NHS
Castle Point and Rochford
Clinical Commissioning Group

Better Care Fund Plan

Part 1

Castle Point and Rochford Clinical Commissioning Group

(developed in partnership with Essex County Council)

DRAFT 1.1

March 2014

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Authorisation and Sign Off

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

Sign on behalf of Castle Point & Rochford Clinical Commissioning Group	
By	
Position	
Date	

Sign on behalf of Essex County Council	
By	
Position	
Date	

Sign on behalf of Essex Health and Well Being Board	
By	
Position	
Date	

1. Castle Point & Rochford CCG – Context & Executive Summary

1.1 Geography & Population

Castle Point and Rochford localities make up a large swathe of land surrounding the Southend Borough Council boundaries in South East Essex. Each locality is served by its own borough council. The CCG is made up of 28 practices. Their total registered population (taken from the Attribution Data Set in April 2011) is 177,000. This compares to an average for all 212 CCGs in England of 261,000.

Castle Point and Rochford CCG (CPR CCG) is responsible for the area of the populations consisting of Rayleigh, Hockley, Rochford, Great Wakering, Hadleigh, Benfleet and Canvey Island. As a CCG we operate across two core locality groups based on our local borough council boundaries: Castle Point and; Rochford. This enables us, as a CCG; to work more closely with the populations we serve and allows us to have insight into the diversity of our population.

We were fully authorised as a statutory commissioning body in April 2013, with a small number of conditions.

Our Population

15.9% of Castle Point and Rochford CCG registered population are under age 15 (England average 17.1%) and 9.3% are age 75 or over (England average 7.5%). 50.6% are female (England average 50.2%). Table 1 below shows how the CCG population is expected to grow by 2015, 2020, and 2025. This is based on applying weighted averages of ONS population projections by age and Local Authority to the CCG's population.

Year	Population	population 75+
Current (2011)	177,091	16,536
2015	181,491	18,817
2020	188,006	22,445
2025	194,855	27,492
Average annual growth rate 2011 to 2020	0.7%	3.5%
England average annual growth rate 2011 to 2020	0.7%	2.3%

Table 1: CPR CCG Population Growth

By 2030, the number of older people with care needs, such as requiring help with washing or dressing, is predicted to rise by 61 per cent and by 2032, more than 40 per cent of households are expected to be people living on their own. The number of people with dementia is expected to more than double over the next 30 years. This increasing ageing population could put significant pressure on our hospitals

1.2 CPR CCG - Overview of Better Care Fund

We are worked very closely with our partners to develop our plans for Better Care Fund (BCF) with Essex County Council, Southend CCG and Basildon and Brentwood CCG, alongside our local providers (namely Southend University Hospital Foundation Trust [SUHFT] and South Essex Partnership Trust [SEPT])

We have already agreed areas of joint work and are keen to develop new governance arrangements to oversee the implementation of these key programmes. Together Castle Point & Rochford CCG, Basildon and Brentwood CCG and Essex County Council are implementing the Better Care Fund agenda, aligned to key QIPP and JSNA priority areas for 2014/15.

For CPR CCG, it is imperative that we develop our plans in collaboration with our colleagues in Southend CCG our partners in a shared (acute, community and mental health) South East Essex health system. Our BCF priorities include:

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

Developing integrated care through BCF is an important part of our CCG's approach to delivering our strategic plan. Since authorisation in April 2013 our CCG commissioning team has been working collaboratively on a programme of work focusing on Integrated Care that brings together all key providers and commissioners in the local health system, with focus on the development of integrated care and service models that reduce rising number of acute unplanned admissions across South Essex. Examples include:

- Our lead community provider (SEPT) has been contracted to deliver care using 'integrated team' specifications,
- We have commissioning a Single Point of Referral (SPOR) shared health and social care telephone referral service for clinicians.
- Commissioned 'befriending service' from local voluntary organisation

The BCF has been implemented in the context of an ageing population and an increasing number of people who have one or more long-term conditions. These two factors mean that the needs of patients and service users increasingly cut across multiple health and social care services.

Increasing demand and financial pressures mean there for us to focus on prevention, reducing the demand for services and making the most efficient and effective use of health and social care resources. It is vital that our CCG and local authority understand the population we serve and how the use of services is distributed within our population in order to target interventions where they can have the most impact. Our Local Joint Strategic Needs Assessment is helpful information in this regard.

1.3 CPR CCG Core Aims for BCF

Our aim is to use the substantial opportunity offered by BCF to bring sources together to address immediate pressures on services and lay foundations for a much more integrated system of heath and care delivered at scale and pace.

This sustainable integrated system will being delivered through a partnership between Basildon & Brentwood CCG, Southend CCG, acute and community providers, local GP practices and partners in Essex County Council and Southend Borough Council. The aim of the programme is to jointly redesign the health and social care system and redefine the way professionals engage with each other around the assessed needs of individuals.

The BCF will fundamentally change the way in which people are supported in taking charge of their own care and conditions. The programme's initial focus, through integration with local authorities, is on caring for older people and its scope will be systematically broadened over the next four years (2014-18) – with Frail Elderly and Long Term Conditions being the focus the first phase of work.

The aim of the collaborative BCF (Integrated Care) Programme is to drive up the quality of care and drive down costs of providing it:

- improving the value of care we provide to local people by joining up care around people, across providers;
- identifying and managing people's care needs better and intervening earlier;
- ensuring care is provided in the most appropriate setting, particularly at times of acute crisis and by ensuring the right incentives exist for providers to work in integrated ways.

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

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services.
- To move care closer to home so that our hospitals have manageable demand
- To work together to ensure people are supported to look after their health and wellbeing.
- To support providers to join up, share information, and make services easier to navigate

To create an Integrated Commissioning Board or similar to align our work and have a single commissioning process

There are over-arching themes that CPR CCG has set out in our Strategic and Operational Plans that play into our emerging BCF plan, namely:

A. Primary Prevention

B. Self-care

C. Managing Ambulatory-sensitive conditions

D. Risk Stratification or Predictive Modelling

E. Falls Prevention

F. Care-Coordination

G. Case Management

H. Intermediate Care, reablement and rehabilitation

I. Managing emergency activity, discharge planning and post-discharge support

J. Medicine Management

K. Mental and Physical Health Needs

L. Improving Management of End of Life Care

M. Delivering Integrated Care

Delivery of BCF programme requires the building of collaborative leadership across health and social care organisations.

