Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Essex County Council**
Clinical Commissioning Groups	**West Essex CCG**
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
	<CCG Name/s>
Boundary Differences	**<Identify any differences between LA and CCG boundaries and how these have been addressed in the plan>**
Date agreed at Health and Well-Being Board:	**<dd/mm/yyyy>**
Date submitted:	**7 March 20014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£17.43m**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£18.98m**

b) Authorisation and signoff

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

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

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

c) Service provider engagement

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

"My Health, My Future, My Say" sets a vision for the West Essex health and care system over the next 10 years. The development of our vision was informed by two major engagement programmes undertook by the CCG with patients, clinicians and service providers in west Essex during 2013. The discussions that took place through this programme have contributed directly to how we plan to design and shape our services for the next 3, 5 and 10 years.

Health and social care organisations in West Essex 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 this activity within 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 CCG and Social Care and 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.

System wide clinicians and social care commissioners and providers are already part of the established clinical reference group governance process, and SEPT has established a Frailty Programme Integrated provider partnership board. Current membership includes:

- Essex County Council
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Princess Alexandra Hospital NHS Trust (PAH)
- North Essex Partnership University NHS Foundation Trust (NEPFT)
- Essex Cares
- Voluntary Sector
- Primary Care
- Ambulance Service

Plans and progress are discussed at monthly system leadership meetings, along with

one off meetings including a stakeholder business event on 17 January and a Lead Provider and Commissioners Workshop on 31 January 2014.

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

What our citizens told us they wanted when we engaged with them over the summer:

- Personal responsibility
- Prevention and early intervention
- Changing culture – caring for people as individuals
- Minor problems are important
- Access to primary care as gateway to all care
- Integrated care.

Patients have been involved throughout the service design for the Integrated Frailty Programme for 2013/14 and 2014/15.

An outcomes framework has been developed with patients and carers for the frailty programme.

A workstream has been established as part of the Frailty Programme for patients and carers that will focus on ensuring:

- We understand patient and carer needs and wants
- Patients and carers understand programme goals and how these will be achieved
- Service changes are widely understood and do not result in public concern or opposition

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Frailty Mandate	West Frail Mandate D1 131024.doc
Frailty Business Case	Draft Frailty Programme Business (
West Essex CCG Planning for Transformation 2014/15	Transformation and redesign event 17th J
West Essex JSNA	**tba**

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?

Health and social care organisations in West Essex have agreed to develop and test new way of working that delivers integrated commissioning and provision of services to realise the vision of the West Essex Clinical Commissioning Group (CCG):

The population of West Essex is enabled to maximise their health and live fulfilled lives, and, those in need of support receive the most appropriate and well-co-ordinated high quality care that restores their health and promotes their continued independence, at best value to the tax-payer.

This will be achieved through:

1) Establishing a joint commissioning system for improved outcomes and efficiency, not inputs (ECC and WECCG)
2) Appointing an accountable lead provider to manage an integrated care supply chain

This work is already underway and is not limited to activity defined within this plan.

The focus of the programme is the frail population and those who are at risk of becoming frail.

The programme scope runs across the whole health and social care economy in West Essex. The work of the programme spans the roles of key local organisations, responsible for both the commissioning of services and their provision:

- West Essex CCG
- Essex County Council
- South Essex Partnership University NHS Foundation Trust (SEPT)
- Princess Alexandra Hospital NHS Trust (PAH)
- North Essex Partnership University NHS Foundation Trust (NEPFT)
- Essex Cares
- East of England Ambulance Service NHS Trust
- Voluntary sector.

The organisations listed above will form a supply chain, with SEPT as accountable lead provider (ALP). The scope of the programme is however wider than the supply chain, encompassing primary care and other important providers such as Barts Health NHS Trust and Cambridge University Hospitals NHS Foundation Trust.

The supply chain will engage closely with primary care to design services will specifically to the needs of each primary care led locality.

