North East Essex
Clinical Commissioning Group

Care Closer To Home

Integrated Community Strategy

2013 -2018



Document Control

Version Number	Date	Authority	Contributions
1	07/08/13	Care Closer to Home Service Group 13/08/13 Bundle Development Meeting 14/08/14	Include impact on carers Include overview on impact and joint working with voluntary sector Review finance section to include potential impact of ITF and personal health budgets Better care – quality assurance could be summarised and the detail contained within the service specification Index inaccuracies Clarification of abbreviations Include prescribing overview and commissioning principles Change picture on front page to differentiate document from integrated strategy. Revision to reablement Additional information from ECC regarding Essex Dementia Strategy pertinent to this document.
1.1	23/08/13	Elected members for information - and comment	
	27/08/13	NEE CCG Programme Board – request approval to consult externally	Insufficient time to review document, to be reviewed on 17/09/13
	03/09/13	CCG Transformation and Delivery Committee	Include information on workforce development planning/ open door programme/ social care strategy. Include information on personal health planning Revise Single assessment process to include single point of referral.
1.2	17/09/13	NEE CCG Programme Board – request approval to consult externally	Approval to consult externally through Communications Team. Combine Independent Living and care Closer to Home bundles into one bundle.
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Foreword

This five year strategy sets out to deliver the North East Essex vision of care closer to home for the people of north east Essex. It is guided by national and regional health and social care directives from NHS England. North East Essex Clinical Commissioning Group (CCG) have worked jointly with other health care and social care partner organisations to deliver a vision, strategy and clear delivery plans that will:

- *Put people at the centre of their care*
- *Involve people in planning and developing services*
- *Commission integrated health and social care which is high quality, evidence-based, cost-effective and sustainable*
- *Ensure people receive seamless services across their health and care needs*

Maternity and paediatric care have been excluded from this strategy due to the specialised nature of these care packages and are addressed separately by relevant planning forums.

Our vision is "Embracing better health for all." The focus is on priority groups within north east Essex, however everybody should experience an improved level of health and wellbeing as a consequence of the services commissioned by the CCG.

North East Essex Integrated Plan 2013 -2018 outlines the approach to partnership working with public, patients and carers to help them have greater choice, control and responsibility for health and wellbeing services:-

- *People will be encouraged and supported to look after their own health and social care needs*
- *Carers will receive the support they need.*
- *Patients, public and community groups will take up opportunities to be involved in planning and developing services*
- *Services will be centred around the patient and will be high quality, evidence-based, cost effective and sustainable*
- *People will receive seamless and joined up services across their health and social care needs*

We are committed to commissioning services which are equitable, inclusive and sustainable. The values at the heart of our work are:-

Patient-centred – We will ensure that services respond to people as individuals, involving them in their individual care decisions and also in the planning of services.
Integrity – We will work in the spirit of public service, professionalism and selflessness to serve our local population.
Inclusiveness - Our commissioning will be driven by the health needs of the whole population. We will prioritise our commissioning towards work which delivers the greatest improvements in health and the best possible experience for all people throughout their care and treatment.
Improvement - Our communities require high-quality services. This means services which are safe, personalised and deliver good clinical outcomes. We will seek to continually improve quality wherever possible and to embrace innovation to achieve this.

We are committed to delivering the pledges of the NHS Constitution and upholding its values.

Executive Summary

North East Essex Clinical Commissioning Group (CCG) is committed to integrated commissioning, as set out in the North East Essex Integrated Plan 2013-18. Since November 2012 we have been working closely with colleagues at Essex County Council (ECC) to develop new ways of commissioning health and social care for local people.

Nationally there is recognition that a radical approach to health and social care is needed in order to meet the growing and changing needs of the population.

We face extremely challenging times in the NHS. Demand for services is rising faster than our funding. The cost of drugs and new medical technology continue to rise. Our population is changing, with an increasing number of older people, who tend to have greater health and social care needs.

There is a gap between the amount of money we receive and how much we need to spend to meet the growing healthcare needs of our population. Over the next 3 years the gap will be between £45m (best case scenario) and £98m (worst case scenario).

Until now, although the NHS has certainly faced challenges, they have not been of this scale.

In the past the care we bought was based on services provided by a limited number of organisations (such as hospital, community and mental health services) rather than tailored packages of care that individuals require. The CCG and ECC have developed this commissioning strategy taking a holistic approach to individualised care planning with the aim of matching up the way we buy services with the needs of patients and carers.

This strategy outlines the integrated approach to services required to meet the health and social care needs for the people of north east Essex. It sets out how we will jointly provide care closer to home through our joint strategic commissioning intentions for the 5 year period 2013 to 2018. By putting care packages together as bundles we will break down the traditional barriers between different care providers. Integrated planning will focus on actual needs and avoid duplication. We will use a rigorous procurement process based on achievement of improved outcomes for patients.

The North East Essex Joint Strategic Needs Assessment, which is developed by Public Health analyses local people's health and social situation and underpins the commissioning intentions for the CCG. A full engagement exercise was also undertaken to understand and determine what services the people of north east Essex want in order to address these health and social care needs. A combination of the feedback from organisations that provide health and social care and local people was then used to decide the model of care to be commissioned.

NHS England set 5 key objectives in optimising the health and social wellbeing for the population nationally. This commissioning strategy takes each of the objectives in turn and outlines how we will turn each objective into reality the objective, by meeting the health and social care needs outlined in the JSNA and ensure care is delivered in a way that the local people told us it should be.

A common theme running through all five objectives is that people should first be enabled and supported to 'do for themselves' rather than being dependant on institutional support. There is much emphasis on self-care and empowerment in the model of care and commissioned services.

In helping people live longer the focus is on prevention of early death through improved awareness, access to diagnostics and treatments. The use of tools such as combined predictive modelling provides information on those people most likely to present in an acute state and allow proactive health and social care planning to take place to manage and maintain optimum health and wellbeing at home.

Much of the feedback from the engagement exercise, 'The Big Care Debate', highlighted delays in accessing appropriate care. We have looked at trials across the country to determine the best approach to care co-ordination. We will commission a community gateway to co-ordinate the patient referrals across the multidisciplinary teams and ensure an individualised care programme approach.

The aim in managing on-going physical and mental health conditions such as diabetes, dementia and depression is to have services in place so that people can stay as independent as possible for as long as possible. A network of services will be available to support patients and their carers which will include physical and mental health providers complimented by tertiary providers such as the voluntary sector.

Assisting recovery from episodes of ill-health is best achieved through partnership working with patients, their families and carers, social services and other agencies. The focus is helping people regain and maintain their independence as much as possible for as long as possible. Reablement services will support people to learn new ways to do things following discharge from acute providers supported with a community bed model to offer a step-up facility for patients in the community who need a more intensive nursing input than can be provided in their own home. Improving access to psychological therapies locally has proven to be enormously effective in managing depression and anxiety, expansion of the service is therefore underway to ensure continued effectiveness and a no delays response to demand.

The feedback from the engagement exercise identified that quality of care is as important as the quality of the treatment and that far more consultation is required at service levels to gain insight and perspective into what local people believe the true measures of quality are. The CCG and ECC acknowledge that the most effective form of care is patient centred and that most care in life is self-care. Therefore a range of commissioning approaches will be incorporated into the commissioning process to include; self care and empowerment, carers, personal health budgets and care advisors.

Safety and the management of risk are fundamental in health care commissioning and provision. The national safety framework provides guidance on the key components of managing risk for NHS organisations. Recent reviews, Francis Report, Keogh Report, have identified areas for improvement which we will work together as a health economy to address.

The ultimate aim of this strategy is to commission the highest quality of care services for the people of north east Essex. The CCG aspire to commission services that will offer local pride in the NHS. The CCG

wants the people of north east Essex to feel confident that their healthcare services are amongst the very best, all of the time.

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1 Background

North East Essex CCG is responsible for commissioning the majority of health services for the people who live in the areas covered by Colchester Borough Council and Tendring District Council. The CCG is made up of the 43 GP practices in Colchester and Tendring. The CCG is led by clinicians and there is a clinical majority on its Board and committees.

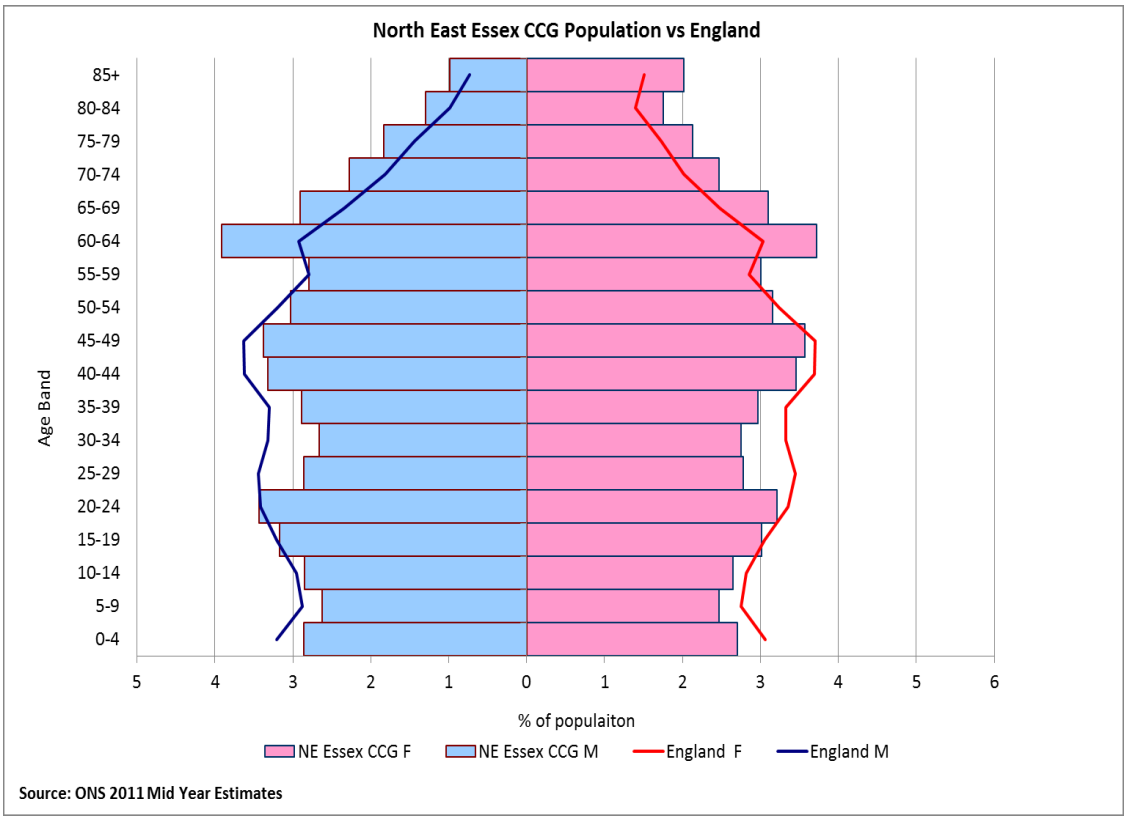
1.1 The Local Health Care Needs Assessment

Demography[1]

The total number of people living in north east Essex is approximately 313,000, with a virtually equal split between men and women (49.1% v 50.9% respectively).

The population structure within north east Essex is different to that of England with fewer people in the 25-49 age ranges but a far higher proportion of people aged over 60 compared to England averages.

Figure 1: 2011 Mid-Year Population Estimates for NE Essex CCG



The population in north east Essex is likely to increase by around 12% over the next ten years (2013-2023). There is likely to be around a 20% increase in the total population aged 65 and over. The population size for those aged 75 and over is expected to increase by approximately 40%.

The proportion of patients aged 65 and over in each GP practice ranges from just 3% to almost 50% in one practice. There is a correlation between emergency hospital admission rates by practice and the percentage of patients aged over 65.

[1] NHS NE Essex Integrated Plan Demography Appendix V 4.0 Authors: Vittoria Polito & Jo Broadbent

The total black and ethnic minority population (BME) is 28,900 in north east Essex – 8.9% of the total population. The BME population within north east Essex is quite 'young' compared to other areas, as only 5.4% of the total BME population is aged 60 or over.

Deprivation and Inequalities

The Department of Health Index of Multiple Deprevation (2010) shows that the *most* deprived small area in England is located within the Golf Green ward in Tendring, more commonly known as Jaywick. At a local authority level, Tendring is ranked 86th out of 326 local authorities and Colchester is ranked at 205 indicating the generally higher levels of socio-economic deprivation faced by the residents of the Tendring district. Pockets of deprivation exist in Colchester.

Within north east Essex, there is a 13.3 year difference in life expectancy between people who live in Alresford ward, a lesser deprived community, and those who live in Pier ward, a more deprived community.

The average life expectancy across north east Essex for all people is 81.4 years, however between the 20% most deprived and the rest of the population, there is a gap of 4.3 years. The gap is greater for men (5.3 years for men compared to 3.2 years for women).

Long Term Conditions and Disability

GP practices in Tendring district have a higher prevalence of every long term condition than average for England. In Colchester this situation is reversed where the majority of conditions have a prevalence lower than the England average. This is likely to be reflective of the different age structures of the two districts.

There is a high level of variability by GP practice in the diagnosis of long term conditions, which suggests that some practices have a high level of under-diagnosis of long term conditions such as heart disease, hypertension, respiratory disease and diabetes.

Promoting self-management and improving the independance of people with long term conditions is key to improving health status and quality of life. By selecting education support for patients with diabetes as a key target for improvement, the CCG hopes to achieve this aim for diabetic patients.

Census data shows that across north east Essex, 9.5% of people reported that they had a long-term health condition or disability that affected their day to day activities "a lot", with a further 10.7% affected "a little". These are higher than both the regional and national average. Rates are higher in Tendring.

1,912 people are registered as blind or partially sighted in north east Essex, and 608 people are registered as having a serious hearing impairment.

Mental Health

The diagnosed prevalence of mental health problems is 0.8%, similar to the national average. The rate varies 5-fold between practices ranging from 0.4% to 1.9%.

Suicide rates locally are falling, in line with the national trend, with rates higher in males than females. Rates of self-harm are lower than national and regional averages.

Learning Disability

People with learning disabilities are 58 times more likely to die before age 50 than expected, and overall mortality rates are 3 times that of the general population.

North east Essex has 1,226 residents with learning disabilities known to social care. This is 31% of the total learning disability population in Essex.

Current GP registers in north east Essex suggest that over 1,800 people are actually known to have learning disabilities, suggesting that some people may not be accessing the support that they are entitled to.

Caring Responsibilities

It is estimated that over half of the people providing unpaid care are aged over 50, and so are more likely to be suffering from ill health themselves.

