Essex Better Care Fund 2016/17

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**North East Essex CCG**
	Mid Essex CCG
	West Essex CCG
	Basildon & Brentwood CCG
	Castle Point & Rochford CCG
Date agreed at Health and Well-Being Board:	**24th March 2016**
Date submitted:	**21st March 2016**
Minimum required value of pooled budget: 2016/17	**£97,665,713**
Total agreed value of pooled budget: 2016/17	**£98,905,799**

a) Authorisation and Sign Off

Signed on behalf of the Clinical Commissioning Group	North East Essex CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Mid Essex CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	West Essex CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical Commissioning Group	Basildon & Brentwood CCG
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

Signed on behalf of the Clinical	Castle Point & Rochford CCG

Commissioning Group	
By	<Name of Signatory>
Position	<Job Title>
Date	<date>

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

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

Essex Better Care Fund 2016/17

Table of Contents

1. Vision and Contextual information

Our Vision
In June 2014 the Essex Health and Wellbeing Board agreed a five year health and care plan. This set out our shared vision for health and care in Essex:

> *'By 2018 residents and local communities will have greater choice, control and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced'.*

Individual CCG plans sit beneath the pan-Essex plan and include other, local priorities, together with greater detail on implementation and timescales.

The Essex-wide vision aims to deliver four system objectives:

A. Promoting independence, choice and control
B. Improving outcomes for the same or less money
C. A healthy and happy Essex – tackling variation in outcomes
D. Safe and high quality services

The five year plan is available online at www.essex.gov.uk or here.

The vision reflects the Essex Health and Wellbeing Strategy 2013-18. This was informed by the findings from the Joint Strategic Needs Assessment (JSNA), which is currently being updated for consideration by the Health and Wellbeing Board in May 2016. These documents are available via http://essexpartnership.org/content/joint-health-and-wellbeing-strategy

To achieve this vision we will commission and deliver integrated care that is person centred, closer to home and ensures that timely multi-disciplinary intervention improves outcomes while leaving the patient and their family feeling in control.

Context and challenges
The Essex health and social care landscape is complex. As well as five Clinical Commissioning Groups (CCGs) serving a population of 1.4 million, there are five acute trusts and two community health and mental health providers serving not just people in Essex but also residents of neighbouring authorities including Thurrock, Hertfordshire and Southend. There are also twelve district councils providing services across the County, as well as around 10,000 voluntary and community groups. There are also links with the neighbouring counties of Suffolk and Cambridgeshire.

Our challenges include:

A growing and ageing population:

i. The Essex population grew 6% 2001-11 and is forecast to grow by 20% up to 2033.
ii. 20% of the population is already aged over 65 (compared with 16% nationally). There are six wards whose population of 65+ year olds is

over 40% of the total population in the ward. All of these are in Tendring in North East Essex CCG which has the highest proportion of older people in the County.

iii. In Essex, the number of people aged 75 and over will have grown by 25% in the decade to 2020. By 2031 the over 65s are expected to grow by 52%.

Challenges acute hospitals

i. All five acute hospitals serve towns of <180k in population with incomes <£300m: a size associated with higher, and increasing, financial challenges

ii. The total number of emergency admissions at Essex hospitals grew by 6% between 2012/13 and 2013/14 (compared to 1% growth nationally); there was 8% growth between 2013/14 and 2014/15 (compared to 4% nationally)

iii. Essex hospitals have a greater proportion of non-elective activity (average of 32%) than comparators (average of 26% among a sample of similar sized hospitals)

iv. Delayed Transfers of Care are improving but remain high

Workforce challenges

i. The GP population fell 1% in 2013/14.

ii. There is a higher ratio of patients to GPs in Essex than nationally. In 2015 the patient/GP ratio was 1,947 compared with a national average of 1,731. Forecasts suggest it could grow to 2,132 by 2020

Financial challenges

i. There is a forecast deficit in the Essex health system of over £200m by 2018/19

ii. Essex County Council needs to needs to deliver a further £374 million in savings and efficiencies between 2016/17 and 2018/19 to balance its budget..

NHS Success Regime

In June 2015 Essex was one of three challenged areas included in the NHS Success Regime. The regime is overseen jointly by three national organisations - NHS England, NHS Trust Development Authority and Monitor.

The Success Regime is focusing on addressing challenges in Mid and South Essex, covering five CCG areas of Mid Essex, Basildon and Brentwood, Castle Point and Rochford, Southend and Thurrock. All health and social care services in Mid and South Essex are involved in the programme, including over 180 GP practices, community services, mental health and social care and hospital services. Dr Anita Donley has been appointed as Independent Chair, effective from 1 April 2016.

Current estimates show the total deficit for the NHS in mid and south Essex will be £94 million in 2015/16. Without changes to way in which we provide health services the deficit would rise to an estimated £216 million by 2018/19.

The Success Regime has set out six areas of focus:

1. **Address clinical and financial sustainability of local hospitals by:**
    a. Increasing collaboration and service redesign across the three sites of Broomfield, Basildon and Southend
    b. Sharing back office and clinical support services.

2. **Accelerate plans for changes in urgent and emergency care, in line with national recommendations of the Willetts Review e.g:**
    a. Doing more to help people avoid problems and get the right help
    b. Developing same day services and urgent care in communities, to reduce unnecessary visits and admissions to hospital
    c. Designating hospital sites for specialist emergency care.

3. **Join up community-based services – GPs, primary, community, mental health and social care** – around defined localities or hubs.

4. **Simplify commissioning, reduce workload and bureaucracy e.g:**
    a. Reduce the number of contracts from around 300 to around 50
    b. Commission services on a wider scale e.g. with one lead provider where several may be involved
    c. Agree a consistent and common offer to focus on priorities and identify limits of NHS funding.

5. **Develop a flexible workforce that can work across organisations and geographical boundaries.**

6. **Improve information, IT and shared access to care records**

The Success Regime offers an opportunity to put new arrangements in place that will support collaboration between local organisations e.g.:

- Exploration and agreement on a group model for the three main hospitals
- A committee for the five CCGs to plan and buy services jointly across mid and south Essex.

Progress within Essex

As well as the Success Regime, the following strategic initiatives are important to note:

- **North East Essex CCG** commissioned and openly procured a 7 year team an integrated 'Care Closer to Home' service for 2016 funded via a (semi) capitated budget the model matches that of a Multispecialty Community provider (MCP) as outlined in the Five Year Forward View. It will be delivered through a single 'Lead Provider model' using an outcomes based approach to commissioning delivered through 4 neighbourhoods across the patch. The system as a whole will come together around that delivery model to form an Accountable Care System (ACS) that focuses on strengthening communities and building commissioned activities on a foundation of co-designed

interventions that are jointly commissioned. The primary care system as also being transformed to deliver primary care at scale.

- **West Essex partners** have come together to re-shape the local health and care system with the strategic intent to form an accountable care organisation to take forward the ambition of the NHS Five Year Forward View. This brings together primary, community, secondary and social care and, longer term, elements of mental health and new capabilities in population health management, prevention, community activation and citizen engagement. Multi-disciplinary neighbourhood teams, based around clusters of GP practices and populations of c45,000, are being rolled-out across Essex to co-ordinate care and better manage risk and demand. To start the process of moving towards the creation of an accountable care partnership, the County Council and CCG are coming together to create a Strategic Commissioning Partnership between ECC and the CCG, as well as an Accountable Care Partnership to bring providers together under a single managing director.

- **Castle Point and Rochford CCG** have established 4 primary care hubs as the basis for care coordination of high risk patients, extended primary care services, future multidisciplinary working and so forth. They have also taken on the commissioning of primary care from NHS England.

Older People's Strategy

We recognise that older people, especially those over 65, have greater need for health and social care than the general population. They are an important at risk group and our strategies and the Better Care Fund aim to improve outcomes for this age group.

Essex County Council has worked with NHS partners to develop a five year strategy for older people up to 2021:

> *By 2021 we envisage Essex as a place where informed, empowered and confident older people and their carers live healthier, longer, lives and have greater choice and control over how their care needs are met.*
>
> *Older people (those aged 65 and over) who need additional support will have access to high quality integrated support rated as some of the best in the country, from a consistent workforce who treat them with dignity and respect.*
>
> *At the right time people are involved in planning their end of life and are provided with this care in a place of their choice.*

The strategy, at its core, is a four part approach that puts older people at the centre of their care and responds to the new duties placed on local authorities and the NHS by the Care Act 2014. The approach will be:

1. **Preventative** – supporting people before a point of crisis and look to direct them to services in their community that can help them maintain their independence for longer.

2. **Integrated** - Older people with complex health and social care needs will have their care co-ordinated by one key worker, have a single health and social care plan, and care is delivered in a proactive and preventive approach. This includes digital solutions to improve integration and information sharing.

3. **Personalised** – We want more people to access a Direct Payment and Individual Service Funds (ISFs) by understanding and removing current barriers. Those clients who have their care managed by Adult Social Care will be reviewed and supported to have their care delivered in a more personalised way. We will work with the care market to innovate and deliver outcome based care.

4. **Asset-based** – We will adopt a new approach based on starting with people's strengths and abilities, rather than deficits as required by the Care Act. The Good Lives approach will be adopted connecting people to community solutions, working with families and carers and not taking long term decisions in a crisis. We will also look to the built environment and digital assets to enable people to support themselves and adopt healthier lifestyles.

The Older People Strategy sets out areas of focus:

Areas of focus

Integration	Undertaking operational changes to deliver co-ordinated health and social care at local level for older and frail people. Practice to change to be proactive and preventative in approach.
Employment and Volunteering	Working with local partners to maximise opportunities for people aged 55 and over to continue in employment or volunteering roles.
Healthy lifestyles	Encouraging people to adopt self-care and take up activities that improve their health and well-being.
Long term conditions	Developing and sharing person-centred best practice across Essex to support people with long term conditions, including people with Dementia.
Housing and accommodation	Improving provision of specialist housing for older and disabled people, through development of independent living and supported living schemes. To identify more opportunities to utilise assistive technology to help people remain at home.
End of life	Improving access to support at end of life.
Access to services	Helping people get the information and services they need.
Monitoring and Safeguarding	Working with providers and residents to make sure there are good quality services in Essex.

Workforce	Improving the skills and capacity of the workforce and spreading best practice.
Carers	Ensuring older people who are carers are supported in accordance with our Essex Carers Strategy

This BCF plan outlines how the BCF will play a role in realising the overarching vision that has been agreed by the Essex Health and Wellbeing Board.

The main components of the Essex-wide transformation programme where BCF will make a significant contribution in reducing demand on health and social care are:

- Improving the frailty pathway
- Improving the management of long term conditions
- Improving mental health services, including the management of dementia

ECC and the five CCG's are developing care pathways which will transform care by wrapping services around the individual irrespective of provider, with the aim of keeping people independent in the community, out of hospital and maintaining or improving their condition. This will include:

- Supporting people at risk of losing independence with personal care services
- Reablement services including residential reablement services and in particular increasing the coverage of reablement and enhancing the capability.
- Supported discharge incorporated within the reablement response
- Continuing healthcare focused around how joint commissioning will improve the quality and reduce the cost of care.
- Joined up, high quality gateway to NHS and social care services through improved primary care and increased joint working between GPs and Social Workers.
- Integrated health and social care teams, working within community and practice based care networks who will manage people with long term need and long term conditions in an integrated way.
- Delivering an improved care pathway for continence care
- Identifying those at risk of falls; setting up fracture prevention services for older people, and medication review with modification/withdrawal
- Improving management of end-of-life care: We will ensure arrangements are in place for the identification of people who are at the end of life and ensure care is co-ordinated: improving the quality of care and reducing the number of unnecessary admissions into the acute setting.
- As many patients who are frequent attenders at A&E have an untreated mental health problem, ensuring that efficient liaison services are provided in our A&E department for patients who have mental health needs.

1.1. Implication of Plan on Providers

Essex is a complicated health and care system. In order to fully understand the implications of the BCF on the system and providers it is necessary to describe this by locality.

1.1.1. North East Essex CCG locality:

The BCF supports the existing programme of work in NE Essex to integrate health and social care and to commission services which are person-centred, focused on prevention and support and which are outcomes-based in a neighbourhood model. The alignment between the BCF and the Care Closer to Home (the new community care contract which runs from 1st April 2016 for a minimum of 7 years) formed part of discussions with the successful bidder. BCF funds have also been used to support community based research into social enterprise and co-designing community solutions to and improving health and wellbeing outcomes building on community assets. The research will inform the implementation methodology of the emerging Accountable Care System (ACS) aligned to the Sustainability Transformation Plan (STP) footprint

The SRG includes providers and commissioners and has agreed system plans to reduce Delayed Transfers of Care and Non Elective Admissions.. Following a system-wide workshop which included the CCGs locality providers (ECC, ACE. CHUFT and EEAST an in depth analysis of the performance was conducted and a plan to manage DTOCs was agreed. CHUFT have confirmed the DTOC plan is aligned and will have a positive contribution to performance.

The Strategic Resilience Operational Group has been restructured to focus on Urgent Care pathways. A number of programmes, also linked to QIPP targets, have been scrutinised. NEECCG are revisiting front of hospital flow – in particular from Ambulance to A&E and looking at how other parts of the system can support this. This work is agreed by CHUFT and partners.

1.1.2. Castle Point & Rochford CCG

Impact on Acute: Our ambitious 2016/17 work programme identifies the impact on A&E attendance and Non-elective admissions. The work streams detail (inc activity reductions) are captured within our CCG QIPP work programme with schemes that focus on: Care Coordination Model (integrated risk stratification, assessment, care planning and case management); Community Geriatrician provision; improved End of Life Care; improved access to falls Prevention; remodelled Reablement services, and; improved access to community beds (including 'discharge to assess' models).

