Essex 5 year health and care plan
2014 - 2019

Document History

Version	Summary of Changes	Author	Date published
1.0	Final version for HWB and CCG Board approval	HB	4th June 2014

Signatories

Approved by	Name	Organisation	Date
		Essex County Council	
		NHS Basildon & Brentwood CCG	
		NHS Castle Point & Rochford CCG	
		NHS Mid Essex CCG	
		NHS North East Essex CCG	
		NHS West Essex CCG	

Contents

1 Introduction

1.1 Submission details

The unit of planning for this submission is the area covered by the Essex Health and Wellbeing Board (HWB). The 7 health and care organisations located within the area of the Board are responsible for completing this submission, and are listed below:

1. Essex County Council
2. NHS Basildon & Brentwood CCG
3. NHS Castle Point & Rochford CCG
4. NHS Mid Essex CCG
5. NHS North East Essex CCG
6. NHS West Essex CCG
7. NHSE

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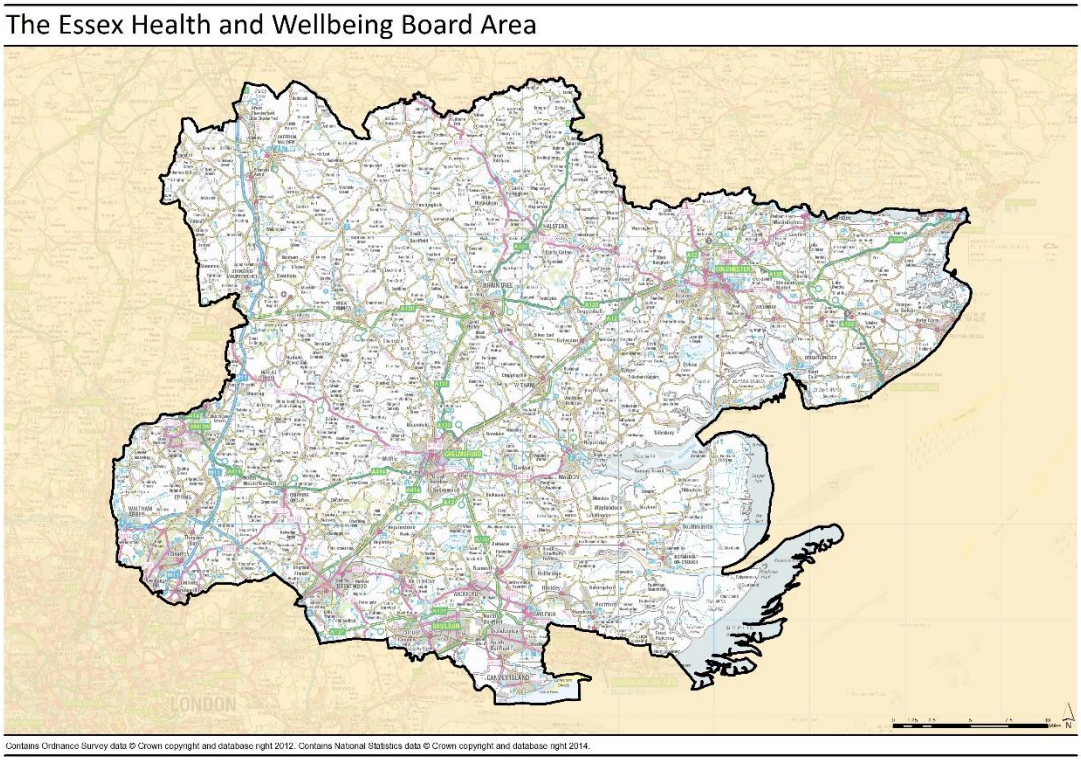
The geographical area covered by this plan is shown in figure 1, below

Figure 1, Area covered by this plan (Essex Health and Wellbeing Board boundaries)



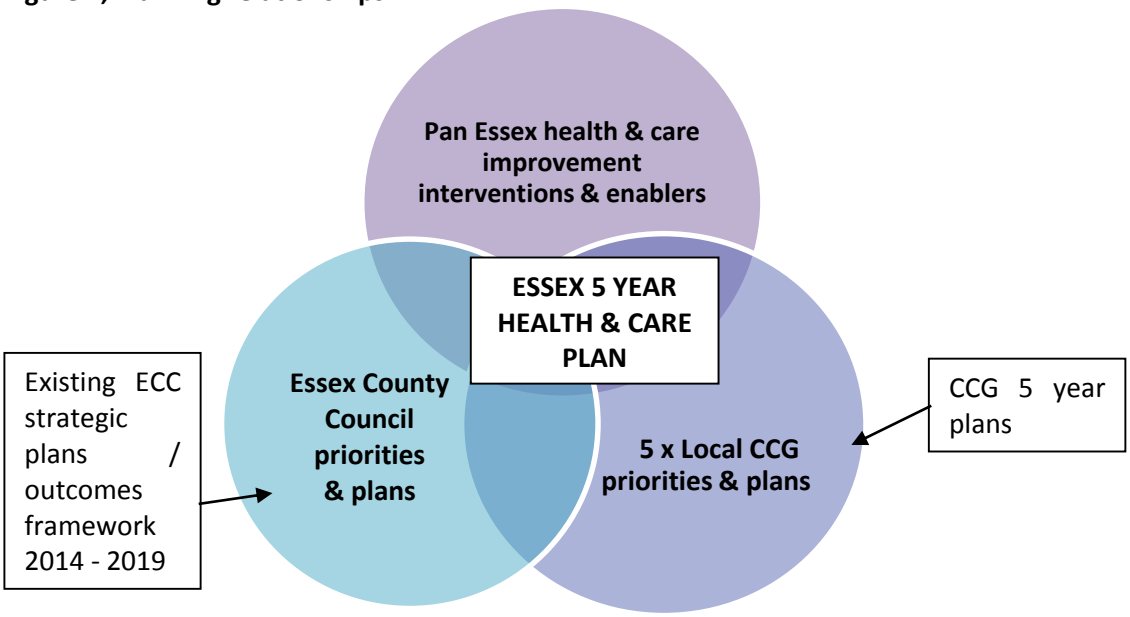
1.2 Scope of this plan and relationship to local CCG plans

This plan focuses upon pan-Essex improvement interventions and pan-Essex enablers, and also provides an overview of the financial impact of the plans of contributing organisations.

Individual CCG plans sit beneath the pan-Essex plan and include other, local priorities, together with greater detail on implementation and timescales. The CCG five year plans are not duplicated in detail here, although executive summaries are included. It is recommended that the reader also refers to individual CCG plans, to ensure that they

Figure 2, below, shows how this plan brings together relevant strategic objectives and projects from the five CCGs and Essex County Council.

Figure 2, Planning relationships



Whilst the focus of our plan is the Essex Health and Wellbeing Board (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.

Significant progress has already been made towards the integration of commissioning arrangements across the five Essex CCGs, the Southend and Thurrock CCGs, Essex County Council and the Southend and Thurrock Local Authorities. For example, Learning Disabilities and Mental Health Services are making gains in service improvement through joint commissioning and all seven Essex CCGs are collaborating on the Acute Services Review described in Chapter 5 of this plan.

NHS provider organisations including Foundation Trusts and NHS Trusts are producing their own five year plans for their individual regulators. Social enterprise such as ACE and Provide have not been formally required to produce their own 5 year plans.

Engagement between commissioners and providers throughout the 5 year planning process has been within localities and through one Essex wide event. The engagement process is described in greater detail in Chapter 4 of this document.

1.3 Why do we need an Essex wide plan?

Our shared vision for In Essex is:

'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'.

Whilst the primary unit of planning for 2014 – 2019 Five Year Plans is the CCG systems, it was agreed by Essex system partners that there were also benefits from developing an over-arching Essex wide plan to enable us to deliver our shared vision. These benefits include:

- Development of a consensus between ECC and the local NHS about the priorities and programmes of work which need to be carried out at a pan-Essex level. The key pan-Essex projects are described in chapter 5 of this document.
- Increased focus upon a number of pan-Essex enablers, for example information sharing and workforce, each of which is essential for delivery of our service development plans and major change programmes. These are described in Chapter 6.
- Agreement of the small number of key measures, which will enable senior leaders in Essex to ensure that pan-Essex plans are on track together with a governance structure to support these and a high level project plan setting out key milestones. The measures are described in Chapter 4 of this plan, and pan-Essex project plan and governance arrangements are included in Chapter 5.

1.4 What will be different this time?

As with any planning process, the process itself and the discussions surrounding it have been of as much value as the resultant plan.

This plan builds upon work completed across Essex over the past eighteen months, which includes the creation of a shared vision, joint working on a number of pan-Essex health and social care projects, including the Better Care Fund project, the shared development of innovative thinking as part of the Pioneer Bid and the gradual development of shared decision making and governance mechanisms between health and social care.

A health and social care integration Accelerated Design Event was held in June 2013, with the aim of identifying a common set of values, an integrated commissioning model, an agreed governance model for integrated commissioning and a set of enabling activities. More recently an Essex system workshop was held in May 2014 to support the development of this five year plan. The outputs from these two events are to be found throughout this document, for example in the 'plan on a page' in Chapter 2 and the enablers described in Chapter 6.

The key messages from these two events were as follows:

Leadership and relationships

- System leaders need to show courage and act with sustained initiative in order to deliver a major change programme over the next five years.
- Build relationships and trust, so that we can unlock innovation

Communications

- Make the vision and plans simple enough to communicate
- Don't assume that everybody in the system understands CCG and other plans

Co-design and public engagement

- Co-design our priorities and what can we not afford to do with the public

Ways of working

- The 100 day challenge…suspend some of the usual rules and governance
- Get an 80% plan and implement, don't wait for the 100% and never get started
- Pull together proactively the way we do in a crisis to fix our major problems
- Find a practical way of dealing with the collaboration/competition tension, don't wait for government to resolve it
- Use Health and Wellbeing Board to help broker and share plans

Professional engagement

- Engage front line staff in identifying problems and designing the solutions
- Need professional/clinical views to drive decision making as much as the organisational view

Some of these messages have been reflected in this plan, for example the importance of co-design and the creation of a simple vision are reflected in the plan on a page, whilst others have already been taken into consideration in the system wide projects described in Chapter 5 and in the enablers described in Chapter 6.

SECTION 1: ESSEX PLAN ON A PAGE [i]

The Essex health and care economy is a system comprised of partners from Essex County Council and the Basildon & Brentwood; Castle Point and Rochford; Mid Essex; North East Essex and West Essex CCGs who have come together to agree, refine and implement the following vision:
'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. '

System Objective One
Promoting independence, choice and control

System Objective Two
Improving outcomes for the same or less money

System Objective Three
A Healthy and Happy Essex – tackling variation in outcomes

System Objective Four
Safe and high quality services

Delivered through the Essex Primary Care Strategy which sets a framework for delivering primary care 'at scale' via primary care hubs, with increased 24/7 working and a greater responsibility for provision of urgent care. Funding will be transferred from the acute sector to primary care to enable these changes.

Delivered through the Essex Acute Services Review which will ensure sustainable acute service provision and less complex patient pathways through acute services provision.

Delivered through the North and South Essex mental health strategies, which propose a tiered model of care, pooled health and social care budgets and closer relationships between physical and mental health care e.g. access to psychological therapies for people with long term conditions

Delivered through the Joint Health and Wellbeing Strategy and the Public Health Outcomes Plan, which include plans to manage demand and focus on preventative work. These strategies will be enacted via commissioning plans and the Children's Partnership.

Delivered through the Model of care for older people, supported by the Better Care Fund programme which promotes a model of care supporting improved quality of life and greater independence for frail and vulnerable people. Plans include provision of community alternatives to hospital & residential care

Delivered through:
- ECC commissioning strategies, which are aligned with the Corporate Outcomes Framework. These include a strategy to ensure that Children and Young People in Essex get the best start in life
- CCG commissioning strategies, e.g. frailty.

Overseen through the following governance arrangements
- Health and Wellbeing Board
- Shared system Programme Board overseeing implementation of the major programmes of work
- Individual organisations leading on specific projects
- Internal governance at each CCG

Measured using the following success criteria
- Improved health and care outcomes
- Reduced variation in life expectancy
- Improved safety, with no provider organisation under enhanced regulatory scrutiny due to performance concerns
- Improved user and carer satisfaction with services
- Increased independence/choice
- Reduced reliance on acute sector, esp. unplanned activity

System values and principles
- Focus on prevention and early intervention
- Care pathways follow the needs of patients/service users not organisations
- Consistent communication with staff, local people and the market
- Honesty with the public about the need to reduce demand and increase self-care and self-service
- Commissioning decisions based upon evidence and effectiveness
- Integration of commissioning and provision to deliver 'joined up' care and best value for money

SECTION 2: KEY LINES OF ENQUIRY

2 Essex system vision

2.1 Our system vision

This plan is based upon our existing Essex system vision was developed by the Health and Wellbeing Board, and is as follows:

'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. '

The emphasis upon improving both health and wellbeing is common to the visions of the six organisations contributing to this plan which are summarised in the table below:

Figure 3, Visions of contributing organisations

Organisation	Vision	Source
Essex County Council	Vision: 'Where innovation brings prosperity' Supported by seven Outcome Ambitions 1. Children in Essex get the best start in life 2. People in Essex enjoy good health and wellbeing 3. People have aspirations and achieve their ambitions through education, training and lifelong-learning 4. People in Essex live in safe communities and are protected from harm 5. Sustainable economic growth for Essex communities and businesses 6. People in Essex experience a high quality and sustainable environment 7. People in Essex can live independently and exercise choice and control over their own lives	Corporate Outcomes Framework
NHS Basildon & Brentwood CCG	'A healthier population that is receiving the right care in the right place at the right time'	Individual CCG 2014 – 2019 Five year strategy and plan on a page
NHS Castle Point and Rochford CCG	'Improve the health and well-being of the Castle Point & Rochford population'	
NHS Mid Essex CCG	'Our communities working together to create innovative and sustainable local services delivering integrated first class health and social care for all'	
NHS North East Essex CCG	'Embracing better health and wellbeing for all' Empowering people to stay fit and healthy, providing safe, responsive compassionate care when they need it.	
NHS West Essex CCG	"Working in partnership commission good quality services that empower people in west Essex to lead healthy and independent lives to improve their health outcomes and reduce health inequalities."	Mission from CCG website

2.2 Our vision for citizen and carer experience

One of the system values and principles included in our plan on a page is a concern to ensure that the services we commission are designed around the citizen and their needs. The delivery projects described in this plan are intended to provide services which provide the following experience to Essex citizens and carers:

An integrated service

We would like our citizens to receive care that meets that National Voices definition of integration:
'I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me'

A more confident, informed and activated population

- Greater public confidence and knowledge in being able to recognise and manage minor illness and injury and the ability to be able to recognise symptoms of serious illness and seek medical attention from appropriate source
- Greater public responsibility for the sustainability and ownership of their local NHS
- Greater public responsibility for, and access to information and resources to support, their health and wellbeing
- Greater community resilience and resource to support community members during vulnerable times
- Easy access and signposting to all agencies able to contribute to wellbeing and maintaining independence

Clear access to services focused on needs

- Simplified and clearly signposted 24/7 immediate care services underpinned by 111, local community pharmacies and GP practices
- Continuity of care for moderate illness, health advice and disease prevention through GP surgery in local community

Joined up care for the whole person and their carers based on needs

- Models of integrated care across all pathways, supported by new models of integrated commissioning and provision
- Integrated multi-professional health and social care for people with frailty or long term conditions
- Teams of people working across the system with same objectives of supporting people to remain as fit and well, and independent as possible and at home where possible and no seams between different healthcare professionals or services from different providers or sectors
- Resources targeted at those most in need e.g. frail population through the use of risk stratification tools

Continued access to high quality specialist services

- Access to one stop assessment and treatment centres with appropriate follow on discharge care and support
- High quality specialist services which are locally provided where possible and centralised in centres of excellence where necessary

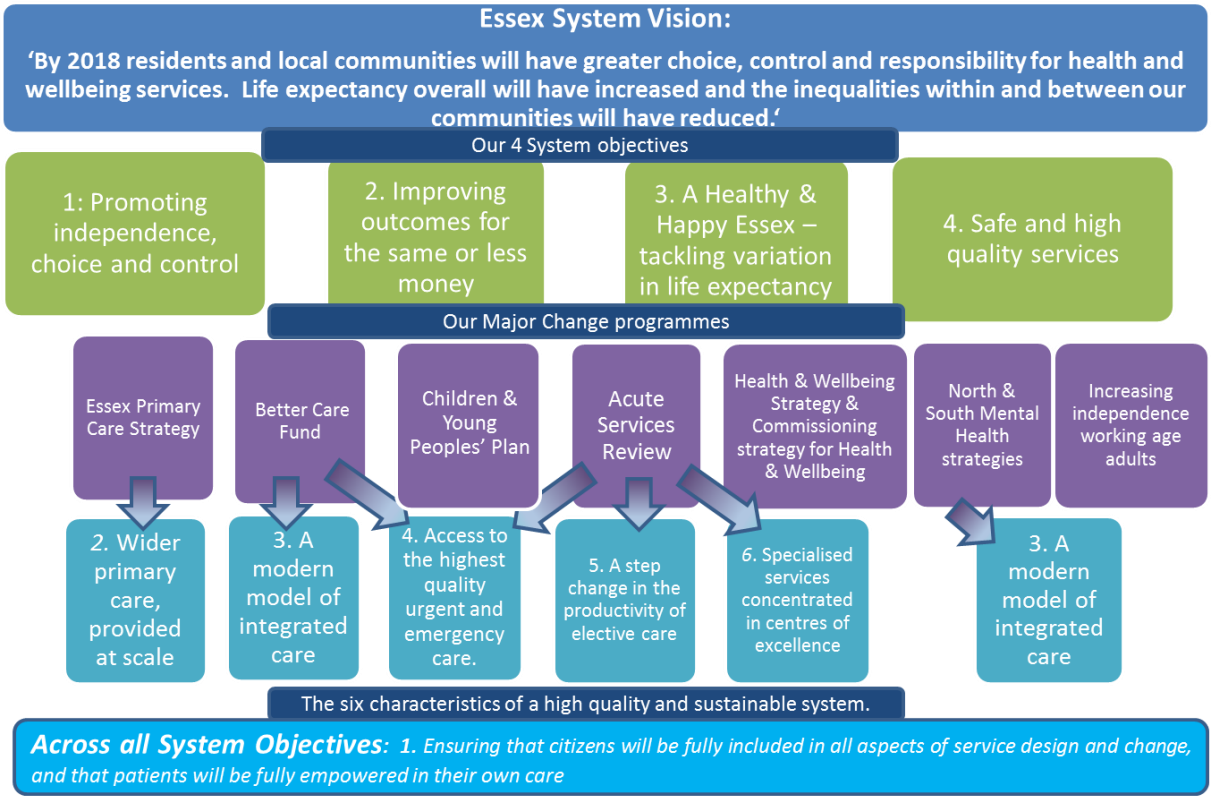
Carers

- Service planning will include carers in decision-making, and for increasing access to respite care, plus advice, practice and emotional support for carers.
- Services will be put in place to ensure that ECC meets the new responsibilities to carers arising from the Care Act
- The NHS 'Commitment to Carers' will be enacted in Essex

2.3 Our vision and the six characteristics

Our vision and four system objectives, as described above in the 'plan on a page' reflect the six characteristics of a high quality and sustainable system. The relationship between our system objectives, vision and the six characteristics is shown in figure 4, below.

Figure 4, Linkage between the Essex System Objectives, major work programmes and the six characteristics



It should be noted that some major work programmes do not directly relate to the six characteristics of a high quality and sustainable system.

3 Current position

3.1 Introduction

This chapter of the strategy begins with a description of the structure of Essex population together with some measures which show the health of the population, highlighting the similarities and points of difference across the five CCG's covered by this strategy. The ambitions of each CCG to improve health and wellbeing in response to these challenges set out in greater detail in the CCG's own five year plans.

A high level review of the resource position across Essex is also included in this chapter. This has been built up from the CCG's five year financial plans and from the Essex County Council's financial modelling. This shows that the 'unmanaged' cumulative deficit across health and social care in Essex would total £m by 2016/17, the latest period for which social care modelling is available.

The remainder of this plan sets out the planned programmes of work which will be put in place to both improver services and outcomes and to mitigate the significant financial risk within Essex.

3.2 JSNA and outcomes

3.2.1 Executive Summary

This section of the plan sets out some of the key measures included in the county and CCG level Joint Strategic Needs Assessments (JSNAs). This chapter does not repeat the detail contained in the overall Joint Strategic Needs Assessments already completed at each of County, District Council and individual CCG level, all of which are available at
http://www.essexinsight.org.uk/grouppage.aspx?groupid=19
The intention here is to highlight:

- Issues which have an impact in common across Essex, for example aging population, increased burden of chronic disease and a need to focus on small areas of deprivation masked by relative overall affluence for all CCGs.

- Areas where there is a differential impact at CCG level, for example, alcohol related hospital admissions in Harlow and Epping Forest, Adult Obesity in Castle Point and the particularly high projected rates of increasing dementia by 2030 in Braintree and Maldon

The population of Essex is close to 1.74 million (including Southend and Thurrock) with Colchester Town and Chelmsford city being the largest urban areas. The total Essex population is forecast to increase and by 2031, Essex will have to absorb an extra 324,000 residents.

The age structure of the Essex population is changing. By 2031, the older population is expected to grow to 28%, with a 15% reduction in the working age group. The number of people over 85 years in Essex will more than double, from about 31,000 to 77,000. These extra years of life will often involve poor health, dementia or disability. This will significantly increase demand for the services provided by health and social care agencies, and many of the plans described in chapter 5 of this document focus upon how best to manage this demand.

