Essex County Council

Report to Health & Wellbeing Board **Report of** Cllr John Aldridge	**Item 6b** **Reference number HWB/008/13**
Date of meeting 16th July 2013 **Date of report** 2nd July 2013	**County Divisions affected by the decision** All Divisions
Essex Pioneer Expression of Interest	
Report by Cllr John Aldridge, Cabinet Member for Adult Social Care, Essex County Council	
Enquiries to Clare Hardy, Senior Manager: Health & Wellbeing, Essex County Council	

1. Purpose of report

1.1. For the Health & Wellbeing Board to formally consider and endorse the Essex Pioneer expression of interest.

1.2. To seek the Health & Wellbeing Boards views on any additional areas that should be progress through our Integration Programme and contribute to the Pioneer process, if our expression of interest is pursued by the Department of Health.

1.3. To seek the Health & Wellbeing Boards views on any requirements we would need from the Pioneer programme (see paragraphs 3.12 & 3.13).

2. Recommendations

2.1. That the Board endorse the submitted Essex Pioneer submission.

2.2. That the Board consider any further areas that they would recommend should be part of our Integration Programme and could contribute to the next stage of the Pioneer process if our submission progresses.

2.3. That the Board consider any further support we should request from the Pioneer programme to support our work.

3. Background and proposal

3.1. On 14 May 2013 the Department of Health, supported by a range of national health and social care partners, launched a framework document: 'Integrated Care and Support: our shared commitment'. The framework sets out how local areas can use existing structures such as Health and Wellbeing Boards to bring together local authorities, the NHS, care and support providers, education, housing services, public health and others to make further steps towards integration.

3.2. The framework includes an agreed person-centred definition of 'integrated care', developed by National Voices, (a national coalition of health and care charities). National partners have adopted this definition and are asking local areas to sign up to using it too.

3.3. Alongside the publication of this document, the minister announced the desire to see integrated health and social care as the norm by 2018. To support the accelerated development of health and social care integration the government announced an 'Integrated health and social care pioneer' programme.

3.4. Local areas were asked to express an interest in becoming 'pioneers' to act as exemplars, demonstrating the use of ambitious and innovative approaches to efficiently deliver integrated care. Pioneers will need to work across the whole of their local health, public health and care and support systems, and alongside other local authority departments as necessary, to achieve and demonstrate the scale of change that is required. The Government is keen to see pioneers build upon the work started within Community Budgets.

3.5. The benefits from being a pioneer are subject to negotiation but include the allocation of a dedicated account manager who will manage access to:

i. Organisational/development support;
ii. Flexibility to develop local payment systems;
iii. Clarity regarding rules on choice, competition and procurement in an integrated care context;
iv. Employment advice and workforce development;
v. Public engagement expertise;
vi. Data analysis, financial modelling capacity.

3.6. The deadline for submitting expressions of interest was 28 June. The Department of Health originally indicated their intention for there to be 10 pioneers, this may vary depending on quality and there will be further opportunities. The application process stated that submissions should have 'the involvement and support of Health and Wellbeing Boards (as a minimum, by the end of the selection process) will be an essential prerequisite for any area to become a pioneer.' The Department of Health will engage with potential pioneers during July and August to agree the final detail and what the pioneer can offer in terms of support. The final pioneers will be announced in September.

3.7. The Pioneer scheme was raised at the Essex Health & Wellbeing Board on 22 May and through follow up with the members of the Board it was agreed that we would make a submission setting out our developing Integration Programme. Health & Wellbeing Board members were clear that if we participate the programme needs to support our current development plans and not detract us from the journey we have commenced. The Business Management Group was tasked with making this happen.

3.8. The Business Management Group felt the outputs of the accelerated design event on the 18/19th June would provide us with the key elements of our submission; this did however make the deadlines very tight. A submission was developed and sent round to the Health & Wellbeing Board members for support prior to submission on the 28th June.

