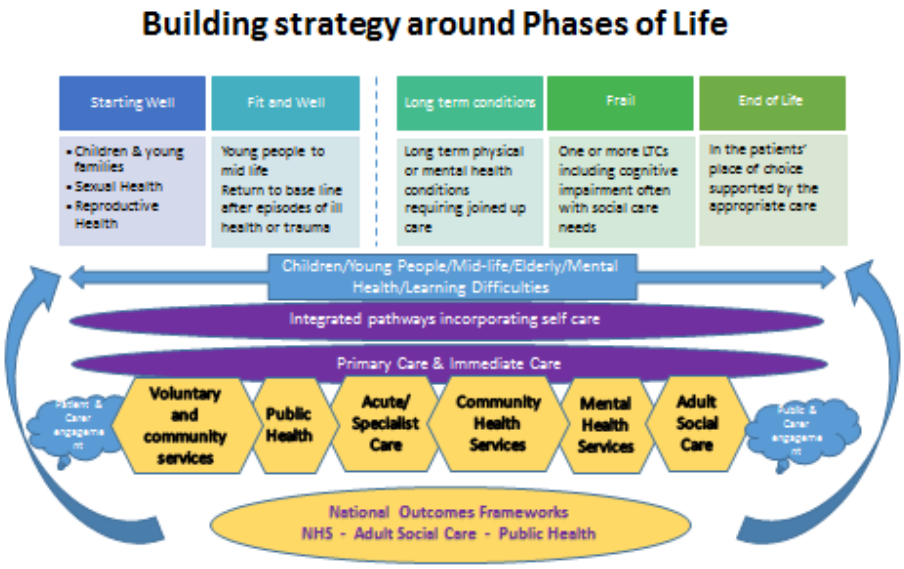
Mid Essex - Better Care Fund planning template – Part 1

CONTEXT

Our aim is to use BCF to improve outcomes for Mid Essex residents by transforming services through greater integration and earlier intervention. Our vision is of our communities working together to create sustainable and local services delivering integrated first class health and social care services for all. The Council and the CCG are working together on an integrated approach to the 'phases of life';



The Better Care Fund will be used to implement integrated services which support people with health and social care services throughout those phases.

Our overall model for integration is for care to be coordinated by lead professionals in multi-disciplinary teams (MDTs) , with a joint assessment and agreed authority to arrange services. We will make sure that services are easily accessible with single points of triage and referral and .we will work in partnership with GPs to target support at those at risk of unnecessary admission. We will target preventative interventions to avoid health and care needs escalating.

This planning document reflects the planning intentions of the Mid Essex Clinical Commissioning Group (MECCGs), Essex County Council (ECC) and partners to the Essex Health and Well-Being Board for the use of the Better Care Fund (BCF) in Mid Essex. It is an appendix to the main Essex Better Care Fund template, and its actions form part of the Mid Essex Two-Year Operational Plan 2014-16.

This document has been informed by the Joint Strategic Need's Assessment's (JSNA), the Health and Wellbeing Strategy (HWBS) for Mid Essex, and by discussions with providers and service users It has been endorsed by the Essex Health and Wellbeing Board (HWB) on 27th March 2014.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**Mid Essex CCG**
Date agreed at Health and Well-Being Board:	**Draft version 12/02/2014** **Final version 27/03/2014**
Date submitted:	**Draft version 10/03/2014** **Final version 04/04/2014**
Minimum required value of BCF pooled budget: 2014/15	**£4,932,000 (County Figure)**
2015/16	**£21,651,000**
Total agreed value of pooled budget: 2014/15	**£4,932,000 (County Figure)**
2015/16	**£21,651,00**

The Plan covers the Mid Essex area of the County, including the Districts of Braintree, Malden and Chelmsford. The CCG and ECC schemes cover these areas, and form a contribution to the Essex-wide Health and Well-Being Board BCF Plans.

b) Authorisation and signoff

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

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

c) Service provider engagement

We have developed our plans for BCF Schemes with local health and care providers and we expect their shared leadership for implementation of transformation programmes, in particular using clinical networks and system leadership groups. This submission therefore reflects a number of existing transformation programmes developed with providers, including the recent reviews undertaken within the CCG as part of its sustainability review. More details of that are contained within the Two-year Operational Plan.