It is estimated that two thirds of people with dementia are looked after by unpaid carers.

Dementia

Nationally, the Department of Health aim is to see two-thirds of people with dementia identified and given appropriate support by 2015, an increase from 39 per cent in 2010 and the current average of around 45 per cent. The CCG aims to increase the current dementia diagnosis rate from 35.2% (of the expected rate) to 53% by 2014-15, with a further stepped diagnosis rate increase to 66% by 2015 -2018.

All the practices in north east Essex have an under-diagnosis of dementia, varying from 6% - 88% under-diagnosis.

A further local priority is to reduce the anti-psychotic prescribing rate to 25% over the next five years, and by 3% in 2013-14.

Premature Mortality

North East Essex CCG is an outlier for premature (under 75) deaths from cancer, compared to other similar CCGs, although rates are below national averages. The CCG has an ambition to bring cancer mortality down to the level of the best in Office of National Statistics cluster over the next 5 years.

1.2 The National Health Care Agenda

This strategy will provide the overarching direction and guidance to inform the commissioning process in the procurement of health and social care services that will deliver 'care closer to home'. Key objectives within this strategy will be driven by the Government's Mandate to the NHS as well as local public health recommendations. The Government's Mandate to the NHS Commissioning Board, now known as NHS England, sets out the objectives for the NHS and highlights the areas of health and social care where the Government expects to see improvements.

Figure 2: The NHS Mandate 13th November 2012

The Mandate identifies five domains which provide direction for health and social care commissioning organisations, to buy services that meet the health and social care needs of the local population. In delivering this Mandate the CCG, working in partnership with ECC, have developed a 'care bundles' approach to commissioning health and social care.

Three care bundles have been identified;

End of Life	Care Closer to Home	Urgent Care
•Integrated community services •primary care management •patient and carer involvement •medication and equipment •Integration with 111 •Preferred Place of Care •End of Life register •Integrated Palliative care Coordination centre	•Virtual Ward •Care Coordination •Single assessment •Long term Conditions •Reablement •Telehealth •Community Mental Health •IAPT •Recovery & Reablement •Reach-out •Self-care/Personal Health Budgets •Planned Care	•Crisis assessment and response service •Admission avoidance •Community beds •Out of Hours •Minor Injuries •Walk in centre

1.2.1 Care Bundles

Following a review of the commissioning processes of North East Essex CCG and its commissioning partner ECC, the decision was taken to align health and social care

commissioning requirements. Information identified within the government mandate, JSNA and local public health findings supported an approach whereby NEE CCG and ECC could align services with similar purpose into a multifunctioning care bundles.

You said

Traditionally, health and social care have been organised more around specific services, rather than the needs of each individual person. This has led to people sometimes receiving fragmented care, delivered by many different people. Some care is duplicated, some care may be missing. The 'Big Care Debate' flagged these inefficiencies identifying poor communication and services falling short of expectation.

We will

By aligning the two organisations and by using single commissioning process efficiencies will be gained through the avoidance of duplication, overlap and service gaps. A single commissioning process will also ensure communications between commissioning and provider organisations are clear.

In addition to this we will be able to better monitor not only the traditional performance measures but also those also how services are meeting the needs and expectations of patients and their carers. One of the ways we will do this through the use of real time patient satisfaction surveys.

This strategy is consistent with other strategies including:

- North East Essex Integrated Plan 2013 – 2018
- North East Essex Clinical Commissioning Group Governance Assurance Framework
- North East Essex Clinical Commissioning Group Quality Strategy 2013 – 2018
- North East Essex Clinical Commissioning Group Urgent Care Strategy 2013 – 2018
- North East Essex Clinical Commissioning Group End of Life Strategy 2013-2018

2 Aims

Many people will experience a variety of health and social care needs throughout their lifetime. The spectrum of care they need may range from information on self-management to acute or urgent care. The profile of services commissioned by the CCG will cover this spectrum of need and will ensure that as patients step in either direction from one level of need to the next this step will be seamless and appropriate.

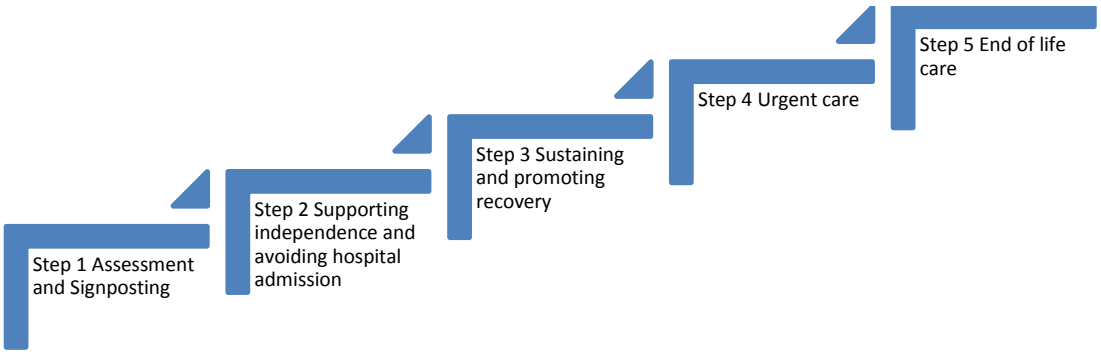


Figure 3 CCG Commissioning Steps

The commissioning of the care closer to home bundle will incorporate service redesign to provide care in the community that aims to;

- *provide timely health and social care assessment and signposting to relevant community services,*
- *support independence and avoid hospital admissions*
- *sustain and promote recovery*

These aims will incorporate the delivery of the 5 areas of improvement outlined in the Government Mandate (DH 2012). This strategy provides a fully encompassing approach in the commissioning of health and social care which meets the needs of the local population and is quality assured and safe.

Aims

- *Helping people live longer*
- *Helping people manage their on-going physical and mental health condition*
- *Helping people recover from episodes of ill-health or injury*
- *Making sure people experience better care*
- *Providing safe care*

3 Helping People Live longer

The NHS is being asked to reduce the number of early deaths from those illnesses that can be prevented through better early diagnosis and treatment, such as cancer and heart disease, so that more people can enjoy a long and healthy old age

Too many people die too soon from illnesses that can be prevented or treated – from cancer, liver and lung disease. There are also persistent differences in life expectancy and healthy life expectancy between communities.

The Government's ambition is for England to become one of the most successful countries in Europe at preventing premature deaths, with NHS England making measurable progress towards this ambition in the next three years.

This includes:

- *earlier diagnosis of illness*
- *ensuring that everyone has the same access to the best available care*
- *reducing unjustified variation in avoidable mortality between hospitals*
- *focusing on preventing illness, with staff using every contact they have with people as an opportunity to help people stay in good health.*

(The Mandate: A mandate from the Government to the NHS Commissioning Board, Department of Health 2012)

Three developments have been identified by the CCG as key components to the commissioning of the appropriate services within care closer to home to ensure people live longer. They are; risk stratification, virtual ward and single assessment.

3.1 Risk Stratification

A small number of patients account for a large proportion of emergency admissions to hospital[2]. Assessment of these patients and care planning to meet their needs before they become high risk will reduce the likelihood of re-admission and provide the patient with care to optimise their health and support their ability to live in the community.

The CCG commissioned a risk stratification tool called the Sussex Combined Predictive Model (CPM), based on the Kings Fund CPM tool, which is a model that can be used to identify and create a risk score for patients. It depicts their likelihood of an emergency admission to hospital within the proceeding 12 months. All patients within the population, excluding those who have opted out, will be assigned a risk score which has been developed on their individual likelihood of being admitted to hospital. Patients are then categorised into 'very high', 'high', 'medium' and 'low risk'. This will enable doctors to identify patients who are at risk of admission to hospital, so that appropriate support can be provided to prevent admission.

Based on a 3 year admission data set (2009 -2011), patients' resident in north east Essex were assessed on their likelihood of having a hospital admission over a 12 month period.

[2] 2009 General Lifestyle Survey (DH)

Figure 4 shows that the Tendring area has a lower proportion of 'low risk' patients, with a greater percentage than Colchester of 'high risk', 'medium risk' and 'very high risk' patients.

Figure 4: Likelihood of admission from Colchester and Tendring 2011-13

	Tendring		Colchester		Total	
	Number of people	% those at risk	Number of people	% those at risk	Number of people	% those at risk
Low risk	107,931	77.89%	148,580	79.90%	256,511	80%
Medium risk	22,409	16.17%	25,685	13.81%	48,094	15%
High risk	6,690	4.83%	7,738	4.16%	14,428	4.5%
Very high risk	858	0.62%	745	0.40%	1,603	0.5%

Source: Sussex Health Informatics modelling of north east Essex patient risk, Total Population NEE August 2011

This information can be looked at in relation to estimated social care need data to compare the percentage of the population with the different types and level of required need. Figure 5 shows the estimated percentage of the north east Essex population in 2011 with different levels of social care needs.

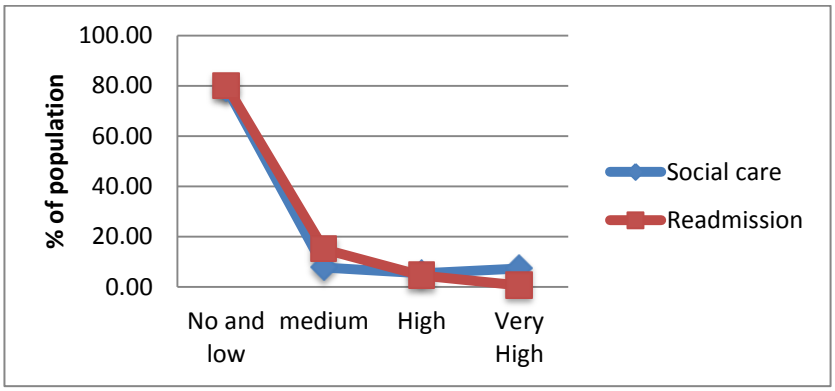
Figure 5: Estimated % of social care needs 2011 north east Essex population

Measure	Number of people 2011	% of population
No needs	250,195	79.56%
Moderate needs	24,258	7.71%
High needs	17,048	5.42%
Very high needs	22,969	7.30%
Total	314,470	100%

Source: Essex Planning 4 Care, Total Population NEE 2011

On comparing the percentage of the population who are at risk of admission with those who have social care needs, it can be seen that the percentage of the population in the no needs/low risk band and the high needs/high risk band are very similar, although some caution must be exercised as predictive modelling can carry a margin of error +/- 3%. There is no correlation between the moderate needs/medium risk bands possibly as a result of a much higher percentage of patients in the community with long term conditions who have no formal social care packages. A correlation is less obvious in the very high risk/very high need categories, where there is a higher percentage requiring social care than are at risk of emergency admission. This is possibly reflective of the numbers with continuing care needs due to disability, but who are not at high risk of emergency admission.

Figure 6: Correlation of social care need and readmission risk



The use of CPM will assist GPs and other health and social care practitioners to work proactively with patients to identify those at risk enabling them to manage disease and disability both in the acute and chronic stages in a primary care/ community setting.

The CCG's expectation is that all GP practices will use the risk stratification information and undertake a multidisciplinary approach to managing patients' conditions, through early diagnosis, reducing the likelihood of admission/readmission to hospital and preventing illness.

3.2 Virtual Ward

Virtual wards operate using the systems, staffing and daily routines of a hospital but without the physical building. Patients are provided with intensive preventative care while still living in their own homes. The ward team share a common set of electronic notes and charts and conduct daily ward rounds supported by a ward clerk to co-ordinate information sharing.

Virtual wards use the output of predictive modelling to select which patients should be offered multidisciplinary case management. The primary objective of predictive modelling and virtual wards is to reduce the rate of emergency admissions, reduce unscheduled acute hospital bed days and minimise health care disparities.

In January 2011 the CCG (previously the North East Essex Primary Care Trust) and ECC commissioned a pilot virtual ward linked with 9 GP practices in the Tendring area. Evaluation of the pilot identified;

System Level Impact

- *Overall, avoidable ambulatory care sensitive (ACS) admissions and all non-elective (NEL) admissions for >65s increased at a lower rate in GP practices supported by a virtual ward than in all other GP practices.*
- *30 day readmissions for long term conditions and NEL ACS bed days increased at a lower rate in GP practices supported by a virtual ward than the other GP Practices in Tendring.*

Social Care Service Activity

- *Of the 96 patients referred to social care, 45 (47%) had new packages of care. Of these, 13 (29%) had patient and carer services.*
- *On average, patients receiving home care entered the ward with an average package size of 7.4 hours per week. This had reduced to an average of 6.6 by December 2011. Of the total of 60 social care service users in the Virtual Ward, 34 (57%) were still in receipt of services at the end of December 2011.*

Quality Impacts

- *The responses from the virtual ward team and GPs were on the whole positive, particularly with regard to communication between the Community Matrons and the GPs and the value of the FSC. Further support and information is required to promote the roll out of the predictive modelling tool.*
- *It was felt that there needed to be better communication between the virtual ward team and the hospitals with regard to accepting and discharging patients.*

The Evaluation report approved the roll out of the virtual ward across north east Essex as a clinically effective and financially prudent service provision.

The CCG expectation is that the virtual ward model will be established across north east Essex, with full participation of all GP practices, utilising predictive modeling to identify appropriate patients supported by a multidisciplinary approach to care planning.

3.3 Community Gateway & Single Assessment

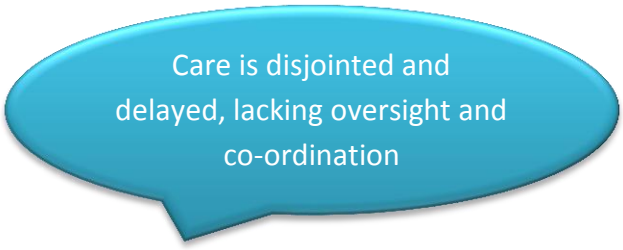
This strategy is based on a revised community model of care to address these patient concerns.

You said

'The Big Care Debate' identified much of the care received in the community was disjointed and many patients experienced delays as their care was passed between providers.

We will

The commissioning of a community gateway will co-ordinate the long term management of all patients within the community who need health and social care input to maintain their wellbeing in a community setting. The community gateway will work in collaboration with other community functions such as reablement and virtual ward, which are time limited services designed to assess treat and improve a patient's wellbeing in the community. The community services will maximise the patients outcomes, identify the continued long term needs and handover the patients to the community gateway and care co-ordinating team. This team will reassess patients on a regular basis to ensure their long term care package addresses the needs identified to manage risk and optimise health. It is anticipated that the community gateway will be supported by a consultant led MDT to provide support and advice to care co-ordinators when a patients risk stratification has changed significantly and a revised package of care is required.