Engagement: All providers are members of the CCG Cross System Delivery Board which enables collective executive ownership of our system vision, aims and objectives and delivery against our transformation work programme The activity reductions and associated schemes now form part of acute contract negotiation for 2016/17

Demographic Impact and Capacity: CPR CCG has commenced a programme of transformation of primary and community services in 2015/16, which is aligned to our Better Care Fund integration programme. Initial focus in 2015/16 has been on building a Care Co-ordination model operating within our 4 x distinct geographical 'neighbourhoods'. Our neighbourhood populations are between 40,000 and 50,000 population. The focus of schemes is largely prevention in nature ensuring 'upstream' early intervention to prevent reliance on acute trust.

Capacity: Capacity within community and primary care provider is without doubt a challenge. It is clear that investment is in some key areas to enable delivery in plans. To date this has included care coordination team, community geriatrician, community pharmacy, strengthen voluntary sector roles. To this end a Workforce & Development strategy is being developed to underpin and enable deliver of CCG transformation plans.

1.1.3. Basildon and Brentwood CCG

Reducing non elective admissions and improving flows out of hospital are core to the CCG's "Fit for the Future" transformation plan. This transformation programme, of which the BCF is a tool to support the implementation of, is being progressed in collaboration with all of our stakeholders including Basildon Hospital, North East London Foundation Trust, South Essex Partnership Trust, primary care and social care. The CCGs are currently negotiating block contracts with the acute providers within the Essex Success Regime. This arrangement will offer stability and allow the leadership focus to be on transformation.

A key element of the plan is a redesigned pathway for Intermediate Care. Through this process, we are seeking to reduce the out of hospital bed base commissioned but instead invest in alternative domiciliary based services (often joint health and social packages). It is anticipated that this initiative will enable both a reduction in non-elective admissions through a step up pathway focus, whilst also supporting a reduction in DTOCs through offering new pathways out of hospital. Through the System Resilience Group, the CCG and ECC are seeking to address concerns within the nursing/residential and home care market.

1.1.4. West Essex CCG

Older People Plan for 2016-2018 which was agreed by Health and Care Committee 21st January 2016, identified a locality frailty population at high risk estimated to be 9% of the population (27,000). The plan targets:

- **A&E attendances for over 75's -** West Essex 14/15 per 1000 population = 612. Target is to reduce by 18% to achieve peer average of 500 in 24months

- **Over 75's emergency spells -** West Essex 14/15 per 1000 population = 405. Target is to reduce by 27% to achieve 297 best in class in 24 months (reduce by 7 per day from 27 to 20)

- **Over 75's emergency Length of Stay -** Maintain at 8.2 baseline data 14/15

- **Over 75's emergency readmissions -** West Essex reduce from 22% to 18% best in class in 18 months (Reduce by 2 per week)

- **DTOC plan**

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16
DTOC attributed to PAH	**1.38%**	**1.19%**	**1.00%**	**-**	**-**	**-**	**-**
DTOC attributed to Other	**4.74%**	**4.12%**	**3.50%**	**3.25%**	**3.00%**	**2.75%**	**2.50%**
Total DTOC	**6.12%**	**5.31%**	**4.50%**	**-**	**-**	**-**	**-**

numbers in red represent trajectory

All West Essex system providers as detailed below are aware of these ambitions via the West Essex Older People Partnership Board and working groups and the 2016/17 contract negotiations with PAH and SEPT. Providers include:

- Princess Alexandra NHS Trust
- SEPT
- St Clare Hospice
- NEPT
- Care home providers and domiciliary care providers
- EEAST
- Uttlesford Health
- Stellar Healthcare

The introduction of the integrated neighbourhood model of care from April 2016 will be the key enabler across West Essex for delivery of the reductions in unplanned acute activity.

Scoping for additional capacity will be undertaken by the neighbourhoods using the "100 day challenge philosophy" to determine the needs of each neighbourhood. This will be influenced by the complexity of caseload, demographics, number of care homes and baseline activity during 14/15.

The capacity within the community health services is not known due to the historical block contracts used to commission these services.

1.1.5. Mid Essex CCG

The System Resilience Group (SRG) includes both providers and commissioners and has project plans in place with key actions to improve patient flow across the

Mid Essex system including improving discharge (which also include the reduction of DTOC) and non-elective admissions. This follows support from the Emergency Care Improvement Team which have helped the Mid Essex system in identifying key actions to improve flow.

Whilst DTOC performance is reviewed and tracked by the SRG, the CCG in conjunction with Essex County Council, Mid Essex Hospital Trust and PROVIDE CIC are currently developing a separate action plan regarding DTOC. The Plan and associated targets will reflect the recent, February 2016, national BCF Planning Requirements 2016-17, Technical Guidance Annex 4 which includes the measurement for DTOC. This will then subsequently include who is responsible and/or accountable for the actions detailed within the plan.

The subcommittee of the SRG (the urgent care project group) focuses on urgent care and acts as the delivery agent for the SRG. The aim of the group is to review the system wide project plan and monitor delivery. Any deviation to the plan is escalated to the SRG and the group is represented by partners across the whole system including, acute, community, ambulance and local authority.

1.1.6. Social Care (ECC)

These plans will support our wider integration agenda, which at operational and community level is already on a sound footing. We have implemented aligned social workers to many GP practices across Essex, provide seven day services, jointly commission residential and nursing placements on a common framework with all CCGs to stabilise prices, introduced new practice and culture in the social work workforce towards a greater proactive approach and deliver personalised care for clients.

To support this approach further we have developed a Market Shaping Strategy that sets out a transformational five year approach that is designed to ensure we move towards a situation where people can source the support they need from a functioning market, whether funded by us or not, and where the asset model is firmly embedded. This is essential if we are to meet the challenges presented by a population that is already “super-aged”, and where the rising risks represented by the over 50s is rapidly increasing.

To do this we need to support market transformation activity that promotes an integrated approach to market management and development with our partners in the acute hospitals, the CCGs, and Southend and Thurrock and in so doing addresses the market distortions on the London fringes caused by the having different procurement practices. We will utilise the voluntary and community services sector to maximum effect, as part of a Essex-wide Prevention and Sustainable Communities Programme.

2. Case For Change

The Case for Change remains consistent with that outlined in the 2015/16 BCF.

Our case for change and our focus on integrated commissioning is in the context of our ageing population and the increasing number of people who have one or more

long-term conditions. These two factors mean that the needs of our patients and service users increasingly cut across multiple health and social care services. Increasing demand and financial pressures mean there is a need to focus on prevention; reducing the demand for services and making the most efficient and effective use of our health and social care resources.

The introduction of the Health and Social Care Act (2012) has heralded the start of a fundamental transformation in care. The issues applicable to the health and social care system across Essex include:

- Variations in quality from hospitals to community settings
- Significant financial challenges with both localised deficits and reduction in funding
- Lack of systematic care pathways and poor coordination of services
- Demographic changes and multiple morbidities leading to increasing demand.
- Our health and social care services increasingly need to be able to prevent and manage multi-morbidity rather than single diseases

The Health and Wellbeing Board is overseeing a major shift in organisational culture to tackle these challenges through a combination of strategies including the joint health and wellbeing strategy, the CCG's 2-year/5-year strategies and through locally responsive BCF plans. Our shared vision for Essex is:

'*By 2018 residents and local communities will have greater choice, control and responsibility for health and wellbeing services. Life expectancy overall will have increased and the inequalities within and between our communities will have reduced'.*

It is intended that a large segment of the programme of change will be driven as part of the BCF stream through three key principles:

- Population risk stratification to identify patients with the highest risk of crises. These are usually patients with multiple long term conditions requiring a wide range of health and social care agencies for their care management.
- Care coordination through functionally integrated generic care teams at a locality level comprising all relevant health and social agencies to provide joined up and personalised services through effective information sharing.
- Empowering residents to maximise self-care, self-management and choice and co-production of their care plan leading to delivery of coordinated interventions and targeted care and support.

The main components of the Essex-wide transformation programme where BCF will make a significant contribution in reducing demand on health and social care are:

- Improving the frailty pathway
- Improving the management of long term conditions
- Improving mental health services, including the management of dementia

Population Risk Stratification and Segmentation

The work of the Nuffield Trust indicates that the risk of healthcare utilisation can be forecast as follows:

Highest Risks for health and social care

Risk Level	Population Percentile	No. of Essex Residents	Description
Very High	0% to 1/2%	7,193	Case Management - High dependency
High	Over 1/2% up to 5%	64,741	Disease Management - High risk
Moderate	Over 5% up to 20%	215,802	Supported Self Care
Low	Over 20% up to 100%	1,150,946	Population Intervention
Total Essex CC Population (2014)		**1,438,682**	

High risk people each individually account for a disproportionately large amount of future service utilisation. However, lower down the risk pyramid the population size increases and so although each individual accounts for smaller proportion of future utilisation, there are many more people here and in aggregate they represent a greater proportion of future utilisation.

A significantly higher proportion of people in the “very high” and “high” risk groups are likely to have multiple morbidities, including poor mental health. Falls amongst frail and older people (>65s = 633/100,000) are significantly higher compared to the national average (568/100,000).

Ageing Population

Age	Detail	2014	2015	2016	2017	2018	2019	2020	2021
76yrs & Over		121,186	124,463	127,372	129,387	132,707	137,478	142,986	148,175
All ages		**1,438,683**	**1,453,321**	**1,467,959**	**1,482,562**	**1,497,245**	**1,512,088**	**1,527,013**	**1,542,010**
76 & Over	% of Total	8.4	8.6	8.7	8.7	8.9	9.1	9.4	9.6
90 & Over	% of 76yrs+	12.5	12.8	13.2	13.6	13.9	14.1	14.4	14.7

The ageing population will grow more rapidly in Essex with a predicted growth of 22% in people aged over 75 years and a 44% increase in people aged 90 years and over between 2014 and 2021 – against an overall population growth of 7%.

It is estimated that 30% of people with long-term conditions have a mental health condition with many not identified. Overall it is estimated that 3.1% of the adult population have an unmet mental health need. By 2025, it is anticipated that the prevalence of dementia will have risen by 40% and exponentially to 156% by 2051[i].

What can be improved:

- The management of our most at risk patients. This is key to delivery of a system that is sustainable

- Identifying, treating and supporting people with mental health conditions, especially people with dementia

Improving Care Coordination and Quality

There is considerable scope for configuring services more efficiently across the health and care systems, including improving the coordination of care and ensuring high-quality care and support. The BCF will be utilised to improve some of the key metrics in Essex where we are comparatively poor and have distinct variations:

(1) Mortality Amenable to Healthcare

The national indicator (SHMI) looking at hospital mortality deemed to be amenable to healthcare indicates a local variation in healthcare outcomes in secondary care which can be exacerbated by a range of pressures, such as high levels of non-elective activity. Between April 2014 and March 2015, with the exception of Basildon & Thurrock University Hospitals, all other NHS Trusts had higher than expected mortality rates but are all in the middle band. They all had worse ratings than the same period last year.

Summary Hospital-level Mortality Indicator (SHMI) - April 2014 to March 2015		
PROVIDER	**VALUE**	**BANDING**
SOUTHEND UNIVERSITY HOSPITAL NHS FT	1.094	2
MID ESSEX HOSPITAL SERVICES NHS TRUST	1.057	2
BASILDON &THURROCK UNIVERSITY HOSPITALS NHS FT	0.917	2
COLCHESTER HOSPITAL UNIVERSITY NHS FT	1.067	2
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1.076	2
NORTH TEES AND HARTLEPOOL NHS FT	**1.210**	**(worst) 1**
THE WHITTINGTON HOSPITAL NHS TRUST	**0.670**	**(best) 3**

The conditions with the highest number of observed deaths are pneumonia, cerebrovascular disease, septicaemia, UTIs and heart failure.

(2) Life Expectation across Essex

In 2011/13, the inequality in life expectancy between the local areas with the highest and lowest figures was slightly greater for women than men at age 65. Tendring and Maldon have seen the highest increase in male life expectancy at birth.

Life Expectancy differentials across Essex between 2011-13 and 2012-14

AREAS	2012-14		2011-13	
	Males	Females	Males	Females
Basildon	79.7	83.1	79.9	83.1
Braintree	80.1	83.4	80.2	83.3
Brentwood	81.4	83.9	81.7	84.0
Castle Point	79.7	82.4	79.8	82.4
Chelmsford	81.4	84.9	81.2	84.6
Colchester	80.0	83.5	79.9	83.6
Epping Forest	80.3	83.6	80.8	83.9
Harlow	78.6	83.3	78.4	83.0
Maldon	81.5	83.8	80.9	83.5
Rochford	81.5	84.9	81.3	85.1
Tendring	78.7	82.0	78.0	82.0
Uttlesford	82.5	85.2	82.3	85.4
ESSEX	80.3	83.6	80.2	83.5
ENGLAND	**79.6**	**83.2**	**79.4**	**83.1**

(3) Delayed Transfers of Care

Essex recorded a comparatively lower rate for delayed transfers of care from hospital which are attributable to adult social care, and this amounted to over 19% of all DToCs which is reduction of 4% since 2012/13

Delayed Transfers of Care (DToC) per 100,000 population - 2014/15		
Comparator Group	**All Causes**	**Soc. Care related**
Essex	**10.4**	**2.0**
Staffordshire	**13.8**	**7.4**
Worcestershire	**18.2**	**6.7**
Cambridgeshire	**18.0**	**5.8**
Kent	**7.8**	**2.3**
Somerset	**16.4**	**8.3**
Devon	**16.9**	**4.7**
Gloucestershire	**3.1**	**0.9**
West Sussex	**11.8**	**3.3**
Hampshire	**10.8**	**6.6**
Nottinghamshire	**11.2**	**2.6**
Hertfordshire	**12.9**	**5.2**
Oxfordshire	**27.2**	**11.2**
Northamptonshire	**27.0**	**3.7**
Warwickshire	**17.0**	**4.7**
Lancashire	**12.1**	**2.0**
ENGLAND	**11.1**	**3.7**

(4) Effective Rehabilitation

There are variations between age groups in regards to older people who remain at home after hospital discharge into a reablement or rehabilitation programme – against some of Essex County Council's peers. Essex has seen improvement in the 65 to 70 years age group but a marginal reduction against in 2014-15 against the 2012-13 baseline.

