Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**North East Essex CCG**
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**07/03/2014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£20.987**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£20.987**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	**North East Essex CCG**
By	Dr Gary Sweeney
Position	Chair
Date	**07/03/2014**

Signed on behalf of the Council	<Name of Council>
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

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

c) Service provider engagement

The main providers commissioned by North East Essex Clinical Commissioning Group (NEE CCG) are Colchester Hospital University Foundation Trust (CHUFT), Anglian Community Enterprise (ACE) and North Essex Partnership Foundation Trust (NEPFT).

The CCG has discussed its vision and commissioning intentions with all main providers at Board and Leadership Team level. This includes acute, community and mental health service providers (e.g. meetings held 8th and 23rd January 2014 with CHUFT, ACE and NEPFT and meeting held on 27 February 2014 with CHUFT). Provider representatives sit on the Care Closer To Home clinical reference group and the Urgent Care working group, both of which meet regularly. In addition, all providers have been invited to the Big Care Debate events and will be invited to the events planned for February. It has been agreed with Providers that a workshop including all stakeholders will be held to further develop the NEE economy 5 year plan in April/May 2014.

Further meetings with individual Providers to triangulate their plans with CCG plans are being organised. An Educational Day for Primary Care staff is to be held in April and will focus on integrated planning, incorporating NHS England Essex Area Team's Primary Care Strategy.

The NEE CCG Chief Officer met with senior colleagues from Health Education East of England to discuss the CCG vision and strategy and those colleagues will be attending Care Closer to Home and Urgent Care project groups in February, March and beyond. A Primary Care workforce action group is underway involving Health Education and NHS England.

d) Patient, service user and public engagement

The schemes that the CCG is putting into the Better Care Fund (BCF) are part of our strategic plans for integrated care as set out in the NE Essex Integrated Plan 2013-18. The Integrated Plan was drawn up with input from a range of stakeholders including the NE Essex Health Forum (a public member organisation consisting of 300+ members, which plays a key role at all levels in the CCG). We have patient representation on the Care Closer to Home and Urgent Care project groups, which are taking forward key parts of the Plan, including reablement, carer support, vulnerable groups and 7 day working.
The Care Closer to Home Strategy has been revised following engagement via The Big Care Debate which has engaged over 1,000 local residents, using a series of "You said"… "We will" statements, highlighted by speech bubbles throughout the document. Engagement on that strategy is ongoing.

The Big Care Debate started on 8th November 2013 with a large event at Colchester's Weston Homes Community Stadium and an online survey was opened at the same time. The key engagement dates for the CCG vision of high quality, integrated care are shown below with number of attendees in brackets:-
Oct 26th – Tendring Community Voluntary Services Health and Wellbeing Fair (40)
Nov 5th – Drop in and meet the Board session in Colchester (30)
Nov 12th - Drop in and meet the Board session in Clacton (25)
Nov 12th – Big Care Debate event in Colchester (100+ attendees)
Nov 14th - Big Care Debate event in Clacton (80+)
Feb 20th – Big Care Debate events in Colchester (94)
Feb 27th – Big Care Debate events in Clacton (109)

The online survey closed on 14th February with a total of 216 respondents. In addition to the large events detailed above, CCG staff have carried out a series of visits to local groups in the community to talk about the CCG's plans and get feedback. Groups have included children's centres, BME groups, Carers' Support Groups and luncheon clubs.,

The main feedback themes from The Big Care Debate to date are:-

Self care

People overwhelmingly understood that personal responsibility for their health is important. Diet, exercise and mental well-being were recurrent themes. The role of family, friends and the voluntary sector in providing support mechanisms, care and social contact were also vital in helping people to avoid isolation and to remain independent, fit and healthy.
Use of technology and personal health budgets were supported, as was better training of staff to help individuals become more independent in managing long term conditions.

Access to information and services

Access to information and signposting to services was viewed as important. Use of plain English and guides to services were felt to be important. People felt this was crucial to self-care and to ensuring services were not used inappropriately when people needed support and/or advice for minor ailments and to reduce the demand on other services.

Appointments with GPs, dentists and professions allied to medicine, such as physiotherapy or audiology, as well as access through the walk in centre, were recurrent themes, with some mixed commentary about the 111 service which has only recently gone live.

Overwhelmingly, however, access to GPs for appointments was the single biggest point of satisfaction or concern dependent on how easy participants found it. There was an overwhelming view that GPs are the gateway to prevent other services being overloaded.

Prevention

The theme of access to information also extended to health promotion and education for individuals about how to stay well and healthy and how to manage a long term condition so that the individual remains in control.

Integration of services

There was a level of frustration with the lack of integration of services, particularly around discharge from hospital, but also with support services such as appliances or equipment when bereaved families found it difficult to organise the return of items that were no longer needed.

Suggestions included creating one budget for services and gateways/single point of contact for services that provided more clarity and removed barriers.

Care closer to home and home visits for the vulnerable were key comments throughout the engagement, whilst others felt that centres where a range of services could be accessed together were a good idea.

Culture and Patient Centred Services

People felt there was still some way to go to develop the right culture in the NHS and Social Care - improving the way professionals speak to patients and carers, creating a partnership rather than a dependency. Some black, minority and ethnic community representatives felt that there were communication issues; even when the use of English was not a barrier, cultural values were not always understood.

Duplication/Waste

There was strong support for improving medicines management and a number of participants felt that GPs should not prescribe medicines that are available over the counter to people who do not pay for prescriptions. Some participants felt the challenge facing NHS and social care was too big and that more money should be made available. Some were strongly opposed to the most recent reforms whilst others felt there was still duplication and waste (see integration of services above).

Methods of communication from the hospital was a cause of frustration with respondents who felt that multiple letters to confirm, cancel and then rearrange appointments added additional cost and could be confusing for patients.

A sub theme was the cost of locum staff in hospital and primary care/out of hours – reflecting recent media coverage of the topic. Respondents expressed concern about the ability to plan training ahead of demand, with the resultant additional cost to services as well as a potential lack of continuity of care/knowledge of the patients.