The referral and assessment route will be supported by a single referral and assessment process which will include documentation and definitive information flows. Agreed response timeframes in the management of referrals will be defined by clinical urgency and outcomes, as specified by the Department of Health 18 week referral to treatment targets. The service will also include a rapid response service with a response timeframe of 2 hours. The rapid response service will be defined as a rapid response to support patients to continue their care in the community, preferably at their usual place of residence, however the model does include a step-up bed provision in Harwich and Clacton Hospitals. The rapid response service is not a clinical emergency service; clinical emergencies will be managed through the pathways defined within the urgent care strategy.

Currently there is no overarching single assessment process in place across north east Essex. Some specialist services have established single points of contact which are specialty specific but are not generic signposting and assessment centres. Although there is a current process for referrals between organisations, assessments are then repeated at each new contact leading to added bureaucracy and delays.

Scoping of similar projects across the country shows that an integrated assessment that is completed at the initial point of contact, reduces complexity and can ensure that people are signposted/referred to the most appropriate service first time.

Everyone Counts Planning for Patients 2014/15 (NHS England)[3] clarifies the requirement for all health and social care organisation to share a single data set with universal adoption of the NHS number as the primary identifier for all patients across all providers.

The CCG intention is to commission a care closer to home service model that incorporates a community gateway service that co-ordinates the long-term management of health and social care packages and is supported with a community wide summary care record.

High Level Outcomes - Preventing ill-health and providing early diagnostics and treatment	
Risk Stratification	Identification and management of high and very high risk patients at Practice Level Improved access to real time, clinical patient data Prioritisation of Community Matron workload Identification of appropriate case load for virtual ward
Virtual Ward	Patients will remain at home longer and have more choice about their healthcare. Reduction in ambulatory care sensitive admissions. Reducing on-going reliance on social care packages.
Community Gateway/ Single Assessment	Provision of seamless inter-provider single assessment referral process. Timely and direct management of patient referrals. No delays care management. Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, on general practice and the community.

[3] EVERYONE COUNTS:PLANNING FOR PATIENTS 2014/15 TO 2018/19 NHS England

4 Managing on-going physical and mental health conditions

The NHS will help people manage their ongoing physical and mental health conditions such as dementia, diabetes, and depression so that they can stay independent and have a better quality of life, and so that care is joined up across GP surgeries, district nurses, care homes and hospitals.

We want to empower and support people living in their own homes with long term conditions. One in three people is living with at least one chronic condition, such as hypertension, diabetes or depression.

NHS England is being asked to make measurable progress towards making the NHS among the best in Europe at supporting people with ongoing health problems to live healthily and independently, with much better control over the care they receive.

This includes involving people more in decisions about their own care, furthering the use of technology to help people manage their conditions, providing coordinated care for people who are using a number of different services and making progress with the diagnosis, treatment and care of those with dementia. *(The Mandate: A mandate from the Government to the NHS Commissioning Board, Department of Health 2012)*

Six areas for development have been identified by the CCG as key components to the commissioning of the appropriate services within care closer to home to manage on-going physical and mental health conditions; integrated frailty pathway, dementia care, medicines management, end of life care, assistive technology and community mental health.

4.1 Long term conditions

A long term condition (LTC) is a condition that cannot, at present, be cured but is controlled by medication and/or other treatment/therapies. People with long term conditions continue to see variation in care and services across the country. They are intensive users of health and social care services, including community services, urgent and emergency care and acute services.

[4]People with long term conditions account for:

- *50% of all GP appointments*
- *64% of outpatient appointments*
- *70% of all inpatient bed days*
- *In total around 70% of the total health and care spend in England (£7 out of every £10) is attributed to caring for people with LTCs*
- *This means that 30% of the population in England account for 70% of the spend*

[5]People with long term conditions consistently say:

- *They want to be involved in decisions about their care – they want to be listened to*
- *They want access to information to help them make those decisions*
- *They want support to understand their condition and confidence to manage support to self-care*
- *They want joined up, seamless services*

[4] 2009 General Lifestyle Survey (DH)
[5] Our health, our care, our say: a new direction for community services - consultation P responses from people with long term conditions

- *They want proactive care*
- *They do not want to be in hospital unless it is absolutely necessary and then only as part of a planned approach*
- *They want to be treated as a whole person and for the NHS to act as one team*

LTCs are not just a health issue they can have a significant impact on a person's ability to work and live a full life. People from lower socio economic groups have increased risk of developing a LTC – better management can help to reduce health inequalities. Despite strides forwards there are still huge challenges. Patients universally say that they wish to be treated as a whole person and for the NHS to act as one team[6]. Despite this, those people who have more than one condition, particularly older people, face an increasingly fragmented and 'specialised' response. It is clear that LTC 'needs' transcend the organisational boundaries of social, primary, community and secondary care.

Age is a major factor in prevalence of LTCs but also in those who have multiple LTCs. By 2034 the number of people aged 85 and over is projected to be 2.5 times larger than in 2009, reaching 3.5 million and accounting for 5% of the population. Plans need to be put in place now to address the growing needs of these people.

It is clear that the current configuration of long term care services are not sustainable in the face of this projected future increase in co-morbidity i.e. people with multiple long term conditions, and the level of need predicted. It is important for organisations to commission and deliver age appropriate services and not to discriminate unlawfully on age grounds.

Throughout 2013, joint working with Adult Mental Health, ECC, Primary Care, the acute providers and the CCG will work toward the delivery of integrated care pathways which have the following key elements that will be adopted for all conditions:

- *Commissioners understanding the needs of their populations and managing those at risk using risk prediction techniques*
- *Supporting people to be more confident and in control of their condition using information and self-care as part of personalised care planning which is available electronically and linked to the GP health record, and conforms to the best practice standards.*
- *Providing integrated care teams and joined up and personal services particularly in community and primary care and working closely and effectively with social care*
- *Strong professional and clinical leadership and workforce development to deliver new models of care, incorporating 'The Open Door Programme'*
- *Using new technologies – i.e. telehealth and telecare to support people to be more independent and in control.*

Many patients experiencing long terms conditions will be frail and/or elderly. The national focus is the integration of care around the most frail. Integrated care will cross organisational boundaries both horizontal (primary, social and community care) and vertical (acute providers and community providers) integration.

[6] Andrew Lansley, Health Secretary Modernising NHS 14 March 2011

The CCG will work jointly with all provider organisations to agree and commission an integrated frailty pathway which will include;

- senior clinicians within a team taking full responsibility for people with multiple long-term conditions,
- full responsibility lasting from presentation to episodic care, including personalised care planning for those who would benefit; and
- co-ordination of care including lifestyle support and advice, social care, general practice care and hospital episode care co-management.

4.2 Dementia

In 2009 the Department of Health published 'Living Well With Dementia: A National Dementia Strategy'. The aim of the strategy was to ensure that significant improvements were made to dementia services across three key areas; improved awareness, earlier diagnosis and intervention, and a higher quality of life. The strategy was driven by 17 objectives and when implemented locally, would result in significant improvements in the quality of service provided to people with dementia and promote greater understanding of the causes and consequences.

All people with dementia, and those that care for them, have the right to the best possible healthcare and support. We know that early diagnosis, along with effective intervention and support from diagnosis through the course of the illness, can enable people to live well with dementia. We also know that improving health and social care outcomes in dementia in the short and medium term can have significant benefits for society, both now and in the future.[7]

A local Strategy 'Living well with dementia: A dementia strategy for Essex 2013' has been developed in partnership with the three county councils and the 5 CCGs across Essex. The Strategy has been developed to improve access to high quality diagnosis, treatment, support and advice for all people living with dementia and their carers in Essex, Southend and Thurrock. Local analysis identifies underdiagnoses and inappropriate interventions as key areas for development.

The CCG appreciate that dementia services cannot be commissioned in isolation as dementia is often accompanied by one or more co-morbidity and is most prevalent in the frail and elderly. All of the workstreams within the care closer to home bundle will provide care for people with dementia and their carers and each workstream will be governed by the key performance indicators contained in the care closer to home service specification. The commissioning principles for dementia are derived from the Essex wide dementia strategy 'Living well with dementia'[8];

1. *Ensure that clear pathways are available for all people including those with young onset dementia or learning disabilities to access timely assessment, diagnosis, treatment and support;*

[7] World class commissioning guidance for dementia (DH 2009)

[8] Living well with dementia: A dementia strategy for Essex, Southend and Thurrock 2012

2. *Ensure that people with dementia are able to access admission avoidance schemes, reablement and intermediate care;*
3. *Develop an effective, trained and skilled workforce;*
4. *Ensure that there is appropriate support for carers and to recognise carers as partners in the care of people with dementia;*
5. *Further develop enhanced liaison and in-reach services to acute hospitals and nursing homes which include strategies to reduce the use of anti-psychotic medication;*
6. *Ensure that people with dementia have access to palliative care and support at the end of their life.*
7. *Provide clear, consistent and co-ordinated information to support people with dementia and their carers at all stages throughout the dementia journey*
8. *Continue activities to raise awareness of dementia within health and social care organisations and the wider community to reduce stigma and promote early identification of dementia.*

Commissioning for Quality and Innovation (CQUIN) enables the CCG to reward excellence in provider services through the delivery of national and locally agreed targets. There are 6 local CQUIN targets in providing a holistic approach to dementia care;

- *incentivise the identification of patients with dementia and other causes of impaired cognition alongside their other medical conditions through timely evidence based quality assessments*
- *increase rate of diagnosis*
- *improve access to information about dementia and available support*
- *improve access to peer support*
- *raise dementia awareness and knowledge in the workforce*
- *improve outcomes in relation to end of life care*
- *improve dementia care in acute hospital environments*
- *improve care for carers of people with dementia*

The CCG will commission provider organisations to incorporate the local targets for improvement into the services they provide; improved awareness, earlier diagnosis and intervention, and a higher quality of life.

4.3 Medicines management

The approach to medicines management across the integrated health economy is guided by three basic criteria;

- *Patient safety;*
- *Meeting the clinical needs of patients; and*
- *Securing best value for money from NHS resources.*

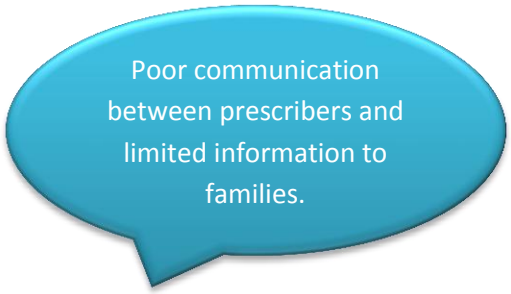
These criteria are underpinned by the following prescribing principles;

- *The decision to initiate treatment or change a patient's treatment regime should be based on up-to-date clinical evidence or national or local guidance, e.g., National Institute for Health and Clinical Excellence (NICE) or other authoritative sources;*
- *Prescribers should make their choice of medicines or devices on the basis of clinical suitability, risk assessment and value for money;*

- *Treatment decisions should take into account individual patients' clinical circumstances, abilities and beliefs;*
- *The individual patient (and their guardian or carer where appropriate) should be included in any decisions regarding their treatment. They should be informed about the proposed action and given opportunities for discussion and support where necessary;*
- *Prescribing guidance, including details of relevant therapeutic evaluations underpinning prescribing practice, should be regularly reviewed and shared across the health economy through a structured communications forum.*

You said

Many people commented on the inefficiencies and poor management of prescribing with particular focus on repeat prescriptions and the waste of money of unused medication.



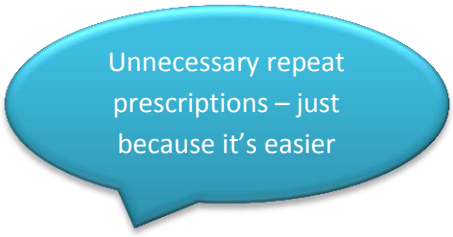
We will

By integrating medicines management we will improve prescribing practices across all aspects of care in the community to maximise the benefit to patients and their carers.

This work includes;

Workstream	Key outcomes	Lead organisation
Medication reviews in nursing homes	Improved cognitive awareness • Improved dementia management • Reduction in falls • Compliance with lithium Commissioning for Quality innovation Framework (CQUIN) • Prescribing remains appropriate and conforms to current good practice • Improved clinical outcomes with potential reduction in hospital admission/A&E attendance • Reduction in waste	NEE CCG
Reablement and home from hospital	• Improved prescribing practice and patient participation and engagement • Improved medication understanding and concordance	ECC
Provide information and prescribing advice on unlicensed special order products	• Improved medication concordance • Improved cost effectiveness • Improved patient safety	NEE CCG
Medication reviews and support for patients in care homes and sheltered/very sheltered housing and those identified as "pharmaceutically frail"	• Improved cognitive awareness • Improved dementia management • Reduction in falls • Compliance with lithium CQUIN • Improved medication understanding and concordance • Reduction in hospital admission	NEE CCG
Central purchasing of	• Achieve economies of scale and standardise	Primary care

appropriate medical surgical supplies and equipment	practice and formulary adherence in stoma care, wound management, tissue viability. • Improved cost effectiveness	provider



The CCG expects all provider organisations commissioned to deliver care for the people of north east Essex will comply with the CCG prescribing principles outlined in the North East Essex CCG Prescribing and Medicines Strategy.

4.4 End of Life

The North East Essex End of Life Service is for adults aged 18 years and over who;

- have an advanced progressive or incurable condition and are expected to die within the following 12 months.
- are at risk from dying from a sudden acute crisis in their condition.
- have a life threatening acute condition caused by sudden catastrophic events

The service offers support to the families and carers during the end of life pathway and a bereavement service after death.

You said

Responses from the Big Care Debate identified that End of Life Care needed improved co-ordination to assure people in the community that they could be looked after safely and efficiently in their own homes.

We will

The NEE CCG End of Life Strategy is a 5 year strategy detailing the future commissioning of end of life services across the health and social care economy. The document identifies the importance of raising the profile of achieving 'a good death' and putting mechanisms in place to achieve this. The Department of Health End of Life Care Strategy acknowledges that there are many challenges to be overcome to ensure that everyone attains 'a good death' irrespective of their background. The focus for the North East Essex Clinical Commissioning Group End of Life Strategy is to ensure that all patients achieve 'a good death' and their families and carers feel supported.

The Joint Strategic Needs Assessment (JSNA) for north east Essex, identifies that people are living longer and the majority of people at end of life are elderly. Forecast increases in population size, in particular the over 75 years age group, will put a strain on the health and social care economy unless improvements in the current service provision are identified with focussed investment to support these improvements.