Older People at Home 91 Days after Discharge from Hospital into Reablement/Rehabilitation						
Comparator Area	2012-13			2014-15		
	65 to 74	75 to 84	85+	65 to 74	75 to 84	85+
Essex	86.0	82.6	80.4	88.7	81.9	79.9
Kent	85.7	85.9	81.9	84.5	86.0	82.3
Lancashire	90.9	85.9	75.8	84.8	79.0	77.0
Warwickshire	83.8	86.2	78.1	85.6	97.9	80.6
Cambridgeshire	89.3	86.7	76.9	73.7	67.7	70.2
Devon	83.3	88.5	87.8	94.7	87.2	88.7
Somerset	91.4	85.7	83.8	93.5	89.0	85.2
ENGLAND	**85.0**	**83.6**	**78.2**	**86.1**	**83.9**	**79.1**

The national position on the financial challenges facing the Local Authorities and the NHS in the next 5 to 10 years is enormous.

In the NHS, the continuing introduction of new technologies and drugs, coupled with rapid demographic changes, are compounding the increasing costs of healthcare.

Health and social care will need to work closely and very differently to deliver the required system-wide savings whilst joint working to maximise early intervention, enablement and rehabilitation and delivering high quality care and improving outcomes.

The BCF will focus primarily on those at the highest risks of accessing health and social care services and act as an enabler to the delivery of reduced hospital admissions and more coordinated services across primary and community care.

3. Delivery

3.1. Governance

The HWB provides strategic leadership and direction for decision-making and joint commissioning across Essex covering all relevant CCGs and ECC. In this capacity it also acts as the final point of governance for BCF.

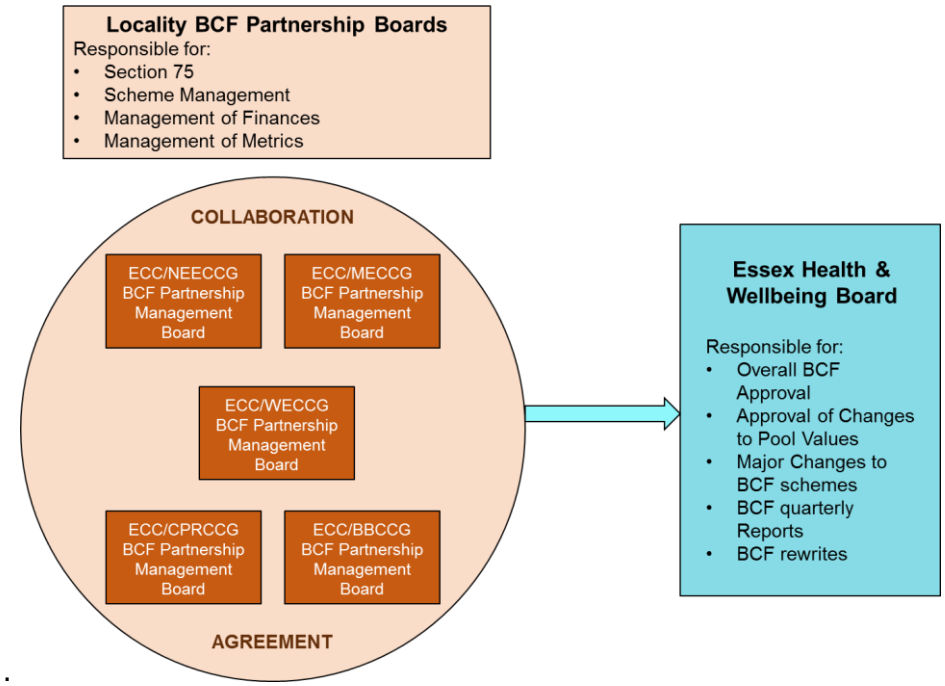
The BCF is governed at a local BCF pool level for the ongoing monitoring of schemes, metrics and financial performance through locality BCF Partnership Management Boards (CCG Accountable Officers and Finance Officers / ECC Integration Directors and Finance Officers). In some localities these Partnership Management Boards are free standing Boards and in others they have been amalgamated into other cross partner integration boards.

Transformational plans and programmes are formally discussed and approved by existing local authority Governance processes and within each CCG's governing bodies.

Within Essex the BCF is separated into five CCG locality based pooled funds, each covered by a separate Section 75 Agreement. These Section 75 agreements are

pulled together by means of a Collaboration agreement between the five CCGs and ECC. Within these pooled funds we are exploring the option of the Fund being split between the commissioners of the schemes within the pool and managed by the commissioners separately in each locality. This will be confirmed in the final version of the plan.

3.1.1. Essex BCF Governance Schematic



.

ECC and the CCGs have agreed use of all pooled budgets in a joint and transparent manner, through jointly agreed governance routes. Decisions about use of funding is based on a clear and shared understanding of the allocation of resources across different areas of Essex, how this relates to population need, the services that will be supported and the outcomes that will be delivered.

The BCF schemes are managed and monitored on a local level by BCF Partnership Management Boards. In some localities this has been merged into alternative boards. For instance in CPR CCG BCF schemes are reported to the Integration Partnership Board and in NEECCG schemes are managed through the Joint Commissioning Group.

In addition to the locality management and monitoring of the BCF. ECC is providing Programme Management and PMO resource to support the Health and Wellbeing Board with its responsibilities to submit plans and quarterly reports to NHS England.

Success Regime governance:

As a programme, the Mid and South Essex Success Regime is accountable to the Regional Directors of the national organisations.

Locally, the Success Regime has a System Leaders Group, chaired by an independent clinical chair, Dr Anita Donley, a consultant from Plymouth Hospitals NHS Trust and clinical vice-president of the Royal College of Physicians. The Success Regime reports to the Essex Health and Wellbeing Board, and the respective health and wellbeing boards covering Southend and Thurrock.

3.1.2. Sustainability and Transformation Plans (STPs)

Every area has to produce a 5 year STP by June 2016. In Essex, STPs needed to be produced for:

a. The NHS Success Regime area of Mid and South Essex
b. West Essex with Hertfordshire
c. North East Essex with Suffolk

These STPs will be signed off by the Essex Health and Wellbeing Board and any other appropriate health and wellbeing board.

3.2. Delivery Milestones

BCF Milestone Plan

	2015/16	2016/17			
	Q4	Q1	Q2	Q3	Q4
2016/17 BCF Section 75 Completed		30/6/16			
New Reablement Contract Starts		4/5/16			
NEECCG MDT in place	Mar 16				
CC2H risk stratification roll out		Apr 16			
BBCCG GP Based MDTs			Mid 16		
WECCG Joint Risk assessment			Mid 16		
Agree DFG operational framework			Mid 16		
DFG pilot housing / social care framework					End16
Development of Agreed DTOC Plan		30/6/16			

3.3. Risks

A full table of risks has been developed jointly by the five Essex CCGs and ECC. This can be found in Appendix 2

3.4. Risk Sharing Plan

The BCF schemes within the Essex BCF are all existing contracts. As such no Risk Sharing plans have been agreed within the BCF pools.

All system partners support the ambition to significantly reduce the number of unplanned hospital admissions for the frail elderly and DTOCs. If the NEA target is not achieved the CCGs bear the risk of tariff activity within the existing contractual framework with acute providers.

CCGs and acute providers bear the financial and operational risk if DTOCs are not reduced.

CCGs also bear the financial risk on all NHS Commissioned services within the BCF pool.

In the event that the Pooled Fund Manager identifies an actual or projected overspend the Pooled Fund Manager will ensure that the other partner and the Health and Wellbeing Programme Board is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification (as set out in the relevant section 75 agreement) shall apply. The performance of schemes against targets/anticipated trajectories will be closely monitored and recovery plans put in place at the earliest sign of targets not being met. CCGs and ECC will jointly review transformation schemes in order to verify their effectiveness. Where unplanned cost pressures emerge through service demand and/or non- delivery of the targeted NEL reductions, the CCGs and ECC will work collaboratively to identify service changes and other opportunities to deliver mitigating savings, recognising the need to ensure that changes do not adversely impact upon care pathways or overall service demand.

4. National Conditions

4.1. Plans to be Jointly Agreed

This BCF Plan has been approved by all CCGs, Essex County Council and the Health and Wellbeing Board (see page 1 & 2).

CCGs have engaged with their acute providers in the development of these plans through their normal contract negotiation processes and in the development of their Operational Plans.

In addition, a senior management group have been meeting since December 2015 overseeing the Essex BCF process for 2016/17. This has included key providers within the health and social care system in Essex. Health and Social Care Providers are also members of the Essex Health and Wellbeing Board who have approved this plan.

Essex County Council regularly engages with the local councils through the Essex Housing, Health & Social Care Partnership Forum and the Essex Housing Officers Group and uses these forums to create closer and more consistent links with health and social care.

It is intended that throughout the 2016/17 BCF year that apart from the DFG being used for its traditional use, the councils will explore with ECC wider uses that more closely align the DFG to health and social care. (See Section 7, Scheme 5 for more detail)

Workforce across Essex, its neighbouring counties and across England has the same systemic issues that need to be addressed. Workforce is a key enabler for a successful strategy and health and social care workforce is particularly complex.

What we know about the Essex workforce:

- In Nov 2015, NHS East of England had over 8,000 vacancies and only 800 placements.

- 50% of the Essex adult social care (ASC) workforce is over 45 (~8000) while only 1800 are under 24 – the workforce is aging quickly and will create supply issues and a potential loss of experience and skills from the sector
- Essex County Council has an average turnover and vacancy rate when compared to our neighbours and England overall.
- Average pay across the adult social care sector is comparable between Essex and England – however, the roles hardest to recruit and retain are generally paid less. The exception is Personal Assistants, where pay is at the average for East of England
- Zero hours contracts make a up a relatively low percentage of contracts, and are generally favoured by employers who need flexibility to match demand and by employees that want the flexibility of working hours and the ability to work for more than one employer (not generally acceptable for part-time contracts)
- Training of staff is very high in Essex comparted to England, but qualifications lag behind
- Approximately 5% of the Adult Social Care workforce is EEA (non-British) and another 7.5% non-EEA, there is a significant risk to supply if migration rules change.

4.2. Maintain Provision of Social Care

This plan continues to ensure that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. We have defined the provision of social care to mean ensuring eligibility criteria and investment remains at sufficient levels to support community based care enabling people to remain independent with a focus on prevention and avoidance of hospital and/or residential home admission. We also believe that ensuring that health services are available earlier and in better co-ordinated ways help to reduce demand for social care and protect a limited resource.

This BCF Plan seeks to maintain the level of investment in social services as for the 2015/16 Plan (£43.8m in 2016/17 / £42.5m in 2015/16). The comparisons of investment over the two BCF Plans can be seen in Appendix 1 Section 10.2

The investment into Social Care has been agreed by all BCF partners and is primarily being used for Home Support Services, Reablement and Carers, all of which contribute to reducing non elective admissions and Delayed Transfers of Care.

Provision of Social Care (Scheme 1), Care Act (Scheme 2), Support for Carers (Scheme 3) and Reablement (Scheme 4) are described more fully in Section 7 “Scheme Details”

4.3. Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.

7 Day services were a National Condition of the 2015/16 BCF Plan and have been in place since January 2016 across all settings that prevent unnecessary admission to hospital or facilitate discharge from hospital

4.4. Better data sharing between health and social care, based on the NHS number

A county wide programme was created before the implementation of the 2015/16 BCF to ensure that all organisations were in a position to share data using the NHS Number with appropriate Information Governance controls in place. This programme included:

- The creation of a county wide Data and Information Sharing task and finish group including the launch of the Whole Essex Information Sharing Framework to enable a process for the sharing of information across Essex. This has already been completed
- Creation of a detailed action plan for identifying the key issues to be resolved by the group.
- Identification of the ability to use NHS Numbers amongst all partners.
- Confirmation that all organisations had adopted APIs.
- Confirmation that all organisations met the requirements set out in Caldicott2.

Essex has met the requirements of all aspects of the Data Sharing National Condition in the 2015/16 BCF year.

West Essex CCG data Sharing Example:

An example of the development of data sharing processes in an integrated health and care system is being developed in West Essex.

West Essex CCG is working towards integration and, in order to deliver seamless health and care has embarked on a number of projects which will allow information to be made available to clinicians across organisational boundaries.

In January 2016, the CCG wrote to GP practices in order to develop the dataset of all health and care activity for patients that can be used to inform planning and improving services for patients. A key step is to add primary care data to the other range of health and care data available. This integrated dataset is accessed via MedeAnalytics, enabling a full picture of resource use by a particular group of patients. The CCG worked with the LMC in some detail to develop and agree a data sharing agreement for practices and they were asked to sign this agreement. The CCG also provided practices with posters and a patient leaflet for their use as fair processing communications and asked that it was uploaded onto practice websites.

Over the next few months, the CCG is working closely with Princes Alexandra Hospital to develop a campaign which shows how we are working together to deliver integration by making information available to clinicians. Princess Alexandra Hospital in Harlow will be introducing a new system which will allow them to access a patient's GP record. They can only access the record with a patient's consent and provided they have not opted out at their GP surgery. Initially this will be in A&E only although consent opt out will cover all areas.