The number of people with learning disabilities may also continue to grow with further advances in medical technology. These factors will have an impact on housing needs, including specialised housing, as well as on health and social care.

A wide range of problems, from poor health to crime to low educational attainment are associated

with deprivation or low income. Deprivation even reduces the likelihood of dying of a terminal illness in one's own home rather than in hospital. Children from the lowest social class are five times more likely to die in road accidents than those from the highest. Effective targeting of action to tackle clusters of issues for deprived communities will be important.

Given its relative level of affluence all areas of Essex suffer comparatively poor educational attainment measured by the Index of Multiple Deprivation (IMD) domain and by the new Marmot measure of educational development at age 5. This represents a key challenge for partners if the children we serve are to enjoy the same relative level of affluence and health as their parents.

3.2.2 Essex population demographics

Population age structure

The aggregate population served by the Essex Clinical Commissioning Groups (excluding Southend and Thurrock) is projected to rise by 23.4% from 1.42 million people in 2013 to around 1.74 million by 2030. This compares to a projected rise of 14.6**%** for England[ii] between 2010 and 2030 and 19.5**%** for the East of England over the same 20 year period[iii]. The two areas of highest population growth by 2035 will be in Colchester District at just under 34% and Chelmsford at 29% by 2035, with lowest population growth anticipated in Castle Point District at just under 16% by 2035.

Figure 5, Essex population structure, 2011 actual and 2030 forecast

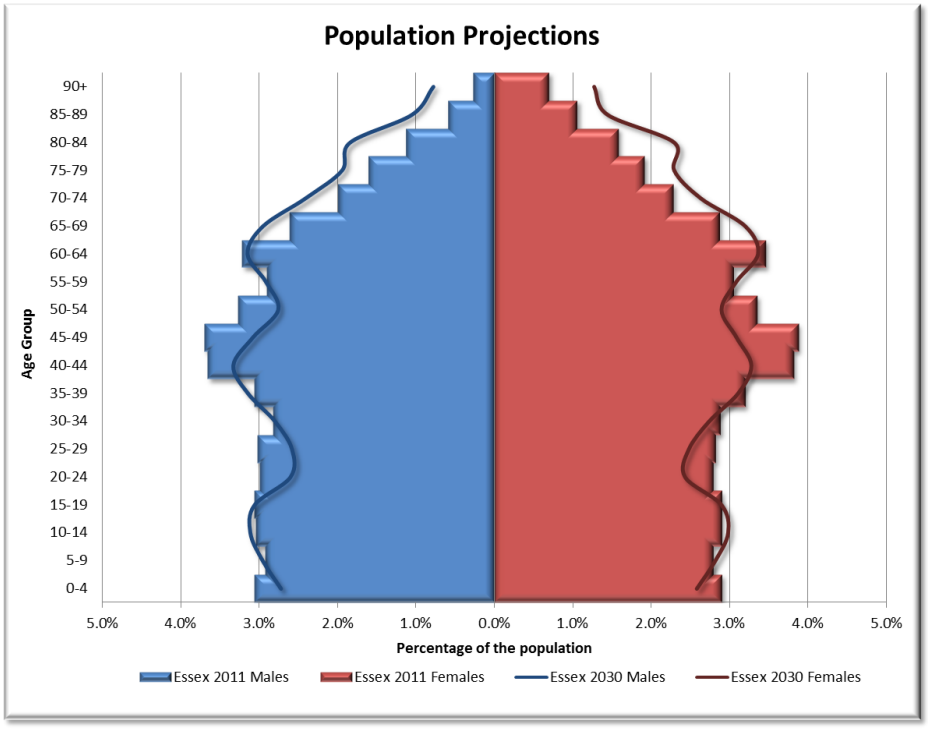


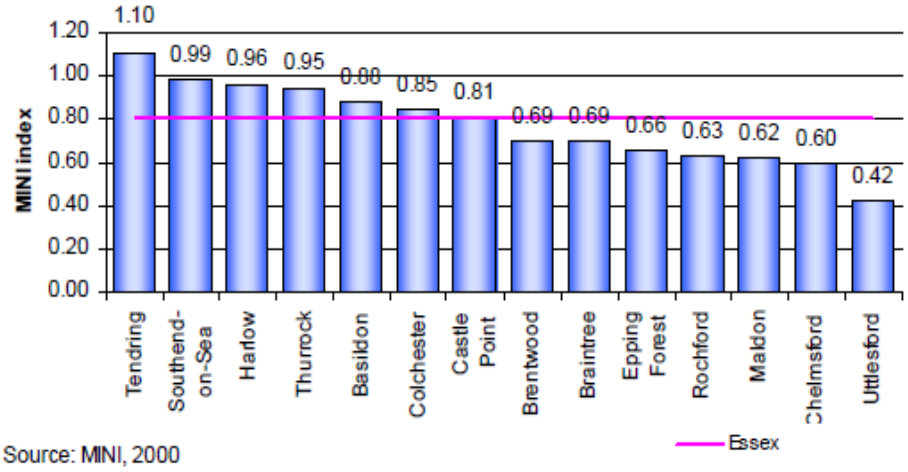
Figure 5 shows the 2011 population age structure, and the forecast structure for 2030. Over this period the working age population (assumed here to be aged 20 – 64) will reduce from 58% of the total population to 53% of the population, whilst the population aged over 65 will increase from 19% to 24%. This is a significant demographic change, which will result in increased demand for health and care services, at a time when the working age population is reducing.

Population health and care need

Over 150,000 Essex residents are expected to be living with a mental health illness, with almost 50% of them having developed this condition in their early teens. Again the range of need by CCG is

demonstrated in Figure 6 below.

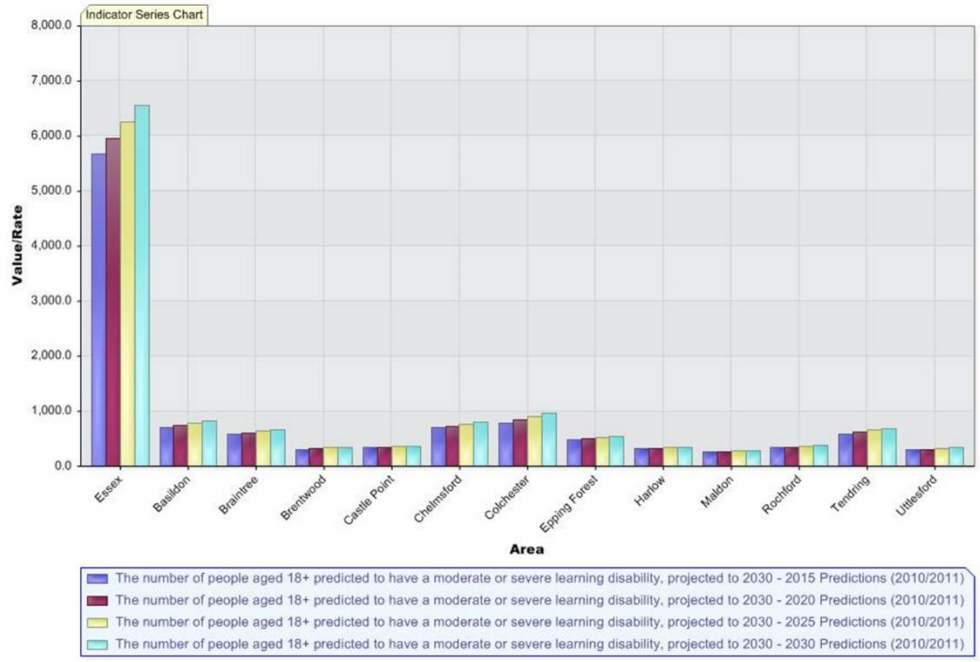
Figure 6, Relative mental health needs



The prevalence of dementia, which increases rapidly with age, is projected to increase by 38% by 2021 which will have a significant impact on public services. Again this varies over time by CCG and District. Going out to 2030 it is anticipated that dementia rates will have risen by 99% in Maldon, 99.3% in Braintree and 98.2% in Castle Point, down to a much smaller rise, although still significant, of 58.5% in Epping Forest and 46.4% in Harlow.

The number of people with learning disabilities may also continue to grow with further advances in medical technology. These factors will have an impact on housing needs, including specialised housing, as well as on health and social care. Figure 7, below sets out forecast increase in learning disabilities across Essex.

Figure 7, learning disability projection

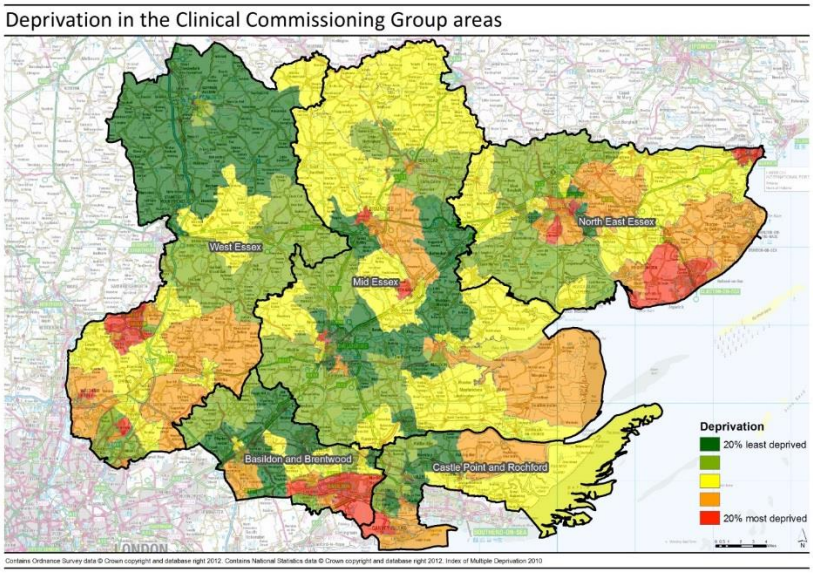


3.2.3 Deprivation and inequalities

Figure 8, shows deprivation in the Clinical Commissioning Group Areas. The map shows the following:

- Basildon and Brentwood's most deprived population lives in Basildon town with the A127 acting as a 'dividing line' between deprived and more affluent populations. The CCG also has a generally younger population compared to the rest of Essex.
- The most deprived small area (LSOA; approximately 1,500 people) in England is in North-East Essex – Jaywick in Tendring District, with the CCG also having a significant traveler community and the highest proportion of carers in Essex.
- Small but significant areas of deprivation exist on Canvey Island and north of the river Roch in Castle Point and Rochford CCG
- There are pronounced areas of deprivation within Mid Essex CCG, such as Heybridge (Maldon), Witham and Bocking (Braintree) and Patching Hall (Chelmsford).

Figure 8



Other inequalities in health status exist in Essex, including:

- Essex is less ethnically diverse than is typical for England, with only around 6% of residents from a non-white background compared to around 19% for England as a whole. Despite lower absolute numbers, some Black and Minority Ethnic communities have a greater prevalence of certain conditions, e.g. cardiovascular disease including diabetes and certain communicable diseases. Black populations are also more likely to be admitted to hospital.
- Essex has the second largest population of Gypsies and Travelers in Britain, estimated at 18,750 (including those living in houses). Gypsies and Travelers are subject to significant health inequalities including living 10-12 years less than the general population.
- Carers often experience poorer health outcomes than non-Carers. Poor health can be a direct effect of the caring role – more commonly seen in relation to mental health issues, or because of the delays that are made to seeking healthcare.
- At least 3,000 people are thought to be homeless in Essex. Homeless people die much earlier than the general population (at age 40-44 on average), particularly from causes related to alcohol and infectious disease. A survey of homeless people in Essex identified major health problems in the including mental illness (41%) and substance misuse (38%). They report an extremely high prevalence of smoking (74%) and very poor nutrition, with 46% reporting that they usually had 1 meal or less per day.

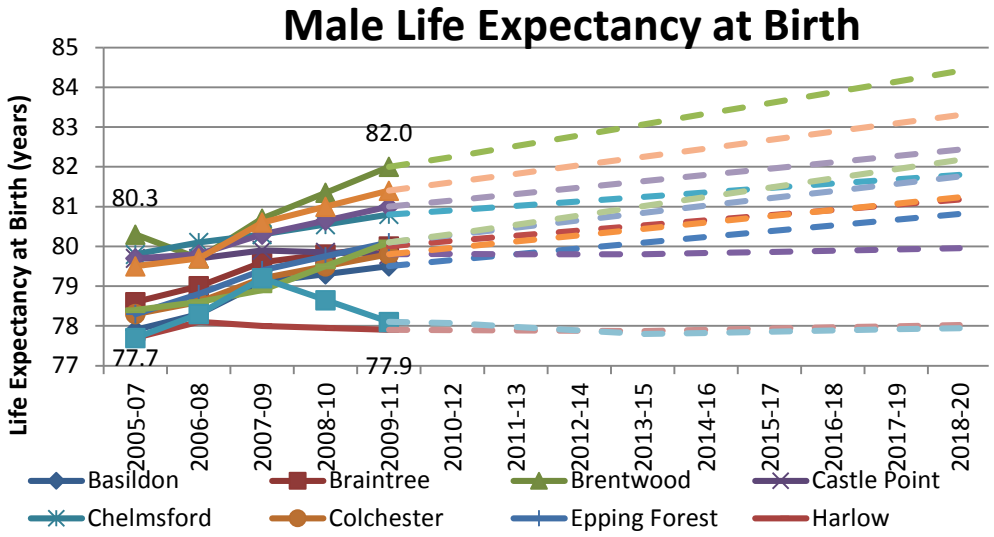
3.3.4 Life expectancy

Life expectancy is above national averages for Essex as a whole, and is close to the East of England average, but this masks significant inequalities in life expectancy both between and within CCGs, particularly for males. For example, between 2006 and 2010, the gap in life expectancy between the

least and most deprived men ranged from 4.2 years of lost life in Uttlesford District to 9.6 years in Harlow District. For women, the comparison over the same period was 0.1 year in Uttlesford and 5.9 years in Harlow.

Figure 9 below shows the projected rise in male life expectancy at district level. This shows that whilst life expectancy is increasing in the majority of districts, it is decreasing in Tendring and Harlow. Circulatory diseases are the most common cause of death, followed by cancer. Life expectancy is shaped by social and economic factors, mediated through individual behaviours.

Figure 9



Whilst life expectancy and the determinants of health is a clearly a critical issue it is not described in detail here but is instead addressed in both individual CCG plans and in the ECC Commissioning Strategy for good health and wellbeing.

3.3 High level view of resources and activity

Editor's note: A national 5 year plan financial template is now expected, however this is unlikely to be available in time for the Essex HWB publication and approval process for this document in June 2014. For discussion with Area Team at 3/6/14

3.3.1 The financial challenge in health and social care

The economic climate for Health and Adult Social Care is both challenging and uncertain. The Council has made £364 million savings over the last four years and needs to save at least a further £235 million over the next three years. To help achieve this, the Council is changing the way it supports its residents and communities to help make a lasting difference to their lives while also saving money. Essex County Council's net revenue budget for 2014/15 is £931.8m, of which £515m is spent on Adults and Children's Social Care (55%). With pressure from an increasing population amounting of £26.7m 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 and rehabilitation to reduce the need for long term care.

Over the next three years £81m of savings are currently planned to be delivered across Adults and Children's Social Care to mitigate inflation and demand pressures as follows:
2014/15 £40.5M
2015/16 £18.5M
2016/17 £22M

Health and social care will need to work closely and very differently to deliver these social care savings with health benefits and securing early intervention, enablement and rehabilitation will necessitate health and social care.

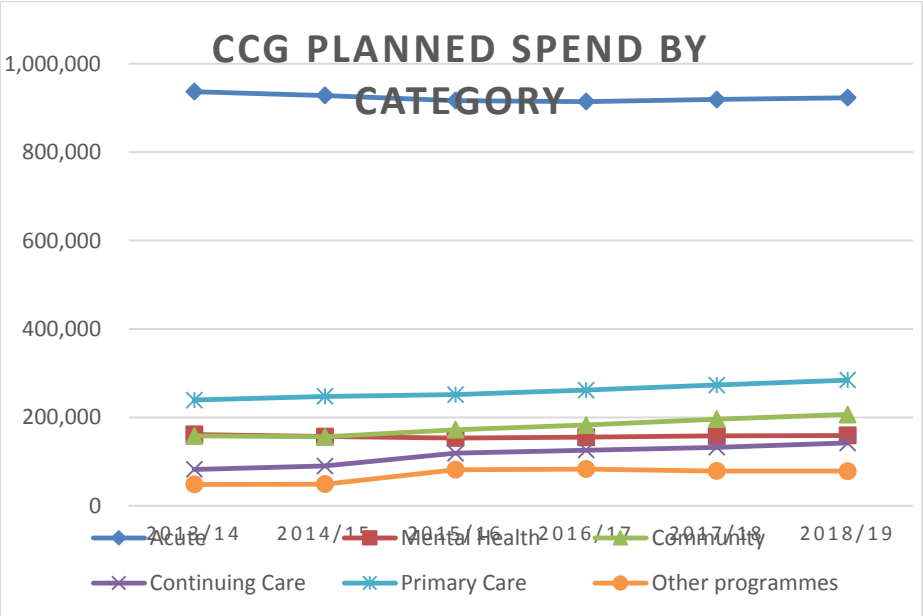
The national position on the financial challenges facing the NHS in the next five to 10 years has been well documented. They system has moved from a period of regular high growth to a period of minimal growth. This has presented significant financial challenges as it is coupled with the impact of an aging population who are living longer and so have a greater burden of disease. There is also the continuing introduction of new technologies and drugs which add to the increasing costs of healthcare.

The high level modelling undertaken nationally suggested that the NHS is facing a £15-20bn shortfall in funding which would need to be addressed in the new system. Each Essex CCG has completed modelling work using a common set of assumptions to identify the financial gap over the next 5 years. This shows a cumulative gap of £84M by 2018/19, if mitigating plans are not put in place. As part of the two year planning process completed during 2013/14, the CCGs have then developed five year financial plans which mitigate this financial position. Figures 10 and 11, below, show planned NHS spend in Essex by category.

Figure 10, Planned CCG Expenditure by category

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	%age change 2013/14-2018/19
Acute	936,790	928,113	916,266	914,099	918,786	923,025	-1.47
Mental Health	161,482	156,774	153,385	155,206	157,979	159,332	-1.33
Community	157,961	156,475	172,371	182,841	196,091	206,724	30.87
Continuing Care	82,535	90,123	119,050	125,746	132,366	142,218	72.31
Primary Care	239,365	247,471	251,616	261,783	273,241	284,393	18.81
Other programmes	48,279	49,170	81,808	83,035	78,964	78,511	62.62
Running costs	33,272	34,507	31,486	31,837	31,959	32,038	-3.71
Contingency	-2,795	12,260	12,822	13,215	13,427	13,662	
Total Expenditure	**1,656,889**	**1,674,893**	**1,738,805**	**1,767,762**	**1,802,813**	**1,839,903**	**11.05**

Figure 11, planned CCG expenditure by category



Figures 10 and 11 show that show the transfer of expenditure from acute Trusts and into primary care services and to a lesser extent community services. This change will be delivered as a result of a number of pan-Essex programmes described in chapter 5 of this plan, including the Better Care Fund and the primary care strategy. Whilst a 1.47% reduction in acute spend over a five year period may appear relatively modest, the real terms impact of this change is much higher and this should be considered to be a 'stretch target', particularly in the light of historical spending patterns on acute services. The programmes of work described in chapter 5 of this plan include work to reduce demand for acute services, in particular as part of the Better Care Fund Programme.

Expenditure on mental health care is reducing by a total of 1.33% during this period, and this might also be regarded as something of a stretch target, given the recent emphasis upon parity of esteem. This change will be delivered through the implementation of the North and South Mental Health Strategies described in Chapter 5 of this strategy.

Significant additional investment (72% increase) in continuing care has been planned over the duration of this strategy. This is in response to the increasing demand associated with an aging population and increased burden of long term conditions described in Chapter 3, above and is also reflective of the level of risk around continuing care pressures.

4 Improving quality and outcomes

Delivery of the four system objectives described in the Essex 'plan on a page' can be evaluated using a range of existing metrics, based upon national and local outcomes. These are summarised below.

Figure 12, Proposed five year local outcome ambitions for Essex 5 year health and care plan

System Objective 1: Promoting independence, choice and control 1. Reduction in permanent admissions of older people (aged 65+) to residential and care homes, per 100,000 population 2. 84% or more of older people still at home 91 days after discharge from hospital into reablement 3. Phased reductions in Delayed Transfers of Care from Hospital per 100,000 population 4. Current levels of avoidable emergency admissions retained (during a period of population growth) 5. Improved coverage of reablement 6. Reduction in the number of people who receive social care support	**System Objective 2: Improving outcomes for the same or less money** 7. Health-related quality of life for people with long term conditions 8. Proportion of people who use social care services who report having control over their daily life 9. Carer-reported quality of life 10. Improving outcomes from planned treatments
System Objective 3: A Healthy and Happy Essex – tackling variations in outcomes 11. Reducing premature mortality from the major causes of death (U 75 mortality from cardiovascular; respiratory and liver disease and from cancer) 12. Excess under 75 mortality in adults with serious mental illness 13. Low birth weight of term babies 14. Self-reported wellbeing 15. Health-related quality of life for older people	**System Objective 4: Safe and high quality services** 16. **Health:** Upper quartile scores in National Patient Satisfaction survey and Friends and Family Test 17. **Social Care:** Overall satisfaction of people who use services with their care and support **18. Social Care:** Overall satisfaction of carers with social services (from Adult Social Care Outcomes Framework) 19. CQC inspection outcomes (health and care?) 20. All Essex acute Trusts have Summary Hospital Mortality Indicator scores that fall within 95% control limits 21. Delivery of NHS Constitution pledges, including Access to Psychological Therapies
Overall delivery **22.** Meet key milestones for Essex wide plans	

Data sources:

- Items 1 – 5 are Better Care Fund metrics
- Item 6 is an existing Social Care target
- Items 7 – 10 are included in either the NHS Outcomes Framework 2014/15 or the Adult Social Care Outcomes Framework
- Items 11 – 15 are included in the Public Health Outcomes Framework 2013-16
- Item 16 is collected by NHS providers and is publically available on NHS Choices
- Items 17, 18 and 20 are part included in either the in either the NHS Outcomes Framework 2014/15 or the Adult Social Care Outcomes Framework
- Item 19 is available via the CQC
- Item 21 is a national requirement

Progress against these objectives will be monitored through individual CCG and ECC plans.

