Essex County Council

Item 3

Report to Health & Wellbeing Board	**Reference number**
Date of meeting 12th February 2014	**County Divisions affected by the decision** *All Divisions*
Title of report **Better Care Fund and CCG 2 Year Operational Plans for 2014-16 – Part 1**	
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) template and Clinical Commissioning Group (CCG) 2 year operational plans as drafts to NHS England as required under NHS Planning Guidance by 14th February 2014.

2. Recommendations

2.1. Note progress in completing the BCF template for Essex and the CCG operational plans.

2.2. Note the timetable for further work to be undertaken to complete these documents for endorsement by the Board at its next meeting on 27th March 2014.

2.3. Endorse the draft BCF documents (attached as appendices 1 & 2) for submission to NHS England by 14 February 2014.

3. Background and proposal

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

3.2. 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".

3.3. Requirements

3.3.1 HWBs are required to agree 2 year BCF plans by the end of March 2014. 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.

3.3.2 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.

Better Care Fund

	2014/15		2015/16 - Minimum		2015/16
	National	Essex HWB	National	Essex HWB	Proposed at 31/1/14
	£000's	£000's	£000's	£000's	£000's
NHS Transfer to Social Care (£859m 13/14)	900,000		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

3.3.3 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 draft by 14th February 2014 and in final form by 4th April 2014 following HWB endorsement, 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 plans.

3.3.4 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.

3.4. Essex BCF template and CCG operational plans

3.4.1. The draft versions of the BCF template Part 1 and Part 2 are attached for the HWB to endorse for submission to NHS England. The final version will be sent to NHS England in April, following endorsement by the HWB at its March meeting. Progress in completing the template has been driven and monitored by the Business Management Group (BMG) of the HWB. There has been agreement on the vision and overall aims for BCF and on the broad headings for schemes that should be included in Essex's BCF:

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 2014/15i

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 need 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.

3.5. Each CCG has produced its own BCF return. These will be embedded in the Essex submission and give detail on its engagement with providers and proposed schemes. The typology for schemes provides some consistency to these submissions. Nonetheless we have agreed in BMG that we should improve consistency between CCG submissions for the final submission and will be working together to achieve this.

3.6. The CCG's 2 year operational plans, of which the BCF should be an integral part, are also attached for endorsement as drafts for submission to NHS England. The HWB received presentations and 'plans on a page' setting out the main points from these Plans at its meeting in January.

3.7. These drafts have been produced to the timetable set nationally. Because CCGs are currently engaged in negotiations with acute hospitals (to be concluded by 28th February 2014) there are still significant gaps and areas to be confirmed or revised in the attached documents. These will be addressed before presentation of the final BCF template and 2 year plans to the HWB on 27th March 2014. The

aspects to be clarified or completed include calculation of benefits of schemes and the impact of planned changes on acute hospitals. Other sections (eg risks and contingency planning) are in turn dependent on these sections being completed. For the purpose of this draft the proposed targets against metrics have been used as a proxy for benefits. The targets themselves need to be explicitly agreed or amended by CCGs. Other sections of the submission will also be subject to review and editing to ensure this presents a coherent set of priorities and schemes and clearly articulates the impact and benefits of our approach.

3.8. The attached timetable has been agreed by all partners on the BMG to ensure that the Essex BCF submission and CCG 2 year operational plans are completed for endorsement at the March meeting of the HWB.

3.9. Conclusions

While there is clear agreement to the vision for Essex between HWB, and to the direction of travel, there are several key aspects of the BCF submission which at this stage necessarily remain incomplete. All CCGs and ECC have made a commitment to revising and completing the draft to the agreed timetable attached, following conclusion of CCG negotiations with acute hospitals. This is essential to meet submission deadlines.

4. Policy context

4.1. The plans and BCF submission are aligned with the Joint Health and Wellbeing strategy.

4.2 The draft 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 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.