e) Related documentation

Document or information title	Synopsis and links
NE Essex Integrated Plan 2013-2018	This document sets out the vision and strategy for the local health and social care economy. It was co-produced with Essex County Council (ECC). It sets out the vision for delivering high quality, integrated services which are responsive to the needs of the individual, with a focus on keeping people independent. Where care is needed, it will be delivered in the home and community, with hospital used only where it adds value.
NE Essex End of Life Strategy	This document is a 5 year strategy detailing the

	future commissioning of end of life services across the health and social care economy. The document identifies the importance of raising the profile of achieving 'a good death' and putting mechanisms in place to achieve this.
NE Essex Care Closer to Home Strategy	This strategy outlines the integrated approach to services required to meet the health and social care needs for the people of North East Essex. By putting care packages together as bundles we will break down the traditional barriers between different care providers. Integrated planning will focus on actual needs and avoid duplication. We will use a rigorous procurement process based on achievement of improved outcomes for patients.
NE Essex Urgent Care Strategy	This is a system-wide strategy setting out how we will:- • Reduce complexity in the system to enable patients and clinicians to make an informed choice • Ensure consistency of provision across the services regardless of what time of day or day of the week the patient presents • Ensure services are provided by people with the right skills, in the right place and at the right time • Utilise the resources available in an efficient way
NEE Quality Strategy	The NEE CCG Quality Strategy defines quality as the 'organising principle' which will provide the CCG Board with the assurance that the systems and processes across the organisational disciplines are coherent and robust in the delivery of clinically effective and safe health care, provide positive patient experience and the financial efficiencies required to deliver the quality and productivity challenge, and at the same time deliver the 5 domains of the NHS Outcomes Framework. The strategy is a draft document and will shortly go out to consultation across the health and social care economy, ready for implementation in 2014.
JSNA	Joint assessment of health and social needs of the local population, focusing on areas where improvement in services is most needed, including reduction of health inequalities.
Essex Health and Wellbeing Strategy	A 5 year strategy, based on the JSNA, for improving the health and wellbeing of Essex residents within overarching framework of Starting Well, Developing Well, Living Well, Working Well and Ageing Well.
Annual Public Health Report	Review of published evidence of what impacts

	on health and social care demand.

2) VISION AND SCHEMES

a) Vision for health and care services

Our vision

As a CCG led by its clinical members, our vision is "Embracing better health and wellbeing for all." Even though we will focus on priority groups within North East Essex, everybody should be able to expect an improved level of health and wellbeing from the services we commission, delivered through a simpler system. People will have greater choice, involvement and control regarding their health and wellbeing.
Our vision is based around 4 overarching principles of care:-

1. Care focused around people, not services
2. Seamless, harm free care
3. Individuals have a large part to play in staying healthy
4. Efficient advice and care

We want to work in partnership with the public, patients and carers in North East Essex to help them have greater choice, control and responsibility for health and wellbeing services.
We are committed to commissioning services which are equitable, inclusive and sustainable

Reconfiguration of services

We will achieve this over the next five years through the joint commissioning with ECC of integrated physical and mental health and social services. Currently services are commissioned around providers, with community physical health services and community mental health services being procured from separate providers. Social care is commissioned by ECC. We are planning to commission services based around the needs of patients and service users and are drawing up outcome-based service specifications in order to procure care which is integrated, seamless and wrapped around the needs of the individual.

Integrated health and social care services will be wrapped around clusters of GP practices, with GPs playing the lead role, supported by a local multi-disciplinary team so that the patient's needs are met by a smaller team, who work together to meet all the individual's care needs. Patients will receive joined up care and will no longer have to repeat their details to a range of different staff who work for a range of different organisations.

We are calling this approach "Care Closer to Home". It will focus on supporting people in their homes and in their local community to care for themselves, signposting them where necessary to a range of support available in the community and focusing on prevention and early diagnosis in order to reduce avoidable admissions to acute hospitals or to care and nursing homes. Where people do require admission to hospital or care/nursing homes, rapid access to reablement and other support services will facilitate their recovery and return to independent living wherever possible.

Support for carers is a vital part of this and the Care Closer to Home incorporates all the relevant elements of the Essex-wide Carers' Strategy.

Feedback to date from the Big Care Debate (see Section 1d above) strongly supports what we are aiming to achieve and the feedback has been incorporated into the draft Care Closer to Home Strategy, using a series of "You said…..We did" statements and quotes.

Delivery of Care Closer to Home is likely to include the up-skilling of staff and maximising the

use of technology so that service users' needs are met by a smaller core team, and so that service users are supported by technology to remain in their own homes.

Services will be commissioned for specific geographical populations so that we can focus on the different needs in different areas. This means that the improvement in outcomes we require may be greater in areas, or groups of people where outcomes are poorer at present.

We will focus on improving outcomes for the four priority populations we have identified with Essex County Council: the frail and elderly, people with mental health care needs, people with learning disabilities and children. However, a focus on vulnerable and marginalised groups will also be included.

a) 7 Day Working (2014/15 onwards)

NEE has a well-established Urgent Care Working Group, which includes all local Providers and Commissioners, and this group will facilitate 7 day discharges as a priority in 2014/15, identifying community resources required to support this, and utilising part of the £1.08m funding available for this from 2014/15.

2014/15 priorities include:

- 7 day discharges from CHUFT (Social Care 7 day working required in 2014/15 to achieve this)
- Community discharge support and rehabilitation services
- 7 day working at the proposed Rapid Assessment Unit at Clacton Hospital

2014/15 – 2015/16 priorities include:

- 7 day admission avoidance via A&E and OOHs services
- Diagnostics to support admission avoidance

b) Reablement (2014/15 onwards)

It is proposed that access to reablement is maximised in NEE as well as quality, as NEE CCG JSNA shows rates of provision are low in NEE, but will need to be balanced against % with successful outcomes. This will include both Domiciliary and Residential, with provision of residential reablement.

c) Carers' Support (2014/15 onwards)

Carers will receive support at the right time and in the right place to enable them to maintain their caring role and their own health and wellbeing. We will achieve this through:

i. Community based & community led activities which support those people who take on a caring role, whether or not they define themselves as carers, helping them to find solutions to issues and support from within their communities and natural networks.
ii. An improved early offer reducing the need for formal assessment through:
   - Information & advice;
   - Practical support to sustain a caring role;
   - Access to time away from the caring role;
   - Carer training.
iii. Targeted specialist support – for example at end of life; at hospital discharge; alongside reablement.

d) Care Closer to Home service bundle (2015/16 onwards)

In line with the procurement timetable for Care Closer to Home (see Appendix A), the 2015/16 BCF will additionally encompass some integrated aspects of health & social care delivery in the

community that form part of this service bundle. These are designed to support people to stay in their own homes, avoid unnecessary admissions, and support the national requirement for case management of over 75s by GPs. Schemes cover a range of sectors, including:

- NHS Community Schemes
- Voluntary Sector Schemes
- Joint Commissioning Continuing Health Care
- Marginalised groups e.g. homeless people
- Primary Care Local Enhanced Services (Patient centred care)
- Housing Schemes
- Diabetes Integrated Pathway

Support for vulnerable groups includes voluntary sector grant funding. NEE is rolling over some high priority grants and opening up bids for the remainder of grant funding in 2014/15. It is proposed that an integrated bid process be used to align with ECC grants.

