commissioning high quality health related services sensitive to local needs, putting the patient and family at the centre of their care.

- Improved patient outcomes and Improved quality of care.
- Improved patient experience.
- Improve access to services for patients.
- Empowered patients.
- Improved Patient Safety.
- Reduced costs without compromising patient care.
- Redesigned pathways with the help of primary and secondary care clinicians to ensure appropriate patient care is available at the right time, in the right place, with the right person
- Improved information to patients to support self-care and choices including alternatives to hospital treatment.
- Sharing of good ideas and best practice with all Constituent Practices.
- Working with other CCGs to help to share risks and learn from each other.

Our vision for the future requires whole system change; in terms of how we commission work from providers, how our providers then interact with patients and with each other. Working together across the local government and health landscapes we are committed to driving behavioural and attitudinal change in partnership all areas of the health & social care system, which will include a much more prominent role for the voluntary, community sectors, and not least our residents themselves.

NHS Castle Point and Rochford CCG (CP&R CCG) has commenced a process to undertake significant reform of the local NHS and wider care system. The objectives of these reforms are to:

- To eliminate unnecessary waste from the system to maximise reinvestment, at the same time improving the quality of services, and to improve the health and quality of life for our population. The CCG will continue to deliver on both national and regional commitments and targets.

- Lead the local health community to ensure that patient insight shapes services, ensuring the best value for the best services.
- Some of the challenges CCGs face are common across the NHS – the economic downturn, more people with long term conditions and an ageing population. As groups of GPs, the CCGs aim to engage and work collaboratively with all stakeholders in redesigning patient pathways to improve efficiency, whilst maintaining standards of care, in such areas.
- Using the Public Health Data available, and by analysing performance reports for both secondary and primary care, the CCG will prioritise programmes with the greatest opportunity to deliver benefit in meeting the goals.
- The CCG will continue to deliver efficiency savings through the successful Peer Review process as the preferred approach to referral management.
- The CCG will work collaboratively with the other emerging CCGs in South Essex on the comprehensive review and redesign of MSK including consideration of Integrated Hub model.
- The CCG will work closely with the Essex County Council and Southend CCG on the transformation of Community Services ensuring that the services commissioned ultimately meet the needs of our patents.
- Close working relationships will be forged with local district and borough councils, in delivering the Health and Wellness agenda and health services in relation to older people.
- The CCG have no significant outlying health indicators, other than CVD and cancer, which Public Health data attributes to the high elderly population. The CCGs do wish to focus on any obvious gaps in health care services evident across the member practices.
- The CCG is keen to assist all member practices in becoming more efficient and cost effective by helping them through their CQC application processes, guaranteeing that they are all fit for purpose.

2.1.1 Changes in the pattern and configuration of services over the next 5 years?

Patients, Service Users and Carers will be empowered to direct and manage their care and support and to receive the care they need in their homes or local community and:

- We will have a single GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Clinical pathways will be designed around the needs of patients, carers and their families

This work starts and ends with individual's experience of care. Through mapping the current experiences, capabilities and needs of our patients and service users, and working with them to develop the future models of care, we have focussed on a number of priority areas.

- Primary Prevention

- Self-care / Self Management
- Managing Ambulatory-sensitive conditions
- Risk Stratification or Predictive Modelling
- Falls Prevention
- Care-Coordination
- Case Management
- Intermediate Care, reablement and rehabilitation
- Managing emergency activity, discharge planning and post-discharge support
- Medicine Management
- Mental and Physical Health Needs
- Improving Management of End of Life Care
- Delivering Integrated Care

This is about not simply looking at people in terms of the cost of their care under the current service model of provision, or the types of interactions with those services that they currently have, but looking further to the root cause of the challenges many of our patients and their families experience today, and how these can be converted into more positive experiences and outcomes in the future.

2.1.2 Difference to patient and service user outcomes?

- People will feel confident about the care they are receiving in their communities and homes. Their conditions are better managed and their attendances and reliance on acute services, including local A&E departments, is significantly reduced. If they do require a stay in hospital then they are helped to regain their independence and are appropriately discharged as soon as they are ready to leave, with continuity of care before, during and after the admission.

- People will routinely report that they feel in control of their care, informed and included in decision-making, are supported in joined-up way, and are empowered and enabled to live well.

- Overall pressures on our acute hospital and health budgets will have reduced, as we shift from high-cost reactive services to lower cost preventative services, supporting greater self-management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved care at home which in turn reduces the need for high-cost nursing and care home placements.

To achieve this we will engage with local health and social care providers, and associated public, private and voluntary and community sector groups, to "co-design" models of care that will engage with and meet people's aspirations and needs.

- People will be empowered to direct their care and support, and to receive the care they need in their homes or other appropriate community settings.
- Over the next 2 to 5 years we will enable community healthcare and social care teams to work closely together in an increasingly integrated way, with single health and social care assessments providing for rapid and effective joint responses to identified needs, provided in and closer to home.
- Our teams will also increasingly work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring a level of health or social care support, so that we help them to remain healthy, independent and well. We will make considerable investment available to empower local people through effective care signposting, peer support, mentoring, self-management and personal healthcare budgets to maximise their independence and wellbeing.
- We will design and implement integrated Community Independence teams tasked with providing a rapid response service to support individuals in crisis and help them to remain at home. Community Independence Teams will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication.
- We will also seek to introduce individuals to the potential of assistive technologies and, where these can be employed, we will ensure individuals are familiarised and comfortable with their use.
- Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:
    - Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;
    - Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

In doing so our plan is to go far beyond using BCF funding to back-fill existing social care budgets, instead working in a truly integrated fashion to reduce long-term dependency across the health and social care systems, promote independence and drive improvement in peoples overall health and wellbeing.

- As a result of the planned changes we expect the volume of emergency activity in hospitals to reduce and we also expect planned care activity in hospitals to also reduce because we will have developed alternative community-based services.
- A managed admissions and discharge process, fully integrated into local specialist provision and Community Independence provision, will mean we will be able to eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that

people are helped to regain their independence after episodes of ill health as quickly as possible.

- Mental health is a key priority, with rising demand on mental health service provision it needs to be given significant consideration alongside frail and elderly which is the main thrust of our integration planning. Our plans therefore are designed to ensure that the work of community mental health teams is seamlessly integrated with community health services and social care teams; organised around groups of practices; and enables mental health specialists to support GPs and their patients in a similar way to physical health specialists.

- By improving the way we work with people to manage their conditions, we expect to reduce the demand not just on acute hospital services, but also the need for nursing and residential care.

2.2 Aims and objectives

The overarching objective for the CCG is to improve health outcomes, reduce health inequalities and develop a sustainable affordable health and social care system. These aims will be achieved by:

- proactive case management
- by stratifying the risk and needs of the patients and service users
- by responsive provision of local and regional services channelled through an effective community, social and primary care offer with a single point of access
- Integrated Care through a lead professional and using a multi-disciplinary team approach focused on early intervention and prevention

2.2.2 Aims and objectives of our integrated system

We see the implementation of the BCF as a two phased programme: phase 1 delivered in 2014/15, and; Phase 2 from April 2015.

The BCF is also a key enabler for the long term strategy that we are looking to deliver in Castle Point & Rochford which is a large scale modernisation programme that will transform the health economy landscape for the borough.

CP&R CCG are basing the approach to the integration fund (BCF) as part of an opportunity to transform the health and social care system for our population, to make it patient/person centric with the system being responsive, sufficient and necessary to meet their needs.

Based on this proviso we have structured the services/pathways that will form part of the BCF in order to meet those criteria. A full list of the current proposed schemes/service lines that we are considering is detailed in Part II of our BCF submission with relevant values where we have clarity at this point in time.

Initial focus in Phase 1 will be on:

a) developing clear synergies with ECC

b) implementing opportunities to prevent admissions to secondary care

c) focusing on primary prevention opportunities

d) Reducing Health Inequalities where they exist

e) Delivering financial economies of scale

f) Joint commissioning informed by needs identified in the JSNA and the HWBS.

2.2.3 Measuring aims and objectives

The success factors will be measuring against national agreed metrics:

- A reduction in admissions to residential and care homes
- Increased effectiveness of re-ablement
- reduced delayed transfers of care
- reduction in avoidable emergency admissions
- improved patient/service user experience.

Target reductions for these metrics will be added in appendix when complete

The advances in IT capability will help us to drill down deeper into the data held which in turn will lead to more information on specific reasons for admissions and by doing so will present opportunities to develop additional preventative measures.

In order to manage and track outcomes, we will be developing business cases to enhance developments in data warehousing, that will help us to work with data, information and intelligence in real time to allow us to make rapid and accurate decisions - including total activity and cost data across health and social care for individuals and whole segments of our local populations. Our vision is to develop interoperability between all systems to provide this real time information and managerial analytics capability.

Our GP practices all use the same IT System 1 providing the opportunity for our care providers to all use the same patient record[1]; the BCF will help ensure this happens by joining up Health and Social Care data across the County provider landscape, all linked together via the NHS number.

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow effective identification and management of need and outcomes across our health and care economy as a whole.

2.2.4 Measures of health gain for our population?

We will be using the national mandated indicators and we will be using locally developed indicators and KPI's that will use the JSNA and the JHWS as the key drivers and sources of intelligence that informs them.

1 Subject to Information Governance constraints

A key measure of success for our CCG will be the impact that the changes we set in motion has on our Acute providers and specifically our A&E departments - how quickly does demand begin to reduce on A&E departments, how quickly do emergency admissions of frail and elderly start to reduce and how much can we reduce our Continuing Health Care bill because we are seeing more people going through a rehabilitation and reablement model that actually works for them and allows/facilitates them to lead a relatively independent lifestyle for longer.

2.3 Description of planned changes

The table sets out the key work streams our BCF programme intends to cover through our joint work programme include:

Theme	**Driver**	**Pointers**
Primary Prevention	Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system.	• supporting individuals to change behaviours such as smoking, for example, through advice during a consultation • community interventions in schools to reduce childhood obesity • regulatory actions such as controlling the density of alcohol outlets • investing in winter preparedness to reduce excess winter deaths • ensuring we get housing right to support people (especially older people) to stay in their own homes • preventing social isolation and loneliness to help to maintain independence
Self-Care	People with long-term conditions account for 70 per cent of all inpatient bed days. Self-management programmes, which aim to support patients to manage their own condition, have been shown to reduce unplanned hospital admissions for some conditions such as chronic obstructive pulmonary disease (COPD) and asthma	• tailoring interventions to the condition; for example, for conditions such as diabetes structured patient education may be beneficial, while conditions such as depression may require behavioural interventions • involving patients in co-creating a personalised self-management action plan, which could include education programmes, medicines management advice and support, telecare and telehealth for self-monitoring, psychological interventions and patient access to their own records • telephone health coaching • behavioural change programmes to encourage patient lifestyle change • as the number of people who are unpaid carers for older people is expected to rise, providing support for informal caregiving .
Managing ambulatory care-sensitive conditions	Conditions where the need for hospital admissions can be reduced through active management (known as ambulatory care-sensitive (ACS) conditions) accounted for 15.9 per cent of all emergency hospital admissions in England	• Early identification of ambulatory care-sensitive conditions, for example, through risk stratification • increased continuity of care with a GP • Early senior review in A&E, and structured discharge planning.
Risk stratification or predictive modeling	Statistical models can be used to identify or predict individuals who are at high risk of future hospital admissions in order to target care to prevent emergency admissions.	• using an 'impactability model' to identify high-risk patients who are most likely to benefit from preventive care • having catchment areas based on the distribution of high-risk patients, for example, smaller catchment areas in deprived neighbourhoods where there are likely to be more high-risk

		patients • organizing these around groups of GP practices or an equivalent • Considering the needs of the local area when developing the staff mix, for example, include a mental health professional in areas with high prevalence of mental illness.
Falls prevention	Older people who are frail are a key concern for health and social care services and are at risk of sudden functional decline including falling or becoming immobile.	• Identifying those at risk of falls • setting up fracture prevention services for older people • strength and balance training • home hazard assessment and intervention • vision assessment and referral • medication review with modification/withdrawal
Care co-ordination	Care co-ordination is a person-centred, pro-active approach to bringing health and social care services together around the needs of service users. It involves assessment of an individual's needs, development of a comprehensive care plan and a designated care co-ordinator to manage and monitor services around the individual, recognised in changes to the GP contract.	• a holistic focus that supports service users to manage their own conditions at home and become more independent and resilient rather than a purely clinical focus on treating medical conditions • a single entry point for care co-ordinators to provide personal continuity for patients and carers as well as enabling access to care through multidisciplinary teams • shared electronic health records can support the process but a 'high-touch, low-tech' approach can promote face-to-face communication, foster collaboration and enable meaningful conversations about care for patients with complex needs • co-ordinating care at the neighbourhood level 'where the benefits of engagement with local communities sit alongside the need to have close working relationships within multi-disciplinary teams dealing with manageable caseloads' • prioritising engagement with GPs and links with secondary care to ensure quality transitions, for example, from hospital to home.
Case Management	Case management exists in many different forms, but it is generally described as 'a targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care co-ordination'	• a focus on early action and prevention, targeted at particular communities to mobilise local people • community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location • a single point of access, single assessment and shared clinical records • targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data • the individual and their case manager co-producing a personal care plan, which brings together an individual's personal circumstances (including housing, welfare and access to informal care) with their health and social care needs • systems to enable all those involved in a patient's care to access up-to-date patient records • continuity of care, including effective communication processes where all information is streamed through the case manager

		• case managers having the necessary skills for the role, as well as clear role boundaries and accountabilities.
Intermediate care, re-ablement and rehabilitation	Intermediate care services, including rehabilitation and re-ablement, have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up). Re-ablement can enable people to stay in their own homes for longer, reduce the need for home care and improve outcomes for users. Rehabilitation and re-ablement provided at home is cheaper than rehabilitation and re-ablement when it is provided as bed-based care	• shared and comprehensive assessment of needs and personalised plans, based on shared information and protocols between health and social care partners to address physical, social and psychological needs of service users • commissioning for outcomes, not time periods and tasks, for example, with lump sum payments, to ensure people move on as soon as they are ready or are able to spend longer than six weeks if necessary • workforce led by a senior clinician, with an appropriate skill-mix and with specific re-ablement training and skills that are distinct from broader home care services and focus on supporting people to do things for themselves • adequate provision for rehabilitation and re-ablement outside acute hospitals, based on demographic characteristics of the local population • spot purchasing nursing home beds or new forms of sheltered or retirement housing known as 'extra care housing' to provide rehabilitation and re-ablement and prevent hospital admission or discharge from hospital to long-term care • where a person needs ongoing support at the end of rehabilitation and re-ablement, planning care to provide those services and maintain the progress.
Managing emergency activity, discharge planning and post-discharge support	A lack of alternative options frequently leads to patients being admitted to hospital when it is not clinically justified. It is vital that there is capacity to offer rapid responses in the community that offer an alternative to a hospital stay Focusing on reducing length of stay for older people may have the most potential for reducing use and cost of hospital beds NHS and social care should work together to provide good discharge planning and post-discharge support. A structured individualised discharge plan can reduce readmissions by around 15 per cent Early supported discharge has been shown to enable people to return home earlier, remain at home in the long term and regain their independence in activities of daily living	• early discharge planning to ensure referral to community services is in place in advance of discharge • an agreed discharge process that includes timescales and protocols for assessment and decision-making for different agencies to work together • ensuring patients with existing community services are discharged as soon as possible with care re-started • use of 'discharge to assess' models to enable people to be assessed in their own homes • rehabilitation to ensure people do not become dependent or disabled in hospital • 'in reach services' from social care and community services • Supporting capacity in integrated locality teams to ensure patients are discharged to alternative supports.
Medicines management	Between one-third and one-half of medication prescribed for long-term conditions is not taken as recommended As the number of people taking multiple drugs increases, so do the challenges for clinicians in managing this.	• effective team working between patients, doctors, nurses and pharmacists avoids the risks of polypharmacy • educational information and outreach services reduce prescribing and monitor errors, for example, training in managing complex multi-morbidity and polypharmacy for general practitioners, orthogeriatricians or nurse specialists

		• use of IT and decision-making support tools • longer GP consultations for patients with multi-morbidity to allow sufficient time for the use of drugs to be reviewed • enabling patients to attend a single clinic to have their long-term conditions reviewed by a clinical team, rather than several disease-specific clinics • improved systems for transfer of patient medication details at admission and discharge • medication reviews or practice-based audits linked to peer review of prescribing practices • providing clinicians with benchmarked information on prescribing performance • use of pharmacy technicians to support general practices • taking into account patient perspectives, as some patients face challenges in managing their medications and patients may not be taking the drugs that clinicians think they are.
Mental and physical health needs	Many patients who are frequent attenders at A&E have an untreated mental health problem. Liaison services should be provided in A&E departments for patients who have a mental and physical disorder to ensure all their needs are met. Rapid Assessment Interface and Discharge (RAID), a model for liaison services which includes health and social care capacity as well as specialist skills to provide a complete mental health service in an acute trust, has been shown to reduce hospital bed use, particularly by older people	• improved identification of mental health needs among people with long-term conditions • strengthened disease management and rehabilitation by including psychological or mental health input • commissioning services based on the collaborative care models recommended by NICE (2009) to improve the interface between primary care, mental health and other professionals • expanding Improving Access to Psychological Therapies services to support people with long-term conditions • improving the mental health skills in general practice and intermediate care, with training designed specifically for primary care professionals.
Improving management of end-of-life care	Identification of people who are at the end of life and co-ordination of care can improve the quality of care, and there may be some scope for cost savings through reduction of unnecessary admissions into the acute setting	• facilitation of discharge by ensuring there is adequate capacity to provide end-of-life care outside of the hospital setting, for example, by investing in services such as Marie Curie nursing service • rapid response services being available during periods out of hospital to prevent emergency admissions to hospital at the end of life • centralised co-ordination of care provision in the community • 24/7 care outside of hospital to prevent emergency admission and facilitate discharge from hospital at the end of life.
Delivering integrated care	Integrating primary and social care has been shown to reduce admissions, and integration of primary and secondary care for disease management of patients with certain conditions has been shown to reduce unplanned admissions	• find common cause with partners and be prepared to share sovereignty • develop a shared narrative to explain why integrated care matters • develop a persuasive vision to describe what integrated care will achieve • establish a shared leadership • create time and space to develop understanding and new ways of working • identify service users and groups where the potential benefits from integrated care are greatest • build integrated care from the bottom up as well as the top down

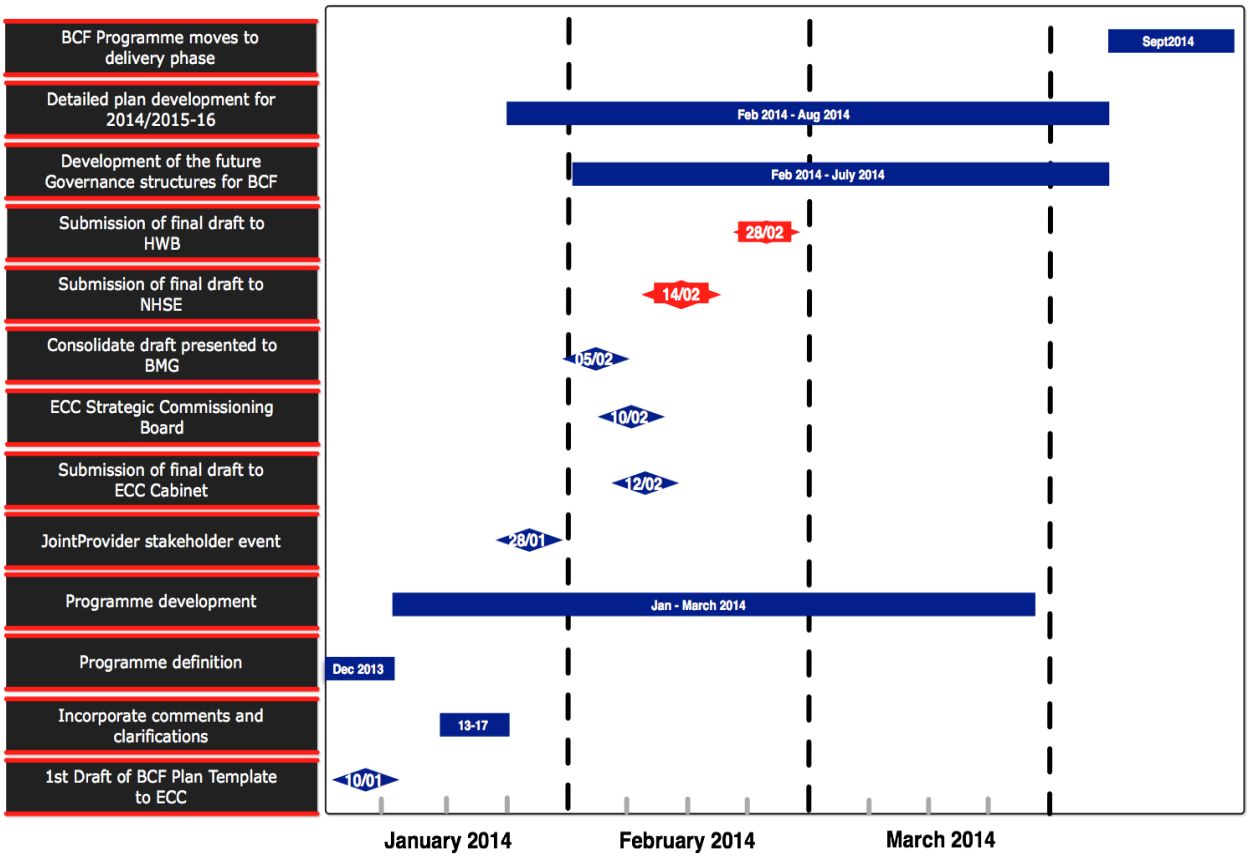
		• pool resources to enable commissioners and integrated teams to use resources flexibly • innovate in the use of commissioning, contracting and payment mechanisms and the use of the independent sector • recognise that there is no 'best way' of integrating care • support and empower users to take more control over their health and wellbeing • share information about users with the support of appropriate information governance • use the workforce effectively and be open to innovations in skill-mix and staff substitution • set specific objectives and measure and evaluate progress towards these objectives • be realistic about the costs of integrated care • act on all these lessons together as part of a coherent strategy. • Consider 'House of Care' Model

2.3.1 Processes, End Points and Timeframe

The weekly meetings that take place with ECC and CCG leads has ensured that we have gained momentum in planning terms and the membership of the group has meant that we have executive decision making capability and authority in the room at all times which has ensured that we have not been unnecessarily delayed whilst we wait for decisions.

See Section 2.5.1 for BCF Programme Board Structure

Associated timeframes are set out in table below



Short term high level BCF programme plan

A fully detailed plan is being developed in collaboration with ECC and with Basildon and Brentwood CCG, NHSE and local district councils.

We are actively ensuring that all CCG related activity will align, including the JSNA, JHWS, our emerging CCG Strategic, CCG Operational plans and Local Authority plans for social care

The JSNA will be used to provide the evidence to support our commissioning intentions as it does for the Health and Wellbeing Strategy

2.4 Implications for the acute sector

Implications of the plan on the delivery of NHS services

Not dissimilar to many other parts of England our acute providers are feeling the strain of excessive demand, particularly in A&E Departments. Clearly the level of demand being placed on our Acute Trusts is not sustainable so something has to change. This is recognised by both Commissioner and Provider. The CCG has a productive dialogue with Southend University Trust Hospital, a dialogue that has already started to explore and agree new approaches to commissioning and payment models which will be reflected in the 2014/15 contracts currently under negotiation.

Including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

2.5 Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Governance around BCF is considered to be two work streams that apply to separate and distinct phases of the implementation and delivery of the BCF programme:

a. The programme definition and development stage which encompasses 2014/15

b. The programme delivery and move to business as usual stage which will manage the delivery of BCF from April 2015 going forward.

The diagram below describes the current Governance structure that we have developed to manage Phase 1.

ECC has a strong history of collaborative working with health commissioners and providers across the county. This has continued under the new structure for Health with the authorisation of multiple CCG's in Essex, of the seven CCG's in Essex only two of which are not aligned to ECC's health and wellbeing board.

Under this current structure the South Essex Commissioning Programme Group meets weekly and the Business Management Group, whose membership includes the Accountable Officers from the five CCG's, ECC and NHSE, meets fortnightly.

To deliver the ambition that the establishment of the BCF offers, we recognise that we need to develop robust yet agile strategic and operational governance arrangements that will stand the test of both internal and external scrutiny and possibly public scrutiny. We therefore propose to look at, as part of this process, what are the specific arrangements that will work best in order to discharge our management responsibilities and accountability across social care and health services, whilst at the same time ensuring that we deliver for our residents and patients and as a whole.

We are still in the process of developing potential commissioning scenarios which will form part of our options appraisal that will determine which is the most appropriate vehicle to deliver the joint commissioning functions - be this a jointly resourced commissioning team or a legally constituted Commissioning Trust. Whichever the model we select we would see our future commissioning management team for the commissioning of integrated care, accountable through the Health and Wellbeing Board, to both the Local Authorities and the CCGs.

In parallel, we will ensure that the leadership of the CCG and Local Authority have clear and shared visibility and accountability in relation to the management of all aspects of the joint fund.

We are in the process of developing detailed programme plans for the implementation of the BCF programme in collaboration with ECC.

2.5.1 BCF Programme structure

The development and delivery of the BCF programme is expected to be complex and challenging, in particular, the communications, engagement and governance elements of the programme. Therefore based on this we have adopted a working group and task and finish group approach to programme management. The following diagram describes the main standing groups that will sit during the development and early stages of delivery. These will be complimented, when and where necessary by task and finish groups which will be convened for a time limited task specific period.

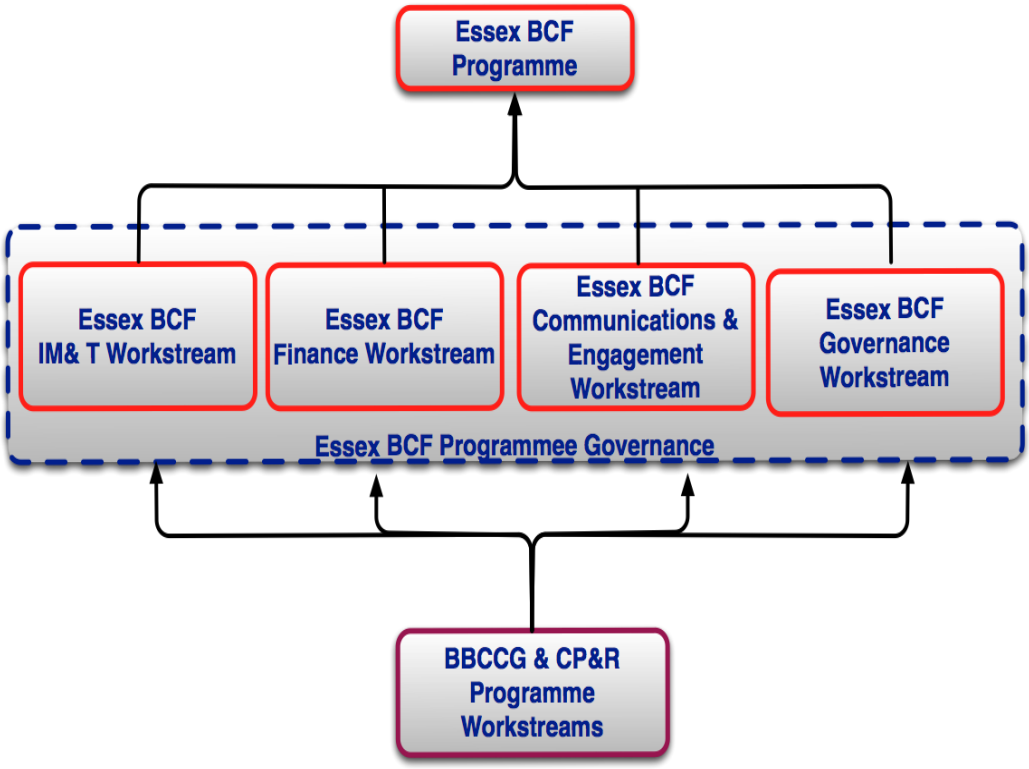


Fig x- BCF Programme Structure

2.5.2 Financial Implications

We see the implementation of the BCF as a phased programme with 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We

are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure to provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

CP&R CCG and ECC are having productive discussions around the sums that should go into the integrated fund, both parties recognise that if we simply deposit the minimum amounts as allocated by DH then it is unlikely that there will be sufficient monies to bring about real transformation of our health and social care systems in Essex. So whilst we still have considerable work to do, we are confident that we will collectively be contributing more to the pooled fund than the minimum amounts stipulated.

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for 2014/15 will be considerably different and smaller scale than those transferring in 2015/16.

2.5.2 2014/15 CP&R CCG Investment

Following a recent meeting of the Business Management Group it was agreed that consistency of terminology would make for ongoing development easier and reduce potential confusion between the various collaborating organisations. Based on the agreement the tables overleaf for 2014/15 will be identical in terms of structure to that for 2015/16 albeit that the numbers will differ.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 (£000's)	Minimum contribution (15/16) (£000's)	Actual contribution (15/16) (£000's)
Essex County Council		£4,932	£8,009	£8,009
NE Essex CCG		£0	£20,987	£20,987
Mid Essex CCG		£0	£21,651	£21,651
West Essex CCG		£0	£17,435	£18,980
Basildon & Brentwood CCG		£0	£16,041	£18,444
Castlepoint & Rochford CCG		£0	£10,833	£11,166
BCF Total		**£4,932**	**£94,956**	**£99,237**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

2015/16

As we have established the size of the BCF will grow from 2014/15's allocation of **£3.422M**, which is mainly constructed from similar S256 amounts from 2013/14, to approximately **£11.166M** for 2015/16. Whilst we still have work to do and challenging conversations to have the table overleaf describes and sets out our ambition for 2015/16.

3. National Conditions

CP&R CCG will align with the national requirements as mandated by NHSE and those that are contained in the planning guidance issued on the 20th of December 2012. Specifically in relation to BCF we are developing plans that meet the following preconditions:

- Plans to be jointly agreed.
- Protection for Social Care services (not spending)
- 7 day services in H&SC to support patients being discharged and prevent unnecessary admissions at weekends.
- Better data sharing between health and social care, based on NHS number
- Ensure joint approach to assessments and care planning and ensure an accountable professional where integrated care package is funded.
- Agree on consequential impact of changes in the acute sector

We also recognise that there will be a significant performance linked payment(s) which CCG's and the integrated commissioning functions will need to deliver.