National guidance (DoH) identifying best models of care as well as recommendations from local reviews (Keogh, JSNA) have been used to inform the model of care within this strategy that will be commissioned. The commissioning intentions are detailed within the strategy with an overall focus on empowering the patients and their families to identify their end of life care preferences and how this is then communicated and co-ordinated across the economy. Models of care such

as the Gold Standard Framework and the Amber Care Bundle will be implemented to assure the quality of care provided across multiple providers.

The focus will be an integrated approach, co-ordinated through a single point of access and determined by the end of life register and advance care planning. The elements of the model to be commissioned include;

- End of life register
- Advance Care Planning
- Single Point of Access
- Key workers/care co-ordinators
- Rapid response
- Specialist Nursing and community teams
- Improving Access to Psychological Therapies
- Hospice Care
- Transport
- Social care

There is a high prevalence of undiagnosed dementia across north east Essex and people with dementia who are dying should have the same access to end of life care services as those without dementia. The Care Closer to Home Strategy will commission services to improve early diagnosis and care for people with dementia, and the End of Life Strategy identifies actions required across the economy to support end of life planning for patients, their family and carers and the health and social care workers providing care and support specific to the needs of people with dementia.

The End of Life model of care within this strategy focusses on investing the knowledge and skills into the community and provider services, working jointly with voluntary sector organisations to provide the best quality, clinically safe service for people and their families within the community setting. People nearing the end of life should not have to be admitted to the acute hospitals as a default position due to the lack of experience and/or co-ordination in the community and primary care sectors.

Having the right support and services within the community will give the patients and their families the confidence to remain at home and experience ‘a good death’.

The CCG will commission an End of Life service that will continue the development of the best practice model of care which incorporates; End of life register, Advance Care Planning, Single Point of Access, Key Workers/Care Co-ordinators, Rapid Response, Specialist Nursing and Community Teams, Improving Access to Psychological Therapies, Hospice Care, Transport, Social Care

4.5 Assistive technology/telehealth

The population of north east Essex is growing. At the same time, the expectations and needs of people continue to rise and technological innovation continues to increase the possibilities to meet these expectations in new and more effective ways. Telehealth is already used to a limited degree across north east Essex, for example equipment to remotely monitor blood pressure, blood glucose or oxygen saturation. Assistive technology provides functional support to assist people with physical disabilities such as mobility devices and equipment for fine motor skills.

When used to its full potential, to the point where assistive technology is adopted as routine to support care needs, the use of simple to use devices can play a major role in improving safety and quality of life for people who, through its use, can lead their lives with greater choice, independence and personal control, allowing people to have more choice and say in their own care arrangements.

Used wisely, we know that assistive technology and telehealth offer local care partnerships an opportunity for transformational change in the way patients/customers and their carers receive support, and in the types of support that can be offered and providing a more joined up, whole systems approach to health and social care delivery.

The CCG intend to commission provider services that maximises the opportunities offered by the use of assistive technology to support independence, choice & control whilst reducing the reliance on health and social care interventions.

4.6 Community mental health

North Essex Mental Health Joint Commissioning Strategy sets out the vision and provides a detailed explanation of the standards and course to commissioning mental health services in north Essex moving to 2017. The strategy has been developed through dialogue with a wide cross section of mental health stakeholders. It will ensure that all services are integrated, including mental health, physical health and learning disability and with a seamless transition between adults moving from children's services and adults moving into older adult services. The vision[9] is that the mental health services we commission will deliver the following health and social care outcomes for people in north Essex:

- *People will have good mental health*
- *People with mental health problems will recover*
- *People with mental health problems will have good physical health, and people with physical health problems will have good mental health*
- *People with mental health problems will have the best possible quality of life*

This Strategy shows how we plan to improve outcomes to all aspects of mental health care. We aim to:

- *Develop and support community well-being and encourage people to maintain healthy lifestyles and keep themselves mentally well. This includes offering therapies to people at times in their lives when they feel particularly anxious and at an early stage, to prevent their mental health from deteriorating into more serious problems.*
- *Enable people to make choices, take control and be supported by their peers.*

[9] Clinical Commissioning Groups (CCGs) & Essex County Council (ECC) on behalf of the north Essex population – Mid Essex, North East Essex and West Essex.

- *Support individuals to be free from dependency on health and social care services recognising appropriate housing; employment and healthy relationships play an important role. This mental health strategy centres on services that will support people to maintain and strengthen these aspects of their lives.*
- *Equip GPs, primary care staff and other community health and social care providers to recognise, assess and support people with mental health needs and to be more effective in treating people's mental health needs alongside their physical health.*
- *Improve the access and gateway into services so people are directed and provided with the right support at the right time and in the right place.*
- *Ensure specialist services continue to develop and are available for people who have severe mental health conditions. It is our intention that wherever possible, short term intensive support will be provided to help people develop skills that enable their recovery.*
- *Ensure people experiencing a mental health crisis will get help quickly, from a range of services. Full use will be made of available technology and social media to keep in touch with people at times when they need additional reassurance but do not want or need more intensive health intervention.*
- *Actively support individuals who may not have had access to services previously, including those who are socially excluded – services to 'fit' around individuals, not individuals to 'fit' into services.*

The key areas for immediate attention are:

- *Identifying and making better use of good quality services that already exist within the community and voluntary sector, primary and secondary and social care.*
- *Effective integration across health and social care commissioning and provision to maximise opportunities with regards both service delivery and financial effectiveness.*
- *Strengthening the interface between mental and physical healthcare, particularly for older people, those with drug and alcohol related dependency and people with long-term conditions*
- *Reducing unnecessary bed use in acute and secure psychiatric wards*
- *Improving workforce productivity*
- *Increasing the use of personalisation to deliver a model of service driven by supporting individuals to have more choice and control over their situation.*

During the next three years we will focus on four key priorities:

- *To improve mental health through the development and active promotion of wellbeing and prevention services*
- *To improve access to services thus reducing waiting times for assessment and treatment*
- *To develop agreed care pathways for mild, moderate and severe need*
- *To maintain people's mental health post-treatment through better primary and community care services.*

The strategy supports the delivery of a comprehensive range of services building on promoting health and wellbeing within communities to specialist care and support, through secondary care provision.

4.6.1 New Model of Care

The National Institute for Health and Care Excellence (NICE) commissioning guidance[10] identifies the benefits of using a stepped care approach to commission services for

[10] NICE National Institute for Health and Care Excellence: publications.nice.org.uk/commissioning-stepped-care-for-people-with-common-mental-health-disorders

people with common mental health problems. NICE recommends that a stepped-care model is used to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. The core principle of stepped care uses different levels of care to ensure the consistent flow of services between the steps, resulting in no waiting lists. The steps are graduated from low to high intensity. Individuals may begin their journey at any step of the pathway as the care pathway is integrated to reflect that recovery is built into each of the steps. There will be more support to GP's from specialist care service so that people are managed in primary care. People are matched to an intervention that is appropriate to their level of need and preference through timely referrals to mental health services. The person can step up or down the pathway according to changing needs and in response to treatment. Therefore, these services are likely to be cost effective and less invasive.

You said

Feedback from the Big Care Debate identified the need for improved access to mental health services within the community and improved support for the families of people with mental health challenges.

We will

The model of care will support the wellbeing agenda.

- *There is recognition that suicide prevention is a responsibility for all.*
- *All people with a mental health condition will receive care in the most appropriate place for their treatment end experience a smooth transition from adolescent to adult and adult to older people through a seamless service.*
- *There is a need to ensure there is a holistic approach with true integration of mental health services with physical health provision; for example Long Term Conditions and patients considered to be frail.*
- *There is a need to transfer low intensity services into the community to develop greater provision in primary care.*
- *We will maximise our impact by commissioning services through jointly agreed strategies; such as Children and Adolescent Mental Health, learning disabilities, older people and the recently produced mental health clinical outcomes framework.*
- *There is a need to work more closely and collaboratively with voluntary and community services to support local populations.*

4.6.2 Local commissioning intentions

Our vision is that all services will be designed around the NICE commissioning guidelines with strong foundations within the community which will then support the stepped care approach and meet local need. The transitions between each step, including the transition to secondary care services, should be experienced as seamless and the whole approach is predicated on the active involvement of service users and their family and friends.

Despite substantial investment there is considerable scope to improve the range of mental health services, access to them and their quality. For example we want to:

- *Establish community wellbeing, supporting and empowering individuals to manage their own mental health.*
- *Establish integrated primary/community based care for the delivery of mental health services and the management of Long Term Conditions.*
- *Develop improved crisis pathways to reduce A&E attendances, admissions and the time people stay in acute beds.*
- *Improve access to services and reduce waiting times for assessment, diagnosis and treatment.*
- *Increase the number of carers receiving support.*
- *Increase the number of people on direct payments or self-directed support.*
- *Provide more coordinated care for people with a dual diagnosis.*
- *Provide a more coordinated and seamless service approach for people considered to be frail; and*
- *Improve value for money, e.g. on accommodation and specialist services – this includes moving from residential care to supported housing.*

We will not only improve existing pathways (including a review of the care pathway for personality disorders (PD)), we will work with specialist commissioners with regards to the development of a Tier 4 PD pathway (specialised services).

The intention will be to use innovative service models to improve the mental health of people with long-term physical conditions and enable individuals to support themselves and their peers by providing emotional support and appropriate resources, and initiatives to strengthen communities and build resilience. Examples include liaison mental health services, talking therapies for people with long term conditions and services for people with medically unexplained symptoms. This approach will be the basis for a local stepped care approach to providing services.

We will encourage people to maintain healthy lifestyles through the promotion of mental health wellbeing. Some examples of intervention include services which will provide guided self-help, assistance with housing, employment & finance, advice & support and education and work closely with children's services (including looked after children) to ensure smooth transition into adult services. Currently around 60% of those looked after (children) in England have been reported to have emotional and mental health problems after leaving care

4.6.3 Substance Misuse

The Dr. Foster Hospital Guide 2013 identified an increasing number of patients with multiple attendances as a direct consequence of drink and drug issues. These patients tended to be older with a longer term dependency, not binge-drinking teenagers. The report goes on to state that drug and alcohol dependency is one of the biggest contributors to hospitalisation among middle-aged people. More than 500,000 people have been hospitalised for this reason at least once in the past 3 years. The peak age for such admissions has increased over recent years, suggesting a generational problem among people in their forties.

In 2012/13, 19% of emergency admissions for people aged 40-44 were for those with a known drug or alcohol issue. This means that around one fifth of emergency hospital care for middle-aged people is linked to drug and alcohol abuse. Whilst this problem affects people from all sections of society, 8.6% are from the wealthiest fifth of the population; 36% were from the most deprived areas of the country.

The Department of Health reports[11] that between 2011 and 2012, an estimated 8.9% of adults used an illegal drug. Although this is the lowest level of drug use since figures were initially collected in 1996, drug misuse continues to have a negative effect on the health, wellbeing and quality of life of too many people.

It also drains public resources. For example, crimes related to drugs cost the UK £13.3 billion every year.

In 2010, the Department of Health published the National Drug Strategy for England[12]. The strategy sets out the national direction for helping people to live a drug free life.

The prevalence of drug misuse locally has reduced, however the joint aim, working with ECC, Local Councils and Public Health and in line with the National Strategy, is to reduce the number of people misusing illegal drugs and other harmful drugs and increase the number of people who successfully recover from dependence on these drugs.

The main commissioning focus will be;

- *To encourage people to live healthy lives and provide education on the consequences of drug misuse;*
    - *providing accurate information on drugs and alcohol through drug education and the FRANK service*
    - *Working with Local Councils through the Business Rates Retention Scheme to create programmes to help prevent young people misusing drugs in the first place*
    - *helping people who have problems with drugs by giving them treatment and support, including supporting them in other areas of their life (for example with housing or mental health problems), so that they don't return to drug use as a way of coping with these problems*
- *Help people to recover from drug dependence by commissioning services based on outcome indicators;*
    - *service users become free from dependence on drugs and/or alcohol*
    - *reduced re-offending or continued non-offending*
    - *improved health and wellbeing*
- *Helping offenders who misuse drugs to get treatment through joint working and direct referral pathways to treatment services as early as possible in their contact with the criminal justice system.*

[11] Reducing drug misuse and dependence: Department of Health March 2013
[12] Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life: Department of Health December 2010

Reducing Harmful Drinking

In England, the 'lower-risk guidelines' for alcohol state that men shouldn't regularly drink more than 3 to 4 units per day and women shouldn't regularly drink more than 2 to 3 units per day. Although many people who drink do so within these guidelines, binge drinking accounts for half of all alcohol consumed in the UK[13].

Drinking more than the amount suggested by the guidelines can damage a person's health. For example, alcohol is one of the biggest behavioral risks for disease and death (as well as smoking, obesity and lack of physical activity). In 2010 to 2011 there were 1.2 million alcohol-related hospital admissions and around 15,000 deaths caused by alcohol. Every year, alcohol-related harm costs society £21 billion[14].

The problem is being tackled nationally with government campaigns, for example Change4Life and NHS health check designed to inform people of the risks associated with excess alcohol consumption, how this relates to them and the steps they can take to improve their life choices.

Acute providers are providing a model of care to ensure ongoing support is offered to young people presenting in A&E with alcohol-related problems, including alcohol liaison nurses.

Local councils are working collaboratively with the health and well-being board to understand local needs and to set public health priorities. Councils are able to commission prevention and treatment services that meet the needs of local people.

The CCG will commission alcohol recovery services based on the three national outcome indicators;

- service users become free from addiction to drugs and/or alcohol
- reduced re-offending or continued non-offending
- improved health and wellbeing

4.6.4 Older people's mental health

Older people with mental health issues often present with other health and social problems as a natural consequence related to ageing. Mental health in older adults does not specifically relate to dementia but to other conditions such as depression, anxiety etc. A range of services is therefore required in the assessment and treatment of older people's mental health.

Older people's mental health services are of particular importance to the CCG and ECC given the high proportion of elderly people locally and the continued growth forecasted for this particular age group. Older people are disproportionately high users of health and social care services.

[13] Reducing Harmful Drinking: Department of Health March 2013
[14] Department of Health Alcohol Strategy 2012

For many years the commissioning and provision of mental health services has been based on the guidelines within national frameworks which has resulted in segmenting older people's mental health care. This approach contributes to ageism and other forms of age related discrimination. This has also resulted in duplication of resources across service providers.

The CCG and ECC will commission mental health services for all adults regardless of age, integrating elderly patients into mainstream mental health services supported by the specialist expertise for co-morbidity and dementia.

The CCG will continue to commission mental health services in north east Essex with an aim of ensuring commissioning achieves the best possible quality care and outcomes and ensures that services are accessible and aligned to physical health needs.