A whole system engagement event was held in June 2013 involving voluntary sector, health and social care providers, local authorities and CCGs to define what integration

could look like in Essex. Details of this consultation work can be found *in "Health and Social Care Integration"* (see Related Documentation section).

Further engagement events took place during December 2013 and January 2014. Working together, ECC and individual CCG's have jointly developed the vision, aims and objectives for health and wellbeing in their localities.
The joint integration programmes/schemes that the BCF will include were discussed and provisionally agreed at these events, subject to further planning and validation.

d) Patient, service user and public engagement

The Business Management Group, (a subcommittee of the Health and Wellbeing Board), has led the development of this submission and includes representation from Healthwatch to help ensure that this plan reflects a patient and service user perspective.

ECC and the CCGs routinely engage with a number of patient and public forums and service user representative groups as part of their planning for future commissioning and service development. The outputs from these sessions have been used to develop schemes within this BCF plan.

A number of consultation and engagement events have taken place to enable patients and the community to shape the commissioning and planning of local services. ME CCG is in the process of embedding its refreshed PPE structure and strategy across its organisation and work which will facilitate a comprehensive engagement programme across its services and the integration agenda.
We will work in partnership to use all existing engagement routes to maximise opportunities to engage with the public including Healthwatch Essex. Patient Engagement Groups events that took place during 2013 which provided the opportunity for patient views to be heard and considered, i.e. to act as an information exchange conduit. Patient and Community Reference Groups act as formal reference sources for CCGs and forums to discuss broad strategy and integration. These groups link to the localities through lay members of CCG Governing Bodies.

- CCG locality managers ensure local views and connections are maintained. CCG officers regularly attend patient and other stakeholder groups and meetings, presenting information and receiving feedback from patients and the public. Each CCG publishes a prospectus each year.

In summary, whilst developing this plan, the key messages that we have heard from patients and service users are the need for:
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- Personal responsibility for their health and social care.
- Prevention and early intervention schemes in their health care
- A change in the culture – 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.

Further engagement with voluntary and community sector (VCS) organisations will include the facilitation of focus groups to obtain further feedback from service users and patients as we refine and develop these plans. Healthwatch Essex will work with us to develop user engagement and feedback forums specifically focussed on the BCF.

e) Related documentation

Document or information title	Synopsis and links
Health and Social Care Integration (Accelerated Design Event)	The vision for service users and commissioners, the collective ambition and strategy for commissioning, priority areas for service redesign  1372316_Essex Accelerated Event AS
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	
ECC BCF Template	The ECC Better Care Fund Planning Template Parts 1 & 2
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

Our vision is of our communities working together to create sustainable and local services delivering integrated first class health and social care services for all. This means 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 health and care needs in Mid 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 7 days a week.
- Service delivery will be integrated with lead providers coordinating care on our collective behalf.
- 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 approach will take account of the wider determinants of people's lives including their families, carers and communities
- Communities will be resilient and sustainable, with a new partnership about 'Who Will Care?'

For commissioning in Mid Essex:

- We will use outcomes-based commissioning on the basis of robust evidence and detailed analysis, that will identify clear triggers for interventions;
- We will be commissioning-led and have whole systems sustainability based on local, joint commissioning arrangements
- We will 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;
- We will consistently engage with providers to encourage innovation, manage markets to streamline and deliver efficient and effective pathways;
- We will align and pool budgets and finances to deliver the most effective impact, integrating resources where possible.

The key enablers for change are;

- A joint commissioning approach that oversees BCF Schemes.
- Leadership at a system-wide level
- Simple access to information;
- Earlier intervention;
- Community engagement and community-based services which reduce demand on health and social care services;

- 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.

Aims and objectives

In Mid-Essex we have developed a strong clinically-led Phases of Life model which seeks to support people to be strong fit and well, and to intervene when people need support with long term conditions, frailty or end of life care. Essex Social Care Services provide services and personal budgets to enable people with long term needs to remain independent.