3.1 Protecting social care services

The objective of integration is to develop a more effective, efficient and affordable health and social care economy. Integral to this will be the continued development and enhancement of social care services. Our stated ambition is to move more activity out of an acute setting and into a community based setting; this will require a stable and accessible social care system in order to make the changes sustainable. If we move the activity out of acute settings remove the capacity and then find we are unable to sustain it the change we will find ourselves in a uncomfortable situation.

The local authority, ECC, will continue to allocate additional spending for local social care services to the same financial level in 2014/15 as they did for 2013/14. This will enable the purchasing of community based social services within each CCG locality. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principle mechanism for this is ECC social care resource allocation system (RAS) and support planning

3.2 7 day services to support discharge

ECC already operate a six day discharge support service and in line with national guidance CP&R CCG is working with ECC and our providers to deliver a seven day access to health services programme. This work is being undertaken: Locally, Across multiple providers and regionally across the County. The programme includes: Radiology, Consultant cover, PAU, GP Admission avoidance, Pharmacy, Social care discharge, Reablement, Step down, Rapid response via an out of hours emergency duty team, Care homes to ensure they are able to accept 7 day planned admissions, Community services medical input provisions.

CP&R CCG has implemented a collaborative working arrangement with key providers across the borough, to develop the necessary support and infrastructure that will facilitate a sustainable response to the requirements for 7 day working in the NHS. ECC are running a pilot programme that has extended their 6 day supported discharge team's working window to 7 days. An evaluation of the success and outcomes of this will be carried out at the end of the financial year.

3.3 Data sharing

We are not currently able to use the NHS number but we, along with ECC, do have plans to do so in the future.

ECC also have plans in place to adopt the use of the NHS number as the default identifier.

It is our expectation that we will be in a position to implement usage of the NHS number by Quarter 3 of the 2014/15 Financial year.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The use of the NHS number is to a large extent governed by the rules around Information Governance and until some of these issues are resolved we cannot put a firm date against this item.

We will continue to work with NHSE and the Local Authority, ECC, to ensure that we are ready and able to implement the use of the NHS number as soon as it is possible following authorisation to do so.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Assuming that we mean: Application Programming Interface, then yes as a CCG we are open to and actively exploring the use of API's.

Traditional business partnerships, joint ventures and integrated working arrangements can be time-consuming and expensive to create and maintain. In comparison, the open API model is "designed for nearly effortless, asymmetric scale", where almost all the work needed within the partnership is reduced in terms of Human resource requirements.

Implementation will of course be subject to both organisations evaluating various issues in order to maximise the rewards, as well as manage the implications associated with an open API model and of course the requirements and constraints of the Information Governance arrangements for the NHS and CCG's in particular.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The changes that integration effects and the impacts it has will take place with due regard and compliance with our Information Governance framework, and we are committed to maintaining five rules in health and social care to ensure than patient and service user confidentiality is maintained. The rules are:

- Confidential information about service users or patients should be treated confidentially and respectfully
- Members of care teams should share confidential information only when it is needed for the safe and effective care of an individual
- Information that is shared for the benefit of the community should be anonymised
- An individual's right to object to the sharing of confidential information about them must be respected
- Organisations should put policies, procedures and systems in place to ensure the confidentiality rules are followed

3.4 Joint assessment and accountable lead professional

One of the key benefits of a commissioning organisation led by local GPs is we know our patients and routinely interact with them as they move through each stage of their life. In 2013 we made extra efforts to make sure that we also heard from other people in our communities, both patients who don't regularly use services and organisations who see and hear from people in different ways.

The aim is that geographic, GP federation configured, 'Named GP Teams' would be the sole deliverer of front line care to people with complex needs and long term conditions, this would include existing generic community, social care and mental health resources.

In practice, this would mean that every patient who is covered within these teams has a named GP who is responsible and accountable for their care and outcomes.

This being said there will be some patients and some situations that would benefit from a different configuration e.g. A Multi-Disciplinary Team approach that may in fact be led by a Community Geriatrician. CP&R CCG is in the process of designing and trialling this and other models of care in the community.

For example: Development of the Lead Professional model for Care Co-ordination:

3 categories will be developed to define the level of health and social care expected to be available to each individual 75 years and older:

- ‘Well’ – those individuals with a relatively non-complex health profile, who are able to maintain an appropriate level of wellbeing and independence, with minimal recourse to primary, community or secondary health care, and do not require social care. Care co-ordination will be via routine GP practice or patient initiated contact with relevant health services as required.
- ‘Moderate complexity’ – those individuals with a more complex health profile, including co-morbidities and/or frailty, and increasing social care needs, requiring frequent monitoring and intervention within primary and community environments, and close co-operation with secondary care consultants within the relevant medical specialties. The Lead Professional Care Co-ordinator for individuals within this category will be a named GP, and the care co-ordination vehicle will be the GP Practice-level MDT, on an ongoing basis.
- ‘Significant complexity’ – those individuals identified, either through the GP Practice level MDT, or following presentation at the ED/admission to an acute bed, as experiencing significant exacerbation in the complexity of their health needs and/or significant increase in their social care needs, requiring intensive specialist intervention within a community environment, with a view to transferring the individual back to the care of the GP Practice-level MDT once their condition has been stabilised. The Lead Professional Care Co-ordinator for individuals in this category will be a Consultant Geriatrician, and the vehicle for assessment/planning and implementation of required care will be the Geriatric Case Management Team.

In order to implement this model it will be necessary to develop effective a risk stratification tool that will allow professionals across the health and social care system to apply a common approach to identifying individuals that fit within the ‘moderate complexity’ and ‘significant complexity’ categories:

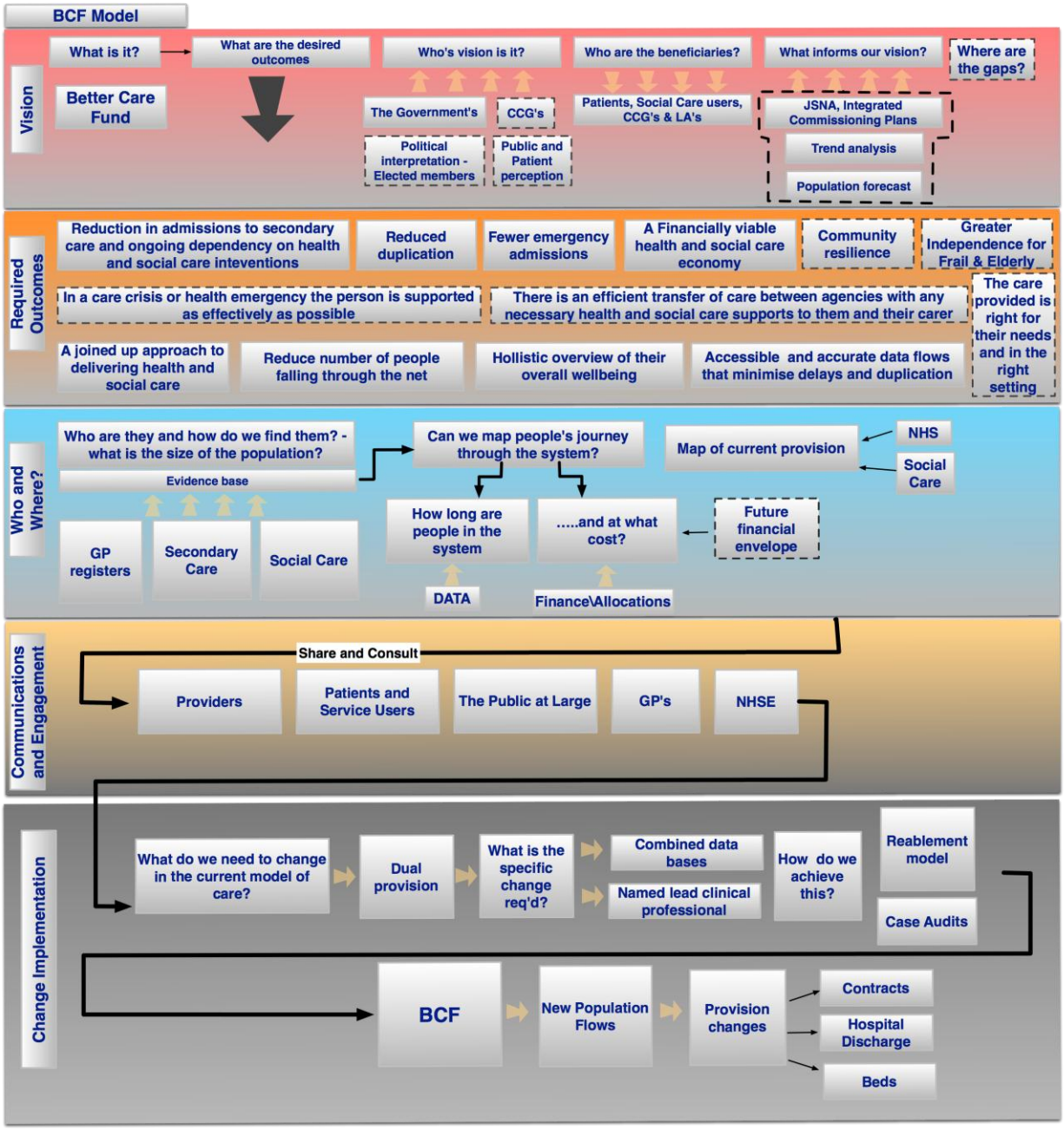
4. RISKS

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

The BCF will create risks as well as opportunities. The BCF pooled budget is not new or additional money. For CPR CCG finding money for BCF will involve redeploying funds from existing NHS services. Guidance makes clear that the BCF will entail a substantial shift of activity and resource from hospitals to the community – 'hospital emergency activity will have to reduce by 15%' (NHS England 2013). This could place additional financial pressures on providers already facing the quandary of how to maintain and improve quality of care while achieving financial balance. In addition, the Better Care Fund does not address the financial pressures faced by local authorities and CCGs in 2015 which 'remain very challenging' See ***Appendix 2*** for more detail on proposed risks and mitigating actions.

It is clear that although CCGs will lead local discussions about how the BCF is used, the engagement of providers in discussions is vital. Decisions will affect providers' existing activity and funding and the risks arising from this need to be assessed and managed; providers also have indispensable knowledge and capability to deliver innovative solutions. The most effective local plans will be those that arise from collaboration across the whole system of health, care and support, engaging all NHS and local authority partners, including acute and community health care organisations.

(I) Appendix 1


BCF Model
Vision
What is it?
What are the desired outcomes
Who's vision is it?
Who are the beneficiaries?
What informs our vision?
Where are the gaps?
Better Care Fund
The Government's
CCG's
Political interpretation - Elected members
Public and Patient perception
Patients, Social Care users, CCG's & LA's
JSNA, Integrated Commissioning Plans
Trend analysis
Population forecast
Required Outcomes
Reduction in admissions to secondary care and ongoing dependency on health and social care inteventions
Reduced duplication
Fewer emergency admissions
A Financially viable health and social care economy
Community resilience
Greater Independence for Frail & Elderly
In a care crisis or health emergency the person is supported as effectively as possible
There is an efficient transfer of care between agencies with any necessary health and social care supports to them and their carer
The care provided is right for their needs and in the right setting
A joined up approach to delivering health and social care
Reduce number of people falling through the net
Hollistic overview of their overall wellbeing
Accessible and accurate data flows that minimise delays and duplication
Who and Where?
Who are they and how do we find them? - what is the size of the population?
Evidence base
GP registers
Secondary Care
Social Care
Can we map people's journey through the system?
How long are people in the system
.....and at what cost?
DATA
Finance\Allocations
Map of current provision
NHS
Social Care
Future financial envelope
Communications and Engagement
Share and Consult
Providers
Patients and Service Users
The Public at Large
GP's
NHSE
Change Implementation
What do we need to change in the current model of care?
Dual provision
What is the specific change req'd?
Combined data bases
Named lead clinical professional
How do we achieve this?
Reablement model
Case Audits
BCF
New Population Flows
Provision changes
Contracts
Hospital Discharge
Beds

Appendix 2 Key Risks

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. This is far too long and needs condensing in a few key risks

In a Health and Wellbeing region that consists of five CCGs and five Acute Hospitals there is a risk that a system failure in one organisation affects the overall performance measures of the HWB Board region which results in the underperformance of the BCF against the metrics which subsequently results in the non eligibility to receive the health premium	High	ECC Integration Directors and CCG leads are working together to ensure that the programmes nominated for inclusion in the BCF have SMART targets and that providers are appropriately performance managed to ensure that they are sustainable. The BCF metrics will be disaggregated to CCG level to ensure that individual CCG's are not measured in a detrimental way.
Factors outside the control of CCGs and the local authority have an adverse effect on Urgent and Acute care services (i.e. Flu epidemic etc.)	Medium	CCGs will continue to monitor all significant changes to demand for Urgent and Acute services. ECC, CCG's and Providers will maintain and update ads necessary their emergency response plans and business continuity plans and by carrying out regular joint exercises will ensure that they are able to respond appropriately.
There is a risk that if there is any lack of clarity of system cost and investment coming from the centre it may inhibit accurate reporting and progress	High	Develop positive and transparent relationships with NHSE to ensure that lines of communication and challenge are maintained and where necessary escalation processes are in place that help to minimise the risk
The pace of change required does not allow safe commissioning of high quality appropriate services	High	Ensure that we deploy the necessary resources with the right skills and competencies to ensure that we continue to commission legally and within the required timescales, costs and quality standards
There is a risk that the lack of robust and appropriate Governance processes delay the integration of services resulting in poor and slow decision-making across the system	High	We will implement locally approved governance structures across Essex at the earliest opportunity – by September 2014 at the latest
There is a risk that if we implement New models of care we could destabilise existing providers		Through a process of communication and engagement with providers and by making sure that we plan the implementation carefully and collaboratively – moving activity before we execute capacity reductions we will deliver stable and sustainable change

There is a risk that new and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity	Medium	As with the previous risk mitigation plan we will deliver phased and planned capacity movement
Financial –There is a risk that failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing financial pressure as an ageing population increases demand		At the outset of the programme, being clear on: • Clear and achievable Financial objectives • Well planned phased service model changes to deliver greater efficiency
Clinical and quality – there is a risk that the planned changes do not improve quality but worsen it, resulting in a poorer outcomes and patient experience		Service model changes will be designed and reviewed throughout the programme process , with contract mechanisms and measures established to evaluate all proposed changes, and where appropriate pilots will be run and evaluated
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits		The programme will be properly planned, with agreed timescales, dependencies. Progress will be reviewed through the programme management process, including Exception reporting, Highlight reports and Project status reports, contingencies will be developed where necessary
Commitment and engagement – failure of the local health and social care community to remain committed to the programme and its objectives		The governance structure formalises senior level commitment to the programme; throughout the programme on-going support will be reviewed and expanded as necessary
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining contracts and the evaluation of results		We will design and implement a thorough intelligence process to put in place processes, checks and balances that will help us to capture and analyse our patient cohorts in a way the minimises potential gaps in our knowledge.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Essex County Council		£4,932	£8,009	£8,009
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Basildon & Brentwood CCG		£0	£16,041	£18,444
Castlepoint & Rochford CCG		£0	£10,833	£11,166
BCF Total		**£4,932**	**£94,956**	**£99,237**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The functions and services that will go into the BCF are based on service redesign and moving activity away from an Acute setting wherever possible. The service redesign work will be taking place during 2014/15 and it very important that as commissioners we do not close down capacity in the Acute Trusts until we are sure that the activity really has been moved and that the patients are familiar and comfortable with the revised pathways.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	371,000	
	Maximum support needed for other services (if targets not achieved)	371,000	
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 actual spend	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Intermediate care, re-ablement and rehabilitation									
Transfer of social care money						£2,672,270		£2,672,270	
Reablement Monies						£904,000		£904,000	
Social Care Uplift						£749,728		£749,728	
Delivering integrated care									
Integrated Community Teams	SEPT					£3,367,013		£3,367,013	
Community Geristricians	SUHFT					£85,000		£00,000.00	
Collaborative Care Team	SEPT					£243,038		£243,038	
Care Coordination									
SPOR (Health Element)	SEPT					£97,908		£97,908	
Occupational Therapy	SEPT					£217,504		£217,504	
Carers						£50,000		£50,000	
CAVS Befriending Service	CAVS					£18,500		£18,500	
Managing emergency activity, discharge planning and post-discharge support									
Intermediate Care Beds	SEPT					£350,000		£0.00	
Rosedale Rehab/Reablement Beds	Rosedale					£130,315		£130,315	
Rosedale Therapy Input						£154,332		£154,332	
Tissue Viability	SEPT					£43,414		£43,414	
Leg Ulcer	SEPT					£92,503		£92,503	
Stroke (Community Service)	SEPT					£159,951		£159,951	
Pressure Relieving Equipment	SEPT					£112,981		£112,981	
Continence	SEPT					£356,832		£356,832	
Mental and physical health needs									
Dementia Intensive Support Team	SEPT					£70,118		£70,118	
Older People Community Mental Health Teams (inc. Assessment Service)	SEPT					£780,107		£780,107	
Older People Day Care (Mental Health)	SEPT					£160,584		£160,584	
Wheelchair Services	SEPT					£305,600		£305,600	
End of Life Care									
Havens Hospice	Havens					£410,689		£410,689	
Total						**£11,541,476**		**£11,168,476**	

Association England

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The Essex BCF schemes are designed to provide care earlier in our patients and service users care pathways through early intervention and prevention schemes and to keep our service users as independent as possible in their normal place of residency for as long as possible. The metrics will demonstrate the achievements of these outcomes by:-
- Showing a reduction in the number of permanent admissions to residential and nursing homes
- Demonstrating an increase in the number of people being presented to reablement services (local additional measure) and improving the outcomes of those going through reablement
- By investing in additional reablement services including home from hospital schemes we will demonstrate a reduction in delayed transfers of care from hospital

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Not applicable

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance plans that will support these Outcomes and Metrics will be assured across the County and by each CCG. These arrangements will include assurance by the Executive Director for People Commissioning in the local authority and the relevant sub-committee (or GB) of the CCGs.
The score cards demonstrating progress against the metrics will be reviewed at the Business Management Group of the Health and Wellbeing Board. The Health and Wellbeing Board will also review performance against these metrics regularly

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

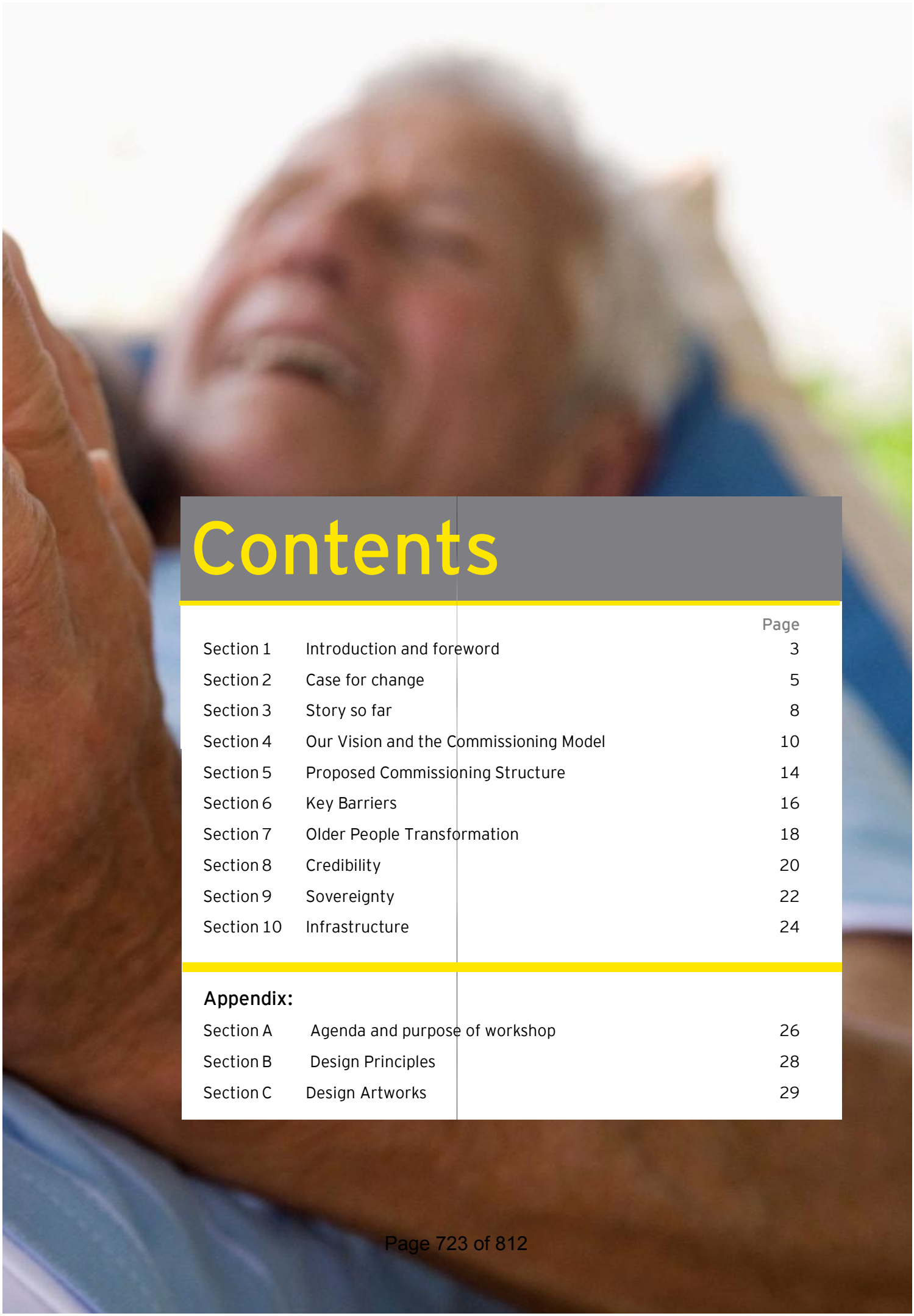
Not applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	Metric Value	565	N/A	503
	Numerator	215		204
	Denominator	38055		40600
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Metric Value	82%	N/A	82%
	Numerator	133		169
	Denominator	163		207
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	Metric Value	23	22	22
	Numerator	384	281	183
	Denominator	139052	139500	140900
			(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	Metric Value	1636	1635	1627
	Numerator	2916	2963	2945
	Denominator	178238	181006	181006
				(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]				(insert time period)
Additional Local Measure - Coverage of reablement	Metric Value	1842	1874	2196
	Numerator	701	744	892
	Denominator	38055	39700	40600
				(insert time period)

Health and Social Care Integration Workshop

18/19th June 2013

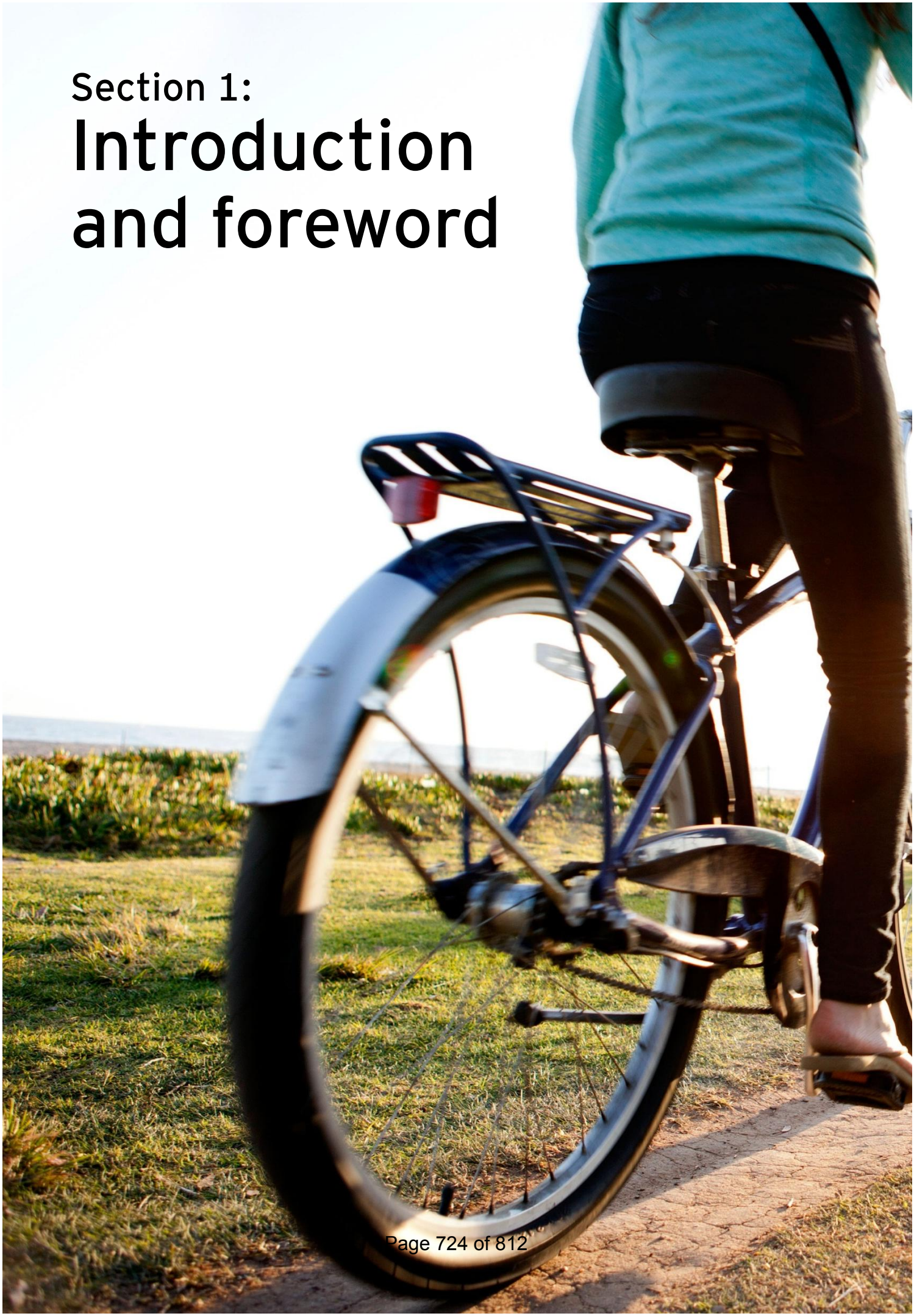
Building a better working world

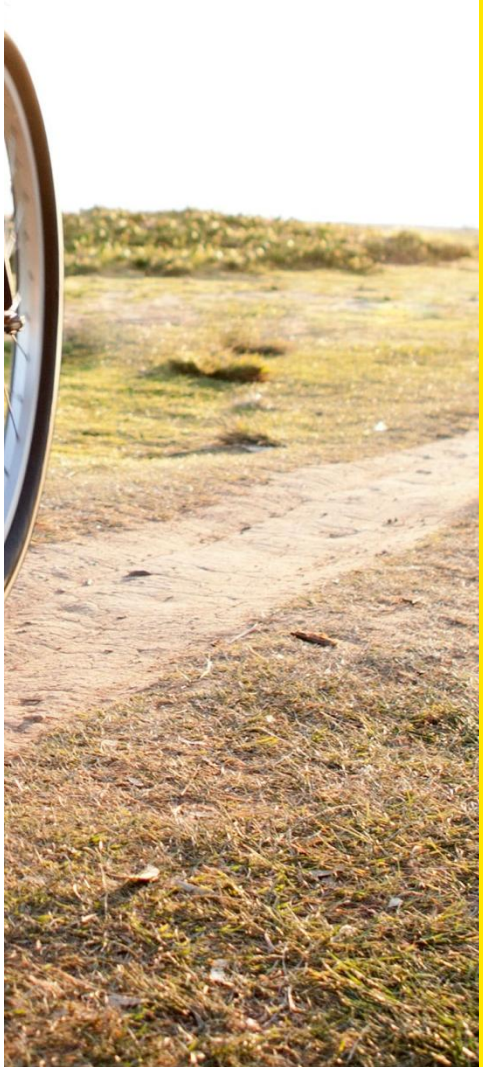


Contents

Section 1:

Introduction and foreword





Introduction to the Health and Social Care integration workshop

Introduction

Delivering our ambition for the integration of health and social care services will improve the quality of life for the people of Essex. This is ultimately the reason that you spend your time working hard to improve services and achieve better outcomes on a day to day basis. The challenge facing Essex County Council and the Essex CCGs is great – the coming years will involve more people needing services, greater public scrutiny over the quality of services, and less resources. Integration offers the opportunity to address this challenge.

To continue the good work we all do everyday, to improve the lives of the people of Essex won't be easy. We have a history of re-organising public services locally and have attempted this many times before. The size and scale of Essex, the complexity of the landscape, the multiple tiers and geographies, not to mention the local complexities around population needs make this a daunting challenge. A geography like Essex has never seen integration in the whole of the history of the NHS and modern welfare state. However, the opportunity presents itself like never before: we can't afford to fail because failing will impact those we profess to serve. If we succeed we will be a shining star in the UK public sector.

Our 2 day workshop

Our two day event was a unique opportunity to take control of our destinies and shape the future of services in Essex! Thank you all for coming and engaging, challenging and discussing. We had an agenda which has enabled us to work with some highly experienced, talented and enthusiastic individuals in the health and social care space in Essex and develop relationships with your counterparts at the CCGs/Council. Like most of you, I found the workshop inspiring, connecting and enjoyable.

What we need from you

We have made good progress to date. We have good intentions, an increasingly strong partnership and robust plans. What we now need is to build upon this momentum and ensure serious organisational commitment at all levels are in place, which translates to driving integration through.

At the two day event, we agreed a number of things that are outlined in this document:

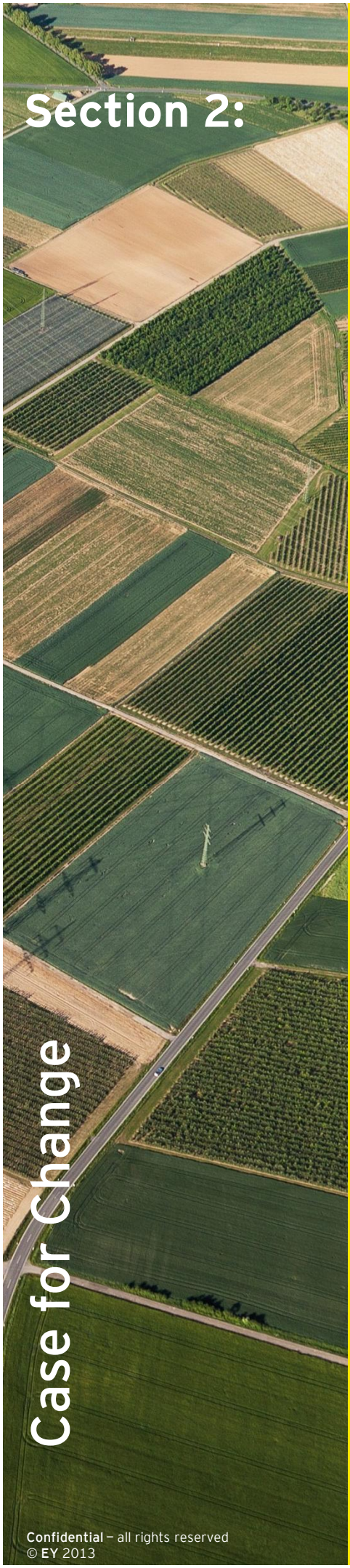
- Our vision for service users and for commissioning
- Our collective ambition for commissioning
- How we want to work together
- Identified priority areas for service redesign and developed plans around them
- Identified key barriers and strategies for overcoming

We also committed to:

- Mobilising this action plan by the 28 June
- A follow up 1 day event in autumn

The key test for all of us is how we translate the rich discussion and agreement into action. I hope you will join us in driving this forward.