High Level Outcomes - Managing on-going physical and mental health conditions	
Long term Conditions	1. Implement an integrated multidisciplinary approach in the management of specific long term conditions with a focus on minimising the likelihood of exacerbation and management of the condition within the community setting.
Dementia	1. Improved awareness across health and social care professionals and the people of north east Essex, 2. Earlier diagnosis and intervention, 3. A higher quality of life for patients and their families.
Prescribing	1. Improved medication prescribing, understanding and concordance by patients, their family and carers, health care practitioners, and GPs.
End of Life	Provision of integrated care, co-ordinated through a single point of access and determined by the end of life register and advance care planning. The elements of the model to be commissioned include; • End of life register • Advance Care Planning • Single Point of Access • Key workers/care co-ordinators • Rapid response • Specialist Nursing and community teams • Improving Access to Psychological Therapies • Hospice Care • Transport • Social care
Telehealth	1. Maximising the opportunities for Assistive Technology to support and promote independence, choice & control whilst reducing reliance on health and social care interventions 2. Exploring AT's contribution to the achievements of personalised health & social care outcomes for individuals. 3. Analysing the role of AT in supporting and contributing to the delivery of wider outcomes in areas such as shifting the balance of

	care and the management of long-term health conditions
Community mental health	1. People will have good mental health 2. People with mental health needs will recover 3. People with mental health needs will have good physical health and people with physical health needs will have good mental health 4. People with mental health needs will have the best possible quality of life.

5 Assisting recovery from episodes of ill-health

The NHS will help people recover from episodes of ill-health or injury, such as after a stroke or other emergency or a planned operation, so that they can regain their independence as quickly as possible.

Every year, millions of people rely on the NHS to help them through a spell of ill health or injury, through effective treatment and then help in recovering quickly and regaining independence. Supporting people to recover and regain their independence is not something the NHS can achieve alone, but requires better partnership with patients, families and carers, social services and other agencies.

Because standards are high overall, most people assume all NHS services are equally good. Yet there are huge and unwarranted differences in quality and results between services across the country.

NHS England is highlighting these differences and unacceptable practices, to inspire and help people to learn from the best.

This includes ensuring greater equality between access to mental and physical health services and improving transparency so the NHS leads the world in the availability of information about the quality of services. *(The Mandate: A mandate from the Government to the NHS Commissioning Board, Department of Health 2012)*

Four developments have been identified by the CCG as key components to the commissioning of the appropriate services to assist recovery from episodes of ill-health; reablement, improving access to psychological services, care home improvement plans and community step-up beds.

5.1 Reablement

Reablement is a model of care provision that has been championed as an approach to keep people independent. The Department of Health have described reablement as a service that supports people with poor physical and/or mental health, to relearn the necessary skills for daily living in order for them to rebuild or maintain their independence.

Reablement offers intensive short term support (up to 6 weeks) provided in the patients place of residence by one or more of the multidisciplinary team. Reablement is focussed on patients learning/relearning to do things for themselves, differentiating this from the adult social care service model of domiciliary care.

The CCG and ECC view reablement as the opportunity to work in partnership to deliver a service that will provide a cross section of tailored health and social care, and are working together to remodel reablement provision. The broad aims of this joint working were identified as; improving quality of life, prevent unnecessary long term social care and residential placement through management of independence, reductions in unplanned hospital admissions and prevent readmissions within 30 days of an acute stay, and overall reduction in the length of stay following unplanned admissions.

A joint review of reablement services is underway to ensure that the most appropriate reablement service model is rolled out across north east Essex by October 2015 when the currently commissioned reablement service contract ends.

5.1.1 Residential Reablement

In some situations, it is not possible for some patients to receive reablement in their own home and these patients are therefore offered a programme of residential reablement. This is currently provided by ECC in Chelmsford. Following a successful pilot, ECC are working with the CCG to review the possibility of providing this service locally within north east Essex.

5.1.2 Hospital to Home

The CCG and ECC commission a hospital to home service which is a grant funded community service that provides environmental risk assessments of patients' homes and make safe services such as repositioning of furniture, installation of equipment and key safes.

The service also provides financial/benefits assessment and sign posting service. The aim of the service is to support safe discharge of patients from hospital and promote a patient's ability to continue in their usual place of residence.

The expansion of this service going forward will include referrals from community services to work toward improving admission avoidance.

The CCG will continue to work jointly with ECC as the lead commissioner, to fund an integrated reablement model that will support people with poor physical and/or mental health, to relearn the necessary skills for daily living in order for them to rebuild or maintain their independence.

5.2 Continence

ECC are leading an Essex wide project in developing a strategy for the provision of continence service following research that highlighted incontinence is a major reason for the breakdown of the relationship between the carer and the person they are caring for. This can lead to admission to residential or nursing home care. Incontinence is second only to dementia as an initiating factor for such moves. In addition, initial research suggests that the majority of older people receiving a social care service have some bladder and/or bowel issue and many use incontinence products. Experts agree that up to 80% of cases of urinary incontinence would be responsive to treatment irrespective of the age of the individual.

Current NEE data also evidences that a significant number of our patients being admitted to CHUFT are suffering from a urinary tract infection indicating that continence is a priority area.

The CCG will work jointly with ECC to commission a service to promote earlier detection and increased training around the signs and management of incontinence to ensure continence issues are more proactively managed in the early stages, reducing the number of patients who reach crisis point and require an acute attendance/ admission. This should also have an impact in reducing demand for residential home placements with incontinence being a primary reason

5.3 Falls

The number of falls and injuries resulting from a fall continues to be an area of significant pressure for the North East Essex health economy, particularly in relation to the number of A&E attendances & ambulance calls outs with falls being the single greatest demand for our ambulance service.

North East Essex CCG held a Falls Learning Event on the 26th June 2013 where there was representation from all Providers across the current falls pathway. From this a number of areas for improvement and increased integration were highlighted;

- *Single assessment template available and to be promoted to a range of stakeholders.*
- *Multi-factorial assessments and signposting.*
- *Exercise programmes to be individually focused.*
- *Targeted focus to care homes - increased training, best practice guides.*
- *Maintain a falls database to target interventions to frequent fallers.*
- *Ensure effective links with social care.*
- *Provide equality of Care line services between Colchester and Tendring.*
- *Increased links with the voluntary sector for ongoing support.*

It is anticipated that patients will benefit from improved access to the falls prevention service as well as earlier detection of patients being at risk of falls, helping patients to live more independently and increase their quality of life.

Both the ambulance service and CHUFT should benefit from reduced 999 calls, with an increased number of preventative actions being implemented which in turn should result in a reduced number of non-elective admissions as a result of a fall.

Social care will also benefit through people being able to maintain independence by living in their own homes reducing demand on the need for residential placements.

The CCG and ECC will work jointly to commission improved integration of falls services across the economy, to ensure patients are seen at the most appropriate place in a timely manner.

There will be increased awareness of the falls prevention services by all Health Care Professionals through the use of the single assessment tool and increase links and integration with the voluntary sector to expand the number of patients targeted.

Interventions will be targeted at the most at risk patients.

The commissioned service will ensure the community based falls service acts as the default referral option to act as a gateway to the acute clinic.

5.4 Improving Access to Psychological Therapies (IAPT)

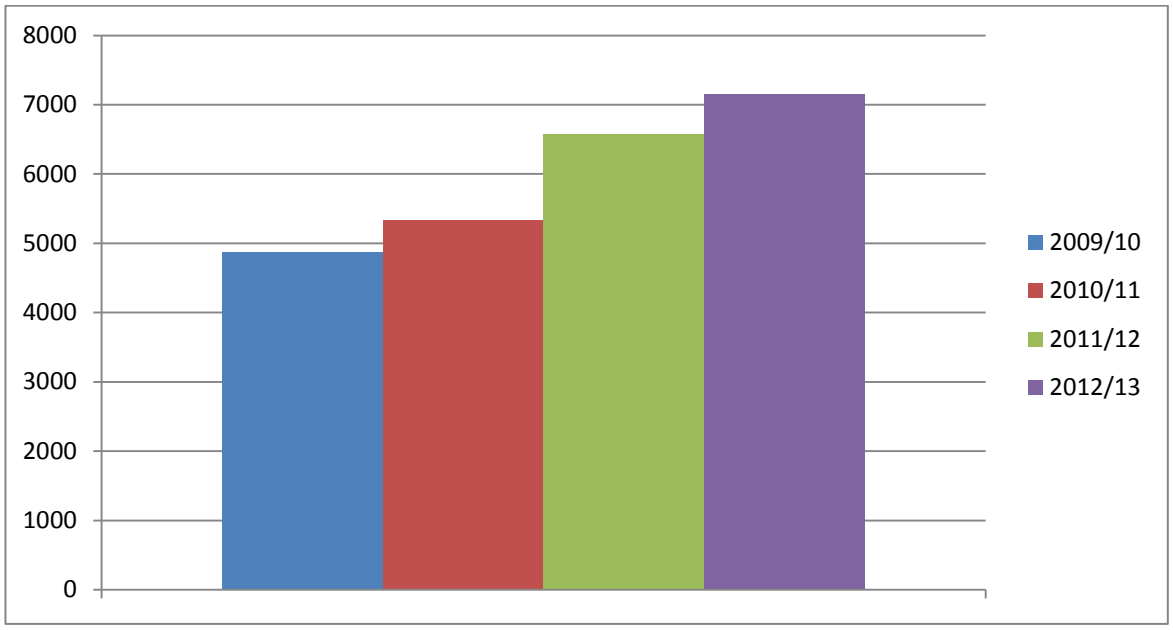
Improving Access to Psychological Therapies is an NHS programme rolling out services across England offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders.

By March 2015, access to high quality evidence-based psychological therapies, capable of delivering recovery rates of 50% or more, is expected to be available for at least 15% of the adult population. The scope of IAPT is also expected to have been extended to other groups in need. In order to achieve this goal the CCG will commission service providers to provide:

- *Continued monitoring of patient satisfaction, safety and clinical effectiveness*
- *Sufficiently trained practitioners to meet service demands*
- *Evaluating which models deliver evidence-based services in the best way to support sustainable investment*
- *Expanding services to address local needs on an equitable basis*
- *Extending the scope of the programme to specific groups at risk, including children and young people, people with a severe mental illness or personality disorder; people with a long term physical health conditions and / or medically unexplained symptoms.*

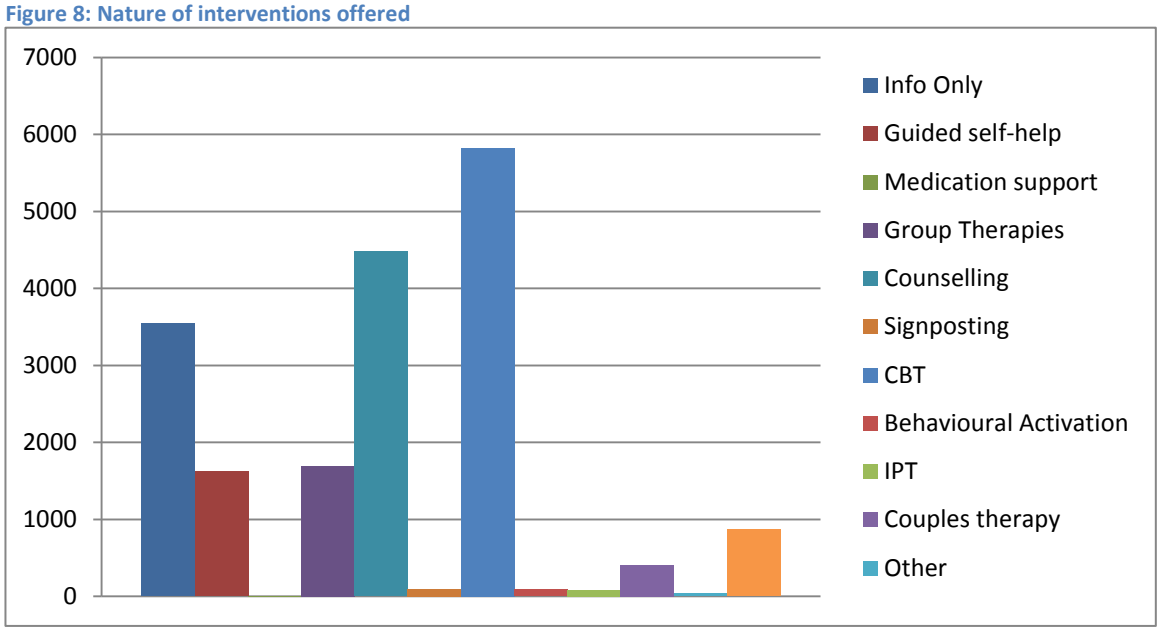
The referral rate to the current IAPT service has grown substantially over the last 4 years, and a further growth is anticipated as the service extends further to particular at risk groups.

Figure 7: Referrals by year to IAPT services 2009 -2013



Analysis of the interventions identifies a high uptake in cognitive behavioural therapy and counselling.

Figure 8: Nature of interventions offered



The CCG will continue to commission a robust suite of Primary Care based mental health services, commissioned on improved clinical outcomes data to ensure that people progress quickly, and will develop a continuum pathway of mental health care from the low level STaR Worker through Primary Care Counselling/CBT/Talking Therapies, and via 'Step 3.5' services onto commissioned secondary mental health services smoothing out gaps in and between the services

5.3 Care Home Improvement Plans

Improving outcomes for people in Care Homes and other residential settings.

Following increases in emergency admissions at Colchester Hospital University Foundation Trust (CHUFT) during 2011/12, analysis of the data suggested that admissions from Care Homes were a contributing factor.

In January 2012 the registered population of north east Essex was 327,542. Of this figure 3739 are resident in local care homes and other residential settings. This is approximately 1.14% of the overall NEE population.

During the period April 2011 to March 2012, 6901 ambulance calls were made from care homes. This equates to an estimated 16.43% of the total ambulance calls for the same period.

Both North Essex CCG and Essex County Council agreed to work collaboratively through joint commissioning plans to address this issue. Initial investigation suggests that falls, end of life care and the management of long term conditions were the main reasons for the emergency ambulance call outs. Action plans were agreed and put in place for each of these areas of concern.

As a direct result of this work we will ensure that those people who live in care homes and residential settings are not disadvantaged and are only taken to hospital when required. This work will be undertaken by the 'Better Transition Network' (BTN) working group which is made

up of representatives from Colchester Hospital, Care Home Managers and is financially supported by ECC. The BTN will be responsible for the implementation and effectiveness of the action plans, success being measured through the reduction of care home residents attending A&E and improved clinical outcomes for these residents.