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 has been 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 recommendation of this technical group will be made to the BMG before inclusion in the BCF final submission to this Board in March.

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).

5.4 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.

6. Legal Implications

(This section should be written by the relevant senior or principal lawyer advising on the scheme or project. This section should set out the key legal issues arising from the report)

6.1. The BCF is central government funding to which the Council does not have a statutory entitlement. For 2015/16 the conditions of entitlement for funding require recipients to establish a pooled fund under section 75 of the National Health Service Act 2006. This is a fund which is to be spent jointly by local authorities and NHS bodies. Such a fund can only be established by agreement, and it seems clear that 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. The decision establishment of a s75 agreement will need to be considered in accordance with the decision making processes of each party.

6.2. It is clear that 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 today 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 also 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.

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 draft plans.

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

9. Background papers

9.1. Better Care Fund Part 1 and Part 2 Templates
9.2. Time table for Better Care Fund and 2 year Operational Plans
9.3. NHS England Better Care Fund Guidance
http://www.england.nhs.uk/ourwork/sop/

Once legal and financial implications have been incorporated, reports need to be signed off by the Section 151 Officer and the Monitoring Officer and agreed by the Health & Wellbeing Board member presenting it and relevant Cabinet Member before being submitted to the HWB secretariat.

Appendix 1 Better Case Fund Part 1 Template

Essex - Better Care Fund planning template – Part 1

CONTEXT

(Awaiting further revisions of Context, Visions, Aims & Objectives for March submission)

It should be noted that this Essex wide document reflects the generic planning intentions of the five Essex CCGs and Essex County Council with regard to the Better Care Fund (BCF). It does not necessarily accurately reflect the specific strategic intentions and aims & objectives of every CCG in every section. For CCG specific strategic intentions please refer to the embedded documents as well as the CCG Operational Plans.

This document is a draft developed by Essex's 5 Clinical Commissioning Groups (CCG) and Essex County Council, informed by the Joint Strategic Need's Assessment's (JSNA) for each CCG, the Health and Wellbeing Strategy (HWBS) for Essex, informed by discussions with providers and service users and endorsed as a working draft by the Essex Health and Wellbeing Board (HWB) on 12th February 2014. It represents Essex HWB response to the opportunities presented by the BCF to achieve our shared ambition of improved health and social care outcomes for our population through integration and earlier intervention.

This draft has been developed with contributions from each CCG as part of the development of their two year operational plans linking across Essex through our HWB arrangements. The proposals, costs and benefits set out in this document will be refined as CCG's plans are finalised in discussion with NHS England (NHSE), partners, providers and service users. The HWB is committed to maximising the opportunities offered by the BCF to improve health and social care for the population of Essex.

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 Essex County Council being responsible for social services in the area and five Clinical Commissioning Groups responsible for the health economy in the area.

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 (CPRCCG) 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 area 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). SUHT is located in the Southend CCG (SCCG) area and services both SCCG and CPRCCG.

Although not part of the Essex Health and Wellbeing area, Essex includes Southend Borough Council and Southend CCG plus Thurrock Council and Thurrock CCG. CCGs in the South collaborate closely on a cross border basis with shared providers and contracts in place

This document, where possible, tries to combine the individual strategies, vision, aims and objectives of Essex County Council and the five CCGs. The individual organisation's plans are embedded in the **Related Documentation** section

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:	**Draft version 12/02/2014** **Final version 27/03/2014**
Date submitted:	**Draft version 14/02/2014** **Final version 04/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**
Total agreed value of pooled budget: 2014/15	**£0.00**
2015/16	**£0.00**

Boundary Differences:

South West Essex/South East Essex sub economies
Neither Basildon & Brentwood CCG nor Castle Point & Rochford CCG is the sole commissioner for their main acute providers.
Therefore, all parties recognise that there will need to be continuous collaboration and shared planning between South Essex, Thurrock and Southend.

