Annex C

NHS
Basildon and Brentwood
Clinical Commissioning Group

BETTER CARE FUND
PLANNING AND PROPOSALS
2015/16

Document Control

Change history

VERSION	REASON/SUMMARY OF CHANGES	DATE	AUTHOR
V0.1 & V0.2	**1st Drafts for review**	**10/01/14**	**Stuart A Brown**
V0.3	**3rd Draft incorporating Risks and Finance**	**30/01/2014**	**Stuart A Brown**

Document approvals - this document requires the following approvals

NAME	TITLE	VERSION AND DATE
Dr Anil Chopra	**CCG Chairman**	**V0.3 - January 2014**
Tom Abel	**Chief Accountable Officer**	V0.1 -January 2014 **V0.3 - January 2014**
Tracey Easton	**Chief Finance Office**	**V0.3 - January 2014**
Tonia Parsons	**Chief Operating Officer**	**V0.3 - January 2014**
CCG Governing Body	**All**	**V0.3 - January 2014**
Nick Presmeg	**Director of Integration - ECC**	**V0.3 - January 2014**

Distribution

NAME	TITLE	DATE OF ISSUE	VERSION
BBCCG Governing Body		06/02/14	V0.3

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 the Better Care Fund Submission.

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

1. CONTEXT

Basildon and Brentwood CCG is responsible for the area of Basildon, Billericay, Brentwood and Wickford, which has a total population of 264,630. As a CCG we work with four locality groups for Basildon, Billericay, Brentwood and Wickford. This enables us, as a CCG; to work more closely with the populations we serve and allows us to have insight into the diversity of our population.

We were authorised as a statutory commissioning body in April 2013, with a number of conditions and directions we had to meet before we could take on full commissioning responsibilities. We have worked hard to address these and we are now confident that from April 2014 we will be able to assume full responsibility for our statutory functions.

We recognise that we still need to describe and provide more specific details about how and when we will deliver the planned system change envisioned for not just the BCF but the wider health and social care system in Basildon and Brentwood. This is currently constrained to a certain extent by the planning that we are doing and contractual arrangements we are in the process of concluding with our providers for 2014/15.

One of our most immediate priorities it so procure and implement a risk stratification tool.

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

- To commission services that target frail and older people who are vulnerable or at risk of losing their independence. The newly developed integrated community services teams will ensure a multidisciplinary approach that is targeted and risk based.
- To work with primary care to develop and commission integrated health and social care services that will reduce the need for people with a long term condition to utilise health and social care services;
- To move care closer to home so that our hospitals have manageable demand, one of the enablers for this will be the newly commissioned integrated health and social care rehabilitation and reablement service;
- To work together to ensure people are supported to look after their health and wellbeing;
- To support providers to join up, share information, and make services easier to navigate;
- To create an Integrated Commissioning Board or similar with ECC and other local authorities as appropriate, to align our work and have a single commissioning process, services and work.

The CCG's draft 5 year strategy outlines three care concepts underpinning the future of Healthcare in Basildon and Brentwood:

1. The establishment of **Excellent Primary Care** consistently across Basildon and Brentwood.

2. The creation of **Named GP Teams, working as Lead Professionals** for people at risk providing GPs with the responsibility and authority to ensure the provision of integrated and co-ordinated evidence based care to each individual. These teams will be built from geographic Primary Care Federations, with an opportunity to consider differing integration forms and models.

3. The development of **Specialist Pathways of Care**, integrating existing community, acute and specialist service provision for designated indications. Such pathways will be evidence based and time limited.

Whilst we have some high performing services, the system has become complicated with overlaps, and involves too many hand overs between organisations and services. For example, our management of long term conditions and services to the frail and elderly require much greater integration particularly focussing on who is in charge, or who is responsible for their health and care.

This situation provides a clear driver for integration across health and social care. This document describes our high level plan for the implementation of the integration agenda in Essex and Basildon and Brentwood in particular - and specifically the implementation of the first tranch of the Better Care Fund (BCF) in 2014/15.

Basildon & Brentwood CCG will work in collaboration with Essex County Council; striving to achieve seamless provision of health and social care where integration can work in the best interests of the local people of Basildon and Brentwood.

2. PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and sign off

Signed on behalf of the Clinical Commissioning Group	**Basildon and Brentwood CCG**
By	**Tom Abell**
Position	**Chief Accountable Officer**
Date	**<date>**
By	**Anil Chopra**
Position	**Chair of the CCG**

Signed on behalf of the Council	**Essex County Council**
By	**Nick Presmeg**
Position	**Director of Integrated Commissioning & Vulnerable People**
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

Basildon and Brentwood CCG and the South Essex sub- economies

BBCCG is not the sole commissioner for our main acute provider - Basildon and Thurrock University Hospital. It is a shared provider with Thurrock CCG, this means there will be overlaps between the BBCCG part of the Integrated Plan and the Integrated Plans of Thurrock and to some degree Southend.

All parties are seeking very similar outcomes and recognise the importance of giving clear direction to providers and the market place that will only come through close working. We will utilise existing forums such as the Unplanned Care Working Group to ensure that there is consistency in appropriate levels of strategic and operational commissioning intentions.

This first draft reflects a number of existing programmes that are designed to include health and social care providers as active participants; together with a range of GP locality groups, and our voluntary and community sector as a whole. Our intention is to encourage providers to take and active role in developing future plans.We have a major provider engagement event jointly with Castle Point and Rochford CCG planned for the end of January 2014.

It is our intention, as the programme gathers momentum, to invite representatives from key providers to join the South Essex BCF Commissioning Group, currently chaired by ECC which meets weekly. This will ensure that the design of future services and clinical pathways is jointly driven and jointly owned.