These outcomes will include:

- Regular Medication Reviews.
- Better management of Skin Tears
- Reduction in the number of Urinary Tract Infections (UTI)
- Improved protocols in the assessment and management of suspected head injury
- Improved end of life care
- Improved outcomes and better management of long term conditions

The expectation of the CCG and ECC is that Care Homes will continue to improve the care of residents through;

- the improved management of hydration, medications, falls risk assessments, and the local management of minor injuries
- improved management of long term conditions including end of life care

5.4 Community step-up beds

North East Essex CCG has been working with health economy colleagues to develop an alternative care model for the use of community beds at Clacton Hospital. The intention is to change the current model of care of medically led step-down beds (beds in a community setting used for patients from an acute provider who no longer require acute care but who are not yet able to return to their previous place of residence) to a nurse led step-up bed model (patients in the community who require a higher level of nursing care than can be provided in their own place of residence), supported by a rapid assessment unit. A further consideration, currently being reviewed, is the feasibility of creating a palliative care ward.

Reablement services are currently receiving a total of 200 referrals per month and of the clients that they accept 87% are successfully re-abled to no longer needing care packages. Many patients who would have been transferred from CHUFT to the community hospitals are being transferred directly home to the care of reablement. The length of stay in the community hospitals is reducing due both to the availability of reablement and the success of their service. This is reducing the requirement for step down beds at Clacton. Bed occupancy of the step down community wards at Clacton Hospital has not been at optimum levels for some time, resulting in poor utilisation of staff and beds.

There is evidence to suggest that the discharge planning process for patients transferred to the step-down beds from CHUFT is not started until the patients are admitted to Clacton Hospital. Delaying the discharge planning can extend the length of stay and can increase the patients' dependency on services. In a step-up ward, discharge planning can be instigated early to minimise the length of stay and dependency on support services.

A clinical audit report[15], February 2013, on use of Community Beds, demonstrated that the majority of patients admitted to Clacton Hospital primarily required nursing care. This supports the proposal to change the care model from medically led to nurse led, which would also be cost effective. Forty six percent of the transfers to Clacton Hospital were likely to have been suitable for direct admission to a community step-up bed. 33% of patients apparently had no or limited medical input when they were admitted to Clacton Hospital, questioning whether the level of medical cover was necessary.

Step-up beds offer the opportunity to manage people in the community by assessing and planning treatment to maintain independence, where the patients and families/carers can remain closer to home. Defined clinical criteria (established in the proposed new care model) supported by appropriately skilled staff, will optimise bed occupancy and make better use of resources and better meet the current needs of the health economy.

Extending patient choice by offering an alternative option at the time or as part of the Preferred Place of Care facilitates anticipatory planning, shifting the balance from dependency and demand for unscheduled care towards better scheduled/planned care interventions.

The CCG intend to commission a 'step-up' bed resource and rapid assessment unit at Clacton Hospital for Clacton and Tendring patients.

High Level Outcomes - Assisting recovery from episodes ill-health	
Reablement	Avoid/reduce hospital admissions/readmissions. Avoid/reduce delayed discharges from hospital. Reduce the requirement for residential care Enable people to maintain their independence within their usual place of residence.
IAPT	By March 2015, there will be access to high quality evidence-based psychological therapies, capable of delivering recovery rates of 50% or more, for at least 15% of the adult population. The scope of IAPT will include other at risk groups including children and young people, people with a severe mental illness or personality disorder.
Care Home Improvement Plans	Improved patient outcomes through; Improved management of falls Improved management of long term conditions Improved end of life care
Community Step-up Beds	Provide a timely and appropriate service for patients with exacerbated illness that can be managed safely within the community setting, keeping people and their families closer to home Shift the balance from dependency and demand for unscheduled care towards better scheduled/planned care interventions and as a consequence reduce the unplanned attendances at A&E Maximising the resource utilisation and ensure value for money of public funds

[15] Anglia Community Enterprise Community Bed review February 2013

6 Better Care – Quality Assurance

The NHS will make sure people experience better care, not just better treatment, so that everyone can expect to be treated with compassion, dignity and respect whenever they come into contact with the NHS.

Quality of care is as important as quality of treatment. No-one going in to hospital should have to worry about being left in pain, unable to eat or drink, or going to the toilet. And those who have relatives or friends who need support should have peace of mind that they will be treated with compassion, respect and dignity – whether at home or in residential care.

In incidents of major failings in care, it is frequently older and vulnerable people and those with complex conditions who bear the brunt – people who are less likely or less able to complain.

NHS England is undertaking a range of things to help improve people's experience of care, including;

- *making rapid progress in measuring and understanding how people really feel about the care they receive and taking action to address poor performance*
- *asking people whether they would recommend their place of treatment to a family member or friend*
- *improving the standards of care and experience for women and families during pregnancy and in the early years for their children*
- *ensuring that the views of children, especially those with specific healthcare needs, are listened to and that they have access to the services they need*
- *ensuring timely access to services by upholding the rights and commitments set out in the NHS Constitution.*

(The Mandate: A mandate from the Government to the NHS Commissioning Board, Department of Health 2012)

You said

A constant theme that was fed back to the CCG and ECC throughout the Big Care Debate was the need for better access in relation to place and time of care.

We will

The ultimate aim of the Care Closer to Home Strategy is to commission the highest quality care services for the people of north east Essex. The CCG also want the implementation of the strategy to provide local pride in the NHS and want the people of north east Essex to be confident that their healthcare services are amongst the very best, all of the time.

The CCG and ECC share four quality ambitions which provide a focus for all of its commissioned services, as follows;

- *Mutually beneficial partnerships between patients, their families and those delivering health care services which respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision making.*
- *There will be no avoidable injury or harm to people from health care they receive and an appropriate clean and safe environment will be commissioned for the delivery of health care services at all times.*
- *The most appropriate treatments, interventions, supports and services will be provided at the right time to everyone who will benefit and wasteful or harmful variation will be eradicated.*
- *Foster a partnership approach with social care providers to provide joined up high quality patient care and outcomes*

The CCG will also strive to ensure that the high quality health care they commission is provided on the basis of its on-going commitment to equality of experience and outcomes, to everyone in north east Essex, no matter who they are or where they live.

6.1 National and Local Context

This strategy provides a quality framework for the CCG to function as a commissioner for health and social care services focussed on providing care closer to home and as a statutory body. To this end, our agreed quality strategic aims are:

- *Operate clinically led commissioning processes in partnership with GPs to;*
  - *add value to patient care,*
  - *prioritise resources on the basis of clinical need*
  - *improve patient outcomes*
- *Work in partnership with local providers so that they are first choice for healthcare for the population of north east Essex.*
- *Embrace the QIPP (Quality, Innovation, Productivity and Prevention) agenda and to commission and deliver cost-effective care within the CCG resources.*
- *Foster a partnership approach between member practices, supporting each other in providing high quality primary care services.*
- *Demonstrate a strong commitment to openness and transparency, specifically in information and data sharing among member practices within the CCG.*
- *Ensure patient safety and improve patient experience*
- *Reduce the health inequalities of our population.*

Nationally there are multiple policy drivers that influence the quality agenda across the NHS and these determine the monitoring and reporting mechanisms required locally in the delivery of this agenda. These policy drivers focus on what is collectively summarised as harm free care.

The Francis Report into the failure in NHS care at Mid Staffordshire Hospital published in 2013, places a much greater emphasis on commissioners taking responsibility for actively managing the quality of services.

The CCG address each of the national directives associated with harm free care in the organisational Quality Strategy, therefore this commissioning strategy is governed by the directives within the Quality Strategy.

The service specification developed specifically for the commissioning of this care bundle will detail key performance indicators required to ensure all service providers have a clear and deliverable quality directive.

In addition to the key performance indicators associated with harm free care, the CCG is also guided by the national quality programme to ensure appropriate accreditation and evidence based practice is in place. The programme includes;

- *Care Quality Commission Registration*
- *Quality, Innovation, Productivity and Prevention (QIPP)*
- *National Quality Board (NQB)*
- *The National Institute for Clinical Excellence (NICE)*
- *The Commissioning Outcomes Framework*
- *GP Quality and Outcomes Framework (QOF)*
- *National Reporting and Learning System (NRLS)*
- *Safeguarding*

6.2 Planned Care

The Department of Health have provided frameworks detailing a shift in the provision of some services from the acute to the community setting; for example dermatology, ophthalmology (in particular glaucoma), musculoskeletal with the potential to shift further services through the appropriate role development and enhancement, for example GPs with special interest; ENT, Urology.

You said

Feedback from the Big Care Debate was very clear about the need for improved provision and access to services in the community.

There has been a number of policy initiatives that have attempted to encourage a shift of care out of hospitals and into the community over the last decade, further work is required

locally to realise this potential. The arguments for moving more care closer to where patients live are no less compelling now than they have ever been. Hospitals are expensive and impersonal places in which to deliver care that does not require a high tech and specialised environment[16]. The challenge for healthcare leaders is a significant one: how exactly do we overcome a centuries-old trend of increasing centralisation of healthcare provision?

All health services are facing the enormous challenge of delivering better care while controlling costs. Rethinking traditional patterns of where and how care is delivered is fundamental to addressing these challenges.

We will

Research from the Health Foundation 2011 suggests that there are potential gains to be made from shifting at least some acute services from hospital into the community. Those potential gains include better health outcomes for patients, greater patient satisfaction with services and more cost-effective delivery of treatment.

- *Primary care can be an effective alternative to hospital treatment for some patient groups, in particular the elderly and those with complications arising from long-term conditions such as heart failure and chronic obstructive pulmonary disease (COPD).*
- *Intermediate care from community hospitals may reduce mortality and lead to similar quality of life compared with inpatient care in elderly people with acute illness.*
- *The effectiveness of primary care solutions is very much influenced by the quality of those services rather than simply the setting (primary or secondary) in which they are provided.*
- *Patients seem more satisfied with treatment at home compared to hospital inpatient care.*
- *Early discharge from hospital into community-based care settings is associated with better patient satisfaction scores and equivalent quality of life scores.*
- *Patients report high satisfaction with community-based minor surgery due to ease of access, shorter travelling times and reduced waiting times. However, in some cases, minor surgery delivered by GPs may be of lower quality than that done by surgeons in hospitals.*

The commissioning focus will be;

Criteria	Specialty
Primary care based minor surgery	Dermatology, ENT
Admission avoidance	Virtual ward management of specified conditions such as exacerbation of COPD, heart failure, cellulitis
Referral refinement	Ophthalmology, Musculoskeletal, pain
Outpatient Consultation	Dermatology, ophthalmology, lymphoedema and tissue viability, musculoskeletal, spinal, pain (Medically Unexplained Symptoms), rheumatology, urology, ENT, neurology.
Community Hospital Intervention	Stroke recovery

[16] *Evidence: Getting out of hospital?* the Health Foundation 2011

The suggested service shifts is not exhaustive and commissioners will undertake a review of the suggested proposals and identify further clinical areas for review.

6.3 Self care and empowerment

The CCG acknowledge that the most effective form of care is patient centred, where the patient is part of an informed decision making process, is empowered to identify health and social care needs and has the control over the service they receive. Patient centred care is therefore at the heart of the quality agenda. To this end the CCG will commission a range of services to facilitate this shift in decision making and purchasing power that will provide the care and support that people need and want and ensure efficient use of NHS resources.

6.3.1 Carers

Carers provide care to family members, other relatives, partners, friends and neighbours of any age affected by physical or mental illness (often long-term), disability, frailty or substance misuse. Sometimes the cared-for person will have more than one condition. The carer does not need to be living with the cared-for person to be a carer. Anybody can become a carer at any time, sometimes for more than one person. The lives of carers and the cared-for are closely intertwined, but they are not the same. The CCG has set out its plans for carers in the North East Essex Carers Strategy. The aims within the strategy are;

- *Support early self-identification and involvement in local and individual care planning;*
- *Enable carers to fulfil their educational and employment potential;*
- *Personalise support for carers and those being cared for;*
- *Support carers to remain healthy;*
- *enable the commissioning of care pathways rather than services or individual interventions, based upon a future needs assessment;*
- *enable a shared approach to investment and disinvestment;*
- *enable efficiency in procurement and other enabling functions;*
- *ensure clear alignment between commissioning plans and the statutory Health and Wellbeing Strategy;*
- *Make allowances in our Engagement plans so carers can engage. This requires particular attention and has been raised at the Health Forum committee. Because Carers need assistance for those who are in their care, funding for this may have to go beyond normal arrangements;*
- *Translating the principles of the Essex wide joint commissioning framework for Carers locally;*
- *Share best practice between our local practices;*

These aims will be achieved through the delivery of the following objectives;

- *Ensure advice, information, support and advocacy available;*
- *Support carers to have a voice in local decision making*
- *Raise awareness with partners likely to encounter carers, both in terms of identification and consistency of messages and guidance. This will include developing and providing training courses across all sectors to embed the 'think carer' culture of practice;*

- *Provide training for carers e.g. manual handling*
- *Develop a pathway with ECC so carers are informed of the benefits of Assistive Technology;*
- *Provide breaks from caring role, that offer flexibility and choice;*
- *Jointly working with ECC to enable carers to consider their learning and work needs, develop relationships with Job Centre Plus, job clubs, Employers for Carers and other forums which may support carers to identify and access learning and work opportunities. Support for income maximisation, Support carers to have choice and control via personalisation, supporting carers to creatively use direct payments, accessing local leisure facilities on preferential terms, consider the development of a 'carers passport', universally accepted concessionary rates.*
- *Recognise that carers effects all areas of the CCG and that we reduce silo working in or CCG on the issue;*
- *Support carers to understand how emergency planning contributes to health and wellbeing. Actively promote and develop the emergency planning service.*
- *Recognise that carers groups are different. For example black and minority ethnic organisations asylum seekers and emerging/migrant communities, Travellers, older people, LGBT(Lesbian, Gay, Bisexual and Transsexual), those who work, young carers, mental health carers, Drug and Alcohol carers and Palliative care and end of life*
- *Work with partners to develop and provide direct bespoke training courses across all sectors, public, private and voluntary to embed the 'think carer' culture of practice.*

Carers have had the right to recognition since the Carers (Services and Recognition) Act was passed in 1995. They have also had the right to be consulted about their willingness and / or ability to provide or continue to provide care for another person. They have had the right to have a Carer's Assessment in their own right since the Carers and Disabled Children's Act 2000.

Caring about carers: A national strategy for carers was published in 1999. This was then reviewed in 2010 after consultation. The document Recognised, valued and supported: next steps for the Carers Strategy sets out the Government's priorities for carers and identifies the actions we will take to ensure the best possible outcomes for carers and those they support, including:

- supporting those with caring responsibilities to identify themselves as carers at an early stage, recognising the value of their contribution and involving them from the outset both in designing local care provision and in planning individual care packages
- enabling those with caring responsibilities to fulfil their educational and employment potential
- personalised support both for carers and those they support, enabling them to have a family and community life
- supporting carers to remain mentally and physically well.