Dave Hill Clare Morris Shane Gordon



Case for Change

The Challenge

- Delivering our ambition for the integration of health and social care services will improve the quality of lives of the people of Essex.
- Essex County Council and Essex CCGs have the collective ambition to improve the quality of the services we deliver.
- However, the challenge is great – the coming years will involve more people needing services, more complex needs and greater public scrutiny over the quality of services, and less resources. Integration offers the opportunity to address this challenge.

National context

- Nationally, regionally and locally, services focused on Adults and Children across Local Authorities and Health Authorities are going through a significant transition.
- Current legislation across all these services is increasing the push for a system wide perspective, recognising the need for services to be designed around patients and service users rather than from the point of separate organisations.
- The Health and Social Care bill radically changed the operating model for the NHS bringing clinicians to the heart of commissioning and expanding the obligations for local and health authorities to commission and provide services in an integrated way.
- This significant change to the way services are commissioned explicitly aims at taking a patient centred perspective which will result in system wide reform.
- In this context ECC and Essex CCGs have seized the opportunity created by sector wide reform. The local public service landscape in the Greater Essex area is complex with a County Council, two unitary authorities and seven CCGs.
- The existing way of delivering services has achieved a significant amount but cannot continue within the limited financial envelope available especially in the context of the complex needs of the local population resulting in increased demand.

Case for Change (cont'd)

Local Context

- The population of Essex is close to 1.74million. The older population is expected to grow to 28% by 2033, with a 5% reduction in the working age group. Currently 12.4% of the population are from ethnic backgrounds.
- The County holds some of the most affluent and some of the most deprived areas in the country, with further pockets of disadvantaged communities that are hard to identify.
- The number of young people in Essex not in education, employment or training (NEET) is higher than national and regional averages.
- The prevalence of dementia, which increases rapidly with age, is projected to increase by 38% by 2021 which we expect will have a significant impact on public services.
- The prevalence of diabetes is likely to rise over coming years, especially with poor lifestyle choices
- The mortality and morbidity rates for conditions related to liver disease are increasing, especially among younger people, primarily due to the excessive consumption of alcohol.
- To continue the good work conducted everyday and improve the lives of the people of Essex with these constraints integration is the only option available.
- In this context ECC and Essex CCGs have seized the opportunity created by sector wide reform. The local public service landscape is complex with a County Council, two unitary authorities and five CCGs.
- To continue to provide quality services which achieve the outcomes both want to achieve, they have taken the bold step to explore a more developed commissioning partnership which will ultimately reshape the delivery of services aiming to make the most of the limited resources available.

Health and Social Care services in Essex collectively spend around £3.1bn

All services are facing demand pressure, increased public scrutiny over service quality and reductions in funding. These pressures make the provision of health and social care services unsustainable in their current form.

Essex County Council has a budget of £969m in total for 2013/14. There are five CCGs in Essex. For 2013/14 North East Essex has a budget of £368m, Mid Essex also £368m, West Essex £310m, Basildon and Brentwood £292m and Castlepoint and Rochford £192m.

Essex County Council

"The projected gap between available budget and demand for ECC services is forecast to be £200m by 2016/17"

- Increased demand particularly in the Adults, Health and Wellbeing service area represents close to half of ECC's controllable budget.
- Overall ECC will shrink from being a £930m organisation in 2012/13 to an £850m organisation by 2016/17 (excluding new responsibilities in Public Health and the Learning Disability Grant).
- This shift will occur after Essex has already reduced expenditure significantly. Over the last 4 years Essex County Council has embarked on an ambitious transformation programme and achieved savings of £300m by 2013. This is one of the largest savings targets of any local authority in the country.
- If Essex CC is to continue to provide quality services and achieve the desired outcomes for its residents and particularly its vulnerable people a radical shift in the commissioning operating model is required.

Essex Health Services

"Essex CCGs are faced with a collective funding gap of £354m in years 2013-2017"

- The NHS in Essex face comparable cost pressures and similar growth in demand for services.
- While not losing cash in the same way as the County Council (due to variation in central government reductions) the NHS in Essex faces unprecedented efficiency demands which equate to on average a 5.5% reduction.
- In 2013/14 alone the Clinical Commissioning Groups' QIPP challenges require savings of c£84m to meet growing demand and cost pressures.
- The NHS and the County Council both face significant financial and demographic challenges which, if not addressed in partnership, create the risk of even greater fragmentation of service quality.

Section 3:

The story so far

Summary story so far

Public service reform is not new to Essex. There have been numerous attempts at moving towards integrated services which have made significant progress but never managed to achieve the level of success we all know Essex is capable of. This latest wave of change has to be different. We have already made some significant progress:

The Whole Community Budgets pilot achieved a high level vision and approach

> *"Community Budgets are not about any one local public service provider having a monopoly on power and resources, but about how partners come together to jointly transform local public services."*
>
> **Community Budgets Prospectus 2011**

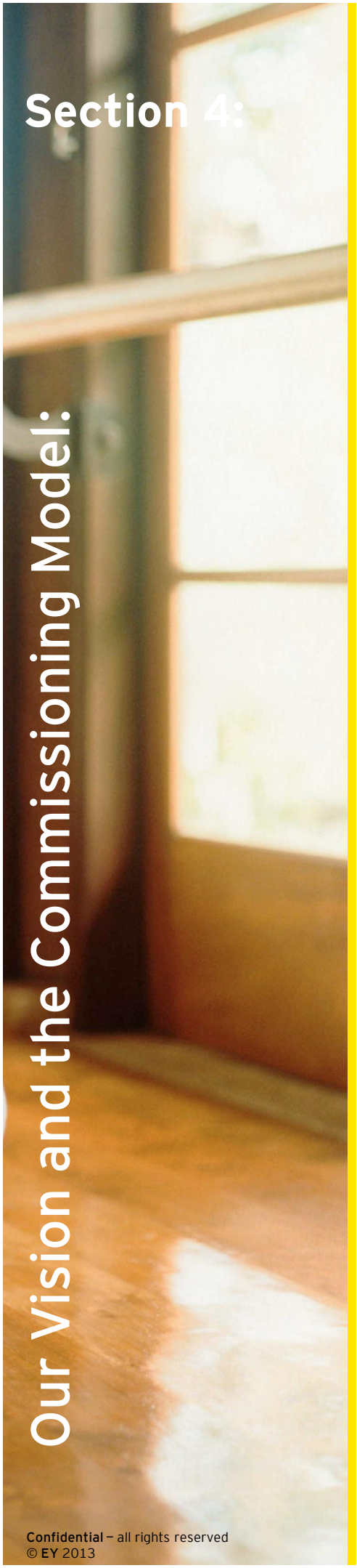
The integrated commissioning plans are a practical basis for taking forward the vision and the CCGs and Council have created an overarching programme approach to bring together these plans

An outline framework to progress integrated commissioning has been agreed by partners across health and social care. This framework is shaped through five key service areas:

- Older People
- Mental Health services
- Learning Disabilities
- Children's services
- Public Health

We have spent time engaging you as stakeholders which has involved building mutual trust, understanding around financial pressure, aligning commissioning cycles and transformation programmes transparency. These developments will form a key part of the programme plan going forward.

In addition, ECC and the CCGs supported by the HWB have submitted an application to the Department of Health for pioneer status.



Section 4:

Our Vision and the Commissioning Model:

Our vision

Our vision for patients, service users and the people of Essex is for a system of care which is designed with them at the centre. We agreed on five overarching vision statements for the people who receive care in Essex:

- We commission and deliver integrated care that is person centred
- The care we deliver will be consistent in quality with an appropriate response across the whole of the County
- We are able to predict and prevent needs including proactively identifying long term needs
- Our responses will be delivered in a timely fashion. We should be available 24 hours where appropriate
- We will be fair in delivering care. This means being 'uniform' across our patients and service user groups
- Our care will take account of the wider context of peoples lives including their families, carers and communities

These statements have significant implication for how care is commissioned. On the basis of the above statements, we identified five statements on our vision for commissioning:

- We will practice outcomes based commissioning on the basis of robust evidence and strong analysis, identifying clear triggers for interventions
- We will have a commissioning strategy for the whole of Essex which aims to provide care that is sustainable over the long term
- We will consistently engage with providers to manage markets and aim to reduce the number of providers responsible for delivering the pathway(s)
- We will align budgets and finances to where they can have the most impact, integrating resources where necessary
- We will incentivise provider behaviour which aligns to our overall strategy

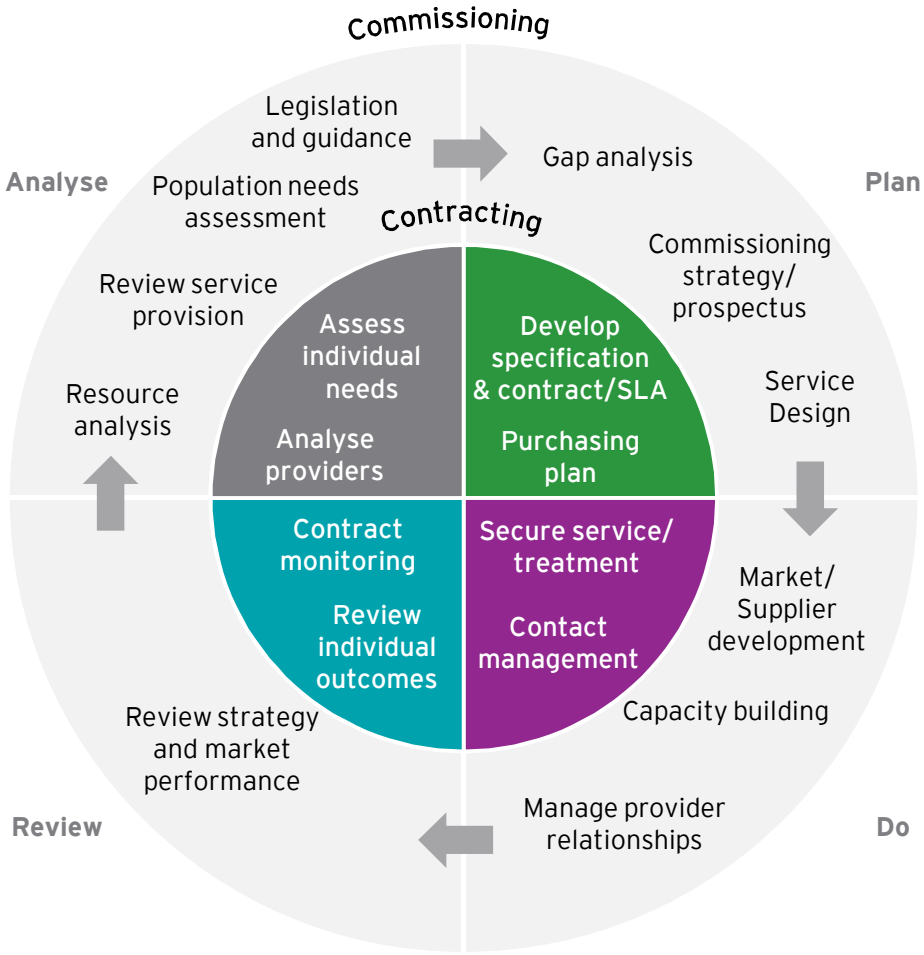
We also agreed on a set of design principles which will be applied through the service redesign to achieve the vision. These are listed in Appendix A.

One of the core objectives of the two day event was to redefine the way in which stakeholders from different organisations behaved towards each other and worked together. We agreed a list of behavioural values which they committed to living in their interactions with each other. These are:

- Trusted
- Honest
- Collaborative
- Pragmatic
- Disruptive

What is commissioning?

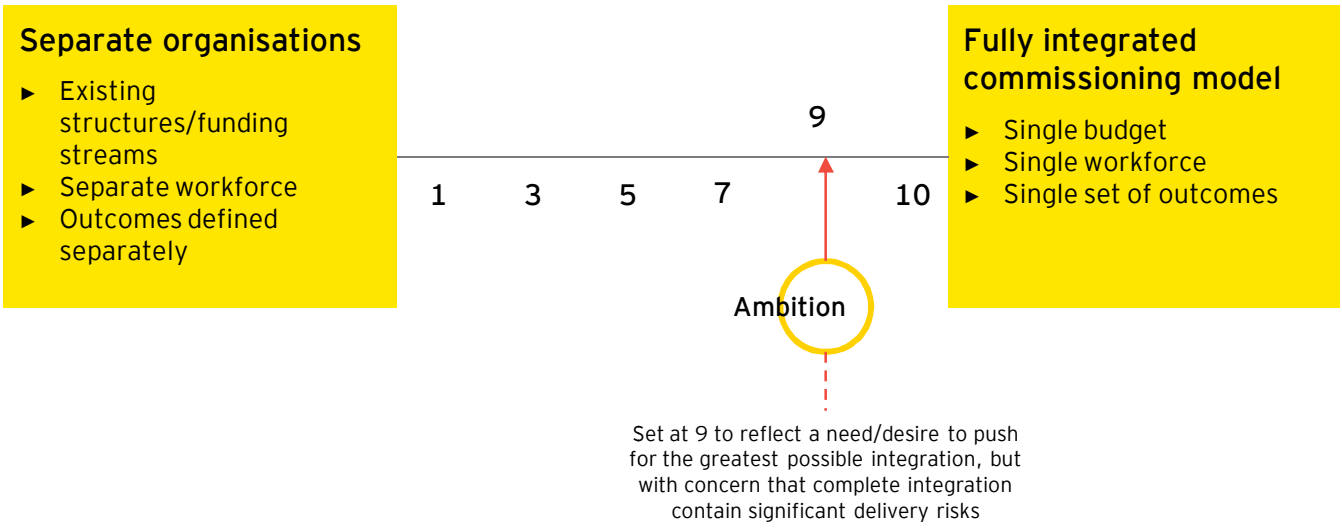
The integrated commissioning cycle for Essex CC relates to the achievement of service outcomes at the strategic or aggregated level. Integrated commissioning in our definition does not relate to the micro-commissioning of individual care packages. The Essex commissioning cycle is shown below.



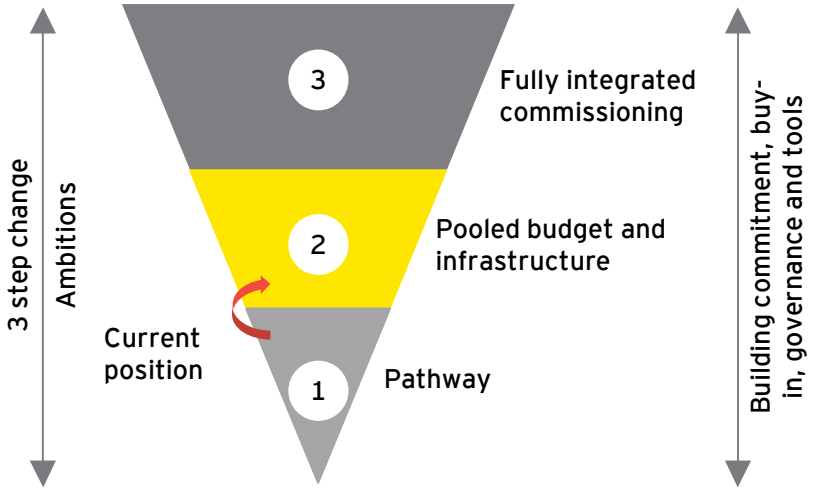
The commissioning model

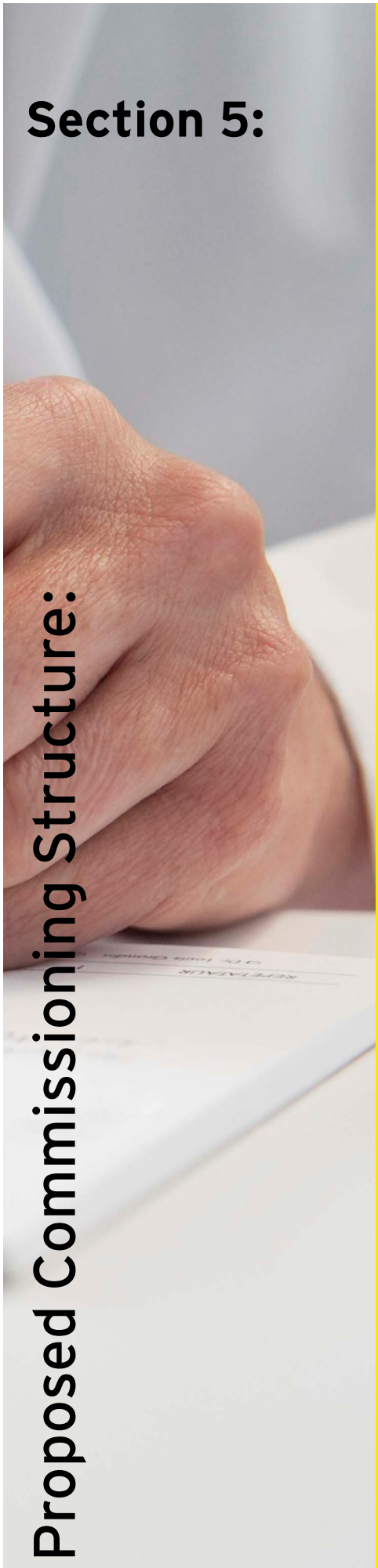
During the course of the event, we described our ambition for the Essex commissioning model. The group were presented with a spectrum ranging from, at one end, separate organisations with separate funding, structures, workforce and outcomes to a fully integrated model with single funding structures, workforce and outcomes.

We rated our ambition from 1 to 10 as shown in the diagram below. The results show the average ambition across stakeholders.



We further developed our thinking in the phasing for realisation of this vision. The model below shows a 3 phase approach for integrating the commissioning model. We recognised that progress towards integration is currently between phases 1 and 2 and further progress requires development of integrated funding processes and infrastructure.





Section 5:

Proposed Commissioning Structure:

Decision Making & Governance

Overview

One of the key areas of focus for the group was to test the structure of the commissioning programme as a basis for defining the governance of the overall economy. The original commissioning structure is included below.

Service	System Level (at which commissioning will take place)	Lead Commissioner/ Commissioning Coordination
Older People	► CCG level ► Essex for CHC	► CCG or ECC (to be agreed) ► Lead CCG or ECC (to be agreed)
Mental Health	► South Essex Cluster ► North Essex Cluster	► CP&RCCG ► NEECCG
Learning Disabilities	► North and South Essex Clusters to start ► Potential move to Essex-wide	► ECC lead commissioner with WECCG as Coordinating Commissioner in the North Cluster. ► ECC lead commissioner with CPRCCG as Coordinating Commissioner in the South Cluster (TBC)
Children's services	► Some at local level (e.g., maternity and early years, including children's centres) ► Some Cluster or Essex-wide (e.g., Integrated CAMHS & Behaviour)	► NHS or ECC (to be agreed) ► Note the NHS CB role also in Health Visiting to 2015.
Public Health	► Essex for population health programmes (e.g., Sexual Health) ► CCG for some very specific interventions (e.g., case finding) ► Public Health England for immunisations and screening programmes	► Mostly ECC for Public Health

The above table was presented to small groups and each of the assumptions in the table were tested for agreement against the following questions:

- Where commissioning decisions will be made in the system
- Who will lead on commissioning decisions
- Principles of where commissioning decisions will be governed

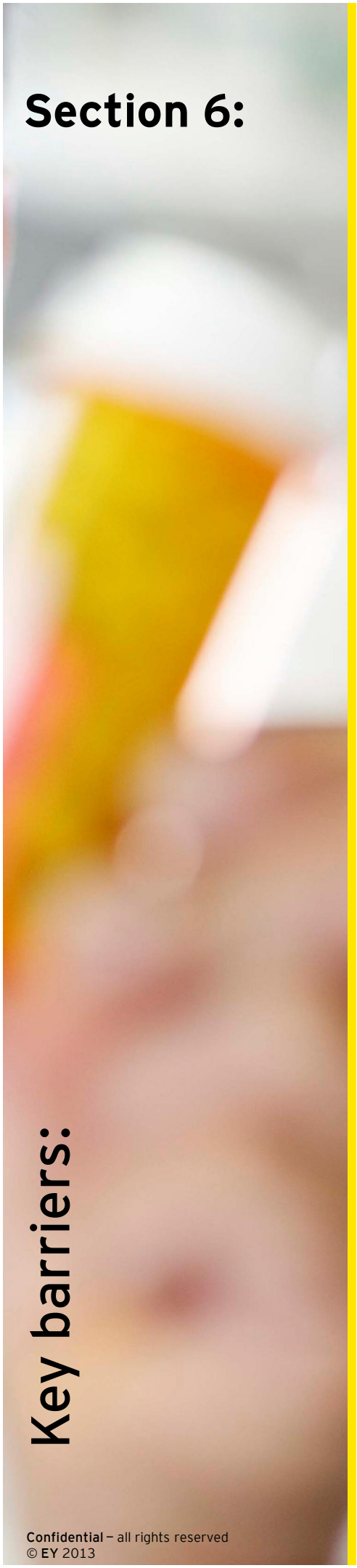
Decision Making & Governance (cont'd)

The table below shows the results of the exercise and demonstrates there is broad agreement around the current commissioning structure. Disagreement, comments or challenges are also included in the table below and will form the basis of the work identified in the section on key barriers.

		Key statements and principles	Approve/Not Approved	Key comments/challenges
Key Statements	1	**Older People (CHC only).** *Decision required if ECC or Lead CCG*	Approved by majority	▸ Risk of not understanding locality and its needs ▸ Need to fully understand the benefits of centralisation ▸ Further work to clarify why this is done as a single service ▸ NHS cannot legally devolve , need to understand challenges of this if LA use a localised approach
	2	**Public Health (PH) – Wider population health.** *Led by: ECC*	Approved by majority	▸ Understand the nuances between PH general commissioning and specific interventions commissioned locally, ▸ PH principles are fragmented ▸ Further work needed on categorisation
	3	**Children's Services – integrated CAHMHS & Behaviour.** *No agreed lead currently*	Not approved by majority	▸ Need s to be part of wider commissioning for children ▸ Need to align with MH & LD services ▸ Solution needs to be a stratification of risk based on wide varying complexities and need
	4	**Mental Health (MH)** ***Led by CPRC CCG/NEE CCG***	Approved by majority	▸ Outcomes need to be established at an Essex level ▸ Currently significant differences on the North approach to the South approach which need to be considered ▸ Local by default and aggregate up? ▸ Cluster approach is interim/medium-term solution , locality is long-term model
	5	**Learning Disabilities (LD)** ***North = ECC Lead & WECCG as co-ordinating South = CPR CCG***	Not approved by majority	▸ High dependency on funding levels ▸ Shared overarching framework (ECC) but has a localised approach, this is to support local needs but to avoid 8 different commissioning models ▸ Understand where the linkage is to children's services
	6	**Older People (exc CHC).** *Led by CCGs*	Approved by majority	▸ Shared overarching framework but local by default ▸ Imperative to ensure alignment with CHC
	7	**Children's Services – including Maternity/Early Years/Children Centres.** *No defined lead currently*	Not approved by majority	▸ Further work needed to define this more clearly ▸ Overarching framework and ECC led but needs to be localised
	8	**Public Health – specific interventions.** *Led by: CCGs*	Approved by majority	▸ Need to clearly define localised specific interventions
Principles	1	**Each 'system' level uses established governance bodies and does not re-create decision making protocols**	Approved by majority	▸ Established bodies need to be more clearly aligned ▸ Determine whether H&W board could play a key governance role ▸ CSU Commission and NHS England could pose a challenge ▸ Need to clearly define the function of each body
	2	**You will create formalised cluster commissioning groups to oversee decisions at this level**	Not approved by majority	▸ What are the inter-relationships with existing structures? ▸ Need to understand where it is necessary to delegate upwards ▸ Impact of specialised roles such as MH
	3	**You will have one overriding integration board to manage the transition to integrated working and co-ordinate the programme**	Approved by majority	▸ Who would sit on this board and how would we include political leadership? ▸ Need to reflect a system wide approach for example; including a dialogue with trusts ▸ Create one with delegated powers and understand any overlaps or duplication

Comments/challenges applicable to all: 2 Unitary authorities need to be reflected/considered in all approaches
Direction of travel should be towards integrated or aligned budgets so that financial mechanism supports approach

Majority approval **Majority not approved, as further work required**



Section 6:

Key barriers:

Overcoming potential challenges

One of our objectives going into the session was that we were keen to identify and overcome any potential barriers to achieving the vision for integrated commissioning. Four sessions were run which aimed to identify the key barriers and the potential solutions to overcoming them.

Key Barriers

Identified barriers were grouped into five overarching themes as shown below:

- **Sovereignty:** Health and Local authority organisations in Essex are independent organisations which have responsibilities and accountabilities that are set out in statute. When aiming to bring together funding and resources to support integration, there are a number of challenges which relate to management of these independent accountabilities to support a strong, Essex wide partnership whilst allowing for the appropriate level of scrutiny and devolved political and strategic autonomy.
- **Credibility:** Health and Local authority organisations in Essex have tried to move forward on integration a number of times in the past and have had mixed success. There are three key groups critical to the success of the integrated commissioning programme which rely on strong credibility that the programme will be delivered. These are:
  - People of Essex, patients and service users: Without the support of this group, decision makers are unable to take the bold decisions necessary to make integrated commissioning a reality
  - Staff: The transition to integrated commissioning must be whole organisation, from top to bottom, front line to back office. Without the support of the commissioning workforce, integrated commissioning is likely to be unsuccessful
  - Providers; Integrated commissioning is ultimately about the quality of care and experience of those who receive it. Without provider belief that integrated commissioning will become a reality and change the commissioning model, the overall vision is likely to be unsuccessful
- **Identifying priority areas and taking action:** there was broad consensus that a significant amount of planning work had been progressed over the past 12-24 months and that the programme needed targeted action to support building of momentum, development of integrated decision making, funding and infrastructure, which would see a step change in the delivery of the programme. Common consensus around priority areas of focus was seen as a significant barrier to success.
- **Infrastructure:** health and social care organisations operate different systems, different structures and have various levels of capacity and capability in multiple locations. This variation creates a significant challenge in providing a consistent integrated offer to the people of Essex, e.g., sharing information to identify a single view of patient need. Two priority areas were identified as presenting particularly large challenges;
  - Information and communications technology and governance
  - Commissioning support

Section 7:

OP Transformation Programme:

Older People Transformation

With an increasing ageing population leading to a rise in demand for services, the provision of health and social care services for the older population in Essex is unsustainable in its current form. The projected imminent gap in supply and demand for these services has highlighted the need for expeditious transformation in their commissioning and delivery and this has been the driver for the creation of an Integrated Transformation Programme for Older People's services.

This session was intended to identify key objectives, key deadlines and milestones, programme of work, key stakeholders and next steps for the implementation of this Programme.

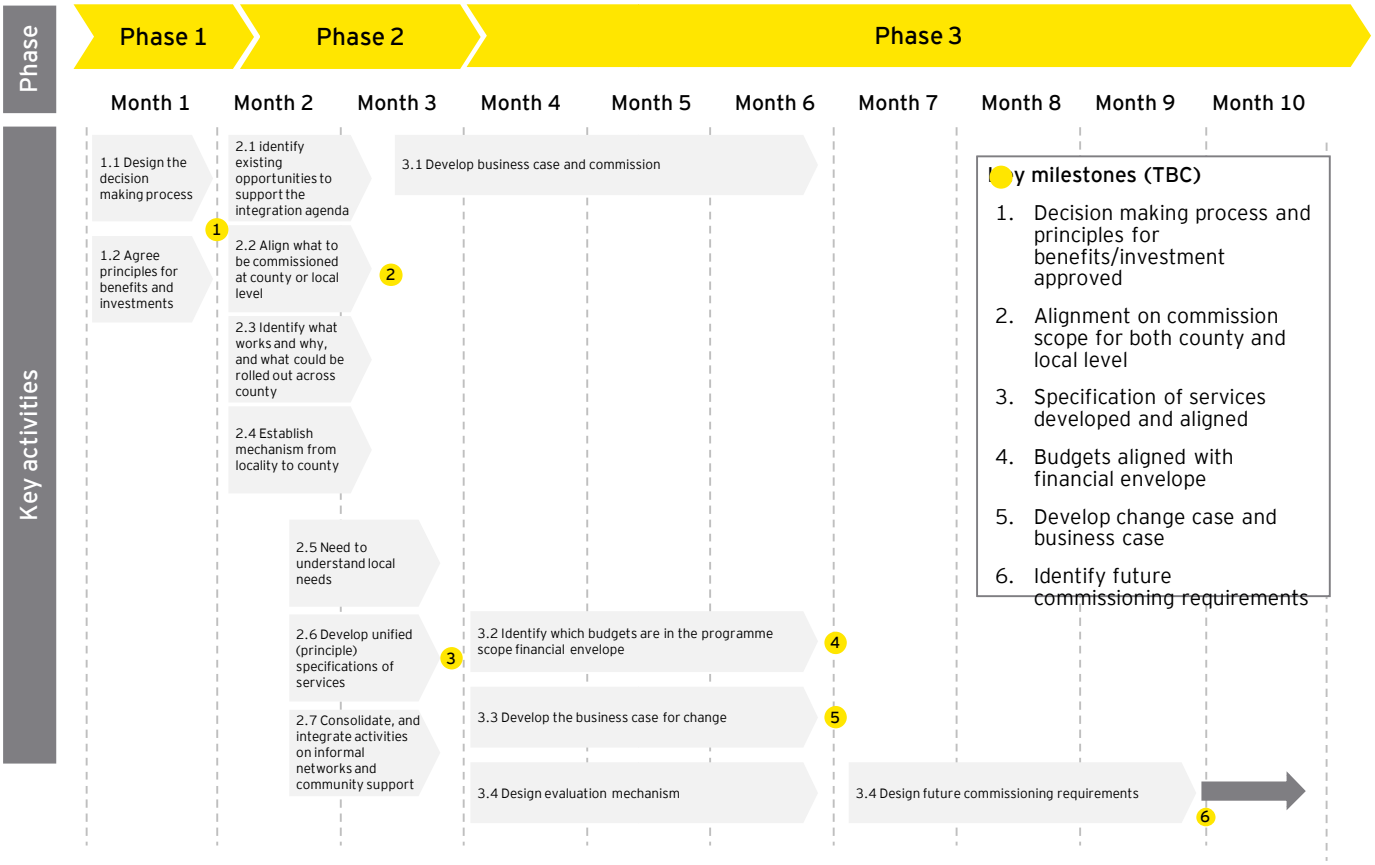
Ambition

To commission enhanced services at a reduced cost, providing a seamless customer experience for the older people of Essex

Overview plan

- An overview approach to designing an integrated commissioning of services for Older People (OP) is outlined below. The plan shows initial work carried out during the event and is subject to further review and revision in building a more robust, aligned and accountable action plan.