3.9. Our expression of interest focuses on our current work to develop an accelerated programme of integration that manages the scale of Essex through a plural approach. Developed through the accelerated design event which started with the patient voice, the plural approach enables us to have a county wide programme but explore within that more local models of integration. There is potential to explore different models such as Accountable Lead Provider and Year of Care in different places. We set out that we already have an infrastructure in place through the Health & Wellbeing Board and the Business Management Group and we have a programme office emerging.

3.10. Whilst the HWB provided initial sign off for this submission (copy attached at appendix a), there is an opportunity to consider any areas of omission that we could contribute to our Integration Programme and feed into the next stages of the pioneer process.

3.11. All partners have been clear that the pioneer should support our developing Integration Programme, if the Department of Health are interested in our submission they will engage with us over the summer around what we can offer the programme and how the pioneer can best support us. We need to identify what support we need from the pioneer programme.

3.12. Within the submission we identified the following areas in which we would be looking for the pioneer to support us:

- The application of policy and financial freedoms and flexibilities e.g. around pricing, contracting, competition, data sharing;
- Flexibility of employment;
- The possibilities of revisiting the commissioner/provider split;
- The extended role of primary care and associated contractual freedoms;
- Support in developing our evaluation programmes and local evidence base.

3.13. We would also benefit from additional resources to contribute to the programme office and a commitment from the pioneer programme that it will not involve complex reporting mechanisms which we do not have resource.

4. Policy context

4.1. The purpose of the pioneer programme is to accelerate the development of health and social care integration. The role and purpose of the Health and Wellbeing Board is to encourage integration and this is the core enabler of the Joint Health & Wellbeing Strategy as well as being at the heart of the organisational plans of the Council and the CCGs.

5. Financial Implications

5.1. We are currently at the expression of interest stage and therefore are not committed. Partners are clear that the pioneer needs to add value to our developing Integration Programme and not have additional unfunded resource implications. However it should be noted that there are no additional funds available to support the development of the bid beyond those funds already in budgets.

5.2. Financial implications will emerge from our developing Integration Programme and further decisions will be required.

6. Legal Implications

6.1. We are currently at the expression of interest stage and therefore are not committed. The Department of Health have confirmed that approached developed through pioneers will need to be within the confines of existing legislation as no new primary legislation is planned in this area.

6.2. Legal implications will emerge from our developing Integration Programme and further decisions will be required.

7. Staffing and other resource implications

7.1. We are currently at the expression of interest stage and therefore are not committed. Our Integration Programme has agreed a joint programme management approach, which will also be required for the pioneer, at present the programme office staff are principally from the County Council and we need to consider the scale of programme support required and how this will be fully funded. We may wish to explore with the pioneer programme if that is able to make a contribution to the programme office.

7.2. Further staffing and resource requirements will emerge from the development of our Integrated Programme and further decisions will be required. The Council's new structure has been designed to better support the integration of health, social care and public health.

8. Equality and Diversity implications

8.1. The decision was screened for Equality and Diversity issues and it does not of itself have a disproportionate adverse impact on any equality groups. Our Integration Programme as set out in the pioneer expression of interest is a person-centred approach. As we look to integrate our work around the individuals we will be best placed to respond to their individual needs.

8.2. Our integration work is based upon the needs identified by the Joint Strategic Needs Assessment and prioritised in the Joint Health & Wellbeing Strategy which went through an Equality Impact Assessment. As we develop our Integration Programme further Equality Impact Assessments will be required on the programme as a whole and on individual decisions.

9. Background papers

9.1. Integrated Care and Support: Our Shared Commitment

9.2. National Voices Integrated Care definition

9.3. Pioneer letter

9.4. Joint Health & Wellbeing Strategy

9.5. Whole Essex Community Budgets

Appendix A

Essex Health and Social Care – Pioneers at Scale

Expression of interest – Health & Social Care Integration Pioneer Programme

Within three years, the people of Essex will have single health and social care commissioning and joined up services providing fully personalised care. People will have a better experience of care and we will meet the challenge of our time to manage escalating demands within fiscal constraints.