The difference for patients and care outcomes

• People will be encouraged and supported to look after their own health and social care needs
• Carers will receive the support they need
• Patients, public and community groups will take up opportunities to be involved in planning and developing services
• Services will be centred around the patient and will be high quality, evidence-based, cost effective and sustainable
• People will receive seamless and joined up services across their health and social care needs
With regard to specific outcomes to be commissioned against, we are aligning the vision with national outcome framework targets and identifying specific local priority outcomes in order to secure quality improvements in line with national guidance. This will be detailed in the 5 year plan.

b) Aims and objectives

Our aim is to commission integrated care and support, based in people's homes and local community, using acute services only where they add value (see Appendix B). We will commission services which:-

- Are wrapped around the needs of the individual, giving them maximum choice and control
- Deliver an excellent experience of care – right care, right place, right time – where people are treated as partners not patients
- Support people to be and remain independent and to manage their own health and wellbeing
- Are proactive and well planned, using risk stratification
- Reduce unplanned hospital admissions
- Enable services to be sustainable into the future – ensuring services are fit for

purpose at a time when elderly population/health needs are growing and budgets flat-lining.

We will measure :-

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Avoidable emergency admissions
- Patient / service user experience via patient surveys and other engagement methods
- Measures of health gain, including those in the CCG Outcomes Framework, such as Potential Years of Life Lost.

These will be monitored through CCG processes and fed into Integrated Governance processes as necessary.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The details of the specific schemes included in the BCF are being developed through a series of joint workshops between NEE CCG and ECC. Once the modelling work on acute services is completed 9see section 2d), it will be linked with social care modelling.

2014/15

The Fund will consist mostly of existing funding streams in 2014/15, totalling about £8.2m, including:

- Core Baseline Funding
- Reablement Funding
- Sustainability Funding
- Carers Allocation

2015/16

2015/16 will see an increased transfer of funding from CCGs to upper tier local authorities. In NEE, the BCF pooled budget will total around £21m, including the £8.2m outlined above. The schemes funded through this pooled budget will include some pre-existing integrated schemes and new schemes as outlined below:

Proposed NEE BCF Schemes by Year

In BCF from 2014/15 onwards	In BCF from 2015/16 onwards
7 Day Working • 7 day discharges from CHUFT • 7 day working at Rapid Assessment Unit at Clacton Hospital • Community discharge support & rehab services	**7 Day Working** • 7 day admission avoidance via A&E and OOHs services • Diagnostics to support admission avoidance • And/or other elements as required
Reablement • Domiciliary reablement • Residential reablement	**Care Closer to Home** • NHS Community Schemes • Voluntary Sector Schemes

	• Joint Commissioning Continuing Health Care • Marginalised groups e.g. homeless people • Primary Care Local Enhanced Services (Patient centred care)
Carers **Sustainability Fund Services** • Including social care input into virtual ward	

The BCF will be used to:-

- Support people with multiple and complex needs to remain in their own homes and reduce their risk of health or social crisis, through integrated care from health, social care and other agencies. Through our Care Closer to Home plans, GPs will be at the centre of co-ordinating the care of people with long term conditions and will be able to refer people into a virtual ward, to enable them to receive the level of support they need whilst staying in their own homes, thus reducing the risk of decompensation. This includes a single assessment and single point of access. All providers of the Care Closer to Home contract will be required to deliver integrated care. Contracts will be aligned with Public Health contracts to ensure a seamless service.
- Support the development and implementation of 7 day working, including 7 day discharge from acute care, supported by social care, community and reablement services and including 7 day avoidance of admission supported by simplified and integrated urgent care system

The BCF planning is being integrated into the wider planning for the care economy, and as such will be aligned with 2 and 5 year planning. Strategic planning has started with consideration of the JSNA, and commissioning plans are being jointly developed across health and social care.

The Disabled Facilities Grant funding is also included, but no changes to services are currently planned. Further discussions with local authorities will be held.

Within the “Everyone Counts” planning guidance, NHS England has determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

The £5 per head funding has been included in the BCF to support closer integration between primary and social care.

d) Implications for the acute sector

The NEE health economy is aiming to hold the rate of avoidable hospital admissions level at 1,863 p.a., stemming the increase seen over recent years. This equates to 6,302 admissions during 2014/15. Ambulatory Care Sensitive (ACS) admissions are a major component of the composite indicator. Between 2010/11 and 2012/13, the quarterly cost of ACS admissions in NE Essex was on average 17% below expected levels based on national data (NHS Comparators, 2014). This means that it is relatively harder for NE Essex to make large reductions in admission rates compared to other CCG areas. The CCG JSNA shows that achievable reductions in admissions are likely to be marginal, and will result from targeted rather than generic improvements.

Although being lower than national and regional averages, avoidable admission rates in NEE are steadily increasing in line with national trends: standardised ACS admission rates increased 1.6% in 2011/12 and 0.9% in 2012/13. The NE Essex population is forecast to grow 1.6% over 2014/15, with relatively higher increases in the very young (under 5s) and the very old (over 75s), the specific age groups that form the bulk of the avoidable admissions measured by the BCF metric. Aiming to keep the avoidable admission rate level in 2014/15 and beyond (ie achieve a 0% increase) therefore represents a real, but achievable, improvement in performance.
The impact of the BCF and the likely impact on avoidable acute admissions were discussed with CHUFT, NEE CCG's main acute provider, on 27th February 2014. These discussions indicated an agreement between the CCG and CHUFT on the general level of likely achievable change in the BCF avoidable admissions metric, which will be further explored with providers before final submission on 4th April

Avoidable emergency admissions will be monitored monthly by the CCG, allowing intervention if the metric is off-target. The CCG has commissioning bundles focusing on each of the four measures in the composite metric.

Care Closer to Home impacts on the number of avoidable admissions of older people with Ambulatory Care Sensitive (ACS) conditions. A number of services to be included in this bundle are already in place including risk stratification and multi-disciplinary case management through virtual wards and other services to support case management of >75s in primary care.

The aim for the Care Closer to Home element of the BCF will be to reduce avoidable unplanned ACS admissions to the Acute Hospital setting, enabling funding to be released to commission more efficient and effective integrated services across our Primary and Community settings, and contribute towards the overall Quality, Innovation, Productivity and Prevention (QIPP) challenge.

Care Closer to Home impacts on avoidable ACS admissions among older people will be enhanced from 2015/16 through the introduction of a Community Gateway and enhanced use of risk stratification.

In addition to releasing financial savings to the commissioner, our local evaluation of data from

the Virtual Ward pilots indicates that the acute sector should also see a reduced Length of Stay (LOS) of approximately 40 bed days per 100 patients admitted per annum, contributing to improved patient flow through the system.

Urgent Care impacts on avoidable acute admissions among older people and children. From 2014/15, 7 day working and admission avoidance through a new Rapid Assessment Unit in Clacton will be implemented.

End of Life Care impacts on avoidable acute admissions among older people. A single point of access to care and support has been implemented in 2013/14 and includes enhanced palliative care in non-acute settings.

Children's Services impact on avoidable chronic condition admissions among children.