1.4 Service provider engagement

CP&R CCG share a main acute and community providers with Southend CCG within a South East Essex health system. Southend CCG is host commissioner for the acute contract with CPR CCG operating as an associate. CPR CCG is host commissioner for the mental health and community contracts with Southend CCG acting as an associate. As a consequence; all parties acknowledge that there will be significant overlaps between the CP&R CCG and Southend CCG Strategic and BCF Plans.

A strong working relationship with the local Acute and Mental Health / Community Foundation Trusts based upon clinician to clinician engagement has been a priority for the CCG in 2013/14 and will be actively developed further during 2014/15 as part of the CCG's organisational evolution.

All parties are seeking very similar outcomes and recognise the importance of giving clear direction to providers and the market place that will only come through close working. We will utilise existing collaborative forums such as Urgent Care Steering Group (that operate in both Health sub- economies) to ensure that there is some consistency in the strategic and operational delivery of commissioning intentions.

This first draft reflects a number of existing programmes that are designed to include health and social care providers as active participants; together with our GP locality groups, and our voluntary and community sector as a whole. Our intention is to encourage providers to take an active role in developing future plans. We had a major provider engagement event jointly with Basildon and Brentwood CCG, acute and community providers and ECC on the 28th January 2014.

It is our intention, as the programme gathers momentum, to invite representatives from key providers to join the appropriate Essex BCF Programme work stream project group. This will ensure that the design of future services and clinical pathways is jointly driven and jointly owned.

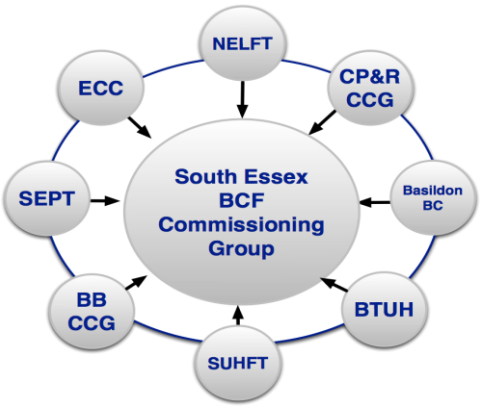


Fig 1 - South Essex BCF Commissioning Group

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

1.5 Patient, service user and public engagement

Our vision is to design and implement an integrated care system based on our resident population needs, that will be articulated by the residents themselves via the various patient and service user engagement forums that we have already established and a number of additional groups that we are planning to establish over the coming weeks and months. The CCG has implemented a wide range of activities to help ensure that our patients and community feel fully engaged with the planning and quality monitoring of local services.

Commissioning Reference Group

We will be using our established Patient Involvement Forum (Commissioning Reference Group) to engage directly with our patient and public representative on this agenda. We have a single Patient Engagement Group (Commissioning Reference Group [CRG]) which meets monthly to hear patient views and acts as an information exchange.

The CRG acts as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc. Members include our CCG lay representative, 2 x CVS, local authority, Healthwatch Essex and GP lead for PPI. Key roles of the group include receiving reports from the CCG Leaders responsible for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year etc.

The CRG links to the GP practice Patient Participation Groups to ensure local views and connections are maintained. The work plan of the CRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval.

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

Other Patient Engagement Activities

- CCG Communication and Engagement Strategy (will be updated to include BCF)
- A prospectus for patients is published each year (due for review)
- Two 'Call to Action' events in Oct 2013
- Board meetings are held in public, who are invited to become actively involved.
- The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.
- The CCG has its own website where all plans (including the Integrated Plan), policies and documents are published and accessible to the public

www.castlepointandrochfordccg.nhs.uk

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

1.6 Related documentation

The below documents relate to BCF

Ref	Document	Synopsis
1	Joint Health and Wellbeing Strategy	A partnership document detailing the vision and aims for improving health and wellbeing in Essex.
2	CCG Operational Plan (2014-16)	CPR CCG's two year operational plan
3	CCG Strategic Plan (2014 – 19)	CPRCCG's five-year strategic plan
4	Joint Strategic Needs Assessment	Analysis of the health needs of Essex's residents to inform planning and commissioning.
5	Draft Primary Care Strategy	The Strategy outlines the vision for Primary Care in Essex and identifies how the vision will be delivered.
6	Delivering Seven Day Services	Describes how seven day services across health and social care will be delivered.
7	Strategic Housing Market Assessment	This is a study of current and future housing requirements and housing need across south Essex. It provides evidence to support development of local housing strategies and also the planning of other services such as health, education and transport.

2. VISION AND SCHEMES

2.1 Our Vision for Health and Care Services

Our CCG has a vision for integrated commissioning that sees health and social care services working together to provide better support at home and earlier treatment in the community to prevent people needing emergency care in hospital or care homes.

Our Vision: To enable the people of Castle Point and Rayleigh Rochford localities to live longer, healthier and with improved quality of life through commissioning high quality health related services sensitive to local needs, putting the patient and family at the centre of their care.

- Improved patient outcomes and Improved quality of care.
- Improved patient experience.
- Improve access to services for patients.
- Empowered patients.
- Improved Patient Safety.
- Reduced costs without compromising patient care.
- Redesigned pathways with the help of primary and secondary care clinicians to ensure appropriate patient care is available at the right time, in the right place, with the right person
- Improved information to patients to support self-care and choices including alternatives to hospital treatment.
- Sharing of good ideas and best practice with all Constituent Practices.
- Working with other CCGs to help to share risks and learn from each other.

