Essex County Council

AGENDA ITEM 5B

Report to Health & Wellbeing Board	**HWB/10/14**
Date of meeting 27th March 2014	**County Divisions affected by the decision** *All Divisions*
Title of report: Better Care Fund	
Report by Dave Hill – ECC Director for People Commissioning	
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1. Purpose of report

1.1. To seek the Health and Wellbeing Board's (HWB) agreement to submit the attached Better Care Fund (BCF) templates to NHS England as required under NHS Planning Guidance by 4th April 2014.

2. Recommendations

2.1. Endorse the BCF (attached as appendices 2 & 3) for submission to NHS England by 4 April 2014.

2.2. Endorse the proposal contained within the BCF templates that ECC will hold the pooled budget

3. Background and proposal

3.1. The Government's intention is for NHS and local government services to become fully integrated. This was set out in ***Integrated Care and Support; Our Shared Commitment*** and recent guidance (December 2013 and February 2014) on the BCF, formerly Integration Transformation Fund. The shared commitment requires HWB areas to achieve integration within 5 years.

3.2. The BCF is intended by the government to help take forward health and social care integration at scale and pace, and to act as a catalyst for change. It should support better care for vulnerable people through greater integration of services and expansion of care in community settings. The BCF from 2015/16 is to be a single pooled budget for health and social care services to work closely together in local areas, based on a plan agreed between NHS organisations and local authorities. The BCF is a pooled fund consisting of NHS and local authority resources "already committed to existing core activity". NHS England has commissioned the development of a simplified control statement for use by both local government s151 officers and CCGs but this has not yet been received. Locally a finance officer technical sub group of the HWB BMG has been established to provide advice on the s75 arrangements including determining the hosting of the pool. The recommendation of this Technical Group is that ECC host the pooled fund. The BCF submission has a requirement to identify who will host the pool from 2015/16; there is a HWB BMG work programme to ensure implementation of the arrangements by 1 April 2015.

3.3. **Requirements**

3.3.1. HWBs need to agree 2 year BCF plans by 4th April 2014. In considering the BCF plans the HWB is required to consider whether "they are sufficiently challenging and will deliver tangible benefits to the local population (linked to the Joint Strategic Needs Assessment and Health and Wellbeing Strategy)"[1]

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3.3.2. The BCF plan is required to identify which organisation will hold the pooled fund. It has been agreed, in principle, to establish a pooled Better Care Fund from 1st April 2015 under section 75 of the National Health Service Act 2006 and for Essex County Council to host on behalf of all partners.

3.3.3. The plans are required to meet 6 national conditions:

- Jointly agreed plans
- Protection for social care services
- 7 days services (discharge and avoidance of unnecessary weekend admissions)
- Data sharing (based on NHS number)
- Joint assessments and care planning with accountable named professional
- Agreement on consequential impact of changes on the acute sector.

3.3.4. The table below sets out the BCF allocations for 2014/15 both nationally and for Essex HWB. It also demonstrates the value of the 2015/16 pool that is subject to achievement of performance.

[1] Annex to the NHS Planning Guidance, December 2013

Better Care Fund

	2014/15		2015/16 - Minimum		2015/16
	National	Essex HWB	National	Essex HWB	Actual Contribution
	£000's	£000's	£000's	£000's	£000's
NHS Transfer to Social Care (£859m 13/14)	900,000	22,199	900,000		
Better Care Fund allocation (14/15)	200,000	4,932	200,000		
DH & other Government Department					
Transfers (Capital Grants)			134,000	3,296	3,296
Disabled Facilities Grant			220,000	4,713	4,713
- reablement funding			300,000		
- carers' break funding			130,000		
- core CCG funding			1,916,000	86,947	91,228
Total	**1,100,000**	**4,932**	**3,800,000**	**94,956**	**99,237**
Total BCF revenue funding potentially subject to pay for performance measures				**25,129**	**25,129**

Notes re pay for performance:

1. 50% pay for performance will be paid April 2015 based on achievement of the following metrics:
   - delayed transfers for care from hospital per 100,000 population
   - avoidable emergency admissions
   - local metric (Essex=coverage of reablement)

   plus 4 of the national conditions:
   - protection for adult social care services
   - providing 7 day services to support patients being discharges/prevent unnecessary admissions
   -agreement on impact on acute sector
   - ensuring there is an accountable lead professional for integrated packages
2. 50% paid in October 2015 against all national and local metrics
3. Pay for performance monies only relate to the **minimum** contribution into the BCF

3.3.5. The BCF plans are part of the wider NHS planning framework which includes

- 2 year operational plans which are also due to be submitted in final form by 4th April 2014 following HWB endorsement (a separate item on this agenda), and
- 5 year strategic plans to be submitted in draft by 4th April 2014 and in final form by 20th June 2014.

CCGs are required to involve ECC in the development of both sets of plans.

3.3.6. The BCF submission involves the completion of a template covering the HWB area. There is a narrative section covering vision, aims and objectives and sections showing how Essex has met the BCF requirements including provider and service user engagement; fulfilment of the national conditions set out above; planned changes to services covering the BCF schemes; implications for the acute sector of these changes; governance and risks. The rest of the submission covers metrics: baselines and targets proposed against the required and local agreed measures; and details of BCF investment with expected financial benefits.

3.3.7. The BCF Plan is necessarily high level. Each CCG has therefore produced its own plan for BCF. These have informed the Essex submission and set out details of how each CCG has developed its plans locally with providers and

service users, the schemes in which investment is planned and the benefits these will deliver.

3.4. Essex BCF template

3.4.1. The final versions of the BCF template Part 1 and Part 2 are attached for the HWB to endorse for submission to NHS England. Progress in completing the template has been driven and monitored by the Business Management Group (BMG) of the HWB. It was agreed that the broad headings for schemes that should be included in Essex's BCF were:

Protection of Social Care Services with a health benefit
The local authority and NHS commissioners will work together to bring sustainability to the health and social care system.

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Community Health services including admission avoidance
Development of new provider models between community health, community care and primary care providers.

Reablement
Over the two years of the BCF we intend to;

- Continue to fund reablement and intermediate care services
- Expand reablement and intermediate care capacity in each CCG area to meet demand and increase community-led referrals.
- Vary existing social care reablement arrangements during the current contract to commence integrated health and social care reablement in each CCG area during 2014/15.

Joint Nursing and Care Home commissioning (Including Continuing Health Care)
We will review commissioning for Nursing and Residential Care Commissioning in each CCG area with a view to shifting the pattern of care towards a reablement model of service, which seeks to improve independence and functioning and which minimises inappropriate admission to service.

Discharge support
Essex Social Care Services and Acute Hospital providers in Essex will continue to work together and with Community Health providers to ensure effective discharge support. We will use our investment in reablement to promote ward led discharge, development of rapid response services and to ensure assessment is taking place at the appropriate time in the appropriate environment.

Acute Mental Health and Dementia
Mental health is a key priority with rising demand for mental health services.

We are seeking to implement the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services.

Primary Care (Including the requirement for GPs to be accountable for improving quality of care in older people)
We expect Primary Care to form the basis of care coordination for Health and Social Care services.
We will establish Multi-Disciplinary Teams where GPs will be at the centre of organising and coordinating people's care alongside social care and other health professionals and the service users themselves.

Investment to meet requirements of the Care Bill
We will work together as a system to define the requirements of the Care Bill using a joint programme management approach during 2014/15 to prepare for the changes required in 2015/16.

Early intervention and prevention
We aim to identify needs early and intervene to prevent escalation of problems and crises.

Community resilience:
We want to strengthen and mobilise communities to take on a greater role in caring for vulnerable people.

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

Disabled Facilities Grant (DFG)
The DFG is included in the capital element of the fund which comes into play in 2015/16. While no changes are planned immediately, BCF provides an opportunity to explore a holistic approach to improve the process from Occupational Therapist assessment through to DFG in the medium term.

The Plan includes details of how Essex complies with national conditions or sets out how we will ensure that we can do so before the commencement of the BCF in April 2015.

3.5. The Essex Better Care Fund Plan has been written taking account of feedback from service providers and consultation with patients / service users following a series of engagement events. This has included:

- Essex Health and Social Care Integration Accelerated Design Event in June 2013 involving ECC, the CCGs, providers and voluntary sector organisations.
- The consultation undertaken by the ‘Who Will Care?’ commission in 2013

- CCG provider engagement events throughout December 2013 and January 2014
- NEECCG Big Care Debates held throughout December 2013 and January 2014 involving patients and service users.
- CCG public engagement events under the “Call to Action” in December 2013

The draft BCF Plan has been revised following feedback from HWB in February and following the dual assurance process governed by NHSE through the Local Area Team and by the Local Government Association (LGA). The feedback Essex received through the assurance process was largely positive. The Essex submission was rated “green” in 20 of the 27 sections assessed, “amber” in 4 and “red” in the remaining 3.