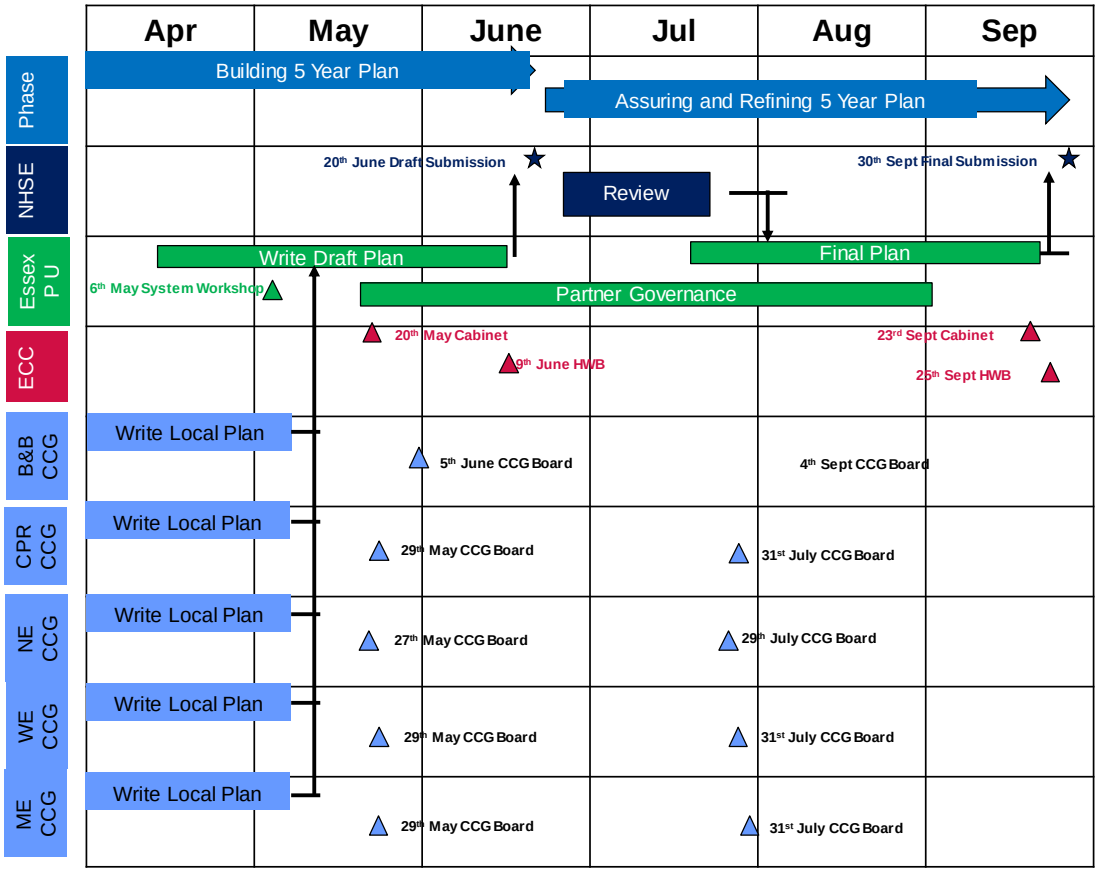
4.1 Consultation and engagement

This section of the plan describes the consultation and engagement process completed as part of the five year planning process across Essex. In addition many of the Pan-Essex projects described in this plan have been subject to widespread consultation and engagement with service users and carers, the wider community, clinicians and the Health and Wellbeing Board, and some of these wide consultation processes are also described below.

Development and sign off process for this plan

Figure 13, below, shows the consultation and sign off process for this plan.

Figure 13, Essex Five Year Plan development and sign off process



This process included a whole system workshop on 6th May, with over 60 attendees from across ECC; CCGs, acute, mental health and community provider Trusts; Health and Wellbeing Board members and the third sector. In addition to this relatively formal consultation process, consultation and engagement arrangements across Essex are described below.

Health and Wellbeing Board

The Essex Health and Wellbeing Board was formed in 2013. The Board includes membership from across health, social care and the third sector, along with elected members of ECC and District Councils. The Board and has played an active role in developing a strategy, which sets out how the partners will work together to improve health and wellbeing in Essex over the next five years. This strategy was developed from the Joint Strategic Needs Assessment and Pharmaceutical Needs Assessment.

The Health and Wellbeing Board has played an active role in the development of other health and care strategies, notably the Better Care Fund work. The Health and Wellbeing Board recently agreed

changes to membership and sub-committee structure to further develop its role, and these changes together with the involvement of the HWB in the governance of this plan are described in chapter 5, below.

Community engagement

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. CCGs continue to support Patient Engagement Groups, which provided the opportunity for citizen 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 examples of community engagement in specific projects and initiatives are given below:

- **Mental Health:** The North and South Essex mental health strategy development process included wide scale service user involvement and a consultation process.
- **Services for children and families**: Essex County Council has undertaken a number of consultation activities with families, lead bodies, partners and the wider market to seek their views on the focus and possible shape of future Children's Centre Services.
- **Services for Adults with Disabilities**: ECC led a formal consultation process to test and develop a set of principles intended to increase independence for Adults with Disabilities. 383 people participated in this consultation during the period October – December 2013, and there was broad support for the principles proposed, although some reservations about how the principles could be turned into practice.
- **Call to Action** – CCGs undertook a number of consultation and engagement events to enable citizens 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.
- **Who Will Care?** In January 2013, five independent commissioners began the task of tackling one of the most challenging questions facing the people of Essex – how will we care for ourselves and our communities right now and in the future? As part of the Who Will Care? Review process the five Commissioners took evidence from hundreds of people of all ages in libraries, hospitals, community centres, from the young to the most frail. This evidence was used to develop a set of five high impact solutions to prevent a future crisis in health and social care in Essex. The Who Will Care principles are being enacted through a number of programmes, including the Better Care Fund and the ECC Commissioning Strategies.

Some of the key messages that we have heard from citizens and service users throughout these community engagement projects 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 citizen 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.

5 Improvement programmes

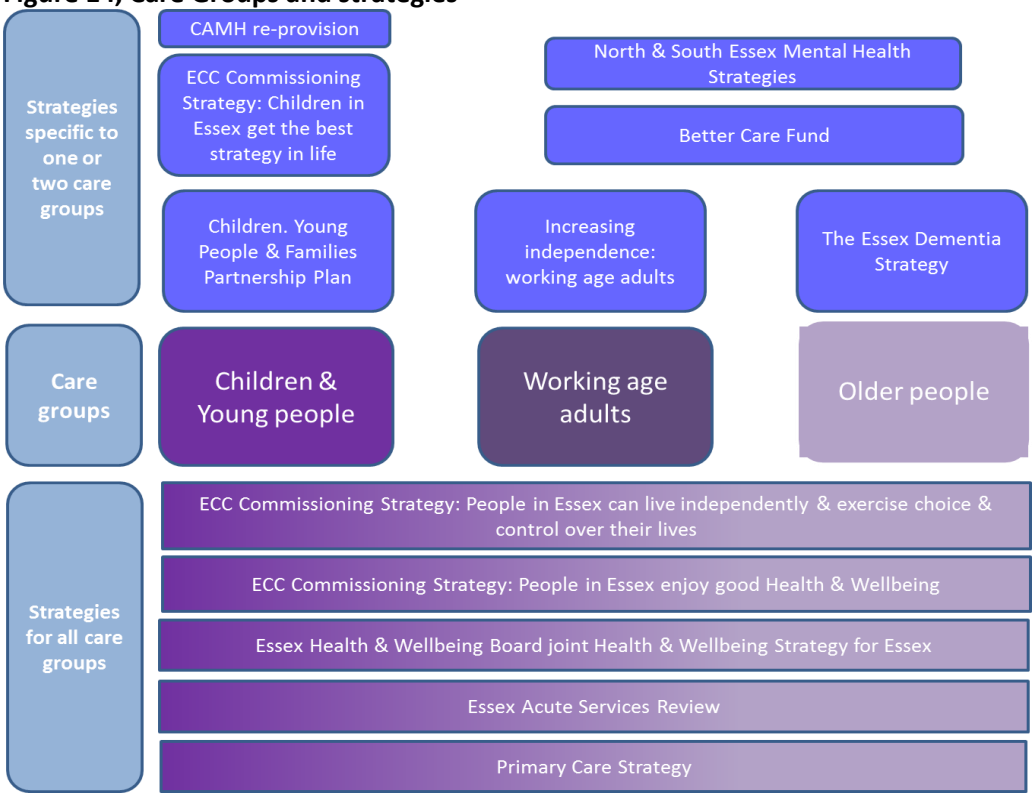
5.1 Introduction

A significant number of improvement programmes or initiatives are in place on an Essex wide basis. These include the following:

- The Essex Dementia Strategy (2010)
- The Essex Health and Wellbeing Board Joint Health and Wellbeing Strategy for Essex (2012)
- Mental Health strategies for North and South Essex (2012), currently under review to ensure that they reflect more recent guidance on achieving parity of esteem between mental and physical health
- ECC Integrated Plans 2013-16 and Outline County Council Health and Wellbeing Plan
- The Essex Primary Care Strategy (2013)
- The Essex Children, Young People and Families Partnership Plan (CYPP) 2013-2016. (2013)
- The Better Care Fund (2014), which incorporates previous work on health and social care integration and work on the provision of seven day services
- Increasing Independence – Working Age Adults (2014)
- The Essex Acute Services Review (2014)
- The ECC Commissioning Strategy for achieving Outcome 1 – Children in Essex get the best start in life (May 2014)
- The ECC Commissioning Strategy for achieving Outcome 7 - People in Essex can live independently and exercise choice and control over their own lives (May 2014)
- The ECC Commissioning Strategy for achieving Outcome 2 – People in Essex enjoy good health and wellbeing (May 2014)

These have been described in greater detail below. The relationships between the various initiatives and the three principal care groups recognised by health and care practitioners is described in figure 14, below.

Figure 14, Care Groups and strategies



5.2 Strategic Context

The past two years have been a time of significant legislative and structural change in both health and social care services, during a period of intense financial pressure particularly for local government.

5.2.1 Legislative changes

A number of important legislative changes have occurred over the past few months. These include:

The Health and Social Care Act 2013: This Act describes a series of major structural changes to the NHS and Social Care. Clinical Commissioning Groups were created, with the intention of ensuring that clinical commissioning decisions were clinically led. Specialist Commissioning Teams were established, with the remit of commissioning a range of specialist services including health visiting and primary care. Responsibility for provision of public health transferred from the NHS to Local Authorities.

Local public health services will now be commissioned by local authorities rather than the NHS. The act stipulates that all local authorities must appoint a director of public health.

The Act created new health and social care co-ordination bodies, called Health and Wellbeing Boards (HWBs). These bodies will bring together representatives from across the NHS, public health, adult social care and children's services, as well as elected representatives and representatives from the Local Healthwatch, to jointly plan how they can best meet local health and social care needs.

Finally, the Act clarified the roles of the health and social care regulators Monitor and the Care quality Commission. Monitor was given a new duty to 'prevent anti-competitive behaviour'.

The Care Act 2014: This Act received Royal Assent in May 2014**.** The Care Act is the biggest reform of social care law since the 1940s, and it will have a significant impact on demand and the way in which ECC supports people to live independently.

The Act provides the basis of a system of charging for care, including a new cap on care costs. As a result of this legislation it is likely that the number of people eligible for adult social care services will significantly increase and the number of people that ECC will have to support will increase. ECC will also have a new prevention duty to people who are on the margins of social care support, which will in turn mean that ECC are responsible for supporting a new group of people who are currently unsupported.

The Act includes a legal **duty to promote the integration of health and social care** where the local authority considers that integration of services would either promote the wellbeing of adults with care and support needs (including carers), contribute to the prevention or delay of developing care needs, or improve the quality of care in the local authority's area. For the purposes of the Care Act, housing is considered a health-related service.

The Act has Implications across various care groups:

- **Older people**: ECC expects to see an increase in the number of people being supported though Adult Social Care, in particular older people.
- **Working age adults with disabilities**: The eligibility criteria will also expand so that more working age adult with disabilities will be supported due to the changes in eligibility criteria.
- **Children and young people**: The Act requires local authorities to continue providing a person with children's services until adult care and support is in place to take over with no gap.
- **Carers:** The Act gives the same rights to carers as those given to the people they care for. Local Authorities now have a duty to provided carers with their own assessment of support needs.
- Increased responsibility for Information, advice and advocacy across all groups.

Although the government has allocated funds to help support authorities implement the Care Bill, calculations suggest that it is unlikely that the additional funds will cover the cost of implementation in Essex.

The Children and Families Act: This Act is currently progressing through Parliament. The Act outlines the Government's plans to extend the special educational needs system from birth to twenty five. ECC will need to implement the reforms, including replacing old statements with a new birth to twenty-five education, health and care plan and by offering families personal budgets. The Act also requires local authorities to complete needs assessments for young carers. In addition, this Act placed a requirement upon CCGs to jointly commission services for those with Special Educational Needs.

The Welfare Reform Act: Changes to benefits and employment as outlined in the Welfare Reform Act will have an impact on families in Essex and present additional challenges to Local Authorities, landlords and partners. ECC may be responsible for providing social care support to those vulnerable people impacted by the changes to employment and benefits.

5.2.2 National policies

The Government published, 'Everyone Counts: Planning for Patients 2014/15 to 2018/19'in November 2013. This document provides extensive guidance on strategic priorities over this four year period. Key requirements include the following:

- **The creation of strategic plans covering a five year period**, with first two years at operating plan level. This plan has been created in response to this requirement.
- **An outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them
- **Citizen inclusion and empowerment** to focus on what patients want and need
- **More integration between providers and commissioners**
- **More integration with social care –** including cooperation with Local Authorities on Better Care Fund planning
- Plans to be explicit in **dealing with the financial gap and risk and mitigation strategies**. No change not an option.

The model of care described in this document includes the concentration of specialist acute services in a smaller number of major acute centres; the creation of a new model of urgent care to replace the current patchwork of provision of urgent and emergency care and wider primary care provided at scale. Services are expected to operate on a 24/7 basis. The driving principle is to ensure the provision of consistent high quality and safe care across England, based upon measurable standards and outcomes. Many of the plans described in the remainder of this chapter will help to deliver the vision set out in 'Everyone Counts', including the Primary Care Strategy and the Acute Services Review.

The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas. Better Care Fund plans in Essex are well advanced and these are described later in this chapter.

5.2.3 What does this mean for Essex?

The legislative and policy changes described above have created new responsibilities for health and social care, and will in particular increase the demands placed upon social care services. This comes at a time when demand for services is also increasing as a result of the demographic pressures described in chapter 3 of this plan. Current policy strongly promotes the integration of health and

care commissioning and provision, and there is an expectation that commissioners will make effective use of competition and market management.

The Essex health and care system will not be able to respond to these changes simply by doing more of the same for less money. Instead, a bolder vision is required, underpinned by a new health and care model which is based upon integrated services and pathways. The new model of care and the programmes of work required to deliver it is described in the remainder of this chapter.

5.3 Health and care models

This section of the document describes the health and social care models developed over the past couple of years. Although health and social care are described separately here, we acknowledge that health and social care are working closely together to develop an integrated model of care. There is much common ground between the two models, for example a focus upon preventative care and self-care and a determination to develop integrated services for a wide range of client groups, including children's and mental health services.

5.3.1 Health model

Whilst the five CCG plans are reflective of local need and circumstances, there are some similarities between the plans, and it is possible to describe a model of health care that is broadly similar across the CCGs.

Key features of the model include:

- Increased 24/7 working, including improved access to primary care
- Development of primary care 'at scale', to provide integrated primary, community, mental health and social care to local populations
- Development of integrated services/pathways for vulnerable elderly and frail citizens, including 'predictive case finding' approach
- Immediate care – simplifying and joining up urgent and emergency care services, reducing reliance on acute care
- Full range of integrated children's services with a seamless transition between child and adult services
- Integrated CAMHS and behavioural services tier 1-3
- Ensuring parity of esteem between physical and mental wellbeing
- Ensuring that the same health interventions and services will be accessible to people with learning disabilities that are available to any other citizen within Essex
- Self-care and community resilience
- Focus on preventative care, healthy lifestyles and inequalities

5.3.2 Social Care model

Key features of the Social Care model are described below

- Increased availability of advice, information and advocacy to support people with care needs to plan their care.
- Personal budgets as the default mechanism for providing care
- Increased 7 day working to facilitate hospital discharge and prevention of hospital admission
- Increased investment in domiciliary and residential reablement services
- Development of integrated services/pathways for vulnerable older and frail people, including 'predictive case finding' approaches based on risk
- Full range of integrated children's services with a seamless transition between child and adult services.
- Integrated CAMHS and behavioral services tier 1-3
- Development of specialist dementia support services
- Increased levels of carers support services

- Increased levels of housing support as an alternative to residential and nursing care
- Preventative care and self-care approaches
- Introduction of care coordination and co-location of social services alongside community health care into Multi-Disciplinary teams in Primary Care settings.

5.4 Services for children and young people

There are a number of strategies and initiatives in place across Essex County Council and health services aimed at improving outcomes for children and young people. Whilst these strategies may have been authored by one lead agency, they all reflect the principles of partnership working between care and health commissioners and providers.

5.4.1 ECC Children, Young People and Families Partnership Plan 2013-2016

Early Help Offer

In Essex partners have developed a wide range of commissioning and service responses so that Early Help is available to all children, young people and families who need it. Crucial to the delivery of Early Help in Essex is the understanding of the Effective Support guidance and windscreen. The Effective Support windscreen is a "conceptual model for meeting children and families' needs" and the guidance is for all practitioners working with children and families. The guidance identifies four levels of need: Universal, Additional, Intensive and Specialist**.**

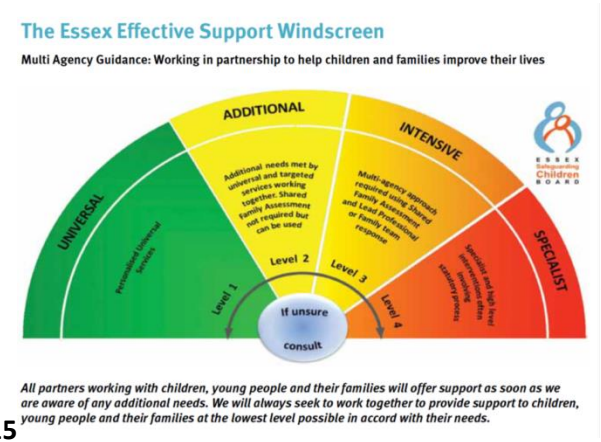


Figure 15

Early Intervention

A range of early intervention provision at level 2 exists across Essex through schools, health local authorities and other partners in the form of services, projects and programmes, much of which is commissioned from the voluntary and community sector. We are working together to strengthen the Early Intervention offer in Essex through the integration of grants and contract funding and targeting resource more effectively for best impact on reducing demand on statutory services.

The Early Help and Advice Hub

The Early Help and Advice Hub was established in September 2013 to support activity at levels 2 and 3. Information, advice and guidance is provided to all practitioners working with children, young people and families. The Early Help and Advice Hub acts as the entry point into **Family Solutions (FS)**.

Family Solutions (including Essex 'Troubled Families' programme)

Family Solutions (FS) offers family support to families who are not likely to suffer significant harm and works on a voluntary basis, by finding solutions collaboratively with the family. Arrangements have been developed between Children`s Social Care (CSC) and FS to facilitate a consistent step up and step down to ensure each child receives intervention at the right level. Support for families who have been

through the FS programme and whose needs have reduced from Intensive to Additional will be negotiated between FS team and relevant targeted services.

5.4.2 Child and Adolescent Mental Health Services Re-provision

Introduction
The current configuration and delivery of CAMHS services at Tier 2 and 3 is particularly complex and fragmented. The service is difficult to access and gaps exist for some of our most vulnerable children and young people. (Joint Strategic Needs Assessment, JSNA)

Planned improvements
Since 2013, lead commissioners from Health's 7 CCGS, Essex County Council, Southend Council, Thurrock Council and NHS England; have been working in partnership to develop a redesigned, integrated (Tier 2 & 3) service model that will improve the emotional Wellbeing & Mental Health of children and young people, aged 0-25, with these needs. It will do this by

- A Joint commissioning approach across Southend, Essex and Thurrock LAs and the 7 CCGs with one provider will result in a reduction in provider management costs and estate costs therefore more of the budget can be used to meet the current demand on services.
- Increasing the number of C&YP who receive a service by using evidence based interventions which are traditionally more effective and shorter. This will enable practitioners at tier 2 & 3 to work with more cases annually.
- Providing easier access to services with quick responses and improved consultation, advice, support, training and guidance.
- Improved joint working with adult mental health services with a smoother transition for 14 to 25 year olds.
- Admission criteria will be consistent across Essex to meet estimated needs in each area.
- Use of a pathways approach agreed and consistent across the whole area.
- More delivery in the home and in local school, health and community venues.
- Prioritisation for vulnerable groups

After exploring options to achieve the new C&YP EWMH service model, the recommended option by the project board, is to go out to tender using a competitive dialogue (CD) process, for one provider to deliver the new service across Greater Essex with a locality based teams.

