Thurrock Better Care Fund
Draft Submission – version 0.6

Local Authority
Thurrock Council

Clinical Commissioning Group
Thurrock Clinical Commissioning Group

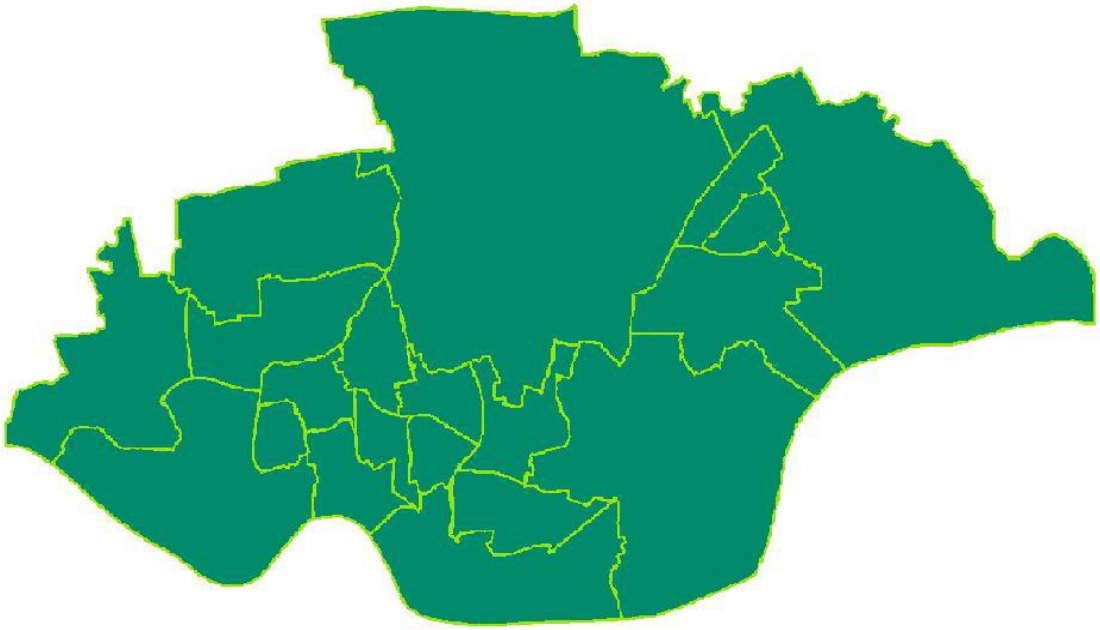
Boundary Differences
Co-terminous

Date to be agreed at Health and Wellbeing Board
10th February 2014

Date submitted

Minimum required value of BCF pooled budget:	**2014/15**	£2,862,000
	2015/16	£10,565,00
Total proposed value of pooled budget:	**2014/15**	£3,724,000
	2015/16	£10,565,00 (BCF) £10,410,536 ASC Budget for services for older adults £13,000,000 CCG Unplanned Care (TBC)

Thurrock Profile



Thurrock lies on the River Thames immediately to the east of London. Thurrock hosts two international ports which are at the heart of global trade and logistics and is strategically positioned on the M25 and A13 corridors, with excellent transport links west into London, north and east into Essex, and south into Kent.

Our Vision is:

'Thurrock: A place of opportunity, enterprise and excellence, where individuals, communities and businesses flourish'.

There are five strategic priorities to achieve this vision:

- Create a great place for learning and opportunity;
- Encourage and promote job creation and economic prosperity;
- Build pride, responsibility and respect to create safer communities;
- **Improve health and wellbeing**; and
- Protect and promote our clean and green environment.

Thurrock's current population is 157,705 (2011 census) – an increase of over 10% since 2001 and 22% since 1991, and is projected to be 207,300 by 2033. The population group aged 85 and over is projected to double. 12.4% of people live in the 20% most deprived areas of England, and the BME population in Thurrock has risen from 7.2% (2001) to 19.1% (2011).

Thurrock has three key health providers – North East London Foundation Trust (NELFT) who provide community services, South Essex Partnership Foundation Trust (SEPT) who provide mental health services, and Basildon and Thurrock University Hospitals Foundation Trust (BTUH) who provide acute and secondary care services.

The Primary Care provision in Thurrock consists of 42 GP practice locations (main and branch) and 167,946 registered patients as at 1st April 2013. There are 21 dental practices, 18 opticians' practices, and 32 pharmacies.

Thurrock is currently under-doctored, and 30% of the current Thurrock CCG GP workforce is over the age of 60. A number of the areas with a shortage of GPs are also Thurrock's most deprived areas.

With expected ageing and growth of the population, we can expect a rise in disease prevalence and consequential increase in demand on health and social care services. For example, the expected rise in long-term conditions and people suffering with two or more long term conditions, and the prevalence of dementia. Dementia is predicted to increase steeply in Thurrock – from 2012 to 2020 we are predicted a 25% increase in the number of people over 65 – which is expected to keep rising.

Lifestyle factors will also have a significant impact on the demand for health and social care services in Thurrock unless we are able to at least halt current levels. 22% of Thurrock adults are smokers, with smoking prevalence and smoking-related deaths significantly higher than the national averages. 25.1% of year 6 children and 28.1% of adults are classified as obese – this too is significantly higher than the England averages.

Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We have established a Strategic Leadership Group that meets bi-monthly and reports to the Health and Wellbeing Board's structure. The Group includes all the main NHS Trusts working within Thurrock – North East London Foundation Trust; South Essex Partnership Foundation Trust; and Basildon and Thurrock University Hospitals Foundation Trust.

The Strategic Leadership Group is responsible for the following:

- Contributing to the development of our strategy for integration;
- Reviewing national policy and overseeing its local application as well as the implications for local commissioning of the NHS payment system so that we can see a real shift in resources and activity from the acute sector into primary care and community services;
- Building a strong Thurrock identity for integrated care amongst all our providers;
- Working together to create and evaluate new models of care to secure improvements in quality and outcomes at an early stage; and
- Registering and managing risks and issues for residents, commissioning and providers, where these relate to the integration agenda.

Thurrock's Better Care Fund Plan has been developed and tested in conjunction with the Strategic Leadership Group. Aspects of the Plan have already been rolled out with provider input. Providers will continue to be engaged as the Plan develops further and particularly as developments and improvements to service models are considered.

Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it.

An event was held for stakeholders in March that enabled a broad range of organisations to input in to the development of this Plan. We do not see engagement as a 'one off' event, but as an on-going conversation.

We already have a range of networks established [including …] where we engage with and involve stakeholders and patients. In addition, we have via the CCG a 'Change One Thing' campaign, which asks the public to identify one thing they would change about the NHS. The results of the 'Change One Thing' campaign have been used to identify 'themes' and have helped to identify our Direction of Travel.

The development of our Plan has been carried out with the involvement of Thurrock HealthWatch, the CCG's strong and well attended Commissioning Reference Group (with a membership of just under 40 Patient Participation Group members), the CCG Board's lay member for patient and public involvement and local voluntary organisations including Thurrock CVS and Thurrock Coalition (a User-Led Organisation working to uphold the rights and entitlements of disabled people, older people, their families and carers). It is worth noting that a number of the different

elements of the BCF are not new and have been discussed and planned with services users over a number of years – e.g. the RRAS

Related Documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Ref	Document	Synopsis
1	Joint Health and Wellbeing Strategy	
2	Joint Strategic Needs Assessment	
3	Draft Primary Care Strategy	
4	Delivering Seven Day Services	
5	Building Positive Futures Programme	
6	CCG Operational Plan	
7	CCG Strategic Plan	
8	Thurrock Council Corporate Plan	
9	Community Strategy	
10	Strategic Housing Market Assessment	

Vision for Health and Care Services

Please describe the vision for health and social care services for this community for 2018/19.

- *What changes will have been delivered in the pattern and configuration of services over the next five years?*
- *What difference will this make to patient and service user outcomes?*

Thurrock's Vision for Health and Wellbeing

Thurrock's Vision for Health and Wellbeing contributes to the Community Strategy priority:

Improve health and wellbeing

Thurrock's Health and Wellbeing Strategy 2013 - 2016 establishes the overarching Vision for enabling all Thurrock residents to achieve good health and wellbeing:

Resourceful and resilient people in resourceful and resilient communities

Four aims underpin this Vision:

- Every child has the best possible start in life;
- People stay healthy longer, adding years to life and life to years;
- Inequalities in health and wellbeing are reduced; and
- Communities are empowered to take responsibility for their own health and wellbeing.

Thurrock's Vision for Health and Care is consistent with the Vision for Health and Wellbeing and is fundamental to the delivery of better health and wellbeing.

Thurrock's Vision for Integrated Health and Social Care Services

In late 2013 Thurrock Health and Wellbeing Board and Thurrock Clinical Commissioning Group Board worked together to develop a set of principles that frame Thurrock's Vision for integrated health and social care services. We believe these will support our vision of 'resourceful and resilient people in resourceful and resilient communities'.

Our BCF Plan will initially focus on care for older adults, before being extended over the next five years to all care pathways, so that all adults and children and young people can benefit from our health and well-being strategy and Better Care Fund plans. The overarching vision and the principles that frame our vision will enhance and improve the quality of services and outcomes for all our residents. In doing so we will ensure that we can achieve our aim of managing demand within available resources.
The principles that frame our jointly developed vision are:

1. Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing

2. Health and care solutions that can be accessed close to home

3. High quality services tailored around the outcomes the individual wishes to achieve

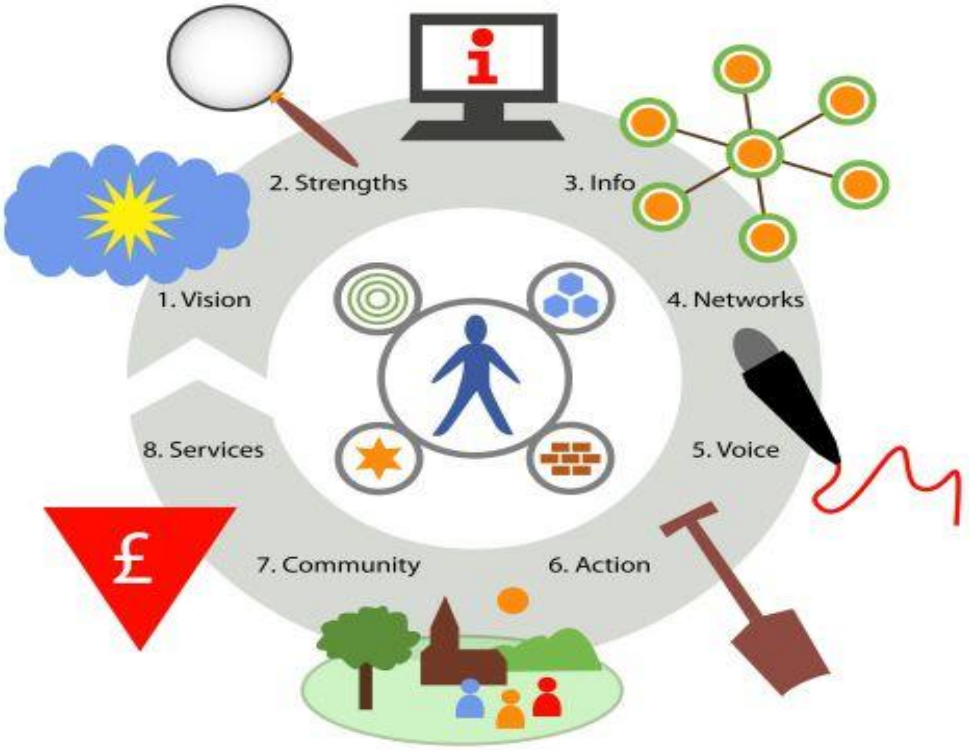
4. A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible

5. Systems and structures that enable and deliver a co-ordinated and seamless response

What each of these principles mean in terms of changes and benefits is detailed below. This will be further developed throughout 14/15.

Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing

We want local citizens to be equal and active partners with the CCG and the Council in achieving health and well-being for the people of Thurrock. In fact individual residents, not health or social care services, need to be in charge of their health and wellbeing. This means ensuring that the health and care system is co-produced and that citizens are part of an on-going conversation about the support and services they require. Achieving this will mean ensuring that co-production is an integral part of our planning and commissioning process. The delivery of health and social care personal budgets will provide an opportunity for people to take more personal responsibility and to achieve the outcomes they want in the way they want. Also, applying strength-based approaches to assessments will switch the conversation from ‘what are your needs’ which are then assessed against the services that we can offer to a much broader question ‘what would make a good life for you?’ This facilitates a conversation that takes into account the whole person.



For many people, getting the support they need to be healthy and well in their communities will not mean having recourse to community health or care services. In many cases timely access to information and advice, or benefits or education, housing or leisure services, or sympathetic help in a shop or on a bus, will provide what they need. So part of our integration plan is to ensure that universal services, and not just those provided by the Council, but across the public, voluntary and private sectors are attuned to the needs of older adults.

Work is already underway to create more hospitable, neighbourly, resourceful and resilient communities, recognising that such communities create health & well-being. For example we have an ambitious target for becoming a dementia friendly community by [?] and the Alzheimer's Society has invited Thurrock to become an early adopter in the pilot phase for the recognition process for dementia friendly communities.

We have introduced a number of strength-based initiatives including Local Area Coordination (LAC) and Asset Based Community Development (ABCD). ABCD is based on the recognition that communities and the residents who live in them have many - often untapped - strengths, gifts and passions. We are encouraging communities and individuals to come together to identify and use those untapped resources. By recognising this, we encourage individuals, families and the wider community to think first in terms of local solutions to challenges rather than narrowly looking at "needs" that only the statutory sector can meet – assuming the individual meets the local authority eligibility criteria. One of the intended outcomes of our

ABCD programme will be the development of local health and well-being community plans that are developed and owned by local communities themselves. As a start we are piloting a strength-based approach to a locally based JSNA in one area of Thurrock. This will link strongly with the emerging Primary Care Strategy's direction of travel – e.g. a locality-based primary care model.

We want people to be empowered to own and co-produce their personal 'care' plans. Our ambition is for people to have 'wellbeing' plans, which not only focus on care 'needs', but focus on the individual's strengths and how they might achieve their outcomes through community-driven support and advice. Achieving this will require us to have a new approach to assessment and management – and also to how we manage 'risk'. We will actively pursue this approach as part of our Plan.

Part of citizens being equal and active partners also means individuals taking responsibility for their own health and wellbeing. Working with our voluntary and community sector, and patient and service user groups, we will develop an approach aimed at changing behaviour and encouraging greater personal responsibility. Success will depend upon ensuring that individuals can identify and access the information and support they need where they live. We want to ensure that resources are used appropriately, but that people are able to self-manage where possible – for example long-term conditions, and have the information required to improve or maintain good health and wellbeing.

We need to be able to offer greater choice for those who require services. To do this, we need to shape the market to offer better quality and greater choice of health and social care services– this is particularly important to the success of personal budgets. We will use our jointly developed Market Position Statement to ensure that we achieve plurality, and that our commissioning and procurement process for integrated health and social care services aids rather than prevents this objective. In particular we will commission community health care and social care services jointly, under the terms of a single contract whenever it is beneficial to do so – add link with the Primary Care Strategy and the role of the GP through the MDTs. This will not only enable more co-ordinated care under a single service specification but also streamlined contractual arrangements and performance management and by so doing reduce wasteful duplication.

Public Health initiatives are also a fundamental part of enabling individuals and communities to take more responsibility for their own health and wellbeing. Thurrock's population has poor health outcomes resulting from higher than average obesity levels for both adults and children, and smoking prevalence. We will ensure that public health commissioning complements our work to strengthen communities as well as how we commission health and care to improve personal responsibility alongside prevention and timely intervention.

Health and care solutions that can be accessed close to home

We will ensure that people can access the help they need at home or close to where they live. This will include a health and care, information and advice service, support that is both web based and available within and provided by the community itself as part of our community hub development programme.