There is a shared commitment to integrate commissioning and to develop integrated health and social provision based on integrated pathways in particular for frailty, people with long terms conditions, admission avoidance, immediate care needs, 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 development. A strong theme in these models is access to enhanced reablement and intensive support to promote independence and minimise the need for continuing health or social care.

The JSNA and the Essex's Joint Health & Wellbeing Strategy have informed our outcomes.

Aim/Objective	Measured by
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
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 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
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

The JSNA highlights inequity of access to services and inadequate support for self-care as well as a rapidly ageing population, is contributing to an increasing gap in health inequalities and life expectancy.

Work on the BCF schemes, and wider Transformation Programme in the CCG and Essex County Council should result 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 have identified the Metrics identified in BCF Template 2. The targets we have set and the assumptions behind those targets have been developed for Essex as a whole and 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. 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%. To maintain 82% requires an increase in 256 people to achieve the reablement target during 2014/15
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 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

b) Description of planned changes

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.

Mid Essex CCG has developed, in partnership with the Council, a Transformation Programme based on its vision for support during life phases, to deliver system-wide change and sustainability. We will take action in 2014-15 on the following programme of work to deliver change and to create sustainable funding for the health and social care system. These schemes are designed to enable the CCG to return to sustainability, and for the County Council to achieve savings required by its Transformation Programme:

Programme	Life phase
Safe and well at home - developing capacity for self-care, community resilience	All
Long Term Conditions - House of Care, developing LTC Hubs integrating primary care, community health services & specialist services around needs of people with complex needs and co-morbidities - Integrated care MDTs and risk stratification - Supported self-management - primary and secondary prevention	LTC
Mental health and dementia Continuing the support community-based facilities delivered through community-based organisations	LTC and frailty
Frailty - Pathway; proactively identifying frail people and integrating health, social care & housing to support independence	Frailty
Frailty - Continuing Health Care - Working with ECC and cross-Essex group to redesign early intervention and prevention, assessment and review and joint procurement	Frailty
End of life - continuing to promote conversations about EOL and preferred place of care choices - joining up EOLC services, working with Hospice	EOL
Immediate Care - simplifying and joining up urgent and emergency care services	All
Primary care - bedrock for (nearly) all programmes - engaging practices to develop as providers at scale - advice and guidance/CRS - extended/enhanced primary care - using changes in QOF - community pharmacy	All
Enablers – IT/IG, workforce, pharmacy, estates, PPE, etc	all

This programme then contributes to the following Better Care Fund Schemes which are grouped according to headings across all CCG BCF schemes.

1. Continued 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.

£4.136min 2014/15 will be used to mitigate reductions in purchasing budgets and a further £1.550m will be used to continue our preventative early intervention and reablement services. £1.595m will be used to develop additional capacity for reablement services and preparation to implement the Care Act.

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 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 its resources 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

<u>Integrated Community Health and Social Care</u>

We will develop a lead provider model for health and social care integration involving community health services, admissions and discharge pathways, adult 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 develop arrangements in Mid Essex for the first two years of the BCF before further implementation in line with 2 Year and 5 Year operational plans. We will co-produce the models with user-led organisations in Mid Essex. A further description of work with Primary Care is outlined in part 7 below.

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 (inc. 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 other 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 an 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 play a lead role in the care coordination for Health and Social Care services in Essex. We will establish Multi-Disciplinary Teams (MDT's) where GPs will be at the centre of organising and coordinating people's care in conjunction with social care and other health professionals and the service users themselves.

The risk assessment process used 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 Hallet 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.

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.

13. Other schemes and enablers

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..

c) Implications for the acute sector

Our BCF plans will have a significant impact on avoidable admissions. This impact will be achieved through a more integrated health and social care approach to admissions avoidance, immediate care, 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 health and social care services including rapid response services, 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.