Procurement will start 1st July 2014 and the new service 'Go Live' will commence on the 1st November 2015.

5.4.3 Safeguarding for children and young people

Introduction
Current safeguarding provision includes the following services:

- Safeguarding advice to schools;
- an Initial Response and Referral Service into Children's Social Care which also provides advice to other agencies including health professionals)
- Emergency Duty Service.
- Family centres and supervised contact to support families where there are concerns about the family's care for the child.
- Specialised support to young people on the edge of care (Divisional Based Intervention teams - D-Bit) and Assessment and Intervention and Family Support and Parenting teams to assess and work with families where there are concerns about the care of the children

Objectives

The 2013-2016 Integrated plan includes a number of shared social care and health objectives, including the following:

- Improving the links and joint working opportunities between CCGs, Health Providers and ECC staff to ensure appropriate and timely reports and contributions are made by health staff to Child Protection Assessment, Conference and core group, Planning and Review activities and that health staff work with other agencies to deliver joined up interventions to children In need or on a Protection Plan are embedded into health contracts.
- Work between ECC and the CCGs to ensure continuing joint development and resourcing of the Essex Safeguarding Children's Board

5.4.4 Joint Commissioning SEND

Joint commissioning activity between ECC, health and other partners is developing an infrastructure to support the effective implementation of the SEND requirements of the Children and Families Act. Commissioners are engaging in joint commissioning activity across education, care and health in order to:

- set the strategic direction through co-produced strategic plans
- Establish Joint / lead arrangements for commissioning
- agree the pace of change and allocation of resources
- manage and lead the whole system, including agreement of common outcomes and shared performance indicators
- Develop the systems, operating structures and processes required to support self-directed support
- Provide Personal budgets to support Education Health and Care Plans
- Develop the market to ensure choice and control over provision, to be underpinned by strategic commissioning principles supporting personalisation
- Align individual provision planning to strategic planning e.g. through JSNAs

Examples of Joint commissioning activity currently underway across a range of services between education, health and care:

- Equipment Services
- Child and Adolescent Mental Health Services
- Equipment Services
- Specialist Health Care Tasks
- Joint health and care plans for continuing care

SERVICES FOR WORKING AGE ADULTS

5.5 Mental Health

Introduction

Both North and South Essex have through dialogue and consultation developed joint Mental Health commissioning strategies for the period 2013 – 2017 (2018 for South Essex). The visions of these two mental health strategies are consistent with health and social care services being commissioned to support the identical strategic outcomes, as follows:

- 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

Model of Care

Both Strategies describe a stepped model of care based on NICE commissioning guidance. The core principle of stepped care is that people are matched to an intervention that is appropriate to their level of need and preference through a seamless service which is integrated with physical health provision. It is apparent that this model also supports the wellbeing agenda.

The steps are graduated from low to high intensity and individuals may begin their journey at any step of the pathway. People are matched to an intervention that is appropriate to their level of need and preference through timely referrals to mental health services. A greater level of these services will be provided in the community there these are likely to be more cost effective and less invasive. Though not described in the same way by the two strategies the Model of Care steps include:

- **Step 0** – Mental Health wellbeing, Self-help and advice, prevention and resilience, health improvement, personalisation, education. (this is not covered in the South Essex Mental Health Strategy)
- **Step 1** – Recognition, Initial assessment, watchful waiting. Provision of care in primary care, community care settings (excluding secondary care services) together with, social care, independent and voluntary sector.
- **Step 2** – Early detection and intervention, low intensity supported interventions, signposting, exercise, Improving Access to Psychological Therapies (IAPT). Supported provision of care in primary care, community care settings (excluding secondary care services) together with, social care, independent and voluntary sector.
- **Step 3** – Medium to high intensity psychological interventions, IAPT, social support, Medications management. Supported provision of care in primary care, community care settings (excluding secondary care services) together with, social care, independent and voluntary sector.
- **Step 4** – Complex psychological interventions, focused on outcomes personalisation and recovery. Care provided by community health teams and mental health specialists.
- **Step 5** – Crisis and risk to life interventions, focus on home assessments and reducing admission to secondary care, care provided by secondary care providers, provide specialist care and support in community setting where possible.

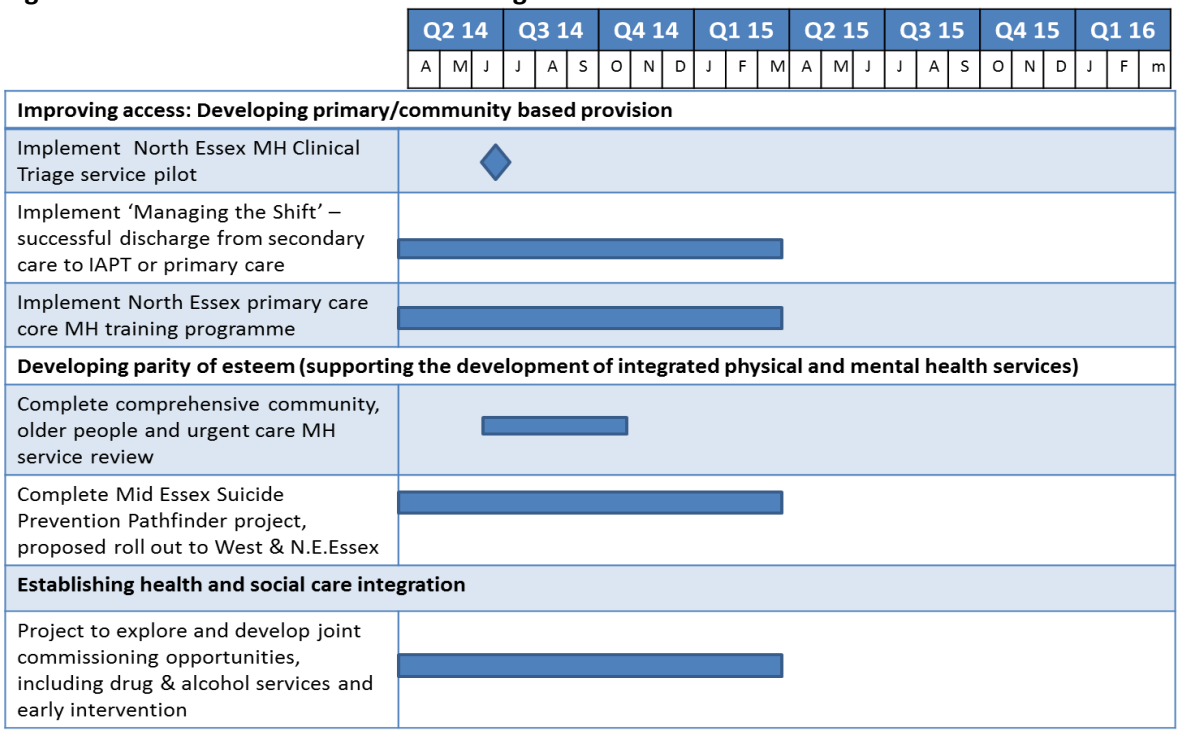
North Essex Outcomes & Programme of Work

The expected outcomes from this model of care in North Essex include:

- Well Being of community, working collaboratively with public health
    - Public Health Outcomes Framework 2013-16
- Improving access to services
    - Directing into services more effectively, for example through the ‘making every contact count’ triage service
    - improved use of existing provision, including the further development of primary care services
- Services and discharge
    - Right support at the right time in the right place
    - Ensure a speedy return to an optimum level of health
- Patient and Care experience of services
    - Positive experience and service user involvement.
- Improved integration between health and social care through exploration of joint commissioning opportunities
- Developing parity of esteem (supporting the development of integrated physical and mental health services)

A detailed programme of work has been put in place to achieve these outcomes, and a brief summary of this is set out in figure 16 below.

Figure 16 - North Essex Mental Health Programme of work



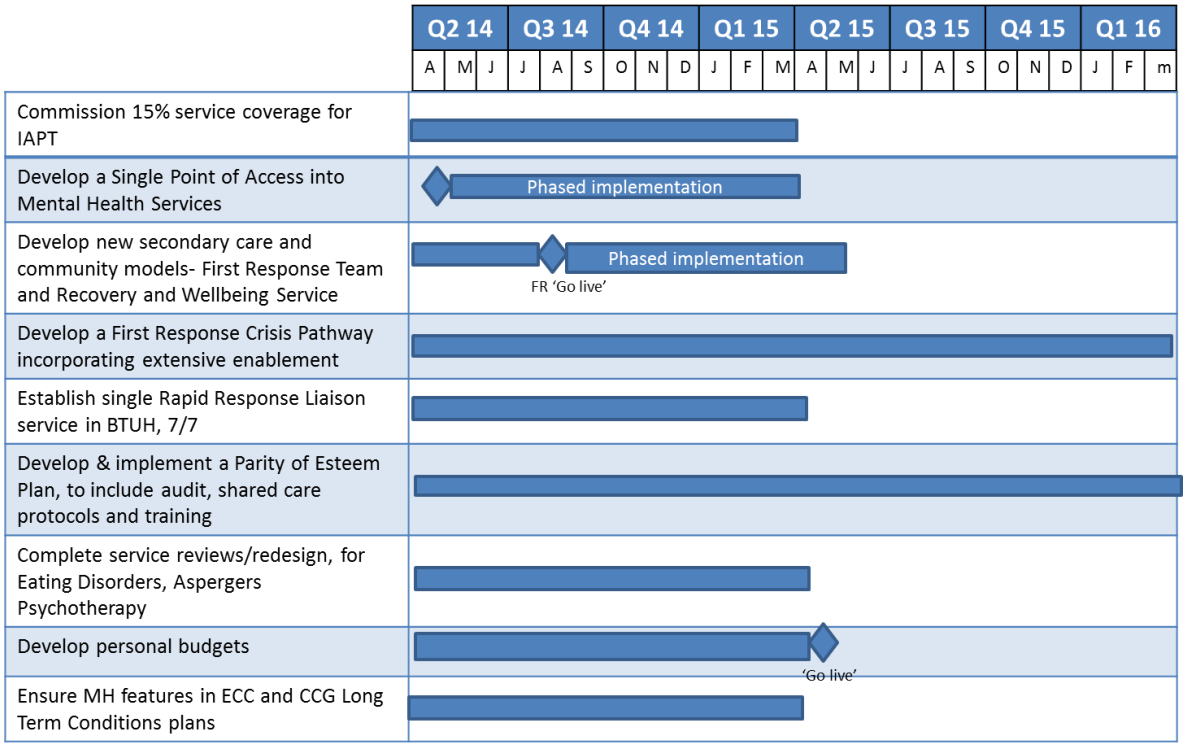
South Essex Outcomes & Programme of Work

The expected outcomes from this model of care in South Essex include:

- People have good mental health.
- People with Mental Health Problems have good physical health and people with physical health problems have good mental health.
- People with mental health problems recover.
- People with mental health problems achieve the best possible quality of life

A detailed programme of work has been put in place to achieve these outcomes, and a brief summary of this is set out in figure 17 below.

Figure 17 - South Essex Mental Health Programme of work



Enablers for Delivery

The following enablers are required for delivery of the above programmes of work.

- *Voice*: Hearing and accounting for the needs of Service Users, carers and families when designing any services for change.
- *Health Improvement and Early Intervention*: Working with public health colleagues to develop public policy and structural approaches that address issues affecting mental health.
- *General practice, primary care & community resources*: Develop a holistic, MDT approach to an individual's care, including those services provided by GP, primary care, community care, social care and the voluntary sector.
- *Integrated commissioning:* Developing Integrated commissioning to achieve effective outcomes for service users by; simplifying the decision-making processes, ensuring better use of resources, reducing communication failure etc.
- *Effective contract management*: Introduce outcomes focused contracts, monitor and hold providers to account to ensure that providers are supported to deliver the best possible quality of service within available resources.
- *Market Development:* Develop the market for mental health services, including the voluntary and community sector, to support the role of transforming services and provide an environment to deliver change, such as reducing the demand for residential care, stimulating greater community support, and developing the capacity to target services in order to prevent poorer care and health outcomes.
- *Technology*: Develop and stimulate the use of tele-mental health services/support systems to provide resources, contacts and materials for people with mental health problems, including management of anxiety, depression, and providing crisis support.

5.6 Transforming services for Adults with Disabilities

5.6.1 Introduction

The ECC Working Age Adults service is facing increasing pressures in terms of rising demand relating to demographic changes, coupled with decreased funding from central government. The current service model is exacerbating this situation through creating life-long dependence on services, and in particular on more institutional forms of support such as residential care and traditional day services.

ECC published a large scale three year plan for the transformation of the service offer to Working Age Adults with disabilities in March 2014. The plan describes a whole system approach to change that will result in a re-modelled support pathway that reduces demand on, and costs to the council and its partners, particularly health.

The project is based upon principles of enablement and progression. Enablement is an approach that is focused on developing people's capabilities to do things for themselves and become more independent. Progression is the term given to the step by step approach to increasing skills and independence and in some cases can mean a move into more independent living arrangements.

The development of this plan was supported by a formal consultation in late 2013, with the aim of agreeing a set of principles for the future provision of these services.

Integration is Department of Health strategy and an ambition embraced by ECC and partners through work around the Better Care Fund and Integrated Plans. Learning Disability was signposted as a pathfinder in the 2013-2016 integrated plans and the subsequent County Council Health and Well Being plan which were approved by HWB in May 2013. Integration it is believed is therefore the best way to manage the financial pressures, to safeguard best experiences and outcomes for people with LD and to best manage the risks to which both agencies are exposed. Integration will also deliver the necessary response to the Winterbourne View concordat.

The evidence suggests that successful partnerships tend to be incremental; the proposals outlined below reflect this learning, building on the part-time co-location of North Essex and ECC LD Commissioners since December 2013, and moving towards the ambition to let an integrated contract by 2016. These incremental steps, set out below, are both with regard to the level of funds invested into the pooled arrangements, as well as building incrementally across the whole County.

Phase One

- Agreed formal collaboration creating an Integrated LD commissioning team of CCG and ECC LD Commissioners
- Delivery of a pooled fund between ECC and the North Essex CCGs
- Both formalised by a Section 75 agreement.

Phase Two

- Depending on the initial success of this arrangement and the appetite of the CCGs in the South, extend the scope and scale of the partnership from 2015 to include the 2 South CCGs.
- Based upon success look to broaden the budgets included in the pooled arrangements.

Phase Three

- Designing an integrated specification and market testing. The aspiration is for this to be tendered and in place by April 2016. This will be the delivery vehicle that will deliver integrated pathways to contractually improve the service user experience. :
- An incremental approach to integration with the ultimate ambition of letting an integrated Pan Essex contract for April 2016

- A single shared Health and Social care strategy for Adults with LD in North Essex
- To implement an integrated team for Commissioning of LD services in North Essex across Health and Social care, with ECC acting as the Lead Commissioner; this will be enabled through a Section 75 agreement to be signed by all of the parties
- To implement a pooled fund between the North Essex CCGs and ECC for 2014/15 of £12.983million; this will be enabled through the Section 75 agreement to be signed by all of the parties.

5.6.2 Objectives and outcomes

The overall objective for the transformation programme is to make significant progress towards adults with disabilities having the same opportunities and outcomes in life as their non-disabled peers. Four commissioned outcomes have been identified to deliver this service, and these are summarised below.

1. A revised service offer to adults with disabilities in Essex, Delivered through:

- Reductions in people living in residential care (-249) and using traditional day services (-61) by March 2017
- Evidence that 701 people have increased their independence
- Equality in the offer for people with sensory impairments
- A joint Health & Social Care pathway for people with learning disabilities
- A sustainable, cost effective range of social care services in the community

2. An increase in adults with disabilities living in safe & stable homes, Delivered through:

- Increases in people with their own tenancies or own homes (+156) and people living in Shared Lives schemes (+84)
- 13 people identified under the Winterbourne View programme moving from secure facilities into community settings
- Fully developed housing/accommodation market which ensures more appropriate options for people with disabilities
- An increase in the number of older family carers better able to continue in this role, and better plans for the adult children's future

3. An increase in adults with disabilities in employment

- An increase in the number of people with learning disabilities known to social care known to social care in paid employment from 10% to 15%

4. The achievement of £22.8m demand management by 2016/17

- Delivered through the revised service offer

5.6.3 Critical actions

The report sets out the following work-streams:

I. Increasing social work capacity
II. Increasing housing options
III. New crisis response service
IV. Improved support to older family carers
V. Re-commissioning Short Breaks for carers
VI. Improving services for people with learning disabilities whose behaviours challenge services
VII. A redesigned offer for people with sensory needs
VIII. Increasing access to and uptake of employment

5.6.4 Enablers for delivery

The reform of the current service model will require the development of two new social work teams, in order to deliver the care management capability to facilitate changes for individuals and their families. A wider culture change will also be required to help the delivery of the new model of care.

5.6.5 Finance

The service transformation will require Transformation Reserve funding of £4.762m and is expected to deliver gross cumulative annual savings of £23,489m by 2017/18. The forecast cumulative annual savings represent 8.7% of the relevant budgets.

SERVICES FOR OLDER ADULTS

5.7 Older people and frailty

5.7.1 Introduction

Introduction

ECC and local health organisations have completed a considerable amount of joint work over the past five years to develop integrated commissioning and provision, in particular for older people. This journey began with some work commissioned by South East Essex PCT and ECC in 2009 to develop a joint older peoples' strategy. This became a pan-Essex project in 2010, when ECC and PCTs collaborated to project a model of Joined up Care for Older People. This work was then taken forward through the Whole Essex Community Budgets work in 2012/13 and in the 2013/14 Essex Integrated Plans.

As a result of these projects Essex has now developed integrated care pathways for older people; developed some pooled budgets for commissioning these services and closer integration of health and social care governance arrangements and is in a very strong position to progress to fully integrated provision and commissioning.

3.7.2 Strategic framework and principles for Older Peoples' care

There is consensus across Essex that services for Frail Older People should be commissioned locally (within CCG boundaries) within an overall draft ECC/CCG strategic framework, against locally determined priorities.

The strategic framework aims to achieve optimum levels of independence for older people and reduce health inequalities. It has a set of common strategic themes:

- Social inclusion, including prevention and early intervention - information and advice.
- Dementia.
- Falls Prevention.
- Continence Management.
- Support for carers.
- Urgent Care Pathways - crisis avoidance and crisis response, long term conditions.
- Support for professional carers to raise standards in care homes, linking with providers of community services.
- End of Life Care.
- Continuing health care - children and adults.

3.7.3 The Better Care Fund

The £3.8bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and

social care. The Better Care Fund (BCF) is a single pooled budget to support health and social care services to work more closely together in local areas.

Since late 2013, the Better Care Fund has been used as the vehicle to continue the development and implementation of services for integrated care in Essex. Within Essex we have prioritised work with the frail elderly as a key area within the Better Care programme.

The Essex Health and Care economy has recently completed a major programme of work to identify the outcomes that it wishes to achieve through use of the BCF and the individual schemes that need to be enacted to deliver these outcomes. These are described below.

Outcomes

The following outcomes have been agreed for the Essex BCF programme:

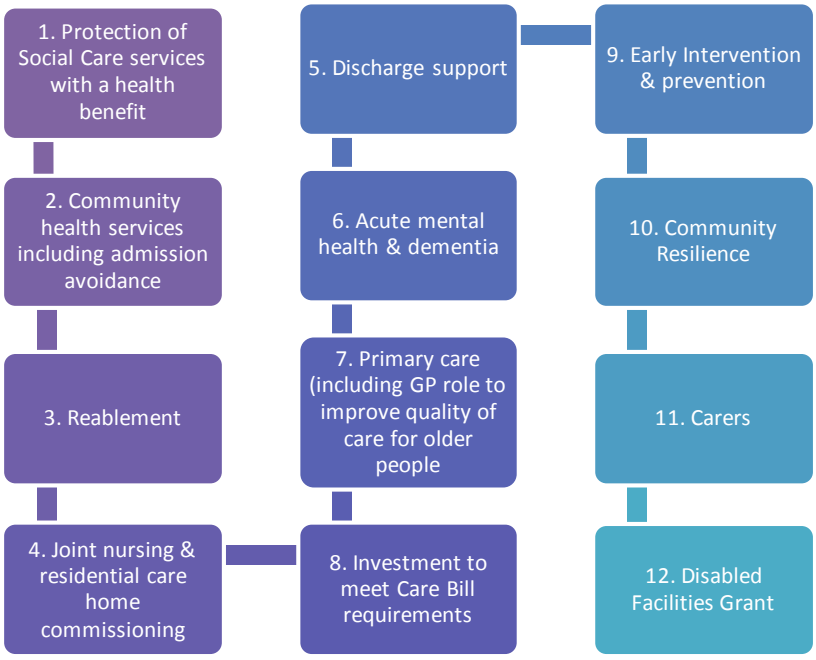
1. 5% reduction in permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
3. Delayed transfers of care from hospital per 100,000 population (average per month)
4. Maintaining the current rate of avoidable emergency hospital admissions
5. LOCAL METRIC: The coverage of reablement. (This metric will measure an expansion in the number of referrals from community into reablement.)