The Council in conjunction with the CCG and other health partners will provide advice and information about health and well being readily accessible via the web allowing people to serve themselves. Over time all our information and transaction services will be delivered online through My Account providing a consistent customer service no matter how or when or where people seek help with health or social care needs. This will enable residents to reduce multiple contacts - providing basic information only once, and receiving regular updates on progress.

As part of our channel strategy, and following the success of the South Ockendon Centre, we will continue to roll out our place-based community hub programme which empowers communities so that they are resilient to any future reduction in public funding. This programme includes:

- Opportunities to integrate health and social care services at a neighbourhood level.
- A focus for Local Area Co-ordinators and citizens engaged with Asset Based Community Development to explore ideas and connect people so they are better supported in the community, by the community.
- The development of community plans to prioritise local improvements including, housing, health and the built environment.
- The place where people think of first if they cannot find what they are looking for via the web.
- Where a community solution is the first consideration with traditional services sought where specific needs are required.

We also plan to increase the number of Local Area Co-ordinators we have working in and with specific communities. Our LACs are already working successfully with GPs in our pilot areas and the prevention and timely intervention offer will be further enhanced by the introduction of health trainers to support service users in healthy lifestyle choices.

As part of the Primary Care Strategy we will see more primary care providers working at larger scale in primary care hubs. Some primary care led sites will offer a full range of diagnostic and other hospital based services outside acute settings. The primary care workforce will change with a greater role for nurses, community pharmacists and health care assistants. There will be new and innovative opportunities for staff development within each hub linked to our community hub programme that will fully integrate community health services adult social care. Patient voice will be strengthened within each primary care hub, building on the further development of patient participation groups.

Telecare is now embedded in all joint assessments to support service users to remain independent. Over the past year Telecare usage has increased - with an average of 18 installations each month, and is included in 39.9% of all council funded

social care packages. Over the next year, Telecare will be expanded with a wider range of equipment to support the changing needs of Thurrock's population, including projects such as the digital befriending service currently being piloted - Age UK is using Skype and TVHD webcams to combat social isolation by connecting families and friends by video conferencing.

In furthering the principle of care closer to home we will continue to involve partners beyond health and social care, for example, working with housing colleagues to provide and develop across Thurrock suitable accommodation to support people as they grow older, such as our "HAPPI" standard specialised housing scheme at Derry Avenue where 28 flats for older people are closely linked to the resource available at the South Ockenden Centre.

Services that when required are of high quality and tailored around the outcomes the individual wishes to achieve

Thurrock's Health and Wellbeing Strategy has a clear priority to 'improve the quality of health and social care'. The focus of this priority is the quality and capacity of primary care services. There are a number of reasons for this which includes under-doctoring, number of GPs at or over retirement age, difficulty in recruiting new GPs to Thurrock, and the number of single-handed or small practices.

Whilst our ambition is to reduce the number of people that need a 'service', we recognise that some people will always require a service and when they do, the service should be accessible, of high quality, and tailored to meet the outcomes the individual desires. We will involve citizens in conversations that help to define what 'good' quality means.

We will also ensure that we have a good integrated Quality Assurance System in place.

[need more content here]

A focus on prevention and timely intervention that supports people to be healthy and independent for as long as possible

We know that if we want to continue to provide 'services' to those who need them and ensure that those 'services' are of high quality, we need to both shift demand 'down stream' whilst also seeking to reduce overall demand.

We have a number of initiatives in place already that focus on shifting and reducing demand for services. We will evaluate and build on these initiatives.

As part of our Better Care Fund Plan we propose to initiate the Timely Intervention and Prevention Pilot service (TIP) which:

- builds on the success of our two integrated health and care teams – the Rapid Response and Assessment Service (RRAS) and Joint Reablement Team (JRT) - a partnership with NHS South West Essex Community Services(NELFT) - which offer integrated services at the point of delivery (the

approach is based on work undertaken by the Institute for Public Care with ADASS Eastern Region in 2011);
- will address high spend on adults aged 65+ when compared to its CIPFA statistical neighbours as well as those with Long Term Conditions;
- builds on a housing initiative which targets vulnerable people living in conditions that are detrimental to health & well-being as well as common causes of acute care including dementia, falls, COPD and loneliness; and
- also builds on our Primary Care Multi-Disciplinary Teams (MDTs) which are now in place and are highly successful at pro-active case management. Primary Care Multi-disciplinary Teams (MDTs) are effective because they ensure that the health and social care services provided to identified vulnerable older people are successfully co-ordinated so as to maximise individual independence and well-being, thus reducing the risk that the service user's condition will deteriorate to the point that they require admission to secondary care/residential care. Most primary care practices within Thurrock CCG have engaged in regular MDT meetings and has allowed the MDT to support robust patient / person centred clinical decision making and integration of care.

(review this section to avoid repetition)

Systems and structures that enable and deliver a co-ordinated and seamless response

Wherever appropriate we will have one process, one assessment and care record, one pooled pot of money, one organisational response, and importantly, a single wholistc response to the needs of our residents. The focus will be on achieving the right outcomes. The elements of the health and social care economy that we do not integrate will be managed as part of the 'whole system' so that care is co-ordinated at every point that touches a resident, service users or patient.