The CCG will be running a widespread, west Essex campaign which demonstrates how the project will provide:

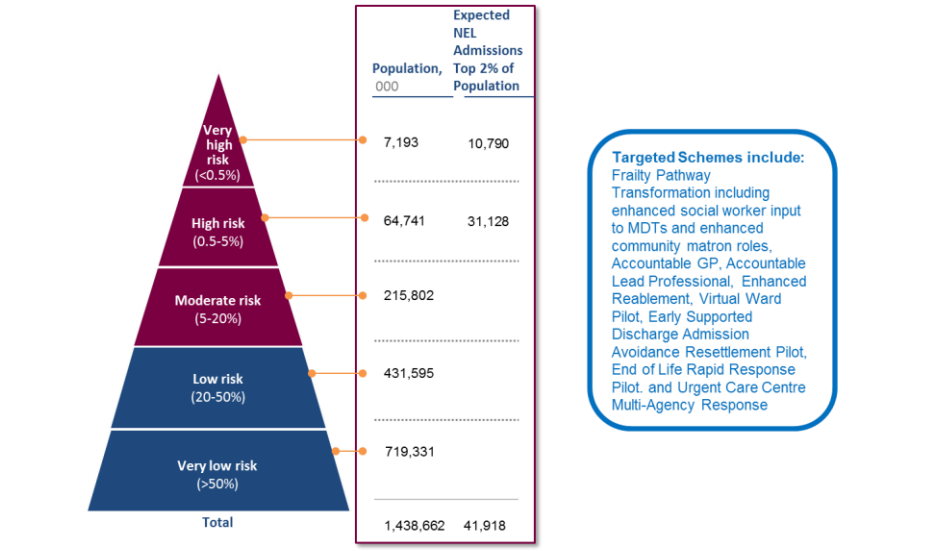
- joined up and improved care for the patient
- how we are caring for people holistically, treating the whole person and not individual conditions in isolation

This campaign will aim to communicate the professional accessing of data in a transparent way to the people of west Essex and we will be rolling out over a period of three months.

4.5. Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

We recognise the importance of using risk stratification tools to identify those at risk of hospital admission. National assumptions estimate that 0.5% of the population are at "Very High" risk of needing to access health and social care services and that 5% are at "High" risk. Although using slightly different tools, all areas have adopted the "Rockwood" approach to risk stratification.

Impact of Risk Stratified Approach



GPs, community service providers and social care are working together to ensure that vulnerable patients are promptly identified and entered into frailty registers which will ensure that appropriate care information is available to all agencies involved in providing care to those patients. Identified patients and their families discuss their care preferences and these preferences will be available to the various care agencies along with better information on the patient's typical level of ability/capacity. This will provide more robust data upon which to risk assess a patient's care requirements both for planning day to day requirements and also responding during a period of crisis.

Across the County there is a commitment to developing the lead accountable professional model and this is being taken forward in a number of innovative ways throughout the County.

With some local variations, the principles of the risk stratification is that individuals are assessed by the GP led MDT against the Rockwood Frailty categories. Those who fall into categories 5, 6 or 7 will be referred onto the Frailty Pathway and be case managed by an accountable lead professional and supported by a care co-ordinator

A joint approach to risk assessments and care planning has begun in all CCG localities from Quarter 3 2015/16.It is expected that full implementation will be in place from Quarter 2 2016/17:

- North East Essex CCG has implemented a series of Multi-Disciplinary Team (MDT) pilots that will be fully implemented by March 2016. The Care Closer to Home contract includes a risk stratification tool that will be rolled out from April 2016
- Mid Essex CCG have MDTs aligned to each GP Surgery responsible for joint assessments and care planning. The risk stratification tool used in Mid Essex was the "United Health" tool but this is being replaced with the tool within SystemOne
- Basildon & Brentwood CCG have aligned health and social care staff with GP practice. Fully aligned, GP Practice based MDTs will be implemented in the first half of 2016/17
- Castle Point & Rochford CCG have MDTs operating out of each GP surgery with care plans being coordinated across the various agencies.
- West Essex CCG have MDTs in place with named Community matrons and Community Psychiatric Nurses working alongside social workers with integrated care plans scheduled to be implemented by April 2016. Joint risk assessments are due to be implemented during 2016/17

  Whilst not a BCF scheme, dementia services and care coordination are currently being reviewed across the Essex system, leading to a redesign of community dementia support services to ensure that those living with dementia and their carers have access to the care and support in the community. This is aligned to the views of carers and service users.
  This insight is based on considerable research and evaluation conducted by ECC, CCGs and the Trusts jointly in 2015.
  Although early in the design phase, it is intended that this service would include personalised navigation support for individuals, carers and families who would support and signpost to the most appropriate services to ensure connected, clear and continued support within the process. This service is being developed for implementation from October 2017.

4.6. Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

This section is yet to be completed. It will be completed for submission of the final version of the plan on 25th April 2016. To achieve this, the acute providers are involved with the creation of this outstanding part of the Essex BCF

4.7. Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

Within the Essex 2015/16 BCF the entire investment was either made by the local authority in community based social care or by the CCGs in NHS commissioned community services, this included the use of the ring-fenced amount. It is intended to repeat this for the 2016/17 BCF.

As the fund is being invested in existing services it has been agreed that no risk share agreements are required for Essex.

It has been agreed that, in the event that any scheme overspends or that over activity within the system creates overspends outside of the BCF, that the commissioner of the service would carry the risk. This is documented within the Essex BCF Section 75 Agreements.

4.8. Agreement on local action plan to reduce delayed transfers of care (DTOC)

There is no single Delayed Transfer of Care plan for Essex. Each of the CCGs have plans that influence the level of DTOCs in their locality and these form parts of their SRG plans.

In addition it is expected that the Success Regime Plan will also have an effect on DTOCS as will the other two STP Plans for parts of Essex.

Essex BCF locality DTOC plans will be described in the final version of the plan to be submitted on 25th April 2016.

A more stretching DTOC Metric will also be included in the final version of the plan that takes account of DTOC targets in CCG Operational Plans and the STP Plans as well as the Essex performance compared with our geographical and statistical neighbours.

As this metric is developed we will keep our Better Care Manager informed of progress

Essex County Council

Delayed transfers of care are subject to statutory guidance contained in section 15 and Annex G of the Care and Support Guidance (Department of Health 2016). This is supported by the wider duty to cooperate set out in Sections 6 and 7 of the Care Act 2014. We currently adhere to these standards and report against them.

Over the last two years Essex County Council has wholly reorganised its Adult Social Care function with the express purpose of facilitating the delivery of its responsibilities under the Care Act and its associated guidance.

This has included working with colleagues in the CCGs and acute hospitals to improve hospital discharge pathways. A lot of work has already been done. At a policy level the authority has implemented clear discharge processes and is working with the acute hospitals to develop these further, including strengthening the links between the hospital discharge MDT and the community teams to promote effective and timely transfers of care.

To do this successfully requires significant change in the way we work with all acute hospitals and the provider market. To a/ensure we have locally agreed protocols in place that cover the discharge process, b/to work with the provider market to ensure that their offer reflects our aspiration that no one should be admitted to long term residential care directly from hospital and c/ to ensure we build resilience through community level integration and greater use of assistive technologies.

This approach will support our wider integration agenda, which at operational and community level is already on a sound footing but requires support if it is to achieve the step change required to ensure that transfers of care not only happen in good time, but also appropriately and in a person centred manner.

To support this approach further we have developed a Market Shaping Strategy that sets out a transformational five year approach that is designed to ensure we move towards a situation where people can source the support they need from a functioning market, whether funded by us or not, and where the asset model is firmly embedded. This is essential if we are to meet the challenges presented by a population that is already "super-aged", and where the rising risks represented by the over 50s is rapidly increasing.

To do this we need to invest in market transformation activity which:

a. promotes an integrated approach to market management and development with our partners in the acute hospitals, the CCGs, and Southend and Thurrock and
b. in so doing addresses the market distortions on the London fringes caused by the having different procurement practices. This will require support in the transformation activity, without which the opportunity to make a step change away from the current service driven model will be lost.
c. utilises the voluntary and community services sector to maximum effect, as part of a Essex-wide Prevention and Sustainable Communities Programme.

North East Essex CCG

The NEE DTOC plan will be the key document to hold the health and social care economy to account for the improved performance, management;, reporting and recovery of the Delayed Transfer of Care metric across the footprint of North East Essex Health and Care system. Although DTOC at CHUFT has had a good history of performance compared to its peers nationally, during 2015/2016 performance has deteriorated from 1.45% in January 2015 to 4.11% in January 2016. SRG agree this is totally unacceptable as it is placing patients at greater risk

There are reasons for the drop in performance and these include:

- Availability of social care domically packages

- Patients requiring ongoing therapy whilst occupying acute beds
- Reduction in care homes supporting the increasing range of complexity of care need
- Delays due to patient and family choice
- Increase in numbers of patients waiting over 21 days
- Increasing demand from frail elderly people, with complex co-morbidities including dementia

As part of a system wide "Make it Happen" programme in October 2015 commitments were made to address performance. However, a significant number of the agreed actions were not delivered and subsequently further system wide workshops have been held. The key principles agreed include:

1. Discharge planning is normal business activity for all organisations and is planned at point of admission – elective and non-elective
2. Discharge to assess

Mid Essex CCG

Mid Essex CCG has been working with MEHT and Social Services to develop a plan that supports all discharge planning and the use of a multi discipline team to ensure the pathway from admission to discharge is a smooth transition and has the best outcome for the patient. Delayed transfers of care (DTOC) from hospital to home, or between any other part of the system, represents major pinch points where services and processes often struggle to be truly integrated around the needs of individuals. The plan will include continued work:

- Discharging planning
- Care homes and reduction on admissions
- Social care packages
- Reablement support both to stop an admission and to aid discharge
- Reduction on bed days lost
- Reduction in inappropriate use of acute beds
- Support to Care homes for patient with complex needs

MEHT had historically been one of the poorest performers but since April 2014 MEHT has been improving significantly on the number of days lost and decreased from >1000 days to <450days, a 49% reduction. Urgent care pressure with an increase in admissions over the winter period 15/16 has impacted on social care delays, but performance is still within an improvement trajectory.

The Better Care Fund is being used to leverage system-wide integration, including improving local areas' approaches to managing delayed transfers of care (DTOC) and develop a clear, focused action plan for managing delayed transfers of care, including locally agreed targets.

5. Metrics

In setting the metrics for the 2016/17 BCF Plan statistical analysis of existing performance and the effects of both BCF and non BCF schemes have been taken into account.

5.1. Non-elective admissions (General and Acute)

We do not recognise the NEL data published in the template and are therefore unable to offer a target for NELs for 2016/17. Discussions are underway between CCGs and NHS England to resolve this and a stretching NEL target will be completed for submission of the final version of this plan

5.2. Admissions to residential and care homes;.

A BCF target has been set for 2016/17 and is based on maintaining current performance at 566 per 100,000 population. This is in line for our latest forecast for 2015/16 and is below our planned outturn for 2015/16 of 599 per 100,000 and below the 2014/15 actual of 583 per 100,000.

There is a large amount of 'Market Shaping' work ongoing to create an environment in which there are viable alternatives to residential care admission. A Housing Dashboard has been developed to capture and monitor activity which aims to increase supply of specialist accommodation. We have a target to increase numbers of specialist accommodation housing units by 80 per annum from 2014-2017, a total of 240 units, offering alternatives to residential care. The County currently funds 420 extra care units. There is a strategic aim to develop at least an additional 80 extra care places as alternatives to residential care. Each placement will save us £4475/year per person compared with a residential placement.

The Increasing Independence Team are supporting working age adults to have a greater choice and control over their lives, with a focus on where people live. The outcome so far, as seen a reduction in the use of traditional services, an increase in independence and an increased quality of life for adults. The team has supported 34 adults to move on from residential care since April 2015. A delivery plan is currently in production to enable this work to continue through 2016/7.

There is a plan to re-procure residential and supported living services that may take 12 months or more to implement, with the primary aim of creating a supply of housing opportunities that support ECC strategic intent.

Dementia assessments are less likely to lead to a service. Across Essex 12% of dementia assessments resulted in no service compared with 5% of all over 65s.

Domiciliary reablement does have a positive impact on avoiding or delaying residential care. Reablement in Essex is more likely not to lead to further support, with 60% of reablement cases leading to no ongoing services compared to 38% national average. ECC also commissions residential based Reablement. Only 21% of clients following this programme go into a long term residential placement.

The section is to be completed for submission of the final version of this plan

5.3. Effectiveness of reablement;

A BCF target has been set for 2016/17 and is based on maintaining current levels of Reablement quality with 82.1% of people remaining out of hospital for 91days. This is in line with the 2014/15 actual and 2015/16 forecast.

There are two key reasons for not increasing this target metric – 1) the Essex performance is in the upper quartile of its statistical neighbours, and, 2) ECC and the five CCGs have jointly recommissioned reablement services from 4th May 2016, this new contract significantly increases the number of reablement starts in the County (Reablement starts per 100,000: 2014/15 actual 2,496, 2015/16 forecast to be similar to or slightly below this number. Expected starts in 2016/17 will be in excess of 3,400 due to the commencement of a new reablement contract)

Maintaining current performance is therefore a stretching target.

5.4. Delayed transfers of care;

The section is to be completed for submission of the final version of this plan with reference to section 4.8

A stretched DTOC metric target will be included in the final version of the plan that takes account of DTOC targets in CCG Operational Plans and the STP Plans as well as the Essex performance compared with our geographical and statistical neighbours.

As this metric is developed we will keep our Better Care Manager informed of progress

6. Schemes Details

Scheme ref no. 1

Scheme name: Provision of Social Care

Overview of scheme

Adult Social Care Services in Essex will continue to be provided and supported as part of these plans, and is consistent with offer and approach in 2015/16.

We will ensure that those in need within our local communities continue to receive the support they require in a time of growing demand and budgetary pressures. We have defined the protection of social care to mean ensuring eligibility criteria and investment remains at sufficient levels to support community based care enabling people to remain independent with a focus on prevention and avoidance of hospital and/or residential home admission. We also believe that ensuring that health services are available earlier and in better co-ordinated ways help to reduce demand for social care and protect a limited resource.