BCF schemes

These outcomes will be delivered via a number of schemes, each one of which represents a significant change in the way that care is commissioned or provided. The 12 principal BCF schemes are summarised on figure 18, overleaf.

Each CCG has created its own timelines for implementation of activity that supports the BCF schemes, and these are described in greater detail in individual CCG 5 year plans and in CCG's BCF plans.

Figure 18 BCF schemes



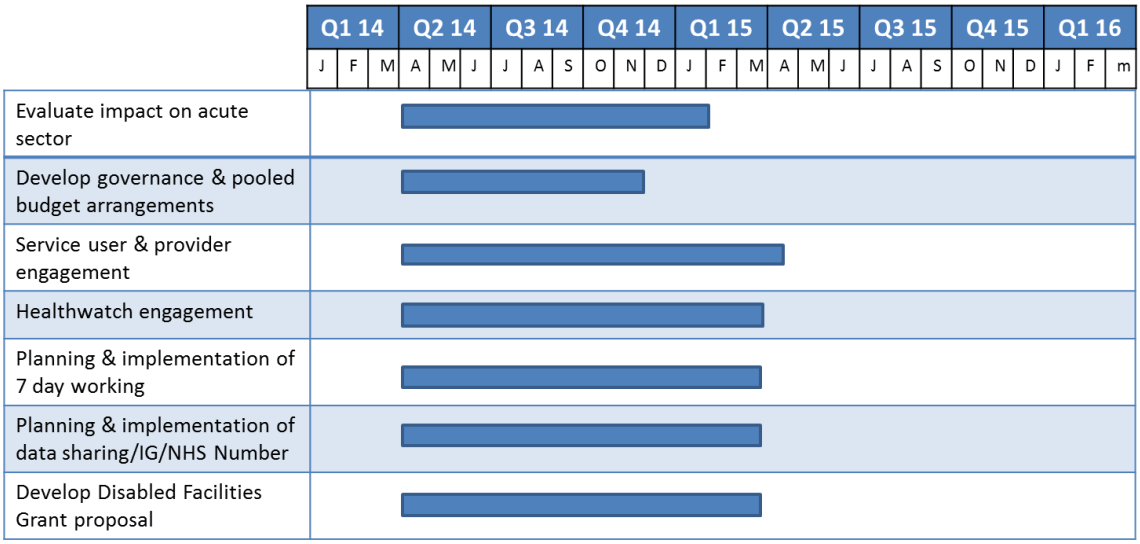
Enablers required
The key issue for this Essex five year strategy is to ensure that the pan-Essex enablers required to deliver the BCF project are put in place. These include the following:

- Simple access to information: Safe and timely sharing of data to support commissioning and service design and planning
- Joint Commissioning and CCG and District level to oversee BCF Schemes and impact

Chapter 6 describes detailed plans to deliver these enabling projects.

Implementation timeline
The high level implementation timeline for the Better Care Fund programme is set out in figure 19, below:

Figure 19, BCF high level action plan



CROSS CUTTING SERVICES

5.8 Primary care

5.8.1 Essex Primary Care Strategy

Introduction
The Essex Primary Care Strategy was published by NHS England in 2014 in liaison with the 7 Essex CCGs. The services covered by the strategy are general practice, dental practices, pharmacies and optometrists.

The strategy explains that the current situation is not sustainable. Current services are not integrated, with over 1000 independent contractors delivering primary care services. There is no new money available, and there is a need to ensure that current spend is distributed more evenly. The quality of interventions is variable and we are sometimes failing the most vulnerable.

At a time when demand for primary care services is increasing as a result of demographic changes and an increase in long term conditions, there is a crisis in primary care staffing, with an estimated 143 additional General Practitioners needed across Essex in order to reach the England average of GP's per head of population.

Aims

The aim of the strategy is to create sustainable and integrated primary care services, supported by the transfer of service provision and funding from a hospital setting and into a primary care setting.

The future vision is for the creation of Primary Care hubs, within which primary care will be provided on a larger scale, each covering a suggested minimum of 20,000 population. The development of Primary Care hubs will facilitate an integrated approach to the delivery of primary care, community health services (both physical and mental) and social care for a registered population. There is no single template for a hub, they will be developed on a locality basis to ensure the best fit for patients and practitioners.

The strategy includes some specific commitments to Essex residents about the future provision of primary care services, key points of which are summarised below:

- **Consistent:** Easy access online or in person to information, advice or support, with advice provided by primary care professionals being consistent with best practice.
- **Personalised:** Patients aged 75 and over will have a named clinical lead who will oversee and co-ordinate all aspects of their care.
- **High Quality:** Patients will be seen and treated by highly trained healthcare professionals
- **Responsive and Accessible:** Patients will be able to access a primary care professional within 24 hours whenever they feel their primary care need is urgent, and routine appointments will be available within 5 days. Services will be accessible over weekends.
- **Integrated:** Patients will feel that care is seamless and holistic, taking account of physical, mental and social care needs.
- **Sustainable:** Patients can be confident that the primary care service they are receiving today will be dynamic and evolving, and there over for them over the next 25 years.
- **Preventative:** Citizens will be actively involved in the management of their own care, receiving more information and support about maintaining their own health.

Critical actions

A number of actions have been identified to be undertaken on a pan-Essex basis:

- Make full use of NHS funded premises, decommissioning those buildings which are not utilized effectively
- All new developments requiring investment from NHS England will be made available 7 days a week, and to primary and community care providers.
- New or replacement GP practices will be commissioned with a minimum list size of 4,500 patients serviced by the equivalent of 2.5 whole time equivalent GPs. The aim is to ensure peer review and support, provide choice of GP to registered patients, ensure continuity and subsequently make general practice a more attractive place to work.
- Number of GPs working in Essex will increase through the establishment of more training practices and enhanced roles within hubs that attract professionals into Essex.
- Patients will be able to access their practice at all times throughout the contracted hours of operation (8:00am to 6:30pm Monday to Friday).
- All practices will reflect on their general practice cancer profile and take a number of actions aimed at ensuring early diagnosis of cancer.
- The number of nurses working in Essex will increase through the enhancement of nurse practitioner training and enhanced roles within hubs.
- Practices who are unable to evidence they are delivering high quality care will be supported to improve in the first instance but ultimately decommissioned if there is insufficient improvement.

Implementation timeline
A detailed timeline has not been published for these pan-Essex actions and each CCG will be responding with their own proposals for local implementation.

Costs
The primary care strategy aspires to see a shift of up to 5% from hospital resources into primary care, equating to a transfer of up to £90M into the system. It has been left up to each CCG to determine the scale of this shift, and details of CCGs' local plans are to be found in the CCGs' five year plans.

In 2014/15 CCGs will work with GPs to commission services to help deliver the shift of patient activity from the acute sector. National guidance sets out that this is the equivalent of £5 per head of population (by practice) from the 2.5% CCG transition reserves.

5.8.2 Other primary care issues

A number of national and local issues will occur over the coming years which will present both opportunities and risks to delivery of the plans described above:

- **Co-commissioning**: Since the publication of 'Transforming Primary Care in Essex' NHS England has announced that it will introduce provisions that allow NHS England to delegate budget responsibilities for some or all aspects of primary care through joint committees with CCGs. This announcement is too recent for the implications for Essex to be widely understood, but it may enable CCGs to have a direct influence upon the development of new models of primary care.
- **Practice income guarantee:** When the new GMS contract was introduced in 2004 a Minimum Practice Income Guarantee (MPIG) was introduced to match practices' basic income levels before the introduction of the new contract Since then the number of practices receiving these payments have gradually reduced but MPIG is now to be withdrawn completely over the 7 years commencing 1 April 2014 and a number of Essex practices will be affected.
- **Contractual changes**: Some GP practices operate under a Personal Medical Services (PMS) contract which may contain a number of locally agreed aspects. Most PMS contracts also attracted additional funding in return for additional staff or services. PMS contracts are now being renegotiated which will most likely result in a reduction in income for practices.
- **Estates:** GP practice premises are funded by NHS England at a level determined by the District Valuer. Recent changes to the basis used for valuation are likely to result in a number of practices holding a lease or paying rent that is not fully reimbursed, or not recovering the full cost of providing their own premises. The process of approving capital funding to practices for building or extending existing premises has changed which may make it more difficult for to improve primary care estate.
- **List Validation**: There is evidence that nationally, practice registered lists are inflated by about 5% but in some regions this is believed to be by as much as 30%. NHS England have already developed a policy for practice list validation and it is possible that list cleansing activities will be undertaken by the Area Team in the near future. This could have a significant impact on some practices.

5.9 Acute Services

5.9.1 Introduction

Essex has five acute hospitals. There is no single teaching hospital which provides specialist services such as radiotherapy, interventional cardiology or specialist cancer surgery. As a result patient pathways can be complex, for example a patient might receive a cancer diagnosis at one hospital; surgery at a second hospital and radiotherapy at a third.

The acute sector is facing considerable financial and operational pressures over the next five to ten years, including the challenge of moving towards 24/7 working and difficulty in recruiting sufficient medical and other staff to sustain their current configuration of services. There is increasing evidence to support the principle of the centralisation of specialist services on the basis that this produces better clinical outcomes for patients.

The Acute Services review was initiated by the five Essex acute Trusts and the seven Essex CCGs (including Thurrock and Southend) to address this issue. The Acute Services Review began in April 2014.

5.9.2 Aims

The aims of this project are as follows:

- To complete a review of Acute Services configuration across Essex, with the aim of developing a sustainable pattern of acute services across Essex going forward, based upon the principle of 'local where possible, specialist where necessary'
- To complete a review of acute 'back office' services, with the aim of delivering improved quality and value for money via outsourcing or shared services arrangements

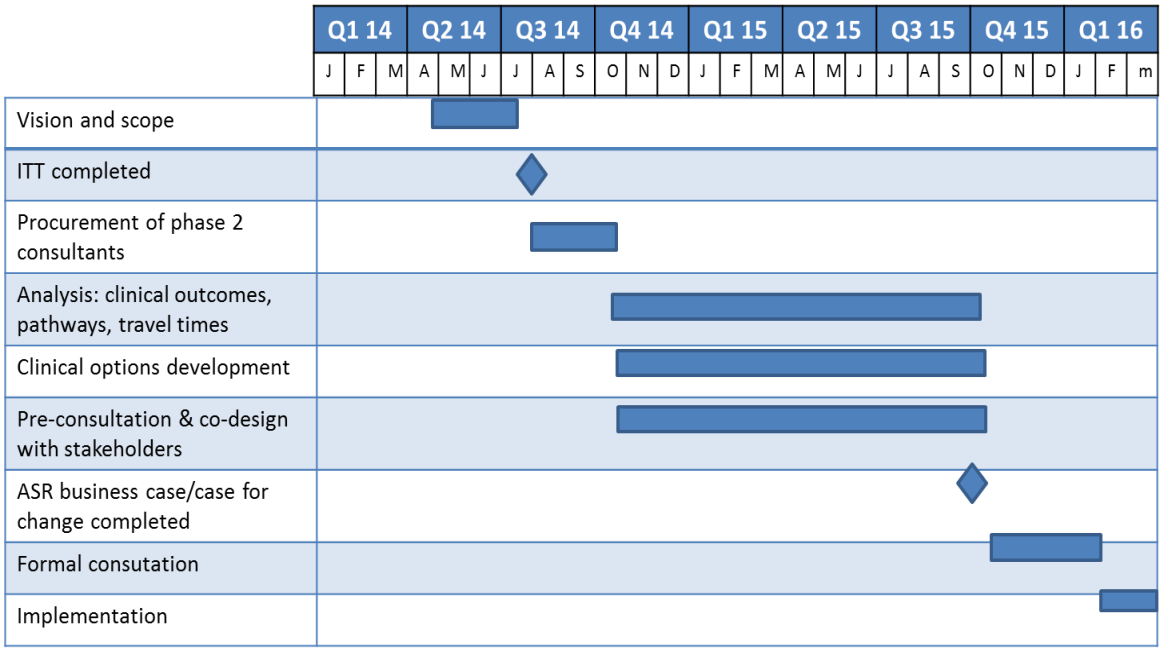
The scope of services to be covered by the review is still under discussion with CCG and Trust Chief Executives and medical leaders, but at time of writing it seems likely that the configuration of specialist surgery, smaller surgical specialties, Accident and Emergency and trauma services.

5.9.3 Implementation timeline

This programme consists of two phases. Phase 1 runs from April – July 2014 and will produce an initial programme scope and a detailed invitation to tender for consultancy and other specialist support to phase 2 of the programme. Phase 2 will include the completion of both back office and acute services reviews. The acute services review process is expected to take up to 1 year, with implementation phased over a period of up to five years.

A high level timescale is included on figure 20, below. At this early stage in the project this should be regarded as provisional.

Figure 20, Acute Services Review high level timeline



5.9.3 Risks and confidence levels of implementation

Learning from similar scale reviews completed elsewhere suggests that there are several risks to the delivery of this kind of programme of work. Potential risks include:

- Failure to adequately engage with the public, professionals or politicians and consequent resistance to the proposed service configuration
- Failure to make a convincing clinical case for change
- Difficulty achieving consensus amongst a complex set of NHS stakeholders and need to develop high levels of trust in order to achieve this

These and other risks have been reflected in the design of the ASR programme and risk mitigation plan.

5.10 Public health priorities

5.10.1 Introduction

ECC are responsible for the health of the public we serve. While this was formalised with the shift of responsibility for public health from the NHS in April 2013, it has long been a recognised Council Outcome that, 'People in Essex enjoy good health and wellbeing'. In this context the WHO (World Health Organisation) definition of health as a state of physical, mental and social wellbeing not just the absence of illness is applied.

Much of what ECC does impacts on public health whether it is a direct use of the public health grant to commission a specific service or the impact of our broader policies around social care, education, the economy and the environment and communities. Indeed the shift of public health responsibilities to the Council was driven by a national recognition of the critical importance of these factors in enabling good health and wellbeing.

Key Issues around the health of the public are

- Life expectancy (LE) in Essex is improving but slowly and level could be better.
- There is geographical variation, Harlow and especially Tendring are NOT seeing an improvement currently.
- Vulnerable groups e.g. people with mental health have lower LE.
- Key causes of early death are heart disease, stroke, and cancers.
- Mental health issues are the commonest cause of ill health.
- While LE improves, it is likely older people will be as a rule, in better health (80 as new 70)

Key issues defining our response are:-

- Health is driven by broader determinants that are within the sphere of influence of ECC
- These are largely linked to material wealth. The most important influences are Economic growth and employment, early years support and Educational attainment. Delivering health improvements through these areas may take decades in some cases.
- Community safety, housing and the environment are other key broad determinants
- Lifestyle choices drive health and include smoking, alcohol, weight, physical activity, substance misuse and sexual health. Many of these can have a quick impact on health.
- Short term gains are best achieved through clinical preventative interventions delivered through largely primary care addressing blood pressure, cholesterol, falls, continence and depression. Many of these can have a quick impact on health.

Public Health principles in Essex have been set by a Member's Reference Group and include a focus on addressing inequalities. This is an important driver in our actions to deliver this outcome. While generally an affluent county, the most deprived area in the whole of England lies within Essex and there are particular vulnerable groups within the Essex population who suffer poor health outcomes.

Our strategic response needs to address this. Services need to be available to the whole population but should be particularly targeted at those with the greatest needs who are often less likely to engage. We also need in some areas to have extra bespoke services addressing the specific needs of these people... This approach is called Proportional Universalism

5.10.2 Aims

The overall aim of this strategy is to improve the health and wellbeing of people in Essex. The indicators chosen to support this outcome reflect the breadth of action required to deliver improved health. These are set out in figure 21, below. The Strategy emphasises the need to recognise process and output measures as relevant as we strive to achieve often very long term improvements in outcomes.

Figure 21, Public Health Strategy Indicators

Group	Agreed indicators (and groups)
A	People in Essex have a healthy life expectancy
	Reduced differential in life expectancy across different areas of Essex
	Prevalence of healthy lifestyles
	Percentage of Essex residents who consider themselves to be in good health
	Life satisfaction rates (ONS condition of wellbeing)
B	Percentage of children achieving at school
	Percentage of working age people in employment
C	Percentage of families living in safe and suitable housing
	Percentage of households living in fuel poverty
D	Prevalence of mental health disorders among children and adults
E	Teenage pregnancy rates

5.10.3 Critical actions

The public health strategy will be delivered through a combination of:

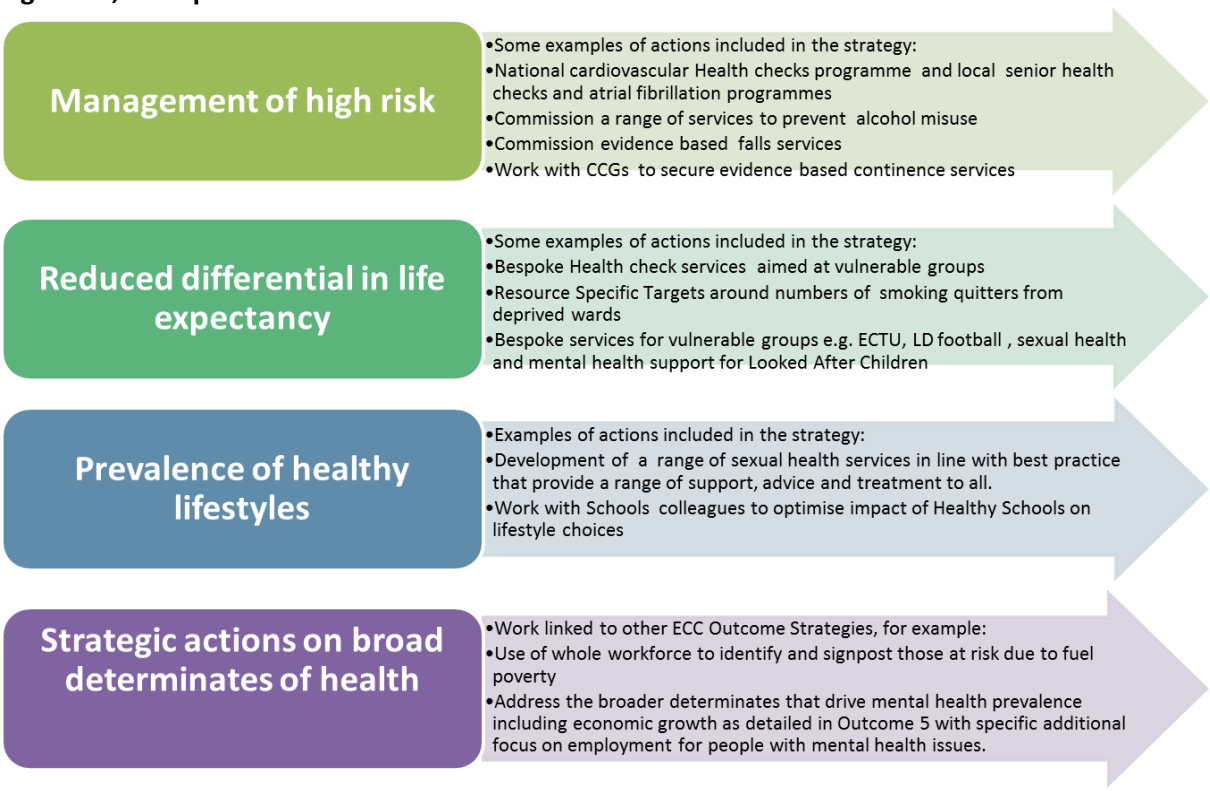
- **Addressing broad determinates** of health, for example school achievement, employment and giving children the best start.
- **Addressing lifestyle**
- Identification and **management of people at high risk** or with conditions through clinical interventions.

There will be a specific additional focus on reducing inequalities

The Public Health Strategy describes a programme of initiatives and actions that will be implemented over the lifetime of the strategy. A brief summary of some of the action areas and actions is included in figure 22, below.

Success in this work will require close work with other key partners who have a major impact on public health, these include the NHS, district, borough and city councils, schools, police, fire services and voluntary sector groups, local employers and communities

Figure 22, Examples of Public Health initiatives and actions



5.10.4 Implementation timeline

The majority of initiatives and actions included in the strategy are due to be implemented during 2014/15 and 2015/16. The programme is complex and includes many initiatives that deliver several of the ECC Outcome Ambitions. Many initiatives addressing broader determinants will take decades to yield optimal health gain.

5.10.5 Costs

The Public Health budget aligned to this outcome is wholly funded through the national Public health grant. Historic public health spend by the NHS in Essex has been low and the Essex Public Health grant shortfall may rise to be around 10% below target, by 2015/16. The gross expenditure budget in 14/15 for Public Health services is £51.7m. Unless Essex is able to attract its “fair share” capitation, it will not be possible to deliver all elements of the strategy.

5.11 Governance and risk

5.12.1 Introduction

This section of the document describes the governance arrangements in place to oversee delivery of the pan-Essex projects and strategies described above, and also includes a summary of the main risks to delivery.

5.12.2 Governance

The overall governance for the delivery of most of the pan-Essex initiatives described above is the responsibility of the Health and Wellbeing Board. A paper has recently been approved by the Board recommending some changes to governance arrangements, in part to accommodate the increased volume of joint working resulting from key developments such as the Better Care Fund, pooled budgets and integrated and joint commissioning arrangements.