All parties are seeking to achieve similar outcomes and recognise the importance of giving clear direction to providers and the market place. This will only be possible if all parties collaborate in an open and transparent manner.
Existing forums will be utilised (i.e. Unplanned Care Boards that operate in both sub economies) to ensure that there is consistency in the operational delivery of commissioned services.

Essex/Southend/Thurrock local authorities and CCGs
A significant amount of 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 our plan's focus 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.

b) Authorisation and signoff

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

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

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

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

Signed on behalf of the Clinical Commissioning Group	**Castle Point & Rochford 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>

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. This first draft submission reflects a number of existing programmes which have included health and social care providers as active participants. Providers are engaged in the development of future plans.

A whole system engagement event was held in June 2013 involving voluntary sector, health and social care providers, local authorities and clinical commissioning groups 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, Essex County Council and the individual CCG's have jointly developed the vision and aims & objectives for health and wellbeing in their localities.

The joint integration programmes/schemes that the BCF will include were also discussed and provisionally agreed at these events, subject to further planning and validation.

On a locality basis extensive and on-going engagement has taken place with service providers to create locality visions for jointly commissioned services. An example of this is:

- South Essex Partnership University NHS Foundation Trust (SEPT) as lead provider with an integrated supply chain which will include Princess Alexandra Hospital, Essex Cares, and North Essex Mental Health Trust. Aspirations for the programme are to develop the supply chain further and expand the role of the voluntary sector. ambulance service (See individual CCG submissions in the Related Documents section for further details regarding Provider Engagement)

The relevant key provider engagement dates across Essex were:

- North East Essex CCG / ECC – Throughout November and December 2014 NEECCG have discussed with main providers at Board and Leadership Team level. Providers have been invited to be part of the Care Closer to Home project groups and are already members of the Urgent Care Working Group. In addition

all providers have been invited to the Big Care Debate. Specific Provider meetings were held on 8th and 23rd January 2014

- West Essex CCG / ECC – 2 major engagement events in 2013
- Mid Essex CCG / ECC – Integrated Commissioning Workshop 12th December 2013
- South Essex Integrated Commissioning Workshop (Basildon & Brentwood CCG, Castle Point & Rochford CCG, Essex County Council) – 28th 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

The Business Management Group of the Health and Wellbeing Board has led the development of this submission also includes representation from Healthwatch ensuring that this submission reflects a patient and service user perspective.

Essex County Council and the Clinical Commissioning Groups routinely engage with a number of service user representative planning groups as part of their planning for service commissioning and development. The outputs from these sessions have been used to develop schemes within this BCF plan. It is our intention to engage with third sector organisations to facilitate focus groups to obtain further feedback from service users as we refine and develop these plans. Healthwatch Essex has agreed to develop user engagement and feedback forums with respect to the BCF specifically. A wide range of consultation and engagement events have taken place to enable patients and the community to shape the commissioning and planning of local services:

- The Patient Engagement Groups events that have taken place during 2013 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.
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- 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 NEECCG the “Big Care Debate” has been used to engage with patient groups and representative organisations.
- In WECCG patients and service users have similarly been involved with setting the vision by being involved in “My Health, My Future, My Say (see Related Documentation section).

e) Related documentation

Document or information title	Synopsis and links
Health and Social Care Integration (Accelerated Design Event)	The vision for service users and commissioner, 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 locality (excluding Thurrock and Southend localities) http://www.essexpartnership.org/content/health-and-wellbeing-board
"Who Will Care" commission report	130911 Who will care v FINAL.pdf
BBCCG BCF Template	The BBCCG locality Better Care Fund Planning Template Part 1
CP&R CCG BCF template	The CPRCCG locality Better Care Fund Planning Template Part 1
MECCG BCF Template	The MECCG locality Better Care Fund Planning Template Part 1
WECCG BCF Template (including WECCG related embedded documents)	The WECCG locality Better Care Fund Planning Template Part 1 plus supporting documentation
NEECCG BCF Template	The NEECCG locality Better Care Fund Planning Template Part 1