The 7 areas of the BCF plan that needed improvement have been revised to address the points raised. The most significant of these relate to:

- the implications of BCF plans for the acute sector
- the scale of ambition for the BCF targets on reduction of emergency admissions and the effectiveness of reablement.

We believe that further work is needed to model the impact of BCF schemes on the Essex population and health and wellbeing system. This will enable us to estimate and describe with more confidence the likely impact of BCF plans and the scale of ambition we can aim to achieve from 2015. This work is now being scoped and timescales for delivery are set out in the BCF submission. The Plan also includes actions and timescales to agree the most appropriate and effective governance for the BCF. We will report back to the HWB on the progress of this work and its implications for our BCF plans.

The inclusion of action plans to address outstanding issues is in line with the latest BCF guidance from NHS England issued on 24th February 2014. This states that further refinement and development of the BCF may take place after 4th April 2014 submission.

3.6. **Conclusions**

Having revised the BCF draft plan and taken account of feedback from NHS England (Local Area Team and local government peers) through the assurance process, we recommend this is now endorsed by HWB. In doing so we recognise that there are aspects of our BCF plans which, in common with other areas, require further work and refinement. In these instances action plans with clear timescales have been included in the template. There will be further reporting to HWB on progress in implementing these plans and preparation for the pooled fund in 2015/16.

4. Policy context

4.1. The plans and BCF submission are aligned with the Joint Health and Wellbeing strategy. The Health and Wellbeing Vision for Essex is “By 2018 residents and local communities in Essex 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. Every child and adult will be given more opportunities to enjoy better health and wellbeing.” The priorities for achieving this vision are:

- Starting and developing well: ensuring every child in Essex has the best start in life.
- Living and working well: ensuring that residents make better lifestyle choices and residents have the opportunities needed to enjoy a healthy life.
- Ageing well: ensuring that older people remain as independent for as long as possible.

The BCF plan supports the achievement of these priorities through schemes that support individuals to be more independent, for as long as possible, and by supporting timely discharge from hospitals with appropriate care and support packages.

4.2. The plans and BCF submission also have direct relevance to the whole system leadership role of the Board and the challenge of integrating health and social care commissioning.

4.3. Revised arrangements for community health and community care will form a core part of the implementation of revised assessment and case management arrangements for people entitled to a service from social care services. In particular the implementation of the Care Bill will entail the development of a ‘Care Coordinator’ role across health and social care organisations dealing with community care. This may require additional resources during a period of transition whilst integrated approaches are developed.

4.4. Nationally £185m (£50m capital and £135m revenue) has been made available in the 2015/16 BCF to invest in the development of capacity to manage information between organisations including case management systems and the development of mechanism to give access to virtual or actual patient records between organisations. This funding also covers the requirements for better information and advice, advocacy and safeguarding and other Care Bill duties. For ECC the national funding translates to £1.1m capital and £3.3m revenue.

5. Financial Implications

5.1. The BCF was announced in June 2013 providing an opportunity to transform local services so that people are provided with better integrated care and

support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The fund provides for £3.8bn of funding in 2015/16 to be spent locally on health and care to drive closer integration, to improve outcomes for patients, service users and carers.

In 2015/16 the fund will be created from:

- £1.9bn of NHS funding,
- £354m of capital funding (including £220m DFG, currently allocated to second tier authorities)
- £1.1bn existing transfer from Health to Adult Social Care,
- £300m CCG Reablement funding
- £130m Carers' break funding.

5.2. Detailed guidance in respect of the BCF was issued on 19 December 2013 alongside the CCG allocations for 2014/15 and 2015/16.

5.3. In 2014/15 an additional £200m will be added to the nationally available funding for transfer from Health to Adult Social Care. This additional funding is to enable localities to prepare for the BCF in 2015/16 (for ECC this totals £4.932m and will be transferred via a s256 agreement from NHS England Local Area Team). There are no extra conditions attached to this money but it will only be paid when local authorities have jointly agreed and signed off two-year plans for the BCF. It must be used to make early progress against the national conditions and performance measures set out in the locally agreed plan in order to secure the performance element of the 2015/16 BCF.

5.4. In 2015/16 the BCF will be a pooled budget under s75 joint governance arrangements between CCGs and ECC. NHS England has commissioned the development of a simplified control statement for use by both local government s151 officers and CCGs but this has not yet been received. Locally a finance officer technical sub group of the BMG was established to provide advice on the s75 arrangements including determining the holding of the pool, taking into account factors such as tax advantages/disadvantages of the local authority or a CCG. The technical group's recommendation that ECC be the pooled fund host was agreed by the BMG on 5th March and is included in the BCF final submission.

5.5. The guidance highlights some areas within the BCF national allocation against which there should be clear plans to ensure no deterioration of existing services (Essex figures in brackets).

- £130m NHS funding for Carers' breaks (£3.267m).
- £300m NHS funding for Reablement services (£7.539m).
- The DFG has been included to ensure that the provision of adaptations/equipment to properties can be incorporated into strategic plans. But the statutory duty to provide DFG to those who qualify for it remains with local housing authorities, and funding will have to be allocated from the BCF to the district councils to enable them to continue to meet their statutory duty.

There will be other conditions around the DFG, including timely payment, spending the grant within the year and minimum allocation levels (£4.713m).

- £50m of the capital and £135m revenue funding has been earmarked for a range of new duties coming in from April 2015 as a result of the Care Bill, including ensuring an appropriate IT system is in place £4.398m.

5.6. From 2015/16 an annual financial benefit of £1m has been identified from functions that transfer into the BCF.

5.7. Further work will be undertaken to identify the level of financial benefit. As part of this work the financial risks and contingency arrangements will be finalised.

5.8. Three of the CCG's have identified financial contingency values if there is a failure to deliver the financial benefits associated with the BCF. Two of these values relate to a QIPP saving which sits outside the BCF and therefore any failure to deliver would need to be addressed by that specific CCG. The other is an element of the benefit relating to a scheme within the BCF, should this failure to deliver the identified benefit the consequence would be that element of the total benefit would not be available for re investment in the pool.

5.9. The risk of 'penalties' for failure to deliver on BCF targets in 2015/16 has been removed. It has not yet been decided whether to hold cash back based on performance from 2016-17 and beyond.

6. Legal Implications

6.1. The BCF represents additional central government funding. For 2015/16 the conditions of entitlement for funding require the Council and clinical commissioning groups to establish partnership arrangements including a pooled fund under section 75 of the National Health Service Act 2006. This fund is to be spent jointly by the Council and clinical commissioning groups in accordance with the agreed partnership arrangement. Such arrangements can only be established by negotiation and agreement, and agreement in this case is likely to be reached. It will be necessary to have a formal legal agreement which sets out the purposes of the fund and how it will be governed and administered. Approval of theS.75 agreement will need to be considered in accordance with the decision making processes of the Council and each clinical commissioning group.

6.2. NHS England view the HWB as having a crucial role in ensuring that the BCF is set up in the best way possible to meet local needs. Although the decision recommended in this report relates only to a proposal which is draft and, to some extent, incomplete, it is clear that this endorsement is also regarded by NHS England as key. The Board will be invited to endorse the final proposals in March 2014.

6.3. Some of the funding is conditional upon performance measures being attained and the parties need to assess the prospects of receiving this money and ensure

that there are arrangements in place for performance monitoring and the management of risk.

7. Staffing and other resource implications

7.1. Any staffing and resource implications for CCGs will be addressed in their operational plans.

7.2. The staffing implications for ECC will be assessed during the design and development of individual BCF schemes. It is expected that, in order to meet the BCF National Condition of 7 day working, assessment staff working arrangements may need to be modified.