Home Support Services provides a domiciliary care service across Essex and is delivered in the person's home. The Home Support Service includes personal care, cleaning & house care, practical & social support, minor health related tasks (excluding district nurse tasks), administration of medication and support during the night (either night sleep or night sitting).

Intermediate Care/Reablement Pathway services provides a service model that aims to offer a period of rehabilitation/recovery to patients to enable them to reach their optimal rehab/reablement goals prior to any long term care need assessment being undertaken (if required)

Early Supported stroke discharge social workers are also funded from the Provision of social Care as are ECCs share of the BCF Programme and Administration costs and Head of Dementia Post. There will be no further locality based schemes funded from Provision of Social Care funds

Scheme	MECCG	CPRCCG	NEECCG	WECCG	BBCCG	Total
Home Support Services	£5,866,724	£2,594,437	£4,871,365	£4,515,366	£3,875,334	£21,723,226
Domiciliary Reablement Contract	£1,432,505	£ 647,324	£1,193,722	£1,108,263	£ 954,552	£ 5,336,366
Head of Dementia	£ 7,196	£ 3,566	£ 6,849	£ 5,909	£ 5,230	£ 28,750
Programme & Admin	£ 12,500	£ 12,500	£ 12,500	£ 12,500	£ 12,500	£ 62,500
Integrated Stroke Pathway Social Worker	£ 89,760	£ 89,760	£ 89,760	£ 89,760	£ 89,760	£ 448,800
Total	£7,408,685	£3,347,588	£6,174,196	£5,731,797	£4,937,376	£27,599,642

Description of the proposed schemes and impact on outcomes,

In 2016/17 we will use the Provision of Social Care funding in the Better Care Fund to enable independence and support people to live at home by continuing to invest in Home Support Services plus Domiciliary and Residential Reablement services.

The total amount allocated to the Provision of Social Care in this BCF is shown in

Appendix 1, section 8.2.1

In setting the level of protection for social care we have agreement from all partners that any change does not destabilise the local social and health care system as a whole.

The expected outcomes will fall into two categories:
a) Maintenance outcomes for example to enable someone to continue living at home despite failing health
b) Change outcomes such as where people experience improvements in the quality of their life which leads to greater community involvement and or less dependency on services

The following core tasks and support that the service provides are:

a) Personal Care

i. assisting the Service User to get up and/or go to bed
ii. assisting the Service User to move in bed
iii. assisting the Service User to dress and undress and change clothing
iv. assisting the Service User to wash, bathe or shower
v. assisting the Service User to attend to hair care, shaving, denture and oral hygiene, hand and finger nail care, foot care (but not that requiring a state registered chiropodist)
vi. assisting the Service User to address toileting needs and assist with continence management including necessary cleaning and safe disposal of waste
vii. assisting the Service User to eat and drink including food and/or drink preparation and associated kitchen cleaning
viii. prompt, support and administer non-invasive prescribed medication
ix. other medication related tasks as defined by council policy
x. apply prosthetics if required

b) Cleaning and House Care

i. assisting the service user with lighting fires and boilers and assisting with the maintenance of warmth e.g. switching heaters on and off, monitoring temperatures
ii. assisting the service user with making beds and changing linen
iii. assisting the service user with taking washing to the launderette
iv. assisting the service user with washing clothes and soiled linen by hand or machine in Service User's own home
v. assisting the service user with ironing
vi. assisting the service user with cleaning the home which may include vacuuming, sweeping, washing up, cleaning floors, windows, bathrooms, kitchens, toilets and general tidying, using domestic equipment and appliances as available
vii. assisting the service user with care of pets and assistance dogs
viii. assisting the service user with disposing of household and personal rubbish

c) Practical and Social Support

i. assisting the Service User with managing personal and financial affairs, including household administration, paying bills, completing forms and record keeping
ii. assisting the Service User with correspondence and letter writing
iii. assisting the Service User with making telephone calls

iv. assisting the Service User with the consequences of household emergencies including liaison with local contractors
v. assisting the Service User with liaison with other agencies and providers
vi. assisting the Service User with attending day centres or general practice and hospital appointments
vii. assisting the Service User with visiting recreational and community facilities including shops
viii. assisting the Service User with maintaining links with family and friends
ix. assisting the Service User with shopping and errands
x. assisting the Service User with collecting pensions and benefits. No Care and Support Worker shall request or be privilege to any Personal Identification Number (PIN) relating to a Service User's bank, Post Office or building society account.
xi. assisting the Service User with ordering and collecting prescriptions
xii. spend time talking to, relating with and understanding the lives of Service Users
xiii. assisting the Service User with accessing community based services such as laundry, shopping, gardening, home decoration and home security services.
xiv. achieve maximum mobility within the home, using appropriate equipment where necessary. If the provider for whatever reasons determines that a double visit is required the provider, not the Council will bear any additional costs until such time as the Council ,following an urgent review or use of the minor package increase process gives agreement to the increase cost.
xv. ensuring that the Service Users achieves maximum levels of independence in performing any support activities
xvi. assisting the service user to undertake day activities as an alternative to day care
xvii. assistance with mental health after care as specified on the care plan

d) Health Related Tasks
These tasks will exclude nursing care (which is the responsibility of the National Health Service) except where this has been specifically agreed and the Provider's Staff have received the appropriate training and been deemed competent by a health care professional.

e) Night sleeping
i. The provision of a care and support worker to sleep in a Service User's home for a specified period of the night
ii. The care and support worker being available to be woken up to three times a night in order to provide any of the Services outlined in 'Personal Care' of this specification. Times and length of disturbance should be recorded by the Provider
iii. The care and support worker will normally be able to use a separate bedroom in the Service User's home. Where this is not possible, the Provider must provide a suitable portable bed for the care and support worker to use in the living area and separate from the bedroom or room occupied by the Service User
iv. During the first and last hours of the night sleeping service, the care and support worker must be available to assist the Service User with their personal care needs
v. When providing night sleeping services, bedding for the care and support worker must be available and laundered at no additional inconvenience or cost to the Service User or the Council.

f) Night Sitting Service
The provision of a care and support worker to remain awake in a service user's home and being readily available to provide care and support for a specified period of the night.

g) 24 Four Hour Live-in Care and Support
The Provider shall ensure that continuous and adequate care and support, which may involve any of the activities outlined above and cover is provided over 24 hours each and every day, including during the normal care and support worker's time off and breaks if required. Such off-duty periods are to be mutually agreed between the Provider, Service User and care and support worker.
5.5 The service specification of the Existing Contract with North East London Foundation Trust for the Intermediate Care/Reablement Pathway services:
a) provide an outcome/goal based service that enables people to achieve their maximum potential to return to their usual place of residence with or without the ongoing support they require to be independent;
b) allow and enable people to maximise their potential to reduce their need on long term care (domiciliary or residential) as far as possible;
c) to provide input into the long term "frailty model" work being undertaken jointly by the Council and the CCG.

The key success factors including an outline of processes, end points and timeframes for delivery

Describe the links to longer term integration, sustainability and transformation plans

It has now become the norm in Essex that planning of domiciliary and Reablement care is now always considered as part of a joined up integrated experience for clients and a move to a recovery model through enablement ethos. By providing high quality care at home we can demonstrate how this reduces unnecessary acute hospital admission (especially as a result a falls, stroke, and poor infection control). Helping people remain independent at home will at the the heart of Integration, sustainability and transformation plans.

Describe the links to and the effects on the National Conditions especially Delayed Transfers of Care (data sharing, joint assessments / accountable professional, 7 day working, DTOCS, ring-fenced for out of hospital services)

Provision of social care meets the National Conditions. Care and Reablement is provided seven days a week and enables timely hospital discharges. We have social worker and Reablement officer presence in hospitals seven days a week to support weekend discharges.

Scheme ref no. 2

Scheme name: Carers Support / Carers Breaks / Care Act

Overview of scheme

A programme of work that delivers our joint Health and Social Care strategy 'Carers Count In Essex' so that wherever possible both the carer and those they support are able to live independently and exercise choice and control:

- Supporting the carer to maintain their own independence, by focusing on their health, wellbeing and life chances
- Improving outcomes and increasing independence for service users, by working with and involving carers as expert partners in care

The scheme will address key elements of the Care Act, so that:

- Carers' rights to achieve their day to day outcomes and to access information have been improved.
- An emphasis on prevention will mean that carers should receive support early on and before reaching crisis point.
- Information and integration of services should make it easier for individuals to access support and plan for their future needs.

And respond to the themes identified in the NHS Commitment to Carers:

- Recognise me as a carer (this may not always be as 'carers' but simply as parents, children, partners, friends and members of our local communities);
- Information is shared with me and other professionals;
- Signpost information for me and help link professionals together;
- Care is flexible and is available when it suits me and the person I care for;
- Recognise that I also may need help both in my caring role and in maintaining my own health and well-being;
- Respect, involve and treat me as an expert in care; and
- Treat me with dignity and compassion

Description of the proposed schemes and impact on outcomes

We have an established Carer Partnership Board, with representation from ECC and all CCGs as well as Carer representatives and provider organisations, to oversee the delivery of our joint strategy and actions for carers in Essex, that operates at four levels:

1. **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.

2. **A locality level 'first-stop' model**, with a lead provider acting as first point of contact, offering information and advice and co-ordinating support for carers across the county

3. **Social care assessment and support** in relation to:

- Carer assessments
- Combined assessments of the carer and service user
- Support planning and direct payments

4. **Professional awareness and engagement**:
    - Recognition and involvement as a partner in care from primary, acute, and social care professionals
    - Carers' role, contribution and support needs factored into mainstream service commissioning

The model set out in the strategy is being developed through a a two staged approach:

- A transitional voluntary sector grant funding round for the period January 2015 to March 2017
- Development and procurement of an integrated 'Early Offer' hub for carers, to be implemented countywide from April 2017.

Whilst the value of the investment into Carers Breaks has reduced from 2015/16, this has had no impact on services because the scheme was not fully commissioned in the BBCCG locality in 2015/16. The funding for Carers was redirected to SPOR activity. This has been reflected in the 2016/17 BCF plan.

Adult operations will be trialling a focused approach to carers based on a "Good Lives" methodology. This will focus on identifying and supporting carers at risk of crisis..

The aim of this approach is to provide intensive, short term to support carers to reduce the risk of carer breakdown. We plan to expand this approach to a third sector carer's organisation to increase the opportunity for early intervention later in the year. The Good Lives methodology is focused around "three conversations" and seeks to enable individuals to become more connected to their local communities and support networks. Essentially, it is a person centred, enabling approach which recognises individual need. It may include supporting carers to access services or personal budgets as well as community support but with a focus on sticking with the carer to help ensure the support is sustainable.

Although the Good Lives methodology has an evidence base it has not been applied specifically to carers and the trial will include data collection to support evidence based outcomes.

Carers have told us that carers assessments are not as effective as they would like and often do not lead to a significantly improved outcome. This approach aims to address this.

Expected outcomes include; an increase in carers assessments; an increase in the take up for carers personal budgets as well as more bespoke support being purchased; reduced need for support for the cared for person, better self- reported outcomes for carers.

The key success factors including an outline of processes, end points and

timeframes for delivery

Key success factors for these schemes include:

- achievement of improved outcomes for carers, whereby carers are better able to maintain their own independence, health and wellbeing, they are less isolated and more able to link into wider community networks, and they are better able to cope with their caring role
- Improved alignment and joint working across agencies, with clear referral routes from health and social care and collaborative working across voluntary sector organisations

Each organisation received funding for the whole two year period 2015-2017, to enable time to develop, implement and evaluate schemes. Evidence from year one demonstrates that the schemes are building links, reaching targeted groups and beginning to achieve improved outcomes. As these schemes now move into year two, the emphasis is on expanding the numbers of people supported and analysing the most effective elements to build into the longer term model

Describe the links to longer term integration, sustainability and transformation plans

Schemes delivered during these two years will support development of a longer term integrated model which will be based around a number of core principles:

- Carers will receive an integrated package of support
- All health and social care staff will be aware of the needs of carers and of referral routes to access local support
- Carers will be supported by the improved sharing of information between health, social care and carer support organisations
- Carers will be respected as expert care partners and will be involved in the planning of care for the cared for,
- The needs of vulnerable carers, particularly those at key transition points, will be identified early through improved risk stratification

Focus on carers remains priority for CCG and ECC and will form integral part of emerging neighbourhood / hubs integrated operational models ensuring rapid access to assessment for carers, ECC commissioned services and local voluntary and community carers support provision. Recent 'Social prescription' service mobilisation will also improve pathways to carers support

Describe the links to and the effects on the National Conditions especially Delayed Transfers of Care (data sharing, joint assessments / accountable professional, 7 day working, DTOCS, ring-fenced for out of hospital services)

Early intervention support provided through funded schemes will enable carers to manage their caring role and their life outside of caring, thus reducing risk of crisis and demand on health and social care services; and enabling safer discharge from hospitals services for the cared-for person.

Facilitating rapid discharge from hospital remains a priority, which benefits family carers also. To this end CCGs are working with ECC to establish dedicated Reablement in-patient provision to support rapid discharge to access; reviewing

community be provision; using opportunities with new Reablement provision to enhance and improve rapid response; strength community expertise e.g. community geriatrician

Scheme ref no. 3

Scheme name: Reablement

Overview of scheme

Reablement at Home is a jointly commissioned service by all five CCGs and Essex County Council. It operates within Essex County Council boundaries on locality basis; Mid, North East, South East, South West and West Essex.

ECC in partnership with the CCGs has entered into a five year contract in each CCG area across Essex for the provision of a reablement at home service from 4 May 2016, with the current Domiciliary Reablement contract running until 3 May 2016.
This is a description of the new scheme which will be in place form 4 May 2016.