Achieving this will require transformation of existing systems and structures. This will include developing the capability for sharing real-time information across all providers engaged in the care of older adults. It will also require complementary information management systems for commissioners and providers to enable effective management of performance, accountability and information governance. This will be a key part of the initial focus on managing care for older adults but will also provide the model for integrated services for adults who may be vulnerable because of learning disabilities or mental health problems, as well as children and young people.

Thurrock Council and CCG are carrying out a joint project to integrate health and social care data – bringing user and patient intervention and cost information together to enable intelligent and targeted evaluation of interventions on, reducing demand and pressures on acute support, measuring the impact and cost effectiveness of reablement. The system is also being used to help inform targeted multi-agency effort at GP Practice level through detailed risk profiling.

Review this section to remove repetition

Thurrock Better Care Fund Plan

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How these principles will change and improve outcomes in Thurrock

Principles	What will change over the next 5 years	What difference this will make
Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing		
Health and care solutions that can be accessed close to home		
High quality services tailored around the outcomes the individual wishes to achieve		
A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible		
Systems and structures that enable and deliver a co-ordinated and seamless response		

Integration Aims and Objectives

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

- *What are the aims and objectives of your integrated system?*
- *How will you measure these aims and objectives?*
- *What measures of health gain will you apply to your population?*

Our aims and objectives will drive the achievement of the following national conditions:

- Protecting social care services;
- 7-day service to support discharge;
- Better data sharing;
- Joint approach to assessments and care planning.

Our **aim** is……

Our objectives are to:

- Reduce the number of people requiring a service response
- Empower communities to take responsibility for their own health and wellbeing
- Build a whole person approach to the health and care system
- Bring health and care close to home
- Ensure people are able to live as independently as possible for as long as possible

The approach to achieving our aim and objectives is multi-faceted and will take time to achieve. This Plan starts to define what a redesigned health and social care system in Thurrock will look like, and the initial steps that will be taken. Our project plan is appended to this document.

Over the next two years we will:

- Undertake a series of thematic reviews which will identify if and how services and pathways need to change.
- Develop and define appropriate integrated service models – based upon the results of thematic reviews.
- Develop locality plans to enable commissioning and service development and deployment on a geographical basis and based around the strengths and needs of particular areas.

- Shift resource from secondary care to community and primary care and start to incentivise community care providers to keep people out of hospital.

- Through the delivery of the Primary Care Strategy, the development of geographically based primary care hubs will be underway. Multi-disciplinary teams made up of primary, secondary community and social care will start to be established based on the hub 'footprint'. There will also be consideration of how certain secondary care services can be accessed closer to home as part of this work.

- Develop an integrated leadership group and integrated commissioning arrangements – sitting beneath and reporting to the Health and Wellbeing Board.

- Develop and start to delivery joined up care – including single assessment process, single point of contact.

- Continue to explore how prevention and timely intervention can be developed and delivered.

We have invested in Caretrak, a system designed to analyse health and social care data with the purpose of enabling us to effectively target care and support solutions. The system will enable us to deliver risk stratification by identifying those individuals who are most at risk against our chosen criteria.

Furthermore, the system will enable us to identify whether the initiatives and solutions we put in place are having the desired effect by an ability to track outcomes – e.g. reduced admissions, reduced cost etc.

We will continue to develop and identify how we can measure the impact the system is having as it changes.

The BCF Plan performance measures that we have identified are appended as part of this document.

Description of Planned Changes

Please provide an overview of the schemes and changes covered by your joint work programme, including: 1. The key success factors including an outline of processes, end points and time frames for delivery 2. How you will ensure other related activity

will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care.

Achieving the Vision set out within this Plan will require significant transformational change. Whilst some of this is already in train – e.g. developing community resilience, other aspects of transformation are being developed and will continue to be developed. We have described the process through which the Plan, and therefore system redesign, will continue to evolve – governance. Our robust programme management arrangements alongside our Health and Wellbeing Board, Integration Leadership Group, and Strategic Leadership Group will provide the focus for both developing and delivering the required changes.

Schemes and Projects

1. Empowered citizens who have the choice and independence and take personal responsibility for their health and wellbeing (community development, market development, personal health and social care budgets)

No	Scheme	Description	Investment Type	Min	Max
	Empowering citizens	Range of initiatives to support the empowerment of service users (assistive tech worker, direct payments officer, local area coordinators, mental health support, sensory worker)	Recurrent	£196k	£381k
	Voluntary Services	Review of services currently commissioned separately by the CCG and LA to look for development opportunities	Nil	Nil	Nil

2. Systems and structures that enable and deliver a co-ordinated and seamless response (Whole system development, locality based MDTs, risk stratification)

No	Scheme	Description	Investment Type	Min	Max
	Caretrak	Implementation of Caretrak across Health/Social	Recurrent	£25k	£25k
	Primary Care MDT	Coordinator to	Recurrent	£51k	£51k

		support case identification and MDT process			

3. Health and Care solutions that can be accessed close to home (system redesign)

No	Scheme	Description	Investment Type	Min	Max
	Stroke Services	Potential redesign of stroke services following consultation exercise (potential investment in Early Supported Discharge)	Recurrent	£75k	£75k
	Community Equipment	Redesign of equipment services currently delivered by Essex Equipment Service	Nil	Nil	Nil

4. High quality services tailored around the outcomes the individual wishes to achieve (service development)

No	Scheme	Description	Investment Type	Min	Max
	Community Bed Provision	Review and further development of Rehab/Nursing Home and Intermediate Care Capacity (Collins House, Mountnessing Court and Elizabeth Gardens)	Recurrent	£435k	£555k