The Care Bill 2013 gives the same rights to carers as those given to the people they care for. Local authorities will now have a duty to provide carers with their own assessment of support needs. This will look at the impact on the carer in providing this role, what they want to achieve in their own life and if they are able and willing to continue in their

caring role. The carer should receive a personal budget and can ask for direct payments to manage their own support in line with that available to be person being cared for. This bill will take full effect from 2016 and will have major implications for commissioning and provider organisations.

The commissioning intentions for care closer to home will ensuring that all service providers respect these rights through compliance within the CCG carer commissioning principles.

6.3.2 Empowering Patients to Self-Care

Most care in life is self-care. It is an integral part of active daily living and can be defined as the care taken by individuals towards their own health and wellbeing (both physical and psychological). It includes the care extended to children, family, friends and others in neighbourhoods and local communities, recognising and valuing these social support systems (95% of all care is provided in this context of the community)[17].

Some of the elements of self-care include:

- *maintaining good physical and mental health*
- *meeting both social and psychological needs*
- *preventing illness or accidents*
- *caring for minor ailments and long term conditions*
- *maintaining health and wellbeing after an acute illness or discharge from hospital*

In self-care the patient or client is a co-provider of their care. The professional has a key role to play in providing the necessary support to enable the individual to do enhanced self-care.

North East Essex CCG currently commission services that comprise elements of self-care support, such as structured education programmes, behaviour modification i.e. IAPT, rehabilitation and reablement services. This has resulted in several positive outcomes both locally and nationally[18];

- *increase in life expectancy*
- *better control over symptoms*
- *reduction in pain, anxiety and depression levels*
- *improvement in quality of life with greater independence*
- *reduction in days off work by up to 50%*
- *increase in social capital (more trainers, active citizens).*

Benefits can be realised for the health economy as a whole;

- *improved quality of consultations*
- *visits to GPs can reduce by 40 - 69%*
- *hospital admissions can reduce by up to 50%*
- *length of stay or number of days in hospital may decrease by up to 80%*
- *outpatient visits can reduce by 17 - 77%*
- *A&E visits can reduce by up to 50%*
- *medication intake, e.g. steroids reduced*
- *medicine utilisation is improved by 30%.*

[17] Department of Health, Self Care – A Real Choice: Self Care Support, A practical Option (2005)
[18] A framework for commissioning support for self care: Working in Partnership Programme DH 2008

The CCG appreciate that self-care is about ensuring that people have the skills, knowledge and confidence so that they;

- Understand their condition as much as possible
- Can identify what holistic factors must be impacting on their quality of life.
- Set goals and action plans to address these factors where possible.
- Are able to apply the knowledge of their condition and holistic factors to better manage their health.
- Are less likely to experience avoidable complications.
- Are able to work in partnership with their medical team on the occasions they require professional support. Plan to extend the commissioning of self-care into other areas of care, treatment and prevention.

6.3.3 Personal Health Budgets

On 1st August 2013, the Direct Payment in Healthcare regulations came into force across England. This means that the NHS can now lawfully offer direct payments for healthcare. All CCGs will need to be able to deliver personal health budgets by April 2014. A personal health budget is an amount of money to support a person's health and wellbeing needs, planned and agreed between the person and their local NHS team.

The CCG vision for personal health budgets is to enable people with long term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive.

North East Essex CCG are working jointly with NHS Central Eastern Commissioning Support Unit and the continuing healthcare team to provide a scaled service akin to personal health budgets throughout 2014-2015.The providers will be offering a service which includes the necessary staff to receive referrals for suitable candidates for personal health budgets and to provide support plans for individuals identified for the scheme. The CSU will also provide assistance to personal budget holders on employment, governance and risk assessments.

6.3.4 Volunteers

NHS Central Eastern Clinical Commissioning Group values the role of volunteers and recognises that they can provide a meaningful contribution in supporting local providers. The design of local services with volunteers in mind can add real value.

You said

There was much public support for the work undertaken by the voluntary organisations and charities.

We will

The CCG and ECC expectation is that provider organisations will work in partnership with patients using tools such as the well-being star for personal health planning.

Working with statutory and non-statutory organisations (such as the Community Voluntary Services) we want the system to identify, recruit and retain a wide range of

volunteers so a "bank" of skilled people with a diverse range of competencies and knowledge can contribute in delivering outcomes for local people. North East Essex CCG currently commission volunteer-based/peer support services, for example 'life after stroke'. The impetus is to learn from these examples of good practice and further integrate volunteers across the health and social care service provision.

Volunteering can also bring benefits to volunteers too by improving skills and confidence and developing new interests.

High Level Outcomes - Better Care – Quality Assurance	
Quality	Clinically led commissioning processes in partnership with GPs to; add value to patient care, prioritise resources on the basis of clinical need improve patient outcomes Confidence in local providers so that they are first choice for healthcare for the population of north east Essex. Cost-effective care within the CCG resources (QIPP) Partnership approach between member practices, supporting each other in providing high quality primary care services. Ensure patient safety and improve patient experience Reduce the health inequalities of our population.
Self-care and empowerment	The patient is part of an informed decision making process, is empowered to identify health and social care needs and has the control over the service they receive

The CCG will commission a range of services that support personal health planning to ensure efficient use of NHS resources; this will include the use of statutory and non-statutory voluntary organisations.

7 Providing safe care

The NHS will provide safe care, so that everyone is treated in a clean and safe environment and people are at a lower risk of avoidable health problems such as infections, blood clots or bed sores.

The NHS Constitution gives patients should the right to expect to be treated in a safe and clean environment and to be protected from avoidable harm. In recent years the NHS has made progress in developing a culture of patient safety through the introduction of stronger clinical governance within organisations. *(The Mandate: A mandate from the Government to the NHS Commissioning Board, Department of Health 2012)*

The commissioning of safe care for north east Essex is based on the national safety framework which puts patients at the centre of all decision making. The CCG Quality Strategy provides the organisation with the guiding principles of commissioning safe services.

This strategy is based on these principles and the service specification will capture the key performance indicators in relation to;

Quality of Care

- *Assist in the development of learning organisations*
- *Measurement of patient safety related outcomes*
- *Horizon scanning and development of patient safety CQUIN and KPIs*

Organisational Capability

- *Develop a patient safety culture across north east Essex*
- *Develop a patient safety focused commissioning workforce*
- *Strengthen intelligence in patient safety*

Partnership & Engagement

- *Partnership working with providers across the health economy*
- *Effective communication with patients, carers and the public*
- *Organisational engagement*
- *Sustainability*
- *Effective procurement of healthcare services with a record of and a design for patient safety- commissioning of services that are known to meet requirements in relation to patient safety will be influenced through a robust procurement process.*

Much of the focus of the CCG will be on the outcomes of the recent The Keogh Review into the quality of care and treatment provided by Colchester Hospital University Foundation Trust in July 2013 and Report into the Immediate Review of Cancer Services at Colchester Hospital University NHS Foundation Trust, December 2013, in assuring the clinical pathways going forward both within the acute provider but also the horizontal and vertical integration of pathways across multiple providers. Further assurance is required in the management of patient outcomes in care homes with regard to the competencies and training of the staff within these organisations as well as the competencies of staff within support organisations such as the ambulance service and community nursing.

The CCG will commission safe care that is based on the national safety framework which puts patients at the centre of all decision making.

7.1 High Level Risk Summary

Basic Assessment Information Care Closer to Home		
Category	**Risk Description**	**Mitigation**
Operational	Failure to meet commissioning timeframes	Implement strict project management regulation in the delivery of this strategy with clear objectives for each of the workstreams within the bundle. Achieve organisational sign off for procurement timeframe by January 2014
Operational	Failure to appropriately address information governance standards in relation to combined predictive model which is a fundamental requirement for risk stratification and appropriate patient management for the virtual ward project and admission avoidance. Work currently on-going with current provider.	Work closely with NHS England and other CCGs to implement information guidance regulation in the implementation of CPM
Operational	Failure to engage with GPs and gain sign-up in participation with risk stratification and virtual ward functionality.	Enhanced payments in place to encourage sign up for CPM. GP engagement in the virtual ward working group.
Corporate	Identification of service providers with sufficient expertise and resource to undertake bundle contract	National experience identifies multiple providers within the market.
Finance	The costs associated with the revised model of care within the bundle will not realise the QIPP target.	Each element within the bundle will have a financial plan detailing costs and QIPP
Finance	Costs are underestimated/understated and the full value of services is not stripped out of the current contract, leaving the balance with the provider and creating an additional cost pressure for the commissioner.	Detailed financial planning prior to procurement process to fix pricing
Finance	The market is destabilised as a result of re-procuring services, leading to problems in other areas.	Impact analysis on local provider organisation to be undertaken prior to procurement process beginning and appropriate actions based on analysis.
Finance	The potential for double counting as services are sliced in a different way.	Detailed financial planning prior to procurement process to fix pricing
Finance	The specification/KPIs do not deliver desired outcomes, savings/disinvestment are not possible.	KPIs will be derived from identified outcomes within the strategy and the service specification will identify the reporting mechanisms required to capture outcomes measures.
Finance	Providers perceive the bundles model as too difficult/not large enough to generate sufficient profit.	Extended market engagement exercise within procurement process.

8 Workforce Planning

The JSNA provides the understanding of the health and social care requirements for the local community and is one of the fundamental building blocks in determining the strategic direction and commissioning intentions of the CCG and ECC. The Care Closer to Home Integrated Community Strategy addresses these care requirements and outlines a revised model of care which focusses on co-ordination and integration of the workforce and the care they deliver. The Francis report reinforces the need to recruit staff with the correct values and the need to put the delivery of high quality, compassionate care at the heart of the NHS. Whole system workforce planning considerations are specifically important therefore to commissioners and provider organisations when new models of care are being commissioned, as well as an understanding of the impact on providers in the delivery of this new model.

The NHS Mandate, and consequently this strategy, makes clear the drive to deliver more care in the community and in people's homes. Investment in the NHS and social care workforce will therefore need to reflect the changing needs of patients, carers and the local community with health and social care providers taking greater responsibility and accountability for the training, skills and competencies of the workforce they employ. Service providers will need to work with their organisations, to identify, develop and implement the additional skills and training needs required to deliver new services and identify any organisational constraints in the overall implementation timelines.

It is critical that these commissioning intentions are explicit with regard to the social and clinical service outcomes to ensure that providers are in a position to determine the workforce requirements and what they will be held accountable for. Statutory requirements, organisational accreditation, professional registration requirements and job descriptions which outline specific duties and expectations will all form part of the qualifying factors within the service specification. Achievement of consistent quality tailored outcomes for people who use services is identified as the key success factor of integrated working.

This new model of care will be supported by the HEE local workforce and skill priorities strategy[19]

Skills strategy - service development priorities:

- Extended day and week service models
- Integrated care across systems / organisations
- Delivery pressures - particularly in urgent and emergency care
- Service access pressures in end of life, dementia and care of the frail elderly
- The need to focus on the vulnerable, for example mental health and learning disability services

Skills strategy - workforce development priorities:

- Developing a more generic workforce, with appropriate reliance on specialist skills
- Embedding key skills in all health and social care workers
- Improving access to health careers
- Developing the pre professional workforce
- Ensuring that smaller/specialist workforce groups find a clear place in our plans

Skills strategy - skills development priorities:

- Focussing on values and behaviours and care and compassion

[19] 2020 VISION Health Education East of England Workforce Skills Strategy 2013 - 2020

- Integrated skills across care pathways and sectors
- The importance of leadership skills in delivering high quality care
- The health education, prevention and public health agenda

Skills strategy - local transformation priorities

- ***NHS Constitution values and behaviours*** *- to ensure EoE delivers the highest quality patient and service user care through raising awareness of the NHS Constitution, reflecting this in our recruitment and working with our partner employees to ensure these values are reflected in ALL of our staff*
- ***High quality care for the frail elderly (including those with dementia)*** *– improving the quality of care, reducing acute admissions and embedding a patient centred approach through integrated roles, training and leadership, developing the community and primary care workforce, balancing the need for diagnosis and treatment with the need for care and compassion and embracing technology to support self care and mobile working*
- ***Improving urgent and emergency care services and reducing avoidable admissions and preventing unnecessary hospital stays*** *– enabling integrated care pathways and the development of community based services*
- ***Delivering high quality effective care across children's and young people services*** *– ensuring children's and young people care is centred and tailored to individuals and family's needs by integrating care services and supporting and enabling workforce development*
- ***Open door programme*** *- a practice nurse development programme first introduced by the NHS in Tower Hamlets in 2008, with the aim of developing and mentoring nurses to give them both the theory and the working knowledge to improve the lives of local people.*

  An independent evaluation of Open Door, carried out by London South Bank University in 2010, found the scheme to be highly effective. The results[20], demonstrated that the programme was effective in providing a community nursing resource competent in the working knowledge, skills and aptitude required to improve the lives of local people; in particular diabetes, asthma, lung conditions like COPD and other chronic and long term conditions.

  The expectation of the CCG is that community providers will incorporate this programme into their organisational resource planning and training and education programme as a quality indicator of the level of expertise within the provider service.

  This model aims to support people to be involved, informed, independent and in control of their condition(s). This approach works equally for people with single conditions or multiple co-morbidities. It is also equally effective for physical and mental health issues and is applicable to people of all age groups including the frail elderly.

The Health and Social Care Act January 2012, created a duty on service providers to support the collective planning of future workforce supply. Providers have a duty to consult with patients, local communities, staff and commissioners about how they plan to develop their workforce and future workforce needs. Local Education and Training Boards (LETBs) will work collaboratively with providers to deliver effective workforce planning.

[20] Journal of Nursing Education and Practice (2013, Vol. 3, No. 10)

9 Financial Overview

In order for the CCG to remain clinically and financially viable, the Care Closer to Home Strategy will be required to deliver QIPP (quality, innovation, productivity and prevention). This strategy purposely focusses on innovation and collaboration both as sound clinical developments and demonstrative of financial prudence in both the medium and long term.

The commissioning of the care closer to home care bundle will be responsible for delivering, in part, the organisations QIPP target over the 5 year period. There is financial rigor in place to deliver this;

- Predictive modelling to allow the CCG to flex its resources and shift funding
- Contracting controls to optimise value for money
- Learning from benchmarking with peers
- Incentivised commissioning to drive quality and productivity
- Collaboration with all service providers
- Decommissioning of ineffective services

NHS England have published a 'vision' for how the pooling of £3.8 billion of funding, will ensure a transformation in integrated health and social care. The 'Integration Transformation Fund' (ITF), renamed as 'The Better Care Fund' is a national single pooled budget for health and social care services to facilitate working more closely together in local areas which will take full effect from 2015/16.