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

NHS Castle Point and Rochford CCG (CP&R CCG) has commenced a process to undertake significant reform of the local NHS and wider care system. The objectives of these reforms are to:

- To eliminate unnecessary waste from the system to maximise reinvestment, at the same time improving the quality of services, and to improve the health and quality of life for our population. The CCG will continue to deliver on both national and regional commitments and targets.

- Lead the local health community to ensure that patient insight shapes services, ensuring the best value for the best services.
- Some of the challenges CCGs face are common across the NHS – the economic downturn, more people with long term conditions and an ageing population. As groups of GPs, the CCGs aim to engage and work collaboratively with all stakeholders in redesigning patient pathways to improve efficiency, whilst maintaining standards of care, in such areas.
- Using the Public Health Data available, and by analysing performance reports for both secondary and primary care, the CCG will prioritise programmes with the greatest opportunity to deliver benefit in meeting the goals.
- The CCG will continue to deliver efficiency savings through the successful Peer Review process as the preferred approach to referral management.
- The CCG will work collaboratively with the other emerging CCGs in South Essex on the comprehensive review and redesign of MSK including consideration of Integrated Hub model.
- The CCG will work closely with the Essex County Council and Southend CCG on the transformation of Community Services ensuring that the services commissioned ultimately meet the needs of our patents.
- Close working relationships will be forged with local district and borough councils, in delivering the Health and Wellness agenda and health services in relation to older people.
- The CCG have no significant outlying health indicators, other than CVD and cancer, which Public Health data attributes to the high elderly population. The CCGs do wish to focus on any obvious gaps in health care services evident across the member practices.
- The CCG is keen to assist all member practices in becoming more efficient and cost effective by helping them through their CQC application processes, guaranteeing that they are all fit for purpose.

2.1.1 Changes in the pattern and configuration of services over the next 5 years?

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

- We will have a single GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Clinical pathways will be designed around the needs of patients, carers and their families

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

- Primary Prevention

- Self-care / Self Management
- Managing Ambulatory-sensitive conditions
- Risk Stratification or Predictive Modelling
- Falls Prevention
- Care-Coordination
- Case Management
- Intermediate Care, reablement and rehabilitation
- Managing emergency activity, discharge planning and post-discharge support
- Medicine Management
- Mental and Physical Health Needs
- Improving Management of End of Life Care
- Delivering Integrated Care

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

2.1.2 Difference to patient and service user outcomes?

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

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

- Overall pressures on our acute hospital and health budgets will have reduced, as we shift from high-cost reactive services to lower cost preventative services, supporting greater self-management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved care at home which in turn reduces the need for high-cost nursing and care home placements.

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

- People will be empowered to direct their care and support, and to receive the care they need in their homes or other appropriate community settings.
- Over the next 2 to 5 years we will enable community healthcare and social care teams to work closely together in an increasingly integrated way, with single health and social care assessments providing for rapid and effective joint responses to identified needs, provided in and closer to home.
- Our teams will also increasingly work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring a level of health or social care support, so that we help them to remain healthy, independent and well. We will make considerable investment available to empower local people through effective care signposting, peer support, mentoring, self-management and personal healthcare budgets to maximise their independence and wellbeing.
- We will design and implement integrated Community Independence teams tasked with providing a rapid response service to support individuals in crisis and help them to remain at home. Community Independence Teams will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication.
- We will also seek to introduce individuals to the potential of assistive technologies and, where these can be employed, we will ensure individuals are familiarised and comfortable with their use.
- Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:
    - Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;
    - Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

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

- As a result of the planned changes we expect the volume of emergency activity in hospitals to reduce and we also expect planned care activity in hospitals to also reduce because we will have developed alternative community-based services.
- A managed admissions and discharge process, fully integrated into local specialist provision and Community Independence provision, will mean we will be able to eliminate delays in transfers of care, reduce pressures in our A&Es and wards, and ensure that

people are helped to regain their independence after episodes of ill health as quickly as possible.

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

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

2.2 Aims and objectives

The overarching objective for the CCG is to improve health outcomes, reduce health inequalities and develop a sustainable affordable health and social care system. These aims will be achieved by:

- proactive case management
- by stratifying the risk and needs of the patients and service users
- by responsive provision of local and regional services channelled through an effective community, social and primary care offer with a single point of access
- Integrated Care through a lead professional and using a multi-disciplinary team approach focused on early intervention and prevention

2.2.2 Aims and objectives of our integrated system

We see the implementation of the BCF as a two phased programme: phase 1 delivered in 2014/15, and; Phase 2 from April 2015.

The BCF is also a key enabler for the long term strategy that we are looking to deliver in Castle Point & Rochford which is a large scale modernisation programme that will transform the health economy landscape for the borough.

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

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

Initial focus in Phase 1 will be on:

a) developing clear synergies with ECC

b) implementing opportunities to prevent admissions to secondary care

c) focusing on primary prevention opportunities

d) Reducing Health Inequalities where they exist

e) Delivering financial economies of scale

f) Joint commissioning informed by needs identified in the JSNA and the HWBS.

2.2.3 Measuring aims and objectives

The success factors will be measuring against national agreed metrics:

- A reduction in admissions to residential and care homes
- Increased effectiveness of re-ablement
- reduced delayed transfers of care
- reduction in avoidable emergency admissions
- improved patient/service user experience.

Target reductions for these metrics will be added in appendix when complete

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

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

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

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow effective identification and management of need and outcomes across our health and care economy as a whole.