8. Equality and Diversity implications

8.1. There are no equality and diversity implications relating to the BCF template and plans.

8.2. Appropriate assessments will be carried out as and when schemes and services are set up to deploy the BCF funding.

Attached papers

Appendices:

- ✓ Appendix 1 - BCF High Level Action Plan
- ✓ Appendix 2 - Better Care Fund Part 1 Template
- ✓ Appendix 3 – Better Care Fund Part 2 Template

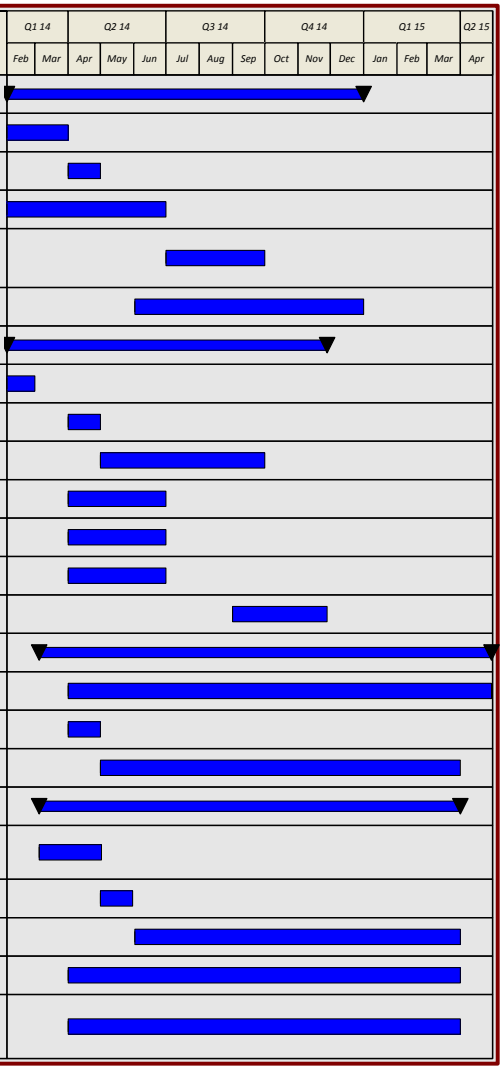
Other Supporting Documents:

- ✓ Outcomes and Metrics - CCG Details
- ✓ NEECCG BCF Template – Part 1
- ✓ NEECCG BCF Template Part 2
- ✓ WECCG BCF Template – Part 1
- ✓ WECCG BCF Template Part 2
- ✓ MECCG BCF Template – Part 1
- ✓ MECCG BCF Template Part 2
- ✓ BBCCG BCF Template – Part 1
- ✓ BBCCG BCF Template Part 2
- ✓ CP&RCCG BCF Template – Part 1
- ✓ CP&RCCG BCF Template Part 2
- ✓ Health and Social Care Integration (Accelerated Design Event)
- ✓ The Seven Day Services Improvement Programme
- ✓ “Who Will Care” Report

Appendix 1- BCF High Level Action Plan

High Level Action Plan to Support Essex BCF Planning Activity

ID	Task Name	Start	Finish	Duration
1	**Impact on Acute Sector**	**03/02/2014**	**31/12/2014**	**238d**
2	Complete Acute Contract Negotiations	03/02/2014	31/03/2014	41d
3	Identification of functions that impact on Acute Sector	01/04/2014	30/04/2014	22d
4	Modelling of BCF Functions to Acute Activity	03/02/2014	30/06/2014	106d
5	Define Contingency Plans based on outcomes of Acute Sector Modelling / BCF Schemes	01/07/2014	30/09/2014	66d
6	Evaluation of 2013/14 s256 Demand Management Schemes	02/06/2014	31/12/2014	153d
7	**Governance and Pooled Budgets**	**03/02/2014**	**27/11/2014**	**214d**
8	Creation of Governance & Pooled Budgets Task & Finish Group	03/02/2014	28/02/2014	20d
9	Scoping of Partnership Agreements and Functions to be Delegated	01/04/2014	30/04/2014	22d
10	Financial Arrangements and Legal Protocols	01/05/2014	30/09/2014	109d
11	Agree and set up quarterly BCF Monitoring arrangements	01/04/2014	30/06/2014	65d
12	Agree and set up HWB Programme Board twice yearly BCF review	01/04/2014	30/06/2014	65d
13	Review TORs of existing HWB to take account of Programme Board role	01/04/2014	30/06/2014	65d
14	Review TORs of HWB following proposed legislation changes	01/09/2014	27/11/2014	64d
15	**Service User and Provider Engagement**	**05/03/2014**	**29/04/2015**	**301d**
16	Further CCG led engagement throughout 2014/15	01/04/2014	29/04/2015	282d
17	ECC Community Resliience Engagement Event	01/04/2014	30/04/2014	22d
18	Further ECC engagement Events	01/05/2014	31/03/2015	239d
19	**Healthwatch Engagement**	**05/03/2014**	**31/03/2015**	**280d**
20	Agree scope of Essex Healthwatch in future Engagement with Service Users	05/03/2014	01/05/2014	42d
21	Develop Service User Engagement Plan	01/05/2014	30/05/2014	22d
22	BCF Focussed Engagement	02/06/2014	31/03/2015	217d
23	Healthwatch Hospital Discharge research	01/04/2014	31/03/2015	261d
24	Healthwatch Carers Experience Research	01/04/2014	31/03/2015	261d



High Level Action Plan to Support Essex BCF Planning Activity

ID	Task Name	Start	Finish	Duration
1	**BCF National Conditions**	**03/02/2014**	**31/03/2015**	**302d**
2	Define scope for Task & Finish Group for County Wide approach to National Conditions	05/03/2014	01/04/2014	20d
3	Agree resources for Task & Finish Group	05/03/2014	01/04/2014	20d
4	**7 Day Working**	**01/04/2014**	**31/03/2015**	**261d**
5	Identify functions and services that will be affected	01/04/2014	30/06/2014	65d
6	Negotiate contract variations where required	01/07/2014	30/09/2014	66d
7	Create Project Teams in each Service Affected	02/06/2014	31/07/2014	44d
8	Create Action Plan to Implement 7 Day Working	01/07/2014	30/09/2014	66d
9	Identify skill gaps / training requirements	01/10/2014	30/01/2015	88d
10	Create communications plan	01/05/2014	30/06/2014	43d
11	Employee and Trade Union Consultations	01/08/2014	31/03/2015	173d
12	**Data Sharing / IG / NHS Number**	**03/02/2014**	**31/03/2015**	**302d**
13	County Wide Task and Finish Group Created	07/02/2014	07/02/2014	0d
14	Information Sharing Protocol Launch Date	27/03/2014	27/03/2014	0d
15	Create County wide Project Teams as required	10/02/2014	29/08/2014	145d
16	Create High Level IS Plan	03/02/2014	31/03/2014	41d
17	Create Detailed Action Plan for Data Sharing National Conditions	01/04/2014	30/06/2014	65d
18	IS Implementation	01/09/2014	31/03/2015	152d
19	**Disabled Facilities Grant**	**05/03/2014**	**31/03/2015**	**280d**
20	Agree County wide Task & Finish group to develop enhanced DFG services(including tier 2 councils)	05/03/2014	30/04/2014	41d
21	Define Scope for Task and Finish group for DFG	01/04/2014	30/05/2014	44d
22	Develop DFG proposals	02/06/2014	31/03/2015	217d
23				

Appendix 2 Better Case Fund Part 1 Template

Essex - Better Care Fund planning template – Part 1

CONTEXT

Essex Health and Wellbeing Board is committed to ensuring the people of Essex experience high quality and consistent health and care outcomes. We aim to commission and deliver integrated care that is person centred, closer to home and leaves people in-control. We want residents and local communities to have greater choice, control and responsibility for health and wellbeing services. As far as possible we seek to prevent problems occurring and to intervene before these escalate, or become entrenched. To help achieve this aim we are committed to developing more effective community based services and helping communities to play a greater role in supporting those with health and care needs.

The Essex Health and Wellbeing Board covers an area with a population of 1.41 million. Essex has a two tier local authority system with ECC responsible for social care services and five CCGs for the health economy.

The Clinical Commissioning Groups are:

- North East Essex CCG (NEECCG) covering the second tier local authorities of Colchester and Tendring;
- Mid Essex CCG (MECCG) covering the local authorities of Chelmsford, Maldon and Braintree;
- West Essex CCG (WECCG) covering the local authority areas of Harlow, Epping Forrest and Uttlesford;
- Basildon & Brentwood CCG (BBCCG) covering the local authorities of Basildon and Brentwood; and
- Castle Point & Rochford CCG (CP&R CCG) covering the local authority areas of Castle Point and Rochford.

The second tier local authorities are responsible for Housing in their areas and also for discharging the legal responsibilities relating to the Disabled Facilities Grant (DFG).

The county is serviced by five acute hospitals, these are:

- Colchester University Foundation Trust Hospital (CHUFT);
- Mid Essex Hospital Services NHS Trust, Chelmsford;
- The Princess Alexander Hospital NHS Trust, Harlow;
- Basildon and Thurrock University Hospital NHS Trust, Basildon (BTUH); and
- Southend University Hospital NHS Trust, Southend (SUHFT).

BTUH is located in the BBCCG area and serves both BBCCG and Thurrock CCG (TCCG). SUHFT is located in the Southend CCG (SCCG) area and services both SCCG and CP&R CCG.

Our plans have been made in a challenging financial climate. Funding received from central government for both social care and health will continue to reduce in real terms as demand for services increases due to population growth and demographic change.