Older People Transformation (cont'd)



The table below shows the initial analysis of services in scope:

1. Community Geriatrician
2. Hospital
3. Out of Hours
4. OT – Health and Social Care
5. Community physio
6. Community matrons
7. Reablement

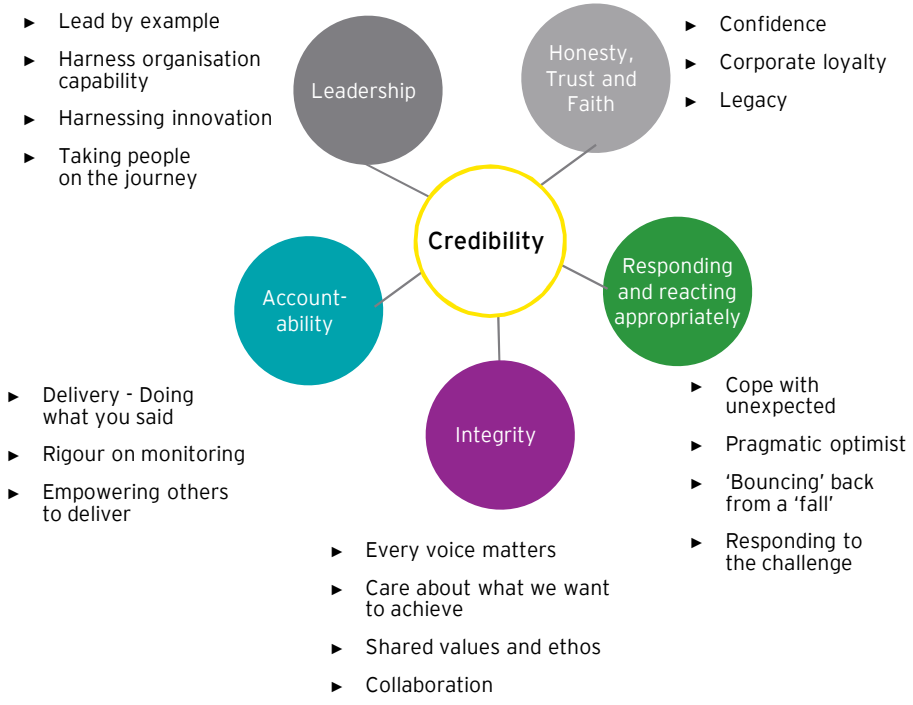
8. Home care
9. Social Work
10. Residential & nursing care
11. MH assessors/CPN
12. District nurses
13. Voluntary sector services
14. Housing/benefits advice

Credibility

Credibility is not an independent work stream but something that will be achieved by delivering the Vision described above. Credibility fundamentally underpins all areas of the programme, it can only be earned through consistently demonstrating the principles of being credible and keeping the values at the core of any change journey.

What is Credibility and how do you demonstrate it?

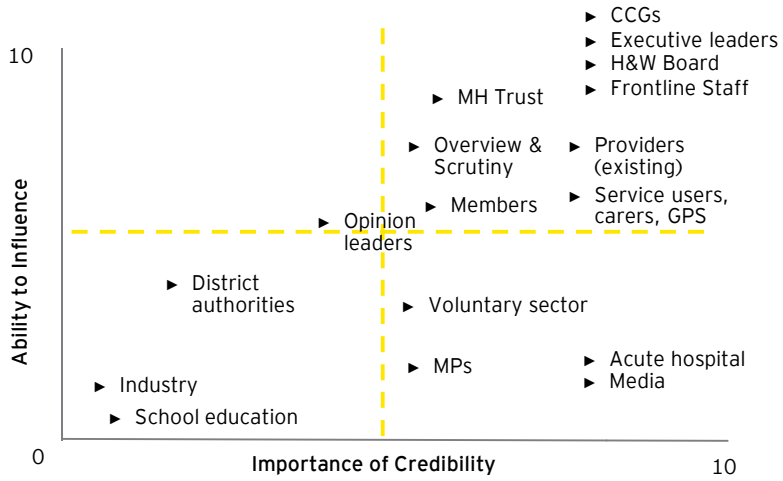
Credibility will be achieved by continuously demonstrating a set of Values and behaviours, some of which are outlined below:



Credibility (cont'd)

Credibility – importance vs. influence

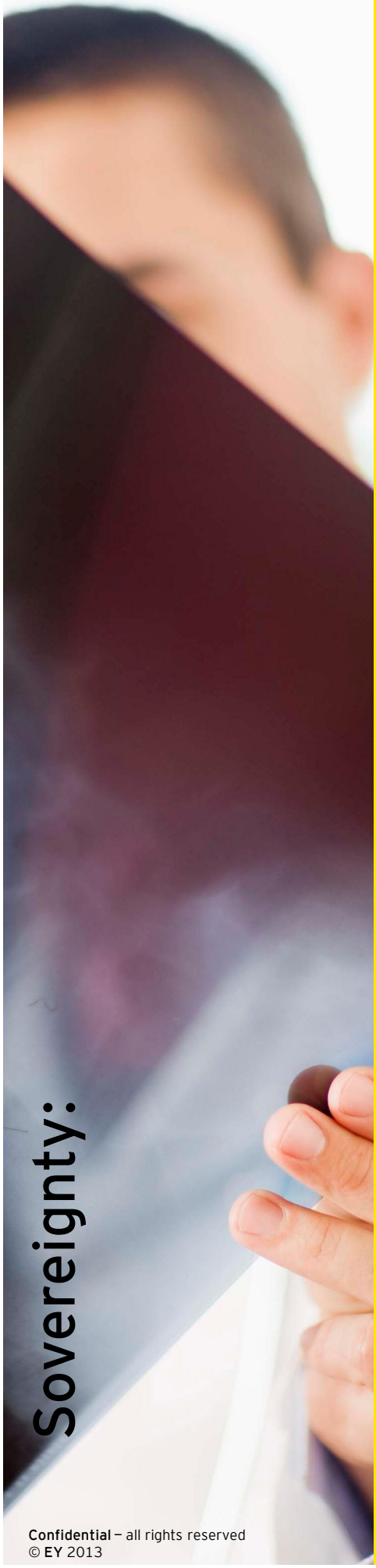
One of the most important elements when building and maintaining a relationship with your key stakeholders - you say what you are going to do and you do what you say. The chart below shows an initial view of key stakeholders, recognising that this continually evolves and changes, and to what extent is being credible important versus the ability to influence credibility:



Next step:

This analysis is based on only a brief discussion during the workshop. It is proposed to update and finalise this analysis, so that it can be incorporated in all future communication strategy

Section 9:



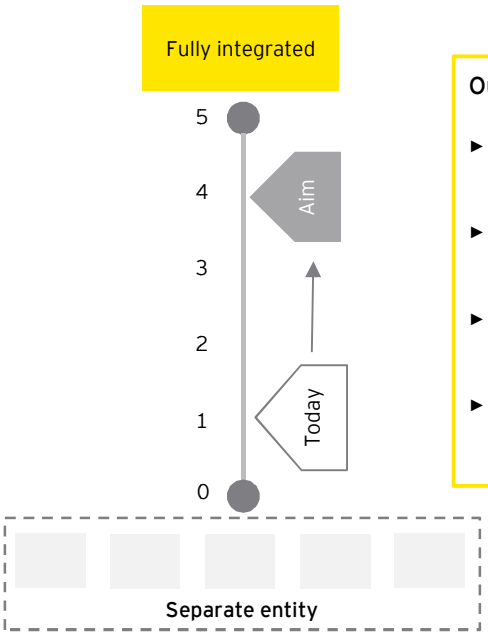
Sovereignty:

Sovereignty

Sovereignty is a key element for the integration of the commissioning function and needs to be managed effectively. How the multiple commissioning organisations make effective decisions in a timely manner whilst achieving the legislative accountability set out in statute is critical to the success of the overall integration programme. This section outlines our ambitions and the set of work products that we need to proceed with across the next 12 months.

Integration level

This is an opportunity for us to think outside our norm and shape up Essex with a high degree of integration. The chart below demonstrates (on a scale from 0 to 5) the extent to which we would like to have a fully integrated model.



Our Ambitions are strong:

- Reduce the number of 'kings/queens' from 22 (current). Eg. 7
- Keeping domestic mandate, but support shared structure and agreement
- Realistic level of achievement, while enabling and protecting locality and legislations
- An opportunity to further enhance the relationship between citizen and local council

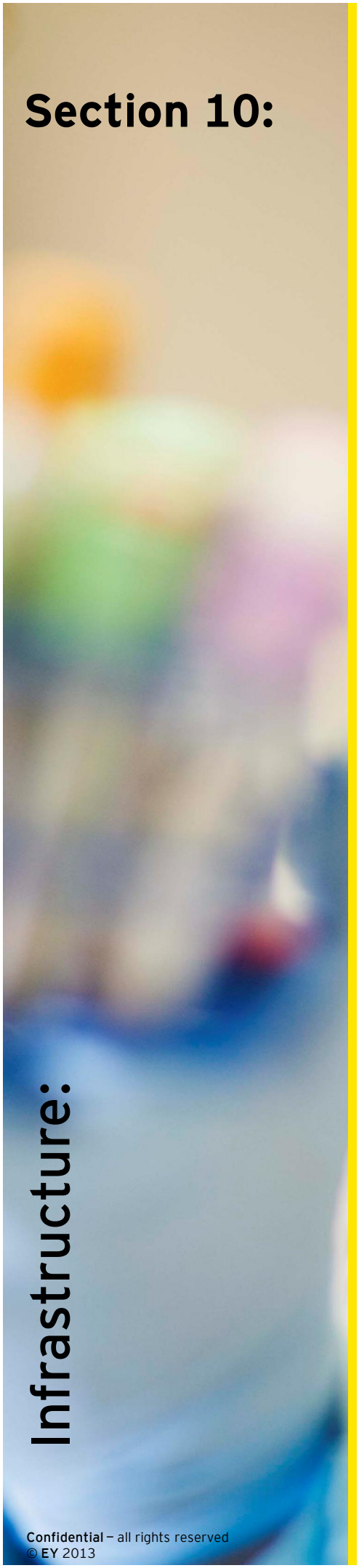
Sovereignty (cont'd)

Key Work Products

The table below specifies 7 distinct work products that are required to achieve the ambition outlined above. Out of this list there are 3 key work products which are recommended for an immediate start.

	Work Products	Comments/Key questions to address	Timeline
1	The vision	► Shared vision statement ► What is the end prize or gain?	HIGH PRIORITY Immediately (0-6months)
2	Route map	► Resource and communication plan aligned ► Single PMO approach across transformation ► Change management process aligned	
3	Leadership and decision making model	► Support the development of an agile commissioning service ► Stakeholder mapping for decision making	
4	Enablers	► Data analytics and predictive tools ► Shared and/or integrated information systems	
5	Evidence base	► Align function and organisation structure (avoid duplication) ► Mapping pathway with decision points	Within 12 months
6	Performance and quality framework	► Quality framework and metrics agreed ► Embed continuous learning process ► Encourage the right behaviours in moving forward	
7	Planning and budget	► Incentived sharing model (pooling of budget and savings)	

* There is a need to ensure that there is an evidence base underpinning all of these products



Section 10:

Infrastructure:

Infrastructure

Integration of commissioning will require effective alignment of infrastructure. This session explored the key ambition and requirements around IT and Commissioning Support in order to enable effective integration between Health and Social Care commissioning.

Our approach

We have identified two key elements of establishing the infrastructure for the integrated commissioning function – IT Governance and the underlying Commissioning Support. To actively proceed, the focus group discussed and identified key actions and a set of work products required across the next 3 -6 months as outlined below.

1 IT Governance

Ambition	1. Link H&SC data sets through appropriate systems 2. Establish universal access to data to inform smart commissioning 3. Establish a shared approach to consent
Actions	1. Develop single purchasing and strategy for hardware, software and commissioning 2. Get CCG buy-in to integrate system at H&WB level 3. Get principles of agreement from H&WB
Work products	1. Joint procurement strategy for ICT 2. Supporting data sharing, protocol consent and integrated proposal 3. Joint IT commissioning strategy
Deadline	19 October (in 3 months); Next board (planning strategy)

2 Commissioning Support

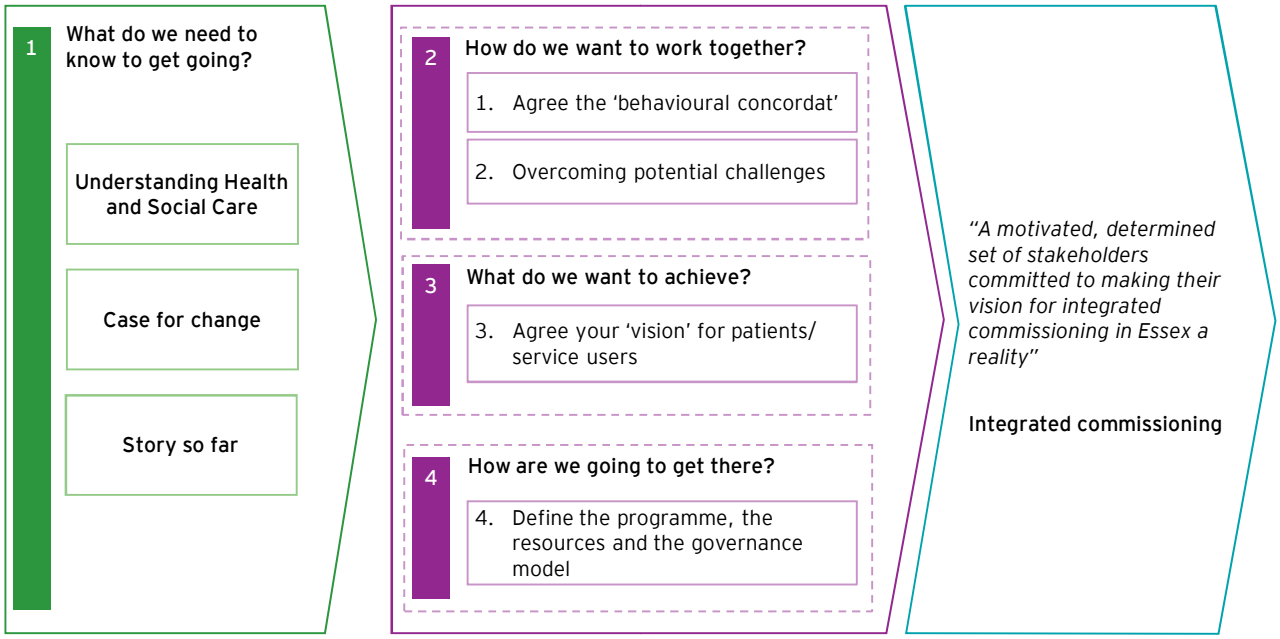
Ambition	Achieve a flexible model which varies according to local commissioning requirements
Actions	1. Integrated commissioning will be flexible to accommodate the local needs and priorities of local commissioning organisations 2. Commissioning support needs will be efficient, allowing resources to be directed towards the front line 3. Align commissioning support with integrated model. Eg. pathway 4. Co-ordinate approach avoiding instability and supporting the long term sustainability
Work products	Joint and integrated options on commissioning support for future state of CSU across Essex, including council commissioning strategy
Deadline	3 – 6 months (19 January 2014) – adjusted against OP and LD

Appendices:

Appendix A: Agenda and purpose of workshop

Integrated Commissioning Programme

This section outlines the key focus and agenda that was developed for the 2 day workshop, based on the inputs required to form and plan an integrated commissioning programme. In order to move forward with integrated commissioning, elements of the vision must be developed as inputs as outlined below.



Key section	Session	What will we cover?	Who will facilitate this?
1. What do we need to get going?	Case for change	Identify demand, funding and operational pressures	Pre-reading
	Story so far	They key agreements, decisions and progress made to date	Pre- reading
2. Agree barriers to change and how to overcome them?	Agree the 'behavioural concordat'	Agree and commit to the personal behaviours that will positively support the delivery of the programme	Robin Fritz/Howard Karloff (Engagement Specialists)
	Agree the potential challenges to change and how to overcome them	Identify they key barriers covered in constraints and how we overcome them. Identify what additional elements are needed for integration to be successful, e.g., How will investment work?	Darra Singh & Matt Huxley (EY Local Government/Health)
3. What do we want to achieve?	Agree your 'vision' for patients/service users	Identify what integration means for individuals and how commissioning/provision will change	John Baker & Emily Tuft (EY Health & Social Care)
4. How are we going to get there?	Agree the programme, resources and governance arrangements	Agree how to organise change activity, process for moving forward and identify the necessary resources	Neil Sartorio & Victoria Evans (EY Health & Social Care)

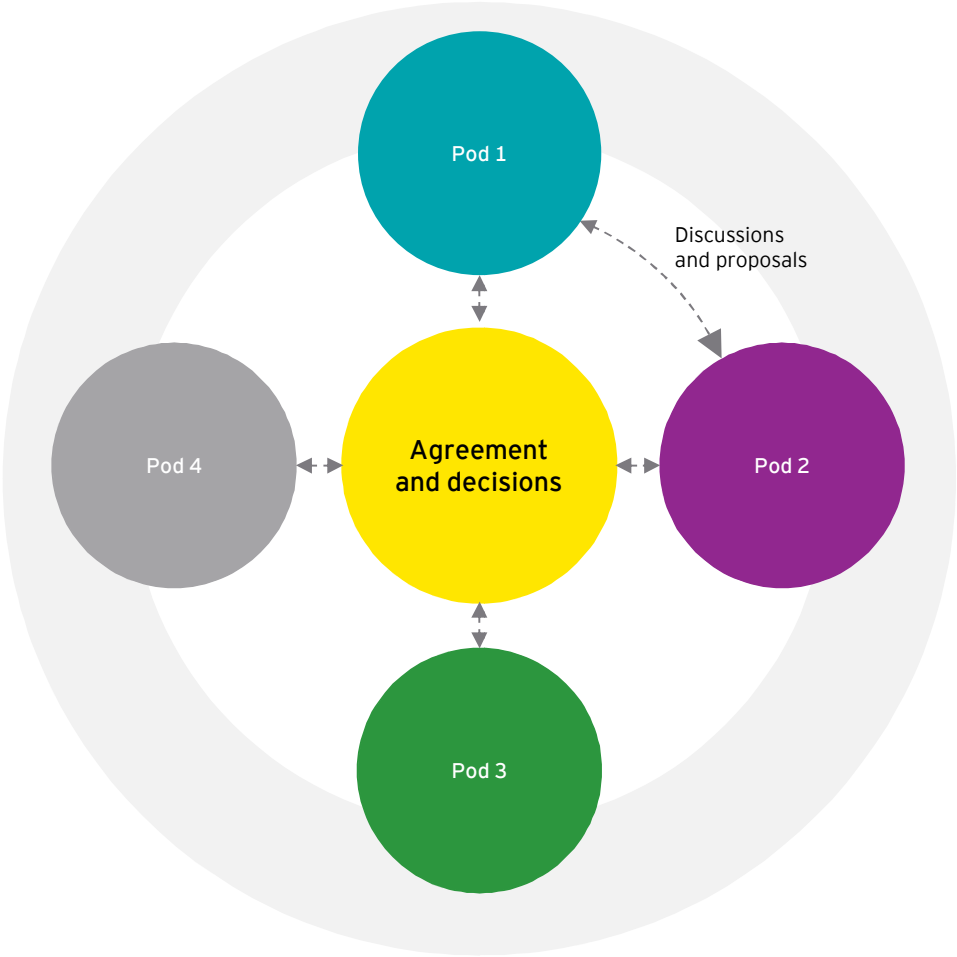
Additional Specialist Speakers

- Derek Myers – Joint Chief Executive at R B Kensington and Chelsea and LB Hammersmith and Fulham
- Joanna Killian – Chief Executive Essex County Council
- Robin Fritz and Howard Karloff– Engagement specialists

Appendix A: Agenda and purpose of workshop

Facilitation of the event

- The event was run through a combination of whole group sessions and smaller 'pod' group sessions for targeted discussion of particular topics. The whole group sessions was held in a main room and lead by EY. Speaker sessions were also held in this room.
- The attendees were split into groups of 4. There were 4 pod discussion topics, each of which were owned by a facilitator or two facilitators. Groups were circulated from pod to pod in each discussion session joining a new facilitator each time.
- There were 'runners' feeding in key points and information to the central plenary for feedback and discussion. There was also a visual presenter artist capturing discussions in each pod and representing these in the central plenary.
- Information captured in the pods were collated and fed back in the central plenary where key issues and themes were identified, a plan was developed for day 2 accordingly.



Appendix B: Design Principles

Design Principles and Values

Design Principles and Values

Design principles form the basis of the commissioning model and will be the guiding principles during the design phase. The Key values underpin the design of the commissioning model and provide the ethos and philosophy for how the model should be designed to operate.

The following principles and values were identified. These will be used to inform and test the design of the commissioning model.

Key Design Principles

1. Patient centred, and empowering individuals
2. Value and needs based
3. Proactive approach of prevention, early identification and intervention
4. Outcome focused
5. Co-produced: Patient/Citizen are partner with commissioners and providers
6. Quality

Key Values
(beliefs which underpin the design)

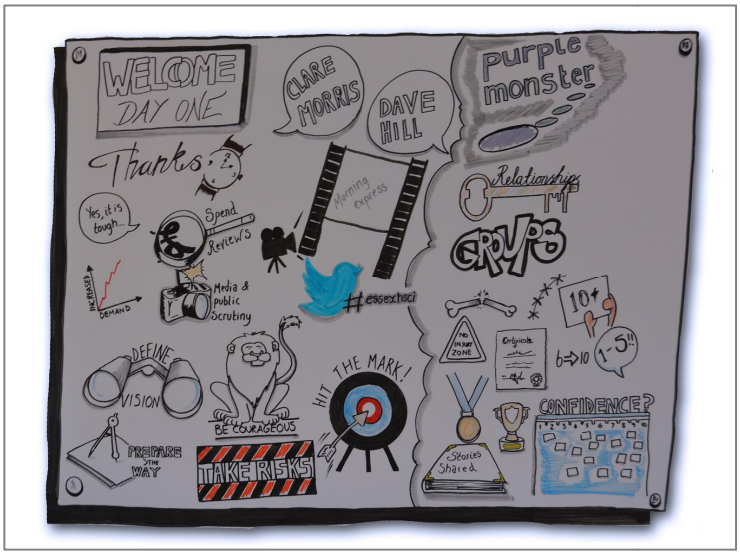
1. Affordable and cost effective
2. Sustainable and long-term
3. Innovative but informed by an evidence base
4. Shared risk and benefit
5. Effectively manage demand
6. Honest, fair and accountable
7. Continuous learning
8. In line with individuals

Appendix C: Workshop Artworks

Design Artworks

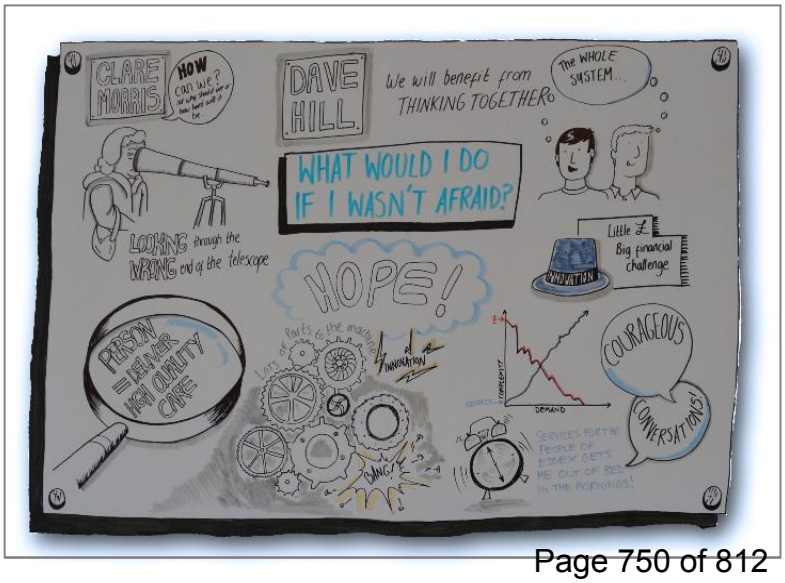
There was a visual presenter artist capturing discussions in each pod and representing these in the central plenary across both days of the workshop. This section showcase these artworks as shown below:

Day 1 - Welcome

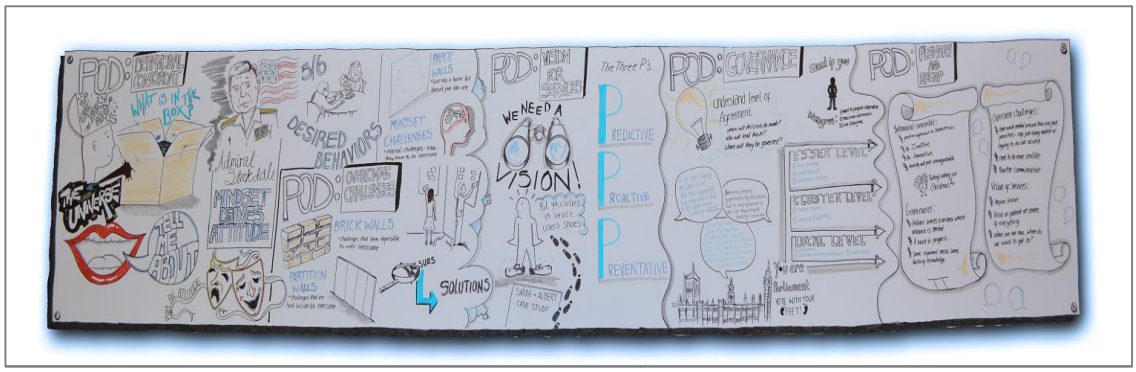


Day 1 – Derek Myers

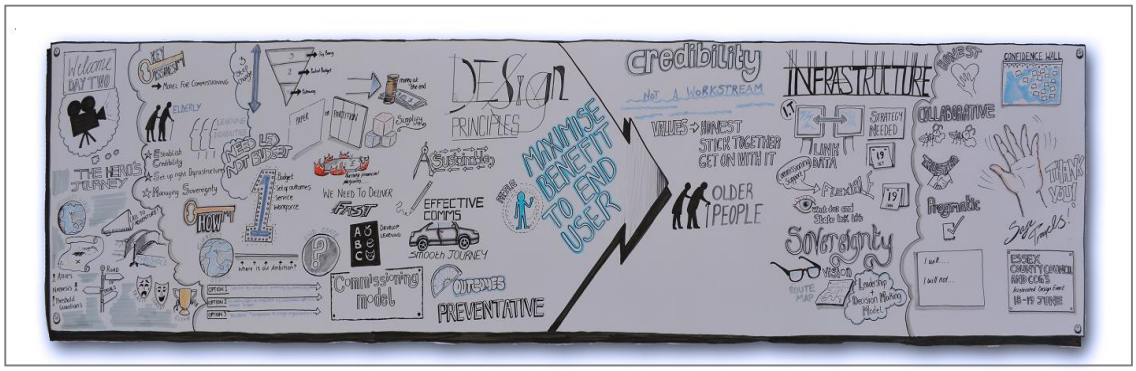
Day 1 – Clare Morris and Dave Hill outputs



Day 1 – Pod outputs



Day 2 – Live Scribing



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The Seven Day Services Improvement Programme

Expression of Interest

Southend University Hospital NHS
NHS Foundation Trust

NHS
Castle Point and Rochford
Clinical Commissioning Group

NHS
Southend
Clinical Commissioning Group

Seven Day Services in South East Essex Health and Social Care System

Executive Summary

In our part of Essex, we have had some notable successes in improving our service. We have been improving our seven day services on a continual basis for many years. However, we recognise that patient care will be significantly improved by better integration of care across the whole care pathway.

- We have teams of highly qualified and experienced clinical staff that provide excellent high quality care. And yet we know there are occasions when patient outcomes are affected by the day of the week.
- Our length of stay in hospital is one of the lowest in the country1. And yet we know that we really struggle to get patients out of hospital and back home on a Sunday.
- Our Emergency Patient Pathway work has recently delivered significant improvements and we now achieve the 4 hour target consistently. And yet we know that a significant number of patients come to the A&E department because they are unable to access primary care closer to where they live.
- Our Hyper Acute Stroke Unit is regarded as one of the best in the country. And yet we know that delivering timely thrombolysis can sometimes be affected by the day of the week.

We have a vision where all health, social, community and third sector services are fully integrated, within and across organisations. We will provide the best care in the most appropriate setting, regardless of time of day or day of the week.

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.

We know that understanding where and how we need to improve is going to be challenging and difficult. It's a typical "wicked problem" [2]

We believe we have the local leadership and commitment to make great changes.

- Southend Hospital, under the leadership of a new CEO, has improved it's Inpatient and Staff survey scores since 2011
- Southend Council was awarded council of the year in 2012
- The board of Castle Point and Rochford CCG has been nominated for an awards by NHS England to the NHS Leadership Recognition Awards scheme
- The accountable officer of Southend CCG, Dr Paul Husselbee, is a member of the National Advisory Group, chaired by Professor Sir Bruce Keogh
- A strong link with other acute Trusts through Anglia Ruskin Health Partners
- Prof John Kinnear, the Director of Medical Education, is leading on inter-professional education and development for the Postgraduate Medical Institute

We have managed and delivered major improvement programmes across organisational boundaries with significant improvements in patient care and experience. We have a Programme Management Team of 12 staff that has solid reputation for delivering a range of complex projects successfully, e.g. IT systems such as eRostering, pathway developments to support achieving Best Practice Tariffs, and stewardship of the Trust's cost improvement programme.