5. A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible (admission advoidance, reablement, protection of social care)

No	Scheme	Description	Investment Type	Min	Max
	Rapid Response Assessment Service and Reablement	Review of existing provision/refining model/sustainable commissioning	Recurrent	£1,002k (need to review these figures in light of	£1,388k

				overall funding availability)	
	Protection of Social Care	Maintaining eligibility criteria	Recurrent	TBC	TBC
	Hospital Social Care Team	Additional support for acute social care team. Ensuring 7 day service provision	Recurrent	£80k	£80k

Implications for the Acute Sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Implementing the Vision for care in Thurrock will have an impact on all providers across the health and care system including care homes, community and mental health providers, third sector organisations and others. In addition, the Vision is reliant on working in close partnership with our acute providers (primarily Basildon and Thurrock Hospital).

In conjunction with the lead commissioner (Basildon and Brentwood CCG), we are currently negotiating a block contract for non elective care with Basildon Hospital introduced over two years. We will devise a system that incentivises primary care and community providers to see more people for longer and to keep people out of hospital. By making this agreement, we seek to offer stability to the acute system to allow for focus on service redesign to create a longer term sustainable health and social care system.

The block contract will support the achievement of the NHS Constitution Targets and Ambitions (? needs clarification).

We are keen for our providers to work with the CCG/LA to support the development and delivery of our integration/vision for care model. To this extent, we have established the Strategic Leadership Group. This group has executive representatives from our local provider organisations in addition to the CCG and LA. Ensuring cross organisational leadership is key to delivering our vision and goals.

Governance

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

Although subject to review as our plan evolves, our proposed arrangements for oversight and governance of progress and outcomes are as follows:

Integration Officer Group (to be confirmed)

Through our joint programme management arrangements, the CCG and Local Authority have discussed the formation of a Integration Officer Group to oversee and deliver the BCF Plan and to further the development of integration and joint working between the CCG and Council. The Group will report to the Health and Wellbeing Board as the vision owner. Key decisions will continue to be made by the CCG's Board and Local Authority's Cabinet, subject to delegations. (needs more discussion

on the overall governance model and how this will fit in with the Section 75 agreement)

Within existing delegations, the Group will be responsible for agreeing how the pooled budget will be spent – this includes commissioning decisions. Commissioning arrangements will report to and receive direction from the Group.

The Group will be responsible for ensuring that areas of spend are performing as set out within the Plan – e.g. required outcomes are being delivered. A Finance and Performance group will be established and report to the Leadership Group. The Group's purpose will be to provide assurance to the Leadership Group on areas of finance and performance. The Finance and Performance Group will also be responsible for escalating risks and issues that occur and getting agreement for corrective action.

The Leadership Group will oversee the ongoing integration agenda. As such, it will be responsible for the delivery of the project plan and act as the project board. Programme management arrangements will continue over the next two years at least and ensure the continued development and delivery of the 'better care' agenda in Thurrock.

Integrated Commissioning Arrangements

The CCG and Local Authority have agreed to consider ways in which commissioning across health and social care can become more fully integrated. There are a number of options to be considered which include:

- Establish a single organisational integrated commissioning structure;
- Appoint a single Head of Integrated Commissioning across the Council and CCG who would manage all staff, but have dual accountability;
- Co-location with team members working on single projects for both organisations; and
- Limited changes amongst the staff but strengthen the governance arrangements through a more formal Joint Commissioning Board.

No final decision has been taken and will be explored and agreed during 14-15. Depending upon the option chosen, there may be a stepped approach to achieving full integration of both organisations' commissioning arrangements.

As work progresses, the CCG and Local Authority will look to expand the range of structures that are integrated – for example finance, performance.

National Conditions

1. Protecting social care services

a) Please outline your agreed local definition of protecting social care services

b) Please explain how local social care services will be protected within your plans

Our approach to protecting social care services is two-fold:

1. Reducing overall demand:

Efficient, effective social care services are essential to reducing demand away from acute services and have a key role to play in the future. We will use the BCF to strengthen social care provision across the whole spectrum, starting with a review of all existing care services with a view to determining:

- Value for money – improving efficiency through integrated working with health;
- Person-centred and prevention/re-ablement-oriented – re-focusing services and re-procuring services as necessary;
- Opportunities for out-sourcing to local community-based providers (CICs, micro business etc)

We will also use the BCF to review commissioning and procurement to develop:

- Joint commissioning of integrated health, social care and housing services;
- A mixed economy of locally run care services; and
- Social prescribing – need to expand what this means

The BCF will help us accelerate the transformation of social care which is already underway in Thurrock in partnership with housing, planning, health and our local communities: we are embarking on a housing development programme to develop HAPPI housing for older and vulnerable people (partly funded by the HCA and our own HRA); we have successfully piloted Local Area Coordination and are extending the approach in order to divert people away from formal services and find informal local solutions; we are actively encouraging micro-businesses and community enterprises as a flexible, cost-effective approach to service delivery. We are putting in place Community Builders (supported by the ABCD Institute) to develop communities where health and well-being is actively promoted. All of these initiatives are being developed alongside the re-focusing of our social work teams.

2. Shifting resource

We will look at the BCF in its entirety with a view to placing resource where it will have the greatest impact. This approach will help to manage the demand for both health and social care services but also ensure that we are able to continue to provide services for those who meet our eligibility criteria. We will be using a proportion of the £200 million available (£520k for Thurrock) from 14/15 to support demographic pressures and allow us to maintain our existing eligibility criteria. The review of services and pathways that we will undertake as part of developing and delivering our approach to integration will help to ensure that resource is in the right place – and help to identify where we resource should be shifted.