The programme is timetabled for three years (2014/15 to 2016/17), plus a preparatory period in 2013/14:

Year	Work undertaken
2013/14	Preparation for the implementation of change in the commissioning and provision of services
2014/15	Year one – piloting of new models of care and 'shadow' new accountable lead contracting arrangements; early wins
2015/16	Year two – analysis of year one and roll-up of successful pilot / shadow arrangements into core ways of working; further agreed improvement and change
2016/17	Year three – full embedding of successful change; significant and sustained changes to the model of care, including significant and enduring shifts of activity to community settings
2017-19	Years four and five – continued realisation of the benefits of change; all financial targets met

From a patient perspective, the goals of the frailty programme can be summarised as:

- Increasing the length of time known conditions are maintained in a stable condition, and therefore reducing the frequency of acute exacerbations
- Decreasing the severity of acute exacerbations when they cannot be prevented, by early detection and rapid response
- Reducing the impact of acute exacerbations by shortening the duration of the episode through rapid response and effective reablement
- Reducing the levels of vulnerability/ frailty by managing the risk of developing/ worsening additional co-morbidities.

Patients will see the difference through:

- Care closer to home
- Fewer 'crises' requiring acute admission
- A slower transition to frailty for those at risk of becoming frail
- Fewer organisations delivering care

The CCG and its partner practices have over the last 12 months been exploring how a programme of transformation within primary care can support a different approach to providing care to our population. Each of our 3 primary care localities, Harlow, Uttlesford and Epping are proposing to establish themselves business entities to facilitate their ability to act as lead coordinators for the management of care for a number of conditions over and above core services. This could involve practices taking responsibility for a total budget for a group of patients. Plans are being developed as follows:

- Localities to form business entities by 1 April 2014
- Extended range of provision of ACSC (Plus) commencing **July 2014**
- Extended provision- 7 day working **June 2014**
- Commence co-location of services /community based hubs from **Sept 2014**

From a financial perspective, the goal is to ensure that the health and social care economy is able to meet rising demand (due to an ageing population) within available resources.

b) Aims and objectives (should this be dumped and just embed the outcomes document?

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?

Our overall aims and objectives for integrated care within the frailty programme are to:

- Demonstrate a marked improvement in patient experience and quality of care, which is centred on the needs of the individual
- Work through organisational boundaries and promote inter-organisational working
- Develop a commissioning landscape that supports prevention of crisis
- Share risk and gain appropriately through the West Essex care system
- Invest in infrastructure that will improve sharing of patient information across organisations involved in care; and also support performance management
- Improve productivity and make better use of resources.

The basic assumptions underpinning the programme are:

- That the quality of patient care can be improved by integrating services
- That integration can be facilitated by the appointment of an ALP with a supporting supply chain, covering acute, community and social care
- That ALP arrangements and integration can in turn be facilitated by a new form of contract – where risk and gain are shared between commissioner and provider
- That joint commissioning between health and social care will support an integrated provider response
- That integrated care will remove inefficiencies from the care process and make better use of resources
- That better use of resources will help the health economy to manage demand pressure and, over time, establish a secure financial position.

The programme also assumes that the local health and social care community can work together to deliver the programme in a co-operative and transparent way.

The ALP will be commissioned to deliver a change in outcomes – work is underway to agree how the change will be measured. A draft copy of the outcomes framework is provided:

Frailty Outcomes framework - social ca

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

Within the scope of the programme is the development of new service models and commissioning arrangements for those defined as frail or likely to become frail. Most of these patients will be elderly, though not all. The wider patient population within scope is defined as:

- Anyone over the age of 75
- Anyone under 75 years with conditions that are amenable to frailty
- Anyone with dementia or in a long term care home.

This definition is being refined to produce an identified and 'sized' population cohort, on which the programme will focus.

The key criterion is frailty – defined as a patient who has or is likely to have a set of health conditions and/or social circumstances that mean they can readily fall into a crisis resulting in (for example) unplanned acute hospital admission. The scope of the frailty programme population includes services for those who are very ill or at the end of their lives, but importantly it includes services for those who are at risk of becoming frail.

The boundaries of the programme are wide, but will be bounded in order to ensure that it is manageable; the population cohort is capable of being robustly commissioned for; and success can be properly evaluated.

A summary of proposed changes in the service model is given below. This will be refined in early 2014.