Health and Adult Social Care services in Essex collectively spend around £2.5bn each year. Essex County Council's net revenue budget for 2014/15 is £931.8m, of which £378.0m is spent on Adult Social Care (41%). With pressure from an increasing population amounting to £13.4m and inflation of £11.2m in 2014/15 there is a need to maximise savings through joining up services with health partners and through working closely with the care providers to develop services which focus on early intervention, enablement (to ensure vulnerable adults can maintain their independence for as long as possible in the community) and rehabilitation to reduce the need for long term care. Over the next three years £73.2m of savings are currently planned to be delivered across Adult Social Care to mitigate demand and inflation pressures; this will necessitate working very differently[2]. The five CCG's under the Essex Health & Wellbeing Board have a combined budget of £1,631.0m for 2014/15[3], but in order to make the budget balance have to make savings in the region of £84.0m[4] (5%) next year.

We recognise that the only way to ensure financial sustainability within the Essex care system is for health and social care to work together in a more integrated way.

[2] ECC Budget Book 2014/15
[3] Source: NHSE Total CCG Programme Budget Allocations 2014/15.
[4] Health and Social Care Integration Workshop 18-19 June 2013, page 7

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**North East Essex CCG**
	West Essex CCG
	Mid Essex CCG
	Basildon & Brentwood CCG
	Castle Point & Rochford CCG
Date agreed at Health and Well-Being Board:	**Final version 27/03/2014**
Date submitted:	**Final version 04/04/2014**
Minimum required value of BCF pooled budget: 2014/15	**£4,932,000**
2015/16	**£94,956,000**
Total agreed value of pooled budget: 2014/15	**£4,932,000**
2015/16	**£99,237,000**

Boundary Differences:

Our plans have been formed taking full account of the boundary differences set out below. Where there are differences, we have collaborative arrangements in place to ensure that the people of Essex experience consistent and high quality services and outcomes. Significant progress has already been made towards the integration of commissioning arrangements across the seven Essex CCGs and Southend, Essex and Thurrock Local Authorities. For example, Learning Disabilities and Mental Health Services are making gains in service improvement through joint commissioning.

Whilst the focus of our plan is the Essex HWB footprint, we are actively working with other stakeholders outside our HWB's borders on broader initiatives and the local arrangements we have put in place support this process.

South West Essex/South East Essex sub economies
Neither Basildon & Brentwood CCG nor Castle Point & Rochford CCG is the sole commissioner for its main acute provider. In the South East Essex health system, CPR and Southend CCGs share lead acute, mental health community and voluntary providers. It is crucial therefore that the CCGs continue to collaborate and jointly plan to deliver shared system priorities for inclusion in their respective Operational and

Strategic Plans. All parties are seeking to achieve similar outcomes and recognise that there will need to be continuous collaboration and shared planning between South Essex, Thurrock and Southend.

They recognise the importance of giving clear direction to providers and the market place. Existing forums (i.e. Unplanned Care Boards that operate in both sub economies) provide a mechanism to ensure that there is consistency in the operational delivery of commissioned services.

The planning footprint for CPRCCG and BBCCG is aligned with ECC to support and ensure our health and social care services work closely together in our local areas. ECC are interested in working to a South Essex (County Council) planning model creating close working alliances between the two CCGs and ECC in the development of our health and social care BCF integrated plans.

b) Authorisation and signoff

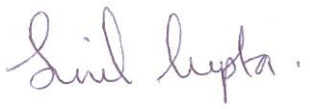
Signed on behalf of the Clinical Commissioning Group	**North East Essex CCG**
By	Will not sign until after the CCG Board meeting on 25th March 2014
Position	
Date	

Signed on behalf of the Clinical Commissioning Group	**West Essex CCG**
By	Clare Morris 
Position	Chief Officer
Date	17th March 2014

Signed on behalf of the Clinical Commissioning Group	**Mid Essex CCG**
By	Caroline Rassell (by email)
Position	Interim Accountable Officer
Date	17th March 2014

Signed on behalf of the Clinical Commissioning Group	**Basildon & Brentwood CCG**
By	Tom Abell 
Position	Chief Accountable Officer

Date	14th March 2014

Signed on behalf of the Clinical Commissioning Group	**Castle Point & Rochford CCG**
By	Dr Sunil Gupta 
Position	Chief Clinical Officer
Date	18th March 2014

Signed on behalf of the Council	**Essex County Council**
By	Dave Hill (by email)
Position	Executive Director for People Commissioning
Date	14th March 2014

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>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We recognise that it is only by tackling the challenges we face as a health and social care economy on a system-wide basis that we will achieve transformational change. We have therefore developed our plans for BCF with local health and care providers and will work closely with our providers to implement our transformation programmes, making effective use of clinical networks and system leadership groups.

This strategic engagement with our providers is well-established. For example, a whole system engagement event was held in June 2013 involving voluntary sector, health and social care providers, local authorities and CCGs to define our vision for what integration could look like in Essex. Details can be found *in "Health and Social Care Integration"* (see Related Documentation section). We have continued to develop our plans with providers over recent months. In particular engagement events took place to develop BCF plans during December 2013 and January 2014 and work will continue in the year ahead.

On a locality basis extensive and on-going engagement has taken place with service providers to create local visions for jointly commissioned services. These are set out in detail in individual CCG plans. Examples include:

- South Essex Partnership University NHS Foundation Trust (SEPT) is lead provider with an integrated supply chain which will include other health and social care providers including Princess Alexandra Hospital, Essex Cares Ltd, and North Essex Mental Health Trust. Aspirations for the accountable lead provider

programme are to develop the supply chain further and expand the role of the voluntary sector.

- In West Essex, health and social care organisations have agreed to develop and test a new way of working that delivers integrated commissioning and provision of services. The West Essex BCF plan focuses on the Integrated Frailty Programme as this is the first pathway to be developed. As this pathway is in its early stages of development it is likely that scope will extend beyond the detail and funding of the BCF plan. The Integrated Frailty Programme will be commissioned jointly by WECCG and ECC and be provided by SEPT as accountable lead provider with an integrated supply chain including Essex County Council, Princess Alexandra Hospital, Essex Cares, Primary Care, Ambulance Service, North Essex Mental Health Trust and voluntary sector, with aspirations to develop the supply chain further and expand the role of the social care sector. All organisations have been involved in the development of this plan
- In North East Essex the CCG has discussed its vision and commissioning intentions with all main providers at Board and Leadership Team level. This includes acute, community and mental health service providers (eg meetings held 8th, 23rd and January and 27th February 2014). Provider representatives sit on the Care Closer To Home clinical reference group and the Urgent Care Working Group, both of which meet regularly. In addition, all providers have been invited to the Big Care Debate events and the further events that were held in February 2014. A workshop on five year plans, including BCF impact, is planned for May 2014.

Further engagement with acute providers will be undertaken as part of the contract agreement process through CCGs and as BCF plans are developed.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

A critical part of our vision for Essex is that residents and local communities will have greater choice, control and responsibility for health and wellbeing services. We believe that engagement, involvement and co-production have the potential radically to improve and transform services. We have therefore been determined to engage patients, service users and the wider public in developing our plans for BCF. In doing so we have drawn on the wealth of information we already hold at a local and county level: for example the evidence gathered by the 'Who Will Care? commission in 2013. Across the county and as individual CCGs we routinely engage with patient and public forums and service user representative groups as part of our planning for commissioning and service development. The outputs from this activity have been used to develop schemes within this BCF plan. In addition, over the last year, Healthwatch Essex, ECC and the CCGs have put in place new arrangements for ensuring that people's voice and lived experience inform our plans.

Some examples include:

- A Call to Action – CCGs undertook a number of consultation and engagement events to enable patients and the community to shape the commissioning and

planning of local services. These events allowed CCGs to set out the challenges and opportunities facing the NHS and social care. For example, the “Big Care Debate” engaged patient groups and representative organisations, and over 1000 people responded to or were involved with the debate. The message from the public was that primary care services and GPs in particular, are key to bringing about person centred healthcare over the next five years.

- CCGs continue to support Patient Engagement Groups, which provided the opportunity for patient views to be heard and considered, and which function as an information exchange conduit. In addition new Patient and Community Reference Groups are acting as formal reference sources for CCGs to discuss broad strategy and integration, and allow outreach to extend into the voluntary and community sector. These groups link to the localities through lay members of CCG Governing Bodies.

Some of the key messages that we have heard from patients and service users are the need for:

- Accepting personal responsibility for their health and social care.
- Access to information and services.
- Prevention and early intervention schemes in their health care
- A change in the culture – being patient centred and caring for people as individuals
- An acceptance that minor problems are important to our citizens
- Access to primary care as gateway to all care that should then be integrated.

These themes have helped to shape our planning.

Over 2014/15, Healthwatch Essex will help to develop BCF plans through its programmes of applied social research and outreach and engagement. Two scheduled pieces of research, on hospital discharge and the lived experience of carers, will be completed over 2014/15, In addition, Healthwatch will use its Voice Network and Community Ambassadors (i.e. community-based volunteers) to gather so-called ‘Stories of Integration and Disintegration’: the provisional title for a year-long programme of outreach to gather people’s experiences of navigating health and social care in the county.