Best practice tariffs facilitate a preventative approach which stabilises the condition and allows management in the community, with acute specialist care when clinically required. This approach demonstrably reduces the number of unplanned admissions and A & E attendances and reinforces service user 'ownership' of their condition

A Children's Epilepsy Nurse has been in post for 2 years and a best practice tariff will be implemented in 2014/15. A best practice tariff is already in place for children's diabetes services. Asthma is subject to revised NICE guidance.

Modelling of Impact on Acute Providers

The detailed impact to our providers is complex and requires detailed planning and modelling to understand the full effect of this and other pathway changes. The CCG has commissioned modelling work, currently underway, which includes:-

a) Benchmarking our current provider with peers/best in class to understand achievability
b) Considering any best practice/national reference data based on local pilot data/knowledge
c) Taking into account current contract planning rounds/negotiation
d) Cost analysis of providing the service in acute as opposed to other care settings
e) Potential impact on emergency thresholds
f) Modelling the impact by service Bundle, and amalgamate to a whole system impact
g) Triangulating with work modelling outcomes to be achieved
h) Assessing our ability to deliver national targets for reduction of elective and non-elective activity **(by 20% and 15% respectively)** through our current plans and identifying any gaps
i) Assessing the impact of the plans on the sustainability of the system in the longer term
j) Assessing the impact of 7 day working including how it will facilitate discharge and patient flow through the system

The systems modelling will cover 5 care areas:-

- Acute activity
- Care closer to home
- Urgent care
- End of life care
- Children's services

The project will take an approach which will include:

1. Aggregating baseline data into a back-end database;

2. Forecasting data over 5 years;

3. Applying modelling assumptions to derive the impact of outcomes-based initiatives on forecast activities and finances. This will include an analysis of acute activity that could either be stopped altogether or moved into a community setting;

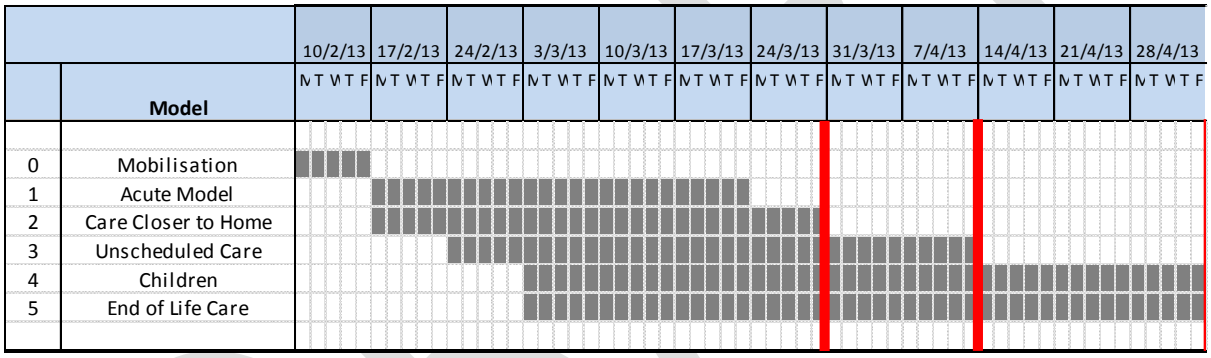
The same phases will be followed for each of the five care areas. However, rather than having five separate models, the project will build incrementally on the same model, adding on the impacts of initiatives in each bundle to the same dataset. This will mitigate the risk of double-counting benefits, because for each HRG (Healthcare Resource Group) it will be explicit which activity and cost assumptions have been applied in each bundle. HRGs which have been impacted by initiatives in more than one bundle will require a review at the end of each phase to ensure that there has been no double counting.

A summary of the project plan for the modelling work is shown below. The key milestones are:-

28 March 2014: Completion and delivery of acute and care closer to home bundles

14 April 2014: Completion and delivery of the unscheduled care bundles

5 May 2014: Completion and delivery of the children and end of life care bundles



In order to model future changes to the health system as set out in the project blueprint, we will first need to generate an activity forecast for the planned care services delivered in the acute setting. We will then determine which services (at a HRG level) will be reduced in the future (e.g. avoidable non-elective readmissions) and which will be moved to other, more appropriate, areas of the health system.

A linear trend forecast based on historical SUS (Secondary Uses Service) activity will be produced. The model will forecast activity forward five years. It should be pointed out here that the relatively short period of historical data may create larger margins of error in the forecast output.

The forecast can include the projected impact of a range of events, including:

- Changes to demand
  - Population increase.
  - Impact of increase of diagnosis across various conditions (The JSNA reports that under-diagnosis is a problem in a range of long term conditions).

- Changes to activity

    - Reducing/stopping services - Admission avoidance: The new service design is intended to bring efficiency gains and so result in reduction of activity over time. Attain can model estimates of admission reduction in addition to the financial impact of moving acute services into the community. For example, an estimate of the reduction in non-elective readmissions brought about by the planned changes to the system can also be incorporated into the model. This will allow the CCG to assess how close it will be to achieving the required 15% reduction in non-elective admissions

    - Moving services to more appropriate settings: A list of current activity better suited to delivery in other settings will be agreed with the team. Attain has already done some work in this area but will ensure that the list is appropriate for the local environment. This list will include ambulatory care sensitive conditions (ACSC) as well as a range of other condition.

    - We will then model the shift of this activity over time into the appropriate setting (there may be a reduction in activity volume at the same time as it is shifted). The model will allow different start dates for the shift and different rates of shift to allow for different scenarios.

- The forecast, with all the events described above, will be at a HRG level, which will be aggregated to POD (place of delivery) level and specialty level to give bundle level analysis, then to an overall system level.

The modelling work is in phases, so by the middle of March we will have some idea of the potential activity that could either stop or transfer. There then needs to be an internal discussion to see how much of that is appropriate/desirable, and we then need to have the conversations with the providers. Alongside this the modelling work will also link the possible stop/transfer to actual schemes. The modelling is being carried out in conjunction with conversations with providers and is taking into account the providers' own impact assessments.

The CCG is also undertaking work to ensure that the BCF plans and QIPP schemes are not being double counted.

The modelling outcomes will enable an assessment of workforce implications of the local economy, to be carried out in conjunction with Health Education East of England.

The CCG is also liaising with providers on the BCF, 2 and 5 year plans through a series of planned meetings.

e) Governance

Within Essex, the Health and Wellbeing Board has delegated the HWB Business Management Group (BMG) to act as a Programme Board. The BMG meets monthly and will be responsible for oversight and governance of progress and outcomes.