Pre-shadow & Year 1	Year 2	Year 3
Start to integrate health and social care: access to social care information & access to rapid response social care via SPA for A & E & RAC	Fully integrated health and social care access via a Care Co-ordination centre to all piloted services	Establish full capability of care co-ordination centre
Improve access to reablement for hospital discharge	Extend access to rapid response to community	Embedding and roll – out of all successful pilot schemes
Front end of PAH changes to support admission avoidance activity	Improve rates of community based rehab at home	Re-design and re-pilot unsuccessful schemes
Improve access to RAC	Set up specialist MDT's	Establish full MDT working
Working towards dedicated step up beds in focussed units.	Increase capacity for step up intermediate care	
Focus on admission avoidance from care homes	Ambulance trust changes to support admission avoidance	
Extension to mental health crisis support for AA	Revised focus on community dementia support and liaison	
Pilot MDT's in willing and able GP practices, developing risk stratification tool	Delivery of supportive end of life pathways, revise integrated community team working including falls pathway	

The key interfaces between this programme and other work are:

- The CCG's other transformational programmes with complementary aims; including -
    - Working age adults with ambulatory care sensitive (ACS) conditions – linked in terms of caring for patients with long term conditions
    - Primary care - where changes in the service model are complemented by changes in primary care provision
    - Non-supply chain providers – contracting with (for example) tertiary hospitals must complement the main frailty programme
    - Within the CCG, there are clear linkages to the work to commission improvements in urgent care, NHS 111, stroke care and end of life care.
- Alignment with ECC transformational programme

d) Implications for the acute sector

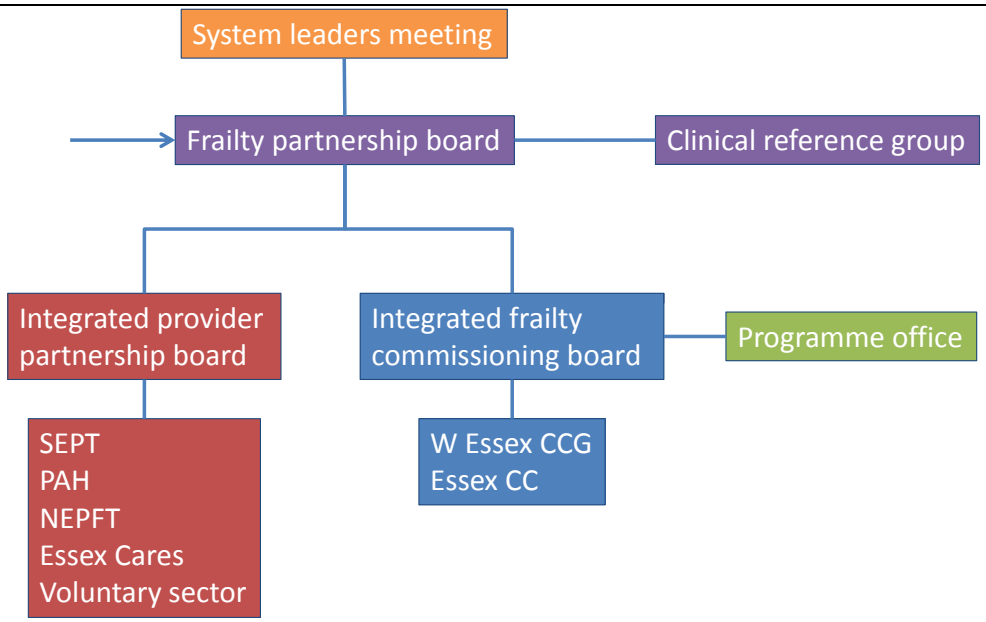
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings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

The BCF fund spending 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.

During 15/16 the programme aims to avoid inappropriate admissions across the acute sector that serves west Essex patients. The exact numbers are still in development This should have a positive impact on the acute sector by releasing capacity to deliver more elective capacity and reduce outsourcing.

e) Governance

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



Each named organisation is accountable through its own governance structures and to national structures. The nature of this programme is one of collaboration between independent organisations.

The governance roles of each body are set out below:

Body	**Role**
Integrated partnership board	Authorisation of the programme, including changes in provision and commissioning arrangements
Clinical reference group	Agreement of the service model for integrated care; required outcome measures; etc
Joint frailty commissioning board	Forum for the CCG and ECC to agree their commissioning approach and requirements for frailty
Integrated provider partnership board	Forum for SEPT and the supply chain to agree the frailty provider approach and manage delivery

Terms of reference will be agreed for each of the bodies listed.