Councillor David Finch, Chairman, Essex Health and Wellbeing Board

1. Introduction

Our health and social care system is in serious jeopardy. Facing the facts, our older population is expected to reach 28% by 2033. The prevalence of dementia is expected to increase by 38% by 2021. The number of adults with a learning disability supported by Essex has increased by 7% over the last three years, and is likely to increase by 17% by 2030. We have an estimated 332,800 children and young people and this is expected to grow to 361,000 by 2021. Data suggests, not just an increase in the number of people who need care, but also an increase in the number of people and families with complex needs.

Such rising demands, if not managed, create a gap between available budget and demand for Essex County Council services forecast to be £215m by 2016/17. Similarly, over the period, 2013-2017, the five Essex County CCGs face a funding gap of £354m.

All partners are highly motivated and committed to achieving a solution within the next three years. Inspired by the outcomes of integrated care that we have achieved over the last two years, the Essex health and social care system is embarking upon the most ambitious and radical programme in its history. We are agreed that we need an innovative approach to challenge preconceived barriers such as issues of governance and data sharing. As part of the development of our Integration Programme, we held a system wide accelerated design event exploring vision, ambition, priority areas and how we will work together. The senior decision-makers at the event described their ambition to achieve a single budget model of commissioning with a single workforce and single set of outcomes.

The Essex Integration Programme is already in progress with a broad action plan and governance framework. It matches the criteria for Pioneer status and we would maximise the benefits of the Pioneer platform to test radical ideas and navigate the unknown.

In this bid, we explain our three-year Integration Programme, building upon our partnership approach to public service transformation and integration, accelerated through the Whole Essex Community Budget Programme (WECB) that we started as one of four national pilots in 2012.

The following case study from North East Essex offers a strong local example of the person centred approach we are aiming for at scale:

John's story
John is over 70 and has diabetes. One weekend he suffered four falls. On Sunday, his neighbour found him lying on the floor and called an ambulance. While receiving emergency treatment to avoid life-threatening ketoacidosis, John's only concern was to get back home. His wife has Alzheimer's and John is her main carer.

Traditionally, John would have been admitted to hospital, but John lives in an area where there is a "virtual ward", a team or "ward" of nurses working closely with John's GP, all health services, social care and the voluntary sector. Following referral to the virtual ward, John went home and both he and his wife were immediately assessed for health and social care. In addition to the specialist diabetic care John needed, within 48 hours, John and his wife had several service arrangements in place, from outpatient appointments to a new front door lock.

John, who admitted that, until the virtual ward, he thought he would "walk off the pier", tells the story of how his life turned around in a video at the following link:
http://www.youtube.com/watch?v=vzhmJTkMqww

Current outcomes evidence from the Integrated Health and Social Care Pilot for Older Adults (Virtual Ward) in North East Essex:

- Excellent individual and family feedback on their experience of personalised care and involvement in decisions;
- 19% reduction in avoidable hospital admissions, which potentially saves £58k a year per 1,000 patients;
- 40% reduction in hospital bed days;
- 17% virtual ward patients already receiving social care found to need reduced social care input, suggesting yearly savings of around £230k per 1,000 people;
- 85% GPs describe better communications between agencies and professionals
- 72% GPs report better care for long term conditions.

2. The Essex Vision for Integrated Care – a complex, multi-level, three-year programme

We have a vision of a service that anticipates needs and avoids crises; that is delivered through a partnership with shared responsibilities between the person and their service providers; a service that is free from systematic and professional constraints.

2.1 A plural approach
The locality characteristics and diversity in Essex lead to different solutions in different contexts. Already through integrated health and social care plans at CCG level, transformation is exploring, for example; a lead provider approach, Year of Care model, liberating primary care and a step-wise transition from joint to single budget commissioning.

The aim is to develop several pioneering models of integration within a three-year, system-wide programme. This is led strategically by the Essex Health and Wellbeing

Board (HWB), with its Executive Group providing operational leadership, monitoring and evaluation.