This funding mechanism requires truly integrated multi-agency working so that local health and social care systems work as a whole to respond to the needs of local people. This strategy provides the stepping stones towards this integrated working and financial management.

Much of the integrated work outlined in this strategy; reablement, virtual ward, community gateway, hospital to home, has the potential to be funded through the Better Care Fund.

The management of Personal Health Budgets will be implemented in April 2014, the option appraisal undertaken by the Project Team at the CSU identifies 5 options on the management of personal health budgets from April 2014;

- Each CCG in house
- Lead CCG
- CSU aligned to CHC function
- LA
- Third sector/ independent provider

The CCG will take these options into consideration and decide on the preferred management process. Regardless of the preferred option, the CCG expectation is that all provider organisations will comply with the national guidance on personal health planning and support patients through the transition process.

9.1 Modelling Assumptions

Workstream	Modelling Assumptions	Lead Organisation
Risk Stratification/Virtual Ward	Patients will remain at home longer and have more choice about their healthcare. Reduction in ambulatory care sensitive admissions. Reducing on-going reliance on social care packages.	ECC
Single Assessment	Provision of seamless inter-provider single assessment referral process. Timely and direct management of patient referrals. No delays care management.	CCG
Long term Conditions	Develop and implement an integrated approach in the management of frail and elderly patients which will encompass all patients with long term conditions and their carers.	CCG
Dementia	Improved awareness across health and social care professionals and the people of north east Essex, Earlier diagnosis and intervention, A higher quality of life for patients and their families.	
Prescribing	Improved medication prescribing, understanding and concordance by patients, their families and carers, health care practitioners and GPs.	CCG
End of Life	Develop an economy wide end of life register To improve access to end of life care for the people in north east Essex	CCG
Telehealth	Maximising the opportunities for Assistive Technology to support and promote independence, choice & control whilst reducing reliance on health and social care interventions Exploring AT's contribution to the achievements of personalised health & social care outcomes for individuals. Analysing the role of AT in supporting and contributing to the delivery of wider outcomes in areas such as shifting the balance of care and the management of long-term health conditions	ECC
Community mental health	People will have good mental health People with mental health problems will recover People with mental health problems will have good physical health and people with physical health problems will have good mental health People with mental health problems will have the best possible quality of life.	CCG
Reablement	Avoid/reduce hospital admissions/readmissions. Avoid/reduce delayed discharges from hospital.	ECC

Community step-up beds	Provide a timely and appropriate service for patients with exacerbated illness that can be managed safely within the community setting, keeping people and their families closer to home Shift the balance from dependency and demand for unscheduled care towards better scheduled/planned care interventions and as a consequence educe the unplanned attendances at A&E Maximising the resource utilisation and ensure value for money of public funds	CCG
IAPT	The scope of IAPT will include other at risk groups including children and young people, people with a severe mental illness or personality disorder. Provide a timely and appropriate service for patients with exacerbated illness that can be managed safely within the community setting, keeping people and their families closer to home Shift the balance from dependency and demand for unscheduled care towards better scheduled/planned care interventions and as a consequence educe the unplanned attendances at A&E Maximising the resource utilisation and ensure value for money of public funds	CCG
Quality/Planned care	Clinically led commissioning processes in partnership with GPs to; add value to patient care, prioritise resources on the basis of clinical need improve patient outcomes Confidence in local providers so that they are first choice for healthcare for the population of north east Essex. Cost-effective care within the CCG resources (QIPP) Partnership approach between member practices, supporting each other in providing high quality primary care services. Ensure patient safety and improve patient experience Reduce the health inequalities of our population.	CCG
Self-care and empowerment	The patient is part of an informed decision making process, is empowered to identify health and social care needs and has the control over the service they receive	CCG

10 Procurement

The Integrated approach to planning and commissioning by North East Essex CCG ensures partnership working with patients, carers and families, partner organisations across the public, voluntary, and community sectors, and the Essex Health and Wellbeing Board.

Services will be procured predominately in line with the bundles approach to integrated care commissioning and will hold providers of services to account for the performance, quality, and safety of their services. The CCG will be held to account by NHS England, and by the democratically elected members of the Essex Health Overview and Scrutiny Committee.

The NHS Standards of Procurement details the CCG's requirement to be open and transparent in decision making, and regularly hold meetings of the North East Essex CCG Board in public and ensure that the CCG meets its legal duty with regard to compliance with the Public Procurement Regulations 2006.

Each care bundle to be procured will be supported by a service specification detailing the key performance indicators for each of the component workstreams. The procurement process, based on the contract service specification will ensure;

- *Engagement with all stakeholders and relevant parties when a procurement is undertaken*
- *To undertake and understand relevant guidance regarding procurement type (e.g. full tender/single provider tender/ AQP)*
- *To ensure quality of services are achieved and enhanced*
- *To enable greater choice for patients*
- *To ensure North East Essex CCG achieves value for money in its procurement activities*
- *To ensure the CCG makes the appropriate decision whether procurement is necessary following Procurement, Patient Choice and Competition Regulation 2013.*
- *To avoid possible conflicts of interest where Primary Care may be a Potential Provider*
- *To work closely with partnership commissioning services in Essex to ensure that each procurement complies with all relevant guidance and legal regulations.*

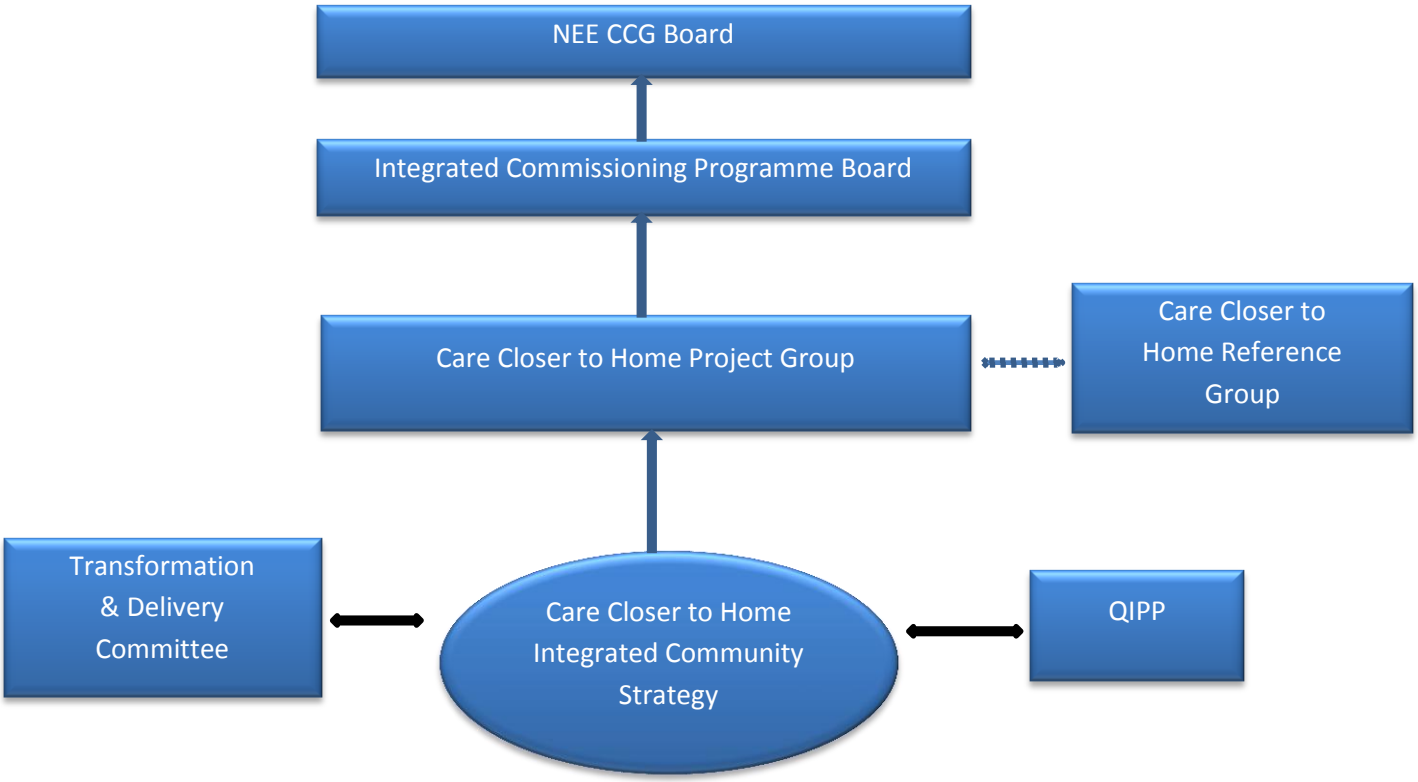
11 Programme Governance

The CCG governing body and its sub-committees have all adopted the key principles of:

- *Clinical Commissioning must be focused on individual needs and promote the health and wellbeing of communities, as well as addressing health inequalities.*
- *Clinical Commissioning must work in the spirit of public service, professionalism and selflessness to serve our local population.*
- *Clinical Commissioning should be driven by the health needs of the population, prioritising our commissioning towards work which delivers the greatest improvements in health and the best possible experience for all.*
- *Clinical Commissioning will seek to continually improve quality wherever possible and to embrace innovation to achieve this, within available resources and ensuring value for money.*
- *Clinical Commissioning must be drivers of strong clinical leadership and enablers of clinical empowerment.*

This strategy has been developed based on these commissioning principles and the internal rigor in the authorisation of this strategy is outlined in figure 9 below;

Figure 9: North East Essex CCG Programme Governance Structure



12 Next steps

The realisation of this strategy is dependent on the successful commissioning and service delivery of key components within the care bundle. These components have been bundled into 7 key workstreams;

1. The Community Gateway - Care co-ordination, Single Assessment, Telemed, Risk Stratification, Therapies & Equipment
2. Reablement - Virtual ward and Risk Stratification, , Hospital to Home, domiciliary and residential reablement
3. Community mental health – older people and adults, dementia
4. Improved Access to psychological therapies – GP advisors, village agents
5. Falls and Continence
6. Planned Care – Primary Care Based Minor Surgery, Admission Avoidance, Referral Refinement, Outpatient Consultation, Community Hospital Intervention
7. Community Beds – rapid assessment service

Each workstream is derived from the care closer to home commissioning intentions and model of care and will be commissioned and performance managed on the high level outcomes identified within this strategy and the SMART objectives and KPIs within the care bundle service specification.

Implementation Plan; Care Closer to Home Strategy 2013 – 2015	
Milestones	Time frame
Project initiation	29/07/13
Programme governance confirmed	27/08/13
Option appraisal – report recommendations to Programme Board	27/08/13
Care Closer to Home Strategy Version 1	27/08/13
Work stream Version 1 Short Business Case	26/11/13
Work stream Version 2 Short Business Case	10/12/13
Engagement exercise – big care debate	End 02/01/14
Care Closer to Home Service Specification Version 1	10/12/14
Care Closer to Home Strategy – CCG Board Sign off	28/01/14
Procurement approach confirmed by Programme Board	28/01/14
Begin Market Engagement	28/01/14 – 31/5/14
Care Closer to Home Service Specification Version 2	25/02/14
Service Specification completed	31/05/14
Pre-qualification Questionnaire Process	12/06/14 – 28/08/14
Invitation to Tender	03/07/14 – 04/09/14
Contract award and evaluation	04/12/14
Contract mobilisation	01/01/15 – 31/03/15
Delivery of end product	01/04/15
Project Close	01/05/15

Appendix 1 Glossary of Terms

AQP	Any Qualified provider
BCD	Big Care Debate
CCG	Clinical Commissioning Group
CCTH	Care Closer to Home
COPD	Chronic Obstructive Pulmonary Disease
CQUIN	Commissioning for Quality and Innovation
ECC	Essex County Council
EoL	End of Life
IAPT	Improving Access to Psychological Therapies
ITF	Integration Transformation Fund
LETB	Local Education and Training Board
LTC	Long Term Conditions
MSK	Musculoskeletal
NEE	North East Essex
NEL ACS	Non-elective ambulatory care sensitive
NHS	National Health Service
QIPP	Quality Innovation Productivity and Prevention

Appendix 2 Care Closer to Home High Level Outcomes

1. **People with long-term conditions, and their carers, will be supported to be independent in their own homes and avoid hospital admissions; through effective, personalised and integrated community based services.**

This outcome is supported by the following detailed outcomes:

- People will be able to access services through a single point and then assessed with a validated assessment tool
- People will be supported to make informed choices about their care pathways
- People will receive the least complicated and intrusive care necessary to meet their needs.
- People will be supported through care planning processes by a named care co-ordinator
- People with physical or mental health problems will be supported to have the best possible quality of life
- Assistive Technology will be utilised to support independence, choice and control whilst reducing reliance on health and social care interventions.
- People with mental health problems will be supported to have good physical health and people with physical health problems will be supported to have good mental health.
- Patients will have early diagnosis of secondary conditions
- People will be given high quality care at home leading to a reduction in the occurrence of avoidable health problems
- Patients with terminal conditions have a dignified death.

2. **People will recover from episodes of mental or physical ill-health or injury in their own homes, and avoid hospital admission, through effective, personalised and integrated community based services.**

This outcome is supported by the following detailed outcomes:

- Patients are discharged from acute care with fully supported reablement plans.
- There will be reduction in the number of residential care admissions following acute care episodes
- Patients' rights and commitments set out in the NHS Constitution will be upheld
- People will be supported to make informed choices about their care pathways
- People with mental health problems will be supported to have good physical health and people with physical health problems will be supported to have good mental health.
- High quality care at home leading to a reduction in the occurrence of avoidable health problems

3. **People are enabled to live healthy lifestyles and are empowered to live independently and to take control of their health and social care needs during periods of ill health**

This outcome is supported by the following detailed outcomes:

- Access to services that promote and facilitate healthy lifestyles
- A comprehensive screening programme that leads to the early diagnosis of illness
- An immunisation programme to protect the population from preventable disease

- Access to services that treat them as a whole person prevent illness and that make every contact they have count.
- Services designed and delivered to target those most at risk of ill-health
- Partnership working to influence the wider determinants of health such as housing, transport and the environment
- People know how and where to access the appropriate service giving care in the right place at the right time,
- Seamless transition of care between services
- Use of a validated assessment tool resulting in people being referred to the most appropriate services at first point of contact
- People with mental health problems will be supported to have good physical health and people with physical health problems will be supported to have good mental health.

Performance indicators will be developed as part of the new service specification to demonstrate the delivery of the outcomes described above.

Appendix 3 Care Closer to Home Model of Care