Resource will be used to protect and develop the following social care services:

- Reablement
- Rapid Response and Assessment
- External Placements

National Conditions

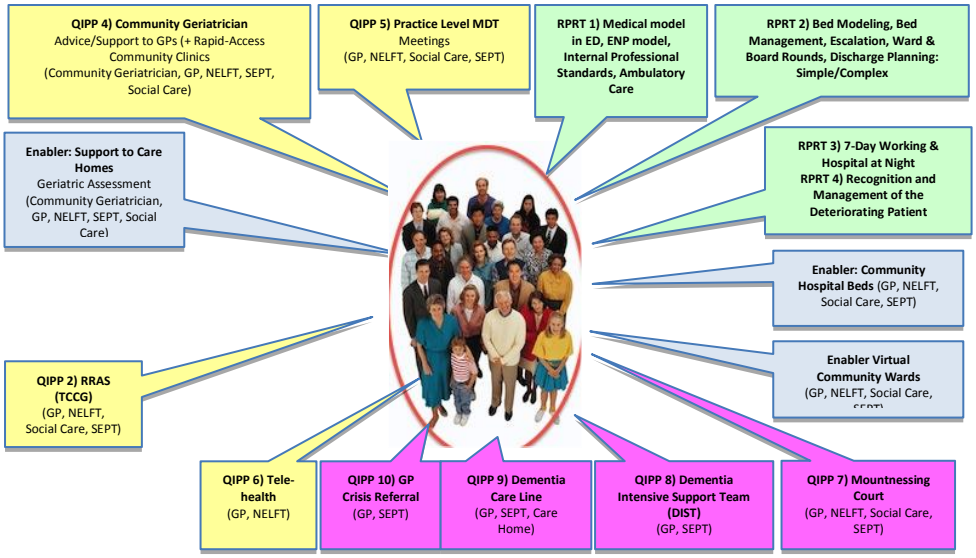
2. 7-day services to support discharge

a) Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy)

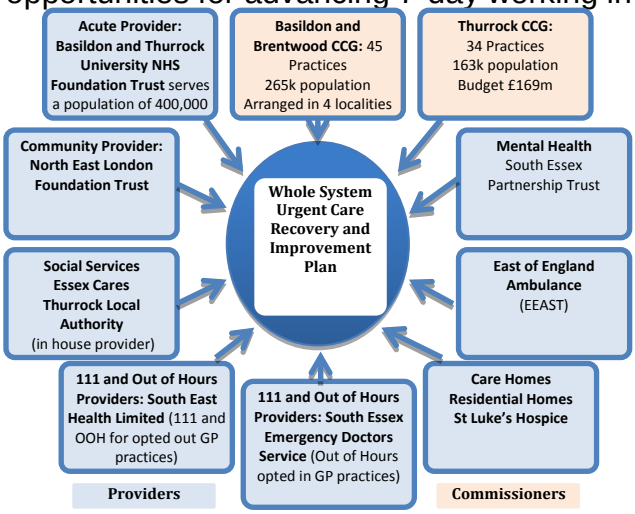
b) Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends

Under the governance of the South West Essex Urgent Care Programme Board, there has been a whole system focus on a few 7-day service initiatives, based on lessons from last winter. An executive level Task and Finish Group, has overseen the introduction of a new GP 'Streaming' role in the Emergency Department, and a Frailty Assessment Specialist Team in the Emergency Department comprising Consultant Geriatrician and Admissions Avoidance Team, both implemented from September 2013. These join existing initiatives outlined below which already include elements of 7-day working:

Thurrock Better Care Fund Plan



Through the BCF and integrated working, we are committed to improving the quality of services provided for its population and continues to seek new ideas and opportunities for advancing 7-day working in partnership with its providers.



National Conditions

3. Data-sharing

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

The NHS Number to be the primary identifier across Thurrock by April 2015

b) If you are not currently using the NHS Number as a primary identifier for correspondence please confirm your commitment that this will be in place and when by.

N/A

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

Health and Social Care are committed to adopting systems that are based upon Open APIs. Steps have already been taken to advance this commitment. They include:

Social Care uses an IT system that allows health partners and staff to view information, contribute to information and to support the provision of support and services. The system also enables data and information to be shared with and interfaced with other systems where required. The system and developments meet requirements outlined in the IG Toolkit.

To enable integrated working, we will review and improve systems - either through use of a single shared system or through enhanced interfaces, connections and

access across systems. This will improve data sharing and enable practitioners across health and social care to view and contribute to an individual's information and records. This will also support enhanced and more accurate data quality assurance by earlier identification of gaps or inconsistent records. This will be underpinned by use of the NHS Number.

Health and Social Care are piloting an electronic software solution that aims to capture, aggregate and analyse health and social care data through a single consistent format. This will support a consistent single view of health and care information across the whole pathway. This will also improve risk stratification and modelling capability and provision of targeted interventions and resources where needed. This will be supported by use of the NHS Number.

Social Care will review options and seek to improve the functionality of its systems to support service user access to view information and to undertake elements of self-assessment, planning and commissioning via an online platform.

d) Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott2.

Health and Social Care are committed to ensuring that the appropriate IG Controls will be in place that meet the requirements set out in Caldicott 2 and other areas as required.