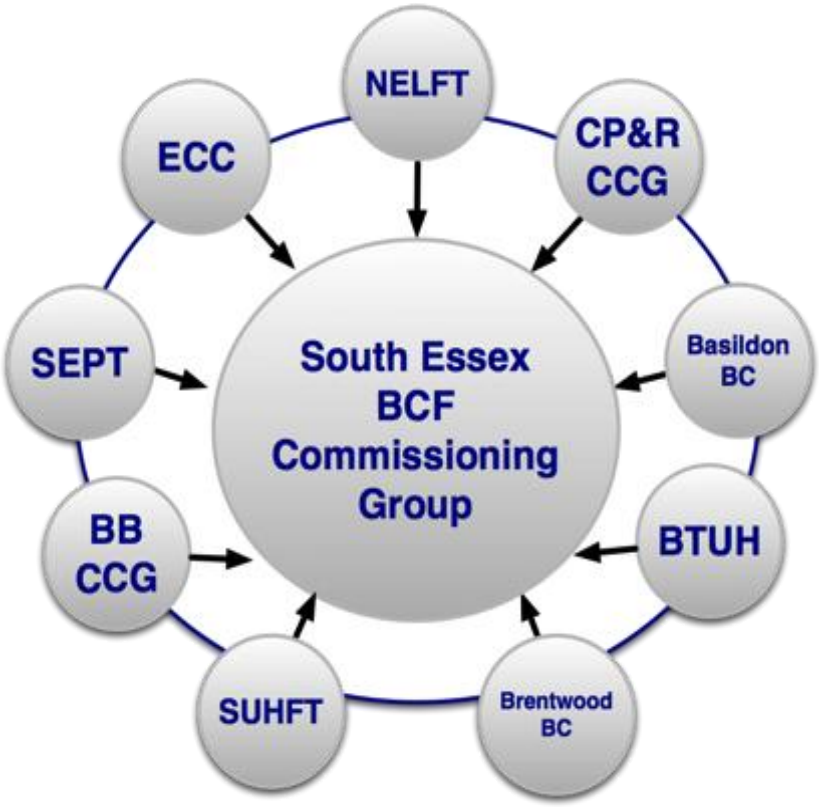


Fig 1 - South Essex BCF Commissioning Group

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

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

Our vision is to design and implement an integrated care system based on what our resident population needs, that need will be articulated by the residents themselves via the various patient and service user engagement forums that we have already established and a number of additional groups that we are planning to establish over the coming weeks.

The CCG has implemented a wide range of activities to help ensure that our patients and community feel fully engaged with the planning and quality monitoring of local services:

All 4 locality groups have Patient Engagement Groups (PEGs) which meet monthly to hear patient views and act as an information exchange.

The CCG has a formal Patient and Community Reference Group (PCRG)in place, acting as a formal reference source for the Governing Body, receiving proposals for service developments, commissioning plans, etc.

Members include 9 lay reps, 2 x CVS, 3 local authorities, Healthwatch Essex and GP chair of the CCG. Key roles of the group include receiving reports from the Patient Leaders for monitoring quality of service delivery, participating in planning services with the CCG, receiving reports on specific service areas throughout the year, etc

The PCRG links to the locality PEGs through lay members and CCG locality managers to ensure local views and connections are maintained. The workplan of the PCRG is aligned to the national and local planning process to ensure that the group has the opportunity to influence commissioning and integrated plans prior to Board approval. http://www.basildonandbrentwoodccg.nhs.uk/patient-and-community-reference-group

As well as being the CCGs representative on the Essex Health and Wellbeing Board, the GP Chair of the CCG is a member of the Basildon Health Partnership and a Brentwood GP is a member of the Brentwood Council health forum.

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

Board meetings are held in public, with questions invited, and some GP locality groups have patient representatives as members.

The CCG Chair and executive officers routine liaise with local MPs, local authority elected councillors and other community groups.

The CCG has its own website where all plans (including the Integrated Plan), policies and documents are published and accessible to the public www.basildonandbrentwoodccg.nhs.uk

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

Our current engagement map is described below in Fig 2:

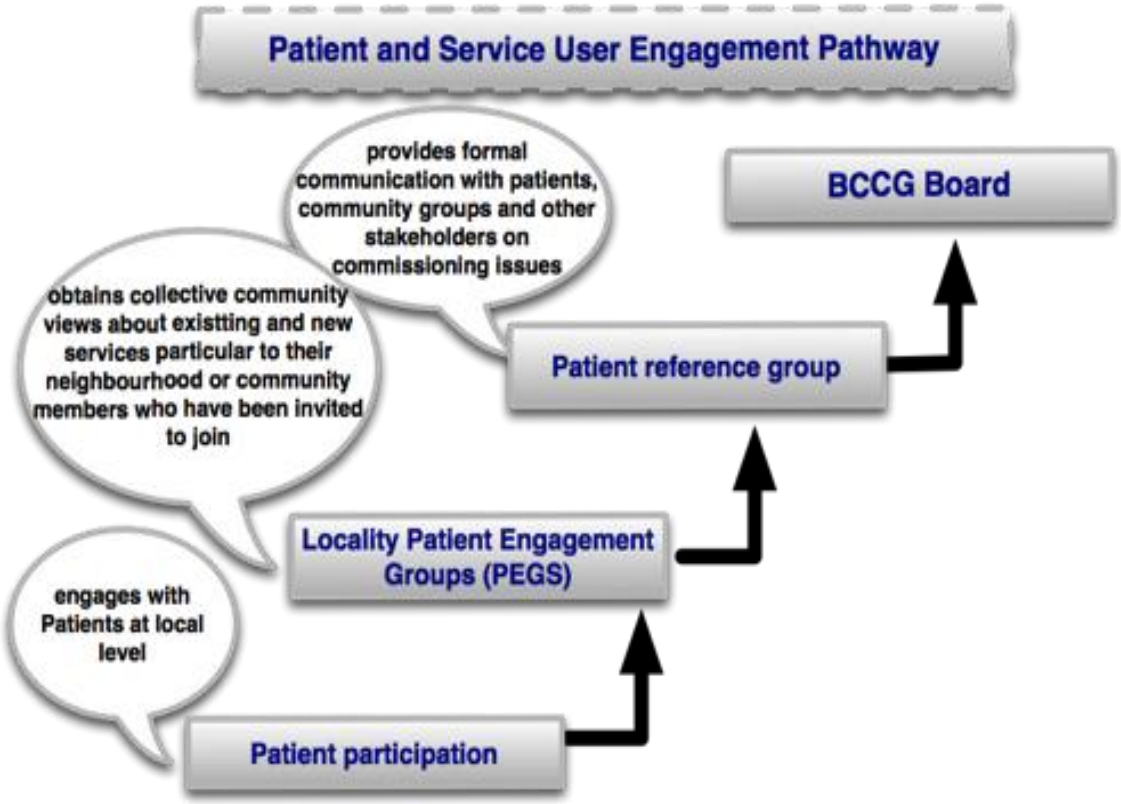


Fig 2 - Patient and public engagement process

e) Residency versus GP Registration

All residents within the geography of Essex County Council are covered by ECC's social services. Access to health services is dependent on the address of the GP that the individual is registered with. This can lead to ECC residents receiving their healthcare from CCG areas outside of ECC's geography and some residents from neighbouring local authorities receiving their healthcare from within the Essex Health and Wellbeing geography.

f) 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.

The table overleaf describes the key Basildon and Brentwood documents that feed and inform the development of the BCF submission. There are other national documents and guidance that also inform the BCF submissions including :

The NHS Outcomes Framework;

The ASC Outcomes Framework;

The BCF Planning and Technical Guidance;

The "Everyone Counts" planning guidance.

Document or information title	Synopsis and links
BBCCG Integrated Commissioning Plan	Describes the five year plan for Basildon and Brentwood Clinical Commissioning Group - setting out in detail the services we intend to commission, the services we intend to reform and improve and the services we may wish to de-commission.
BBCCG Strategic Plan	This document sets out the challenges and the issues we face as a CCG and defines the strategy we will adopt to address those challenges in the coming years as we strive to reform and modernise the local health economy
BBCCG Operational Plan 2014-2016	Provides the specific detail that describes how and what we will measure in relation to such things as improving Patient Safety, Safeguarding, Standards of Care in our providers.
Citadel Healthcare Future State V0.2	A mindmap translation of the Citadel Workshop held in November 2013 and attached as an appendix to this document
Citadel Healthcare Workshop Scan - Graphic	A graphic representation of the Citadel workshop held in November 2013, a copy of which is attached as an appendix to this document

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.

The current provision of health and social care services is not sustainable from either a quality or capacity perspective or a financial perspective in the long term. Therefore we are committed to significant radical reform to design and build a health and social care system that is: based on quality and safety, is accessible, affordable, responsive, agile, patient centric and delivers the levels of quality that our residents demand and rightly deserve.

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

NHS Basildon and Brentwood CCG (BBCCG) is commencing a process to undertake significant reform of the local NHS and wider care system. The objectives of these reforms are to:

- Design, develop and implement a patient centric integrated health and social care system that delivers the right care in the right place at the right time;
- Improve the quality and safety of local services;
- Improve outcomes for our local populations and reduce health inequalities;
- Move to a local health and care system that is financially sustainable.

The system reform proposed focuses on three core work elements:

- The establishment of 'Excellent General Practice' consistently across the area;
- The creation of integrated 'Named Accountable Professional Teams' who will be responsible for managing the health and care of people with long term complex needs;
- The creation of integrated 'Specialist Pathways of Care' for people with specialist needs.

What changes will have been delivered in the pattern and configuration of services over the next five years?

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

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;

People have a named GP and someone from the surgery co-ordinates all the different services within their joint Care plan. A single patient and care record which can be accessed and controlled by the clinicians and care workers who are involved in their care. Which gives them the assurance that they will have continuity of care and support, seven days a week, even if they need to go into hospital for a short spell. The GP will , using teams consisting of Community nurses, OT's, Social Workers and Geriatricians, co-ordinate the patients care ensuring a fully integrated delivery model.

- Systems will enable and not hinder the provision of integrated care;

People have a single care plan and where appropriate have been provided with simple devices and support that allows them to self-manage as much of their conditions as possible on a daily basis. With clearer information and advice, and knowing that professional support will be provided if they need it.

- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy.

Frail and Elderly are linked into local voluntary schemes for older people, which facilitates the sharing of experiences for mutual support.Care coordinators are proactive

in ensuring that support is available to them within their communities, through difficult times. Local shops and other community-based services play their part in helping to ensure that they are able to live healthy, well lives in their own homes.

- Clinical pathways will be designed around the needs of patients, carers and their families

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

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

What difference will this make to patient and service user outcomes?

As a result of these changes:

In line with the NHS Outcomes Framework and the five domains of:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long-term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm

and the four domains of the Adult Social Care Outcomes Framework of:

- Enhancing quality of life for people with care and support needs;
- Delaying and reducing the need for care and support;
- Ensuring that people have a positive experience of care;
- Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm.

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

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

Overall pressures on Essex hospitals and health budgets will have reduced, as we shift from high-cost reactive services to lower cost preventative services, supporting greater self management and community based care; and our social service budgets are going further, as new joint commissioning arrangements deliver better value and improved

care at home which in turn reduces the need for high-cost nursing and care home placements.

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

People will be empowered to direct their care and support, and to receive the care they need in their homes or other appropriate community setting.