2)VISION AND SCHEMES

(Awaiting further revisions of Context, Visions, Aims & Objectives for March submission)

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?*

Essex County Council and CCGs share a vision. 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 who receive care in Essex:

- We will commission and deliver integrated care that is person centred
- The care we deliver will be consistent in quality with an appropriate response across the whole of the County
- We will better understand our population demographic and be more able to predict and prevent increasing demand, including proactively identifying long term needs ;
- Services will be available 24 hours a day seven day a week where appropriate;
- We will be fair in the delivery of care. This means being consistent across our patients and service user groups;
- Our care will take account of the wider determinants of people's lives including their families, carers and communities

For commissioning in 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 have a commissioning strategy for the whole of Essex which aims to provide care that is sustainable and is 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 manage markets to streamline our provider arm to deliver efficient and effective pathways
- We will align budgets and finances to deliver the most effective impact, integrating resources where possible
- We will work with providers to develop behaviours which aligns to our overall strategy

. Through collaboration and, where appropriate, shared resources we will achieve:

- Integrated and sustainable health and social care systems across Essex, improving outcomes through responsive high quality care and support;
- 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;

- 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.

Within 3 years we want to achieve the following change across our health and social care system:

- Coordinated health and social care with an allocated case manager for every vulnerable person;
- People who are frail and older will have targeted services that concentrate on prevention and early intervention;
- People with mental health problems will experience better outcomes with support based around their needs;
- Disabled people will have support that enables them to gain and retain independence longer and be able to access proactive health services;
- Outcomes for people with long term conditions will have been improved by better coordination and support concentrating on pro-active care, preventative outcomes and admission to secondary care avoidance;
- Urgent or unplanned care interventions will have significantly reduced;
- Improved management of avoidable demand will have led to sustainable budgets across health and social care.

Aims and objectives
(Awaiting further revisions of Context, Visions, Aims & Objectives for March submission)

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 across Essex to integrate commissioning and to work in partnership that will lead to the development of more integrated pathways across the health and social care landscape.

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.

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**
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; shorter length of stay
Reduction in emergencies and other unplanned activity	• Reduced admissions, reduced A&E attendances
Improved clinical information	• Evidence of sharing data / use of shared systems / 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	• 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 in the level of deprivation and the provision of prevention services. Inequity in 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.

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 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

The Aims, Objectives and the Benefits of the BCF will also be manifest in the achievement of the Metrics identified in BCF Template 2. 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 target a 5% reduction in the number of admissions to residential care. This is based on 6.1% of current residential admissions occur directly following a new client assessment at hospital. It is intended for BCF schemes will be developed to prevent these people going into crisis and to 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 proposal is for the Metric target to be to "maintain" current performance. We expect, over the 14-15 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 to be offered reablement in Essex resulting in the target to “maintain” being a stretching target. Essex currently compares favourably with both its geographic and its statistical neighbours. Essex currently achieves 82% against this metric which is 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% for the April 15 performance period and a further 2.5% for the Oct 15 Performance period. We believe that this is a stretching target as the Essex performance is 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 (1674) whilst the population increases 2% in the first performance period and a further 1% in the second performance period.
5. **Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]** 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 the number of community referrals we expect in the first target period, increasing these for the October 2015 payment. This will reflect schemes that will be put in place developing additional referrals in the first half of the 14-15 financial year.

b) 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

A. 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 need, against a backdrop of pressure on service capacity and resources. We know that to achieve this we need 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.

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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B. Community Health services including admission avoidance

We will develop new provider models of integration between community health, community care and primary care providers. The local authority is committed to ensuring equity in outcomes and will work with each CCG to develop the appropriate model in their locality. The models will focus upon risk stratification of vulnerable people, the development of 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 some areas of Essex for the two years of the BCF before procurement of fully integrated services. We will co-produce the models with user-led organisations in Essex.