The following changes have been put in place:

Membership and structural changes

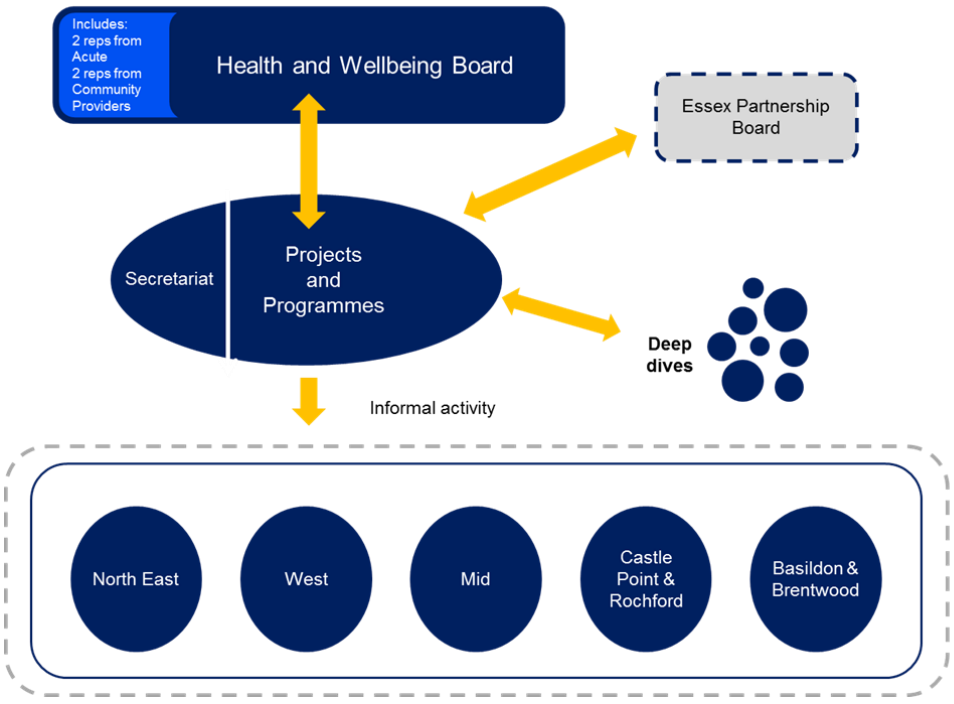
- The appointment of additional members to the Health & Wellbeing Board, including two representatives from the Essex acute hospital trusts and two representatives from the mental health and non-acute providers
- The establishment of a Secretariat representing health partners to plan the Board's business including the Health and Wellbeing strategy; to ensure that regular strategic reports are considered by the Board, giving assurance on agreed spend and outcomes in pooled budget areas and having regard to safeguarding
- The Board will appoint task and finish groups, chaired by a HWB member, to undertake special reviews on specific areas to report back to the Board on their findings. In planning this work, the HWB would have regard to HOSC's forward programme and other review activity.
- The establishment of a 'Health and Social Care Programme and Project Board', representing health partners, to manage the health and social care integration agenda.
- Each CCG will invite a member of the Council, nominated by the Leader, to attend and speak at their Board meetings.

Scope of work - pooled budgets and strengthening and mobilising communities

- The Board will (subject to approval by the ECC Cabinet and CCG Boards) consider annually the County wide pooled budget arrangements between Essex County Council and the CCG's, including the 'envelope' of resources
- The key activity of strengthening and mobilising communities arising from the 'Who Will Care?' commission will be progressed by the Essex Partnership Board, with regular reports to the Board.

The governance structure is set out in figure 23, below

Figure 23, Health and Wellbeing Board structure as at May 2014



The Programme Board will oversee many of the improvement programmes described above, and each programme will have a health and an ECC Lead.

5.12.3 Risk

A high level risk register for the pan-Essex projects is included below. Risks will be monitored by the Programme Board.

ID	Project/Initiative	Description & Implication	Mitigating Actions & Updates
1	Primary care + BCC	Risk to sustainability of acute providers as a result of transfer of funds to other sectors, e.g. via BCF and primary care strategy	Acute Services Review, commissioner/provider discussions, ?transitional financial support
2	Primary care (?others)	Risk of strategic failure due to lack of appropriate workforce to support new models of care	Workforce strategies to address
3	Health & Wellbeing strategy and others	Public unable or unwilling to move towards a model of self-care	Engagement strategies (and already engaged in planning process), partnerships with third sector
4	All	Failure to realise financial savings required, resulting in unplanned collapse of service provision	
5	All	Statutory agencies unable to maintain pace of change required	Leadership/OD programme, investment in PMO capacity,
6	All projects including major service change	Risk of legal or competition challenges, prevention of major service reconfiguration	Time and resource allocated to public and political engagement, focus on strong clinical case for change

5.12 Confidence levels of implementation

The pan-Essex plans described above are bold, and involve the creation and delivery of a new model of health and social care. It will be challenging to implement these during a period of intense financial pressure for both health and social care.

However, the organisations who are signatories to this plan are confident that once the challenges and risks are taken into account, this plan can be delivered successfully. This confidence is in part based upon a strong history of joint working across Essex, supported by the development increasingly close governance arrangements.

6 Enablers

6.1 Introduction

Chapter 2 of this plan describes work undertaken over the past 12 months to consider the enablers required to ensure the successful delivery of our ambitious pan-Essex plans. Participants in these workshops identified the following major issues:

- Community mobilisation
- Workforce
- Data sharing and Information Technology
- Development of integrated commissioning models, including a single public sector commissioner
- Ensuring that we develop a model of leadership and a way of working appropriate to the challenges that we face, for example:
    - Consideration of distributed leadership model
    - Pan Essex organisational development work to support system leaders during a time of major change
    - The wider adoption of the '100 day challenge' approach to delivering rapid service improvement
    - Ensuring that we co-vision and develop plans with service users

Some work is already in hand to deliver these and other relevant enablers and this is briefly summarised below. Further work may need to be commissioned or existing work accelerated on the following areas:

- The creation of a Pan-Essex integrated workforce plan for both provider and commissioner staff
- Rapid development of information sharing protocols and supporting IT system [subject to confirmation once detail received of existing Informatics/IT work]
- Leadership development and a focus on changing the way that we work together

6.2 Community mobilisation

Introduction and aims

One of the solutions proposed by the Who Will Care? Commission to the challenges facing Essex was to mobilise communities to play a greater role in supporting vulnerable people. This proposal builds on existing work to strengthen communities being undertaken through Whole Essex Community Budgets.

Planned work

One important initiative is Community Agent Essex. This is a new county wide approach to help meet the care needs of an ageing population. The scheme was initiated by a partnership of voluntary sector organisations in direct response to the 'Who Will Care?' Commission's report. It will be fully owned and led by the voluntary sector, (Age UK Essex, British Red Cross, Rural Community Council of Essex and Neighbourhood Watch) with ECC funding the initial stimulation of the model.

Through the establishment of a network of community agents and volunteers, the scheme will manage demand on social care and health services targeting those older people and their carers most likely to require support in the near future – identified through referral by Social Care Direct, GPs and the community – and delay or divert their need by helping individuals to identify and implement solutions to the issues they face, with the support of their local networks and communities.

It is expected, that once fully established that the scheme will support 6,000 people per year, helping them gain and regain independent living skills and enabling them to find their own solutions.

In addition a Mobilising Essex event was held in April and identified agreed 3 successful local VCS schemes that should be replicated across Essex. ECC is now funding the roll out. The event also identified the support that groups thought was needed to help them thrive. These ideas are being taken forward through a multi-agency group which is also supporting the development of time and care banking, volunteering schemes and work to celebrate and promote caring. This group reports to the Essex Partnership Board which it has been agreed will lead work on mobilizing communities. The work on mobilizing communities is complemented by the development of a VCS strategic framework setting out how the public and voluntary sectors can work together to tackle rising demand at a time of diminishing resources.

In addition each CCG is working on its own approach to community mobilization as set out in individual plans.

6.3 Market development

Several of the programmes of work described in chapter 5 of this plan require commissioners to help the health and care market to collaborate and deliver single offers to large contracts for integrated services centred on a particular client group, for example the learning disability service which will be mobilised by 2016 and the re-provision of CAMH services in which ECC and all 7 CCGs are participating. Commissioners need existing good quality providers to make this transition with us, and we want to help them to collaborate.

The CCG Five year plans include a range of local plans for market development. There is some common ground within these plans, in particular across the following areas:

- Development of new methods of contracting, including the Accountable Lead Provider Model. Under this type of model, a single provider takes a prime contractor role, and assumes responsibility for the provider supply chain. This has already been implemented in North East Essex for
- Development of new contract currencies, for example 'year of care'. These currencies typically provide funding to providers on a population wide basis, with the provider then sharing the risk of providing care for a population group or a care pathway, for example for a group of frail elderly citizens or provision of all clinical care for diabetes patients. The aim with this type of initiative is to incentivise behaviours that are conducive to seamless integrated care and to the provision of care closer to home.
- Market management to increase the range of providers available, for example contracting with primary care for a wider range of services or contracting with third sector providers for appropriate services.
- Development of outcomes focused service level agreements and contracts

6.4 Information sharing and information technology

Introduction and aims

Difficulties in sharing data between health and social care partners, and even between health partners has long been recognised as a key enabler of closer health and care integration, and often as a barrier to progress at both an operational level and for commissioners. The 2013 Caldicott review of information governance across health and social care identified a new data principle which states that:

'The duty to share information can be as important as the duty to protect patient confidentiality'

However, in practice in Essex as elsewhere in the country, there has been considerable anxiety about the Information Governance implications of data sharing, as well as difficulty in developing the systems required to support information sharing and the creation of shared health and care records.

The 'Who will Care?' Commission identified the need to **'Use data and technology to the advantage of the people of Essex'** as one of their four high impact solutions. A Task and Finish Group was subsequently established to take this forward.

Planned work

A Task & Finish group has been established, made up of different organisations from around the County, including Essex Fire, CCGs, NHS, Police & Crime Commissioners, Commissioning Support Unit and University of Essex. It was originally put together to work with the Cabinet Office on shaping guidance being drawn up as part of the future 'Data Bill'. The Task and Finish Group has the potential to contribute to this work.

The Task and Finish group supports the process of cross agency challenges of information and data sharing within Essex and encourage the sharing of large scale data and information across key agencies, e.g. large group information that could be used to plan services. We want to overcome the 'micro' information sharing challenges (the sharing of smaller scale individual data across key agencies), e.g. information that assists the planning for and safeguarding of individuals.

The production and ratification of formal information sharing protocols are agreed by all key agencies represented within the Task and Finish group.

The Task and Finish group are exploring opportunities to lobby central government with regards to future information sharing legislation and guidance, with particular reference to the future 'Data Bill'. To date, the Task and Finish Group has achieved:

- Data Sharing Protocols have been written and are being signed up to by external partners across Essex
- A Whole Essex Information Sharing Framework (WEISF) has been set up as a central repository for external partners to find out how to share data, review and sign up to the Protocols and review policies
- A Launch event took place on 27 March to get external partners to sign up to the Framework
- A Predictive Tools Analysis is being led by Anglia University – this piece of work is looking at sharing data around patients that are at risk of falling and how by data sharing, organisations can be more proactive at putting steps in place that reduce the risk.
- Anglia University are putting an application forward to NHS England to request funding as part of the Regional innovation Fund (RIF). Cllr Finch and Chris Martin have agreed to partner and support the application

North East Essex CCG have commissioned a health risk-stratification tool and have received confirmation from NHS England that the can share information with their provider under current guidelines for this purpose. This will be rolled out for use by services such as General Practice.

A separate project has now been launched by the Essex Area Team to develop an information strategy for Essex.

6.5 Workforce

Introduction and aims

The successful implementation of the initiatives described in chapter 5 of this plan is highly dependent upon the availability of a workforce in the right numbers and with the necessary skills.

A number of gaps have already been identified in the current workforce, for example the Essex Primary Care Strategy has identified a need for 143 additional General Practitioners and the creation of 100

new General Nurse Practitioner posts. Workforce shortages are a driver in other projects, for example the Acute Services Review was partly started in response to concerns about workforce pressures in acute hospitals. Some limited workforce planning work is in place in the NHS, and this is described below.

However, it feels as though workforce planning in Essex is still rather piecemeal, despite the best efforts of individual projects and workforce planning initiatives. It is proposed that a pan-Essex workforce strategy is created across health and social care, in order to support the implementation of this five year plan.

Planned work

Health
The Essex Workforce Intelligence Group has been convened by health provider organisations in Essex. The group is taking a pan-Essex strategic view of future workforce requirements, based on triangulating the following plans:

- Commissioner plans (2, 5 year and BCF)
- Provider workforce plans – to be completed by 30th June
- Financial planning from both commissioners and providers

The Group is considering examples of best practice from elsewhere and the Implications for Education commissioned, training of new recruits and (re)training of staff already in the system. The Group is due to produce a report and recommendations in September 2014.

To date this process has identified disconnects between the commissioner plans and the provider forecasts of staff requirements.

A separate project is also underway to identify education requirements across the health care workforce, and work is also in hand to develop a workforce plan for the primary care workforce.

Social care
The Adult Operations team at ECC published a workforce strategy in June 2013. The strategy is based upon the core principle of 'Developing plans that meet the workforce needs which will also build professional competence and confidence while minimising bureaucracy.' To support this six strategic workforce priorities have been identified:

Strategic Workforce Priorities
Priority 1 – Workforce Intelligence
Priority 2 – Recruitment and Retention
Priority 3 – Qualified and Unqualified Workforce
Priority 4 – Leadership & Management
Priority 5 – Productivity & Performance
Priority 6 – External Care Workforce

A number of actions have been identified to enable this strategy to be delivered, including the development of new delivery models, behaviours and culture change.

The health and care workforce
A significant amount of work has been completed or is underway to develop workforce strategies and plans and education strategies. However, this work does not feel well co-ordinated or integrated at present and it seems seem sensible to link together the various workforce strategies and planning

processes described above as part of this five year planning process, to create an Essex health and care workforce strategy.

6.6 Estates

The new model of primary working described in chapter 5 of this plan have created an urgent need to understand where an how extended provision can be delivered and how the investment required might be funded. NHS England is about to start some work on this issue.

There are also wider issues around identifying premises suitable for the co-location of integrated teams and the need for CCGs to work with provider organisation to assess the impact of the shift of care from hospital based provision on existing hospital building stock and that any investment decision on increasing community based capacity takes into account any stranded costs for providers left by under-utilised estate.

The "better use of public sector estate programme" offers an opportunity to make the best use of estate across health and ECC.

6.7 Integration and pooled budgets

Introduction

Essex has already made considerable progress towards the delivery of integrated commissioning, supported by the creation of pooled budgets. ECC, the CCG's and the NHS Commissioning Board understand that lock-in to integrated commissioning will only happen when joint service contracts are signed. In reality, due to contractual commitments already in place this will happen mainly from 2014/15 onwards.

A significant amount of work has already been undertaken in preparation for this, and achievements to date include the appointment of Integration Directors with fully delegated responsibility, aligned to each CCG, supported by a business management function and Public Health Consultants within each CCG.

Planned work

There is emerging consensus across Essex on adopting an Integrated Commissioning approach to a set of common themes to enable independence, provide support, care and services at different system levels across a range of care groups:

- Older People – to be commissioned locally on a CCG footprint, within an overarching strategic framework for the county.
- Mental Health services – to be commissioned on a north and south Essex basis.
- Learning Disabilities – to be commissioned on a north and south Essex basis to start and explore opportunity for Essex-wide approach.
- Children's services – a mixture of local and Essex-wide as appropriate.
- Public Health – mainly at Essex level, some at local level and some by Public Health England.

A formal Section 75 arrangement for Essex was put in place for Learning disabilities in North Essex in April 2014. This is intended to be the first agreement in an intended 'pipeline' of similar arrangements for each care group. Discussion has begun about how this model could be extended across Essex, underpinned by pooled budgets.

The CAMH re-provision described in Chapter 5 of this document will also need to be underpinned by the development of pooled health and social care budgets.

The Better Care Fund Programme of work includes a work stream to develop integrated commissioning and pooled budgets, with a focus primarily on care for Older People. The Essex Chief Financial Officers Group is currently developing the Section 75 agreements for the Better Care Fund, and this will underpin the scope of the use of pooled budgets. CCG's have identified funding for the pooled budgets as per the national guidance in 'Everyone Counts'.

6.8 Development of system leadership

In order to respond to the challenges set out in this Five Year Plan it is proposed that a system wide organisational development programme is considered, to support system leaders so that they can lead Essex health and care services through a period of major change.

7 CCG Executive Summaries and Plans on a page

7.1 Basildon and Brentwood CCG Executive Summary and plan on a page

7.1.1 Introduction

Our vision is to create 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 intend to **improve outcomes** for our local communities and 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.

We are working with others in the system, especially Essex County Council as commissioner of social care services, but also our service providers, large and small. To strengthen these arrangements, in 2014 our aligned ECC Director of Integrated Commissioning became a joint appointment with the CCG to lead the commissioning integration programme across our organisations and ensure that our commissioned services provide holistic care to our patients. A key development during the lifetime of this plan is the introduction of the **Better Care Fund** and the pooling of up to £25m from our NHS budget to a joint commissioning fund with social care. Our aim is that this helps to achieve a reduction in emergency admissions by 15% by 2019 and only those patients with an appropriate medical need will be admitted to hospital.

7.1.2 Specific Outcomes

We will take immediate steps **to reduce health inequalities** in our local communities through the implementation of 8 high impact pathways identified from the JSNA, 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 medical outcomes for people with long term mental illness.

We will prioritise delivery of the requirements set out in **NHS Constitution**, in particular focusing on our work to introduce 7 day working, 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 patients will know that any contact they have with services will be available to their named primary care clinical lead.

We will maintain the necessary rigor and discipline to maintain our **Financial and QIPP** position and we intend to deliver the national planning requirements in terms of both our surplus and non-recurrent funding headroom. We will work with our providers to help them achieve a 20% productivity gain.

We have a **Patient and Community Reference Group** in place and more than 20 **Patient Leaders** engaged to participate in the quality assurance of service delivery and co-production of service redesign.

Primary Care

We have identified 3 key aims to deliver our programme, mostly centred around supporting the development of new primary care models across our practices. We will be exploring the options for **co-commissioning** with NHSE Area Team to facilitate delivery of these ambitions and promote the new model of primary care delivery we believe is necessary if we are to achieve the outcomes we want for our patients.

Aim 1: Excellent primary care

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 have worked 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.

Our practices are now coming together to form federations (a local form of the primary care hubs described in the formative Essex Primary Care Strategy) with a view to:

- allow for peer-support between GPs
- provide a mechanism through which practices can tackle financial sustainability issues
- offer consistent appointments, across both extended hours and 7 days a week
- allow GPs to specialise in particular care areas
- work with NHS England to support general practice to improve the standard of care
- address the workforce issues and encourage the spread of training practices.

The formation of the federated teams is taking place across two of the existing CCG localities, and some new arrangements which span different locality groups where this makes community or geographic sense. Based on locality profiles, the expectation is that there could be up to 5 federations each serving a population of between 30,000 and 75,000 patients. This is aimed at delivering the extended range of care processes and to move general practice towards a 7 day service, operating for longer hours each day. Not all our practices will have the workforce or infrastructure to achieve this but by working together in federations we can help them maximise existing resources. Patients will access a local network of services, facilitated by the single care record.

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.

Federation configured, 'Named GP Teams' will be the sole deliverer of front line care to people with complex needs and long term conditions, to include existing generic community, social care and mental health resources. This clearly aligns with the requirements of the new GP contract and our aims for 7 day working mentioned above.

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. All services will be clustered around patients, with most commissioned jointly by health and social care through the Better Care Fund (BCF).

It is proposed that these teams would first 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 and ultimately towards a formally configured single integrated care organisation.

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.

7.1.3 Local system challenges

There is expected growth of up to c25, 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 also recognise existing workforce shortages as we are already experiencing difficulty in recruiting GPs and Essex already has one of the lowest levels of GPs/1000 population in the country.

We have had some very high profile quality challenges in our provider units resulting in a number of inspections and remedial plans, but our providers have responded positively and proactively. We have seen some vast improvements over the past months but it has made us aware that we must not become complacent and quality must remain at the heart of all we strive for.

Many people in our communities who are not high risk or regular users of the health service are not satisfied with their current ability to access the NHS on an episodic basis. We must respond to this message and make sure our services are fit for everyone's needs.

Whilst we have some very good commissioned services in place, the system has become very complicated with a high degree of overlap, and involves too many hand overs between organisations and services.

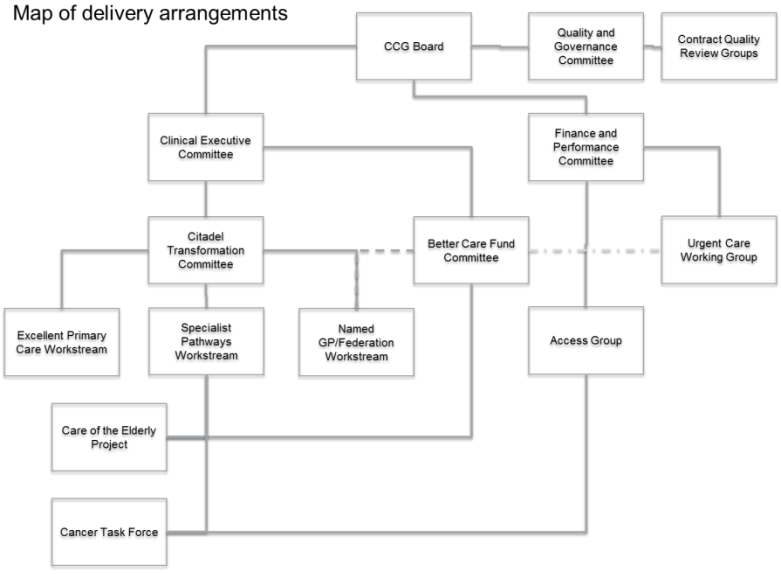
And we recognise that public services alone will not provider for every demand– we must play our part in building and maintaining community resilience to help people take more care of their own health and wellbeing.