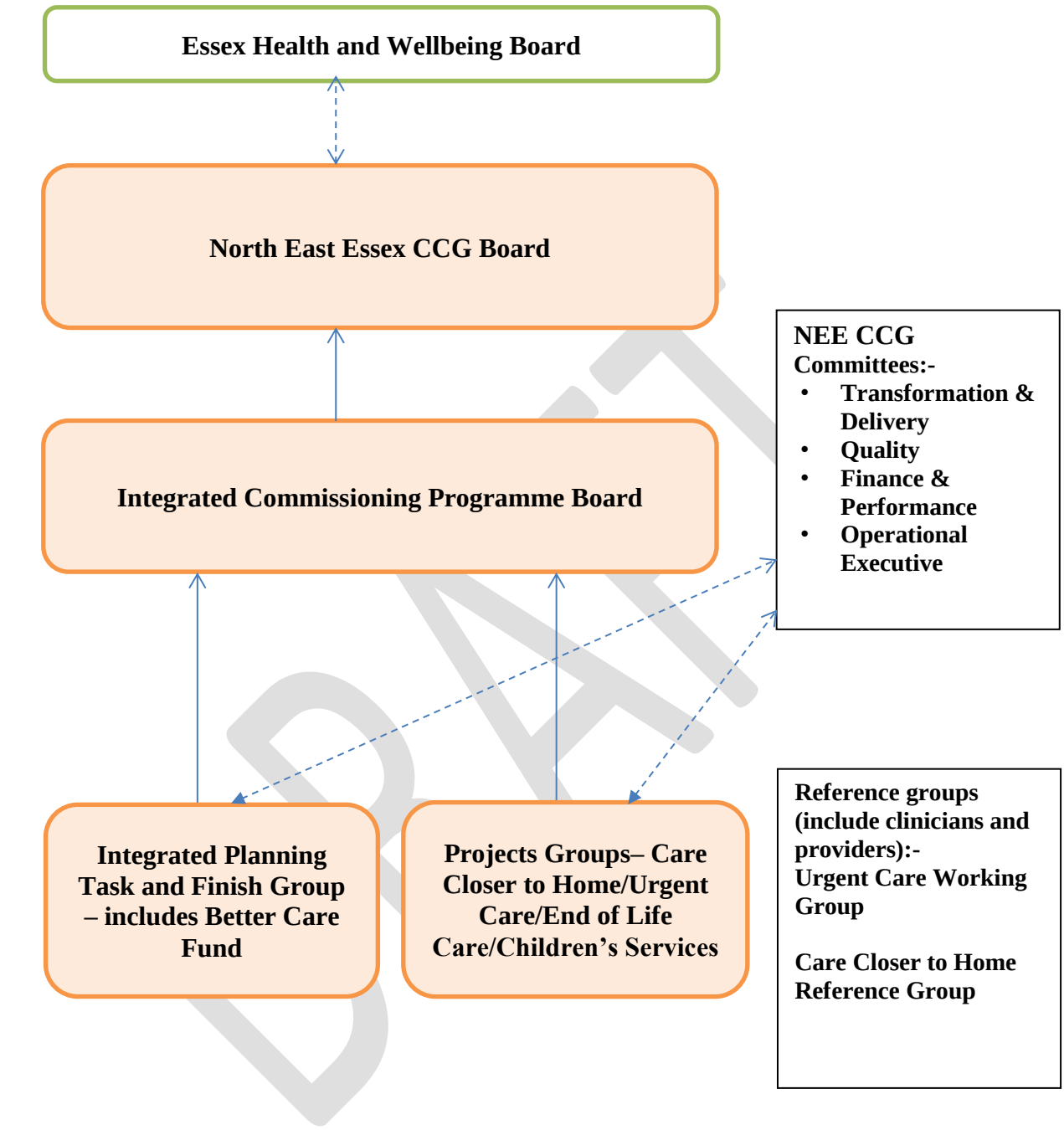
NEE CCG uses programme management structures and processes to manage the production and implementation of plans to support the delivery of their vision, including the production of the Better care Fund Templates, 2 year operational and 5 year strategic plans.

The sponsoring organisation is the CCG Board, with an Integrated Commissioning Programme Board (ICPB) which reports directly to the CCG Board. The ICPB is chaired by the Clinical Chief Officer and includes Elected Members (GPs and a Practice Manager), members of the CCG Leadership Team, senior ECC colleagues and patient representatives. The ICPB oversees all work on the delivery of the CCG vision and has delegated responsibility for the day to day work of producing the plans to the Integrated Planning Task and Finish Group. All plans, including the BCF, are also reviewed by key CCG committees – Transformation and Delivery Committee (clinical scrutiny), Quality Committee (quality scrutiny) and Finance & Performance (financial and activity scrutiny).

A chart showing the NEE CCG governance structure for the BCF and transformation projects is shown on the next page.

Essex County Council has agreed a way forward to accelerate integration, to include a proposal for councillors to sit on CCG Board as invited attendees with speaking (but not voting) rights. Once fully formulated, this proposal will be presented to NEE CCG Board for discussion and approval.

North East Essex CCG Governance and Programme Management Structure



KEY

Essex County Council representatives sit on these boards/groups

Accountable to

Reports to

3) NATIONAL CONDITIONS

a) Protecting social care services

The CCG and ECC will protect social care services in Essex by ensuring that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. Our ambition is to maintain current service level and to develop integrated care pathways that enable individuals to remain as independent and healthy as they are able. By proactively intervening to support people at the earliest opportunity and ensuring that they remain well and are engaged in the management of their own wellbeing, and wherever possible enabled to stay within their own homes, our focus is on protecting and enhancing the quality of care by tackling the causes of ill-health and poor quality of life, rather than simply focusing on the supply of services.

Social Care Sustainability
Part of the s256 sustainability monies in 2014/15 will be used to fund Essex-wide modelling of flows out of hospital and into social care and community care including reablement and residential/nursing homes, to inform how to intervene to reduce demand.

2014/15 Proposed Allocation NHS Transfer to Social Care and 2014/15 BCF Allocation	
2014/15 Social care base budget areas of spend	**2014/15 BCF spend to be agreed**
Reablement (in addition to s75 Reablement Agreements)	
Hospital Teams	
Carers' Services	
Dementia Services	
Older Adult Mental Health Teams	
Prevention Services including Third Sector Funding, Extra Care Schemes and Virtual Ward	
Telecare Services	
Floating Support	
	Preparation for Care Bill and BCF National Conditions

The local authority has engaged in a transformation programme that has led it to become an outcomes based commissioner with a strong locality focus and has released efficiencies enabling it to maintain its current eligibility criteria. Discussion on local social care spending is ongoing to enable local social care services to be maintained. Community based social care means those services which enable people with critical and substantial social care needs to remain independent. The principal mechanism for this is the ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained

in 2015/16 and 2016/17 to allow for contract procurements.

b) 7 day services to support discharge

Social Care
ECC operates a 6 day hospital discharge service which is flexed to a 7 day operation during periods of increased pressure and is committed to support 7 day services to support discharge. ECC intends to fund community health and social care reablement services and social worker support to operate 7 days per week during the lifetime of the BCF. ECC will introduce this with immediate effect for reablement and will continue their weekend social care assessment services. ECC will introduce 7 day working generally as part of the implementation of the Care Bill.