C. Reablement

We have jointly commissioned community based and residential reablement services with CCGs in Essex for the past two years. We have invested in reablement funding on community based services and in integrated health and social care reablement models, including residential-based models using s256 NHS transfer money.

Over the two years of the BCF we intend to;

- Continue to fund reablement and intermediate care services using NHS reablement funds in 2014-15.
- 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
- Pool all NHS and social care reablement funding in 2015-16
- Develop an integrated intermediate care statement of capacity for each CCG area during 2014-15
- Use pooled funds to purchase revised intermediate care services (including reablement services) from the market commencing in the autumn 2015.

D. Joint Nursing and Care Home commissioning (inc. 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 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.

Essex County Council will work in partnership with the Care Home Market and housing providers to shift the pattern of services towards greater levels of community based dementia care, and greater levels of extra-care housing; and as a consequence reduced proportions of residential care placements

E. Discharge support

Essex social care services and Acute services 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, 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 (see Community Services above) 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

F. 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 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.

Explain the South Essex Mental Health strategy for March submission
Explain the Essex Dementia strategy for March submission

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

H. We expect Primary Care to take a lead role in the care coordination for Health and Social Care services in Essex.

I. We will establish Multi-Disciplinary Teams (MDT's) 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.

J. Primary Care will be the vehicle we use to lead the risk assessment process which vulnerable people will need to identify their care needs and identify opportunities for early intervention. We will use BCF schemes to respond and co-ordinate the resultant needs and interventions.

K. 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 enabled voluntary sector organisations.

L. 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

M. Essex GPs are taking a positive approach to their role in care coordination and we will continue to support them to do so.

N. Investment to meet requirements of the Care Bill

Revised arrangements for community health and community care be 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 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

We will use a proportion of the BCF 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.

O. Early intervention and prevention

We aim to identify needs early and intervene to prevent the escalation of problems and prevent crisis. This means supporting people in their communities.

Individuals and communities value their independence and their ability to make their own decisions and choices. We will focus on early intervention and prevention, helping equip vulnerable people with the support and skills that they need to live independently for longer and to help themselves.

One example might be enabling 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 (see below).

A further example of this will be 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 and offering an alternative to traditional health and social care 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

P. Community resilience:

Essex commissioned the Who Will Care? Commission to take a whole system view of what needed to change. This has resulted in a shared vision for changing the relationship between the individual and the state and putting in place a framework and incentives for mobilising communities on a county-wide scale supported by timely and safe information-sharing. The Whole Essex Community Budgets programme supports this vision by building capacity within and across Essex communities to utilise community assets and build reciprocal support in partnership with the voluntary and community sector.

Q. 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

R. 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.

S. Other schemes and enablers

Historically one of the main areas that have adversely impacted joint working between health and social care has been the lack of shared IT systems, information sharing processes and governance. In order to maximise the impact of the partnership working set out in the BCF there is a real need to work towards this in a more constructive way and to develop a system of data and information sharing to inform the strategic direction and its impact.

CCGs are working with ECC to develop local governance structures for integrated commissioning that will both satisfy individual organisations' governance processes while promoting more agile decision-making at partnership level
Part of the BCF fund will be used to develop these programmes of work.

c) 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.

Essentially all CCG's are committed to reducing activity in Acute settings, the specifics of which will not be known until the outcomes of the contract negotiations are known. Negotiations are currently underway between CCGs and providers which are expected to be concluded on the 28th of February. Therefore this section cannot be completed for submission of the 14th February draft

The BCF spending plan will be expected to have a significant impact on non-elective admissions. The resultant reductions 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.

Acute activity levels will have been agreed with hospitals including a reduction in unplanned acute activity as a result of increased investment in admission avoidance and community based reablement schemes.

d) Governance

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

The County Council and the CCG's have invested heavily in building strong and effective working relationships at both officer and elected member levels. The County Council 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 of our CCGs and the local authority.