2.2.4 Measures of health gain for our population?

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

1 Subject to Information Governance constraints

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

2.3 Description of planned changes

The table sets out the key work streams our BCF programme intends to cover through our joint work programme include:

Theme	**Driver**	**Pointers**
Primary Prevention	Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system.	• supporting individuals to change behaviours such as smoking, for example, through advice during a consultation • community interventions in schools to reduce childhood obesity • regulatory actions such as controlling the density of alcohol outlets • investing in winter preparedness to reduce excess winter deaths • ensuring we get housing right to support people (especially older people) to stay in their own homes • preventing social isolation and loneliness to help to maintain independence
Self-Care	People with long-term conditions account for 70 per cent of all inpatient bed days. Self-management programmes, which aim to support patients to manage their own condition, have been shown to reduce unplanned hospital admissions for some conditions such as chronic obstructive pulmonary disease (COPD) and asthma	• tailoring interventions to the condition; for example, for conditions such as diabetes structured patient education may be beneficial, while conditions such as depression may require behavioural interventions • involving patients in co-creating a personalised self-management action plan, which could include education programmes, medicines management advice and support, telecare and telehealth for self-monitoring, psychological interventions and patient access to their own records • telephone health coaching • behavioural change programmes to encourage patient lifestyle change • as the number of people who are unpaid carers for older people is expected to rise, providing support for informal caregiving .
Managing ambulatory care-sensitive conditions	Conditions where the need for hospital admissions can be reduced through active management (known as ambulatory care-sensitive (ACS) conditions) accounted for 15.9 per cent of all emergency hospital admissions in England	• Early identification of ambulatory care-sensitive conditions, for example, through risk stratification • increased continuity of care with a GP • Early senior review in A&E, and structured discharge planning.
Risk stratification or predictive modeling	Statistical models can be used to identify or predict individuals who are at high risk of future hospital admissions in order to target care to prevent emergency admissions.	• using an 'impactability model' to identify high-risk patients who are most likely to benefit from preventive care • having catchment areas based on the distribution of high-risk patients, for example, smaller catchment areas in deprived neighbourhoods where there are likely to be more high-risk

		patients • organizing these around groups of GP practices or an equivalent • Considering the needs of the local area when developing the staff mix, for example, include a mental health professional in areas with high prevalence of mental illness.
Falls prevention	Older people who are frail are a key concern for health and social care services and are at risk of sudden functional decline including falling or becoming immobile.	• Identifying those at risk of falls • setting up fracture prevention services for older people • strength and balance training • home hazard assessment and intervention • vision assessment and referral • medication review with modification/withdrawal
Care co-ordination	Care co-ordination is a person-centred, pro-active approach to bringing health and social care services together around the needs of service users. It involves assessment of an individual's needs, development of a comprehensive care plan and a designated care co-ordinator to manage and monitor services around the individual, recognised in changes to the GP contract.	• a holistic focus that supports service users to manage their own conditions at home and become more independent and resilient rather than a purely clinical focus on treating medical conditions • a single entry point for care co-ordinators to provide personal continuity for patients and carers as well as enabling access to care through multidisciplinary teams • shared electronic health records can support the process but a 'high-touch, low-tech' approach can promote face-to-face communication, foster collaboration and enable meaningful conversations about care for patients with complex needs • co-ordinating care at the neighbourhood level 'where the benefits of engagement with local communities sit alongside the need to have close working relationships within multi-disciplinary teams dealing with manageable caseloads' • prioritising engagement with GPs and links with secondary care to ensure quality transitions, for example, from hospital to home.
Case Management	Case management exists in many different forms, but it is generally described as 'a targeted, community-based and proactive approach to care that involves case-finding, assessment, care planning and care co-ordination'	• a focus on early action and prevention, targeted at particular communities to mobilise local people • community-based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations, for example, through co-location • a single point of access, single assessment and shared clinical records • targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate, which requires access to good quality health and social care data • the individual and their case manager co-producing a personal care plan, which brings together an individual's personal circumstances (including housing, welfare and access to informal care) with their health and social care needs • systems to enable all those involved in a patient's care to access up-to-date patient records • continuity of care, including effective communication processes where all information is streamed through the case manager

		• case managers having the necessary skills for the role, as well as clear role boundaries and accountabilities.
Intermediate care, re-ablement and rehabilitation	Intermediate care services, including rehabilitation and re-ablement, have the potential to reduce length of stay by facilitating a stepped pathway out of hospital (step down) or preventing deterioration that could lead to a hospital stay (step up). Re-ablement can enable people to stay in their own homes for longer, reduce the need for home care and improve outcomes for users. Rehabilitation and re-ablement provided at home is cheaper than rehabilitation and re-ablement when it is provided as bed-based care	• shared and comprehensive assessment of needs and personalised plans, based on shared information and protocols between health and social care partners to address physical, social and psychological needs of service users • commissioning for outcomes, not time periods and tasks, for example, with lump sum payments, to ensure people move on as soon as they are ready or are able to spend longer than six weeks if necessary • workforce led by a senior clinician, with an appropriate skill-mix and with specific re-ablement training and skills that are distinct from broader home care services and focus on supporting people to do things for themselves • adequate provision for rehabilitation and re-ablement outside acute hospitals, based on demographic characteristics of the local population • spot purchasing nursing home beds or new forms of sheltered or retirement housing known as 'extra care housing' to provide rehabilitation and re-ablement and prevent hospital admission or discharge from hospital to long-term care • where a person needs ongoing support at the end of rehabilitation and re-ablement, planning care to provide those services and maintain the progress.
Managing emergency activity, discharge planning and post-discharge support	A lack of alternative options frequently leads to patients being admitted to hospital when it is not clinically justified. It is vital that there is capacity to offer rapid responses in the community that offer an alternative to a hospital stay Focusing on reducing length of stay for older people may have the most potential for reducing use and cost of hospital beds NHS and social care should work together to provide good discharge planning and post-discharge support. A structured individualised discharge plan can reduce readmissions by around 15 per cent Early supported discharge has been shown to enable people to return home earlier, remain at home in the long term and regain their independence in activities of daily living	• early discharge planning to ensure referral to community services is in place in advance of discharge • an agreed discharge process that includes timescales and protocols for assessment and decision-making for different agencies to work together • ensuring patients with existing community services are discharged as soon as possible with care re-started • use of 'discharge to assess' models to enable people to be assessed in their own homes • rehabilitation to ensure people do not become dependent or disabled in hospital • 'in reach services' from social care and community services • Supporting capacity in integrated locality teams to ensure patients are discharged to alternative supports.
Medicines management	Between one-third and one-half of medication prescribed for long-term conditions is not taken as recommended As the number of people taking multiple drugs increases, so do the challenges for clinicians in managing this.	• effective team working between patients, doctors, nurses and pharmacists avoids the risks of polypharmacy • educational information and outreach services reduce prescribing and monitor errors, for example, training in managing complex multi-morbidity and polypharmacy for general practitioners, orthogeriatricians or nurse specialists