Further engagement focussed specifically on the BCF will involve voluntary and community sector (VCS) organisations, as well as focus groups obtaining feedback from service users and patients as we refine and develop our plans.

e) Related documentation

Document or information title	**Synopsis and links**
Health and Social Care Integration (Accelerated Design Event)	This sets out our shared vision for service users and commissioners, our collective ambition and strategy for commissioning and priority areas for service redesign

Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities the Essex locality (excluding Thurrock and Southend localities) http://www.essexinsight.org.uk/Resource.aspx?ResourceID=299
Joint Health & Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for each of the Essex localities (excluding Thurrock and Southend localities) http://www.essexpartnership.org/content/health-and-wellbeing-board
"Who Will Care" commission report	This report sets out the Who Will Care? commission's 5 high impact solutions to meet the challenges faced in Essex by health and social care services
Appendix 1 Essex BCF High Level Action Plan	A high level plan indicating the activity to be undertaken during 2014/15 to meet the conditions of the Better Care Fund in 2015/16
BBCCG BCF Template	The BBCCG locality Better Care Fund Planning Template Part 1 & 2
CPR CCG BCF template	The CPRCCG locality Better Care Fund Planning Template Part 1 & 2
MECCG BCF Template	The MECCG locality Better Care Fund Planning Template Part 1 & 2
WECCG BCF Template	The WECCG locality Better Care Fund Planning Template Part 1 & 2
NEECCG BCF Template	The NEECCG locality Better Care Fund Planning Template Part 1 & 2
Essex Metrics by CCG	The Essex outcomes and metrics table broken down by CCG
The Seven Day Services Improvement Programme	The Seven Day Services Improvement Programme expressions of interest

2)VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

Our vision is that 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. Every child and adult will be given more opportunities to enjoy better health and wellbeing.

For people with care needs in Essex:

- We will commission and deliver integrated care that is person centred, closer to home and which leaves people in-control.
- The care we deliver will be consistent in quality with an appropriate response across the whole of the County
- Service delivery will be integrated with lead providers coordinating care on our collective behalf.
- We will better understand demographic need and be more able to predict and prevent increasing demand, including proactively identifying long term needs ;
- Services will be available 7 days a week
- Vulnerable and frail people will have a named professional working with them
- We will be fair in the delivery of care. This means being consistent across our patients and service user groups;
- Primary Care Services will proactively support people with long term conditions with preventative interventions
- There will be viable alternative to prevent avoidable admissions
- We will provide more intensive community-based reablement services to promote independence and lessen the need for ongoing health and social care services
- Our care will take account of the wider determinants of people's lives including their families, carers and communities

- Communities will be stronger, through a new partnership about ‘Who Will Care?’

This vision has informed the development of our BCF plans. Our approach to for commissioning in Essex and planning our BCF is to:

- use outcomes based commissioning on the basis of robust evidence and detailed analysis, that will identify clear triggers for interventions;
- be commissioning-led and have a strategy to provide care that is sustainable and is based on local, joint commissioning arrangements
- share data in a safe and timely way enabling us to better understand our population so that we can design and commission the services they need and will need in the future;
- consistently engage with providers to manage markets to streamline our provider arm to deliver efficient and effective pathways;
- align and pool budgets and finances to deliver the most effective impact, integrating resources where possible;
- work with providers to develop behaviours which align to our overall strategy and let our providers innovate.

We have identified our key enablers for change:

- Joint Commissioning at CCG and District level to oversee BCF Schemes and impact.
- Simple access to information;
- Earlier intervention;
- Community engagement and community-based services which reduce demand on health and social care services;
- Continuous innovation in all areas of the system;
- Showing dignity and respect, people are treated as individuals with a choice, and their information follows them wherever they go in the system;
- Services, which are joined up, delivered in a timely fashion, and are easy to navigate.

These enablers are reflected in our BCF plans.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

There is a shared commitment in Essex to integrate commissioning and to develop integrated health and social care provision based on integrated pathways in particular for frailty, people with long terms conditions, admission avoidance and discharge support.

We share an understanding that no one can plan, commission or deliver services in isolation, so if we wish to provide high quality services and make efficient use of diminishing resources we must work collaboratively.

We aim therefore to develop provider models which lead and coordinate health and social care, and which support Primary Care. A strong theme in these models is access to enhanced reablement and intensive support which promote independence and minimises the need for continuing health or social care.

The JSNA and the Essex's Joint Health & Wellbeing Strategy have informed the outcomes that ECC and the CCGs will commission.

Aim/Objective	**Measured by**
Reduction in total demand for acute care (not simply a shift from acute to community settings)	• Reduced admissions; reduced emergency admissions, shorter length of stay
Reduction in emergencies and other unplanned activity	• Reduced emergency and unplanned admissions, reduced A&E attendances
Improved quality of life and greater independence for the frail and vulnerable group that supports optimum self-care and has a primary purpose to improve outcomes at its core	• Patient reported outcomes • Patient reported experience
Improved clinical information	• Evidence of sharing data / use of shared systems use of NHS number/ clinician-reported evidence
Increased levels of education and awareness of self-care	• Patient reported engagement in care planning
Better diagnostic monitoring, community and reablement services	• Activity setting shifts
Improved financial performance	• Savings targets realised
Simplified contract monitoring processes	• Reduced time in contract discussions

	• Feedback from providers
Improved working across health and social care services	• Proportion of people with a joint assessment, use of the NHS number, Greater confidence in partners; greater transparency
A new approach to commissioning that focuses and incentivises the whole system to achieve outcomes that meet the needs of service users in their teams	• Evaluation of risk share contract with Providers and integrated care supply chain; evaluation of outcome measures in use

Individual JSNA's have highlighted that there is disparity between the level of deprivation and the provision of prevention services. Inequity of access to services and inadequate support for self-care as well as a rapidly ageing population, are contributing to an increasing gap in health inequalities and life expectancy.

The overall health gains to the population of Essex to be gained from these aims and objectives will be manifest in:

- People maintaining their independence for longer through lower admission rates to residential care
- Reduced rate of acute hospital admissions by age
- Reduced admissions to hospitals as a result of falls and stroke

We want to see improvements against the metrics set for BCF and our locally chosen metric on the coverage of reablement. The targets we have set and the assumptions behind those targets are explained below:

1. **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population:** Essex proposes to achieve a 5% reduction in the number of admissions to residential care (equating to a reduction of 63 people per 100,000 of the over 65 population). This is based on 6.1% of current residential admissions occurring directly following a new client assessment at hospital. It is intended that BCF schemes will be developed to prevent these people going into crisis and divert them along different care pathways.

2. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services**: The Metric target is to "maintain" current performance across four of the five CCG areas and to increase performance in NEECCG are to the average for Essex which will lift the overall Essex performance to 84%. We expect, over the 2014/15 period, that the nature of reablement cases will shift with short stays being replaced with more complex cases. However, our data is inconclusive on whether this will affect the results after 91 days. We will be investing BCF funds into increasing the number of people being offered reablement in Essex thus making in the target to "maintain" performance a stretching one. Essex's current performance compares favourably with both its geographic and its statistical

neighbours, currently achieving 82% against this metric: above the Eastern Region average of 81.5% and shire councils of 80.8%.

3. **Delayed transfers of care from hospital per 100,000 population (average per month):** Current performance is in the top quartile of our statistical neighbours. The proposal is a maximum target reduction of 2.5% (7 people per 100,000 total population) for the April 2015 performance period and a further 2.5% (a further 7 people per 100,000 total population) for the October 2015 performance period. We believe that this is a stretching target as the Essex performance is currently in the top quartile of its statistical neighbours and that the trend has been reducing and is now generally level. However, in the first part of 2014 delays have increased.

4. **Avoidable emergency admissions (composite measure)** NHSE CSU has provided the composite measures to calculate this baseline. This metric will be driven by local CCG admission avoidance schemes particularly around paediatric admissions. The suggested target is to maintain current levels of avoidable emergency admissions (1676) whilst the population increases by 2% in the first performance period.

5. **Patient / service user experience** As ECC and the CCGs do not use comparative methods of measuring this metric it is proposed not to include this metric until the national metric has been developed

6. **Additional Local Metric - the coverage of reablement.** This metric will measure an expansion in the number of referrals from community into reablement. We have taken the 2012/13 baseline and reduced it to take account of inappropriate referrals to reablement. We have identified the number of community referrals we expect in the first target period, increasing these for the October 2015 payment. This reflects schemes that will be put in place to develop additional referrals in the first half of the 2014/15 financial year. The target shows an increase of 99 people per 100,000 population referred for reablement between April 2014 - March 2015 and a further 324 people per 100,000 between October 2014 – September 2015

c) Description of planned changes

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

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

Agreed Better Care Fund Schemes

Within the “Everyone Counts” planning guidance NHS England have determined that there should be a specific focus during 2014/15 on those patients aged 75 and over

and those with complex needs. This is further supported by the new GP contract securing specific arrangements for all patients aged 75 and over to have an accountable GP and for those who need it to have a comprehensive and co-ordinated package of care. There is an expectation that similar arrangements will be put in place for those people with long term conditions in future years. The new contract also introduces more systematic risk profiling and proactive care management arrangements for those patients with the most complex health and care needs.