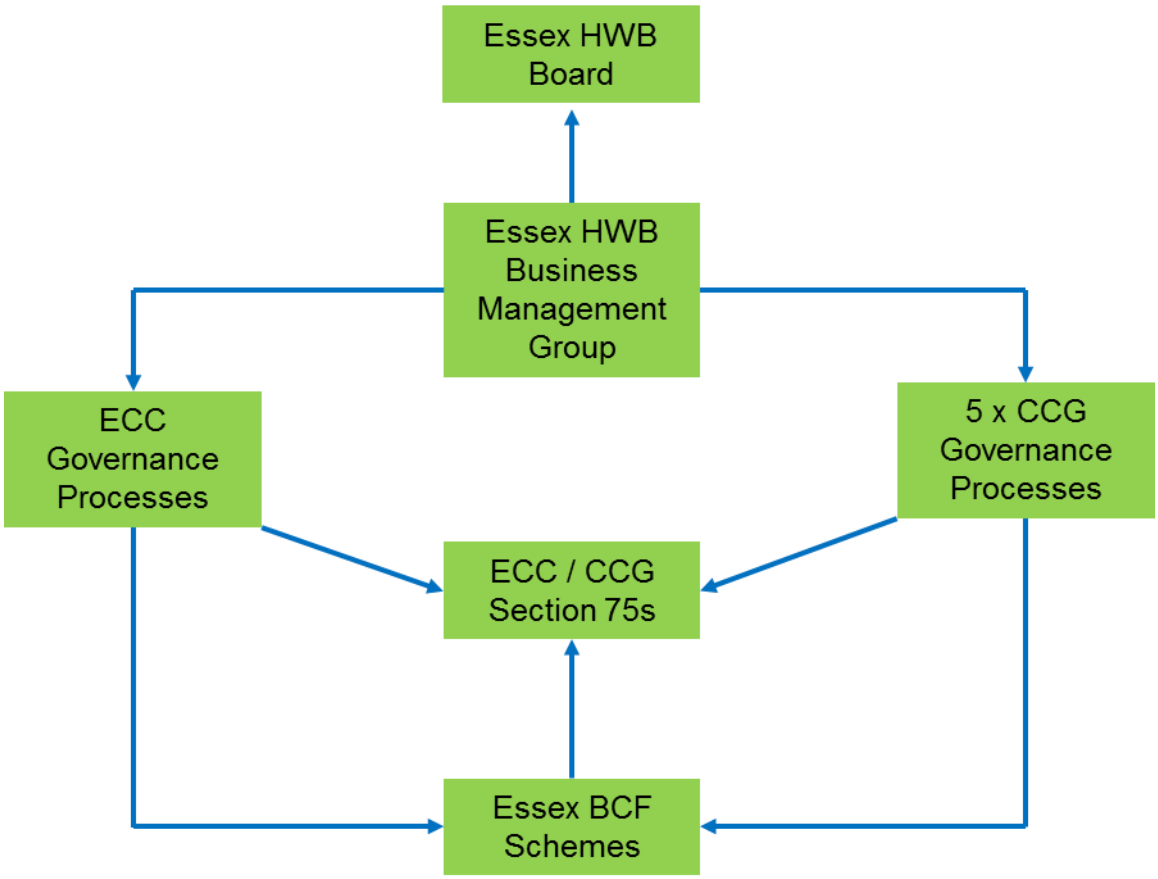
The HWB is supported by regular meetings between the local authority Commissioning Directors and CCG Accountable Officers within the Business Management Group. Our transformational plans and programmes are formally discussed and approved at local authority governance levels and within each CCG's governing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

To deliver the ambition we have for our BCF, we recognise the need to develop further strategic and operational governance arrangements. We therefore propose to look at, as part of the BCF Programme implementation.