We are already seen as leaders in fields such as, Acute Stroke Care, Chronic Obstructive Pulmonary Disease, and have held events to share our knowledge. We have made significant and innovative changes to our services, leading to social workers providing a 7 day services to wards and consultant ward rounds 7 days a week. We have shared our learning with other hospitals such as, University College Hospital, Lewisham Hospital and Mid Essex Hospital.

Our vision will be based on the actions and standards recommended in the recent evidence published by the Royal Colleges, and we welcome the opportunity to work within a national organisation to learn from others and share our own learning.

In summary, we have all the key factors in place to successfully contribute to the programme. We are very enthusiastic about the concept of the Seven Day Services Improvement Programme and are very keen to be part of it. We believe that being involved will help us to focus all parties on delivering our vision.

Professor Sir Bruce Keogh said at the NHS AGM:

"It is going to be radical, it is going to be difficult but we have to be up for it"

In South East Essex, we have the leadership, the commitment and the drive to respond to this challenge.

[1] Ranked 9th on Better Care Better Value benchmarking site
http://www.productivity.nhs.uk/Dashboard/For/RAJ/And/25th/Percentile

[2] Rittel, H. & Webber, M. (1973) Dilemmas in a General Theory of Planning. Policy Sciences, 4, 155-169

1. Our vision for Seven Day Health & Social Services in South East Essex

We will:

- work with patients, carers and all our partners in the health care system, to create a shared vision of our future seven day services.
- implement our shared vision working collaboratively with patients and all our partners
- establish clinically led care pathways which will include services provided by acute, primary, social care and the third sector

We will seek to improve outcomes for:

- Individuals: being able to access treatment as appropriate to them and not limited by the availability services
- Families: access to better support to cope with family members with ill health
- Carers: with improved support from relevant organisations to help them provide better, sustainable care
- Communities: with access to local health care services will be improved to the level where day of the week is not a limitation
- Staff: their working hours and rotas will be improved to ensure that seven day working patterns are sustainable and rewarding

Our vision is aligned with the NHS Outcomes Framework

Domain 1: Preventing people from dying prematurely

- By addressing the deteriorating patient sooner and ensuring the appropriate senior staff are available to provide and direct treatment whether that be in the hospital or the patient's usual place of residence. For example:
    - The Trust currently has a CQUIN specifically aimed at preventing avoidable deterioration of acutely ill patients while in hospital. This addresses all aspects of the patient's hospital journey, but there is an ambition to extend its remit to include the patient's journey before admission and after discharge.
    - We are about to begin a new Friday handover process where weekend medical staff identify and prepare plans for 'at risk' patients with the Critical Care Outreach team.

Domain 2: Enhancing quality of life for people with long-term conditions

- By providing services seven days a week in the hospital and the community, that recognise the nature of their condition and help to enhance quality of life

Domain 3: Helping people to recover from episodes of ill health or following injury

- By spreading the principles of Enhanced Recovery pathways for Colorectal and Orthopaedic surgery across the whole hospital and delivered seven days a week

- Providing better seven day support in the community to continue the recovery process

Domain 4: Ensuring that people have a positive experience of care

- With easier access to appropriately experienced decision makers, in health and social care services, seven days a week. For example,
    - We are about to open a Cancer Assessment Unit where cancer patients will come to for urgent care, instead of the Accident and Emergency department.

Domain 5: Treating and caring for people in a safe environment; and protecting them from harm

- By delivering services that are consistently safe and reliable regardless of the day of the week.

We will measure our success against the above domains by monitoring the data available on the indicator portal at the Health and Social Care Information Centre https://indicators.ic.nhs.uk/webview/

We will also use local hospital measures, such as:

- Standardised hospital mortality index (SHMI), weekend differential mortalities, readmission rates, length of stay, rates of HCAI, friends and family tests, and staff and inpatient surveys.

Over the next 3 years, our seven day services will have:

- an improved SHMI of 0.9 from 1.0 : an improvement of 10%
- no difference between weekday and weekend mortality rates
- readmission rates in the top quartile of Acute Trusts (? Aim for decile, currently 89th)
- a length of stay in hospital reduced by 10 %
- a Friends and Family score of > 90
- improved scores for our staff and inpatient surveys to be in the top quartile

2. Turning our vision into reality

We believe local patients and carers can help us to create the plan we need to make our vision a reality. They will be supported by leaders and clinicians from:

- Southend University Hospital NHS Foundation Trust
- South Essex Partnership Trust,
- Southend Council,
- Castle Point and Rochford Council,
- Southend CCG,
- Castle Point and Rochford CCG,
- the Postgraduate Medical Institute at Anglia Ruskin University,
- East of England Ambulance Service NHS Trust
- Local charities, e.g. AgeUK, CarersUK, MacMillan,etc

We will be investigating in detail how our services work now to identify the gaps and targets for improvement. This will include physical “go and see” events to get the best possible understanding of current issues. For example, we will select a cross-cutting issue, like management of the frail and elderly with chronic conditions, and look at their journey from community to hospital, to rehabilitation, focusing on prevention of avoidable admission, treatment and harm.

We know that the most important factor in preparing and delivering our plan is the willingness of our staff to look at how things are done and come up with creative solutions. As soon as possible, we will be holding sessions with staff in all participating organisations, to involve them in creating, refining, supporting and delivering our vision to provide the best possible seven day services in South East Essex.

Southend University Hospital NHS Foundation Trust is intending to bid to take over the running of local community services, when the services are retendered in November 2013. This will allow us to drive further integration between primary and secondary care, and enable further improvements to our health and social care system.

We have already made great strides in improving our emergency patient pathway, with major changes being made to consultant cover in A&E. We have also established 12 hour consultant rotas, 7 days a week, in our Acute Medical Units. We plan to continue this work along the pathway looking for further improvements in how our patients are treated and cared for 7 days a week. Furthermore, we will be putting in place consultant radiologist cover at weekends with clinics for emergency ultrasound and CT emergency patients.

We are aiming for seven day services that deliver the best care in the most appropriate or convenient place for our patients. This will mean that many patient needs will be addressed successfully by a nurse, a therapist, a pharmacist, or other allied health professional. Drawing on the Hospital at Night model, some patient needs could be managed by any doctor, with appropriate experience of managing general conditions, such as sepsis.

We are launching a revised Friday multidisciplinary handover process where discharge criteria will be identified for individual patients and responsibility for discharge, if the criteria are met, will be assigned to the appropriate grade of staff, e.g. Junior Doctor or Nurse.

We have two Consultant Geriatricians that have been appointed to work both in the hospital and the community, managing the interface between hospital and intermediate care, and delivering education and training to nursing home staff. We will develop and expand these successful first steps across the whole of South East Essex in line with our seven day services vision.

It will be important to develop and expand the skills of the workforce as we reconfigure ways of working to enhance patient care. Anglia Ruskin Postgraduate Medical Institute, with an expertise in healthcare education, will be our academic partner. This will allow creative ways of responding to evolving workforce needs.

We anticipate that our plan will be delivered in phases:

Phase 1: we will improve our understanding of current services and identify our biggest problem areas. This work will be done in detail to allow for accurate description of our problems: in defining our problems we believe we will identify solutions.

Phase 2: we will focus on fixing the high priority problem areas. Some of this work will align with the work we have already started on the deteriorating patient CQUIN.

Phase 3: we will scope our services again, with a greater emphasis on using improvement tools such as value stream mapping, seven wastes identification, etc, looking for areas the will deliver the greatest benefits to patients from improvement,

Phase 4 : we will be designing, testing and delivering improvements to the areas we identify in Phase 3,

Phase 5 : as part of our approach to continuous improvement, we will return to Phase 1. This will ensure that any changes made in subsequent phases have not had unintended negative consequences: one of the defining characteristics of a "wicked" problem.

3. Our commitment to providing better integration of care and support to all our stakeholders across South East Essex ?

We already work closely with our primary care partners and have gained their support to work with us in this programme. Dr Paul Husslebee, Accountable Officer of Southend CCG has confirmed their full support and Dr Sunil Gupta's statement below demonstrates commitment to the objectives of the programme:

"This is to confirm that Castle Point and Rochford CCG is highly committed to improving seven day services and would be very interested in being included in the Seven Day Services Improvement Programme. Castle Point and Rochford CCG believes some of the benefits will be:
- Improved patient experience.
- Improved patient outcomes.
- Closer working between Primary and Secondary Care.
- Closer working between Providers and Commissioners.
- Care being provided in the most appropriate setting, regardless of the day of the week.

Dr Sunil Gupta
Accountable Officer of Castle Point and Rochford CCG

Our Foundation membership is 14,000 strong and is a valuable resource for testing ideas and developments. We have 37 governors which will meet in full council on November 20th and a Patient Carer and Experience group that is due to meet on 5th November, both are well timed to fit in with this programme.

We will set up a Seven Day Services Summit with representation from patient groups and all other stakeholders in the health and social care system. The aim of this will be to:

- agree improvement objectives, in addition to those in section 1, that are locally relevant to our patient and carer population,
- break the work down into workstreams of a sensible size,
- agree a high level plan with timescales
- set up the governance structures to make sure improvements are delivered,
- agree the methods and timing of future communications.

We will also run local learning exchange events with patients groups, in a similar format to the national event http://www.england.nhs.uk/2013/08/22/pat-views-7ds/

We already involve patients in developing our services, some examples being:

- Listening Exercise at the hospital's Eye Clinic. Carried out by Foundation Trust governors interviewing 92 patients and visitors to the clinic
- Patient-Led Assessments of the Care Environment (PLACE) by 35 Foundation Trust members
- Learning Disabilities Committee held at the hospital for hospital staff and community workers and carers
- Member Meeting for 567 members at The Lakeside Suite, Oyster Fleet Hotel, Knightswick Road, Canvey Island SS8 9PA
- The annual Hospital Open Day for members of the public to take part in activities and listen to talks on a variety of clinical subjects,
- CCG A&E research in August 2013 surveyed 89 people at the hospital A&E waiting area using staff and volunteers – positive feedback about NHS 111 services

4. Do we have the capability and expertise to deliver a transformation project of this size in 3 years ?

We have a Programme Management Office at Southend Hospital which has been supporting the delivery of transformation projects for the last 3 years. The team of 10 reports directly to the CEO and works closely with Business Units and our partners in the local health and social care system.

In the hospital, we have a weekly Executive Communications cell to oversee major improvement projects, monthly performance management meetings with Business Units, and Cost Improvement Programme meetings where we track progress on savings and impact on quality.

Our methodology is based on Prince and we have standard documents and processes to support project setup, planning, risk and issue management, KPI tracking, action trackers and logs, highlight reporting and escalation routes. We are

working with CCG project teams to support their development of similar processes and systems.

Examples of successful projects include:

- Achieving the 4 hour target in Accident and Emergency has been our biggest local challenge. We have overcome significant barriers to changing working practices, managing information flows and communication, standardising working practices and escalation procedures.
- Some good work has been done by our Medical Business Unit and discharge team working with primary care and social services. We have consultant-led ward rounds at weekends, social workers in the hospital 7 days a week, and set up weekend services with local care homes to support discharge.
- The 'South East Essex Model for Integrated COPD Care', which brings together Southend University Hospital, NHS South East Essex, general practitioners, the local branch of the Breathe Easy charity and the University of Essex, was been given a special commendation award by IMPRESS in 2009.
- We have been shortlisted for an Health Service Journal 2013 award in the category of Secondary Care Service Redesign.

5. How do we disseminate and promote our learning?

We share our learning and innovations in a variety of ways:

- We have received visits from UCLH, Lewisham, and Mid Essex to learn about our discharge processes. They wanted to understand the improvements we have made to our processes, our multidisciplinary team meetings in Medicine, etc.
- We have strong links with Anglia Ruskin University which we use to share our learning by holding seminars and teaching sessions. We have a growing reputation for the research and clinical trials we are involved in. These include specialties including stroke, ophthalmology, critical care, oncology, paediatrics and renal medicine.
- We are partners in the Anglia Ruskin MedTech Campus – an Essex-wide venture between Anglia Ruskin University, local authorities, medical technology businesses and Southend hospital.
- We have experience in holding national events, such as, the International Symposium on Polymyalgia Rheumatica (PMR), Giant Cell Arteritis (GCA), Large Vessel Vasculitis (LVV) led by Prof Bhaskar Dasgupta.

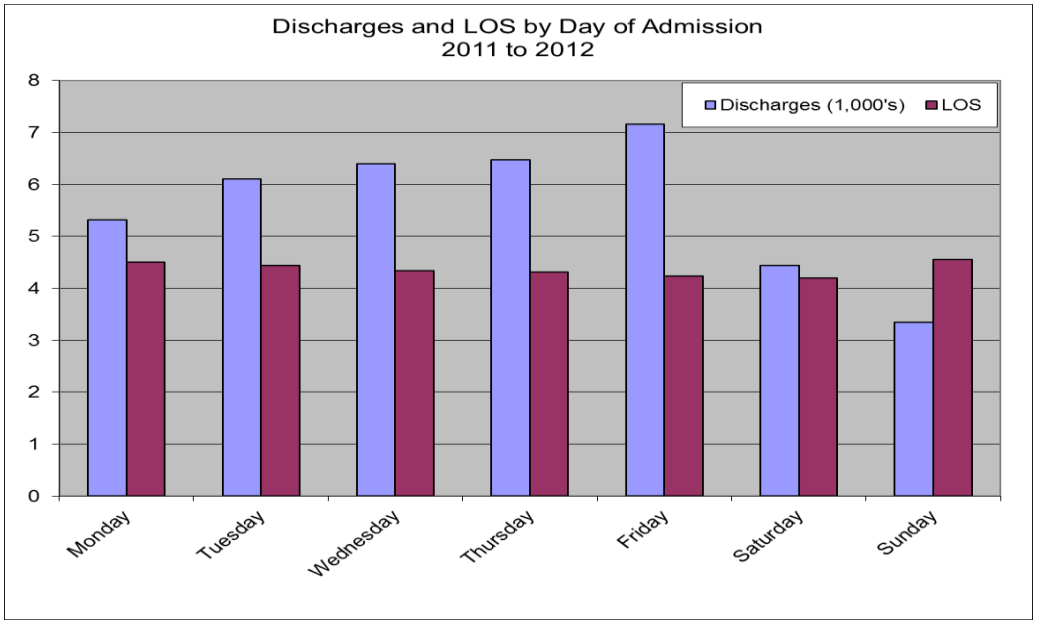
6. The evidence that underpins our vision

We began looking at our seven day services in detail in 2012. We looked at data showing weekday and weekend mortality from 2006 to 2012, which suggested that weekend services for emergency admissions needed to be improved.

2006 - 2012 Emergency Admissions Only, Patients 18+						
	2006-07	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**
Weekday Admissions	18,453	19,907	20,694	21,288	21,446	20,603
Average Age	63.8	63.7	64.2	63.9	64.3	65.2
Average LOS	6.8	6.6	6.6	6.4	5.9	5.7
Average Number of Diagnoses	5.8	6.8	7.5	8.7	11.4	11.7
Deaths	1,362	1,269	1,397	1,241	1,173	1,032
Proportion	**7.38%**	**6.37%**	**6.75%**	**5.83%**	**5.47%**	**5.01%**
Weekend Admissions	5,054	5,602	5,897	6,058	6,008	5,748
Average Age	64.9	64.9	65.8	65.6	65.6	66.8
Average LOS	6.9	6.9	6.8	6.5	6.4	5.9
Average Number of Diagnoses	5.8	7.0	7.7	9.0	12.5	12.8
Deaths	434	425	448	413	387	399
Proportion	**8.59%**	**7.59%**	**7.60%**	**6.82%**	**6.44%**	**6.94%**

We looked at the arrangements for providing senior medical cover out of hours and at weekends, and have made changes over the last 12 months or so. Some of this work fits with the deteriorating patient CQUIN mentioned earlier.

We have looked at length of stay and discharges by day of the week.



This highlighted the work we needed to do on weekend discharge processes. Some changes have been made, e.g. consultant led ward rounds in Medicine, and more are in the pipeline.

We are developing our out of hours and weekend services to meet the standards laid down by the Royal Colleges in their recent reports, “Seven Day Consultant Present Care” December 2012 and “Future Hospital: Caring for Medical Patients” September 2013.

‘Who will care?’

Five high-impact solutions to prevent a future crisis in health and social care in Essex

An independent Commission led by Sir Thomas Hughes-Hallett with Dr Paul Probert

How did you find the solutions?

We agreed from the start a clear approach to ensuring we achieve good answers. The Commission's report is based on eight underlying principles:

1. We base all our recommendations on extensive evidence collected throughout Essex and from talking to others in Britain and internationally who have collected evidence to address similar challenges in other places.
2. We place the interests of the people of Essex above the organisations that serve us.
3. We are frank, bold, and honest in our recommendations.
4. We believe that individuals must take responsibility for their own health care and from an early age.
5. We push back against entrenched interest and conflicts and are prepared to recommend adjustments to traditional working practices and use of buildings.
6. We embrace the benefits of modern technology as has happened in all other walks of life but not always in care.
7. We recommend that all are incentivised in ways that complement each other.
8. We welcome all who can contribute to success from pharmacists to schoolchildren.

By 'Essex' we mean the parts of the county covered by Essex County Council, Southend-on-Sea Borough Council and Thurrock Council.

What is this about?

In January 2013, five independent Commissioners began the task of tackling the single largest challenge faced by the people of Essex since the 1960s – how will we care for ourselves and our communities right now and in the future?

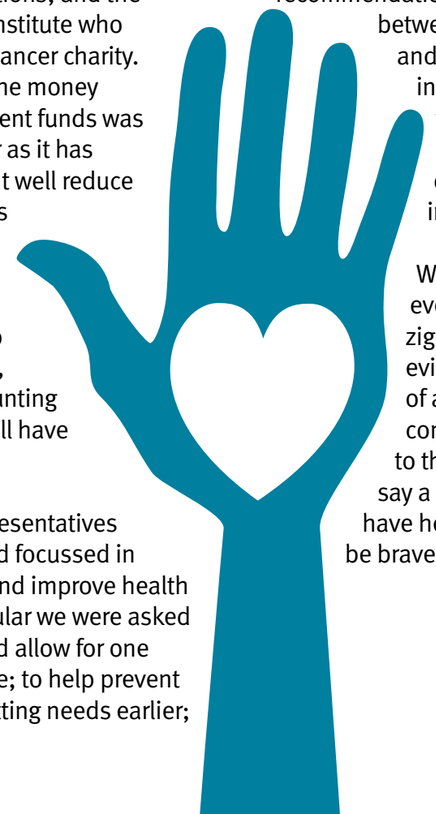
Who will care for us, the people of Essex, when we need support? Our population is getting older, larger in number, and an ageing population has greater and more complex care needs. New government reforms have destabilised and disintegrated further an already complex system of care.

The five of us are a hospital chairman; the chairman of Essex's main community charity; the chief executive of a disability charity; a GP and chairman of one of our new health organisations; and the chairman of an academic health institute who was formerly chief executive of a cancer charity. We recognised immediately that the money available from taxes and government funds was no longer going to grow every year as it has done for the last twenty, and might well reduce just as the need in Essex increases further. In particular we have real concerns about the current political protection of health budgets, which has contributed to cuts in crucial social care budgets, and the likely impact that cost shunting between health and social care will have on citizens.

Our instructions from elected representatives were to be unfettered, creative and focussed in considering how we can sustain and improve health and social care in Essex. In particular we were asked to create the conditions that would allow for one system of care from cradle to grave; to help prevent people needing crisis care by spotting needs earlier; and finally, to understand how all of us in Essex can look out for ourselves and help to support those who need our help most.

We set about this challenge with great enthusiasm and a belief that we would find five high-impact solutions to this very difficult question. We have done that. We believe that each of the five high-impact solutions is practical, and together, if properly carried out, each of you will receive good care when you need it. We have also identified two problems that require urgent further investigation.

There is no option but to take action as otherwise, within the very near future, there will be a real crisis in care for you and your family. Our recommendations set out a new relationship between us as citizens and the state, and explain what needs to happen in order for this relationship to work. It is clear to us that the ability to take more control over our care really is the only game in town.



We have been welcomed everywhere we have visited. We zigzagged across Essex taking evidence from hundreds of people of all ages in libraries, hospitals, community centres, from the young to the most frail. We would like to say a big thank you to all of you who have helped us and encouraged us to be brave, innovative and realistic.

What is this about?

You recognise that there is a shortage of money and you are ready to take on a new responsibility for your healthcare, embrace modern technology, and share your own data for your own good. But you have also said that the NHS, social care, charities and other organisations will have to be bolder, better co-ordinated, easier to access, more convenient, and more flexible with their workforce, if they are to remain supportive of the people of Essex.

You have encouraged us to recommend that if financial resources are constrained that they be targeted to those most in need rather than to 'marginal' benefits such as free spectacles for some. You told us that waste is still common (not least with prescriptions) and services not convenient for you as customers. Many of you now use Google and pharmacists for healthcare advice. You told us that they are available when it is convenient for you, not for them. You wanted pharmacists to receive additional money, while you felt GPs had adequate funding and the wrong incentives.

You want more of the taxpayers' money invested in community services and adult social care and less in hospitals.

You want to know whether we are investing well the significant funding committed to people with learning disabilities.

Many of you have expressed a desire to see stronger, safer, and more supportive communities. This Commission suggests how Essex can embrace a new social movement harnessing the desires that have been expressed to us.

There is much for you to be proud of. We identified so many good examples of great care in Essex, of exciting new innovations, and of communities working together to support each other – but all too often these were in isolated pockets and with little evidence of good practice being shared. But there are encouraging developments taking place including the creation of the Essex Partnership Board to deliver public service reform and an accelerating initiative for collaboration amongst voluntary sector leaders.

As Commissioners, we want to build on the best and the hard work that has already been done by many. No more change for change's sake. We know that Essex is best-placed to be the shining example of care; success will need courage and trust in each other. We hope this report will help Essex achieve that goal.

Sir Thomas Hughes-Hallett

Cllr John Spence, CBE

Mike Adams, OBE

Professor Sheila Salmon

Dr Gary Sweeney

'Who will care?'
Five high-impact solutions to prevent a
future crisis in health and social care in Essex

What are your five high-impact solutions?

Introduction

Our five solutions aim to achieve particular successes:

- a more effective and earlier identification of your needs including support for you to self-identify;
- seamless care and support for all Essex people;
- giving back to you the ownership of your health and care and reducing all of our dependence on the State; and
- value for money.

You told us that crucial to achieving these successes would be making the most of our communities as our most valuable assets. We will need to own and share information about our health and particular needs. We will need to ask the Local Authority and Health commissioners to support achievement of these successes. We need to mobilise Essex's resources to all of our benefit, in a way that is best value for tax payers and rate payers and eliminate unnecessary waste. We need to swap ideas about what works best.

> *'The state, in organising security, should not stifle incentive, opportunity, responsibility; in establishing a national minimum, it should leave room and encouragement for voluntary action by each individual to provide more than that minimum for himself and his family.'*
>
> William Beveridge, *Social Insurance and Allied Services*, 1942

> *'The level of public health corresponds to the degree to which the means and responsibility for coping with illness are distributed among the total population. This ability to cope can be enhanced but never replaced by medical intervention...That society which can reduce professional intervention to the minimum will provide the best conditions for health.'*
>
> Ivan Illich, *Medical Nemesis: The Expropriation of Health*, 1975

The five high-impact solutions

Our first solution:
Agree a new understanding between the public sector and the people of Essex.

The public sector needs to be up-front and honest with us - clarifying the extent of the 'care offer' available to us. We will need to take ultimate responsibility for our own care, becoming key members of the care team – based on the premise that individual care is owned by the people of Essex. The public sector will need to provide core quality services to us, be able to answer questions and to help and encourage us to take on this responsibility whilst guiding us to, and facilitate the provision of, additional sources of support if we need them. You told us that you want to increase your ability to live independently for longer.

To support this recommendation, we call for:

An easy to navigate Citizen's Guide to Care in Essex showing how each aspect of care can be accessed and what the core offering to the citizen comprises. This will be supported by a communication strategy, which will support the desire to create a new contract with the citizen – The "SatNav" of care in Essex.

A new publication, both in hard copy and online, championed by Healthwatch, the body which represents our interests in health and social care. This will give all of us the opportunity to share knowledge about what is best and worst in care services in Essex – The "TripAdvisor" of care in Essex.

The introduction of coaching, training and help lines to allow us to take control of our own health and that of our families. GPs and others will be given the tools to help to support us beyond our physical needs – the "driving lessons" of care in Essex.

A new approach in Essex to the support, acknowledgment, celebration, recognition and reward for informal and unpaid carers and patients who self-manage.

A revolution for the voluntary sector where it reviews, revises and regroups leading to an exciting new offering, supporting us to take ownership of our own care.

Essex to welcome new players and embrace and incentivise greater participation by corporate employers and providers so as to improve accessible, helpful, and customer-focused care services.

'Who will care?'
Five high-impact solutions to prevent a
future crisis in health and social care in Essex

The five high-impact solutions

Our second solution:
Prevent unnecessary crises in care

A new approach to change the focus of care from treating disease and chronic conditions to supporting individuals earlier – preventing crises in care, improving independent living, and creating a responsibility for all of us to identify those most in need of care and support in our communities.

The long term health of families and communities is planned together by us and by those who provide our care and support to ensure that the right care is received in the right place.

To support this recommendation, we call for:

A new record owned by, and accessible to, the individual to be created as a new right for those of us most in need of care and support to allow for advanced planning and improved support at an earlier stage.

The provision of initial intensive care and support when an individual is first identified as being in need of care and support rather than when we reach a point of crisis which in many cases could have been avoided or better planned.

Everyone needing care and support to have the right to choose a co-ordinator/wellness worker to support them in taking responsibility for their care. Communities and the voluntary sector will be encouraged to step into this role but on a new 'person-centred', non-disease based approach.

Essex to support the evolution of Long Term Conditions Centres, nurse led and staffed partly by trained volunteers.

Essex to create online communities to help those of us in need of care and support to live independently and to combat loneliness.

The five high-impact solutions

Our third solution:
Mobilise community resources

A new approach to supporting communities and people – you are Essex's most valuable assets not liabilities! This is not an excuse to make communities deliver care 'on the cheap'. Instead it is an acknowledgement that, alongside occasions when voluntarism can and should play a greater role, there will also be instances where a local approach and local understanding of grass-roots needs can deliver best care, best support, best value, and greater independence for each of us.

To support this recommendation, we call for:

Help for local schemes providing support and care on a voluntary basis – this can include some seed funding, training and information about best practice drawn from other places.

The creation of an Essex-wide organisation embracing paid staff and volunteers so that every household has a team or individual charged with identifying early signs of difficulty, combining concepts such as Health Champions, Neighbourhood Watch, Village Agents, and the current Essex Fire Prevention initiative.

The introduction of a new award scheme for the most vibrant communities in Essex.

Public agencies that commission services to agree longer-term contracts than happen now – one year for pilot projects, but three to five years for services that are proven and essential, subject to annual appraisal of performance. Equally these public agencies should be encouraged to favour consortia of providers to encourage integration of services and better value.

Employers to support staff volunteering.

'Who will care?'
Five high-impact solutions to prevent a
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The five high-impact solutions

Our fourth solution:
Use data and technology to the advantage of the people of Essex

This needs a new approach to making the most of information and technology. Given advances in recent years, it is surprising that the healthcare economy has not done more to embrace the richness of health and care data as well as technology. Organisations and individuals will welcome the benefits of using data and technology better to support independent living, self-care, and co-ordination and to give more convenient access to good advice. Only one out of more than 700 people we interviewed was unhappy with the concept of total transparency of data between professionals.

To support this recommendation, we call for:

The urgent creation of a simple 'good enough' Essex wide data strategy supported by an IT strategy that enables success and sees the individual as the ultimate owner and custodian of their own health and care record.

Borough, city, district and unitary councils and housing associations to work together to create a housing strategy using assistive technology that will enable people to live independently for longer.

A thorough telehealth and telecare trial in a meaningful population to identify and evaluate the benefits and appropriate design of the packages. This should be in an area of good internet coverage, good mobile signal coverage and with all patients consenting to open sharing of their data.

The five high-impact solutions

Our fifth solution:
Ensure clear leadership, vision and accountability

Clear leadership and accountability are the only ways to deliver better, more co-ordinated care. We recommend that implementation of our suggested solutions should be the responsibility of an Essex care partnership of commissioners and providers operating across Essex. This will bring together key partners from the public, private and voluntary sectors to procure and provide cradle to grave, co-ordinated, and convenient care for each individual. Every incentive must be aligned better to allow this to happen, with a clear vision that brings everyone together. If successful, this care partnership could take on broader responsibilities.

To support this recommendation, we call for:

A care partnership with an independent Chair, governed by the Health and Wellbeing Boards, and operating across Essex to bring together key partners from the public, private and voluntary sectors.

A new culture of collaboration through 'a single pot of money' to deliver the identified outcomes. Permission should be sought from the relevant authorities and regulators to allow for this to be successful.

The partnership to focus with urgency and courage on core areas that pose significant care challenges across Essex:

- *Bringing commissioners and providers together, from hospitals to care workers, to achieve the best care, best access, in the appropriate setting, cared for by the appropriate people and at the best value to the taxpayer;*
- *Allowing us to share our data;*
- *Identifying earlier those most in need and most likely to require care;*
- *Making the most of our communities and all our assets; and*
- *Creating a county-wide strategy to support us to take control of our own health and care and make the most of recent technologies to enhance the support provided.*

Investment in the leadership team and the building of trust between us, including working with non-executive mentors from customer-facing organisations.

The integration of provision – in other words make services less fragmented, easier to navigate, and hence better value for money. Commissioners will incentivise providers to work together rather than driving them apart through divisive tendering processes.

Whenever a new service is commissioned another should be decommissioned. Commissioners should be encouraged to identify non-core services now.

Commissioners should be supported to consider greater flexing of the workforce.

'Who will care?'
Five high-impact solutions to prevent a
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The five high-impact solutions

Two thorny problems

The Commission also wants to make two recommendations to problems that need urgent answers.

We call for root and branch reviews to be carried out where you have expressed dissatisfaction with services and concern about value for money. These services are:

1. Appropriate hospital discharge - are Essex citizens being discharged properly from hospital? And are they being discharged to the place they want to go?

2. Learning disabilities - are services for people with learning disabilities and their families optimal given the large financial investment made? We heard few if any compliments from families and service providers alike.

We believe the answers to both questions require a radical rethink by bringing together all interested parties to create new solutions. The new care partnership we propose could lead on these issues as well.