		• use of IT and decision-making support tools • longer GP consultations for patients with multi-morbidity to allow sufficient time for the use of drugs to be reviewed • enabling patients to attend a single clinic to have their long-term conditions reviewed by a clinical team, rather than several disease-specific clinics • improved systems for transfer of patient medication details at admission and discharge • medication reviews or practice-based audits linked to peer review of prescribing practices • providing clinicians with benchmarked information on prescribing performance • use of pharmacy technicians to support general practices • taking into account patient perspectives, as some patients face challenges in managing their medications and patients may not be taking the drugs that clinicians think they are.
Mental and physical health needs	Many patients who are frequent attenders at A&E have an untreated mental health problem. Liaison services should be provided in A&E departments for patients who have a mental and physical disorder to ensure all their needs are met. Rapid Assessment Interface and Discharge (RAID), a model for liaison services which includes health and social care capacity as well as specialist skills to provide a complete mental health service in an acute trust, has been shown to reduce hospital bed use, particularly by older people	• improved identification of mental health needs among people with long-term conditions • strengthened disease management and rehabilitation by including psychological or mental health input • commissioning services based on the collaborative care models recommended by NICE (2009) to improve the interface between primary care, mental health and other professionals • expanding Improving Access to Psychological Therapies services to support people with long-term conditions • improving the mental health skills in general practice and intermediate care, with training designed specifically for primary care professionals.
Improving management of end-of-life care	Identification of people who are at the end of life and co-ordination of care can improve the quality of care, and there may be some scope for cost savings through reduction of unnecessary admissions into the acute setting	• facilitation of discharge by ensuring there is adequate capacity to provide end-of-life care outside of the hospital setting, for example, by investing in services such as Marie Curie nursing service • rapid response services being available during periods out of hospital to prevent emergency admissions to hospital at the end of life • centralised co-ordination of care provision in the community • 24/7 care outside of hospital to prevent emergency admission and facilitate discharge from hospital at the end of life.
Delivering integrated care	Integrating primary and social care has been shown to reduce admissions, and integration of primary and secondary care for disease management of patients with certain conditions has been shown to reduce unplanned admissions	• find common cause with partners and be prepared to share sovereignty • develop a shared narrative to explain why integrated care matters • develop a persuasive vision to describe what integrated care will achieve • establish a shared leadership • create time and space to develop understanding and new ways of working • identify service users and groups where the potential benefits from integrated care are greatest • build integrated care from the bottom up as well as the top down

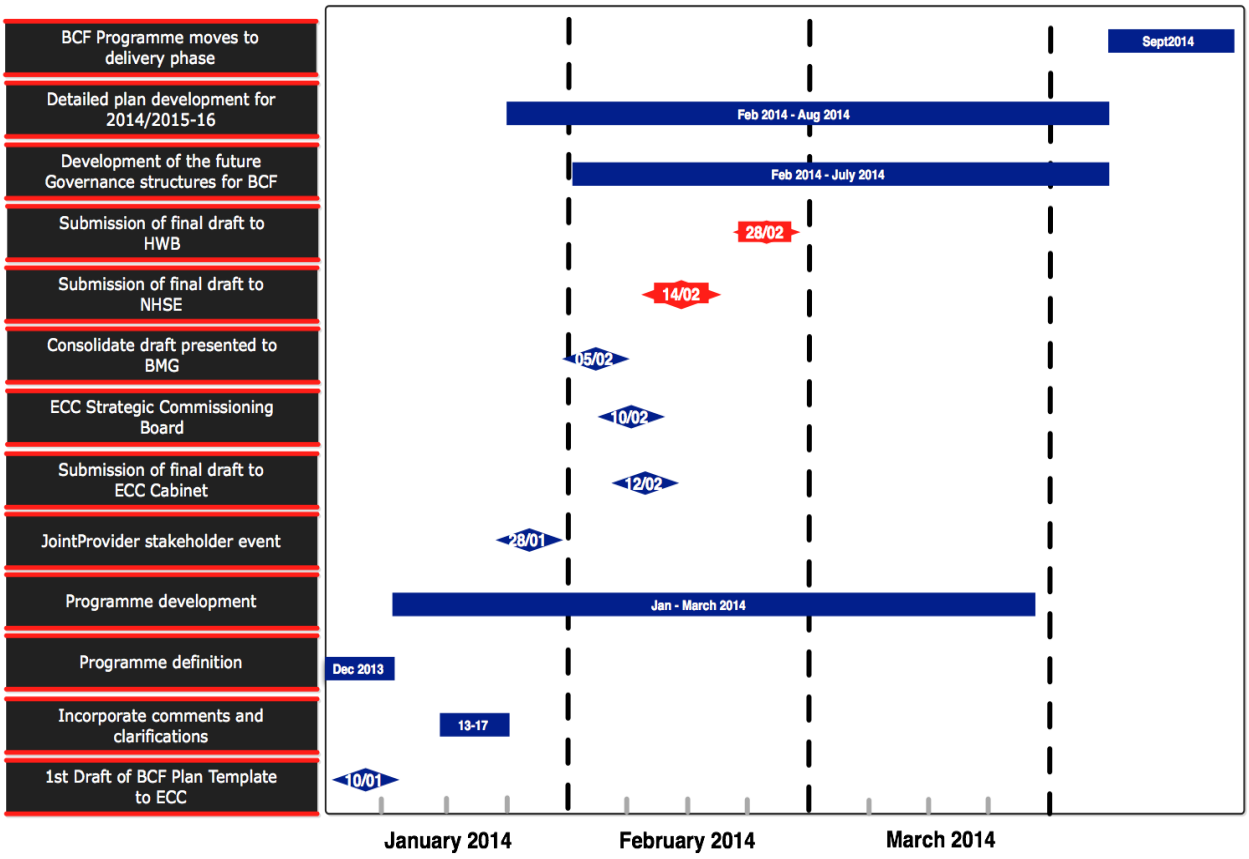
		• pool resources to enable commissioners and integrated teams to use resources flexibly • innovate in the use of commissioning, contracting and payment mechanisms and the use of the independent sector • recognise that there is no 'best way' of integrating care • support and empower users to take more control over their health and wellbeing • share information about users with the support of appropriate information governance • use the workforce effectively and be open to innovations in skill-mix and staff substitution • set specific objectives and measure and evaluate progress towards these objectives • be realistic about the costs of integrated care • act on all these lessons together as part of a coherent strategy. • Consider 'House of Care' Model