This will determine how we start to bring together management responsibilities and accountability across care and health services, for our residents and patients and as whole.

The future management team responsible for the commissioning of integrated care, will be accountable through the Health and Wellbeing Board, and through Local Authority governance arrangements and CCGs governance arrangements.

A governance and contractual risk sharing work group has been established to finalise governance arrangements by September 2014


Essex HWB Board
Essex HWB Business Management Group
ECC Governance Processes
5 x CCG Governance Processes
ECC / CCG Section 75s
Essex BCF Schemes

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. 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 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 15/16 and 16/17 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 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 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 14/15 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.
For specific CCG plans please refer to CCG documents in the Related Documents section

c) Data sharing

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

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

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

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

Appendix 2 Better Care Fund Part 2 Template

Finance - Summary

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

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

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

Contingency plan:		**2015/16**	**Ongoing**
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend (£000's)		2014/15 benefits (£000's)		2015/16 spend (£000's)		2015/16 benefits (£000's)	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
1) Protection of Social Care Services		£0	£0	£0	£0	£26,958	£0	£0	£0
2) Community Health services & Admission Avoidance		£0	£0	£0	£0	£42,595	£0	£0	£0
3) Reablement		£0	£0	£0	£0	£10,604	£0	£0	£0
4) Joint Nursing & Care Home Commissioning		£0	£0	£0	£0	£7,128	£0	£0	£0
5) Discharge Support		£0	£0	£0	£0	£830	£0	£0	£0
6) Acute Mental Health & Dementia		£0	£0	£0	£0	£1,020	£0	£0	£0
7) Primary Care		£0	£0	£0	£0	£0	£0	£0	£0
8)Care Bill Investment		£0	£0	£0	£0	£1,131	£0	£0	£0
9)Early Intervention & Prevention		£0	£0	£0	£0	£218	£0	£0	£0
10) Community Resilience		£0	£0	£0	£0	£19	£0	£0	£0
11) Carers		£0	£0	£0	£0	£1,107	£0	£0	£0
12) DFG		£0	£0	£0	£0	£4,713	£0	£0	£0
13) Others		£4,932	£0	£0	£0	£2,915	£0	£0	£0
Total		**£4,932**	**£0**	**£0**	**£0**	**£99,237**	**£0**	**£0**	**£0**

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

The Essex BCF schemes are designed to provide care earlier in our patients and service users care pathways through early intervention and prevention schemes and to keep our service users as independent as possible in their normal place of residency for as long as possible. The metrics will demonstrate the achievements of these outcomes by:-
• Showing a reduction in the number of permanent admissions to residential and nursing homes through targeted early intervention and prevention schemes.
• Demonstrating an increase in the number of people being presented to reablement services (local additional measure) and maintaining the outcomes of those going through reablement
• By investing in additional reablement services including home from hospital schemes we will demonstrate a reduction in delayed transfers of care from hospital.
• Individual CCGs will be investing in BCF schemes that reduce avoidable emergency admissions. Jointly, investment in risk stratification and identification of individuals at risk of hospital admisdsion will support the early intervention and prevention schemes identified in this plan and the CCG Operational plans

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

Not Applicable

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The performance plans that will support these Outcomes and Metrics will be assured across the County and by each CCG. These arrangements will include assurance by the Executive Director for People Commissioning in the local authority and the Unplanned Care Boards / main Boards of the CCGs.
The score cards demonstrating progress against the metrics will be reviewed at the Business Management Group of the Health and Wellbeing Board. The Health and Wellbeing Board will also review performance against these metrics regularily