The providers in each area from 4 May are:

Mid Essex (Chelmsford Maldon and Braintree) – Allied Healthcare
North East Essex (Colchester and Tendring) – Allied Healthcare
South East Essex (Castle Point and Rochford) – ECL
South West Essex (Basildon and Brentwood) – Allied Healthcare
West Essex (Harlow, Epping and Uttlesford) – Allied Healthcare

Our definition of reablement (as per DoH) is:

"an active period typically of up to 6 weeks of intense activity and support designed to promote people's independence. This is a preventive measure that can reduce people's need for both acute hospital care and can help people to continue living at home for longer."

Reablement is used locally to support individuals avoid admission to hospital or residential care or after an episode in hospital, or any other event which resulted in a loss of life skills and/or confidence e.g. following a fall, bereavement, etc. The service is a short term (up to six weeks), non-chargeable service provided to Adults who have been assessed by a health or social care professional as being able to benefit from a period of reablement.

Description of the proposed schemes and impact on outcomes

Description of the service

The new service will see reablement as the default initial preventative care offer for all suitable adults across Essex who experience a change in circumstance or confidence. With the only exceptions being those whose need is for palliative care, or whose dementia is so complex that they do not have reablement potential. The target outcomes in the new contract reflect that more complex cases will be referred into and offered reablement.

The new reablement specification has the following requirements:

Providers must:

- Meet the needs of adults with a wide range of mobility and skill levels. Reablement as the first offer means that all but the most complex cases (severe cognitive impairment and those requiring palliative care) will be

referred to reablement first

- Provide a 365 day service; 7am – 11pm (Includes starting reablement during weekends and bank holidays)
- Assess for the use of equipment and assistive technology
- Use the specified outcome assessment tool to measure progress
- Independently survey a proportion of adults with a set of prescribed questions
- Have capacity to meet increased demand and flex resources as required
- Undertake activities to increase referrals from the community
- Work closely with the community and voluntary sector, health and social care professionals
- Be responsive and proactive to a changing health and social care environment; service specification, pathways and operational policies will be flexed to fit with pathways being developed locally
- Respond to, and enter data directly onto, the ECC case management system

Outcomes of the service

The Reablement Services achieves cost savings through reducing or removing the need for ongoing support via traditional home care. Investment in reablement needs to be maintained otherwise the number of adults receiving a more costly long term care package would significantly increase.

Below are the outcomes for 2015/16 (Year to Date with projections for February and March 2016) :

- In 2015/16 71.1% of all Reablement cases resulted in service users needing no further ongoing support from completion of their Reablement

It is assumed that community reablement results in the avoidance of unplanned admissions to hospital;

- In 2015/16, 17% of all reablement referrals were from the community (1280 includes projected Feb/Mar) resulting in potential admission avoidance of £1,953,390 (based on £1,490 admission avoidance cost used within BCF assumptions).

Reablement can result in a reduction in delayed discharge and associated costs.

- In 2015/16, 83% (6241) of all reablement referrals came from acute and community hospitals.
- Reablement may also result in primary care savings although there is no robust national source of data to quantify the potential savings from fewer falls, less prescribing and fewer demands on practice nurses.

Financial modelling has been undertaken as part of the re-procurement of the service. This modelling sought to take into account a number of factors, primarily aligning future resources and service capacity with the geographical area of need, rather than using previous performance as a definition of need (with previous performance in some cases being more of an indicator of capacity than need). The modelling also took into account expected demographic growth and the changes in the new service offer.

The project team ran a series of workshops with subject matter experts, commercial expertise, commissioners, finance and the organisational intelligence team to develop KPIs from the outcomes required of Reablement.
The process began in December 2014 looking at the high level outcomes for ECC and CCGs, mapping indicators and measures. Existing performance data was used as a baseline and then developed to reflect the new service. To assist with this, a national expert consultant was engaged to model outcomes and benefits using ECC data supplemented with data from other evaluation studies. The KPIs progressed through series of iterations with CCG and ECC commissioners to enable fine tuning.

The high level outcomes in the new contract are:

1. Adults are able to return home and are enabled to live as independently as possible
   - 90% of Adults who finish reablement should show an improvement and of that 90%, 56.9% should be self-caring.

2. All Adults receive the Equipment required to enable them to remain in their own homes
   - 100% of Adults will be assessed for equipment and assistive technology

3. Avoidance of Hospital discharge delays
   - 97.5% of cases referred for reablement must be accepted.
   - 97.5% of referrals must be responded to within 2 hours
   - 99% of referrals which are accepted must be started within 24 hours
   - 99% of priority reablement referrals must be started within 2 hours

4. Adults are given the opportunity to feedback on their experience of the Service in order that improvements may be made where necessary and/or appropriate
   - 80% of Adults were satisfied or very satisfied with the service received

5. Community based Referrers are aware of the Service which enables Adults to access the Service from the Community
   - By end of Year 2 the ratio will be 50% from the Community : 50% from Hospitals

The key success factors including an outline of processes, end points and timeframes for delivery

New service Goes Live 4 May 2016

If the service is running well, then the process of review and commissioning would begin in October 2018 with a view to a new contract being procured by May 2021.

The contract has break clauses at Years 3 and 4 which would allow for earlier commissioning if it was thought to be necessary.

Describe the links to longer term integration, sustainability and transformation plans

The service will be an important feature within Sustainability and Transformation Plans, as reablement can reduce or remove need for ongoing home care, reduce delayed discharges and associated costs and reduce hospital admissions. The service is jointly commissioned and delivery of the service will sit as part of existing integrated care teams, such as community integrated single point of access and response teams. The service will also form part of hospital discharge teams, ward board meetings and have regular presence in A&E and on wards to facilitate discharge. Going forward the service will form part of neighbourhood teams and will act as referrers to community MDTs to prevent further client deterioration.
Describe the links to and the effects on the National Conditions especially Delayed Transfers of Care (data sharing, joint assessments / accountable professional, 7 day working, DTOCS, ring-fenced for out of hospital services)
Reablement service has a significant impact on Delayed Transfers of Care as 83% of the current capacity is used to support discharge from hospital. The referral route is through either health or social care and comprises of a multi-disciplinary assessment at ward level. The service operates 7 days per week.

Scheme ref no. 4

Scheme name: Community Services (including DTOC plans)

Overview of scheme

CPRCCG: The CCG have a range of schemes that focus on transforming how community services operate and move to a more integrated, multi-agency service model. The collective is to maximise potential for population to remain healthy, well and independent and out of hospital for as long as possible. The key schemes include: Care Coordination Model (integrated risk stratification, assessment, care planning and case management); Community Geriatrician provision; improved End of Life Care; improved access to falls Prevention; remodelled Reablement services, and; improved access to community beds (including 'discharge to assess' models).

Basildon and Brentwood CCG: This scheme focusses on a range of interventions and service developments that aim to

- Enabling people to stay well and maintain independence through proactive care planning, care coordination and integrated service delivery across mental, community and social care services.
- Enabling people to return home sooner from hospital by ensuring the right care packages are available in an out of hospitals setting and coordination of discharges and care packages is improved.

The services included within the Basildon and Brentwood element of this scheme include integrated community services, care coordination and other services that align to the new integrated service model at the heart of the "Fit for the Future" transformation programme.

North East Essex CCG: The most significant aspect of the 2015/16 NEE BCF has been the focus on the future delivery of community health services. Through the community health contract, held by ACE, there was considerable progress made on strengthening of community health services. For example, all National and Operational standards were met in October 2015. Furthermore the overall performance is good with the majority of local quality standards being met. This work is now to continue through BCF 16/17 with a new 7 year contract (known as "Care Closer to Home") recently awarded to ACE.

Mid Essex CCG:

- **Early Support Discharge for Stroke (commissioned from Provide CIC):** The ESD service is an element of the combined ESD and stroke beds service which are covered by a single service specification between provider and commissioner (though only the community ESD element forms part of the BCF). The ESD service, provided by teams of therapists, nurses and doctors, allows Service Users to return home early with necessary rehabilitation, thereby improving long-term recovery. The stroke psychology service provides comprehensive psychological support service to improve outcomes for stroke survivors and their carers.

- **ICT:** The ICT service is Mid Essex's principle community nursing service, supporting a caseload of approximately 6000 patients and works closely with primary care and other healthcare agencies.

- **Multi-Disciplinary Teams (MDT's):** Multi-disciplinary teams (MDT's) are in operation in 43 practices in Mid Essex, comprising of monthly meetings attended by staff from a range of different agencies to discuss and follow up actions for patients with complex medical histories.

- **NWB/IMC:** The acute Trusts commissioned by MECCG have the need to facilitate discharge for Service User(s) who are required to be non-weight bearing for a period of time. This status may mean that they are unable to return to normal activities of daily living and may require some nursing and or social care support until the period of recuperation is reached and they are once more able to weight bear. This pathway was set up to support these patients in the inpatient community hospital setting.

- **Fast Track:** Purchase of packages for Fast Track patients (i.e. with a life expectancy of less than 8 weeks) who have been assessed as eligible for CHC against the national framework and the CCG's CHC policies.

Fast Track packages are packages of care purchased for individual patients who meet appropriate criteria.

- **CHC Assessment Team:** Joint nursing and care home commissioning including continuing healthcare ("CHC") and CHC Assessment. The provision of the assessment service is provided by the CCG's in house team (the "Assessment Service") who assess both CHC patients and funded nursing care ("FNC") patients. The Assessment Team undertake the CCG's statutory duty to perform CHC assessments against the national framework and the CCG's CHC policies

See separate page for WECCG

Description of the proposed schemes and impact on outcomes

CPR CCG

Summary of Schemes	Executive Lead	Planned implementation date	Point of Delivery Impact	Brief Description
Integrated Care Co-ordination	Kevin Mckenny	Sep - 15	NEL Admissions	The Care Co-ordination Service will support Accountable GPs to manage complex and/or frail patients within their own homes and consequently reduce A&E attendances, hospital admissions and admission to long term residential care.
Community Geriatrician	Kevin Mckenny	Aug - 15	NEL Admissions	The Community Geriatrician service will ensure consultant level clinical leadership for frail and vulnerable people within our population who are at risk of hospital admission and require a consultant led comprehensive assessment. The assessment will lead to an individualised plan of care that will

				enhance patient experience through interventions appropriate to their care needs.
End of Life	Kevin Mckenny	Apr - 16	NEL Admissions	Through CCG leadership and facilitation of South East Essex (End Of Life) Locality we will deliver a comprehensive work plan that has a range of initiatives aimed at identifying increasing numbers of patients who are 'end of life' and delivering services that ensure they are enabled to die in their Preferred Place of Care. This includes CQUIN initiative, enhancing MDTS, crisis line for last hours of life, strengthening hospice at home, Macmillan GP supporting practice with GSF, and; providing GSF in Care Homes.
Primary Care Support for Care Homes	Kevin Mckenny	Apr - 16	NEL Admissions	The CCG will develop comprehensive programme of targeted innovation and improvements within care homes that will aim to reduce number of 999 calls, A&E attendances and NEL admissions. Implementation of local enhanced services. Primary focus is mobilising the Enhanced Service for Care Homes
LTC Management	Kevin Mckenny	Apr - 16	NEL Admissions	Key areas of focus for self-management for the CCG are the following: - tailoring interventions to the LTC; for conditions such as diabetes structured patient education , while conditions such as depression will require behavioural interventions; - involving patients in co-creating a personalised self-management action plan, medicines management advice and support, telecare and telehealth for selfmonitoring, psychological interventions and patient access to their own records; - telephone health coaching; - behavioural change programmes to encourage patient lifestyle change; - as the number of people who are unpaid carers for older people is expected to rise, providing support for informal caregiving.
Falls	Kevin Mckenny	Apr-16	NEL Admissions	Identifying those at risk of falls and providing fracture prevention services for older people have been found to reduce hospital admissions and the need for social care such as admission to a care home. The CCG will ensure we are maximising throughput on commissioned falls prevention services

Basildon and Brentwood CCG

For Basildon and Brentwood CCG, the key components of this scheme are;

1. The development of Integrated Locality Teams across primary, community, mental health and social services. These teams will proactive manage patients through comprehensive care plan and early intervention and a named key worker.
2. Implementation of Intermediate Care Review. Through this review, we will reduce the number of out of hospital beds in the system and instead commission a comprehensive range of community services to offer the optimal pathway for patients. This will be supported through the new reablement contract commissioned by ECC. A second phase of the intermediate care review will be considered later in 16/17. This will focus on discharge to assess and other key groups of patients that currently have admission lengths greater than they need to be (e.g. non weight bearing patients)
3. The full roll out of the hospital integrated discharge service. This service was commissioned in winter 15/16 and seeks to provide greater coordination of complex discharges from Basildon and Thurrock Hospital.
4. Development of a single client care plan and contingency plan to be delivered across acute care, primary care, community care and care homes. This will ensure better data sharing of client outcomes and contingency preferences.
5. Roll out of named social worker to GP practices/GP clusters. This will help professionals better understand roles and responsibilities, undertake improved care co-ordination and provider clients with holistic assessments and care.

North East Essex CCG:
Care Closer to Home is an outcomes based contract, focusing on delivering integrated care wrapped around clusters of GP practices. Through care planning, achievement of outcomes agreed with individual patients will form the basis for performance management of the contract and performance related pay. The new service will focus on prevention and early intervention and will use joint assessments and case management to improve service user experience and to reduce unplanned admissions. 7 day services and close working with the reablement provider will make a significant and sustainable contribution to improving performance for delayed transfer of care.

Mid Essex CCG

Stroke: Provision of a seamless transition from the acute episode of stroke through to community support, enabling full potential for independence and providing a single point of access for stroke rehabilitation services. Rehabilitation is delivered in line with care plans that are reviewed by the by weekly multidisciplinary team ("MDT") meetings that enables integration of, health, social and voluntary organisations. The service recommends going care package needs, ensures appropriate onward referrals, carries 6 monthly clinical reviews. The composition of the MDT's includes``:

- A dedicated, full time co-ordinator/manager;
- Physiotherapists;
- Occupational Therapists;
- Speech and Language Therapists;
- Rehabilitation Assistants;
- Nursing staff;
- Stroke psychologist
- Stroke Physician (Consultant) input;
- A social care worker and IASC (information, advice and support coordinator) will be employed by other stakeholder organisations but shall be integral members of the team.