Over the next 2 to 5 years we will enable community healthcare and social care teams to work closely together in an increasingly integrated way, with single health and social care assessments providing for rapid and effective joint responses to identified needs, provided in and closer to home.

Our teams will also increasingly work with the voluntary and community sector to ensure those not yet experiencing acute need, but requiring a level of health or social care support, so that we help them to remain healthy, independent and well. We will make considerable investment available to empower local people through effective care signposting, peer support, mentoring, self-management and personal healthcare budgets to maximise their independence and wellbeing.

We will design and implement integrated Community Independence teams tasked with providing a rapid response service to support individuals in crisis and help them to remain at home.

Community Independence Teams will also work with individuals who have lost their independence through illness or accident and support them to build confidence, regain skills and, with appropriate information and support, to self-manage their health conditions and medication.

We will also seek to introduce individuals to the potential of assistive technologies and, where these can be employed, we will ensure individuals are familiarised and comfortable with their use.

Underpinning all of these developments, the BCF will enable us to start to release health funding to extend the quality and duration of our reablement services. By establishing universally accessible, joint services that proactively work with high-risk individuals irrespective of eligibility criteria, we will be able to:

- Improve our management of demand within both the health and care systems, through earlier and better engagement and intervention;
- Work sustainably within our current and future organisational resources, whilst at the same time expanding the scope and improving the quality of outcomes for individuals.

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

As a result of the planned changes we expect the volume of emergency activity in hospitals to reduce and we also expect planned care activity in hospitals to also reduce because we will have developed alternative community-based services.

A managed admissions and discharge process, fully integrated into local specialist provision and Community Independence provision, will mean we will be able to eliminate delays in transfers of care,reduce pressures in our A&Es and wards, and ensure that people are helped to regain their independence after episodes of ill health as quickly as possible.

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

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

b) Aims and objectives

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

The overarching objective for the CCG is to improve health outcomes, reduce health inequalities and develop a sustainable affordable health and social care system.These aims will be achieved by proactive case management, by stratifying the risk and needs of the patients and service users -through responsive provision of local and regional services channelled through an effective community, social and primary care offer with a single point of access - Integrated Care through a lead professional and using a multi-disciplinary team approach focused on early intervention and prevention.

We have already agreed and implemented work in five specific areas with ECC which are:

- Commitment to jointly procure the risk stratification tool and share the data;
- To jointly specify and procure an enhanced reablement and rehabilitation service (this will include all current hospital discharge, intermediate care and continuing healthcare pathways);
- To develop and implement an integrated community services specification that will bring together social care assessment and care management services and community health provision;
- A joint programme approach to the implementation of the BCF;
- To ensure effective governance though the Joint Board that we have established.

What are the aims and objectives of your integrated system?

We see the implementation of the BCF as a two phased programme, the initial phase being that which we will deliver in 2014/15 and phase two which will go forward from April 2015.

The BCF is also a key enabler for the long term strategy that we are looking to deliver in Basildon and Brentwood which is a large scale modernisation programme that will

transform the health economy landscape for the area. This programme of modernisation and reform, which we have named Citadel, is an integral part of our planning activities for 2014/15.

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

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

Essentially we are focussing on areas that :

1. There are very clear synergies with ECC
2. There are opportunities to prevent admissions to secondary care
3. The are obvious health deterioration prevention opportunities
4. There will be a reduction in Health Inequalities
5. There are financial economies of scale to benefit from
6. Joint commissioning is driven by the needs identified in the JSNA and the HWBS.

How will you measure these aims and objectives?

Using the NHSOF and the ASCOF as our guide, we intend to measure specific nationally mandated and local metrics, the specific details of which will be covered in the Outcomes and Metrics tab of the excel submission template. The success factors will include such things as reductions in hospital attendance and admissions.The advances in IT capability will help us to drill down deeper into the data held which in turn will lead to more information on specific reasons for admissions and by doing so will present opportunities to develop additional preventative measures.

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

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

We will guarantee that individual information is shared in an appropriate and timely way to maximise safeguarding, wellbeing and user experience; and aggregated to allow

1 Subject to Information Governance constraints

effective identification and management of need and outcomes across our health and care economy as a whole.

What measures of health gain will you apply to your population?

We will be using the national mandated indicators[2] and we will be using locally developed indicators and KPI's that will use the JSNA and the JHWS as the key drivers and sources of intelligence that informs them.

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

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

As mentioned previously these are the key changes we will be implementing:

- We will have GP Federations working effectively and efficiently across the borough;
- GPs will be at the centre of organising and coordinating people's care;
- Systems will enable and not hinder the provision of integrated care;
- Our providers will assume joint accountability for achieving a person's outcomes and goals and will be required to show how this delivers efficiencies across the system;
- Integrated health and social care teams will operate seamlessly across the system which links to the joint accountability with all our providers, in order to improve peoples outcomes across the health economy;
- Clinical pathways will be designed around the needs of patients, carers and their families.

Working closely with ECC, and using a programatic approach based on Managing Successful Programme (MSP). The following diagram (Fig 3) describes the three main stages of the MSP process which we will be following.