2.3.1 Processes, End Points and Timeframe

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

See Section 2.5.1 for BCF Programme Board Structure

Associated timeframes are set out in table below



Short term high level BCF programme plan

A fully detailed plan is being developed in collaboration with ECC and with Basildon and Brentwood CCG, NHSE and local district councils.

We are actively ensuring that all CCG related activity will align, including the JSNA, JHWS, our emerging CCG Strategic, CCG Operational plans and Local Authority plans for social care

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

2.4 Implications for the acute sector

Implications of the plan on the delivery of NHS services

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

Including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

2.5 Governance

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

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

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

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

The diagram below describes the current Governance structure that we have developed to manage Phase 1.

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

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

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

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

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

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

2.5.1 BCF Programme structure

The development and delivery of the BCF programme is expected to be complex and challenging, in particular, the communications, engagement and governance elements of the programme. Therefore based on this we have adopted a working group and task and finish group approach to programme management. The following diagram describes the main standing groups that will sit during the development and early stages of delivery. These will be complimented, when and where necessary by task and finish groups which will be convened for a time limited task specific period.

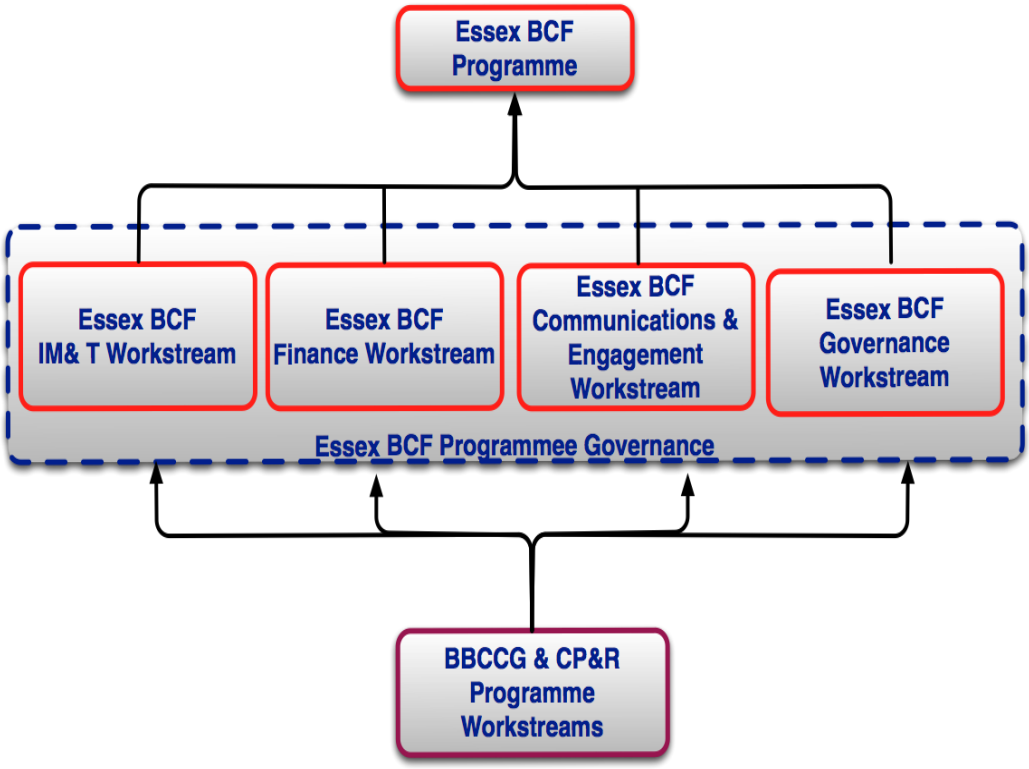


Fig x- BCF Programme Structure

2.5.2 Financial Implications

We see the implementation of the BCF as a phased programme with 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We

are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure to provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

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

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for 2014/15 will be considerably different and smaller scale than those transferring in 2015/16.

2.5.2 2014/15 CP&R CCG Investment

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

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 (£000's)	Minimum contribution (15/16) (£000's)	Actual contribution (15/16) (£000's)
Essex County Council		£4,932	£8,009	£8,009
NE Essex CCG		£0	£20,987	£20,987
Mid Essex CCG		£0	£21,651	£21,651
West Essex CCG		£0	£17,435	£18,980
Basildon & Brentwood CCG		£0	£16,041	£18,444
Castlepoint & Rochford CCG		£0	£10,833	£11,166
BCF Total		**£4,932**	**£94,956**	**£99,237**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

2015/16

As we have established the size of the BCF will grow from 2014/15's allocation of **£3.422M**, which is mainly constructed from similar S256 amounts from 2013/14, to approximately **£11.166M** for 2015/16. Whilst we still have work to do and challenging conversations to have the table overleaf describes and sets out our ambition for 2015/16.