Service delivery include a minimum of 45 minutes of each active therapy that is required, for a minimum of 5 days a week where appropriate, allocation of keyworker for each patient, close working with the community stroke consultant, clear ongoing goal with agreed patient outcomes shall be agreed with the patient/carer and documented in the care plan with copies given to the stroke Service User and provision of information for patients and their families. The stroke psychology provides prompt access to specialist support for appropriate patients and provides and advice for to staff for patients of all intensity levels where needed.

The following outcomes are associated with the service:

- Multidisciplinary approach that contributes towards a seamless pathway with continuity of care.
- Reduction of the length of stay for Service Users within acute stroke unit.
- An evidence based whole systems approach
- Rehabilitation delivered with a person–centred, goal planning approach and promotes secondary prevention for stroke Service Users;
- The stroke Service User to reach, and maintain optimum potential in their recovery.
- Maximise independence of the stroke Service User and their family/carer.

- Reduction of avoidable disability, dependency on social care and the need for the stroke Service User to enter prematurely into long term care.
- Psychology outcomes in include improvements to cognitive, behaviour and mood symptoms, including language ability.

ICT

The following functions are delivered:
Involvement in MDT work with social care, the voluntary sector, mental health staff and primary care, Care post discharge from secondary care including the development of a discharge to assess process, monitoring and support of patients with long term conditions, wound care including treatment of leg ulcers, continence management and provision of continence supplies, catheter care, phlebotomy, Immunisation , End of Life Care and palliative care crisis management, Post bereavement assessment, medication support, management of PICC Line, falls prevention and screening and education of patients and telephone advice line. Admission avoidance is fundamental the operation of the ICT team, delivering an urgent and crisis response service and joint work with Essex County Council Reablement teams to provide rapid response for patients at risk of hospital admission or patients requiring a rapid assessment of health and social care needs and intervention.

Outcomes

- Patients achieve maximum independence and function following crisis or decline
- Reduction of admissions into acute or residential home services
- Reduced length of stay in acute services
- Improved quality of life for patients with long term conditions
- Improved Preferred Place of death rates

Multi-Disciplinary Teams

The monthly meetings are attended by primary care staff, community nurses, social workers, community agents and mental health workers. The patients discussed at the meetings are informed by details held on a Mid Essex wide complex cases register that identifies the 7000 most vulnerable patients in Mid Essex and tracks their healthcare activity. The meetings lead to sharing of information and actions for the patients under discussion.

Outcomes include:

- Improved quality of care and management of patients with complex conditions.
- Greater independence for patients and access to an integrated health care provision
- Improvements in communication and joint working between different agencies

NWB

- To identify NWB Service User(s) that can be discharged from the acute setting and maintained in a recuperative community environment until they become weight bearing and can be discharged home or any necessary rehabilitation can commence.
- To reduce unnecessary excess lengths of stay in a hospital setting.

- To offer NWB Service User(s) safe management during their NWB phase.
- Mid Essex Hospital Services NHS Trust (MEHT), Mid Essex Clinical Commissioning Group (MECCG), Provide (community services) and Essex County Council (ECC) to work collaboratively with the Provider to ensure a seamless transfer of Service User(s) from hospital to a recuperative setting and their subsequent discharge to home or a community rehabilitation facility as clinically required.
- MEHT, Provide and the Council to work collaboratively to provide a pathway to safely manage Service User(s) on an interim basis who are unable to weight bear but have no clinical requirement for an acute hospital bed.
- To help people recover from episodes of ill health or following injury.
- To ensure that people have a positive experience of care.
- To treat and care for people in a safe clinically appropriate environment and protect them from avoidable harm.

During 2015/16 the service provision has been transferred from the CHP to the local Community Service Provider based in a community hospital.

Fast Track
Fast Track packages are put in place where a person who is eligible for CHC has a rapidly deteriorating condition and the condition may be entering a terminal phase.

An effective assessment process and putting in place appropriate packages will make best use of system resources.

CHC Assessment Team
The CHC assessment process is a statutory duty for the CCG. This duty includes case co-ordination, arranging completion of the decision support tool, decision-making, arranging appropriate care packages, providing or ensuring the provision of case management support and monitoring and reviewing the needs of individuals. It also includes reviewing decision with regards to eligibility where an individual wishes to challenge that decision.

The key success factors including an outline of processes, end points and timeframes for delivery

Stroke
The out of hospital stroke pathway is under review, examining all elements provided by community, psychology, social care, the voluntary sector, primary care as well as the interface with acute. The review of the service will lead into the development of a lead provider model that embeds integration and encompasses outcomes based commissioning and will complete in the second quarter of 2016/17

ICT
A review of the ICT services is underway which will differentiate between the planned and urgent care elements of the service and separate out transactional elements of the service that could be better provided elsewhere. This review will clarify the place of the service in the overall structure of services provided for Frail

and End of Life patients and mesh the urgent care element of the service with related admissions avoidance and supported discharge services, tying it in with a central point of access that will span healthcare and social care services. The review of the service will lead into the development of a lead provider model that embeds integration and encompasses outcomes based commissioning and will complete in the second quarter of 2016/17

MDT
The MDT teams are subject to a review of all services for Frail and End of Life Care patients that will assess impacts and outcomes and establish the potential for closer integration across both healthcare and social care providers.

Describe the links to longer term integration, sustainability and transformation plans

All of these elements of the BCF are integral components of the vision of a streamlined integrated pathway for the frail elderly. The vision is to improve the predictive/pre-emptive elements of services in order to avoid patients deteriorating to a crisis and to ensure that hospital stays are minimised and patients returned to their home environment and independence as quickly as possible.

Our Age Well agenda embodies this philosophy and provides a framework to improve multi-agency working to ensure best possible outcomes for our frail elderly population.
Mid
Challenges in managing Delayed Transfers of Care in line with plans during 2015/16 were experienced by the CCG, particularly when social cares service providers were unable to staff services to maintain business as usual. The Mid Essex system has developed an integrated, system wide approach to try to recover the position. The newly procured reablement service that starts in May 2016 will provide a more responsive and better resourced service within increased capacity, more access to therapy provision, an integrated rapid response service and improved pathways that link with other clinical services. Healthcare services work in alignment with the social work team based at Mid Essex Hospitals Trust to identify patients who are ready for discharge and put into place the necessary packages to enable these people leave hospital.

Describe the links to and the effects on the National Conditions especially Delayed Transfers of Care (data sharing, joint assessments / accountable professional, 7 day working, DTOCS, ring-fenced for out of hospital services)

Basildon and Brentwood CCG
For Basildon and Brentwood CCG, the three initiatives will support many of the national conditions. Specifically, the central function of the HID service is to reduce DTOCs through improved coordination of discharges, the Intermediate Care Review increases the level of care being delivered across seven days in a community setting, the development of locality teams will support the roll out of joint assessments, data sharing and accountable professionals.

Essex County Council

Essex County Council will blend its offer with local CCG integration plans. We anticipate Social work to form part of the MDT community based hub, which delivers integrated long term planning and in-reach. Good lives 3 conversation model has been developed and tested within 8 innovations sites including GP Practice, Broomfield Hospital and Social Care Direct.

North East Essex CCG

Care Closer to Home model of care provides out of hospital care and includes joint assessments and case management to reduce demand on acute care and to ensure patients are supported to regain their independence asap. Relevant services are provided across 7 days and the Rapid Assessment Service focuses on intensive input to keep people in their homes, but where necessary step up community beds are available to avoid acute admissions. The step up beds are actively managed to ensure people can return home without delay.

Scheme ref no. 5

Scheme name: Community Services WECCG

Integrated Transformation Programme for Older People – (age 65 and over and anyone with a diagnosis of dementia living in a care home or at the end of life

Overview of scheme

Recognising the inevitability of people ageing and becoming frail the older people programme aims to ensure people are involved and in control of their care which is planned and delivered by integrated services across health and social care. In addition, individuals are supported to live healthier for longer, delaying the onset of frailty for as long as possible.

Description of the proposed schemes and impact on outcomes

Evidence Base

Right care Commissioning for Value - Feb 2015

Indicates that analysis of WECCG with 10 most comparable CCG's identifies programmes that offer the best opportunity to improve healthcare for populations, improving the value that patients received and the value populations received from investment in their local health system.

The over 75 population of West Essex is 24,000 (JSNA ONS Dec 2014)

Inpatient expenditure for 75+ year olds reveals the expenditure by healthcare programmes with the highest spend for admissions covered by PbR.

Hospice at night	Night care provided to EOL pts	2 referrals per night - 75% admission avoidance rate No increase in capacity from 2015/16
Hospice at home	EOL care provided in the community	Delay to increase in capacity in 15/16 so transformation targets: 16/17 60 referrals per month (Apr-Oct) with 65% avoidance rate
Care homes	Integrated support to care home to avoid att & admission	15/16 saw increase in both att and admissions therefore 20% stretch target set for both during 16/17
Rapid response	Urgent health care support to GPs	1 referral per week per GP practise (Apr to Sept) with expectation that 50% will avoid and attendance and 50% will avoid admission

The key success factors including an outline of processes, end points and timeframes for delivery

Achievement of the goals and vision detailed in section 1.1 Monitored by Shadow System Providers Partnership Board, SPQRG's and West Essex Older people programme board
Describe the links to longer term integration, sustainability and transformation plans
All programmes outlined above will support the delivery of greater integrated health and social care for West Essex residents – the neighbourhood models of care delivery will function with integrated support from social care, physical and mental health to support primary care to ensure support/care is provided and wrapped around residents/carers to meet their needs and prevent unplanned attendances and admissions.
Describe the links to and the effects on the National Conditions especially Delayed Transfers of Care (data sharing, joint assessments / accountable professional, 7 day working, DTOCS, ring-fenced for out of hospital services)
Joint assessments – new neighbourhood model and closer working relationships will improve trust and support joint assessment in place of duplication Accountable professional – Named GP for all over 75's – monitored via NHS England for primary care Named case manager to support residents navigation of the health and care system to avoid crisis – this may be social worker, CPN or community nurse or community agent 7 day working – the following community services operate 7 days – further scoping on demand v capacity v cost to be undertaken ahead of extending further 7 day working in community

Scheme ref no. 6

Scheme name: Disabled Facilities Grants

Overview of scheme

The Disabled Facilities Grant is transferred directly from ECC to the twelve District, Borough and City councils to allow them to discharge their statutory duty with regard to DFG.

The main area of focus is the prevention of harm and promotion of independence within the existing home setting.

Description of the proposed schemes and impact on outcomes

The DFG is used by each of the twelve District, Borough and City Councils in Essex to discharge their statutory housing responsibilities.

A total of £8.217m will be transferred to the Essex district, borough and city councils in line with the published allocations, namely:

Basildon	£989,257
Braintree	£730,156
Brentwood	£290,073
Castle Point	£579,533
Chelmsford	£755,993
Colchester	£994,045
Epping Forest	£664,970
Harlow	£615,382
Maldon	£420,343
Rochford	£374,747
Tendring	£1,636,940
Uttlesford	£165,868

Essex County Council regularly engages with the local councils through the Essex Housing, Health & Social Care Partnership Forum and the Essex Housing Officers Group and uses these forums to create closer and more consistent links with health and social care.

It is intended that throughout the 2016/17 BCF year that apart from the DFG being used for its traditional use, the councils will explore with ECC wider uses that more closely align the DFG to health and social care.

These may include:

- Systematic review by landlords, housing associations, care providers and commissioners of those who may be eligible for DFG with support from local housing authorities to provide a proactive service, improving the opportunity for prevention of harm and hospital admission. Evidence base = avoidance of hospital admission, improvement to home (alleviation of Cat 1 hazards, reduction in fuel poverty, satisfaction surveys from clients, avoidance of hospital admission)
- Possible triage at point of admission into hospital / early stage of planning for

discharge (similar to CPA) with social care / OT and local housing authority to assess requirements – whether these will be to facilitate discharge back to home or include use of step-down accommodation to be provided close to home, either may require adaptation using discretionary use of funding beyond existing DFG policy. Evidence base = increase in improvements to homes of those discharged, reduction in delays of discharge, reduction in risk of re-admission, increased use of existing housing stock adapted to meet both individual and longer-term strategic need, avoidance of use of higher cost residential placements – for those returning back to home same outcomes as 1 above as well.

- Assessment of longer-term requirements depending upon the individual requirements of each case, taking into account prognosis and other social and welfare issues such as risk of social isolation, need for other types of support, opportunity to employ telecare, etc. Evidence base = number identified and assisted in addition to more conventional routes (1 and 2 above), reduction in risk of hospital admission and reduction in reliance on statutory services, in particular primary care, reduction in risk of unplanned access into social care.

A plan of action will be developed and agreed between ECC and the Housing authorities to progress this further during 2016/17

The key success factors including an outline of processes, end points and timeframes for delivery

Success factors will be outcomes and evidence base from above, also take into account satisfaction surveys – where used these usually show high scores for what may appear modest investment because the outcomes are so tangible and beneficial to clients' day-to-day living, e.g. ability to access bathroom, enter and leave home, regain independence.

Joint planning and commissioning of services, with closer links between assessment, commissioning and outcomes between health, housing and social care, giving greater choice but also explaining more clearly options and managing expectations – too often assumptions are made that services will be available at time of need but in practice this results in limited rather than wider choice, e.g. only option if planning at time of crisis may be hospital or residential. There needs to be more transparency between agencies and with clients as to both the range of options and the need to consider and plan, which in turn makes better use of existing resources and reduces the need for higher cost, emergency intervention.