At the time of submission we can say with a degree of confidence that we[3] are in the Development phase of the programme. A description of phase 1 - Define can be found in Appendix III of this document

2 As driven by the NHSOF & ASCOF

3 South Essex Commissioning Programme Group

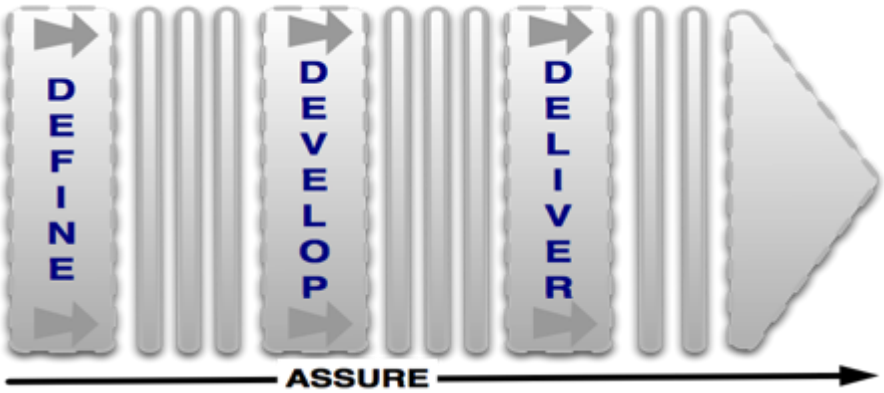


Fig 3 - MSP Programme phases

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

In line with the guidance issued on the 20th of December we will be submitting our initial plans to NHSE and ECC in February, albeit that they may not have gone through our desired full approvals process of ECC Cabinet and HWB.

A fully detailed plan is being developed in collaboration with ECC and with Castle Point and Rochford CCG as well as NHSE and local district councils. The detailed plan may or may not be ready for the initial submission date of 14th of February, if it is a copy will be attached in the appendices and if not it will be forwarded as soon after as is practicable

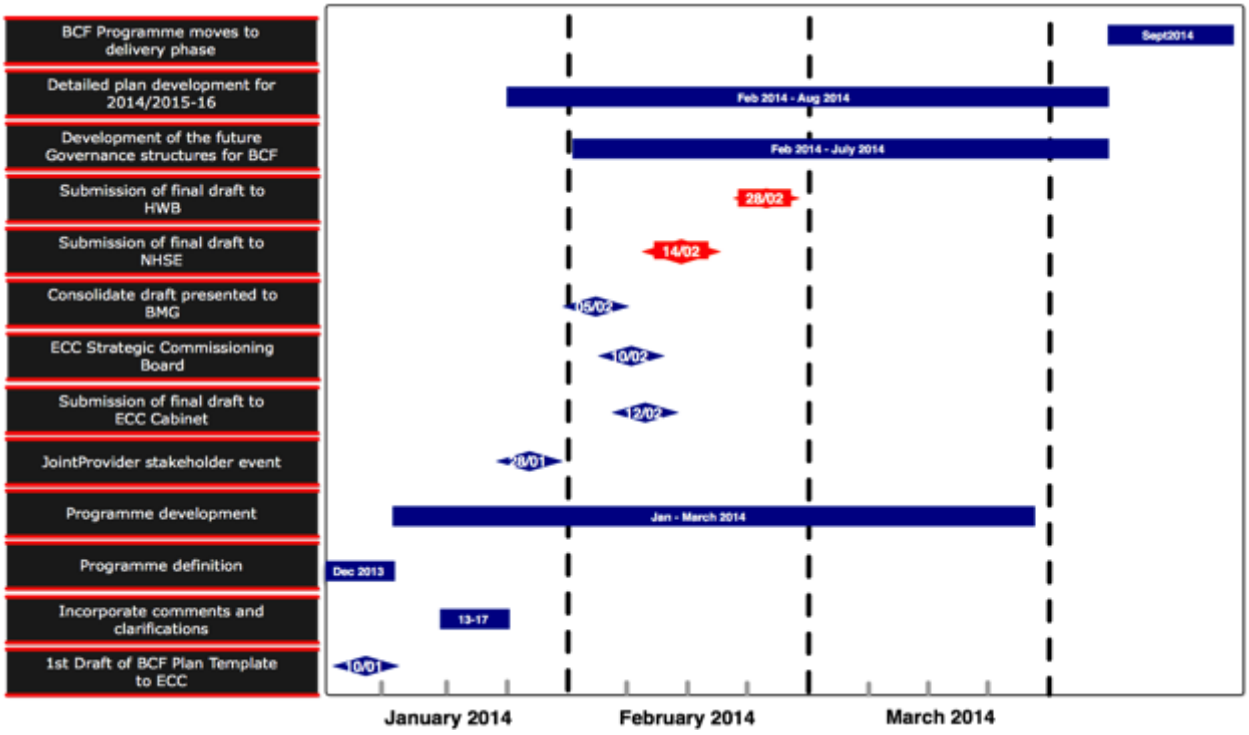


Fig 4 - Short term high level BCF programme plan

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

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

d) Implications for the acute sector

Implications of the plan on the delivery of NHS services

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

At the time of writing CCG's are in advanced stages of contract negotiation and specification, the current timeline for the conclusion is the 28th of February 2014 when all CCG's are required to have signed contracts in place. This will be reflected in the final draft submission for the BCF.

e) Governance

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

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

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

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

The diagram overleaf (Fig 5) describes the current Governance structure that we have developed to manage Phase 1.