Each CCG has created its own timelines for the implementation of activity that supports the BCF schemes (see the Related Documentation section). All schemes will commence implementation through 2014/15 with the aim to be fully functional by 2015/16. Provider contracts are either being varied or new contracts are being arranged to support implementation of the schemes accordingly.

1. Protection of Social Care Services with a health benefit

We want to ensure that those in need in Essex continue to receive the support they require, against a backdrop of pressure on service capacity and resources. We know that to achieve this we have to work in partnership with individuals, carers and communities to help people stay healthy and independent for as long as they can, reducing pressure on services and helping them enjoy better health and wellbeing.

£22.1m in 2014/15 will be used to mitigate reductions in purchasing budgets and a further £4.932m will be used to develop our preventative early intervention and reablement services. These figures have now been apportioned across the other typologies in the BCF Part 2 template.

Through this investment we will also ensure that we build the capacity to deliver 7 day working and integrated services with CCGs. The local authority and NHS commissioners will work together throughout 2014/15 and into 2015/16 to bring sustainability to the health and social care system by:

- investing in preventative health and social care services which will avoid future demand and help people remain safe and independent at home for longer;
- targeting funding at system reform to bring together health and social care provision and avoiding duplication of process through re-designed pathways;
- enhancing services to carers;
- locating care and assessment resources and care services to support people to stay in their homes;
- targeting frail and vulnerable older people to minimise, delay and avoid inappropriate demand;
- Moving as much of resource as possible from residential and domiciliary care into more reablement and proactive case finding.

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2. Community Health services including admission avoidance

We will develop lead provider models of health and social care integration involving community health, admissions and discharge, community social care and primary care services. These providers will be responsible for ensuring access to services, for

effective coordination of multi-disciplinary approaches, and for case management. These lead provider approaches will enable people at risk of frailty or loss of independence to maintain their independence. The models will focus upon risk stratification of vulnerable people and support for people with long-term conditions. They will develop common referral and brokerage arrangements, care pathway review, and asset based community capacity building by community groups. We will work inclusively with acute care providers to invest in admission avoidance and supported discharge. We will pilot arrangements in Essex for the first year of the BCF and will co-produce the models with user-led organisations in Essex.

3. Reablement

We have jointly commissioned community based and residential reablement services with CCGs in Essex. Building on our current joint spending on community based services we will roll out a new integrated health and social care reablement service in each CCG area using existing BCF funds. We consider that reablement is critical enabler to a shift towards care closer to home and a demand management approach for health and social care. This will provide in each area community based reablement to avoid admission and facilitate discharge, it will provide intensive residential and nursing based services to minimise the need for ongoing health or social care, and it will provide an unplanned or rapid response.

Over the two years of the BCF we will;

- Continue to fund reablement and intermediate care services using NHS and Social Care reablement grant funds in 2014/15, allowing for significant growth.
- Roll out additional integrated reablement and intermediate care capacity in each CCG area to meet demand and increase community-led referrals using remaining 2013-14 s256 Sustainability Funds and utilising from 2014-15 s256 NHS Transfer money uplift funding to make that expansion sustainable.
- Pool all NHS and social care reablement funding in 2015/16 and ensure that there are sufficient funds for a significant growth in capacity and reach.
- Agree with CCG's a revised specification and procurement process to replace the existing provision when the contract expires in autumn 2015.

4. Joint Nursing and Residential Care Home commissioning (including Continuing Health Care)

We will review commissioning for Nursing and Residential Care Services in each CCG area with a view to shifting the pattern of care towards a rehabilitation and reablement model of service, which seeks to improve independence and functioning and which minimises inappropriate admission to the CHC service.

We will, in collaboration with the CCG's and the Central Eastern Commissioning Support Unit (CSU), develop a single specification and joint procurement of Nursing Care and Continuing Health Care in 2014/15 with a view to shared management of the market and reduced costs and recognised quality standards.

As part of this work we will work in partnership with the Care Home Market, local housing commissioners and Registered Social Landlords to shift the pattern of services towards greater levels of dementia care support including greater levels of extra-care housing; and as a consequence reduced levels of residential care services. We estimate the need for an additional 2500 places with extra care support of which we would expect to commission 360. We expect a reduction in admission to residential care from social services recipients of 5%.

5. Discharge support

Essex social care services and hospital providers in Essex will continue to work together and with community health providers to ensure effective admission avoidance and discharge support. We will use our BCF schemes for reablement to promote ward led discharge, rapid response services development and ensure that assessment is taking place at the appropriate time in the appropriate environment.

In developing Accountable Lead Provider Models we will ensure that there is a clear accountability for coordinating the care of people in the community who receive in-patient services.

ECC and individual CCGs will continue to build on the development of the integrated discharge team approach to facilitate 7 day discharge and will put in place the relevant infrastructure (community services, transport services etc.) to support this.

6. Acute mental health and dementia

Mental health is a key priority driven by rising demand for mental health services. Our plans are based on the factors that are known to facilitate good integrated care including: information sharing systems; shared protocols; the ability to pool funds from different funding streams into a single integrated care budget; improvements in existing multidisciplinary teams; and the development of new models of liaison services that bring improved outcomes and efficiency savings through reduced admissions to acute hospital care.

The evidence is unequivocal that accommodation plays a key role in mental health recovery pathways and therefore it is important that we are able to implement new accommodation pathways that support discharge from hospital and promote recovery and independent living.

As part of our strategy we will implement the priority areas identified in the recent report "Closing the Gap; priorities for essential change in mental health services" to achieve parity between mental and physical health services.

The three CCGs in North Essex and Essex County Council have produced a Joint North Essex Mental Health Strategy. It is expected that this will be delivered by:

- Developing and supporting community well-being, encouraging people to maintain healthy lifestyles that help keep themselves and their families mentally well;

- Improving access and the gateway into services – more effective direction;
- Ensuring smooth transition between services (CAMHS/Adult/Older People);
- Ensuring a more holistic and integrated approach to mental health and physical health services;
- Developing broader primary care and community based models of care for people across the spectrum of mental health conditions;
- Ensure in-patient and specialist services are responsive and meet the needs of patients with more complex needs.

Driven by this strategy, a joint approach has been undertaken with ECC and across the North Essex CCGs that will lead to the development of a new integrated model of care for adult mental health services.

Dementia: This plan will continue to support and develop the Essex, Southend and Thurrock Dementia Strategy which was developed during 2011. The strategy was agreed and signed off by NHS commissioners the two Mental Health Trusts and Essex, Southend and Thurrock local authorities in January 2013.

The focus of the strategy is to increase uptake of early intervention services that support independence, ensure service pathways incorporate the appropriate range of interventions including commissioning the voluntary sector to provide support to people in the community and at first diagnosis within Memory Clinics.

The strategy recognises the contribution that the NHS QIPP agenda will make in ensuring that the Dementia Strategy can deliver services that meet demographic demands, that services are cost effective and that planning is integrated. Implementation plans are being developed with partners to improve outcomes for people with Dementia and manage demand on statutory services.

- Early progress to date includes ECC awarding a £700,000 contract to the Alzheimer's Society to provide support by Dementia Care Advisors - supporting people following diagnosis in Memory Services.
- Jointly commissioned services provided by the Alzheimer's Society raising awareness and providing information about support to enable people living with dementia & their carers on how they can remain independent.

7. Primary care (including the requirement for GPs to be accountable for improving quality of care in older people)

We expect primary care to take a lead role in the care coordination for Health and Social Care services in Essex.
We will establish Multi-Disciplinary Teams (MDT's) with GPs at the centre of organising and coordinating people's care in conjunction with social care and other health professionals and service users themselves.
The risk assessment process to identify the care needs of vulnerable people and identify opportunities for early intervention will be led by primary care. We will use BCF schemes to respond and co-ordinate the resultant needs and interventions.

We will work closely with primary care to ensure information is shared appropriately so that as well as receiving Primary and Secondary Care services, people are also supported by appropriate voluntary sector organisations.
Our primary care support for Long Term Conditions will link services for Frail / Older People with community based prevention services for people with specific conditions e.g. continence, diabetes, falls prevention.
Essex GPs are taking a positive approach to their role in care coordination and we will continue to support them to do so.