Health Economy
NEE has a well-established Urgent Care Working Group, which includes all local Providers and Commissioners, and this group will facilitate 7 day discharges as a priority in 14/15, identifying community resources required to support this, and utilising part of the £1.08m funding available for this from 14/15.

The work programme will include:

- 7 day discharges from CHUFT (Social Care 7 day working required in 14/15 to achieve this)
- Community discharge support and rehabilitation services
- 7 day working at the proposed Rapid Assessment Unit at Clacton Hospital
- 7 day admission avoidance via A&E and OOHs services
- Diagnostics to support admission avoidance

<u>Delivering the Programme</u>
North East Essex in partnership with Essex County Council and Health Education England will recruit a fixed term programme manager to work across the system to develop:

- 7 day a week service strategy for NE Essex
- A system wide action on how to deliver the clinical standards as defined by the National Medical Directors forum
- A system wide workforce strategy on how the system will deliver 7 day a week services in an environment that needs to deliver consider financial efficiencies
- A strategy that feeds into the overall commissioning strategy for North East Essex CCG
- Progress against this programme of work reports for the Integrated Commissioning Programme Board
- Learning to be shared with the wider Essex community

The North East Essex Health and Social Care system are keen to explore further the benefits for our population on providing a range of services across a 7 day week.
North East Essex CCG have, as part of the call to action and to meet their statutory responsibilities, participated and hosted a number of events (The Big Care Debate) during the past 6 months to capture the views and thoughts of our local population. There have been a number of themes that have emerged from this work which we are including in our planning processes.
One of the key messages from the public was the need to use the resources we have across 7 days a week to maximise efficiencies of estate and workforce. There was a clear message that services, especially those in the community and primary care were often not available during out of hours when required, resulting in patients reaching crisis point and then accessing emergency services.
NHS England have stated in their "Everyone Counts: planning for patients 2014/15 to 2018/19" that 7 day a week services are an essential component for the NHS to focus on. There is no 'one size fits all' answer to introducing seven day services and therefore local solutions need to

be found. However, NHS England did commission a forum, chaired by the National Medical Director, to consider how NHS services could be improved to provide a more responsive and patient centred service across the seven day week. http://www.england.nhs.uk/wp-content/uploads/2013/12/brd-dec-13.pdf

This forum has made a number of recommendations which the CCG plan to consider with system partners – these include:

- The forum's clinical standards should be adopted to support the NHS to drive up clinical outcomes and improve patient experience at weekends and that these should be adopted in every community in England by the end of 2016/17
- That NHS England and other commissioners use incentives, rewards and sanctions through the contract to support the scale of change required.
- That the BCF is identified as a key enabler for change and that CCGs and Local Authorities utilise this resource to support 7 day services in health and social care to support patients being discharged and to prevent unnecessary admissions at the weekend.

The 2014/15 GMS contract changes also support this by introducing a new enhanced service to avoid unplanned admissions and proactive case management and continuing to commission the extended hour access enhanced service

As financial and service pressures intensify within health and social care, the need to accelerate integrated care to improve patient's outcomes and experience have never been greater.

Primary Care

Opportunities need to be explored and tested out with primary care to provide general medical services across a 7 day a week period using the current contractual arrangements and by working with the GP Provider company to maximise resources efficiently. 7 day working is part of the emerging Essex Primary Care Strategy being developed by NHS England Essex Area Team. The CCG is encouraging all GPs in NE Essex to take part in a pilot being run until April 2014 to see if weekend opening of surgeries reduces the pressure on Colchester Hospital's Accident and Emergency Department. Monies from the national Winter Pressure budget is being used to fund the extended opening hours.

Key Points to Note:

- North East Essex health and social care system need to develop an approach to 7 day a week working, from both a commissioner and provider perspective. This approach needs to be developed with the local population.
- 7 day a week working is not just about the hospital – it is about the whole system, which includes health and social care. It does not just mean NHS providers either, NEE will need to co-develop a strategy that covers all providers if appropriate.
- The strategy will need to consider a range of issues and challenges including workforce planning.
- NHS England's "NHS Services Seven Days a Week Forum" has produced a set of clinical standards describing the standard of urgent and emergency care that all patients should expect to receive seven days a week. These should be used in NEE as a basis for developing plans.
- The BCF should be used to enable the health and social care system in North East Essex to develop a comprehensive action plan to deliver the clinical standards.

Actions taken

- North East Essex in partnership with Essex County Council and Health Education England is recruiting a fixed term programme manager to work across the system to develop:
    - 7 day a week service strategy for NEE
    - A system wide action on how to deliver the clinical standards as defined by the forum
    - A system wide workforce strategy on how the system will deliver 7 day a week services in an environment that needs to deliver consider financial efficiencies
- The development of the strategy feeds into overall commissioning strategy for North East Essex CCG
- Progress against this programme of work reports into the Integrated Commissioning Programme Board
- That any learning is shared with the wider Essex community

c) Data sharing

ECC have been working towards using the NHS number, currently we have linked the NHS number to the social care personal ID, which can enable care records to be used in a pseudonymised way, further work is taking place to enable us to share data on the basis of the NHS number

The CCG has not been able to use the NHS number for a prolonged period due to national restrictions. Having been granted Accredited Safe Haven (ASH) status and having put DSCRO arrangements in place, the CCG is now in a position to begin receiving patient identifiable data. Ongoing restrictions apply, but the CCG will be in a position to use NHS number, or a pseudonymised version of, for 2014/15 reporting.

In line with ECC, our strategic ambitions for data management, systems development and performance/financial reporting have the NHS number as a single consistent patient identifier. This is crucial for us in terms of understanding patient pathways and end-to-end commissioning of these – and providing quality data to GP Practices to support patient care. As noted there will be restrictions on the CCGs ability to receive, process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

ECC will be implementing a new social care case management IT system that uses the NHS Number during 2015. Within the current social care recording systems NHS numbers are recorded for the majority of current cases. In the event of delays implementing its new IT system ECC will develop the facility within existing systems to use NHS numbers in correspondence.

ECC is committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)). ECC will be implementing a new social care IT system that uses Open API's and Open Standards. This system will be implemented during 2015.

ECC is committed to appropriate IG Controls and to meeting the requirements of Caldicott2. A Data Sharing project, led by the Leader of the council, is currently underway within ECC with the objective of creating protocols that will enable the council to meet its requirements under the Care Bill as well as the BCF national conditions.