Models will include health, social care, mental health and public health and will sit within our wider partnership vision developed through the WECB pilot: '*To create a vibrant, prosperous place with resilient communities who have access to opportunities. Public services will be affordable and play an enabling role, helping people to do more for themselves and others.*'

Some models are developing on a north/south Essex cluster level in partnership with Southend and Thurrock Unitaries. The five Clinical Commissioning Groups (CCGs) in the Essex area each have integrated transformation plans overseen by system leadership groups, which involve both commissioners and providers.

2.2 Outcomes for individuals

Listening to the individual and collective voice of service users, as well as their 'lived experience' of health and social care, we are reminded that, although the majority of professionals are passionate about caring for people, standards of care are variable and often disadvantaged by organisational barriers.

What people will experience in three years' time:

- Pro-active, person-centred care and support taking in the wider context of their lives;
- Consistent quality and continuity between services;
- Early intervention and support that predicts and prevents need;
- Better information, and support to be involved and in control;
- Better health and wellbeing, avoiding the need for hospital and other institutional care.

2.3 Outcomes for commissioners

Essex has already made good progress, learning for example from an Essex Health and Social Care Joint Commissioning for Older People project in 2010 and the WECB in 2012, leading to integrated commissioning plans in March 2013.

Having exploited fully the potential of traditional efficiency savings, health and social care leaders are working as one on more radical transformation for bigger impact. We recognise that this will challenge the sovereignty of existing commissioning organisations in order to focus on what is best for service users. The ambition and collective leadership is stronger than it has ever been.

Clare Morris, Chief Officer, West Essex CCG

The CCGs, with Council Commissioners, are well advanced in their thinking. Improved outcomes are already evident, for example from multidisciplinary approaches that make use of funding transfers between social care and health for reablement, early supported discharge and multidisciplinary team assessment.

From our Integration Programme commissioners will achieve within three years:

- Single commissioning based on shared goals and outcomes, supported by better quality evidence and analysis;
- Pooled budgets, shared records and IT systems reducing bureaucracy and duplication;
- Risk and gain sharing;
- Success in managing the market with incentives for providers to integrate, where this creates efficiency.

2.4 Outcomes for providers
Within the first six months of working within our Integration Programme, we will progress with provider integration. Each CCG through its system leadership group is already bringing commissioner and provider partners together at a senior level to develop contracts that incentivise integrated care.

We would wish, through the Pioneer programme, to explore potential flexibilities around primary care contracting, leading to a step change in both operations and culture.

The provider landscape in three years' time:
- Widespread integrated teams wrapped around GPs and service users;
- Coordinated care and care planning;
- Different models including new joint health and social care providers, single provider with a single workforce and lead providers with sub-contractors;
- Single points of access to all services from simple home support, to diagnostics and specialised care;
- Access to all information;
- Co-producing with people, as partners in managing their individual care;
- Emphasis on prevention;
- Fewer providers, but with new entrants including greater use of the third sector.

Dr Sunil Gupta, Essex GP

We would offer the Pioneer programme a unique meta-analysis of a complex system, potentially demonstrating and comparing a range of integrated models in both commissioning and service provision. Essex would, in effect, provide a controlled experiment and evaluation that could translate to national scale.

3. The Essex experience and background

In this section, we highlight the unique benefits of Essex as a Pioneer in terms of:
- The benefits of size, scale and complexity;
- Examples of delivering national pilots at pace and scale;
- Examples of successful integration;
- A preview of an independent commission, led by Sir Thomas Hughes-Hallett, to propose solutions to the challenges facing health and social care in Essex.

3.1 Why Essex – size, scale and complexity
Essex has a population close to 1.4 million. It has 12 district councils, five CCGs and many tiers and geographies within its landscape. In diversity, it has some of the most

affluent and some of the most deprived areas in the country, creating inequalities that are being tackled, there is an 18.6 year difference in life expectancy across the county.

