**Thurrock Better Care Fund Plan – Questions and Responses**

| Question | Response |
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| What happens if we do not see a reduction of <15% of emergency access following BCF implementation in the first year? Is there any criteria for what reduction in funding will come, of will it be 20% reduction year on year unless the BCF performs? | There is a target of reducing non-elective care by 15% over the next five years. Whilst the BCF will assist with the target being achieved – e.g. key outcome for the BCF is to reduce avoidable admissions, this target is not an explicit responsibility of the BC F Plan, but of the CCG and is a key part of their 5 year strategic plan. As achieving the reduction in non-elective requires a 'whole system' response, different partners will have different parts to play – e.g. developing good primary care, public health initiatives to reduce and avoid poor health, timely intervention programmes etc.<br>Approximately 25% of the BCF is subject to payment by performance. We will need to achieve at least 70% of the targets set against our BCF performance metrics to attract the performance-related pay element. Part of the Plan will require us to identify our contingency arrangements. |
| In terms of the proposed spendings, the Rapid Response Assessment Service (RRAS) comprises of a LA team, and an NHS team, of which the computer infrastructure does not synchronise and requires additional labour costs/resources to make sure both systems have the same data within. Can any BCF money be ring-fenced for the integration of the RRAS IT systems? | With data sharing agreements and explicit consent provided by patients and service users, person-identifiable data can be shared. The RRAS already operates data sharing through this approach even though both the Council and health provider (NELFT) have separate data systems in place.<br>Achieving one system across health and social care is not, as yet, feasible. Different providers have different systems, GPs have different systems, and acute trusts also have different systems. Bringing all of these together is not something that can be achieved locally, quickly, or cheaply.<br>We are, through the BCF, investing in an information system (Caretrak) across health and social care which will allow us to more accurately target service development. |
| While it is pleasing to see that we are ready to being a degree of | The move towards 7 day services has presented a need for |

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| permanency in having the TBC BTUH team work 7 day weeks. Is BTUH itself geared to fully utilise this service to make sure that the fluidity of beds is maintained outside of Mon - Fri 0900 - 1700. | service change/redesign across all care settings. For BTUH in particular, there are changes required to consultant rotas, nursing rotas, radiology services and pharmacy services (amongst other operational redesign). Whilst a number of changes have been delivered in 2013/14, which have supported the management of the winter period, there is still further implementation required over the next twelve months. The CCGs will monitor the implementation of these plans, in addition to supporting the changes required beyond the hospital, through the Urgent Care Working Group. |
| BCF01 - LAC investment. Much of the narrative within the BCF focuses on the effectiveness and efficiencies of the new LAC pilot. There appears to be much commitment to expand this initiative. However, while some interesting case studies have been published, we have not seen enough financial accountability about what indicative savings have been made due to LAC inputs (i.e. what the care costs could have been unless the LAC intervened when they did?). The National Conditions of BCF targets "Reducing overall demand" - is there enough evidence to account for more LAC's at this time, and if so, can we pilot a CIC-type LAC arrangement so we can compare the effectiveness and efficiencies of the initiative managed via a different work stream? | |
| How much involvement has Essex Police had with the drafting of Thurrock's BCF submission. EP can have large inputs and vision of cases such as dementia and mental health in our community and can be natural 'connectors'. Also what input has the Community Safety Partnership had in the drafting of our BCF draft? | The BCF is a plan developed jointly by the Council and CCG. The Community Safety Partnership is represented on the Health and Wellbeing Board and will therefore have received an opportunity to input in to the development of the Plan. It is anticipated that a wider group of stakeholders and partners will be involved in how the Plan is delivered.<br>Work concerning dementia and mental health is already being delivered. Essex Police are already involved in aspects of this |

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| | work. |
| How frequently will governance arrangements be reviewed, and which body will oversee the final phase of scrutiny around BCF Governance Arrangements (i.e. what independent body will impartially review and approve the recommendations of the Governance Working Group, so to avoid "marking of our own homework" scenarios). | There are a number of issues related to 'governance' that need reviewing. It is very unlikely that governance arrangements will be finalised before April and work will continue throughout 14/15. We are in the process of establishing different task and finish groups to sit as part of the BCF project arrangements. Governance will be one of the task and finish groups. Where the arrangements are signed off will depend to some degree on what is being recommended. It is likely that we will require specialist advice – e.g. with regards to procurement, VAT, risk-sharing etc. We are required to have a section 75 agreement in place which will set out how the pooled fund will operate. This will need to be signed off by Cabinet and by the CCG's Board. Recommended arrangements will be reported to the Health and Wellbeing Overview and Scrutiny Committee prior to receiving Cabinet agreement. |