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

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

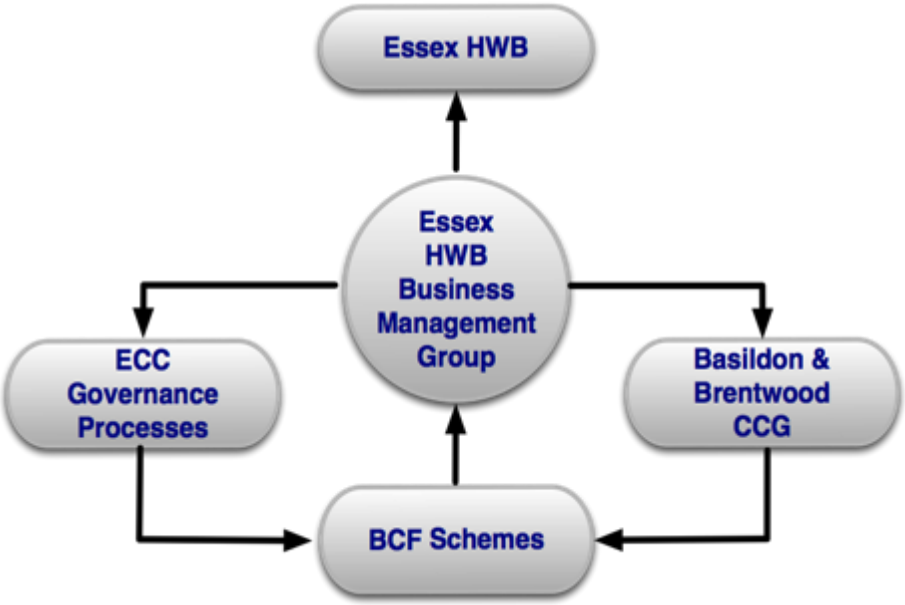


Fig 5 - BCF Phase 1 Governance structure

Joined up management - an integrated approach to commissioning management

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

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

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

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

f) BCF Programme structure

The development and delivery of the BCF programme is expected to be complex and challenging, particularly the communications, engagement and governance elements of the programme. Therefore based on this we have adopted a working group and task and finish group approach to programme management. The following diagram overleaf (Fig 6) describes the main standing groups that will sit during the development and

early stages of delivery. These will be complimented, when and where necessary by task and finish groups which will be convened for a time limited task specific period.

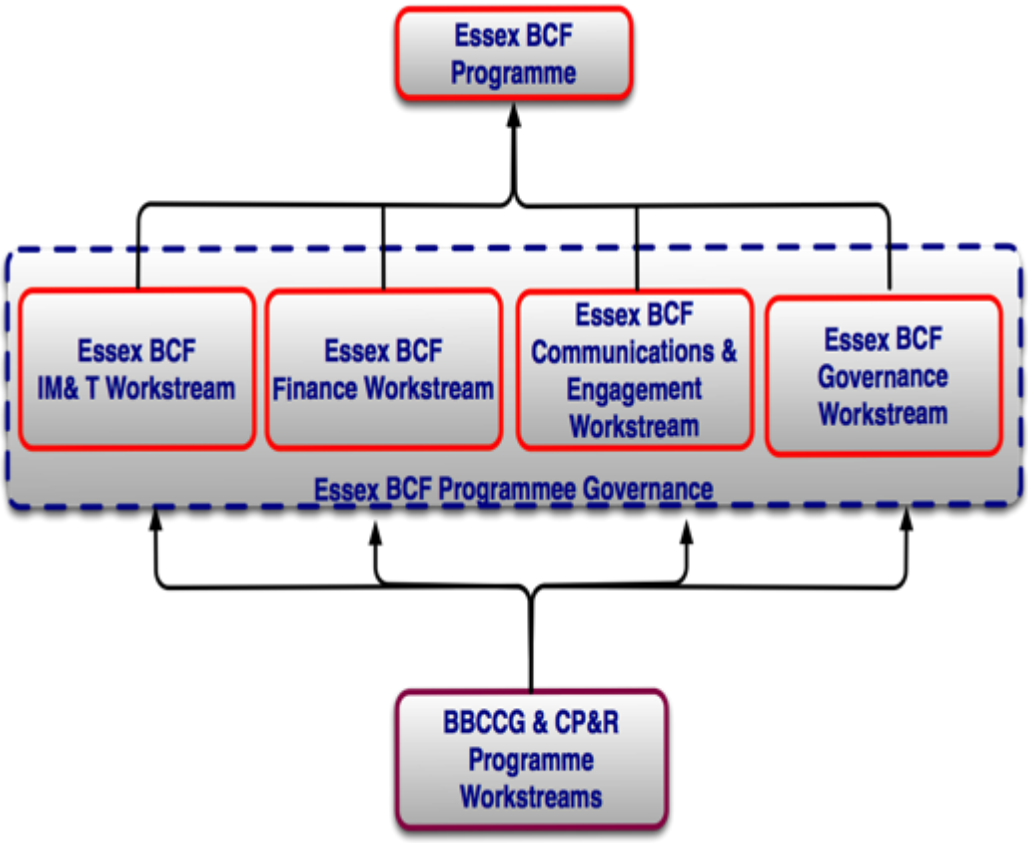


Fig 6- BCF Programme Structure

3. Financial Implications

We see the implementation of the BCF as a phased programme in 2014/15 being, in the main, the development phase for the main bulk of the funding transfer being executed in 2015/16. We are therefore developing the programme timeline accordingly and we will make full use of the time afforded to us to undertake a number of design and resilience testing activities to ensure to provide all parties to the integration with assurance that system change is not only going to work but that it will be both robust and sustainable.

BBCCG and ECC are having productive discussions around the sums that should go into the integrated fund, both parties recognise that if we simply deposit the minimum amounts as allocated by NHSE then it is unlikely that there will be sufficient monies to bring about real transformation of our health and social care systems in Essex. So whilst we still have considerable work to do[4] we are confident that we will collectively be contributing more to the pooled fund than the minimum amounts stipulated.

As stated we see this as a two stage implementation, consequently the functions and resources that will transfer and be managed through the integration arrangements for

4 this work will be taking placduring quarters 1 7 2 of the 2014/15 financial year

2014/15 will be considerably different and smaller scale than those transferring in 2015/16.

a) 2014/15 BBCCG Investment

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

Function/Service Identifier	Description	Min	Max
Protection of Social care to benefit health		**£3.7M**	**£4.854M**
Community Health Services (including admission avoidance)			
Reablement	Residential step-up/step down Community Beds Home from Hospital High Intensity Rehabilitation Hospital In reach Rapid Response SPOR	**£773K**	**£1.546M**
Joint nursing and care home commissioning including CHC			
Discharge support			
Acute mental health and dementia			
Care Bill			
Early intervention and prevention			
Community resilience			
Carers			
Disabled Facilities Grant			
Other and enablers			

Table 1 - 2014/15 Proposed investment

b) 2015/16

As we have established the size of the BCF will grow from 2014/15's allocation of £4.85M, which is mainly constructed from similar S256 amounts from 2013/14, to approximately £11.18M for 2015/16. Whilst we still have work to do and challenging conversations to have the table overleaf describes and sets out our ambition for 2015/16.