	NOW	2014	2015	2016
Understanding	Ongoing: campaign to create a new contract with the people of Essex Autumn 2013: GPs begin to make greater use of social prescriptions, helping us deal with issues beyond the physical Winter 2013: voluntary sector begins to review how it does business, grounded in the principle that our well-being is our responsibility	Spring 2014: launch the *Citizen's Guide to Care in Essex* Spring 2014: extension of coaching, training and helplines to support self-management By mid 2014: introduce a scheme supporting and celebrating carers and those who self-manage By end of 2014: health TripAdvisor Essex launched by Healthwatch Essex	Government changes tax policy to no longer penalise those who save for their disabled children's future	
Prevention	Autumn 2013: begin identifying the 20 per cent of Essex residents most in need of care and support Winter 2013: ensure intensive initial support is in place for those considered most in need of care and support Winter 2013: promotion of online communities to help those in need	Commissioning of new services for those most in need of care and support underway Spring 2014: first nurse-led and volunteer- supported Long Term Conditions Centre opens Spring 2014: introduce a care record owned by Essex residents not public agencies and designed to allow for advanced planning and improved support	Across Essex, every person needing care and support has the choice to appoint their own co-ordinator or wellness worker	
Community	Ongoing: implement community schemes, drawing on local knowledge and appetite - bolstered where apppropriate Winter 2013: consortia of organisations encouraged to collaborate and jointly bid for services By Winter 2013: large employers commit to promoting volunteering and community activity to their staff	Spring 2014: move toward 3-5 year contracts for services commissioned by public agencies Spring 2014: Create village/ town/community groups to care for groups of households End 2014: 1,000 individuals each look out for 600 households End 2014: inaugural '*vibrant communities*' awards for Essex neighbourhoods	End 2015: 1,500 individuals each look out for 600 households	
Data and Technology	In Autumn 2013: begin development of Essex-wide data strategy	Spring 2014: agree telehealth and telecare sites End 2014: housing strategy supporting assisted technologies in place across Essex	Throughout 2015: implement and assess progress at telehealth and telecare sites whilst lobbying for improved connectivity across Essex	Patient-owned records are the default across Essex Early 2016: if appropriate, roll out telehealth and telecare across Essex
Leadership	In Autumn 2013: a Care Partnership is created, develops a common approach to care and begins work on the core health and social care challenges By Winter 2013: business leaders begin mentoring health leaders in Essex - part of the development of a trusting leadership team	January 2014: integration plans agreed Early 2014: 'permission to innovate' granted September 2014: begin measuring success Throughout 2014: integration of provision begins - an ongoing drive to make services less complicated Throughout 2014: decommissioning of non-core services alongside commissioning of new activity Throughout 2014 and ongoing: those providing services are incentivised to work better together	By January 2015: clear progress and improvement in the Care Partnership's areas of focus A culture of measurement, comparison, learning and improvement is in place April 2015: one pot of money alongside one set of outcomes By Winter 2015: a common, collaborative leadership across the Essex health economy	Cradle to grave co-ordinated and convenient care is the norm in Essex

What is the problem and how serious is it?

The problem is a simple one. More people need care and there is not enough money to go around.

> *'In the past 50 years, spending on the NHS in the United Kingdom has increased from 3.4 per cent to 8.2 per cent of gross domestic product (GDP). If the next 50 years follow the same trajectory, the United Kingdom could be spending nearly one-fifth of its entire GDP on the public provision of health and social care.'*
>
> John Appleby, *Spending on health and social care over the next 50 years. Why think long-term?*, The King's Fund, January 2013

Across Essex, publicly-funded health and social care organisations are facing budget pressures. In plain English, some organisations' budgets will reduce, for others the amount of money they have will increase but not quickly enough to meet the increased demand for services.

The money in the system needs to go further. The number of us who make use of health and care services is increasing. Why is this?

For one thing, we are living longer. More people than ever before are living well into retirement. The average baby born in Essex today can expect to live to 80 if they are a man or 83 if they are a woman. This compares to 66 and 71 for men and women born in 1948.

But averages can be misleading. Essex is already home to some 300,000 over-65s – and many people will live long beyond the *'average'*. There are around 36,000 over-85s in Essex. That number is equivalent to a large market town and the figure will more than double in the next twenty years.

We might wish for an active, healthy retirement, but for most of us, the last years of our lives – whether they fall in our fifties, sixties, seventies, eighties or beyond – will see us increasingly frail and increasingly unwell.[i] The average Essex resident in their mid-80s will have three to five illnesses when they die.

Whilst NHS health care is free, many of us pay for our own social care.[ii] Those that don't, look to local councils to provide care. This care is paid for through general taxation. Some have suggested that public spending on social care alone will need to triple over the next twenty years to keep pace with our ageing society – at precisely the same time as the number of us in work is reducing.[iii] There is little evidence to suggest that this is possible. A declining number of taxpayers are being asked to fund health and care services – it is a burden they may struggle to bear.

But this isn't just about people *growing old*. It's about people *getting older* as well. Advances in public health and in medical technology alongside improvements in baby units mean that illnesses and conditions that, as recently as the 1960s, saw babies, children and teenagers die, no longer lead to as early a death. There are men and women alive in Essex today who would not have reached adulthood even a generation ago. Improvements in battlefield medicine also mean that more young men are returning from tours of duty to garrison towns like Colchester with significant physical disabilities.

We should welcome these improvements in medicine. However it does comes at a cost – one that few Essex residents are aware of. For example, the average annual cost to the taxpayer of caring for someone with Learning Disabilities is more than £50,000. This compares to £10,000 typically spent each year on an older person receiving social care.

'Who will care?'
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What is the problem and how serious is it?

This difference is significant both in cost and in duration. An older person may receive social care for four years. A child with Down's syndrome can now be expected to live into their 60s – compared to a life expectancy of only twelve years a century ago. It is not unusual for some children with learning disabilities to receive more than £2,500,000 worth of care over the course of their life.

> *Learning Disabilities - a learning disability affects the way a person understands information and how they communicate. This means they can have difficulty:*
>
> - *understanding new or complex information;*
> - *learning new skills; and*
> - *coping independently.*
>
> *Up to 4,000 people in Essex have severe learning disabilities. This figure is increasing.*

We expect the number of us in Essex needing social care support to grow from 35,000 now to more than 137,500 by 2030. The increasing number of older people needing care, and the cost of supporting a smaller but growing number of children and adults with care needs are two difficult challenges. To these we can add the consequences of us living less healthy lives.

Although there is some frustration at public health messages - *'we've had it pushed down our throats for so long'* as one Basildon resident put it – poor personal choices will likely catch up with those of us who over-eat, drink too much, or smoke (or all three) sooner rather than later.[iv]

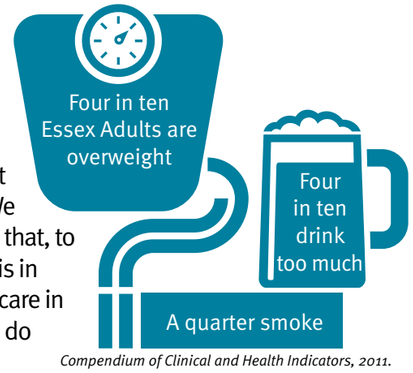
> ***Co-morbidities** – co-morbidity means having more than one long-term health problem - for example, high blood pressure and diabetes, or high blood pressure, diabetes, and heart failure.*
>
> *One disease may make another worse, and the combined effect of all the diseases may be more than each on its own.*

It is not a given that if someone is obese they will also have Type 2 diabetes and heart disease, but there are a growing number of us whose personal choices make it more likely that they will suffer from two or more diseases – diseases that are often avoidable.

More people living into old age, more people living longer and more people living unhealthily are creating a real problem for Essex.

We need to recognise that, even if public spending were to increase, it would struggle to keep pace with the scale of the challenge posed by our changing population.

We need to recognise that, even if we wanted to, we could not spend our way out of the problem. We need to recognise that, to avoid a future crisis in health and social care in Essex, we need to do things differently.



Compendium of Clinical and Health Indicators, 2011.

Almost one-fifth of 10-11 year olds in Essex are obese
(source: NHS Information Centre, 1st June 2012)

What can we all do to help?

Failing to care for yourself is, in the hard-hitting words of one Brentwood resident, a *'self-inflicted wound'*. Our health is our responsibility – or to put it another way: your health is your responsibility.

This is a straight-forward way of recognising that public agencies can play an important role in *helping* individuals to live well but they cannot *make* individuals live well. The primary responsibility for leading a healthy life rests with us as individuals. Although this transfer of control and ownership may trouble some professionals, the evidence we have taken across Essex has convinced us that the residents of Essex believe that their health is their responsibility.

> *'The person is responsible – not the government, not the local health system.'*
>
> Essex resident,
> Pitsea, June 2013

We need to think about our wellbeing and how we can live better. We should focus not on what we can't achieve, but rather on what we can. Each of us has the power to improve not only our own life but also the lives of others.

Importantly, we are not alone. We should be supported by the state, by business, by the voluntary sector, by our communities and our neighbours. Ensuring our health and wellbeing is not a task for local authorities alone, any more than it is the sole preserve of GPs, of Clinical Commissioning Groups (groups of GP practices responsible for commissioning many health and care services for patients), or of hospital trusts (bodies managing NHS hospital care and providing hospital-based services). Our health and wellbeing is best ensured by us as people, communities, and public, private and voluntary sector organisations working together across health and social care.

Those public bodies responsible for taxpayer-funded health services need to take the principle of *'our health, our responsibility'* to heart. The services they offer must meet the needs of the people, not the preconceptions of those who draft current tenders for services. The Commission is convinced that we, the people, own our health.

Employers, as a whole, need to promote not only the health and safety, but also the health and wellbeing of their staff. People spend much of their time at work, and wellness at work matters. Generally, healthy employees are more productive than unhealthy ones; their wellbeing contributes to business success.[v]

The Commission calls on organisations across the county to do whatever they can to promote the health and wellbeing of their people, convinced that there is a strong business case – and a moral imperative - for keeping employees healthy.

It is not only at work and at home, but also in our immediate neighbourhoods, that we can make a difference. We should encourage schools to create voluntary street schemes for those of us most in need of care and support in their catchment area and to provide basic health training for students.

Through the work of the Commission, we have already been able to bring about two neighbourhood pilots in Canvey Island and North East Chelmsford – grass-roots community programmes designed to make a difference on a street-by-street basis.

'Who will care?'
Five high-impact solutions to prevent a
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What can we all do to help?

Speaking to a group of Essex teenagers who were either at work or studying, we asked if they would consider helping someone in need. One, concerned about the potential long-term commitment, said *'I'd like to think I would, but I wouldn't … after getting in from work there's too much to do';* another, recognising the disproportionate value of small-scale acts of kindness, justified her willingness to help by comparing what else she might have done instead: *'half an hour a month … that's only one episode of EastEnders'*.

We all need to make choices about the extent to which we help each other, but we are convinced that if we want our local area to be better, we are the people best-placed to make the change.

> *'They, Rita and Bob, my father's neighbours, always look out, keeping a really good eye on him. We're really grateful to them … I work, I do shifts at Broomfield hospital… I can't be there all the time, knowing there is someone just over the road keeping an eye, it's a great comfort. My brother and I really appreciate what they do.'*
>
> Ann, Great Totham
> *Dave Monk Show,* BBC Essex,
> 16 July 2013

Health and Social Care - a beginners' guide

For many of us, it is difficult to understand what aspects of our wellbeing are health-related and which are social care-related. We have yet to meet any citizen who welcomed (or understood) a health and social care split. However, the system operates on two distinct models, one dealing with health, one dealing with social care, so it is helpful to understand what happens where.

Health – although many private companies provide healthcare for those willing to pay for it, for the vast majority of us, the NHS is our health service. Founded sixty-five years ago, the NHS provides a range of services from ante-natal screening (before the cradle) to end-of-life care (very nearly the grave). GP surgeries, operations, out-patients' clinics and most hospitals are all part of the health system.

Leaving aside some charges – such as prescriptions, spectacles and dentistry – we do not pay for the NHS when we use it. Instead NHS services are funded through general taxation – at a cost, in Essex, of more than £3 billion last year.

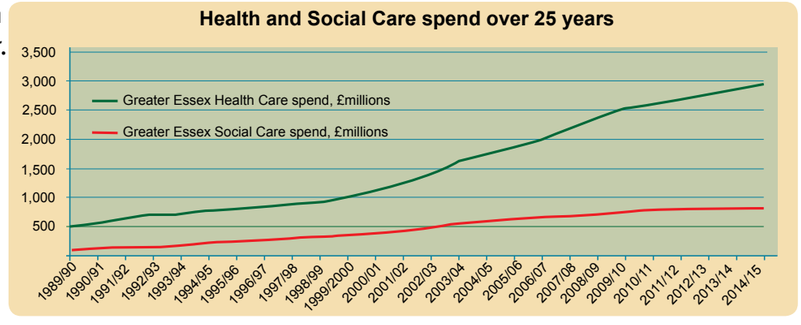
Whilst a majority of Britons view the NHS as the *'envy of the world'*, as we move further away from 1948, there is growing concern that the NHS is primarily focused on dealing with 'illness' rather than promoting 'health'.

Social Care – by contrast, there is no simple definition of social care. It covers a wide range of services - like help with washing, dressing, feeding, or assistance in going to the toilet, meals-on-wheels, day centres, and home-help for people with disabilities. Councils, charities and companies provide social care services to frail older people, to those with mental health problems, to those with physical disabilities and to those with learning disabilities.

Unlike the *'free at the point of delivery'* NHS, and unlike children's social care, adult social care is means-tested – in other words, the amount you pay for care depends on the amount of money you have, with those with savings of over £23,250 having to pay for all their care. From 2017, there will be a limit of £75,000 to the amount of money an individual will need to pay for elderly care before receiving free social care support from their council, funded by tax payers.[vi]

Although spending on social care has increased significantly over time, the number of us receiving services has reduced - the result of stricter eligibility criteria and more complex care needs.

Regardless of the sector, spending on both health and social care has increased significantly over recent years:



For the foreseeable future, public spending increases will be less pronounced. The government has committed to protect NHS spending, whilst reducing local government funding. Although not the full picture, this means that NHS budgets will increase by 4.2% between 2010/11 and 2015/16, compared to a 35% reduction in grants received by local government.[vii]

'Who will care?'
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How you would allocate public funds – creating a People's Care Budget for Essex

The background – In June, 100 Essex residents came together in Basildon and Braintree to debate the future shape of care in Essex. These residents, chosen to be representative of Essex communities as a whole, then decided how they would spend almost £3.4 billion of public money currently spent within the health and social care system in Essex.

The process – Across high-level categories – covering both health and social care services – participants were given an overview of the service provided, the associated budget, the cost per resident and the cost per recipient of service. In groups, participants then began the process of discussing and agreeing Essex's care budget. They were not asked to cut budgets, and instead focused on re-allocating money between services.

The result – There was significant agreement that a care system across Essex should focus more on community activity and preventative work than is currently the case.

GPs were viewed as increasingly unresponsive and difficult to see at times that worked for residents – by contrast, budgets for pharmacists were increased given the improved customer-focus they offered. Prescription costs were considered too high and there was surprise and frustration that cheaper generic drugs were not more widely prescribed.

Increased expenditure on public health, a range of social care services, and community health services gave residents the confidence to reduce hospital budgets (aside from maternity and A&E services) reassured that preventative services were in place.

Activity	Current spend	New spend	Difference
	£m	£m	% change per category
Public Health	64	79	23.44%
Older People Social Care	317	360	13.56%
Mental Health	261	270	3.45%
Learning Difficulties	253	253	0.00%
Physical Impairments Social Care	64	70	9.38%
GP Services	249	235	-5.62%
Prescribing Costs	266	219	-17.67%
Dentistry	94	94	0.00%
Opthalmic Services	16	19	18.75%
Pharmacies	68	85	25.00%
Maternity	79	89	12.66%
General and Acute	1,323	1,217	-8.01%
Accident and Emergency	59	66	11.86%
Community Health Services	263	321	22.05%
	3,376	3,377	

figures may not sum due to rounding

What is the detail behind your high-impact solutions?

Our first solution: Agree a new understanding between the public sector and the people of Essex

Whilst discussing health and care with the people of Essex over the last nine months, we have taken evidence from hundreds of people. They ranged in age from teenagers to nonagenarians - some were in rude health, others were living with chronic illnesses. They represented the public, professionals, practitioners, and a range of organisations, statutory and voluntary, national and local.

Whilst the people were diverse, two things united them. Firstly, although many praised the health and care system, everyone believed it could be improved. More worryingly, not one of them understood what the health and care system could and would provide.

> *'People don't have a clue. They really don't know what care and support is out there.'*
>
> Charity worker, Benfleet, May 2013

People didn't know what was available or who provided it. A Basildon resident summed up a common belief when he said *'we've all paid into the National Health Service and we expect to get something back in the later years of our lives'*. Yet if we confuse the 'free' NHS with the means-tested social care system, the financial reality of paying for our own social care can come as, at best a shock, at worse an impossibility.[viii]

If we do not make some provision for our own future care, our old age will be much bleaker than it need be.[ix] If we spend everything and leave the state, in the memorable words of one Leigh-on-Sea resident, *'to pick over the bones of my carcass'* then no-one will win: as individuals we will receive care only if we are truly frail; as taxpayers we will be faced with an ever-increasing social welfare bill.

This matters enormously. If we do not understand what is available to us, we will struggle to make the right decisions. The health and care system is too complex by far and the reality is that most of us give more thought to our new mobile phone contract than we do our health. This means that the first time we think about health is at the moment of crisis – precisely when we are least able to make effective decisions.

Luckily, all is not lost. One Essex resident who attended a session at Broomfield Hospital hit the nail on the head: *'a lot of people can make informed choices, if they have the information'*. We are more than capable of understanding our wellbeing and deciding what would work for us. We simply need the public sector to help us navigate the system.

The state needs to be clear and up-front with us about the realities of health and care. This is why we call for the production of an easy to navigate *Citizen's Guide to Care in Essex* showing how each aspect of care can be accessed and what the core offering to the citizen comprises. This will set out:

- what we can expect the state to provide for us all;
- what the state will provide for those who are in specific need;
- what other organisations can offer; and
- what we – as individuals – can do for ourselves.

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Our first solution: Agree a new understanding between the public sector and the people of Essex

To show how the idea of a *Citizen's Guide to Care in Essex* might work, we look at three areas: wound care, reablement services and end of life care.

	Wound Care	**Reablement services**	**End of Life Care**
What we mean	*Dressing of wounds, frequently for older people with co-morbidities such as dementia or diabetes – preventing potential loss of limbs or death through septicaemia*	*Service to help people get 'back on their feet' following a medical episode*	*Care and support for those who are dying*
What we can expect the state to provide for us all?	• Dressing and undressing of wounds at specific intervals – typically at a GP surgery, hospital or district nursing centre	• Nothing – service based on likelihood of benefitting from reablement, rather than a universal right	• Regular assessment of patient's needs • A coordinator for the patient to guide them through their journey, signposting patients and families to the full range of services • Social care needs of a patient after they are added to an end of life locality register
What the state will provide for those who are in specific need?	• If you are considered housebound, the service will be provided in your home - but frailty can mean greater risk of infection	• Interim service limited to maximum of six weeks – free to anyone who could benefit from reablement • Support could range from grab rail to microwave oven	
What other organisations can offer?	• Voluntary sector can provide assistance	• Voluntary sector can provide assistance	• Bereavement care • Spiritual care • Complementary therapies • Support for carers and families • Information and advice • Respite care for adults • Play therapy, and other similar interventions
What we – as individuals – can do for ourselves?	• Pay for private care at a place and time of your convenience	• Supplement the state package, by purchasing more / longer care visits • Buy general care, physiotherapy, occupational therapy, specific equipment or 'nice to haves' such as massage	• Pay for additional nursing care • Provide support and care

Our first solution: Agree a new understanding between the public sector and the people of Essex

To ensure that this understanding becomes part of the fabric of Essex life, **Essex must create a communication strategy, which will support the desire to create a new contract with the citizen.** This strategy will provide signposting advice and information about services from all sectors and highlight best practice from across the county and elsewhere. This strategy should take maximum advantage of all forms of media and be accessible to all.

The *Yellow Advertiser* for Southend, Leigh-on-Sea and Shoeburyness ran a fantastic supplement in March 2013 highlighting how people can avoid going to A&E and giving self-management, and pharmacies as possible alternatives and Southend Clinical Commissioning Group have published an excellent and comprehensive guide with the same aim.

We have been struck by the way in which you find out about your options for care. Too often guidance is given at the wrong time and in the wrong place. Deciding appropriate care when someone is at their lowest ebb can lead to the wrong care. Instead guidance should be available not only at the moment of crisis but whenever it is needed.

There is plenty of evidence to prove that self-management can work – reducing costs and improving quality of life. Professionals need to give us the tools to manage our own health. **We want to see the introduction of coaching, training, and help lines to allow us to take control of our own health and that of our families.**

This isn't fanciful. In Mexico more than one million households already pay $5 per month to access a health advice hotline before setting foot in a doctor's office. Facilitated networks like www.patientslikeme.com help patients monitor and manage their own conditions, sharing information about what works well. [x]

> **Self-management** – extensively monitored patients with chronic illnesses can learn to manage their life better and cope with their disease.
>
> Participants reported improved health, less distress, less fatigue, more energy, and fewer perceived disabilities and limitations in social activities after the training. Healthcare costs also fell.
>
> *BMJ,* 2011

As individuals we have a responsibility to care for ourselves. This is fundamental if we are serious about our health. We need to acknowledge this responsibility and do much more to make it easier to self-manage. This means **giving GPs and others the tools to help support us beyond our physical needs** (such as the social prescription scheme run by the Colchester CVS in North East Essex and the Reading Well Books on Prescription scheme run through Essex libraries). It must also mean a greater acknowledgement of the role of carers who do so much to care for friends and family but are frequently overlooked and overburdened.

Professionals can provide guidance and expertise but we, as the people of Essex own our own health and wellbeing - it is up to us, not professionals, to decide what will work for us.[xi] **Healthwatch Essex should champion a consumer 'magazine', in print, online and across other media that will give all of us the opportunity to share knowledge about what is best and worst in care services in Essex** – if

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TripAdvisor why not health TripAdvisor Essex?

The concept of patients as partners isn't a new one,[xii] but all too often the professional continues to take a medical / clinical perspective that sees us as a series of conditions to be dealt with rather than us as the primary owner of our health and wellbeing and a co-producer of our own care. Financial and demographic pressures provide added impetus for professionals to make the cultural leap from patient to person-centred care. In 2008, Lord Darzi warned that:

'If the NHS remains a primarily reactive service, simply admitting people into hospital when they are ill, it will be unable to cope with the increased demands of an ageing population. Our longer life spans require the NHS to be forward-looking, proactively identifying and mitigating health risks.' [xiii]

Five years on, this assessment is more valid than ever.

We believe there should be **a new approach in Essex to the support, acknowledgment, celebration, recognition and reward for informal and unpaid carers and patients who self-manage.** The Commission wants to see self-management and informal caring become a new social norm as we take greater responsibility for ourselves, our families and our friends.

We were surprised that efforts to take greater responsibility often ran up against unintended consequences. In Canada it is possible to take advantage of Registered Disability Savings Plans, contributions to which do not affect disability benefits and are also match funded by the federal government. In Britain, by contrast, any investment in a trust fund for a disabled child would be taxed once income exceeds £10,900. It seems peculiar that an individual can make a donation to the UK disability charity SCOPE and claim tax relief but when they set up a trust fund for their own disabled child they pay tax.

> **Registered Disability Savings Plans** - in 2008, Canada became the first country to introduce plans to provide security, independence and quality of life for a disabled person, with no loss of benefits.
>
> The plan is owned by the individual beneficiaries. Family and friends can contribute up to $200,000 over a lifetime, with earnings growing tax-free.
>
> Government adds up to $3 for every $1 privately invested. 75,000 people have accounts with a total of $1 billion in savings.

The voluntary sector could be encouraged to identify how it too can best support Essex people to take responsibility for their own healthcare – an opportunity for the voluntary sector to review, revise and regroup, leading to an exciting new offering, supporting us to take ownership of our own care. We were delighted to learn that a group of voluntary sector leaders has been formed and meets regularly - this could be the perfect forum to carry out a mapping exercise of additional services that are required to enable good 'whole-person' care to be provided for all.

We were struck by the willingness of Essex residents to consider new ways of meeting their health and care needs. Commissioners must follow suit. There was a strong support for the principles underpinning the NHS, but an equally pragmatic

Our first solution: Agree a new understanding between the public sector and the people of Essex

approach to using providers from a range of sectors – be they public, private and voluntary.[xiv] Given the demographic challenges facing us we need to use everything at our disposal to ensure health and care services are as good as they can be.

The role of the pharmacist and of Google is seen as key by many Essex people – and increasingly more accessible, helpful, and customer focused than many existing services. **Essex should welcome new players and embrace and incentivise greater participation by corporate employers and providers so as to improve accessible, helpful, and customer-focused care services.**

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Our second solution:
Prevent unnecessary crises in care

One Braintree resident summed up the reason behind this recommendation in a single sentence: *'prevention is not only better than cure, it is also more cost-effective'*. Unnecessary crises are both expensive and unpleasant. We should avoid them wherever possible.

The problem is that we spend much more dealing with acute episodes and chronic conditions (long-lasting conditions that can typically be controlled but not cured) than stopping, or at least delaying them.[xv] One Colchester charity went so far as to say that *'there is no preventative work – only crisis intervention.'* We need to change this focus from treating disease and chronic conditions to supporting individuals earlier, whilst also emphasising the responsibility for all to identify those of us in our communities who are most in need of care and support.

When we asked Essex residents to reallocate almost £3.4billion spent on health and social care in Essex last year, so as to create their own health budget, the logic of prevention was quickly understood. A greater focus on keeping people in our community and away from expensive medical settings resonates clearly with our budget makers.

Your gut instincts are supported by academic research. One example, looking at end-of-life care, demonstrated that home-based nursing can reduce hospital use at the end of life and help more people die at home.[xvi]

Long before there is a need for end-of-life care, one way to help limit health crises is to know who is likely to experience a crisis. At present, the state does not know who is most in need of care and support. Individual public agencies know their clients, but there is limited sharing of intelligence between agencies. Essex Fire and Rescue Service has told us that while they install and check smoke alarms, they are unable to know who the people are who are most likely to burn to death in their homes. The reason? A reluctance from GPs to share this information based on the belief that legislation prevents them from doing so.

We call for **a new record owned by and accessible to the individual to be created as a new right for those of us most in need of care and support to allow for advanced planning and improved support at an earlier stage.**

What price a bed? - having the right care in the right place matters enormously.

Taking evidence, there was considerable frustration from relatives who saw family kept in hospital unnecessarily.

What is more, these stays are also much more expensive than caring for someone in a more suitable setting - as these figures for weekly costs show:

- *Hospital* - ***£1,750***
- *Residential care* - ***£525***
- *Home* - ***£140***

Keeping someone in the wrong place can cost the taxpayer twelve times as much whilst reducing individual quality of life at the same time - an unwanted double whammy.

Our second solution:

Prevent unnecessary crises in care

'International best practice suggests that control by a patient is best achieved through the agreement of a personal care plan. In Germany, nearly two-thirds of people with long-term conditions have a personal care plan, whereas the same is true for only a fifth of people in this country. Care planning creates packages of care that are personal to the patient. It involves working with professionals who really understand their needs, to agree goals, the services chosen, and how and where to access them.'

High Quality Care for All, Department of Health, 2008

Access will be given to all approved professionals including fire officers, flood defence teams and police, by the individuals themselves - bureaucratic concerns about data sharing must not be allowed to stop this early identification.

Essex should make increased use of predictive models of health and care needs – we know certain factors (falls, for example) are often early indicators of future needs.

This early identification of the 20% of us most in need of care and support will require services to be commissioned to provide care to this newly mapped picture of vulnerability. What's more, it will bring about a new emphasis by **initial intensive care and support when an individual is first identified as being in need of care and support rather than when we reach a point of crisis which in many cases could have been avoided or better planned.**

The pilot scheme being conducted at Mountnessing Court in Billericay for dementia patients aims to reduce the need for going to acute hospital or reducing the stay there, and enables patients to return to their home environment and prevent premature long term care.

Everyone needing care and support shall have the right to choose a co-ordinator/wellness worker to support them in taking responsibility for their care. Communities and the voluntary sector will be encouraged to step into this role but on a new 'person-centred', non-disease based approach. The Commission thinks this could be fertile ground for a more adventurous use of focussed personal budgets.

There is a clear role for both public health and community-based services to work to keep us away from the wrong part of the care system (typically Accident and Emergency departments) and to provide better support after leaving hospital. Certainly the case for intensive care and support is as equally valid immediately after hospital discharge as it is upon initial identification as someone most in need of care and support.

There is great scope and need for a new skilled workforce to support this recommendation. Our engagement with Essex residents suggests that this is an area where the voluntary sector can have real impact but only on a co-ordinated basis.

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Our second solution:

Prevent unnecessary crises in care

Health Champions - in North East Essex, some 400 Health Champions work alongside employed Health Trainers to support local communities and individuals to make healthier choices.

Anglian Community Enterprise recruits Health Champions from the communities in which they work.

The Health Champions initiate, develop and run local projects, supporting individuals to access support and services, attend community events to promote healthy choices, and, through Youth Health Champions, volunteer in local schools.

The Commission has also been struck by the potential for schemes like the Long Term Conditions Centre under development in Castle Point. This approach would create an environment where personal responsibility, with targeted support, would seek to educate and improve both the health of patients with long-term conditions, their carers and their families.

By adopting an approach that sees health as primarily the responsibility of the individual, the Centre would be able to work with the individual to improve their wellbeing, whilst reducing the demands they would otherwise have placed on more costly acute services. We believe **Essex should support the evolution of Long Term Conditions Centres, nurse-led and staffed partly by trained volunteers**, which blends a flexed workforce and community support to prevent unnecessary crises.

Speaking to the people of Essex, we have been made aware of a paradox. By making it difficult for you to help each other, public agencies are gradually weakening our confidence, as individuals, to do the right thing and look out for each other. The result, as one Clinical Commissioning Group Chair put it, is that we *'end up a million miles from self-sufficiency'*.

Clearly, we cannot rely on the state alone to look out for our neighbours most in need of care and support. This responsibility must rest with anyone who wants to live in a compassionate society. We need a new relationship between state and citizen where we plan together the long-term health of our families and communities knowing the limits of the core offering.