Given its complexity, Essex offers a challenging, but nonetheless vibrant context for testing the benefits of integration. We intend to take advantage of this to develop a plurality of approaches that we can support with agreed design principles, close monitoring and evaluation. Competitive in a cultural sense, Essex offers fertile ground for rapid change. There will be opportunities for partners within localities to learn from each other and to pilot services using a staged approach dependent upon the needs and priorities of each.

3.2 Examples of delivering national pilots at pace and scale

Essex has a proven track record in delivering national pilots at pace and scale, including:

- Whole Essex Community Budget (WECB);
- Healthwatch Essex Pathfinder status;
- Adult Social Care Putting People First Personalisation Pathfinder;
- Clinical Commissioning Group Pathfinders;
- Year of Care Pilots in CCGs;
- Personal Health and Education budget pilots in Special Educational Needs and Children with Disabilities;
- Innovation in social finance and social impact bonds;
- Integrated Support for Families with Complex Needs;
- RSPH Health Promotion and Community Wellbeing award;
- Systems Change pilot run by the Essex Drug and Alcohol Partnership.

Our Integration Programme will be supplemented by findings from the WECB programme and work streams that support the linkages between health and social care and the wider wellbeing agenda. These work streams cover, for example, families with complex needs, the impact of drugs, alcohol and mental health problems on the criminal justice system and strengthening communities to improve and increase resilience. Enablers work includes the role of housing and the importance of engaging Districts in the health and social care agenda. The WECB programme has identified net benefits of £387 million across Essex public services over five years.

3.3 Examples of successful integration

Over the last two years, bespoke pilots have included proactive case finding, crisis response services and accelerated discharge supported by greater investment in reablement services and the section 256 agreements for social care sustainability. We have successfully reshaped hospital discharge in a new pull model resulting in fewer delayed transfers of care.

Such initiatives have contributed to a local evidence base for evaluation and learning. Nationally, there is limited evidence for the financial benefits of integration at scale. We would envisage playing a key role in the development of nationally coherent evidence of benefits realisation.

Current examples of initiatives that we are monitoring include:

- Multidisciplinary teams and single access to assessments, which have already reduced avoidable hospital admissions in mid Essex. The model is being

developed further by Mid Essex CCG in partnership with the district councils and the voluntary sector to achieve affordable, sustainable and flexible health and social care, associated with a reconfiguration of facilities at a local community hospital;

- Exemplar model of Early Supported Discharge for stroke patients in North East Essex. The scheme has halved the number of rehabilitation beds and reduced need for social care from 8.9% (56) stroke patients to 2.7% (14), reducing costs from around £1,033k to £258k p.a. in the first year post-stroke. Savings forecast countywide could be as much as £512k p.a.;

- All-age Disability Strategic Framework led by ECC to drive forward an all–age strategy and investment for disability commissioning;

- Early Intervention teams working with young people to prevent them entering the care system;

- Integrated Support for Families with Complex Needs, providing integrated support to families' intensive needs in mental health, child behaviour and family relationships;

- Personal Health and Education budget pilots in Special Educational Needs and Children with Disabilities;

- Innovation in social finance and Social Impact Bonds driving our multi-systemic therapy programme for young people with complex needs;

- Agreed integrated Mental Health strategy across South Essex including Southend and Thurrock and currently developing one across North Essex.

3.4 Preview of "Who Will Care?", an independent commission for Essex

Led by Sir Thomas Hughes-Hallett and due to report in the early autumn, the commission is offering real, practical solutions to up scaling integrated care. We expect the findings to provide a catalyst to the pace of change.