Timeframe – six months to agree operational framework between housing, health and social care (based on CCG areas?), six months to begin pilot, review of policy, allocation and use of resources.

Critical to facilitating change in practice would be local contact point (suggest that this is sits between OT and Housing) and ensuring that there is capacity to assess practical feasibility (surveyors and administration of financial entitlement and client contributions – Housing and local contractors) so that recommendations can be delivered as quickly as possible.

Describe the links to longer term integration, sustainability and transformation

plans
Relates to overview above – targeted and planned intervention to promote independence, based upon models used elsewhere in housing (homelessness prevention where this has had a dramatic effect on the reduction of homelessness). Recognition of the need to work collaboratively and more transparently on assessing and responding to need and risks, e.g. including risk of social isolation which can undermine rehabilitation and aggravate less serious conditions.
Describe the links to and the effects on the National Conditions especially Delayed Transfers of Care (data sharing, joint assessments / accountable professional, 7 day working, DTOCS, ring-fenced for out of hospital services)
During the course of 2016/17 it is planned to further develop the approach to DFGs within Essex. Closer working between the Housing authorities, ECC and the CCGs are expected to impact on both hospital admissions and discharges. The main focus of a joint approach will be on: 1. Facilitating quicker and more sustainable discharge from hospital and other temporary care. 2. Facilitating moves to more sustainable accommodation which may require adaptation to make more suitable for personal requirements (making better use of existing resources beyond DFG, e.g. housing options, requiring greater changes and better integration of working between local housing authorities, social care and primary care)

APPENDIX 1

7. BCF Contributions

7.1. BCF Investment

BCF Partner	2016/17 Minimum Contribution £000's	2015/16 Minimum Contribution £000's	2016/17 Additional Contribution £000's	2015/16 Additional Contribution £000's	2016/17 Total Contribution £000's	2015/16 Total Contribution £000's
ECC	£8,217	£8,009	nil	nil	£8,217	£8,009
NEECCG	£21,307	£20,987	nil	nil	£21,307	£20,987
MECCG	£22,386	£21,651	nil	nil	£22,386	£21,651
WECCG	£18,382	£17,435	£1,088	£1,279	£19,470	£18,714
BBCCG	£16,269	£16,041	nil	£6,166	£16,269	£22,207
CPRCCG	£11,095	£10,833	£165	£333	£11,261	£11,166
Total	**£97,656**	**£94,956**	**£1,266**	**£7,778**	**£98,909**	**£102,734**

7.2. BCF Scheme Values

7.2.1. Provision of Social Care

Provision of Social Care						
BCF Partner	**2016/17 Minimum Contribution £000's**	**2015/16 Minimum Contribution £000's**	**2016/17 Additional Contribution £000's**	**2015/16 Additional Contribution £000's**	**2016/17 Total Contribution £000's**	**2015/16 Total Contribution £000's**
ECC	nil	nil	nil	nil	nil	nil
NEECCG	£6,174.2	£6,036	nil	nil	£6,174.2	£6,036
MECCG	£7,408.7	£7,281	nil	nil	£7,408.7	£7,281
WECCG	£5,731.8	£5,538	nil	nil	£5,731.8	£5,538
BBCCG	£4,937.4	£4,854	nil	nil	£4,937.4	£4,854

CPRCCG	£3,347.6	£3,422	nil	nil	£3,347.6	£3,422
Total	**£27,599.6**	**£27,131**	**nil**	**nil**	**£27,599.6**	**£27,131**

7.2.2. Care Act

Care Act				
BCF Partner	**2016/17 Minimum Contribution £000's**	**2015/16 Actual Contribution £000's**	**2016/17 Additional Contribution £000's**	**2016/17 Total Contribution £000's**
ECC (from POSC)	nil	£1,000	nil	nil
NEECCG	£833	£600	nil	£833
MECCG	£824	£576	nil	£824
WECCG	£696	£478	nil	£696
BBCCG	£624	£449	nil	£624
CPRCCG	£427	£298	nil	£427
Total	**£3,404**	**£3,400**	**nil**	**£3,404**

7.2.3. Support for Carers / Carers Breaks

Support for Carers / Carers Breaks		
BCF Partner	**2016/17 Contribution £000's**	**2015/16 Contribution £000's**
ECC	nil	nil
NEECCG	£210	£210
MECCG	£151	£149
WECCG	£186	£184

BBCCG	nil	£82
CPRCCG	£50	£50
Total	**£597**	**£675**

7.2.4. Reablement

Reablement		
BCF Partner	**2016/17 Contribution £000's**	**2015/16 Contribution £000's**
ECC	nil	nil
NEECCG	£975	£975
MECCG	£887	£1,087
WECCG	£721	£721
BBCCG	£773	£986
CPRCCG	£688	£688
Total	**£4,044**	**£4,457**

7.2.5. Community Services (including DTOC Plans)

Community Services (including DTOC plans)						
BCF Partner	**2016/17 Minimum Contribution £000's**	**2015/16 Minimum Contribution £000's**	**2016/17 Additional Contribution £000's**	**2015/16 Additional Contribution £000's**	**2016/17 Total Contribution £000's**	**2015/16 Total Contribution £000's**
ECC	nil	nil	nil	nil	nil	nil
NEECCG	£13,095	£13,166	nil	nil	£13,095	£13,166
MECCG	£13095	£12,558	nil	nil	£13095	£12,558
WECCG	£11,010	£10,514	£1,088	£1,279	£12,098	£11,793

BBCCG	£9917	£9,595	nil	£6,166	£9,917	£15,761
CPRCCG	£6584	£5,605	£146	£333	£6730	£5,938
Total	**£51,984**	**£51,438**	**£1,234**	**£7,778**	**£53,218**	**£59,216**

7.2.6. Disabled Facilities Grant

Disabled Facilities Grant		
BCF Partner	**2016/17 Contribution £000's**	**2015/16 Contribution £000's**
ECC DFG	£8,217	£4,713
ECC Social Care Capital Grant	nil	£3,296
Total	**£8,217**	**£8,009**

APPENDIX 2

Table of Risks

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**	**Risk Owner ??**
1. It is not possible to contain Non-elective admissions within agreed target.	4	5	20	CCGs and their system partners have detailed project plans for frailty pathway schemes and risk management arrangements in place There will be close monitoring of NEA activity both at the CCG and H&W Board levels.	Financial – CCGs Hospital flow – SRG partners
2. Acute sector cannot reduce costs in response to reduced activity	4	5	20	CCGs are working closely with their local Acute provider to model the expected financial impact and Trust mitigation plans. This will form part of the CCG contract negotiations and the local System Leaders discussions.	Acute Providers (and therefore CCG commissioners)
3. System unable to reduce DTOCs in line with plans	4	5	20	SRG system partners have detailed project plans for reducing DTOCs and system escalation plans to address performance issues. There will be close monitoring of activity both at the CCG and H&W Board levels	SRG partners
3. Lack of capacity in Primary Care to support	4	4	16	Close working with NHSE to identify capacity issues and mitigation plans e.g.	NHSE and CCGs

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Risk Owner ??
service delivery				recruitment initiatives, extended opening pilots etc.	
4. There is insufficient funding to protect social care services	3	5 Risk falls upon both ECC re meeting service responsibilities and upon demand for healthcare services if expected social care services and funding is not available.	15	£3.3m of additional PoSC funding available as a result of terminating a number of 2015/16 schemes and the PoSC funding uplift. Contract monitoring and financial control to be strengthened by improving data quality on access to services. ECC is underwriting the financial risk of any further overspends on HSS and Reablement and will make payments into the fund to cover overspends on social care services. This is covered within the risk share within the Section 75 Agreements.	ECC Health partners where demand defaults to NHS
5. Healthcare and local sustainability services included in the plan cannot be contained within agreed budget	3	5	15	Operation of existing financial control and reporting arrangements. A significant element of this expenditure is commissioned under block contract arrangements. CCGs are underwriting the financial risk of overspends on healthcare commissioned services and will make payments into the fund to cover overspends on healthcare services. This is covered within the risk share within the Section 75 Agreements.	CCGs

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**	**Risk Owner ??**
6. The Care Act will lead to a significant, but as yet unknown, increase in the cost of care. This would create a cost pressure which could result in the decommissioning of social care services with a potential knock-on increase in demand for system partner services..	3	5 £3.4m cost to be funded from the BCF – 3% variance would represent a £100k risk. Future implementation costs uncertain due to implementation delays.	15	Directions require £3.4m of the additional costs of the Care Act to be funded from the BCF.. Any further cost pressure will be met by additional local authority funding and/ or by ECC outside of the BCF. Robust financial control and reporting arrangements are being implemented as part of the Care Act mobilisation arrangements. Mitigation actions to cover unbudgeted costs could result in community services being decommissioned which are required to support healthcare services inside or outside the BCF. Further national guidance on cost control/risk mitigation is awaited. £3m of funding held in reserves as a result of 2015/16 cost undershoots ECC will liaise with system partners so that the impact of any proposed savings are understood and agreed across the health and social care system.	ECC Demand impact – CCGs, acute, community and voluntary sector providers.
7. The emerging vision for services will see significant shifts in activity across providers. This could potentially destabilise providers..	3	4 Provider capacity issues can be adversely affected by both over and under delivery of activity plans. Financial risks can affect	12	Community and Acute providers are integral to many of the pathway transformation projects. System partners have representation at the H&W Board as well as local SRGs to	All system partners

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Risk Owner ??
		commissioners and providers depending upon the contract financial arrangements (e.g. pay as you go or block contracts). .		facilitate engagement and commitment to the agreed changes. Local System Leaders arrangements facilitate alignment of planning and communication.	
8. Existing contract portfolio exists across county and unitary boundaries (Southend and Thurrock) creating financial and service delivery risks where strategic direction differs between BCF footprints and between the Success Regime and other areas..	4	3 Destabilises existing providers and services being delivered.	12	Work commenced regarding identifying CCG specific activity and cost at a service level, including workforce. Providers engaged and aware of emerging strategic directions. The Acute Services review is currently underway within the Success Regime footprint which also includes Southend and Thurrock CCGs	BBCCG, CP&RCCG and ECC
9. Barriers to implementation and/or monitoring due to information governance issues	3	4	12	Whole Essex Information Sharing framework was agreed in 2014. Close working with providers and IG leads to identify issues and develop solutions.	CCGs and ECC
10. Stakeholders are not kept informed and/or are unclear on the BCF impact. Working relationships deteriorate and undermine service transformation plans.	3	4	12	BCF activity is monitored by the Health and Wellbeing Board which includes relevant providers and patient representatives as well as commissioners. Local System Resilience Groups receive detailed local activity reporting and are able to respond quickly as issues are	CCGs and ECC

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Risk Owner ??
				identified. Continuous engagement with stakeholders through workshops, engagement events. Communications approach under development. CCGs will be co-commissioning or directly commissioning GP services in 2016/17 which should facilitate alignment of planning and communication.	
11. Unplanned cost increases as a result of 7 day working	3	3	9	Secure efficiencies through admission avoidance, reduced length of stay and reduced duplication. Expansion to 7 day working is prioritised on those reducing NEA admissions. Additional funding opportunities (e.g. PM Challenge Funding) to be pursued.	CCGs, ECC and providers
12. Staff not available or willing to work over weekends	3	3	9	Use workforce redesign techniques and continue to work with HEEoE to support our requirements.	Providers (and commissioners if leads to a cost pressure)
13. There are material delays in the payment of providers through the BCF – causing cash flow concerns and putting off providers from providing services.	3	3	9	For 2016/17 payment arrangements will be simplified – with healthcare providers paid direct for CCGs where possible.	Reputational – ECC & CCGs. disengagement of providers - system partners.
14. BCF footprint is not adjusted to align with STP	3	3	9	Discussions needed with NHSE to clarify future BCF/STP alignment.	NEECCG and ECC

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Risk Owner ??
planning footprints, hindering progress on integration.					
15. There will not be arrangements in place to ensure that the BCF pooled fund is managed equitably to resolve disputes regarding risk / benefit sharing	2	4	8	We have developed HWB governance arrangements to cover decisions over services and schemes within the pool – with absolute clarity on decisions which are made at CCG level, at County level and those reserved for a 'dual key' approach from both CCGs and County.	CCGs and ECC
16. Lack of transparency surrounding expenditure by all partners hampers the ability to work collaboratively	2	3	6	Reporting has been developed by all partners to ensure full breakdown of the services being funded, including activity levels, outcomes and benefits with a clear reporting timetable. Arrangements are already in place to increase the co-commissioning and contract monitoring arrangements.	CCGs and ECC
17. System unable to establish/maintain necessary pace across all providers	2	3	6	Implement CQUIN with acute and community providers aligned to NHSE's 10 clinical standards. Continuous engagement with stakeholders to focus on priorities.	CCGs and ECC
18. In constructing the administrative arrangements	1	2	2	. Detailed cashflow plans are agreed.	Mainly ECC but some residual

There is a risk that:	How likely is the risk to materialise? *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	Potential impact *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	Overall risk factor *(likelihood *potential impact)*	Mitigating Actions	Risk Owner ??
for the management of the pool there are adverse cash flow consequences for contributors to the pool or the host of the pooled funds.				For 2016/17 payment arrangements will be simplified – with healthcare providers paid direct for CCGs where possible.	CCG risk
19. Where ECC is the Host Commissioner, CCGs do not have assurance from ECC that systems are in place to verify that the data is correct and has been utilised to inform payment decisions made on behalf of the CCG.	1	2	2	Results of the ECC internal audit of the BCF should provide assurance that control systems are in place. Regular reporting of activity data, together with financial reports, should provide clarity of outcomes attached to investment and inform Value For Money assessment	Mainly ECC but some residual CCG risk

[i] Dementia UK (2014): Second Edition - www.alzheimers.org.uk