We outline ways to help communities play a greater role in the next section of our report but want to emphasise the part we can all play in helping those of us most in need of care and support. We need to use whatever tools we can to look out for each other. By way of example, **Essex should create online communities to help those of us in need of care and support to live independently and to combat loneliness.**

By way of examples, Tyze and Rally Round are both personal on-line networks controlled by the patient/client, close family member or friend and all network members have to be invited to participate. A network could be built for an elderly adult who has suffered a stroke so that care providers and a large circle of family and friends can provide companionship, monitoring and system navigation. NESTA and others have demonstrated such networks can combat loneliness and offer independent living to those who might otherwise be in residential care.

Our third solution:
Mobilise community resources

Again and again across the county, the Commission heard from people wanting to return to a time when neighbours knew and helped each other.

There is a problem, though – we cannot go back to *'the good old days',* assuming they ever existed. Times have changed. So have our neighbourhoods. We need a solution that will work in 2013, not one which made sense in 1953.

Luckily, across Essex, the Commission has seen what it considers to be a possible solution - a real desire for our streets and communities to be better places to live. What's more, the people of Essex recognise where the buck stops – in the words of one Basildon resident who spoke of the need for more neighbourliness: *'it's only us, the people who live in our communities, who can do this.'*

This is fortunate because we do not have an alternative. Having set out its core care offer, the state needs to look at what happens in communities and within neighbourhoods as valuable and complementary to its own provision. Local and national government needs to be careful that it does not throttle voluntarism at birth by excessive regulation.

Little acts of kindness - working with the 'Who Will Care?' Commission, individuals have come together in Canvey Island and North East Chelmsford to make a difference in their neighbourhoods.

On a street-by-street basis they will test a new concept of neighbourhood watch - CareWatch. Their experience to date suggests that what matters isn't organisations and structure but the commitment of people within their communities to make a difference.

We have been told that the NHS is free at the point of delivery but have often mistaken this to mean that healthcare is free. It isn't. What's more, there will likely be less to go around as demand for services grows. The voluntary sector needs to pick up some of the slack. And so do we as individuals.

Formal volunteering has a role to play but we are convinced that the formality of being a 'volunteer' can get in the way of community action. As one Rochford resident put it, many local volunteers have *'never been near a volunteer bureau... they just want to help their community'*. Individuals need to cherish this independent civic pride. Public agencies need to find ways to nurture it –and with eight out of ten local associations unknown beyond their local patch, local knowledge is critical.

To support this civic pride, we want to see **a new award scheme for the most vibrant communities in Essex.** These awards should be financial to help local schemes grow and will be replicated in other communities. Healthwatch should award prizes in partnership with borough, city, district and unitary councils - Essex's (largest) employers could be encouraged to fund these awards.

'We know that loads of really good things happen in communities. And these examples show everybody - from young professionals, to gap year students to older people themselves - wants to be involved in supporting their community.

Governments by their nature must think big. But the challenge of supporting well-being through care and support is to think small, think local. It is in the small places that the greatest triumphs of social care take place.'
Norman Lamb, Health Minister, July 2013

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Employers to also support staff volunteering. We heard that Essex employees would welcome protected employment time to allow them to participate in care in their local communities. Staff from statutory services will be given protected time to work in voluntary care services and local communities – other businesses, not just large corporates but smaller businesses as well, should look to do the same.

Just because something is done by a community or by a charity doesn't mean that it is done for free. Of course, there will be some things – such as the 'little acts of kindness' currently happening through our community action pilots – that don't come at a cost, but for many other activities, funding will need to be found.

West Essex Mind's Befrienders are a dedicated team of volunteers who are an invaluable source of extra support when people's plans for recovery require that bit extra. There are currently 45 Befrienders supporting people with their person-centred plan.

Although Befrienders are volunteers and therefore this is a low cost intervention, it should be remembered that there is a cost involved in delivery. The success of projects such as this is down to having the appropriate training, policies and procedures, expenses and on-going support for the volunteers involved.

This money might not come from the state – there is much greater scope for individual and corporate philanthropy – but the Commission believes that if public agencies value a specific project or activity, they should consider funding it. What is more, this funding should be sufficient to make a difference.

The Commission believes there should be **help for local schemes providing support and care on a voluntary basis – this can include some seed funding, training and information about best practice drawn from other places.** District councillors, mayors, faith leaders, school governors and other local leaders have a critical role to play here.

The other side of the coin is that where there is no taxpayer funding, the role and influence of the state is reduced. Different places will have different approaches – politicians, professionals and public will need to be comfortable with this.

Village Agents - providing free independent information about local services, clubs and groups and a link to the support, Village Agents look to keep people safe and healthy, increase social interaction and help anyone in need. By way of example:
"Mr X has Motor Neurone disease and is unable to leave his home. He asked Chelmsford (City) Council for help with his garden, they passed it onto me. I asked Guiness Trust for help... The garden has now been tidied up. Customer happy. Whilst visiting Mr X I also found out that he is having trouble accessing his bathroon due to his lack of mobility. I have referred him to Social Care Direct to get him a seat with wheels on, to move around small spaces. He is also looking at the telecare leaflets I gave him as he is prone to falling and is unable to get up."
Source: Village Agent case study

Our third solution:
Mobilise community resources

The Commission would like to see **the creation of an Essex-wide organisation embracing paid staff and volunteers so that every household has a team or individual charged with identifying early signs of difficulty, combining concepts such as Health Champions, Neighbourhood Watch, village agents, and the current Essex Fire Prevention initiative.** This organisation would identify those most in immediate need, and help households to manage their own health and the new ownership of their care needs.

The Commission was impressed with the Village Agent model, the Health Champions in North East Essex, and the Community Builders programme and believes Essex should create a countywide scheme similar to these – trained co-ordinators who recruit and train volunteers – with a specific emphasis on improving health and care – to be the face of community action in their neighbourhoods, be they urban or rural.

Whichever organisation runs this scheme has the opportunity to become one of Essex's premier charities. It will need to work with all obvious partners, including Age UK and the Red Cross amongst others. This approach will require great courage and resolve from the voluntary sector. The Commission recommends that statutory bodies provide the core funding for the first five years. This Essex-wide scheme would be responsible for collecting data on those of us most in need of care and support.

Services need to be based on people's local needs. By looking to spend money on people not organisations, commissioners should ensure that their procurement processes support this aim and take into account social value, social capital and local knowledge. We have heard of a number of examples of poor procurement undermining commissioners' aspirations. Providers must be challenged so as to reflect the needs of their people. They must also work to secure collaboration between organisations rather than competition.

> *'Why are we still looking at this in silos? If we look at the journey of the individual - it's about time professionals stopped doing what they've been doing for years and start working for the benefit of the people who pay their salaries.'*
> Essex Resident, Braintree June 2013

A good example is the work in Worcestershire delivering early intervention service for dementia.[xvii] In 2010 the NHS Trust in partnership with Dementia UK and the Alzheimer's Society began to provide a co-ordinated service to assess, diagnose and support people identified with early signs of dementia. Partners have contributed their particular expertise to an overall package, comprising occupational therapy, psychology and memory strategies; local dementia advisers; Admiral Nurses, who provide information, practical advice and emotional support for carers; access to a range of local support services; and onward referrals to other services and to other community groups for advice.

By doing this, commissioning organisations may find themselves pushing at an open door. Our conversations with the people of Essex suggest real frustration when services aren't built around them. Those delivering services are also up for the challenge – as one third sector chief executive said: *'it is a total waste of public money that commissioners are not pulling together organisations that they commission services from.'*

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We were excited by the model being explored in Thurrock around the use of existing state-owned premises to create Community Hubs. The South Ockendon project could be a beacon for the rest of Essex and brings together all services in one building including library, children's services, voluntary services, GP cover, a crèche and 'E-citizen kiosks'.

> **Community Builders** - supporting three trial areas in Southend, Harlow and Tendring, Community Builders will work with neighbourhoods as they identify what would make a difference in their local patch. This isn't a case of 'doing to' a place, but rather an approach that looks to develop local assets, whether active community groups, individual skills and expertise, or community-owned buildings in a way that makes a sustainable difference to neighbourhoods.

Many organisations have expressed frustration with twelve-month pilots and year-long funding agreements. **Public agencies that commission services should agree longer-term contracts than happen now – one year for pilot projects, but three to five years for services that are proven and essential subject to annual appraisal of performance. Equally these public agencies should be encouraged to favour consortia of providers to encourage integration of services and better value.**

Short-term funding can prevent innovation – twelve months is seldom long enough to create, staff, run and assess something new, so why take the risk? Given that the unprecedented challenges we face call out for new thinking, this is a real problem. When a public agency resorts to stop-gap measures such as extending year-long pilots, it does nothing to help medium-term planning. If it is done too often, there is a real risk that providers will leave the market.

Our fourth solution: Use data and technology to the advantage of the people in Essex

Over the last three decades, technology has changed the way we live our lives beyond recognition. Yet it has had less of an impact on day-to-day health and care than in any other sphere. As we listened to Essex residents, we heard time and again the incredulity people felt when they could order groceries on-line and have them delivered to their house at a time that suited but then relied on the manual and sluggish transfer of pieces of paper amongst GPs, consultants, and pharmacists when something as important as their health and care was concerned.

Some definitions

Telecare uses alarms, sensors and equipment to help us live independently for longer. Examples could include a bed sensor which monitors when someone leaves their bed and raises an alarm if they don't return to bed. Telecare is particularly used for people who require social care and health services.

Telehealth helps us manage their long-term health issues. Equipment monitors vital signs - such as blood pressure, oxygen levels, and weight - and share this electronically with health professionals. This helps clinicians monitor progress and take action if necessary. It also prevents avoidable hospital admissions and reduces surgery visits.

Together they allow you to access your medical records, manage your medication, monitor simple health measurements at home and book appointments with your GP and get repeat prescriptions and all while you are at home or at work.

There is real scope to make better use of technology. This isn't science fiction. Technology that can make a real difference to our lives already exists but needs to be better understood, by users and professionals, and better supported.[xviii] If Estonia, with a population similar to that of Essex, can store citizens' health records in the digital cloud, why can't Essex citizens enjoy the same technological benefit? Basic technologies, such as alarms are used, trusted and valued (*'it really is essential'* said one participant at a session hosted by Age UK Essex) but there is a recognition that across Essex we don't make the most of technological innovations.

The Airedale telehub at Airedale hospital is staffed 24 hours a day by experienced senior nurses who provide clinical support to patients. Most of the patients using telemedicine in their own home have one or more long-term conditions and can call the hub if they have any concerns - preventing hospital admissions as well as providing reassurance to them and their families. We are not aware of an Essex equivalent.

Evidence from the dallas programme (delivering assisted living lifestyles at scale – a telecare and telehealth trial site) in Scotland suggests professionals can view technology as a threat to both their judgement and their jobs. We believe this concern is misplaced. Technology complements professional skills. What's more, the scale of the increase for the very services professions provide is growing – technology is a way to manage this pressure; without it, professionals will face a tidal wave of demand.

We know of the statistic that seven million people in the United Kingdom have not used the internet.[xix] This is a very narrow definition. Speaking to the people of Essex, we came across a handful of people who had not used or did not have direct access to, the internet, but none of these people were unable to access the web. Family, friends, and public libraries all played a role in connecting people when they needed to be connected.

There is a school of thought – typically one put forward by professionals – that holds that something should not be used because it is not universal. We disagree. Everyone may not want to use technology but it is wrong to limit its use for this reason. Its life-changing potential should not be ignored.

Housing has been a consistent concern in the background of our taking evidence. **Borough, city, district and unitary councils and housing associations should work together to create a housing strategy using assistive technology that will enable people to live independently for longer.** This is a sensible way of keeping Essex residents in their own homes. We were impressed by the excellent plans in Thurrock for the specialised housing units being developed at Derry Avenue designed to be 'care-ready' so that new and emerging technologies can be easily installed.

A bigger challenge is the infrastructure required to support telehealth, telecare, e-health and m-health. Poor broadband capacity across parts of Essex will limit the potential of much telehealth technology to make a real difference to independent living and self-care. This deficit needs to be addressed.

With time, we are hopeful that infrastructure will improve. Until then, we should continue to learn how technology can help self-management. The Commission advocates **a thorough telehealth and telecare trial in a meaningful population to identify and evaluate the benefits and appropriate design of the packages. This should be in an area of good internet coverage, good mobile signal coverage and with all patients consenting to the open sharing of their data.**

> *'There appears to be little or no sharing of information about families. This is especially true when a parent has a mental health problem.'*
>
> Family Charity, Colchester

The differences between what we want and what professionals are willing to provide is nowhere greater than the issue of data sharing. Essex people want their data shared so as to help them experience better quality care. Compare the comment from a lady in Brentwood - *'how fantastic it would be that someone could log into me ... I see that as a benefit'* – with the reluctance of professionals to share data between agencies, let alone directly with the individual.

Whether this reluctance flows from a hesitancy to let us see our records, entrenched professional interests, or a real concern about data protection is unclear. We take the same view as a former anaesthetist in Basildon who summed it up like this: *'people not wanting to share their information is a red herring ... there isn't a bother about it'*. In fact, we go further and state that individuals should be the ultimate owner and custodian of their own health record - as with their money, so their health. In the Isle of Wight data owned by the individual is now the norm.

Our fourth solution: Use data and technology to the advantage of the people in Essex

Patient-held records - by transferring the ownership of data from professionals to individuals, patient-held records are a symbolically significant shift.

Eclipse provides patient record services across the Isle of Wight. A credit card sized patient record can be shared with GP, pharmacist or anyone else the patient elects to share their information with - the information can range from the medical to the personal, from medical history to who should care for the patient's dog if the individual is taken ill. Whilst the principle of patient-owned records is important, the systems can go much further.

Patient records can be updated in real time, providing an accurate and contemporary assessment of a patient's health. More importantly still, the system can prevent harm - as the number of drugs taken increases, and the patient's health changes, potentially unintended results can occur. While GPs may not have time to review the totality of prescription medications a patient takes, Eclipse's system can.

By way of example, the system can automatically review the results from GP blood tests showing anaemia levels (stored on the patient's record) and cross-reference these results with individual prescriptions (again on the record). This can point to individuals whose iron levels are falling and who are taking aspirin - people whose condition is being worsened by the very medication they are being prescribed.

Eclipse can flag the problem and the GP can stop the problematic drugs, reducing cost by withdrawing the use of medication that is, at a minimum, ineffective and at worse dangerous, while, most importantly, improving the health of the patient.

Across the Isle of Wight, GPs have welcomed the system and the number of patients receiving inappropriate or unsafe combinations of prescriptions is falling.

This is happening elsewhere in Britain. In South London, myhealthlocker has been set up as a personal health record which includes hospital and GP records. People can choose who their information is shared with – based on the principle, summed up by one participant, that *'it really plays an important part in taking your control back which is important for making any kind of recovery.'*

To support this commitment, the Commission calls for the **urgent creation of a simple 'good enough' Essex wide data strategy supported by an IT strategy that enables success and sees the individual as the ultimate owner and custodian of their own health and care record.** There should be no barriers in the way of exchanging data in the interests of the people of Essex. A default position on the exchange of data between recognised professionals should be considered. Data transfer and the ability to interface with the customer are crucial. We encourage Essex to consider the work of Eclipse Systems and others in this field.

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Our fifth solution: Ensure clear leadership, vision and accountability

A greater role for communities and individuals is one of the two fundamental requirements if we want Essex to have a health and care system that works. The other is clear leadership, vision and accountability. Without both of these, nothing else will work.

Talking to others outside of Essex about how they improved health and care, we kept hearing about the importance of those who run parts of the health system working well together. We also heard candid criticisms of a system in Essex which *'incentivises us into a turf war'*. A senior figure in one of Essex's seven Clinical Commissioning Groups spoke of a *'commissioning system [which] has a thread of madness through it... as commissioners, we are doing as we are told ... we are doing exactly as the system tells us to, there are significant penalties if you don't'*. The over-riding perception was one of good people in an imperfect system. As one politician put it: *'I draw a line from cradle to grave: that's care ... to have two different systems, two different philosophies: that's crazy'*.

We think there is real merit in bringing together the key players in the health economy. Clear leadership and accountability are the only way to deliver better, more co-ordinated care. **A care partnership with an independent chair, governed by the Health and Wellbeing Boards, and operating across Essex should bring together key partners from the public, private and voluntary sectors** to procure and provide cradle to grave co-ordinated and convenient care for each individual. Every incentive must be aligned better to allow this to happen with a clear vision that brings everyone together. Ideally the leadership must include providers as well as commissioners and, through Healthwatch, the voice of the Essex people. Critically, you need to move at the speed of the most willing.

The Essex care partnership - a membership drawn from the key health and care organisations across the county:

- Clinical Commissioning Groups;
- NHS England;
- County and Unitary Councils;
- acute sector clinicians, for acute trusts;
- larger care providers;
- city, borough and district councils;
- Healthwatch representing residents; and
- the voluntary sector.

> *'No system trapped in the continuous throes of production, exisiting always at the margin of resources, innovates well. Leaders who want innovation to spread must ensure that they have invested people's time and energy into it.'*
>
> Don Berwick, *Escape Fire: Designs for the future of health care*, 2005

The care partnership has a critical role to play. For it to work we need to **invest in the leadership team and build trust between us, including working with non-executive mentors from customer-facing organisations.** If we need to change the way health and care happens in Essex – and we do – we need a care partnership that takes calculated risks. More importantly we, the people of Essex, local public agencies and national government, need to reward courage and accept mistakes. If we fail to do so, we will only get more of the same – and more of the same will not be good enough.

Our fifth solution:

Ensure clear leadership, vision and accountability

'It is important as innovations diffuse to harvest and then routinely and widely publicise the benefits. Successes need to be showcased and celebrated to build momentum for the on-going journey of system transformation.'

G.Parston et al., *From innovation to transformation,* Institute of Global Health Innovation, Imperial College, forthcoming 2013.

The Essex care partnership will develop a common vision of, and a co-ordinated approach to, care. This approach should be made clear to the people of Essex as well as the professionals and practitioners who work in the health system. Healthwatch must play a crucial role in the crafting of this on behalf of Essex people. Without imposing additional burdens on already hard-pressed commissioners and providers, a culture of comparison, acknowledgement, value, learning sharing and improvement should be encouraged – learning from each other to achieve more.

The Health and Wellbeing Boards will allow the Essex care partnership to co-ordinate the design, commissioning, procurement, and provision of a range of services that will address a small number of significant care challenges. **The Commission recommends the partnership to focus with urgency and courage on core areas that pose significant care challenges across Essex.** These areas of focus should support rather than replace local inputs and could include:

- **bringing commissioners and providers together, from hospitals to care workers, to achieve the best care, best access, in the appropriate setting, cared for by the appropriate people and at the best value to the taxpayer;**
- **allowing us to share our data;**
- **identifying earlier those most in need and most likely to require care;**
- **making the most of our communities and all our assets; and**
- **creating a county-wide strategy to support us to take control of our own health and care and make the most of recent technologies to enhance the support provided.**

We were struck by the unprecedented challenges all public agencies were facing. We were particularly surprised at the scale of the task facing the county's new Clinical Commissioning Groups.

We have been told many times that *'the incentives are in the wrong places'*. Improved accountability can help improve the way money and incentives flow across the system. **A new culture of collaboration through a 'single pot of money' to deliver identified outcomes** – combined with pragmatism about how to deliver will help achieve the best possible wellbeing for Essex residents, whether they are in Chigwell or Clacton, Southminster or Saffron Walden. This would help address the situation outlined by a hospice chief executive who said that *'people are too narrow-minded, too focused on their own budgets ... they are all looking at their own budgets rather than over-all value for money.'* This approach is not the norm, and **permission should be sought from the relevant authorities and regulators to allow for this to be successful.**

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Our fifth solution:

Ensure clear leadership, vision and accountability

The care partnership will look to bring together commissioners and providers. Of equal importance, it will also look to **integrate provision – in other words make services less fragmented, easier to navigate, and hence better value for money. Commissioners will incentivise providers to work together rather than driving them apart through divisive tendering processes.**

'I find it confusing that I have recorded 28 organisations which provide support for carers. This must mean overlap, duplicaton and confusion of effort.'
Carer, Chelmsford, June 2013

Those who know the system admit it is difficult to navigate; those who have to use the system are more critical still. This will require tough decisions and mean people and organisations acting in new ways.

It is clear that the face of health and care will need to change over the coming years - budget pressures and increased demand for services will see to that. The services we will use will be different, based increasingly on professionals working with people to develop individual services. The commissioners, Healthwatch and Health and Wellbeing Boards should work together to identify and decommission services the state will no longer fund. Indeed, **whenever a new service is commissioned another should be decommissioned. Commissioners should be encouraged to identify non-core services now.**

Those who buy services will need to look to joint or combined tenders, funding collaborations rather than individual organisations – for example, why not look to the twenty-eight carers' organisations to provide a single common service for carers rather than twenty-eight different services? Those who provide services will be asked to bid together and to consider the whole system – a *'service-plus'* offer – and **commissioners should be supported to consider greater flexing of the workforce.**

What happens now?

The 'Who Will Care?' Commission was asked to consider how care could be improved for the benefit of all. With the publication of this report, the Commission has fulfilled its side of the bargain. As five Commissioners, we cannot deliver the change Essex needs. That responsibility rests with the people of Essex, with public agencies and health professionals, with business, and with you. We look forward to watching your success in the years that follow this Commission's publication.

'Who will care?'
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future crisis in health and social care in Essex

Who are you?

Sir Thomas Hughes-Hallett is our Chairman. Tom was Chief Executive of Marie Curie for twelve years until taking on this Commission. He is now Chair of the Institute of Global Health Innovation at Imperial College, London. Tom lives in East Anglia and his son was a surgeon at Broomfield Hospital. This is the third Commission he has chaired.

John Spence CBE is Tom's Vice Chair. John worked for Lloyds Banking Group for twenty-two years and has also chaired a range of charities, including Action for Blind People, Vitalise, and Blind In Business. A resident of Chelmsford, he was elected to Essex County Council in May 2013.

Mike Adams OBE is Chair of Healthwatch Essex and Chief Executive of the disability charity ecdp. He is also a non-executive director of CareTech, a private sector social care company. Mike has held a number of senior management positions at the Disability Rights Commission, the National Disability Team for higher education and Coventry University.

Professor Sheila Salmon is Chair of Mid-Essex NHS Hospital Trust. A midwife by training, Sheila has more than three decades of health and social care experience and has served as a Foundation Trust governor and a Non-Executive Director. Sheila is Emeritus Professor of Health at Anglia Ruskin University. She lives in Danbury.

Dr Gary Sweeney is a GP in Clacton and Chair of the North East Essex Clinical Commissioning Group. He has worked in Tendring for almost thirty years, twenty-six of those in his Pier Ward surgery. A former student of St Bart's in London, Gary spent eight years in hospital medicine in Anaesthetics. Gary is also deputy Chair of the Essex Health and Wellbeing Board, which brings together councils and Clinical Commissioning Groups to develop a shared understanding of our health needs.

The Commissioners were supported by a secretariat consisting of **Sara Ismay**, **Julie Leigh** and **Dr Paul Probert.**

Notes

You can read *'Who will care?' Five high-impact solutions to prevent a future crisis in health and social care in Essex* without having to read these notes. However, if you want to know more about the issues we raise and the sources we used when coming to our recommendations, you can find out more here.

[i] Office for National Statistics, *Statistical Bulletin: Health Expectancies at Birth and at Age 65 in the United Kingdom, 2008-2010*, August 2012. Available online: **http://www.ons.gov.uk/ons/dcp171778_277684.pdf**. See also Seshamani & Gray, 'A longitudinal study of the effects of age and time to death on hospital costs', Journal of Health Economics, vol. 23, (2004), pp. 217-35.

[ii] Local Government Association and ADASS, *People who pay for care: quantitative and qualitative analysis of self-funders in the social care market*, January 2011, p23. Available online at: **http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/Localmilestones/People_who_pay_for_care_-_report_12_1_11_final.pdf** Accessed July 2013.

[iii] All Party Parliamentary Group for Housing and Care for Older People, *Living Well at Home Inquiry*, (2011), p. 7. Available online at: **http://www.housinglin.org.uk/_library/Resources/Housing/Support_materials/Other_reports_and_guidance/living-well-at-home.pdf.** Accessed July 2013.

The alternative could require another £50 billion of efficiency measures needed over the next 50 years to cope with the increasing cost of health care and supporting Britain's ageing population. See Office of Budget Responsibility, Fiscal Sustainability Report, (July, 2013). Available online at: **http://cdn.budgetresponsibility.independent.gov.uk/2013-FSR_OBR_web.pdf**. Accessed July 2013.

[iv] See, for example, the reporting of recent research on childhood heart health: 'The unhealthy generation who could die before their parents Millions of British children risk heart disease by shunning vegetables and watching too much television, campaigners warn', *Daily Mail*, 12th August 2013. The original analysis is Townsend *et al*., Children and Young People Statistics 2013, British Heart Foundation Health Promotion Research Group and Department of Public Health, University of Oxford, August 2013. Available online at: **http://www.bhf.org.uk/publications/view-publication.aspx?ps=1002326** Accessed August 2013.

[v] See, for example, Department for Work and Pensions, *Working for a healthier tomorrow. Dame Carol Black's Review of the health of Britain's working age population*, March, 2008, especially chapter three. Available online at: **https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/209782/hwwb-working-for-a-healthier-tomorrow.pdf**. Accessed July 2013. Given the UK's emerging demographic profile of an ageing population, with a smaller proportion of working-age residents, the Chartered Institute of Personnel and Development's *Managing a Healthy Ageing Workforce. A National Business Imperative*, March 2012, is also relevant. Available online at: **http://www.cipd.co.uk/NR/rdonlyres/2778DBAC-B375-4CB5-B5C9-FFD866C7597A/0/5754ManagingageingworkforceWEB.pdf**. Accessed August 2013.

[vi] These figures will change in 2016/17.

[vii] Institute for Fiscal Studies, 'We shall squeeze until the pips squeak', *Post-Spending Round Briefing*, 27 June 2013. Available online at: **http://www.ifs.org.uk/budgets/sr2013/gemma_tetlow.pdf**. Accessed June 2013. Clearly local government delivers a range of services beyond social care but directly comparable national social care figures are not readily available to show changes to budgets in real terms. HM Treasury budgeting and administrative structures fodus on organisations not services – hence the clarity on the NHS budget administered from Richmond House but less certainty on the proportion of local government grant from central government which will be used to provide social care. The Local Government Association in its *Funding Outlook for Councils from 2010/11 to 2019/20: preliminary modelling*, June 2012, cites the King's Fund analysis of a £1.2 billion social care funding gap by 2014/15. Available online at: **http://www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/3626323/PUBLICATION** Accessed August 2013.

[viii] This blind spot isn't Essex-specific, see Wellings, 'Health and Social Care Funding – Public Perceptions, presentation to the King's Fund, January 2013. Available online at: **http://www.kingsfund.org.uk/sites/files/kf/dan-wellings-health-and-social-care-funding-kings-fund-jan13.pdf**. Accessed July 2013.

[ix] Government can do much more to make this easier, see the National Audit office, *Government interventions to support retirement incomes*, July 2013. Available online at: **http://www.nao.org.uk/wp-content/uploads/2013/07/10153-001-Government-Interventions-to-support-retirement-incomes-Book-ES.pdf**. Accessed August 2013.

[x] Macdonnell and Darzi, 'A key to slower health spending growth worldwide will be unlocking innovation to reduce the labor-intensity of care', *Health Affairs*, April 2013.

[xi] On this see The King's Fund, *Patients' preferences matter. Stop the silent misdiagnosis*, 2012. Available online at: **http://www.kingsfund.org.uk/search/site/publications%20patients%20preferences%20matter** Accessed July 2013.

[xii] See Holam & Lorig, 'Patients as partners in managing chronic disease', *BMJ* 2000; 320:526.

[xiii] *High Quality Care for All*, Department of Health, 2008, p. 7.

[xiv] In this respect, Essex residents' attitudes are not markedly different from those of the British public at large – see Bidgood, 'The NHS: the Envy of the World?', Civitas, March 2013.

Notes

Available online at: **http://www.civitas.org.uk/nhs/download/NHS_Envy_of_the_World.pdf**. Accessed August 2013.

[xv] For example, The King's Fund, *Transforming our health care system: ten priorities for commissioners*, revised edition, March 2013. Available online at: **http://www.kingsfund.org.uk/publications/articles/transforming-our-health-care-system-ten-priorities-commissioners** Accessed August 2013.

[xvi] Chitnis, Georghiou, Steventon & Bardsley, *The impact of the Marie Curie Nursing Service on place of death and hospital use at the end of life*, (November 2012). Available online at: **http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/121114_marie_curie_summary-final_0.pdf**. Accessed August 2013.

[xvii] Addicott, *Working together to deliver the Mandate. Strengthening partnerships between the NHS and the voluntary sector,* The King's Fund, July 2013. Available online at: **http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/working-together-to-deliver-the-mandate-jul13.pdf**. Accessed August 2013.

[xviii] See, for example, Deloitte, *Primary Care: Working Differently. Telecare and telehealth – a game changer for health and social care*, 2012. Available online at: **http://www.deloitte.com/assets/Dcom-UnitedKingdom/Local%20Assets/Documents/Industries/Life%20Sciences/uk-ls-telehealth-telecare.pdf** Accessed July 2013.

[xix] The seven million figure comes from the Office for National Statistics. For a recent example of its deployment, see 'Tenants without internet access don't care, landlord survey reveals', *Inside Housing*, 31 May 2013.

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'Who will care?'

Essex County Council

AGENDA ITEM 5C

Essex Health and Wellbeing Board	**HWB/11/14**
Date:27th March 2014	

PRIMARY CARE STRATEGY

Report by: Ian Stidston, Director of Commissioning, NHS England (Essex Area Team)

Enquiries to Ian Stidston

1. Purpose of the Report

1.1 The Essex Area Team is developing a new primary care strategy for Essex. A strategy has been produced following engagement with stakeholders across Essex. A full version of the draft strategy will be available at the end of March. The Area Team will then have a series of engagement events across Essex co-hosted with the respective CCGs. A final primary care strategy will be produced for the end of June 2014.

1.2 This report provides the HWB with some key headlines from the strategy.

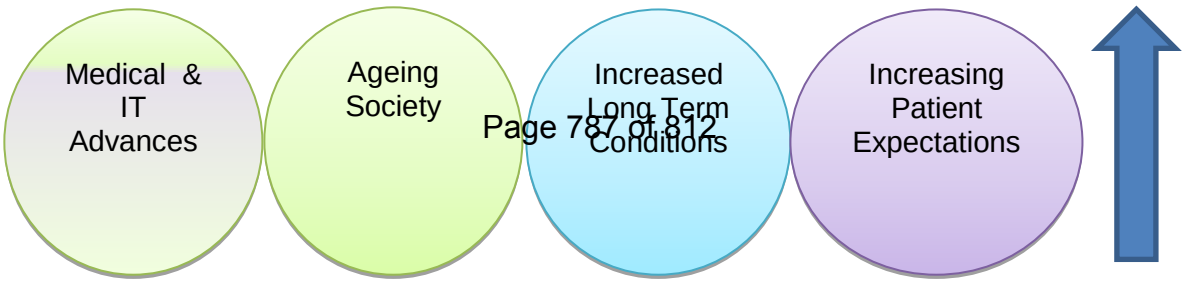
Primary care is the heart of the wider health and social care system. Our vision for primary care in Essex is that it should provide the same high quality service over seven days a week fully integrated with other services creating new models of care and pathways that patients use confidently.

