Winter planning 2025-26

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Approach and principles

- Our approach seeks to build on initiatives from 2024/25 and strengthen what was already in place.

- This includes the continuation of initiatives such as dementia discharge support and process improvement such as the continued roll out of the Reablement Decision Tool which supports better use of capacity we have in place.

- It is based on the learning from previous years and principles agreed with partners that have helped shape our approach. The principles agreed were:

    - To comply with the guidance around funding sources
    - Do not further complicate systems – build on what's already there with a focus on 'home first'
    - Bring providers into the planning conversations where possible
    - Work collaboratively across Health and Social Care to support design, implementations and visibility of our initiatives
    - To explore admission avoidance solutions where funding source guidance allows
    - Focus on fewer but larger interventions, which will support clearer evaluation of impact
    - Where possible, build in the ability for provision to flex for demand
    - Ensure good data collection and systemic sharing of insight

Intermediate Care

- We are working across the system to enhance our intermediate care offer and develop a model which will increase the numbers of people who are supported to stay at home, promote greater use of care technology and continue to reduce the need for long-term care. It will also:
  - Improve flow & efficiency across services.
  - Focus on outcomes rather than hours of support.
  - Be integrated and guided by a single joined-up service specification.
  - Ensure protected capacity for admission avoidance.
  - Focus on continuous improvement across health and care services.

- We are implementing our new Home to Assess (H2a) services (replacing the 'bridging' model) with a focus on ensuring adults go directly into reablement services where appropriate. This will result in fewer hand-offs and faster pickups of reablement, supporting good hospital flow over winter and beyond.
- These new H2a contracts include flexibility to step up or down capacity should trend information suggest that is required. The need to do this will be agreed via the ECC Priority Review Meeting which takes place every Friday.
- Similar flexibility is also a feature of our Alternative Reablement Capacity (ARC) contracts.

- Our Intermediate Care programme will further support health and care services over winter via:
  - Joint work on reviewing decision making points and Intermediate Care pathways to build a shared understanding of responsibilities and agreed criteria– including Continuing Health Care.
  - Procurement activity timed to ensure new contracts are mobilised before the winter period (H2a and Recovery to Home in North Essex).
  - The development of an dashboard to provide more detailed insight on use across the different services and the county.

Essex BCF

Our winter plans are supported by the Better Care Fund which fund several countywide and locality initiatives that support admission avoidance, reducing readmissions and discharges.

Countywide:

- Our Care Technology continues to grow with 14,000 people benefiting from care technology helping to keep them independent in their own homes. It is expected this service will grow to support 19,500 people by March 2026.
- Our BCF plan also recognises the significant contribution carers make to preventing admissions and care needs escalating. Our carers offer funded through the BCF will provide:
    - A central point of Carers can contact directly for early information and guidance and can be referred on to our specialist offer or to social care. Call handlers are trained to identify people that call for other services as carers.
    - Specialist Carers Pathway Co-ordinators are working with partners to improve identification of unpaid carers and their access to support.
    - specialist support that includes; practical solutions to address specific challenges; and solution-focused interventions such as conflict resolution, mediation and emotional wellbeing support.
- Other key schemes and initiatives are:
    - Dementia Community Support Service
    - Funding allocated for ‘spot’ reablement demand
    - We are also working on maturing our TOCH teams to support effective pathway identification and utilisation, making sure people are accessing the right services at the right time.

Locality initiatives

- We also remain committed to expanding the reach of local initiatives at an alliance level which help connect individuals to community-based support that reduce admission and readmission to hospital and residential care including:
    - Falls prevention initiatives such as slipper swaps and information, advice and guidance on strength and balance home exercises to prevent falls, local groups to connect with, and wider social care support.
    - Voluntary and Community Sector discharge support to help people re-settle at home after and admission.
    - Therapy support to Additional Reablement Capacity service

Management oversight and escalation

We continue set a Local Authority Provider Escalation Level (LAPEL) level which guides us in standing up/down infrastructure for response to pressures, including frequency of system calls and reporting.

Senior Leaders convene at the weekly Priority Review Meeting (PRM) to set this level and review our SITREP report as well as give position statements from each locality area. This forum is key in coordinating the ECC response around winter.