3. National Conditions

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

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

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

3.1 Protecting social care services

The objective of integration is to develop a more effective, efficient and affordable health and social care economy. Integral to this will be the continued development and enhancement of social care services. Our stated ambition is to move more activity out of an acute setting and into a community based setting; this will require a stable and accessible social care system in order to make the changes sustainable. If we move the activity out of acute settings remove the capacity and then find we are unable to sustain it the change we will find ourselves in a uncomfortable situation.

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

3.2 7 day services to support discharge

ECC already operate a six day discharge support service and in line with national guidance CP&R CCG is working with ECC and our providers to deliver a seven day access to health services programme. This work is being undertaken: Locally, Across multiple providers and regionally across the County. The programme includes: Radiology, Consultant cover, PAU, GP Admission avoidance, Pharmacy, Social care discharge, Reablement, Step down, Rapid response via an out of hours emergency duty team, Care homes to ensure they are able to accept 7 day planned admissions, Community services medical input provisions.

CP&R CCG has implemented a collaborative working arrangement with key providers across the borough, to develop the necessary support and infrastructure that will facilitate a sustainable response to the requirements for 7 day working in the NHS. ECC are running a pilot programme that has extended their 6 day supported discharge team's working window to 7 days. An evaluation of the success and outcomes of this will be carried out at the end of the financial year.

3.3 Data sharing

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

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

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

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

The use of the NHS number is to a large extent governed by the rules around Information Governance and until some of these issues are resolved we cannot put a firm date against this item.

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

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

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

Traditional business partnerships, joint ventures and integrated working arrangements can be time-consuming and expensive to create and maintain. In comparison, the open API model is "designed for nearly effortless, asymmetric scale", where almost all the work needed within the partnership is reduced in terms of Human resource requirements.

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

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

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

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

3.4 Joint assessment and accountable lead professional

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

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

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

This being said there will be some patients and some situations that would benefit from a different configuration e.g. A Multi-Disciplinary Team approach that may in fact be led by a Community Geriatrician. CP&R CCG is in the process of designing and trialling this and other models of care in the community.

For example: Development of the Lead Professional model for Care Co-ordination:

3 categories will be developed to define the level of health and social care expected to be available to each individual 75 years and older:

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

In order to implement this model it will be necessary to develop effective a risk stratification tool that will allow professionals across the health and social care system to apply a common approach to identifying individuals that fit within the ‘moderate complexity’ and ‘significant complexity’ categories:

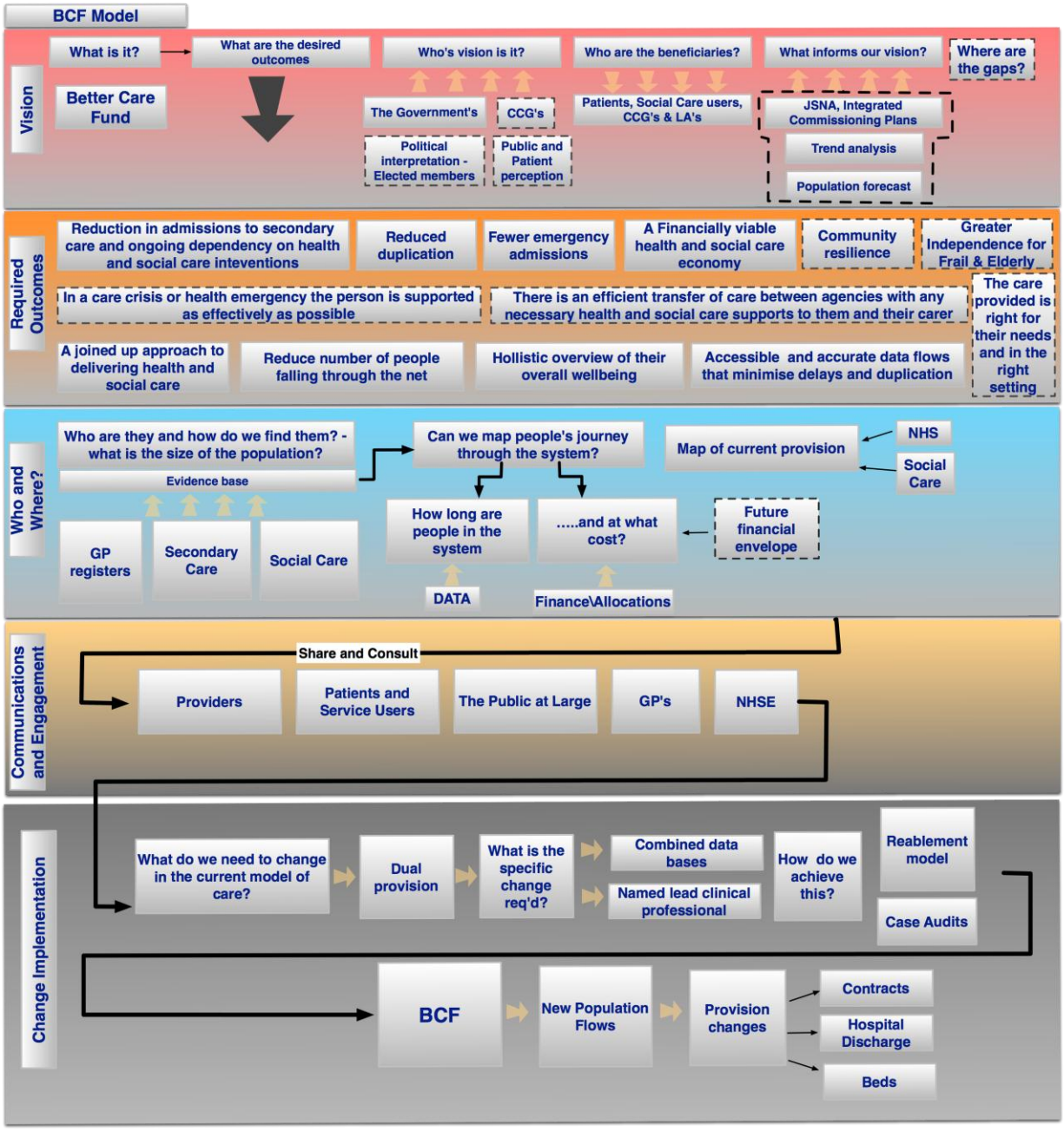
4. RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

The BCF will create risks as well as opportunities. The BCF pooled budget is not new or additional money. For CPR CCG finding money for BCF will involve redeploying funds from existing NHS services. Guidance makes clear that the BCF will entail a substantial shift of activity and resource from hospitals to the community – 'hospital emergency activity will have to reduce by 15%' (NHS England 2013). This could place additional financial pressures on providers already facing the quandary of how to maintain and improve quality of care while achieving financial balance. In addition, the Better Care Fund does not address the financial pressures faced by local authorities and CCGs in 2015 which 'remain very challenging' See ***Appendix 2*** for more detail on proposed risks and mitigating actions.