2. Background

2.1 The strategy is being co-produced by NHS England and our seven CCG's.

2.2 Over the years our local GP practices as well as pharmacists, dentists and optometrists have delivered excellent care for the population.

The way in which we live our lives has changed and continues to change, effecting our healthcare needs and our expectations. The opportunities patients have to live longer and more fulfilled lives have increased along with the expectations patients have. Medical advances have meant more interventions are possible, many of which can now be provided in a primary care setting.



2.3 Following the reconfiguration of health commissioning, it is essential to begin to drive forward new models of primary care that are responsive, integrated and deliver a consistent service for patients.

NHS England recognises that a primary care strategy is needed for Essex, and within that strategy flexibility is needed for each CCG area to adapt their own strategy in line with the needs of their population.

In forming the strategy a series of engagement events were organised in October 2013 which asked a series of questions that helped inform the draft strategy. We also used this as an opportunity to link with the nationwide programme of `Call to Action' for GPs.

3. Proposals

3.1 Why is Change Needed?

The traditional model of how primary care is delivered is not sustainable going forward. This is because:

- Inconsistent quality and interventions
- Primary care services are not integrated and do not offer a seamless service for patients
- There is no new investment available but demands on health services are increasing
- The GP workforce is struggling
- The primary care estate is variable, lacks flexibility and is not being fully utilised
- The current model is not flexible enough to adapt services for the most vulnerable in our community
- The demographics of the population is changing

3.2 What will Primary Care Look Like to the Patient/Carer?

The strategy will be set from a patient's perspective about what is needed and will make a number of statements

- Make it simple for me or my family/carer to access and receive primary care services and advice.

- Help me or my family/carer's awareness of how to self-care and detect health issues early

- Support me to manage my acute or long term physical or mental condition.

- If my need is urgent, provide me with guaranteed same day access to my primary care team.

- Improve my care, experience and outcome by ensuring early senior clinical contact is given

- Wherever appropriate, manage me where I present (including at home and over the telephone).

- If it's not appropriate to treat me where I seek help from (including at home and over the telephone), direct me to a place of treatment within a safe amount of time.

- Make sure information, critical for my care, is available to all those treating me.

- Where I need wider support for my mental, physical and social needs ensure it is available and easy to access.

- I can be confident that the quality of my care is good and I am protected from harm

3.3 Our Commitments to the People of Essex

Our new model of primary care will make a commitment to deliver the following key areas:

C	Consistent

Wherever you live in Essex, you can expect to have easy access, online or in person to information, advice and support. This will be delivered through national initiatives (111) and local services.

You will know that the advice and care provided by your primary care professional is consistent with best practice.

H	High Quality

You will be seen and treated by highly trained health care professionals who are committed to delivering the best quality care to the patient

You will be treated as an individual by professionals and respected at all times

All patients should receive high quality care without unnecessary delay' NHS Constitution

R	Responsive and Accessible

The way you are able to access information and be sign posted to appropriate services will be transformed through the use of new technology and social media.

You will be able to access services over the weekends at access points not currently available.

You will be able to have access to a primary care professional within 24 hours where you feel your primary care need is urgent.

You will not have to wait more than five days for a routine appointment with a GP.
You will be able to change your GP practice easily.

You have the right to choose your GP practice, and to be accepted by that practice unless there are reasonable grounds to refuse, in which case you will be informed of those reasons' NHS constitution'.

I	Integrated

You will find that services are working seamlessly together with you to co-ordinate your care and deliver the support you need to manage your condition. Holistic care will be delivered that addresses peoples physical, mental health and social care needs together and not separately. There will be no duplication.

You will have greater involvement of the voluntary sector, community pharmacists and nurses and social care in the delivery of care for you.

The NHS commits to make the transition as smooth as possible when you are referred between services, and to put you, your family and carers at the centre of decisions that affect you or them' NHS Constitution.

S	Sustainable

You know that the primary care service you are receiving today will be dynamic and evolving but will be there for you over the next 25 years.

P	Preventative

Primary Care Professionals will act as Community Health Leaders.

You will be actively involved in the management of your own health and care.

You will receive more information on maintaining your health.

Under pinning this is the need for services to be innovative and continuously evolve and learn.

3.4 What will the new Primary Care model look like?

The new model for primary care will eventually see:

- Primary care providers working at larger scale within `primary care hubs'. These can be virtual hubs, but where it makes sense will bring together providers physically into one centre.
- Primary care hubs will be fully integrated with community services and aligned fully with social and acute.
- There will be significant shifts in acute urgent care activity as primary care is redesigned to minimise this patient need.
- Real shift in resources and activity from the acute sector into primary care will have taken place.
- Although offering a cradle to grave service, the way primary care is provided will be different for different groups of patients. For example a new way of delivering primary care to patients with long term conditions will be implemented.
- Pharmacists, dentists and optometrists become a fundamental part of the primary care team within the primary care hub.
- Primary care facilities will be fully utilised across seven days a week within a primary care hub.
- The primary care workforce will change with a greater role for nurses, community pharmacists and health care assistants. There will be new and innovative

opportunities for staff development within each hub.

- Patient voice will be strengthened within each primary care hub building on the further development of patient participation groups.

4. Releasing the Potential

4.1 Workforce

There is a need to fully utilise and develop our primary care workforce. As well as giving a strong commitment for additional training facilities within Essex for all professionals (including health care assistants), there is also a need to develop new career pathways and support for staff. The role of the prescribing pharmacist and Independent prescribing Optometrists should be developed and fully utilised, support will be needed from all professionals to ensure this happens.

A training hub for Essex is needed to drive forward a new wave of primary care workforce which is flexible and adaptable to the new models of primary care that will be developed. With this in place, Essex will become a County that people will want to come to and stay

4.2 Optometry

Optometry in Essex has for many years been active in promoting patient care in the community and has some geographical areas of excellence in service. Optometry as a profession is well equipped, well trained, geographically evenly spread and much underused to its full capacity particularly in relation to its wide skill set.

Child eye care, adults with learning disabilities and hard to reach groups need improved knowledge on how to access eye care. The elderly with failing eyesight need equal access to support with good signposting within organisations.

4.3 Dentistry

The provision of dental care has never been joined up between high street dentists, community dental services and hospital services. This will now happen with patients experiencing a seamless service. Dentists will take on a greater role in the community and deliver services closer to where patients live.

4.4 Pharmacy

The public use pharmacies as a regular source of healthcare advice, for maintaining good health and to self-treat simple conditions without needing to see their doctor or practice nurse. Pharmacies already routinely offer a range of

services including stop smoking and sexual health; these services have proven popular with the public who like the ability to access the services without an appointment.

Pharmacy services could be extended to enable greater choice for patients instead of having to attend the GP practice, for example, routine monitoring for medicines treatment, such as that required for anti-coagulant therapy

Pharmacists should become the first point of call for the public, able to triage, treat, refer or signpost as appropriate to help patients access the right service at the right time, reducing duplication of effort and pressure on GPs, out of hours services and A&E departments.

There are already pharmacy prescribers in the community, but this valuable resource is rarely used and should be developed further.

4.5 The Resident

People who become fully engaged with their own health are much better able to manage their conditions and reducing demand on services.

Obesity, children's diet, smoking cessation along with regular exercise, good nutrition and moderation reducing alcohol intake can have an effect in extending years of healthy life. It should be the aspiration of all to help bring this about.

4.6 Information

Too many times we have seen systems fail due to insufficient information being available or not being shared within health and social care. Through the correct use of information with appropriate controls patient care will improve.

The increasing information sharing technology amongst the general population should be used more effectively to share public health messages and enable patients to navigate easily though the health system utilising new methods of health professional consultations.

4.7 Technology

New technology has enormous potential to improve systems and communications. This technology must be utilised and taken advantage of.

It is likely that patient contacts conducted through a digital health environment will exceed face to face contacts in the future. Across Essex only a small percentage of practices are currently utilising their technological capability

(patients having access to records, patients booking appointment online, ability for patients to order repeat prescriptions online).

Electronic Prescription Service (EPS) is being introduced across the country. All GPs and pharmacies are encouraged to make full use of the Electronic Prescribing System which will improve services for patients. For example, patients stabilised on long term medications should find it much easier to obtain their repeat medications without having to order prescriptions from their GP.

4.8 **Changes in Medicine**

The use of shared data and consistent IT systems that can talk to each other is essential. National Institute for Health and Care Excellence (NICE) makes recommendations based on the best available evidence of the most effective care. In Essex we will use NICE guidance to revise pathways of care for patients ensuring they benefit from the most up to date expert recommendations.

5. Initial Questions for Engagement

Do stakeholders endorse the objective to bring primary care services together to form hubs which provide a superior service for patients?

How far should these hubs go?

Should clear statements about minimum standards patients can expect to receive be included in the strategy?

Do you welcome seven day working for primary care?

Do you think pharmacists, dentists and opticians could be doing more in the community? If so, what could they be doing?

Should we embrace new technologies to deliver primary care services differently?

Should the strategy state that all GP contracts should eventually (in the next five years) be held by at least two GPs in partnership to ensure stability and sustainability?

6. Diversity and Equality

The primary care strategy will have a focus on why primary care services need to change to ensure the most vulnerable in our communities have access into services

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Essex County Council

AGENDA ITEM 6

Report to Health & Wellbeing Board **Report of Dave Hill**	**Reference number** **HWB/12/14**
Date of meeting 27th March 2014 **Date of report 10th March 2014**	**County Divisions affected by the decision** All Divisions
Title of report: Implications of the Children and Families Act for Children with Special Educational Needs and Disability (SEND).	
Report by Dave Hill, Executive Director People Commissioning **Enquiries to** Barbara Herts/Tim Coulson	

1. Purpose of report

1.1. To ensure that members of the Health and Wellbeing Board are aware of the implications of the new legislation for joint commissioning of services for Children with SEND between Education, Health and Social Care.

1.2. To consider and approve the next steps in ensuring that Essex has a co-ordinated response to the new SEND legislation in Children and Families Act in time for its implementation in September 2014.

2. Recommendations

2.1. Agree the proposals of the SEND strategic Oversight Group as to how Essex is going to implement the SEND reforms
Specifically that:

- The Strategic Maternity, Children and Young People's Integrated Commissioning Group will oversee and manage the development of joint commissioning in priority areas with health, education and social care, for example, speech and language, occupational therapies as set out in the Integrated Commissioning Intentions document.

- Acknowledge the commitment required of Health partners as outlined in the NHS Mandate and NHS England operational plan, including engagement in the relevant SEND work streams to implement the bill;
    - Joint commissioning
    - Education, Health and Care (EHC) Plans
    - Personalisation
    - Local Offer

3. Background and proposal

3.1 The Children and Families Act covers a wide range of areas for SEND, including implementation of joint education, health and care assessments and plans to replace Statements of SEN and the provision of a local offer to support families, however this report concentrates on the joint commissioning aspects for children and young people with a special educational need and disability.

The Children and Families Act reforms the current Special Educational Needs provisions predominantly laid out in the Education Act (1966.) This follows a number of years scrutiny of the existing legislation which started with Select Committee reports on SEN in 2005 and 2006 and was followed by the Bercow Review into speech and language therapy (2007); the Rose Review into Dyslexia (2008); the Lamb review into Parental Confidence in the SEN System (2009) and the OFTSED review into SEN in (2010). The Government published its response to these in the Green Paper Support and Aspiration (2011), followed by pre-legislative scrutiny (2012) and then the Bill (2013) which will receive Royal Assent by March 2014 with an implementation date of September 2014.

3.2 **The legislation requires:**

- Greater focus on outcomes and achievement for children and young people with SEND;

- The Local Authority to work with health to jointly commission services to deliver integrated support for children and young people with SEN 0-25;

- Consultation with children, young people and their parents in delivering the new system;

- Cooperation with a range of local providers to deliver the new system including providers with whom relationships may not be so well established currently, for example post 16 education and training providers;

- Publication of a local offer of SEN services and provision;

- Local Authority to publish comments on the adequacy of the Local Offer and what steps it will take to improve services where complaints are made.

- Provision of a coordinated education, health and care assessment for CYP 0-25 and a new EHC Plan if required; this will replace the current system of SEN statements in schools and Learning Disability Assessments (LDAs) in further education and training;

- Offering those with EHC plans the option of a personal budget;

- Reviewing transition from children to adult services and whether to use the new power to provide children's services to over 18s to smooth transition

3.3 The Government is currently developing a new SEN Code of Practice which will act as the statutory guidance on implementing these requirements. Draft versions have been available for consultation and a final version is now awaited by spring 2014.

The draft Code of Practice also places an expectation on CCGs that a Health Officer (DHO) should be identified, whose role will be to ensure that the CCG is meeting its statutory responsibilities for SEN.

3.4 The new working arrangements across People Commissioning within the Local Authority will enable the joint commissioning arrangements to be developed with Health through the engagement of commissioners aligned to work within the CCGs and more broadly across children and adult services to provide more co-ordinated services.

CWD/SEN Strategy groups have recently amalgamated to form one reference/stakeholder Group for SEND which will enable the effective consultation on and dissemination of information related to the developments and implementation of the requirements.

A Project Oversight Group has been established, representative of all key partners from education, health and social care to drive the effective implementation of the reforms through the direction and regular monitoring and evaluation of activities undertaken by the work streams.

3.5 The Education Health and Care Planning work stream has been working on what the new approach and format will be for an Education Health and Care plan and more broadly how that might be integrated with a pre statutory stage of the

planning process in ‘One Plan’. The ‘One Plan’ is currently being trialled with 106 families. The new EHC Plan format will also be piloted with families once it has been approved. The Authority will work alongside key health partners to consider what joint arrangements are put in place in line with the statutory responsibilities to jointly commission services in respect of Education Health and Care Plans.

As part of the development of the Local Offer and SEND Strategy the authority has consulted through 4 public meetings, a web based questionnaire (with over 1000 responses) and specific meetings with parents groups on parents’ and young people’s priorities for the Local Offer and SEND provision generally. The feedback, in respect of both the Local Offer and the SEND Strategy, has been positive with both the key parents groups and independent scrutiny welcoming the proposals.

Health and the Local Authority will be expected to have implemented all the requirements of the legislation set out above by September 2014.

4. Policy context

4.1. The implementation of the SEND Reforms will support the delivery of the Health and Wellbeing Board overarching priorities in the Health and Wellbeing Strategy as determined by the JSNA in particular;

- Every child in Essex having the best start in life and being able to make life style choices and have the opportunity to enjoy a healthy life.

4.2. It also links to a number of other plans in the context of delivery and commissioning including CCG Operational Plans, Local Authority strategic Plans, Children, Young People and Families Strategic Plan and Children and Adult Safeguarding Plans.

4.3. The Children and Families Act 2014 introduces some new measures for co-operation through the Code of Practice but also builds up on a number of existing duties to co-operate.

4.4. The policy drives for a change in relationship between health, education and social care professionals to deliver better outcomes for children and young people with SEND.

4.5. The Draft Code of Practice clearly lays out the process for addressing the responsibilities to meet these enhanced requirements for co-operation.

5. Financial Implications

5.1 The Special Educational Needs Reform Grant is a new grant released in light of the bill for those children and young people with SEN, with the main purposes of the grant being:

- It will improve outcomes for children and young people with SEN
- Increase choice and control for parents
- Promote a less adversarial system

5.2 It has been announced that the Authority will receive **£1.6m** from the Special Educational Needs Reform Grant. The funding is not ring-fenced and so can therefore be spent in any way the Authority deems best meets local need.

5.3 The Authority has undertaken some initial analysis on the additional costs that extending support to young people with SEN up to the age of 25. This analysis was based on the current take up of placements and estimated that there could be additional cumulative pressures in social care of up to **£2.0m** from 2014/15 – 2016/17. There could be further pressures on health and schools budgets as well.

5.4 There is a risk of unbudgeted pressures and/or that this grant may not be sufficient to contain all the pressures that the requirements of the bill provide for. Whilst work continues to analyse the extent of pressures as a result of this legislation, it is vital that joint commissioning can ensure that integrated support is delivered as well as opportunities for efficiencies within the system are identified.

6. Legal Implications

6.1 There is a statutory duty on NHS to jointly commission services to support children with an education health and care plan. Education Health Care Plan (EHCP) replaces the current Statement of Special Educational Need and requires the agencies involved to jointly commission any services relevant to that plan.

6.2 The EHCP strengthens existing duties of co-operation between Education, Health and Social Care in the delivery of the Local Offer and the EHC Plan

6.3 The new legislation:

- Extends entitlement to that plan from 0-25 years of age and abolishes the Learning Difficulty Assessment for young adults over 16;
- Introduces new rights of appeal and mediation for services specified in that plan to Health and Social Care;
- Introduces rights to a direct payment (personal budgets) for parents and young people with an EHC plan.

7. Staffing and other resource implications

7.1. These will be determined by the work streams ensuring sufficient capacity to implement the reforms effectively.

8. Equality and Diversity implications

8.1. The new legislation has a strong crossover with the Equality Act (2010) duties where schools and other settings are required to produce Access Plans and also provide reasonable adjustments not already specified within Education, Health and Care Plans.

8.2. The requirement to produce a local offer also extends to Health and Social Care provision within an area.

8.3. These proposals should enhance access and transparency and therefore be positive in respect of Equality Act Implications. Especially with the extension of the strategic and information duties to disabled children.

9. Background papers

9.1. Children and Families Bill 2014. http://services.parliament.uk/bills/2012-13/childrenandfamilies.html
9.2. SEN Draft Code of Practice. DfE. 2013. http://www.education.gov.uk/a00221161/children-families-bill
9.3. NHS Mandate 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/256497/13-15_mandate.pdf
9.4. NHS England Operational Plan 2014-2019. http://www.england.nhs.uk/ourwork/sop/
9.5. Government Briefing to Local Authorities December 2013.
9.6. Essex SEND Strategy (2013) http://www.essex.gov.uk/Education-Schools/Schools/Special-Education-Needs/Documents/SEND_Strategy.pdf

Title of service being assessed	**ECC Special Educational Needs and Disability (SEND) Strategy 2013-18**
Directorate	**SCF**
Name and role of officer completing this assessment	**Adam Thompson (Senior Policy and Strategy Officer)**
Contact Telephone Number	**01245 430230 (20230)**
Date Assessment Completed	**05/08/13**

1. What are the aims and objectives of this service, policy or function? (e.g. what is the likely impact and the relevance?- State whether this EIA relates to an existing, to a proposed change or new service, policy or function and include whether any changes are linked to an efficiency programme)

Essex's Lifelong Learning Strategy 2013-18 was developed in order to meet two key objectives. Firstly to develop an approach to learning from cradle to grave encompassing all people across the County; and secondly to support and develop world class provision and outcomes in Essex. Essex County Council's five year strategy for young people (aged 0-25) with Special Educational Needs and Disability (SEND), the need for which was identified as a key driver within the Lifelong Learning Strategy's implementation plan.

Essex is already proud of the services provided to these young people and yet despite significant investment, is aware that more can be done to improve outcomes for young people and to ensure provision keep pace with changing needs (e.g. increasing autistic spectrum disorder needs) and legislative requirements.

The strategy's overarching vision is *"To ensure that all Children and Young People with SEND have a full range of support and opportunities available to them and are provided with opportunities to maximise their life chances, goals and aspirations"*

In order to achieve this vision the following four priorities were identified and for each the delivery approach and success criteria identified: -

- **Ensure every child with SEND can go to a good or outstanding school or education setting.**
- **Commission/deliver a range of high quality provision for all children and young people with SEND.**
- **Ensure a smooth progression to adulthood for all young people with SEND**
- **Improve the assessment and identification of SEND across agencies**

Accompanying the strategy is an implementation plan which will be reviewed and refreshed on an annual basis.

2a. Which strategic objective does this service support? Please state	**2b. Is this service provided under a statutory or discretionary duty? Please state**

'Vision for Essex 2013 -17' sets out ECC Cabinet's overarching vision and priorities for the next four years and will inform the development of a revised corporate strategy, This SEND Strategy's vision and priorities are clearly in keeping with the corporate priorities identified, these overarching ECC priorities are as follows: - **1. Increase educational achievement and enhance skills** **2. Develop and maintain the infrastructure that enables our residents to travel and our businesses to grow** **3. Support employment and entrepreneurship across our economy** **4. Improve public health and wellbeing across Essex** **5. Safeguard vulnerable people of all ages** **6. Keep our communities safe and build community resilience** **7. Respect Essex's environment** **While the SEND strategy is relevant to most of these corporate priorities the most relevant ones are underlined in the bullet list above.**	**This strategy cuts across many service areas. Many priorities within the strategy relate to statutory duties for the service however there are also some discretionary elements.**

2c Please state whether this EIA will:

- **support a business case development,**
- **provide evidence for scrutiny decisions,**
- **provide evidence to support policy, functions or service reviews and efficiency programmes**

***Note all papers for presented for scrutiny and business case development require, as a minimum, a supporting Section One EIA form. (screening)**

This EIA will provide evidence to support the development of the strategy and its associated implementation plan.

3. Describe which policies and/or guidelines control how you deliver the service and who is eligible to receive it?

The SEND Strategy applies to all Essex residents with SEND aged 0-25. It also has implications for their parents, carers and families.

A massive influence on how the strategy will be delivered is the changing legislative landscape surrounding SEND. Essex and all other Local Authorities will be required to implement the reforms laid out in the Children and Families Bill, which should achieve royal assent by the spring of 2014. A summary of the main requirements can be found below:

- **To produce a 'local offer' which details the services to support children and young people with SEND and their families in a clear and transparent way so they can understand what is available.**
- **To undertake joint assessment, planning and commissioning of services for these children between education, health and social care to ensure more streamlined and integrated support through a streamlined assessment process and single plan (EHC Plan) covering a child and young person from birth to age 25.**
- **To introduce a duty for joint commissioning to ensure joint responsibility for providing services.**
- **To provide an entitlement for parents and young people to have a personal budget to extend their choice and control over the services they receive.**
- **To ensure positive transitions at all key stages within a 0-25 age range, especially in preparing for adulthood. Providing greater powers for the LA to continue services post 18 and introducing new protections for young people aged 16-25.**
- **To extend then SEND legal obligations of maintained schools to Further Education Colleges and academies (including free schools).**

4. Now think about how you actually deliver the service, for example how do people find out about your service? How do they access or use it? Most teams have developed processes to allow them to deliver their service efficiently. Describe all processes here:

The actual delivery of the priorities contained within the SEND Strategy are detailed within a series of annual implementation plans which constantly evolve and develop the first of which will be signed off with the strategy and has been informed by an extensive consultation process. These plans outline the specific actions required to deliver the strategy and include dates and named owners. This will be subject to an annual review and refresh. The delivery of these actions will cut across a number of service areas and providers.

In the future the Local Offer will essentially provide a route map for people to find out about how to access the range of services. This will essentially be an online portal but will also include mechanisms to access this information for those who are unable to go online.

5. Could anything in the existing/ proposed policy, service or function mean that any group could be excluded or disadvantaged (albeit inadvertently)? To help you make this decision think about the governance and delivery of your service in respect of each of the equality protected characteristics (groups), list below brief notes outlining the negative impacts that the service may have on each group. Determine how detrimental these impacts are in accessing services and/or engaging with ECC. High, Medium or Low impact? E.g. High relevance may allude to Discriminatory actions such as inability to access service or undue difficulty in accessing services.

a. **Race and Culture-** Black, Asian and Minority ethnic groups including Gypsies, Roma and Travellers

Need to be careful that Travellers are not inadvertently excluded from parts of the strategy due to their transient nature. For example one delivery objective within the strategy is to 'Provide all parents and carers and service providers in Essex with information, advice and guidance to

support assessment, referral and early intervention', which can be harder to achieve when families regularly move across Local Authority Boundaries.

Travellers have limited access to the internet and low rates of literacy which will need to be taken into account when communicating. This will be considered as the Local Offer is developed.

We must also ensure that those residents who are not English speaking are not disadvantaged. For example missing out on communications that relate to the provision of advice and guidance because they are not available in a range of languages. One step we will take is ensuring that the publication of the local offer through an online portal includes the relevant mechanisms to quickly and easily translate into other languages (Google Translate).

Dealing with bullying has the potential to be an issue as this can have an impact on the ability to learn and to achieve especially for those with SEND. This will be addressed in the implementation plan under the following delivery objective 'provide SEND pupils with a positive and inclusive educational experience'

The strategy includes success measures relating to educational achievement and also post 16 transition data regarding percentages remaining in full time education or those that are NEET. It is important that the future monitoring of success continues to measure and consider race and culture disparities within the data and considers ways in which this can be remedied in future implementation plan. An action within the first implementation plan is already being used to undertake a comprehensive needs analysis for SEND which will bring such issues to the fore.

b. **Age-** including older and younger people

All priorities in the strategy relate specifically to the 0-25 age group which is in keeping with changing legislative requirements outlined within the Children and Families Bill.

c. **Sexual Orientation-** Lesbian, Gay and Bisexual People

See paragraph three under 'Race and Culture regarding bullying.

d. **Disabled people**

The entire strategy is focused on ensuring that this group is not disadvantaged or excluded.

e. **Carers**

During the drafting process the strategy has already been amended to ensure that all previous references to 'parents' are changed to 'parents, families and carers' otherwise it could exclude groups such as children in care or those raised by other relatives such as grandparents. On-going effort is required to ensure this is also reflected through the implementation plan development.

f. **Gender-** Men and Women

The strategy includes success measures relating to educational achievement and also post 16 transition data regarding percentages remaining in full time education or those that are NEET. It is important that the future monitoring of these success measures continue to consider gender disparities within the data and considers ways in which this can be remedied in future implementation plan. An action within the first implementation plan will be to undertake a comprehensive needs analysis for SEND which will bring such issues to the fore.

g **Gender reassignment** – including transgendered people

Same should apply to all groups above.

h**. Pregnancy and maternity**

Local offer will sign post to support services

i. **Marital Status and Civil Partnership**

A single parent may find it harder to provide SEND children with the support they require and may therefore need additional support – this may need to be considered as part of the development of the implementation plan.

Furthermore additional provision to improve the social side of the school experience including extracurricular activity has the potential to inadvertently discriminate against children from single parent households who may find it more difficult to attend afterschool activity. The action schools need to take to address this will need to be considered as part of their 'Local Offer' in accordance with their duties under the equalities act.

j. **Religion and Belief**

Activities to promote the social side of school life including for example afterschool clubs must be careful not to inadvertently discriminate against certain groups who may be unable to attend due to religious reasons/obligations.

k. **Addressing Socio-economic and / or health inequalities**

The strategy actually seeks to reduce inequalities in educational attainment which can have a knock on effect on health inequalities and socio-economic status. .

6. Your Service may already be meeting the needs of the equality strands in some areas. Please list, group by group, the positive actions you have already taken to address possible inequality.

ECC's SEN service delivers a broad range of services which give consideration to all equality strands. It does not feel appropriate to catalogue these individually within this document and would indeed be a massive undertaking – and possibly duplicate any EIA's relating to specific service areas (as this one relates specifically to a new strategy document).

The strategy will be delivered through 5 annual Implementation Plans, the first of which is now seeking approval from Cabinet, and has not yet been delivered. The implementation plans are to be reviewed and revised annually and it therefore seems appropriate to consider the equality strands below as part of this annual process.

a. **Race and Culture-** Black, Asian and Minority ethnic groups including Gypsies, Roma and Travellers

See comment above

b**. Age**- including older and younger people

See comment above

c. **Sexual Orientation-** Lesbian, Gay and Bisexual People

See comment above

d. **Disabled people**

See comment above

e. **Carers**

See comment above

f. **Gender-** Men and Women

See comment above

g **Gender reassignment -** including transgendered people

See comment above

h**. Pregnancy and maternity**

See comment above

i. **Marital Status and Civil Partnership**

See comment above

j. **Religion and Belief**

See comment above

k. **Addressing Socio- economic and / or health inequalities**

See comment above

Conclusion of section 1: You should now have a clear idea of why your service, policy or function is provided by Essex County Council, you should have spent some time thinking about the equality groups and how your service might impact on them, or perhaps why members of these groups are less able to make the best use of the service. Please give a summary of your conclusions and assess the EIA status as High, Medium or Low. The next stage for a High or Medium EIA is to consider the data you could use to help you to support or dispute your initial conclusions. Think about how you will collect this data and/or how you will check your presumptions by consulting with our communities.

Complete the consultation and data plans below. Identify the sorts of data you need and the questions that you need answer to. If you feel that particular organisations or community/ voluntary groups will be able to help you please list these too.

Summary – High/medium impact – Please proceed to gather further data (if necessary) and all High EIAs need to progress to a section 2 EIA.

This equality impact assessment is assessed as LOW impact and a key driver of this is that a considerable amount of consultation has already taken place which has informed changes to the strategy as detailed in the earlier sections of this form.

The development of the strategies implementation plan has paid specific attention to the issues raised in this impact assessment as it was developed.

DATA PLAN FOR MEDIUM/HIGH ADVERSE IMPACTS

What data do you want?	Where are you going to look or who are you going to ask?	What will you do with the data/answer?	Name of planned source (if known)
N/A			

CONSULTATION PLAN FOR MEDIUM/HIGH ADVERSE IMPACTS

What do you want to know?	Who are you going to ask?	What question will you ask?	What will you do with the answer?	Name of planned source (if known)
N/A				

The Next Stage - Section 2:

We need to ensure that the consultation process is managed. Please submit Section 1 of the EIA with the consultation and data plans completed. It is likely that some of the data will be available to you without the need for external consultation and /or other officers may have already sought the views of community groups. This will reduce the level of work that will be required by you to complete the final EIA stage. We also need to control our approaches to partners and community/ voluntary groups so that they are not inundated by Essex officers asking them for help and information. We will be able to co-ordinate these approaches.

The equalities team will be able to offer support and advice during the consultation process. Once the consultation stage is complete you will need to complete section 2 of the Equality Impact Assessment using your initial thoughts and the consultation information to develop an effective action plan for your service.

Completion date for consultation and data collection	**N/A**
Start date for Section two EIA- if necessary	**N/A**

Please submit this form to the equalities team: equalities@essex.gov.uk