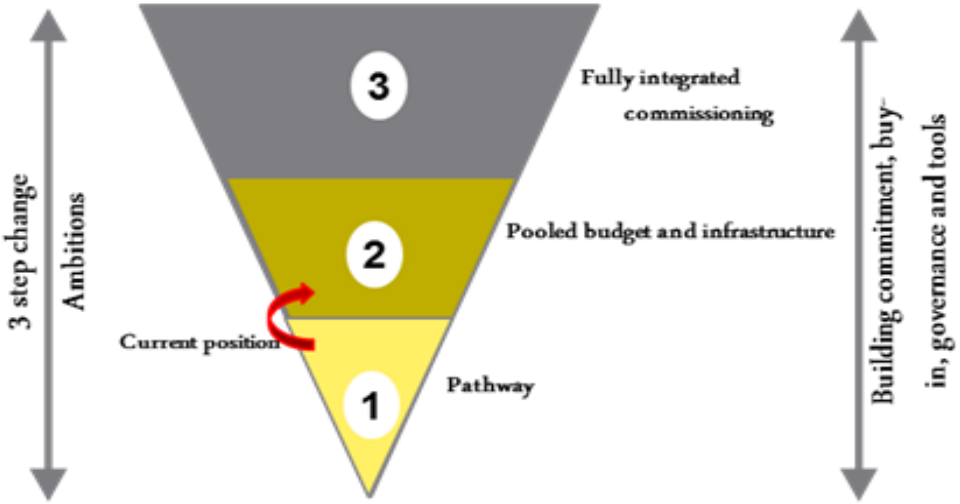
Critical elements of the Commission's thinking include a recasting of the contract between citizen and state, recognising that tax-payer funded services, as currently configured, will soon be unsustainable. Evidence already suggests that, provided they receive clarity about what they can expect, residents recognise the changing realities of public service and are better equipped to deal with them.

The Commission's recommendations are likely to propose ways to clarify the extent of the 'care offer' and support people to take responsibility for their care. It will advise on leadership and accountability to help manage the complexity and cultural issues associated with our Integration programme, and it will include thinking on support for communities and how voluntarism could play a greater role.

4. Delivery and infrastructure

Priorities within our programme have been set to respond to the key risks within the system around capacity in the acute healthcare sector and some of the financial pressures within the community market leading to quality issues.

We have a broad programme framework that begins with frailty and learning disabilities in year one, which will provide a platform for a transition over three years to fully integrated health and social care commissioning with one global budget.



In 2013/14, the Essex HWB endorsed the five CCG integrated plans and a sixth countywide plan which encapsulates the social care and public health alignment.

One example of current developments led by West Essex CCG and partners is a plan to contract on a capitation basis with an accountable lead provider for frailty. This would see the integration of primary, community, mental health and social care around the frailty pathway, led by a single contractor managing a portfolio of sub-contracts, creating a contractual incentive for integrated service provision.

In North East Essex, the forward-thinking GP community is exploring the potential for primary care to lead as a single provider for primary community and social care.

Mid Essex is participating in the national Year of Care scheme, aligning budgets, developing specifications and agreeing shared outcomes.

Promoting safeguarding and protecting the welfare of children, young people and adults is a key component and our commissioning arrangements will ensure all organisations have clear, appropriate and safe procedures in place which reflect government guidance and inspection frameworks linking with the Essex Safeguarding Board procedures policy and practice guidelines.

4.1 Leadership and governance

<u>Established integrated leadership at county level</u>
Our integration programme will be the responsibility of the Essex HWB, and managed by the Board's Executive Group.

The HWB, through its Joint Health and Wellbeing Strategy (JHWBS), has already a vision and commitment to a whole system integrated approach across health, social care, mental health and public health. It has an emphasis on commissioning across a whole life pathway, with a shift to primary and community care settings.

Methods are in place to measure outcomes connected to the national public health, NHS and adult social care outcomes frameworks, and these are included our JHWBS evaluation framework.

We have a ready-made infrastructure, which will include:

- A set of design principles (see below);
- Monitoring, evaluation and analysis;
- Support, research and shared learning;
- Ground breaking advances in shared technology that will start with linked datasets for health and social care and move to universal access.

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

We are committed to commissioning and delivering integrated care solutions beyond our individual boundaries where it is demonstrated that this is the most effective approach. We are, as a system, self-aware enough to know that there is more to do – as evidenced by the 'Who Will Care?' Commission.

Established integrated leadership at local level

The programme will be structured to support and facilitate five CCGs as the main level for locality leadership. At this level there is already a well-established governance infrastructure where Council Commissioning Directors are members of CCG Boards and a Public Health Consultant is aligned to each CCG. Each CCG has an integrated plan operating within the framework of the Essex JHWBS, endorsed by the HWB.