Modelling of Impact on Acute Providers

The detailed impact to our providers is complex and detailed planning and modelling will continue in the period ahead of the formal pooled fund to understand the full effect of this and other pathway changes. Modelling has included

a) Benchmarking our current provider with peers/best in class to understand achievability
b) Considering any best practice/national reference data based on local pilot data/knowledge
c) Reviewing current contract arrangements
d) Cost analysis of providing the service in acute as opposed to other care settings
e) Piloting a frailty approach designed to reduce admissions to the local EAU
f) Assessing impact of the plans on the sustainability of the system in the longer term

The modelling outcomes will also enable an assessment of workforce implications of the local economy.

d) Governance

The Health and Wellbeing Board provides strategic leadership and direction for decision-making and joint commissioning across Essex covering all relevant CCGs and ECC. To deliver the ambition we have for our BCF, we recognise the need to develop further strategic and operational governance arrangements. We are reviewing our governance arrangements to ensure these are effective in managing the BCF and there is an appropriate balance between county-wide and local decision-making.

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.

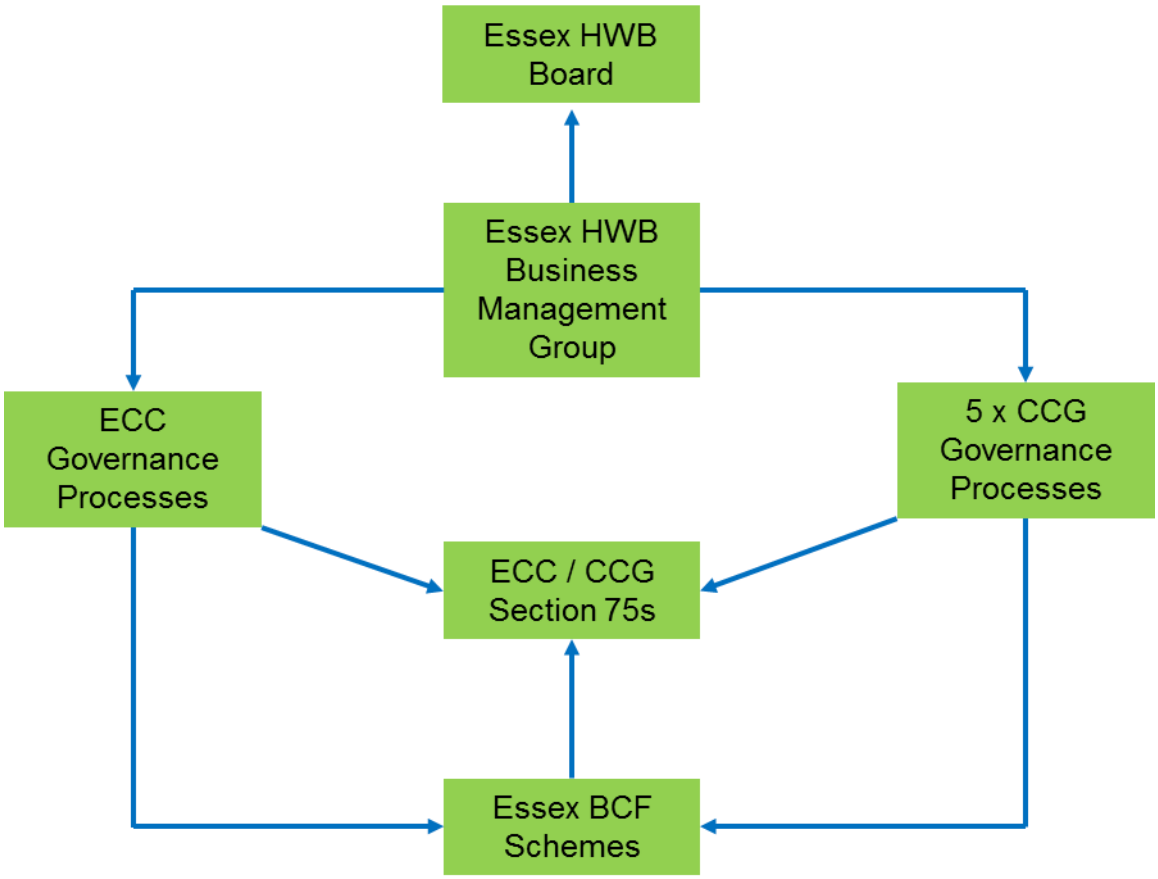
A governance and contractual risk sharing work group has been established to finalise governance arrangements including financial governance by September 2014. This group will also review the Terms of Reference of the Health and Wellbeing Board in light of any legislation changes that may be forth coming as a result of the Better Care Fund.