7.1.4 Governance and Delivery mechanisms

BBCCG has set out in detail how it will achieve national and local improvement interventions in its 2 year Operational Plan, in line with the overarching ambitions set out in the Essex Five Year Plan. In order to deliver our plans, the CCG is currently reviewing the governance and working arrangements which it has in place. The table and graphic below summarises our current thinking on the structural arrangements which are required to ensure successful delivery.

Measure	Primary delivery mechanism	Supporting delivery mechanism
Domain 1/Ambition 1/Measure 1 Securing additional years of life	Transformation Committee	Named GP Teams Workstream
Domain 2/Ambition 2/Measure 2 Health related quality of life	Transformation Committee	Named GP Teams Workstream
Domain 2/Ambition 2/Measure 3 Roll out of IAPT	Transformation Committee	Named GP Teams Workstream
Domain 2/Ambition 2/Supp' M 1 Dementia Diagnosis	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.	Transformation Committee	Named GP Teams Workstream
Domain 3/Ambition 4/ Supp' M 2 65+ at home 91 days after discharge	Integrated Commissioning Programme Board	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	Transformation Committee	Excellence in Primary Care Workstream

Map of delivery arrangements



Details of the Proposals

Further details of the above proposals with supporting financial data and metrics are contained in the following documents:

2 Year Operational Plan (March 2014)

5 Year Financial Plan (March 2014)

Full version of the BBCCG Five Year Plan (draft version June 2014)

BBCCG, Phoenix Place, Christopher Martin Road, Basildon SS14 3HG

Tom Abell, Chief Officer tom.abell@nhs.net

Tonia Parsons, Chief Operating Officer tonia.parsons1@nhs.net

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BBCCG 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

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

7.2 Castle Point and Rochford CCG Executive Summary and plan on a page

NHS CASTLE POINT & ROCHFORD CCG

EXECUTIVE SUMMARY

We are pleased to introduce the NHS Castle Point and Rochford Clinical Commissioning Group 5 year (CCG) Strategic Plan. It is a strategic plan for our localities, which both reflects and builds upon the 2013/14 Integrated Plan for the CCG. The plan sets out the work we are undertaking in collaboration with our partners in neighbouring CCGs and Essex County Council. The plan sets out bold and ambitious plans for transformational change that must take place across our health care system over the next 5 years while maintaining strong focus and delivery quality, meeting public expectations, maintaining financial sustainability and building for the future. Achieving financial balance is expected with the intention to go further and realise efficiency gains.

Our patients will continue to have the opportunity to fully integrate with the commissioning business processes of the CCG. Our aim is for all of our CCG practices to have practice-level patient representative groups linking to our CCG Commissioning Reference Group (Patient Engagement Committee), membership of which is drawn from these practice groups alongside engagement with our third sector.

In order to support the effective delivery of integrated commissioning, the CCG will address five key challenges:

- Making the NHS patient centred;
- Reinforcing the multidisciplinary approach;
- Working closely with the Local Authority;
- Creating a seamless service, and;
- Expanding primary healthcare services.

A fundamental aspect of our future system will be the greater integration of health and social care. We will be working closely with our partners at Essex County Council, NHS Southend CCG and NHS Basildon and Brentwood CCG (alongside local providers) to develop our plans for Better Care Fund (BCF). We have already agreed areas of joint working 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:

- Focus on vulnerable frail elderly across health and social care with particular focus given to admissions avoidance and re-ablement, and in particular in working to shift the balance of care in Castle Point & Rochford.
- Children and Young people's services including safeguarding and re-commission CAMHS services
- Mental Health and Learning Disabilities

This Strategic Plan for 2014/19 details how our localities through the CCG intend to deliver improvements to the population it serves, ensuring the best quality and value in health services. The current economic situation means that the NHS has to continue to provide excellent healthcare while living in leaner times. The CCG's ambition is to ensure that the populations of Rayleigh,

Hockley, Rochford, Great Wakering, Hadleigh, Benfleet and Canvey Island continue to enjoy the best possible health. This strategic plan sets out how the CCG intends to realise that ambition.

CASTLE POINT & ROCHFORD CCG CHALLENGES & PRIORITIES

The challenges the health and care system in Castle Point and Rochford faces now and in the future are not unique.

- The number of people over 65 years will increase by 65 per cent in the next 25 years. Nearly two-thirds of our patients admitted to hospital are over 65.

- We are seeing increasing prevalence of long-term conditions as the population ages – half of those currently aged over 60 have chronic illness.

- We need 'transform' and change if our system is not to fail – which means we need new approaches for the hospital, in our community and for our workforce.

Our District General Hospital cannot provide everything in 2014 and beyond. The demand for health will increase with our ageing population and demands for 7-day service.

WHAT WOULD SUCCESS IN OUR SYSTEM LOOK LIKE?

- More sustainable, integrated services and more patients cared for closer to home
- Higher quality care: our local providers being among the best performers in the country (using NHS Atlas of Variation to compare).
- Enhanced workforce with improved training skills and knowledge of our NHS staff: doctors, nurses but also health care assistants and other support staff.
- More local prevention and self-care: (continued focus on smoking and obesity which underlie half of avoidable deaths in UK men aged 35-70).

HOW DOES NHS CPR CCG INTEND TO ACHIEVE CHANGE?

- ***Reconfiguration****:* we cannot deliver every service everywhere.
- ***Scope of practice***: – highly trained staff should be doing what they have been trained to do, not administrative tasks.
- ***Working smarter***: IT can allow staff to spend more time on patients and less time on 'back office' activities.
- ***Training a flexible workforce****:* the new world will need fewer specialists and more 'generalists'. Some generalists would subsequently train further in a sub-specialty.
- ***Blur primary and secondary care in both directions****:* GPs can be very skilled at keeping people out of hospital and specialists can help manage more complex cases in the community.

Castle Point & Rochford CCG envisages a radically different health care system in 5 years' time, emerging through a focus and commitment to transformation in the following prioritised key areas:

Castle Point and Rochford CCG Vision Priority Areas

1. A focus on **Transforming the care of the vulnerable elderly**
2. Recognition that the **home, and not the hospital**, is the main location where healthcare will take place
3. A focus on **personalised and preventative care** (linked to emerging technology trends)
4. A focus on delivering **Care outside of the Hospital**
5. **Planned Surgical Care**: Driving higher volume through fewer centres
6. Focus on **Children's Health Care**
7. **Significantly Improve Quality in Primary Care**

Castle Point and Rochford CCG Plan on a page

Purpose	Improve the health and well-being of the Castle Point & Rochford population

Vision	Transforming the care of the vulnerable elderly	'Home, not hospital'	Personalised & Preventive Care	Delivering Care outside the Hospital	Planned surgical care: driving higher volume through fewer	Focus on Children and Young People	Quality in Primary Care
Objectives	1. Effective individual LTC, improving outcomes and reducing health inequalities	2. Improve patient experience for both physical and mental health services	3. Drive forward transformation of specialist services, supporting centres of expertise	4. Improve patient safety to reduce harm and increase patient confidence	5. Shifting 5% of resources from secondary to primary and community services	6. Integrating Health Social Care through partnership working	7. Strengthened collaborative commissioning and contracting

Strategic Plan

Key Transformational Changes	Investment	Savings by 2018/19
Vulnerable Elderly - Commission integrated health and social care management hubs in both CCG localities to improve care for the vulnerable elderly.	£1.1m	
Vulnerable Elderly - Developing and implementing community and acute frailty pathways including intermediate care beds and a full review of ambulatory emergency care.		
Home not Hospital - Treating patients in the comfort of their homes, and tailoring care to individual patient's needs through telemedicine and remote consultations		
Delivering care Out of Hospital: Develop and deliver Joint Activity Reduction Plan in partnership with Southend CCG and SUHFT to reduce acute based activity, focus on MSK, ophthalmology, paediatric reductions		£4.3m
Personalised & Preventive Care - Co-production and self-management, facilitated by technology, will be at the heart of this new model, enabling the home to safely be the location for higher acuity health care		
Higher Volume/Fewer Centres: Support the review of Essex acute hospitals and implement recommendations for sub-specialisation		
Children's & Young People Services – We will work with partners to re-commission Children Adolescent and Mental Health Services on an Essex wide basis		
Primary Care: CCG will invest in a programme of targeted primary care development to support the delivery of the Strategy and the associated goals to reduce the variability of primary care quality and outcomes so that patients across the localities receive the same high standard of care		

Support Funct.	**Enabled by** Robust Contract Management Innovation Groups Research & Development	**Governed by** ECC, CPR CCG & B&B CCG system leadership group Business Management Group of the H&W Board System wide Urgent Care Group	**Measured by** Delivery of objectives All organisations report a financial surplus in 18/19 No provider under enhanced regulatory scrutiny due to performance concerns	**Values and Principles** No-one tries harder for patients and the community Best outcomes for every pound invested Cohesive working to build tolerance, understanding and co-operation

7.3 Mid Essex CCG Executive Summary and plan on a page

1. Local system challenges

In common with the other Essex CCGs Mid-Essex is facing a number of major pressures and challenges, and these are expected to increase over the five years covered by this plan.

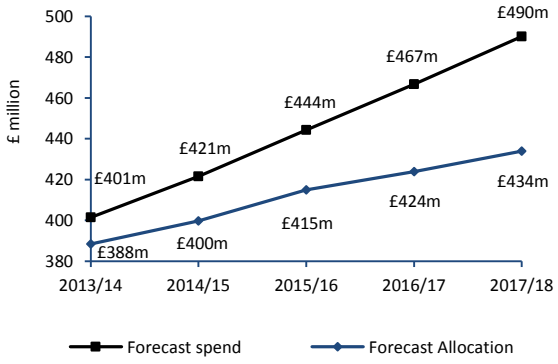
Population need

The population is growing and significantly ageing, with people living longer and having more complex needs. The over 75 age group is forecast to increase by 39% in Mid Essex between 2013 and 2021.

Financial pressure

Funding increases in the NHS and social care service supply are likely to fail to keep pace with demand. This is not sustainable in the long term. Financial viability will inevitably have an impact on patient care. In Mid-Essex under-achievement of QIPP and excess accruals for CHC have led to a 2013/14 draft outturn deficit of £(9.1)million. A 'do nothing' approach would lead to a projected cumulative deficit of £(163) million by 2017/18.

Forecast spend (pre initiatives) and allocation



Maintaining operational performance and clinical outcomes

The CCG performs well in health outcome and patient care measures, with one of the lowest Potential Years of Life Lost figures nationally. Planned and emergency hospital admissions are below the national average (per 1,000 population, based on 2011 data).

The CCG receives a relatively low allocation per head of population. We are exploring how other CCGs with similar allocations and population demographics achieve financial surplus as well as good patient outcomes and care.

Our detailed 5 year plan explains how the CCG will address the challenge of maintaining high quality outcomes whilst reducing costs if it is to achieve the vision of working with partners and providers to deliver sustainable first class health and social care. Work is continuing to develop the plan but the CCG plans to achieve financial balance by 2017/18 and will continue to work with Mid Essex providers and partners to enable the whole system to achieve and maintain financial sustainability.

2. Our vision for the future

Our vision for Mid Essex is: *'Our communities working together to create innovative and sustainable local services delivering integrated first class health and social care for all'*

This vision will be delivered though:

Our Key System Objectives

- Resilient and engaged communities and citizens
- Person-centred and integrated care
- Appropriate use of and access to health and social care 7 days per week
- Improving patient experience and outcomes
- Whole system financial sustainability

Our 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 health and social care system financially stable by 18/19

As the plan on a page illustrates the CCG has developed a series of transformation programmes, based on the clinical vision to transform health and social care services across Mid Essex. These programmes are being developed with system partners to meet the particular needs of people at different life stages with better outcomes at lower costs as well as a big emphasis on supporting patients to self-care and self-manage long term conditions, prevention and early intervention, and developing and connecting with existing community resources. The programmes are described in detail in our CCG 5 Year Plan. The Better Care Fund and associated commissioning integration with Essex County Council is a key enabler for a number of these programmes which will support delivery of the agreed BCF outcomes and metrics.

The clinical model and transformation vision were informed by a series of engagement events with local Practices, as well as meetings and discussions with patient groups, local councils, providers, and voluntary and community groups. Feedback from these sessions has been supportive but with a desire for the CCG to take some difficult decisions and be the driver of this change.

The 5 Year Plan has been informed and supported by the input of nationally commissioned 'critical friends'.

3. Quality and outcomes

Linked to our Vision, the CCG's overarching defining outcomes are:

- Mid Essex residents to live a healthier and longer life
- Mid Essex residents are supported to look after their health and wellbeing
- Reduce inequalities in health for Mid Essex residents by narrowing the gap in life expectancy
- Mid Essex residents will be provided with good quality, harm free and affordable healthcare
- Mid Essex residents who are frail and have a long term condition will receive integrated health and social care services that will reduce their need to utilise health and social care services
- Mid Essex residents to be supported to access and use healthcare services appropriately

The outcomes that the CCG will commission for has been informed by the Essex and Mid Essex Joint Strategic Needs Assessments (JSNAs), the Health and Wellbeing Strategy, national and local NHS priorities and other important sources of information and insight such as from patients, the public and health care professionals. The CCG's JSNA has extensive analyses of clinical benchmarking and made use of programme budgeting information, the CCG's 'Commissioning for Value' pack and latest local data was utilised for cross-validation purposes. We will implement outcome based commissioning of pathways and

use hard and soft intelligence to drive up quality, improve health and care outcomes and continue to drive a reduction in health inequalities.

The CCG's Transformation programme is the cornerstone of integrated commissioning, embracing the proposals of the Essex *Who will Care?* Review and has been aligned to the Better Care Funding agenda. In order to achieve true transformation, we will need different, and often more generic, skill sets with staff working as integrated and multi-disciplinary teams. This potential to work differently and more effectively with greater collaboration extends across all components of our health and care system including acute hospital teams, community staff, primary care and social care. Indeed, integration and close working between these components may influence and facilitate changes to the workforce.

The NHS/CCG Outcomes Framework describes the five main domains of better outcomes that the NHS and our local partners have agreed to secure over the next five years:

- 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.

A detailed analysis of current position against these outcomes is contained in the CCG's 2 year Operational Plan.

4. Governance and policy

The CCG has a statutory duty to consult local people about the services that it commissions. The CCG views local engagement in commissioning as essential to make those we serve equitable partners in shaping a modern health, well-being and social care support service. Clinicians and service providers have also played a central role in the development of our Transformation programme. We will continue to work with drive, passion and commitment, and inclusivity with all stakeholders, to drive up quality, improve equity of provision and help ensure the financial sustainability of our local NHS.
The CCG has also worked closely with the Essex HWB Board to ensure their understanding, support and sign off of the CCG's plans. The CCG has also run a very well supported local integrated health and wellbeing forum for working with ECC and local councils in Mid Essex. This forum is now subsumed within the Mid Essex Living Well and Safe Programme.

As described above the MECCG and system partners have developed a series of programmes to deliver the vision. Detailed service mapping, patient and public engagement, clinical model design and testing, financial scoping and modelling and planning work is underway at various levels of development across the programmes.

All programmes have clinical and managerial leaders and system partner engagement and report through to a CCG Financial Recovery, Innovation and Transformation Group which is a formal Board sub-committee including ECC representation. The Group approves and monitors delivery of both short term recovery and longer term transformation programmes and projects, to ensure the CCG delivers both the challenge of short term savings and long term strategic transformation.

5. Primary care strategy in Mid Essex

MECCG Vision is to support primary care to thrive and develop in Mid Essex and to drive the delivery of the CCG's 5 Year Plan, including transformation programmes, enabling patients to be treated as close to

home as possible in a timely manner-recognising that primary care includes provision of clinical services by community pharmacists, optometrists and dentists as well as GP practices.

Delivery of the Primary Care Work Programme is twofold:

- To support GPs in delivering a consistently high standard of care to patients across Mid Essex through reduction of variability and in building local capability and capacity.
- To support GPs in the transformation of how primary care is delivered, moving towards strengthened surgery/primary care based practice and creating shared provision of services working closely with all primary care healthcare practitioners and social care in an integrated service.

Plan on a Page – Mid Essex CCG 5 Year Plan on a page

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 DRIVES TRANSFORMATION

Starting Well	Fit and Well	Long term conditions	Frail	End of Life
Embedding healthy lifestyles	Developing capacity for self care & community resilience	Integrating 10, 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
- **Long Term Conditions** House of Care - developing LTC Hubs integrating primary care, voluntary and community support for self management, community health services & specialist services around needs of people with complex needs and co-morbidities. Integrating physical and **mental health**.
- **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**– advice and guidance and engaging practices to develop as providers at scale
- **Children and Young People** – integrating around needs - tba
- Enablers – IT/IG, workforce, pharmacy, estates, PPE, etc

B C F

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

7.4 North East Essex CCG Executive Summary and plan on a page

Executive Summary

These are new and exciting times in health and social care. There is a strong focus on health and social care commissioners working together to plan and buy joined up care for local people. Here in North East Essex, the Clinical Commissioning Group and Essex County Council have been working together for almost two years. We are committed to putting patients and service users first and to ensuring that they are always treated with care, compassion and dignity. As public servants, we are here to work for and with the people of North East Essex to achieve our goal of "Embracing Better Health and Care for All."

We have been working with patients, service users, carers and the wider public to shape the future of services. From November 2013 to March 2014 we held a series of public events known as The Big Care Debate, where we asked the public and community groups for their views and ideas on what they needed to stay healthy and independent. We are using their feedback to help develop our strategies and plans. We are delighted that the North East Essex Health Forum continues to grow in strength and support and that our GP Practice Forums are playing such an active role in helping us to improve services.

We are looking forward to building on these foundations and to implementing our five year vision which is set out in this plan. We are working to:-

- Put people at the centre of their care
- Involve people in planning and developing services
- Buy integrated health and social care which is high quality, evidence-based, cost-effective and sustainable
- Ensure people receive seamless services across their health and care needs

Traditionally health and social care has been commissioned around the needs of the service, rather than the needs of people. This has led to people receiving fragmented care, delivered by many different people. Some care is duplicated, some care is missing.

We will commission joined up services based around the needs of the individual. As well as improving the quality and experience of care, we will be able to make the most of our budgets and resources for the benefit of the people of North East Essex, now and in the future.

This new model of care will benefit all, but we will focus particularly on the needs of four groups of people:-children, frail older people, people with mental health care needs and people with learning disabilities.

We will work together to promote integration across the health and social care systems to ensure that services are planned and commissioned in an integrated way, putting the patient and service user at the centre.

Dr Shane Gordon	Barbara Herts
Clinical Chief Officer	Director of Integrated Commissioning for Vulnerable People
North East Essex CCG	Essex County Council

North East Essex 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	Children's development is promoted through multi-disciplinary support based on level of need. Full range of integrated children's services delivered in the community. 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 , 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		

7.5 West Essex CCG Executive Summary and plan on a page

NHS
West Essex
Clinical Commissioning Group

Essex County Council

5 Year Strategic Plan for West Essex Health and Care System Executive Summary 2014 - 2019

1.0 Our Vision

This plan sets out the strategic direction for the west Essex health and care system over the 5 year period 2014 **/15 to 2018/19**

During 2013/14 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 strategic 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 for improvement against the **CCG Outcome Indicators** and the **7 measurable ambitions**.

The 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.

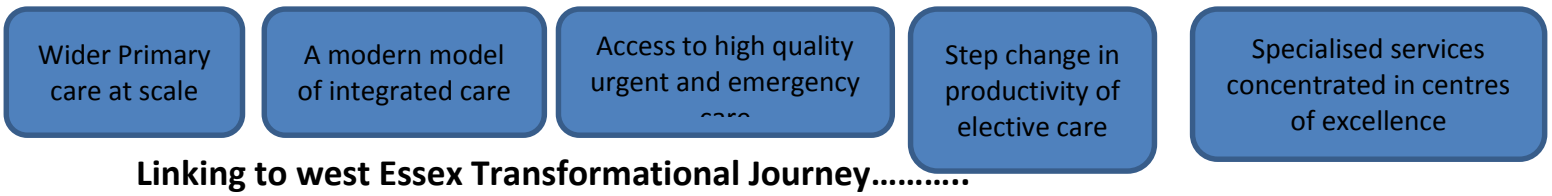
- A step change in **elective care:,** improving how we contract with our providers to ensure the most effective and efficient pathways for our citizens

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.