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 level and to develop integrated care pathways that enable individuals to remain as independent and healthy as they are able, that maximises resilience and builds upon personal capacity and existing support networks. 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 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 we did 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 principle mechanism for this is ECC social care resource allocation system (RAS) and support planning. ECC envisages that the level of protection will need to be sustained in 15/16 and 16/17 to allow for contract procurements. In particular for the West Essex health and social care system this will take the form of further investment in an integrated community based reablement model following our test and learn reablement pilot in West. It is our intention that the identification of such citizens and scheme development will in future be the responsibility of the Approved Lead Provider, using existing metrics and data.

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.

- We are working with all of our 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 SDIPS over the next two years and beyond. We will engage closely with our providers to ensure once action plans are developed to ensure roll out across the system over the plan period in line with contract commitments

- Health and Social care commissioners in west 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.

- In the meantime the CCG is developing an Urgent Care Strategy, in response to associated 'winter pressures' in the acute hospital setting. There is a clear expectation that 7 day support for hospital discharge on a WECCG 'whole system' basis. Priorities including 7 day discharge from PAH, health and social care in-hospital capacity and activity and Health and social care support and reablement services for community discharge are being piloted this winter., supported by rapid assessment, and CARS, improved access to primary care services 7 days a week.
- The accountable lead provider for frailty will be commissioned to develop a set of services that 'wrap around' patients and operate flexibly across a 7 day service arrangement.
- Early diagnosis of ACS conditions is highly dependent on improved and direct access to diagnostics, with urgent reports being provided to GP's within 24 hours. The CCG therefore expects the ACS service model to be available 7 days per week where appropriate. We will be commissioning for outcomes and these outcomes will be the same regardless of day of the week and expect primary care providers to provide extended 7 day a week services from July of 2014

c) Data sharing

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

It is our intention to use the NHS number as the primary identifier in the future. Improved IT systems within ECC to be commissioned later in 2014 will have the ability to enter and use the NHS number. WECCG are currently unable to use the NHS number due to national restrictions which impact upon all CCG's. However, the CCG has been granted Accredited Safe Haven status and will potentially be able to receive patient identifiable data at some point in 2014/15. We already have a data sharing protocol in place between ECC, PAH and SEPT to support the SPOA.

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

As above

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))