The CCG confirms adoption of appropriate IG Controls which cover NHS Standard contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

d) Joint assessment and accountable lead professional

NEE CCG has commissioned a Risk Stratification tool for two years, formerly provided by Sussex Health Informatics Service (HIS), now part of the Health and Social Care Information Service (HSCIC). This service is able to extract and receive data from the Exeter Spine, SUS and local service providers, including community mental health and primary care practices. This tool is a bespoke model that is based on actual activity and risk factors in the NEE population. As part of current contract negotiations, the CCG is requesting that providers directly share data with HIS for purposes of risk stratification.

Restrictions on sharing patient identifiable information (PII) have limited its use in 2013/14, however, now that Government guidance on sharing PII for risk stratification purposes has been received, this tool is ready to be used to identify people for joint review and interventions including holistic case management. The CCG is currently working with all Providers, under revised IG guidelines, to get Information Sharing Agreements signed.

This tool identifies that 0.5% of the population (1,603) are at Very High risk of hospital admission for a chronic condition in the next 2 years, and that 5% (14,428) are at High risk. The CCG is therefore planning that elements of Care Closer to Home will need to review around 15,000 adults over the first few years to identify those who could benefit from a joint care plan. Planning 4 care data suggests that around 8,500 people in NEE have a High or Very High need for social care. Adults over 75 will have a named person in charge of their assessments and care.

The NEE Virtual Ward service has developed a single Health & Social care assessment tool that can be used as a basis for the further development of tools for the Community Gateway, prior to the commencement of the Care Closer to Home service bundle in April 2015/16. The Care Closer to Home plan includes development of joint planning processes as part of this service. The service will provide support for GP case management of people over 75 years old..

Within the “Everyone Counts” planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over and those with complex needs such as dementia. This is further supported by the new GP contract securing specific arrangements for patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs

The risk stratification tool will identify people at high risk of hospital admission who will benefit from care planning. From 2016/15, Care Closer to Home will enable this to happen.

4) RISKS

Risk	Risk rating	Mitigating Actions
1. New models of care will destabilise existing providers	Medium	Mapping all commissioned services, provider by provider, to assess potential impact of procurement and putting in plans to ensure services are protected where necessary. Whole system approach to planning and development, supported by a MOU between CCG and providers.
2. New and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity by 2015/16	Medium	Use of withheld monies to fund unmet need / increased hospital to residential care activity
3. CCG is not able to agree a risk and benefit share with providers of Care Closer to Home. Contract values will be fixed, resulting in CCG carrying all the risk of not achieving the outcome measures.	Medium	CCG contracts team exploring models of risk and benefit share with providers.
4. Balancing demands of business as usual and transformational change	Medium	CCG commissioned external organisation to review its OD in Nov-Dec 2013 and is now working with them to ensure CCG work teams aligned to CCG objectives and to map potential "pinch points" during the annual work cycle. Use of additional support will be commissioned as required.
5. A lack of access to baseline data and the need to rely on current assumptions means that our financial and performance targets for 2015/16 onwards may not be achieved	Medium	The two year allocation enables greater certainty around forecasts. Forecasts are continually monitored and refined where necessary and the CCG is required to carry a contingency.
6.The Care Bill will lead to a significant, but as yet unknown, increase in the cost of care provision from April 2016. This will impact the sustainability of current social care funding and plans.	High	Working with ECC to carry out impact assessment and develop a contingency plan.
7. CCG and provider financial plans will not triangulate in this version of the BCF	High	Ongoing contract negotiations with providers. Strategic alignment with specialist commissioning. Working closely with LAT and other commissioning partners

The general risk of the BCF to the system has been added to the CCG Risk Register as a Red Risk.

Contingency Planning

1. Mitigation through acute contract negotiations in 2014/15 and beyond. Impact of 2014/15 performance felt in 2015/16, limited impact for 2014/15 contract, except for starting target reductions in NEL and Elective activity.

ACTIONS

- Establish in-year monthly monitoring to ensure meeting 2014/15 Avoidable Emergency Admissions target in year, allowing intervention with Providers in year, in line with BCF plans, if off-target
- 2 year plan workshops being held with CHUFT, ACE and NEPFT to align plans
- Contract negotiation strategies to be considered.

2. Mitigation through contract negotiations in 2015/16 and beyond. Risk of contingency loss in 2015/16 from underperformance in 2014/15 = c.£3.2m of CC2H / BCF value. High level contracting strategy for 2015/16 to be developed – including assumption that the BCF will continue beyond second payment in October 2015.