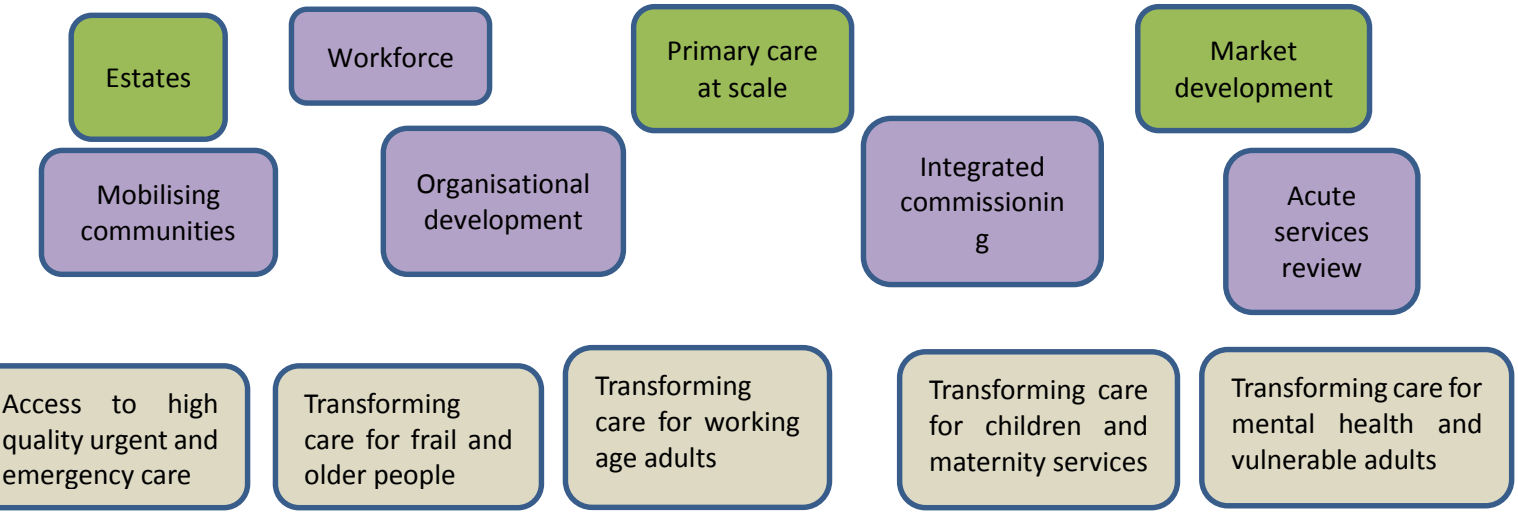
Our ambitious work programme relies on a number of key enablers that will support the improvement in care that we want to achieve. These include:

- Development of a model of **integrated commissioning**
- 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 responsibility.
- 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**

6 Characteristics of a High Quality and Sustainable System (Everyone Counts: Planning for Patients 2014/15 to 2018/19)



Linking to west Essex Transformational Journey…….



2.0 The Quality and Equality Challenge

The average life expectancy for people in west Essex is steadily increasing. A boy born in west Essex today can expect to live until he is 79, and a girl will live until she is 83. Both boy and girl will live one year longer than the England average. However, this average life expectancy differs greatly depending on where in west Essex a child is born because life expectancy is influenced by economic and social determinants, and access to health care services. Someone born in the most affluent parts of west Essex can expect to live up to 11 years longer than someone born in a more deprived area; and there is evidence that the gap is widening within localities.

There are proportionately more people aged 65 or older in west Essex than in the rest of the country, and fewer people aged 15-34. Uttlesford tends to have an older population, and Harlow a younger population. Epping Forest has slightly more older people and fewer young adults. Over the next few years there will be an increase in the proportion of people in west Essex who are 65 or over, especially those aged 85 or over.

'Mortality amenable to health care' is a way of measuring the number of deaths before the age of 75 from complications of conditions such as cancer or diabetes that might have been avoided by better prevention or more timely or better quality care. On average, mortality rates in west Essex are better than the national average, but this is not true in Harlow. In Harlow, premature mortality rates are higher than national and regional average - significantly so for lung cancer. Harlow has the highest rate in Essex for mortality attributable to smoking. Despite improving mortality rates, west Essex's premature mortality rates for circulatory disease, cancer, and respiratory disease have all worsened relative to our peer group. This suggests that the health of the west Essex population is not improving as rapidly as similar neighbourhoods. The NHS Outcomes Framework includes indicators on preventable years of life lost in children and cancer survival. In west Essex the main causes of death in children are genetic and developmental conditions, sudden infant death, conditions of prematurity and low birth weight, cancer and unintentional injuries. With regards to cancer survival in west Essex, one year survival for all cancers is improving but still slightly below national average and not improving as quickly. One and five year survival for breast, lower GI and lung cancers is not significantly different to the national average.

The prevalence of depression (the number of people per 100,000 with the illness) is higher in west Essex than the national average, particularly in Uttlesford. There is a higher prevalence of dementia than the national average, particularly in Epping Forest. The prevalence of coronary heart disease, stroke and diabetes in west Essex is lower than the national average, except Harlow, where there is a higher prevalence of diabetes. However, it is not clear whether a low prevalence indicates a healthy population, or whether it points to the fact that these diseases are going undiagnosed. Data which illustrates expected prevalence rates (based on known risk factors such as age, smoking or obesity) suggest that there are undiagnosed cases of coronary heart disease, stroke and diabetes in west Essex.

Approximately one in four adults in west Essex are obese, and nearly three in ten adults in Harlow. This is likely to be one reason that prevalence of diabetes is higher in Harlow than elsewhere in west Essex. Smoking rates are declining, but we are still seeing high rates of smoking in Harlow, and among routine and manual workers across west Essex. There has been an increase in hospital admissions due to alcohol-related harm.

Not all patients with chronic conditions such as diabetes are receiving the quality of care they should expect (such as blood pressure monitoring, diet and nutritional advice) in primary care. Similarly, people with mental ill health do not always have the best quality care for their physical health needs. We also know that people with learning disabilities and mental ill health have higher premature mortality i.e. they are more likely to die before the age of 75 than other people in west Essex.

These data illustrate the health quality challenge and health inequalities challenges in west Essex. The CCG needs to do more to ensure that local service providers in the area are continuously improving through the robustness over our contract management and development of services so that people have an equal chance of good health regardless of where they live in west Essex, that people receive the same quality care regardless of pre-existing health conditions, that the care that people receive enables them to live in as good health as possible for as long as possible.

The population growth challenge

More people living longer, more children being born in the area, and more people moving to the area mean that the total population of west Essex is projected to increase by 12.1 per cent in the next ten years. This is against a national average of 8.7 per cent. It is our over 75 year age group that will increase the most at 36.6 per cent, however this in line with national expectations. Uttlesford population growth is one of the fastest growth rates nationally, and this is particularly significant in the older population.

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.

West Essex is an area of significant housing growth, whilst the growth in housing is generally in response to ONS population projections, there is also a possibility of increasing demand for housing stock over and above population projections. This is a significant issue particularly for our local acute trust, The Princess Alexandra NHS Hospital Trust (PAHT) who will see the impact of east Hertfordshire's anticipated housing growth of 14.2 per cent against the UK average increase of 6.5 per cent. (43 per cent of PAHT's activity is referred from Hertfordshire).

3.0 Ambitions and Outcomes

Our transformation programmes and improvement interventions are underpinned by opportunities to improve against local outcome indicators. The transformation and quality work programmes will drive an ambitious improvement against the national ambitions set out below over the next 5 years.

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 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	Baseline 74.2% (bottom of the second best quintile) to 79% in 18/19, Plan to reverse the decline between 11/12 and 12/13, consolidate over 14/15 and make progress from 15.16 as primary care initiatives impact. 1% improvement year on year,	Baseline is 1,669 per 100,000 population in 12/13. WECCG is near the top of the 2nd best quintile. Through ACS and frailty programmes ambitions to reduce avoidable admissions significantly with a 54% reduction against the 4 composite measures over a 5 year period.		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	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.	

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

Alignment of Ambitions against System Objectives

To ensure provision of high quality and safe care: 1) Increasing positive experience of hospital care 2) Increasing positive experience of general practice and care in the community 3) Reducing avoidable deaths in hospital	**Ensure sustainable acute hospitals** 1) Increasing positive experience of hospital care 2) Reducing avoidable deaths in hospital 3) Reducing avoidable emergency admissions
Provision of integrated health and care services 1) Improving the health related quality of life for people with a LTC 2) Reducing avoidable emergency admissions 3) Increasing proportion of older people living independently following discharge 4) Securing Additional years life from conditions amenable to healthcare	**Reducing variability in health outcomes, in particular for residents of Harlow** 1) Improving the health related quality of life for people with a LTC 2) Reducing avoidable emergency admissions 3) Increasing proportion of older people living independently following discharge 4) Securing Additional years life from conditions amenable to healthcare
Supporting community empowerment, promoting self-care and prevention 1) Improving the health related quality of life for people with a LTC 2) Reducing avoidable emergency admissions 3) Increasing proportion of older people living independently following discharge 4) Securing Additional years life from conditions amenable to healthcare	

4.0 Transforming Care

Transformation programmes in priority and high impact areas have been establish as follows::

- Mental health services
- Children and maternity services
- ambulatory care sensitive conditions
- Frailty
- Urgent and emergency care

Programmes of service redesign are underway underpinned by the following drivers for change:

Significantly shifting the point of care
Advances in medical technology and changes in the health needs of the population mean that hospital is not necessarily the safest or most appropriate location for much of the healthcare that our patients currently receive. Many of our patients tell us that they would prefer to give birth at home, to die at home, and manage their everyday health needs at home with the support of clinical and social care professionals. However, the historical legacy of how health services used to be delivered means that too much of our local healthcare is currently delivered in hospital settings. Each of the transformation programmes described below is designed to deliver care as close to the patient's home as possible, so acute hospital care is only for those that really need it. Furthermore, much of the hospital care that we currently provide could have been avoided if a patient's ill-health was better managed. Delivering right care at the right time means providing continuous support - preventing the development of long-term conditions, identifying and diagnosing patients with long-term conditions early, and encouraging and educating patients to self-manage their care so that they avoid acute exacerbations of known chronic problems and therefore avoid unnecessary emergency treatment and in-hospital care.

Integrated Care

The west Essex health system like most health systems in the UK has found it difficult to address the health needs of its population as well as it should, in part because the delivery of care is fragmented. Poor communication between general practitioners and specialists and between hospital staff and community staff can hinder effective care. Some components of care are often duplicated whilst some may be overlooked. The absence of a good interface between the health system and social services can allow elderly patients to fall through the cracks because neither side understands the full extent of the patient's problems.

Anecdotal evidence from our engagement programme paints a vivid picture. Carers, for example, told us about the complexities of dealing with many different agencies and still feeling unsure about what care is available. In one extreme example, one lady told us about having one leg treated by one hospital and the other leg by another in the same period.

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 integrated 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.

We have ambitious plans in west Essex for health and social care resources to be pooled from 1 April 2015 working as West Essex Health and Care Commissioning Committee.

Primary Care at Scale

Primary Care will have a key role in supporting the delivery of service transformation in west Essex over the next 5 years. There are 38 GP practices in West Essex serving between 2,000 patients in one of the smallest practices up to about 19,000 patients. The role and responsibility of general practice has increased significantly over recent years and with forthcoming changes in the GP contract, practices are considering ways to provide their current services differently, in order to respond to the vision of West Essex. There are great opportunities for primary care to take a much more prominent role as Provider, and in doing so primary care will look very different in the future.

The *My health, My future, My say* public and patient engagement campaign informed us that local people feel that GP practices are a crucial part of the NHS, but that access needs to be improved. Some patients are struggling to see their GP when they want to and some feel that their consultation is not long enough to discuss their health sufficiently. The CCG and NHS England are working with practices to improve access to GP services. Collaboration amongst practices could enable practices to share the responsibility of patient care more efficiently across the week. Future models of care may include shared home visiting arrangements for more efficient use of time, longer appointments for certain conditions, shared provision of extended GP practice opening hours, out of hours care and 7 day provision of services, ultimately improving access to GP services while maintaining high quality care and improving outcomes for patients. The CCG is currently working with west Essex general practitioners to develop an approach to transforming primary care to support their new role. The models described in the West Essex vision for health and social care, require that GPs act as the lead coordinator for the management of care for many conditions. A practice or a group of practices could take responsibility

for the total budget of a group of patients with the identified condition. This may mean care is provided in different settings, and with referrals between practices to maximise specialist knowledge/skills.
n future, practices will work collaboratively to provide an extended range of services, which may include being the Lead Provider for a particular clinical pathway e.g. diabetes care, respiratory care, cardiology care. This will reduce duplication, offer consistent care and ensure that primary care expertise and capabilities are maximised while secondary care services are truly specialised and only used when entirely appropriate. Collaboration will be formal and practices are actively developing their business models to be able to provide services in 2014/15. The mobilisation will take place in a phased way during the year.

Collaborative working will enable key specialist skills amongst GPs, nurses and practice managers to be shared across practices maximising their impact and improvement in the quality of patient care. GPs are also talking to specialist nurses and consultants about how they could work together to provide services differently across the whole patient pathway, reducing handoffs and improving on patient outcomes. Practices are also considering how they may use community clinics and community hospitals differently by supporting more patients at home or closer to home. Part of this consideration will be ensuring that the buildings and facilities required are well designed, well located and well maintained.

Primary care led services, where primary care takes responsibility for a whole pathway, will ensure the services are patient centred and provide continuity of care, especially for patients with long term conditions. Collaboration should include community nursing, community pharmacy, specialist doctors and nurses, social care and hospital services working in a more integrated way, providing seamless services to the patient with the GP at the centre. Primary care will be seen as the leader of the health system for many conditions in the future.

Frailty

The West Essex system is proposing a fundamentally different approach to the provision of care for the frail population in West Essex through an incremental move to an accountable lead provider model of contracting. 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.

The aim is to introduce new ways of working to drive innovative integrated care models and system efficiencies by reducing contractual and organisational boundaries

Mental Health and Vulnerable Adults

The North Essex Mental Health Joint Commissioning Strategy sets out a vision for MH services across North Essex, shared by the west Essex health and care system over the next 3-5 years:

"*ensure that all services for citizens suffering from a mental health condition, both physical and mental health services, are integrated with a seamless transition for adults and children moving between services"*

We will ensure that the services we commission result in:

- An increase good mental health
- Better recovery from mental health illness
- An improvement in physical health for people with mental health conditions
- Better quality of life for people with mental health problems.

We will do this by:

- developing and supporting community wellbeing, encouraging people to maintain healthy lifestyles and keep themselves mentally well. This includes offering therapies to people at an earlier stage
- supporting and enabling people to make choices and to be free from dependency on health and social care services by focusing on services that help people to maintain employment, housing and healthy relationships
- Ensuring that GP's and other community staff are better equipped to recognise and treat physical health problems alongside mental health problems
- Improving the access and gateway into services so people receive the right service at the right time in the right place
- Ensuring that there is a range of specialist services for people with severe mental health needs
- Ensuring timely access to mental health crisis services
- Actively support people who may be socially excluded to ensure that services fit around individuals and not vice versa

Children

The children programme of work will focus on optimising opportunities to shift from hospital care to home facilitated through enhanced community nursing, clearer clinical pathways and quicker responses to early indicators of risk through better provision of primary care. Over the next 5 years we expect:

- Attendance at A&E and admission to hospital for common conditions such as gastroenteritis, bronchiocolitis and asthma will have significantly reduced due to stronger pathways between primary, secondary and community care
- Health, Education and Social care will be working together to support children with SEND with an education, health and care plan
- Stronger communication and coordination across services and sharing of information between professionals
- Families will feel better informed and empowered to care for their children due to education and support from their communities
- The voluntary sector will be embedded into commissioning and contracting
- A primary care hub model of paediatric care will be in place meaning families will be able to readily access advice and care from all sectors of health

- Pregnant mothers will benefit from a larger well equipped birthing unit at PAH and maternity care tailored to the needs of the local population

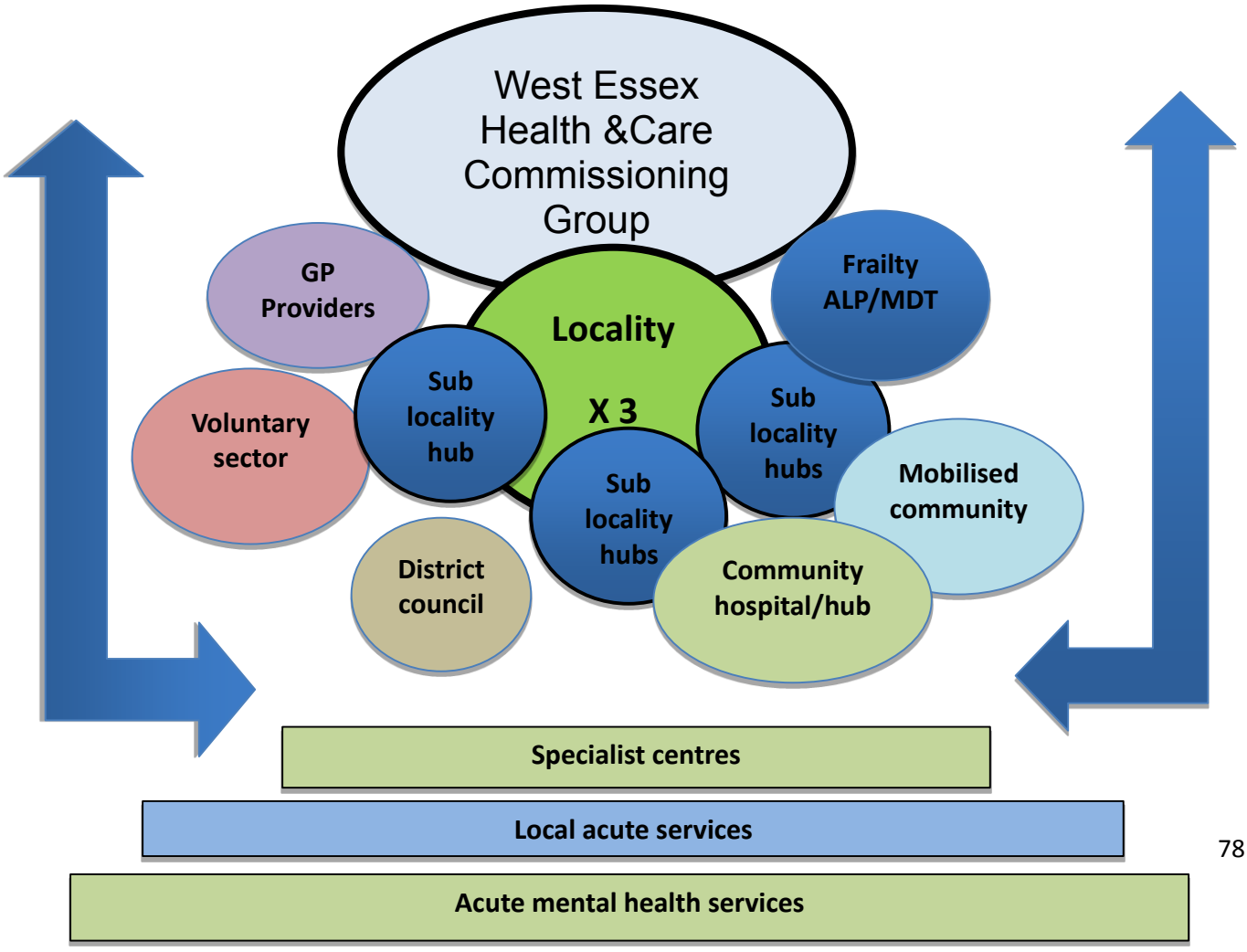
Working Age Adults

The CCG currently provides care for patients with long term conditions through a number of pathways, across primary, community and secondary care settings. It is evident that care is currently provided across numerous complex pathways and with limited formal integration, resulting in the absence of shared management of patients and delays in diagnosing chronic health conditions. There is a gap of specialist support within primary and community care settings, which results in patients not being treated within the correct environments.

We 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.

5.0 Operational Model

The system is exploring the development of an operational model that is wrapped around localities within west Essex. This is illustrated below to show how our three localities might work in future with locality hubs and supporting infrastructure and local organisations:



West Essex Health and Care 5 Year Strategic Plan on a Page

The west Essex health and social care economy is a system comprised of partners from both the commissioner and provider landscape within both the health and social care environments who have come together to develop a 5 year strategy . The 5 year strategy outlines how the system will deliver the vision "My Health, My Future, My Say" developed collaboratively with citizens, providers and commissioners during summer 2013 to improve outcomes and manage increasing demand with reduced resource.

Unified Objectives

System Objective One
To ensure provision of high quality and safe care

System Objective two
Ensure sustainable acute services

System Objective Three
Commissioning and provision of integrated health and care services

System Objective Four
Reducing variability in health and care outcomes, in particular for residents of Harlow

System Objective Five
Supporting community empowerment, promoting self care and prevention

Delivered through:

- Access to high quality urgent and emergency care
- Transforming care for frail and older people
- Transforming care for working age adults
- Transforming care for children and maternity services
- Transforming care for mental health and vulnerable adults

Overseen by:

- System wide leadership group overseeing implementation of the improvement interventions
- System representation on programme boards
- Individual boards signed up to approach

Measured by:

- Promotes greater independence, choice and control
- Improves outcomes for same or less money
- Contributes to an improvement in life expectancy and reduces inequalities particularly in Harlow
- Supports maintenance or improvement of quality and safety

Underpinned by values of:

- Patient centred at our core
- Collaborative
- Innovative
- Dedicated to quality
- Clinically led and locally focussed
- Honesty and respect
- Empowering Individuals
- Use of evidence based best practice

Enabled by:

Integration | Primary care at scale | IT & data sharing | Mobilising communities | Acute services review | Workforce | Market development | Estate

Endnotes

[i] The 'Plan on a page' includes four higher level objectives for the whole Essex system. These have been built from local system objectives and the two sets of objectives are aligned.

[ii] Office for National Statistics, **Estimated and projected age structure of the United Kingdom population 2035**, 2011. Accessed here in May 2014: http://www.ons.gov.uk/ons/dcp171780_240701.pdf

iii Office for National Statistics, Regional Profiles - Population and Migration - East of England, October 2011. Accessed here in May 2014

http://www.ons.gov.uk/ons/rel/regional-trends/region-and-country-profiles/population-and-migration/population-and-migration---east-of-england.html