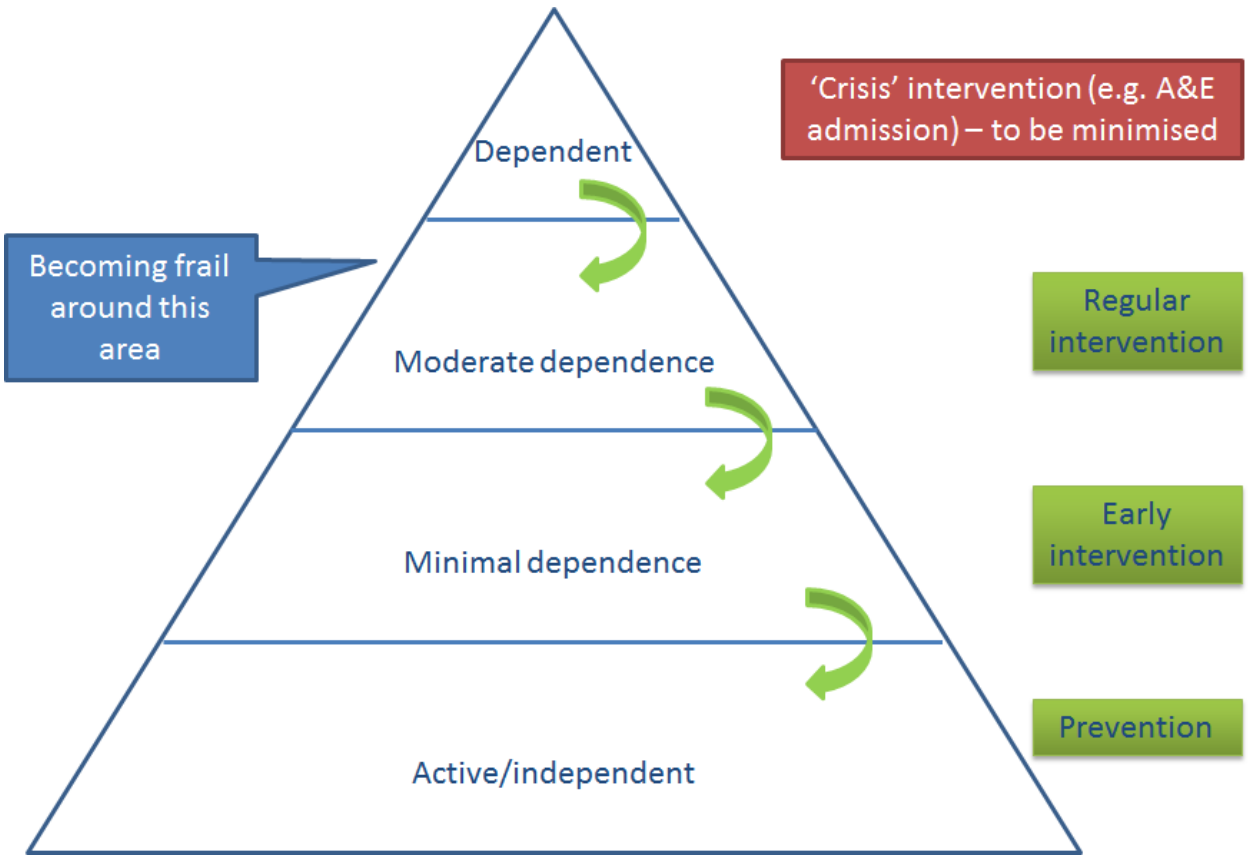
Yes

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.

Yes

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.

Local people deemed to be at high risk of hospital admission will be allocated an accountable lead professional via primary care. At present a jointly agreed risk stratification tool, between CCG and social care has not been agreed or identified. The future approach to risk stratification will be by the Approved Lead Provider for the WECCG area, which will commence in shadow form from April 2014. The ALP will then be charged with the responsibility of a) identifying and sharing a suitable risk assessment tool and methodology b) apply this to the WECCG population. This future modelling will then be able to identify the proportion of the population who at High and Very High risk of hospital Armed with this information, more importantly the ALP will then begin to construct a supply chain around this relevant population that is able ensure early identification and prevent and where possible, reverse frailty and maximise resilience and capacity. 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.



We will put in place a service model that will slow down and where possible reverse the

rise of patients up the pyramid. We will design and commission a model of care that reduces the risk of crisis and reduces dependence.

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
Financial – failure to realise efficiency and productivity gains will mean the health economy will come under significant and increasing pressure as an ageing population increases demand	High	At the outset of the programme, being clear on: • Financial objectives • Service model changes to deliver greater efficiency
Clinical and quality – that changes do not improve quality or worsen it, resulting in a poorer patient experience	Low	Service model changes will be reviewed throughout the programme, with contract mechanisms and measures in place to evaluate all changes
Contracting process – inability to set an agreed baseline and assumptions for the contract; for example, relating to funding for transformational schemes during 14/15	Medium	Contract negotiations and clarifications have begun, with an agreement to make all financial baseline issues transparent
Competition rules – inability to set a contract length long enough to facilitate transformational change while conforming to market testing requirements	Medium to High	Market testing policy to be drafted as part of the contract, to facilitate competition within the supply chain
Objectives / expectations – failure to adhere to agreed programme scope, objectives, etc. and to 'drift'; risk of overlap or conflict with other transformational schemes	Low	The PID and subsequent documents will formally record the scope and nature of the programme, for formal sign-off and review
Timescales – failure to meet agreed timescales, resulting in the slower achievement of benefits	Medium	The programme will be properly planned, with agreed timescales, dependencies, etc.; progress will be reviewed and contingencies developed where necessary

External environment, including politics – challenges to the programme from important external stakeholders or influencers, opposing programme objectives or the means of achieving them	Medium	A stakeholder management exercise will be undertaken to (inter alia) assess any potential challenges, their impact on the programme and how they should be managed
Commitment and engagement – failure of the local health and social care community to remain committed to the programme and its objectives	Low	The governance structure is intended to formalise senior level commitment to the programme; throughout the programme ongoing support will be assessed
Patient cohort – failure to properly identify the target population and the activity and resource identified with it, undermining the contract and the evaluation of results	Low	Early prioritising of a pragmatic population cohort that can be identified and measured