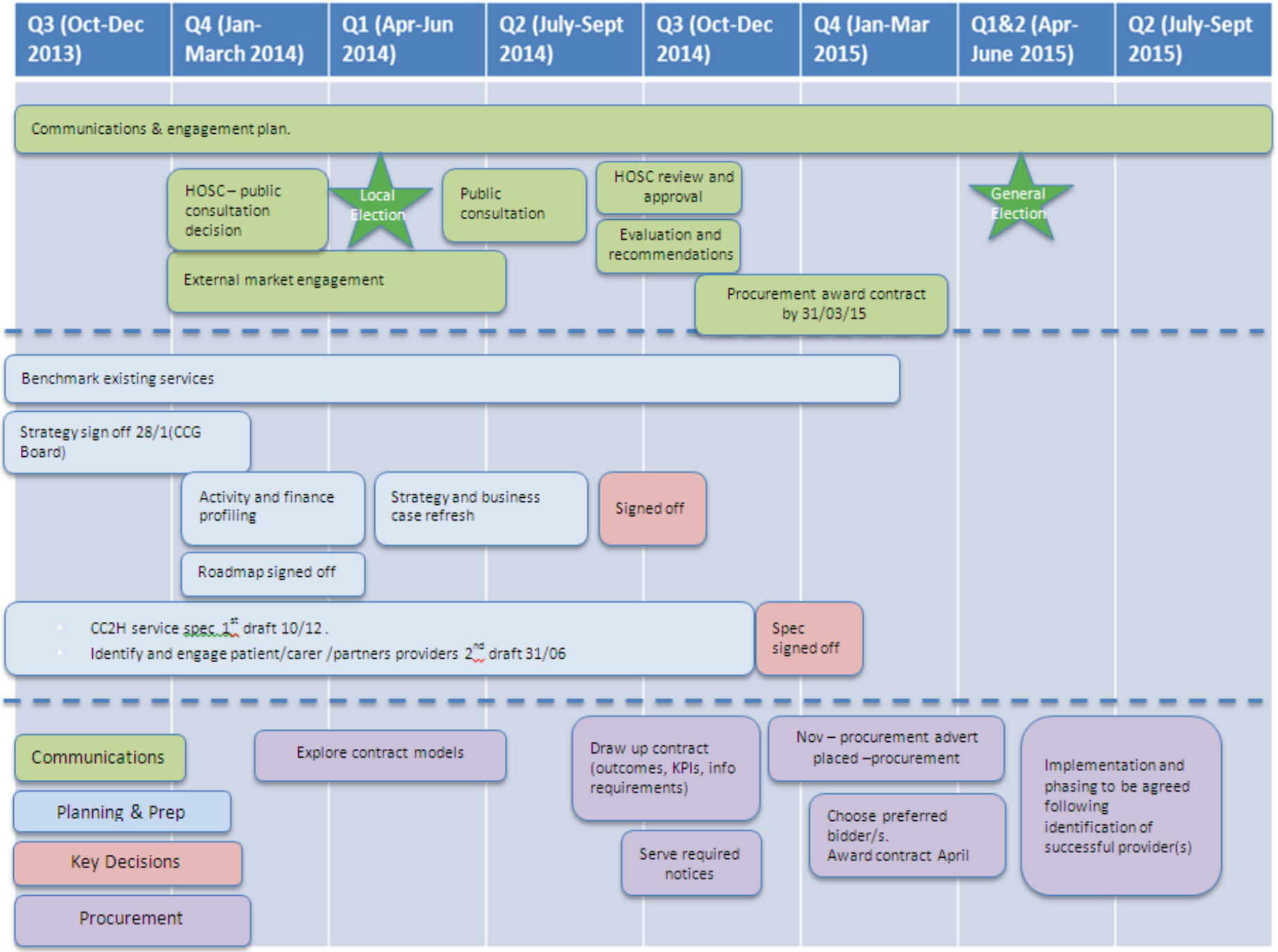
ACTIONS

- Ensure Care Closer to Home contract value includes risk share to appropriate % linked to BCF outcome achievement to mitigate against BCF contingency risk 2015/16 onwards. Being modelled by Attain for inclusion in CC2H procurement.
- Principles around risk-share should be agreed for all Bundles contracting.
- High level contracting strategy for 2015/16 to be developed.

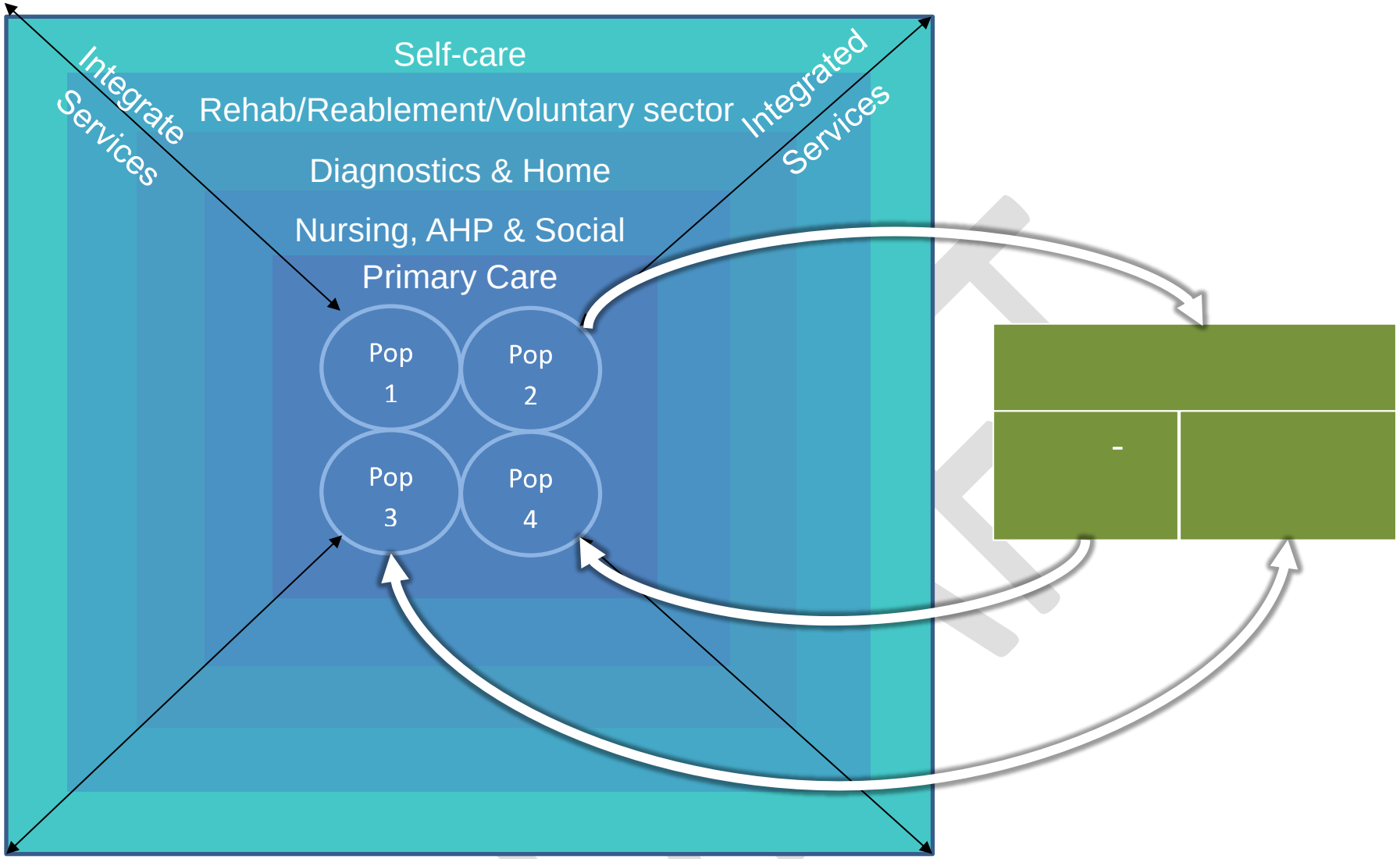
3. Contingency allocation to be agreed through HWB BMG re allocation of contingency in April and October 2015 should targets not be met.

ACTIONS

- Agree risk-share arrangements across Essex CCGs and ECC, and contingency allocations across the metrics


Q3 (Oct-Dec 2013)
Q4 (Jan-March 2014)
Q1 (Apr-Jun 2014)
Q2 (July-Sept 2014)
Q3 (Oct-Dec 2014)
Q4 (Jan-Mar 2015)
Q1&2 (Apr-June 2015)
Q2 (July-Sept 2015)
Communications & engagement plan.
HOSC– public consultation decision
Local Election
Public consultation
HOSC review and approval
Evaluation and recommendations
General Election
External market engagement
Procurement award contract by 31/03/15
Benchmark existing services
Strategy sign off 28/1(CCG Board)
Activity and finance profiling
Strategy and business case refresh
Signed off
Roadmap signed off
CC2H service spec 1st draft 10/12 .
Identify and engage patient/carer /partners providers 2nd draft 31/06
Spec signed off
Communications
Explore contract models
Draw up contract (outcomes, KPIs, info requirements)
Nov – procurement advert placed –procurement
Implementation and phasing to be agreed following identification of successful provider(s)
Planning & Prep
Choose preferred bidder/s. Award contract April
Key Decisions
Serve required notices
Procurement

Appendix A



Appendix B