We will work with our local councils to determine the levels of population growth and the impact on housing requirements to determine the level of Primary Care required in each locality within CCG areas and the requirements for Primary Care practice locations. For example in BBCCG it is expected that over a five year period there will be an increase in our primary care workforce by approximately 1 whole time GP for every 1,800-2,000 new residents.

8. Investment to meet requirements of the Care Bill

Revised arrangements for community health and community care are fundamental to the implementation of revised assessment and case management arrangements for people entitled to services from social services. In particular the implementation of the Care Bill will entail the development of a 'Care Coordinator' role across health and social care organisations dealing with community care. This may require additional resources during a period of transition whilst integrated approaches are developed.

We will work together as a system to define the requirements of the Care Bill using a joint programme management approach to implement change during 2014/15. This will identify the full investment requirements of implementing the Care Bill. However, we expect to invest in excess of £3.39m in new entitlements for carers, introduction of a national minimum eligibility threshold, funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

In addition, we expect to use in excess of £1.13m capital costs to invest in the development of systems, protocols and capacity to manage information between the various organisations, including case management systems and the development of mechanism to give access to virtual or actual patient records between organisations.

9. Early intervention and prevention

We are determined to identify the needs of people earlier and intervene to prevent the escalation of problems and crises. Improved support for people in their communities is at the heart of our approach. Individuals and communities value their independence and the ability to make their own decisions and choices. We will work to equip vulnerable people with the support and skills they need to live independently for longer and to help themselves. Improved management of demand will support the sustainability of the system as well as improve outcomes for individuals and their families.

We will look to enable as much health and care support as possible to be delivered safely in the community and in people's homes.

We will also develop communities' capability to support vulnerable people. An example of this is the community agents model which aims to establish a network of community agents and volunteers that leads to a reduction in the whole cost of care by:

- changing existing patterns of presentation to health and social care services and offering an alternative to those traditional services;
- re-directing from the social care front door and GP practices towards a community-based response - for information, advice, practical solutions, appropriate level care and support enabling vulnerable older people and their carers to find, own and implement the solutions to the issues which affect them

10. Community resilience

Essex is committed to strengthening and mobilising communities and increasing their resilience. The 'Who Will Care?' commission led by Sir Thomas Hughes Hallett recommended five high impact solutions in Essex. These included mobilising communities to play a greater role in supporting vulnerable people. This means engaging people in understanding the challenges facing the health and social care system and the important role that can be played by communities and volunteers. Work is underway to identify successful local schemes and determine how they can be developed as models to provide support county-wide. This will build on initiatives for community building, time and care banking and the creation of a Community Resilience Fund under the Whole Essex Community Budgets programme. We will build capacity within and across Essex communities to utilise community assets and support communities to provide care to vulnerable people.

We are currently discussing with Healthwatch their proposals to develop integrated information and signposting services that are likely to set up in 2014/15. These are designed to provide appropriate and relevant information to help people navigate health and social care, and so improve access to services as well as facilitate better self-management and community-based schemes.

11. Carers

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

a) 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.
b) An improved early offer reducing the need for formal assessment through:
   - Information & advice;
   - Practical support to sustain a caring role;

- •Access to time away from the caring role;
- •Carer training.

c) Targeted specialist support – for example at end of life; at hospital discharge; alongside reablement.

12. Disabled Facilities Grant

The DFG is included in the capital element of the fund which comes into play in 2015/16.
In Essex we have taken the view that the BCF provides an opportunity to explore a holistic approach to improve the process from OT assessment through to DFG in the medium term. Due to timescales we are not proposing changes to the DFG in 2015/16 but are engaging with local housing authorities to explore improved approaches. This includes the creation of a "Task & Finish" group during 2014/15 that will include representation from District, Borough and City councils to develop enhanced DFG services going forward from 2015/16 (see Action Plan Appendix 1).

13. Other schemes and enablers

13.1. Local councils are advising CCGs of a number of proposed housing developments which may have significant impact on the population across the Council area within the next 5 years. The BCF will take account of the implications that this may have on services across Essex. An example from BBCCG of the impact of housing and primary care premises in the Basildon area is shown below.

13.1.1. Pitsea–proposed 5,788 dwellings @ estimated 2.5 occupants each = total of c15,000 new residents; it is likely that new primary care premises would be required. Estimated requirement of 1200msq premises to accommodate a practice of this size.

13.1.2. Wickford – potential c1,200 new dwellings, estimated @ 2.5 occupants = 3,000 new residents; this may require redevelopment of existing premises, or progressing proposals for new Wickford Health Centre to include expansion. Capacity may also be created or found within existing GP practices, depending on the location of the developments.

13.1.3. Central/West Basildon – various schemes are currently underway and included in the 1% growth built in to 2014/15 contracts. Further developments are proposed to a maximum of c3,350 dwellings, estimate c8,500 new residents which would require additional capacity. Options include redeveloping an existing practice and relocate to a new site or a new standalone practice. For either option, assumption is that a minimum of further c500msq of primary care estate would be required.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services 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.

The BCF plan will have a significant impact on non-elective admissions. This impact will be achieved through a more integrated health and social care approach to hospital discharge and better access to services closer to home which prevent the need for emergency admission/re-admission. For example, faster access to urgent social care services including night carers and reablement services, as well as improving the support network in the community which means that patients are less likely to reach a crisis point. The establishment of an integrated community workforce made up of social care, mental health and community services will allow for a more patient centred proactive service.

Examples of the impact on the acute sector are:

- In West Essex the frailty programme aims to avoid approximately 930 inappropriate admissions across the acute sector serving the west Essex patients in 2015/16. Furthermore, a reduction in excess bed days of 475 is also targeted. This will have a positive impact on the acute sector by releasing capacity to deliver more elective capacity and reduce outsourcing.
- In south east Essex, CPRCCG are working in conjunction with the lead commissioner, Southend CCG. Contracts are currently being negotiated with particular emphasis on non-elective activity reductions through QIPP and BCF work programmes. In south east Essex CCGs are looking for systems that incentivise primary care and community providers to see more people for longer and to keep people out of hospital. By making this agreement, we seek to offer stability to the acute system to allow for focus on service redesign to create a longer term sustainable health and social care system. We have submitted estimated reductions in non-elective activity in line with planning requirements.

Modelling of Impact on Acute Providers

The detailed impact of BCF plans on our population and on acute providers is complex and requires further detailed planning and modelling following. This is planned to take place in the next few months.

For instance NEECCG has commissioned modelling work, currently underway, which includes:-

- Benchmarking their current provider with peers/best in class to understand achievability
- Considering any best practice/national reference data based on local pilot data/knowledge
- Taking into account current contract planning rounds/negotiation
- analysing costs of providing the service in acute as opposed to other care settings
- modelling the potential impact on emergency thresholds

- Modelling the impact by service Bundle, and amalgamating to a whole system impact
- Triangulating with work modelling outcomes to be achieved
- assessing our ability to deliver national targets for reduction of elective and non-elective activity through our current plans and identify any gaps
- assessing impact of the plans on the sustainability of the system in the longer term

This work is being done in conjunction with provider conversations and to inform impact assessments by providers.

The Action Plan (appendix 1) shows the high level activities that will be undertaken across Essex throughout 2014/15 to evaluate the impact of the current contract negotiations with the acute sector once concluded and the effect that the BCF schemes will have on acute activity. The outcomes of this modelling and evaluation work will also inform the contingency plans that will be required to support essential services if the schemes do not release the expected benefits. In summary the actions will include:

- Finalising the acute contracts
- Specifying the functions that the BCF schemes will affect
- Modelling of the BCF functions against acute activity
- Evaluating existing demand management schemes.
- Revising contingency plans in light of the modelling undertaken.

- Workforce implications of the local economy.

e) Governance

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

ECC and the CCG's have already built strong and effective working relationships at both officer and elected member levels. ECC has also appointed Integrated Commissioning Directors linked to each CCG.

The Health and Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across Essex covering all relevant CCGs and ECC.

The HWB is supported by regular meetings between the ECC Commissioning Directors and CCG Accountable Officers within the Business Management Group. The transformational plans and programmes are formally discussed and approved at local authority governance levels and within each CCG's governing bodies.

However, to deliver the ambition we have set out in our BCF plans, we recognise the need to develop our strategic and operational governance arrangements. We want to ensure these are effective in leading the health and social care system in Essex. We are also designing governance arrangements for the BCF to ensure we are effective in driving delivery of our plans locally, monitoring performance and problem-solving as necessary. Our aim in doing so is to achieve an appropriate balance between county-wide and local decision-making and monitoring.

The HWB is supported by regular meetings between the ECC Commissioning Directors and CCG Accountable Officers within the Business Management Group. The transformational plans and programmes are formally discussed and approved at local authority governance levels and within each CCG's governing bodies.