Function/Service Identifier	Description	Min	Max	Total Investment
Protection of Social care to benefit health		**£4.853M**	**£4.853M**	
Community Health Services (including admission avoidance)		**£9.809M**	**£14.834M**	
Reablement	Residential step-up/step down,Community Stats, Home from Hospital	**£3.700M**	**£1.850M**	
Joint nursing and care home commissioning including CHC				
Discharge support			**£507K**	
Acute mental health and dementia			**£71K**	
Care Bill				
Early intervention and prevention				
Community resilience				
Carers		**£82K**	**£82K**	
Disabled Facilities Grant				
Other and enablers			**£1.8M**	
	Totals	**£18.444M**	**£24.077M**	

Table 2 - 2015/16 proposed investment

4. National Conditions

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

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

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

a) Protecting social care services

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

The objective of integration is to develop a more effective, efficient and affordable health and social care economy. Integral to this will be the continued development and enhancement of social care services. Our stated ambition is to move more activity out of an acute setting and into a community based setting, this will require a stable and accessible social care system in order to make the changes sustainable.

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

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)

ECC already operate a six day discharge support service and in line with national guidance BBCCG is working with ECC and our providers to deliver a seven day access to health services programme.

This work is being undertaken: Locally, across multiple providers and regionally across the County. The programme includes a number of clinical pathways including Social care discharge, Reablement, Step

down and Rapid response via an out of hours emergency duty team. Care homes are working with us to ensure they are able to accept 7 day planned admissions.

BBCCG has implemented a collaborative working arrangement with key providers across the borough, see Fig 7 below, to develop the necessary support and infrastructure that will facilitate a sustainable response to the requirements for 7 day working in the NHS.

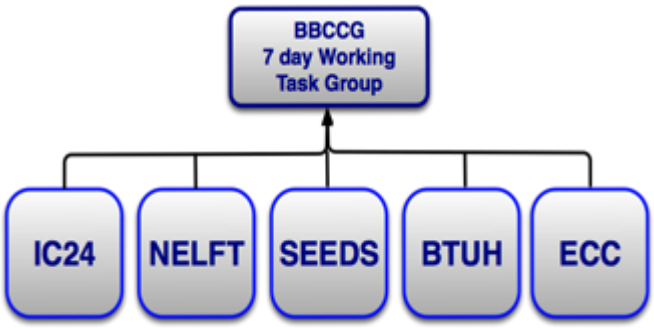


Fig 7 - BBCCG 7 day working task force

The following are some of the initiatives that are being developed :

- Paediatrician cover has shown a marked increase since the Paediatric review;
- McKinzie reviewed 10 specialties and validated job plans. Three workshops in September, October and December have driven this work at pace the success of which has been manifest in increased Attendance rates. The consultants are working to agree the standards and plug existing gaps;
- A pilot started on the 16th November for acute physicians, DMPO and general medicine to increase consultant cover. Improvements have been seen at the weekend, analysis is now underway to assess the impact of the upturn in discharge rates;
- January 2014 sees the implementation of a new model for Trauma &Orthopaedic (T&O) consultants;
- Additional locums have been brought in to increase from a half to full days at weekends. Respiratory coverage is increasing to 6 days per week;
- Discussions with anaesthetics, gastro and diabetes are ongoing to improvements that will be made. (This is managed through right place right time in workstream 3).
- ECC's pilot programme has been extended (moving from their previous 6 day supported discharge team's working window to 7 days). A further evaluation of the success and outcomes of this will be carried out at the end of the financial year.

c) Data sharing

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

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

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

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

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

Because the use of the NHS number is governed by the rules around Information Governance, and until some of these issues are resolved, we cannot put a specific date against this item.

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

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

Assuming that we mean: Application Programming Interface, then yes as a CCG we are open to exploring the use of API's[5].

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

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

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

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

5 The open API model is designed to reduce the process and resource requirements across partnerships and integrated working arrangements

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. professional.

Following the announcement by the Secretary of State for Health in December 2013 that everyone over the age of 75 would have a named GP lead who would monitor and manage their health BBCCG is in the process of working towards the implementation of this directive, we currently do not have full implementation.

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

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

As part of the BCF in practice, this **will** mean that every patient who is covered within these teams has a named GP who is responsible and accountable for their care and outcomes. Our plans for integrated community services within the BCF will ensure that Social Care resources are fully aligned on a multi-disciplinary basis.

Our plans to develop a fully integrated approach to reablement and rehabilitation will strengthen our existing arrangements and ensure we use a joint process to assess risk, plan care and allocate a lead professional

A step up approach to this could see the mobilisation of Multi Disciplinary Teams that may in be led by a Community Geriatician for example. BBCCG is in the process of trialling this along with other models of care in the community.

3 categories are being considered to help us define the level of health and social care that will be expected to be available to each individual who is 75 years or older:

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

intervention within a community environment, with a view to transferring the individual back to the care of the GP Practice-level MDT once their condition has been stabilised. The Lead Professional Care Co-ordinator for individuals in this category will be a Consultant Geriatrician, and the vehicle for assessment/planning and implementation of required care will be the Geriatric Case Management Team.