It is clear that although CCGs will lead local discussions about how the BCF is used, the engagement of providers in discussions is vital. Decisions will affect providers' existing activity and funding and the risks arising from this need to be assessed and managed; providers also have indispensable knowledge and capability to deliver innovative solutions. The most effective local plans will be those that arise from collaboration across the whole system of health, care and support, engaging all NHS and local authority partners, including acute and community health care organisations.

(I) Appendix 1


BCF Model
Vision
What is it?
What are the desired outcomes
Who's vision is it?
Who are the beneficiaries?
What informs our vision?
Where are the gaps?
Better Care Fund
The Government's
CCG's
Political interpretation - Elected members
Public and Patient perception
Patients, Social Care users, CCG's & LA's
JSNA, Integrated Commissioning Plans
Trend analysis
Population forecast
Required Outcomes
Reduction in admissions to secondary care and ongoing dependency on health and social care inteventions
Reduced duplication
Fewer emergency admissions
A Financially viable health and social care economy
Community resilience
Greater Independence for Frail & Elderly
In a care crisis or health emergency the person is supported as effectively as possible
There is an efficient transfer of care between agencies with any necessary health and social care supports to them and their carer
The care provided is right for their needs and in the right setting
A joined up approach to delivering health and social care
Reduce number of people falling through the net
Hollistic overview of their overall wellbeing
Accessible and accurate data flows that minimise delays and duplication
Who and Where?
Who are they and how do we find them? - what is the size of the population?
Evidence base
GP registers
Secondary Care
Social Care
Can we map people's journey through the system?
How long are people in the system
.....and at what cost?
DATA
Finance\Allocations
Map of current provision
NHS
Social Care
Future financial envelope
Communications and Engagement
Share and Consult
Providers
Patients and Service Users
The Public at Large
GP's
NHSE
Change Implementation
What do we need to change in the current model of care?
Dual provision
What is the specific change req'd?
Combined data bases
Named lead clinical professional
How do we achieve this?
Reablement model
Case Audits
BCF
New Population Flows
Provision changes
Contracts
Hospital Discharge
Beds

Appendix 2 Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers. This is far too long and needs condensing in a few key risks

In a Health and Wellbeing region that consists of five CCGs and five Acute Hospitals there is a risk that a system failure in one organisation affects the overall performance measures of the HWB Board region which results in the underperformance of the BCF against the metrics which subsequently results in the non eligibility to receive the health premium	High	ECC Integration Directors and CCG leads are working together to ensure that the programmes nominated for inclusion in the BCF have SMART targets and that providers are appropriately performance managed to ensure that they are sustainable. The BCF metrics will be disaggregated to CCG level to ensure that individual CCG's are not measured in a detrimental way.
Factors outside the control of CCGs and the local authority have an adverse effect on Urgent and Acute care services (i.e. Flu epidemic etc.)	Medium	CCGs will continue to monitor all significant changes to demand for Urgent and Acute services. ECC, CCG's and Providers will maintain and update ads necessary their emergency response plans and business continuity plans and by carrying out regular joint exercises will ensure that they are able to respond appropriately.
There is a risk that if there is any lack of clarity of system cost and investment coming from the centre it may inhibit accurate reporting and progress	High	Develop positive and transparent relationships with NHSE to ensure that lines of communication and challenge are maintained and where necessary escalation processes are in place that help to minimise the risk
The pace of change required does not allow safe commissioning of high quality appropriate services	High	Ensure that we deploy the necessary resources with the right skills and competencies to ensure that we continue to commission legally and within the required timescales, costs and quality standards
There is a risk that the lack of robust and appropriate Governance processes delay the integration of services resulting in poor and slow decision-making across the system	High	We will implement locally approved governance structures across Essex at the earliest opportunity – by September 2014 at the latest
There is a risk that if we implement New models of care we could destabilise existing providers		Through a process of communication and engagement with providers and by making sure that we plan the implementation carefully and collaboratively – moving activity before we execute capacity reductions we will deliver stable and sustainable change

There is a risk that new and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity	Medium	As with the previous risk mitigation plan we will deliver phased and planned capacity movement
Financial –There is a risk that failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing financial pressure as an ageing population increases demand		At the outset of the programme, being clear on: • Clear and achievable Financial objectives • Well planned phased service model changes to deliver greater efficiency
Clinical and quality – there is a risk that the planned changes do not improve quality but worsen it, resulting in a poorer outcomes and patient experience		Service model changes will be designed and reviewed throughout the programme process , with contract mechanisms and measures established to evaluate all proposed changes, and where appropriate pilots will be run and evaluated
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits		The programme will be properly planned, with agreed timescales, dependencies. Progress will be reviewed through the programme management process, including Exception reporting, Highlight reports and Project status reports, contingencies will be developed where necessary
Commitment and engagement – failure of the local health and social care community to remain committed to the programme and its objectives		The governance structure formalises senior level commitment to the programme; throughout the programme on-going support will be reviewed and expanded as necessary
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining contracts and the evaluation of results		We will design and implement a thorough intelligence process to put in place processes, checks and balances that will help us to capture and analyse our patient cohorts in a way the minimises potential gaps in our knowledge.