A technical group (ECC, CCG and NHSE Finance Directors) has been formed to identifying the delegated functions to be included in the section 75 Agreement(s) that will describe the use of the BCF and the arrangements to facilitate and manage the pooled fund.

This group has recommended that ECC should act as the host partner to the pooled fund.

ECC Integrated Directors and the CCGs will agree use of all pooled budgets in a joint and transparent manner, through jointly agreed Governance routes. Decisions about use of funding will be 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.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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

Please explain how local social care services will be protected within your plans.

The local authority has engaged in a transformation programme that has led it to become an outcomes based commissioner with a strong locality focus and has released efficiencies enabling it to maintain its current Fair Access to Care Services (FACS) eligibility criteria. This allows the local authority to ensure that it can allocate additional spending for local social care services to the same financial level in 2014/15 as for 2013/14 using the Social Care Sustainability grant. 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 principal mechanism for this is the ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained in 2015/16 and 2016/17 to allow for contract procurements.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

ECC and each of the CCGs are committed to meeting this national condition of the BCF. Within appendix 1 there is a high level action plan that describes the activities to achieve this condition by 2015/16. These include:

- identifying all functions and work groups affected by7 day working,
- identifying skills gaps and training requirements for staff groups affected by 7 day working,
- identifying and negotiating any contractual changes with providers not already covered in the 2014/15 contact negotiations,
- commence and complete employee consultations with representative bodies and individuals affected.

- Communicate with stakeholders, providers and the public

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

CCGs have specific plans to support the achievement of this national condition. Health and social care commissioners across Essex will expect providers to ensure the same standards of services are provided across seven days. We will be moving towards commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge. CCGs will be working with their acute and other providers throughout 2014/15 to facilitate development of 7 day working. This is likely to include the development of the trusted assessor model and enhancement of community and transport services to facilitate discharge to care homes and normal places of residence at weekends.

Some CCGs in Essex have been successful in becoming early adopters for the Seven Days Services Improvement Programme. The aims of this programme are to:

- work with patients, carers and all partners in the health care system, to create a shared vision of our future seven day services;
- implement a shared vision working collaboratively with patients and all partners;
- establish clinically led care pathways which will include services provided by acute, primary, social care and the third sector.

Outcomes will be improved for:

- Individuals: being able to access treatment as appropriate to them and not limited by the availability services;
- Families: access to better support to cope with family members with ill health;
- Carers: with improved support from relevant organisations to help them provide better, sustainable care;
- Communities: with access to local health care services will be improved to the level where day of the week is not a limitation;
- Staff: their working hours and rotas will be improved to ensure that seven day working patterns are sustainable and rewarding

The CCGs in Essex are working with all NHS providers to develop action plans to support their response to the 10 clinical standards for 7 day working. This will be a key component of Service Development and Improvement Plans (SDIP) over the next two years and beyond. We will engage closely with our providers to ensure, once action plans are developed, that they are rolled out across the system over the plan period in line with contract commitments.

Health and Social care commissioners in Essex will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge.

This vision is aligned with the NHS Outcomes Framework

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

A county wide programme has been created to ensure that all organisations are in a position to share data using the NHS Number with appropriate Information Governance controls in place by 2015/16. This programme is being led by the Chair of the Health and Wellbeing Board and includes representatives from all partners. The high level action plan is shown in appendix 1 and includes:

- The creation of a county wide task and finish group and the launching of Information Sharing Protocols. 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 current ability to use NHS Numbers amongst all partners.
- Implementing solutions to issues by March 2015

NHS Number: Currently, not all organisations use the NHS number as the primary identifier in correspondence. However, all are committed to doing so during 2015.

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 all organisations will continue to work with NHSE 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.

However, we are committed to developing interoperability between all health and social care systems that will provide both real time information and managerial analytics, starting by ensuring that GP and Social Care systems across the locality are integrated around the NHS number, and individual information shared in an appropriate and timely way.

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

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

Those CCGs that do not currently use the NHS number have plans to do so and expect to be in a position to implement use of the NHS number by Quarter 3 of the 2014/15 Financial year.

However it should be noted that there will be restrictions on the CCG's ability to receive, process and share the NHS number with other parties, and this will include data sharing with ECC for non-primary usage purposes.

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))

Open API Systems: All organisations are committed to adopting APIs. ECC will be implementing a new social care IT system that uses Open API's and Open Standards. This system will be implemented in during 2015.
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.

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

Several CCGs have been granted Accredited Safe Haven (ASH) status which will allow them to receive patient identifiable data in the future.
All CCGs have adopted appropriate IG Controls which cover NHS Standard contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2

d) Joint assessment and accountable lead professional
Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

People at high risk of hospital admission have an agreed accountable lead professional:

ECC works closely with the CCGs jointly planning care for those individuals identified by health professionals as being at high risk of hospital admission. The accountable lead professional model is developing in Essex and varies according to location. The general approach is that all patients at high risk of hospital admission will have their care managed by GP led health teams or by accountable lead providers with an identified accountable lead professional. The care packages for individuals are managed

adopting the Multi-Disciplinary Team (MDT) / Single Point of Referral (SPOR) / Virtual Ward type models of cross social and health care.

Health and social care use a joint process to assess risk, plan care and allocate a lead professional:

ECC and CCGs are developing the accountable lead professional concept through their MDT, SPOR and Virtual Ward activity.

In some CCG areas, 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, employed by the Lead Provider.

In other areas risk stratification tools such as the Combined Predictive Mechanism (CPM) is used to identify individuals at high risk of hospital admission. The CPM algorithms are used to predict emergency hospital admission in the next year. The algorithm draws on information from primary and acute care, as well as patients' ages, to make its predictions. The risk is further stratified into patients who have (a) diabetes; (b) chronic obstruction pulmonary disorder (COPD); (c) coronary heart disease (CHD); or (d) if they are over 75.

In west Essex where an Approved Lead Provider (ALP) model is being developed, the responsibility for identifying those at risk of hospital admission and risk stratification will belong to the ALP who will be charged with identifying and sharing a suitable risk assessment tool and methodology and applying this to the west Essex population. This future modelling will then be able to identify the proportion of the population who are at "High" and "Very High" risk of hospital admission. The ALP will be responsible for constructing a supply chain around this population that is capable of ensuring early identification and prevention. The ALP will also be responsible for the development of demand management schemes which, via early intervention and the adoption of early identifier risk stratification models, will be able to offer community based support to prevent crises occurring.

Proportion of the adult population identified as at high risk of hospital admission,

Although risk stratification tools are not universally adopted around Essex we have estimated that in those areas that do currently use risk assessment tools 0.5% of the population are at "Very High" risk of hospital admission for a chronic condition in the next 2 years, and that 5% are at "High" risk.

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

Risk	Risk rating	Mitigating Actions
In a Health and Wellbeing region that consists of five CCGs and five acute hospitals there is an inherent complexity and 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. Modelling work that is planned will help to refine BCF plans based on a better understanding of the impact on the acute sector
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 as 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	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 resulting in poor and	High	We have plans to review our governance arrangements. We will implement locally approved

slow decision-making across the system delay the integration of services and reduce the effective ness of BCF		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	Medium	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. Modelling work that is planned will help to refine BCF plans based on a better understanding of the impact on the acute sector.
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	High	At the outset of the programme, being clear on: • Clear and achievable financial objectives • Well planned phased service model changes to deliver greater efficiency • Close financial performance management • Early identification of issues and contingency plans in place to mitigate slippages or unexpected demand • Rigorous financial governance to ensure robust due diligence is part of BCF S75 Agreement sign-off
Shorter term financial stability actions by CCGs or Essex County Council could inadvertently undermine BCF schemes	High	• Regular communication with finance leads/Accountable Officers to enable early identification of any issues. • Incorporate BCF S75 reporting into financial management business as usual. • Recognition of particular providers/commissioners

		already in fragile financial status Robust risk sharing arrangements built into S75 arrangements for the pooled budget.
Increase in transaction costs incurred by host partner	Low	Clear understanding of requirements of host organisation
BCF overspend/financial liability – role of host partner	Medium	Clear arrangements agreed as part of the S75 agreement
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	Medium	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	Medium	The programme will be properly planned, with agreed timescales and dependencies identified at an early stage. 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	Medium	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	Low	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.
Shorter term financial stability actions by CCGs or ECC could inadvertently undermine BCF schemes	High	Regular communication by finance leads / Accountable Officers to enable early identification of any issues. Recognition of particular providers / commissioners already in a fragile status.

		Robust risk sharing arrangements built into the section 75 arrangements for the pooled budget
Functions are not clearly defined so to be able to articulate how services will be integrated and therefore what the clear delegation of responsibilities are from health to social care or social care to health in. The implication being that benefits cannot be defined or quantified	High	Clear articulation of roles and responsibilities as part of s75 agreement

Appendix 3 Better Care Fund Part 2 Template