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not Applicable

Metrics		Current Baseline (as at 21/1/14)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population ***Proposal is 5% reduction in the number of admissions to residential care.*** *This is based on just over 5% (6.1%) of current residential admissions being directly following a new client assessment at hospital. It is intended for BCF schemes to be set up to prevent these people going into crisis and to divert them down different pathways.*	*Metric Value*	583		520
	Numerator	1575		1496
	Denominator	270160		287900
		(April 2012 - March 2013)	N/A	(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services ***The proposal is for the Metric target to be to "maintain" current performance.*** *We expect, over the 14-15 period, 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 have obtained the national results for the ASCOF measure. It shows that Essex, at 82%, is above the Eastern Region average (81.5%) and shire councils (80.8%).*	*Metric Value*	82%		82%
	Numerator	692		948
	Denominator	844		1156
		(April 2012 - March 2013)	N/A	(April 2014 - March 2015)
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% for the April 15 performance period and a further 2.5% for the Oct 15 Performance period.*** *This is on the basis that the Essex performance is in the top quartile of its statistical neighbours and that the trend has reduced and is now generally level. However, in the first part of this year, delays increased. We believe a 2.5% decrease from 2012/13 levels will be a stretching target.*	***Metric Value***	199	192	185
	Numerator	2212	2157	2103
	Denominator	1109834	1123800	1135200
		2012-13 outturn	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure) Awaiting data from CSU. *NHSE CSU have provided the composite measures to calculate this baseline.* ***NHSE CSU has developed a tool for individual CCGs to select their own target.*** *The suggested target is to maintain current levels of avoidable emergency admissions (1674) whilst the population increases 2% in the first performance period and a further 1% in the second performance period.This metric will be driven by local CCG admission avoidance schemes particularily around paediatrc admissions*	*Metric Value*	1674	1673	1673
	Numerator	5296	5402	5455
	Denominator	316466	322833	326104
		(TBC)	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]			N/A	
		(insert time period)		*(insert time period)*
ADDITIONAL LOCAL METRIC: The coverage of reablement. This metric will measure an expansion in the number of referalls from community into reablement. *We have taken the 2012-13 baseline and reduced it to take account of inappropriate referals to reablement. We have the number of community referrals we expect in the first target period, increasing these for the October 2015 payment.* ***This means that schemes need to be in place to be getting the additional referrals in the first half of the 14-15 financial year.***	*Metric Value*	1451	1540	1864
	Numerator	3920	4317	5367
	Denominator	270160	280300	287900
		2012-13 data	(April 2014 to March 2015)	(October 14 to Sept 15)

Appendix 3

Appendix 3 - Timeline for BCF and 2 Year Plans

Key Date	Activity
27th Jan	CCGs with ICDs complete outstanding elements of CCG BCF templates and make revisions necessary as a result of clarifications at BMG on 22nd Jan
28th Jan	Essex BCF draft circulated to BMG for comments
29th Jan	BMG teleconference to address any gaps/issues remaining
31st Jan	CCG and Essex BCF drafts to NHS England for comments
3rd Feb	Draft Essex and CCG BCF templates and draft outline CCG 2 year operational plans to ECC ready for HWB publication
4th Feb	HWB (Health and Wellbeing Board) papers published
12th Feb	HWB meeting to approve draft Essex BCF submission and draft outline CCG 2 year operational plans
14th Feb	**HWB submit draft Essex BCF and CCG draft 2 year plans to NHS Eng**
28th Feb	Deadline for revisions to CCG BCF templates and Essex BCF submission. Full 2 year operational plans shared between CCGs and ECC
5th Mar	BMG to troubleshoot any remaining issues in final draft BCF and 2 year plans
12th Mar	Final draft BCF and 2 year plans circulated to BMG
14th Mar	Final draft BCF and 2 year operational plans to NHS England
19th Mar	HWB papers published including proposed final BCF submission and 2 yr plans
27th Mar	HWB approve final Essex BCF submission and 2 year CCG operational plans
4th Apr	**HWB submit final Essex BCF and 2 year operational plans to NHS Eng**

Appendix 4 NHS England Better Care Fund Guidance

http://www.england.nhs.uk/ourwork/sop/