In order to take this model forward further it will be necessary to develop an effective risk stratification tool that will allow professionals across the health and social care system to apply a common approach to identifying individuals that fit within the 'moderate complexity' and 'significant complexity' categories. The CCG in partnership with ECC are fully committed to working together to evaluate and procure an appropriate risk stratification tool within 6-9 months, appropriately aligned to other BCF procurements.

a) 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

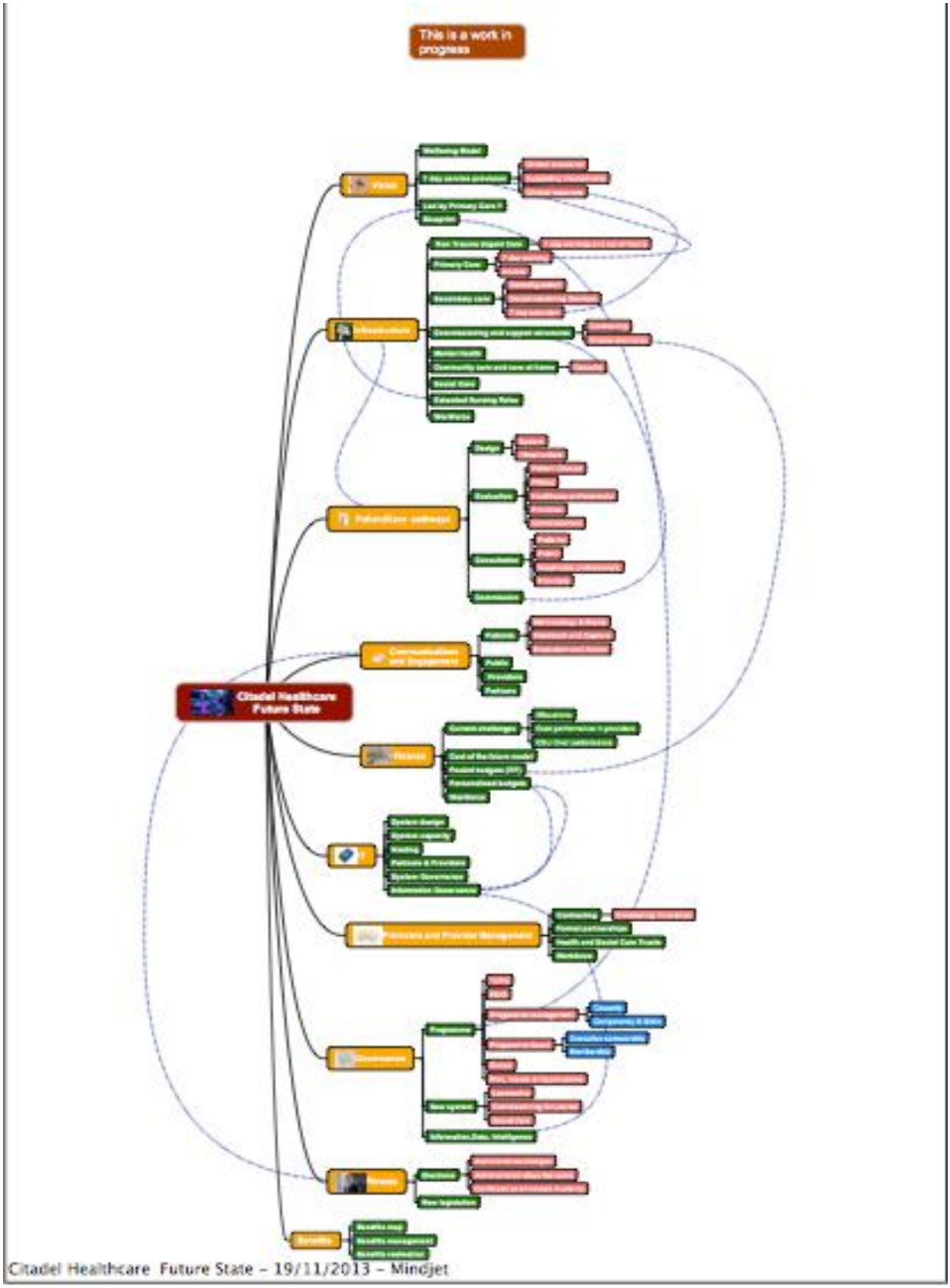
Risk	Risk rating	Mitigating Actions
There is a risk that moving funding from existing pathway provision will destabilise providers	Medium	We will work closely with providers, social care and partner organisations to ensure that when capacity is moved providers are supported and that when the capacity moves the patients move with it.
There is a risk that when services and capacity are moved from an Acute setting into a community or home based setting that patients will not be fully informed or engaged with the changes	Medium	The CCG will lead a programme of communication and engagement in partnership with GP's, Providers, Essex County Council and other partner organisations to provide consultation and educational programmes to support the implementation of the changes.
There is a risk that the current level of ambition for system change is not matched by available CCG resources which will impact on the ability of the partnership to deliver the full impact of the BCF on time	High	The CCG will need to consider the use of non recurrent transformational funding to deploy additional external and/or seconded resources to support the change agenda. Plans are currently being finalised to present to the governing body and to NHSE for assurance prior to implementation.
There is a risk that politicians if not feel fully briefed on the implications, advantages and benefits of the pooled funding arrangements and therefore unable to fully support the plans	Medium	The CCG (s) are working closely with ECC, and will continue to do so during 2014 to ensure that Elected members are fully engaged and briefed on progress towards to implementation of the BCF and the impact of implementation on their constituencies.
There is a risk that if the use of the NHS number by all parties to the pooled funding arrangement is not facilitated by the end of Quarter 2 of 2014 it will have a significant delaying effect on the full implementation of the BCF	High	CCG's have limited ability or scope to mitigate against this risk, the ownership of the risk in reality transfers to NHSE

b) Appendices

(I) Appendix 1

Fig x - Citadel Graphic representation

(II) Appendix II



(III) Appendix III - BCF Programme definition and initial build