Commissioners and providers across the whole system of health, social care, mental health and public health engage through the CCG System Leadership Groups to oversee transformation.

Co-production with service users

Healthwatch Essex, working closely with the HWB, will bring the benefits of innovative new methods in engagement, involvement and co-production, drawing on national and international best practice and collaborative links, such as with higher education institutions and the academic health science networks.

At the local level, service users are embedded in transformational change, largely through a new network of patient and public engagement within CCGs and social care, reaching out as far as practice-based patient participation groups.

We are impressed by the research of the national organisation, Patient Voices, in harnessing the power of patients' stories as a training tool for professionals. As part of our work with the Essex Integration programme, we are exploring these storytelling methodologies as aids to innovation and service redesign.

Mike Adams, Chairman, Healthwatch Essex

Programme management
A programme management approach will provide rigour and accountability, but will be designed to encourage flexibility, innovation and empowerment for the frontline – an innovation in itself.

Leadership and Culture
In Essex we recognise that strong relationships between leaders will influence whether we succeed or fail. We have already demonstrated our individual personal commitment to health and social care by organising and participating in the accelerated design event. We were inspired by the stories from other successful integration leaders at this event; as a result in addition to formal business meetings, we have committed to meeting routinely and to invest time in building and maintaining relationships on what we know will at times be a challenging journey.

4.2 Design principles

Transformational plans and developments in integration will be:

- Person-centred and empowering individuals, both service users and professionals;
- Value and needs based;
- Proactive on prevention, early identification and intervention;
- Co-produced with the service user as partner;
- Able to deliver improved outcomes and care quality.

Values:

- Affordable and cost effective;
- Sustainable and long-term;
- Innovative but informed by evidence;
- Shared risk and benefit;
- Effective demand management;
- Honesty, fairness and accountability;
- Continuous learning.

5. Why we need the Pioneer Programme

Essex is fully committed to whole system integration. Our successful track record as a WECB pilot and the significant progress we have made since then through integrated commissioning plans, led by the HWB, and the outcomes of our recent accelerated

design event, make that self-evident. Pioneer status and its access to leading edge thinking would develop further our strong ambitions.

As Pioneers, we would maximise the opportunities offered by other Pioneer areas and the Public Service Transformation Network for support, benchmarking and shared learning. We welcome this research and evaluation framework and potential access to thought leaders and international exemplars. We are keen to take advantage of flexibilities around pricing, employment, competition, contracting and data sharing – even revisiting the commissioner/provider split.

Our Integration Programme aligns well with the Pioneer Programme and we would like to further explore how the programme can support us, with particular interest in:

- The application of policy and financial freedoms and flexibilities e.g. around pricing, contracting, competition, data sharing;
- Flexibility of employment;
- The possibilities of revisiting the commissioner/provider split;
- The extended role of primary care and associated contractual freedoms;
- Support in developing our evaluation programmes and local evidence base.

Our bid for Pioneer status offers to the national programme a grand scale, multi-model, controlled test for the application of integrated commissioning and provision of care.

Furthermore, there is greater confidence than ever before, that Essex now has the relationships and the commitment to develop fully integrated care. The Essex HWB is at the centre of whole system thinking and CCGs, having come through reforms, are already creating a rich ferment of experimental ideas.

We have an infrastructure that can be mobilised immediately and, above all, the ambition and imperative to make integration a reality that will deliver better outcomes for people.

Our integration approach was developed through a systems accelerated design event involving 55 partners. This submission is supported by the Essex Health & Wellbeing Board including: Essex County Council, Healthwatch Essex, Basildon and Brentwood CCG, Castle Point and Rochford CCG, Mid Essex CCG, North East Essex CCG, West Essex CCG, NHS England, Essex Safeguarding Boards, the Children's Partnership Board, representatives of our District Councils and the Essex Police and Crime Commissioner.