Additionally 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.

The future management teams responsible for the commissioning of integrated care will be accountable through the Health and Wellbeing Board, and through local authority governance arrangements and CCG's governance arrangements.

At the level of Mid Essex CCG we have agreed the development of a joint commissioning approach, as part of our CCG Transformation Programme Board to oversee the progress

of BCF Schemes, the pooled fund, and other transformation programmes. The arrangement will be joint with the Council.



3) NATIONAL CONDITIONS

a) Protecting 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.

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

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.

As part of the contract round for 14/15 the ME CCG will be requiring all providers of acute services within their SDIP to document actions that they will take during 2014/15 to commence implementation of the recommendations of the review into 7-day services.

Confidence in delivery and progress made for 7 day working and its implications will be aligned to the strategic planning process of the CCG and a working group set up to oversee implementation.

For non-acute based urgent and emergency services outside of the hospital, implications for 7 day working is being picked up as part of the Emergency and Urgent Care Strategy (and aligns with the Urgent and Emergency Care Review Phase 1 report) with the majority of these services already operating 7 days a week.

The local Better Care Fund proposals will also support development of 7 day health and social care services including to support 7 day hospital discharge and admission avoidance

c) Data sharing

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.

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.

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.

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

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) 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 the ME CCG is developing the accountable lead professional concept utilising the MDT, frailty pathway and primary care development activity.

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.

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

The following Risks are agreed at an Essex-wide level for the whole BCF.

Risk	Risk rating	Mitigating Actions
In a Health and Wellbeing region that consists of five CCGs and five acute hospitals there is a risk that a system failure in one organisation affects the overall performance measures of the HWB Board region which results in the underperformance of the BCF against the metrics which subsequently results in the non-eligibility to receive the health premium	High	ECC Integration Directors and CCG leads are working together to ensure that the programmes nominated for inclusion in the BCF have SMART targets and that providers are appropriately performance managed to ensure that they are sustainable. The BCF metrics will be disaggregated to CCG level to ensure that individual CCG’s are not measured in a detrimental way.

Risk	Risk rating	Mitigating Actions
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 delay the integration of services resulting in poor and slow decision-making across the system	High	We will implement locally approved governance structures across Essex at the earliest opportunity – by September 2014 at the latest
There is a risk that if we implement new models of care we could destabilise existing providers		Through a process of communication and engagement with providers and by making sure that we plan the implementation carefully and collaboratively – moving activity before we execute capacity reductions we will deliver stable and sustainable change
There is a risk that new and improved models of care increase demand for community services and don't reduce acute hospital / residential care activity	Medium	As with the previous risk mitigation plan we will deliver phased and planned capacity movement
Financial –There is a risk that failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing financial pressure as an ageing population increases demand		At the outset of the programme, being clear on: • Clear and achievable financial objectives • Well planned phased service model changes to deliver greater efficiency • Close financial performance management

Risk	Risk rating	Mitigating Actions
		• Early identification of issues and contingency plans in place to mitigate slippages or unexpected demand
Clinical and quality – there is a risk that the planned changes do not improve quality but worsen it, resulting in a poorer outcomes and patient experience		Service model changes will be designed and reviewed throughout the programme process, with contract mechanisms and measures established to evaluate all proposed changes, and where appropriate pilots will be run and evaluated
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits		The programme will be properly planned, with agreed timescales 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		The governance structure formalises senior level commitment to the programme; throughout the programme on-going support will be reviewed and expanded as necessary
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining contracts and the evaluation of results		We will design and implement a thorough intelligence process to put in place processes, checks and balances that will help us to capture and analyse our patient cohorts in a way the minimises potential gaps in our knowledge.
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		

Risk	Risk rating	Mitigating Actions
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		