We will do this within our appropriate Information Governance Frameworks and through adopting common information governance standards. Steps have already been taken to advance this commitment. They include:

Social Care has completed the IG Toolkit in respect of its existing practice and operation and has achieved accreditation with satisfactory assurance levels in all areas:

- Information Governance Management
- Confidentiality and Data Protection Assurance
- Information Security Assurance
- Care Records Assurance
- Secondary Use Assurance
- Corporate Information Assurance

Social Care has amended its service user information governance statement to incorporate sharing of information with health partners on an electronic basis

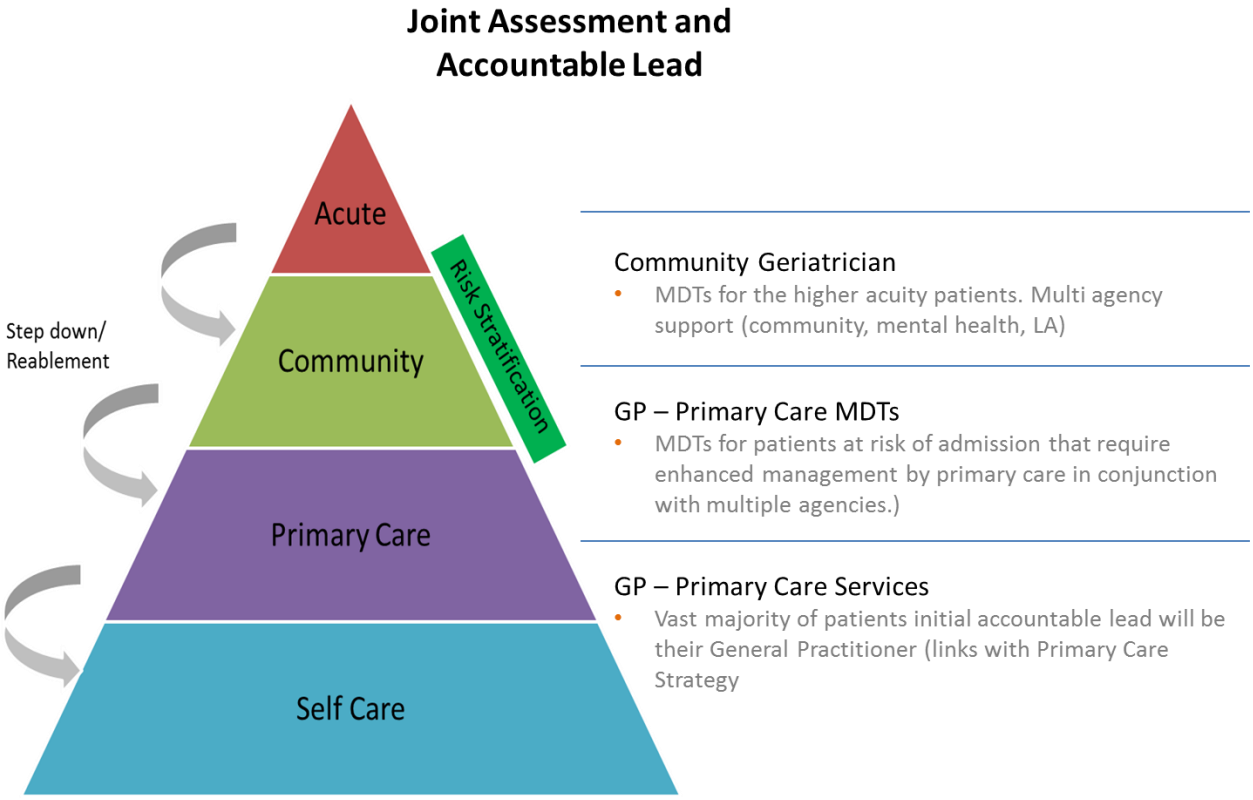
*The development of our data sharing arrangements will be in keeping with the Data Protection Act 1998, particularly principle 7 (security measures taken to protect data), and Article 8 of the European Convention on Human Rights (the right to a private an family life).

National Conditions

4. Joint-assessments and accountable lead professional

a) Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional.

b) Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.



We are currently refining our proposals for the Joint Assessment and Accountable Lead process. The above diagram is the basis of the system that we have begun to implement and are starting to refine across the locality. Within this model, General Practice plays the strongest accountable role for the majority of patients. This model is underpinned by the Primary Care Strategy which seeks to strengthen primary care and improve capacity and sustainability.

The risk stratification process is based on Caretrak. The CCG and LA have been working on implementing a Caretrak solution for two years. This has been delayed due to the Section 251 issues. However, a workable solution has now been identified that will allow for Caretrak to go fully functional in 2014/15.

Key Risks

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers. This is far too long and needs condensing in a few key risks

No.	Risk	Consequence	Probability	Impact	Controls
		STRATEGIC			
	Potential policy differences between NHS England and Thurrock Council	The separate allegiances of the CCG and ASC may impede decision making or lead to conflicting policy direction	1	3	Impact analysis of NHS England policy/guidance to identify potential conflict and develop resolutions
	In the absence of a single organisation of the implementation of Better Care decision making process are not clear	Decisions are not made, or are not made in a timely way or do not have the necessary authority to effect change	1	3	Clear governance arrangements including statutory accountability, schemes of delegation, dispute resolution processes and […] are required
	Co-ordinated care does not reduce demand or produce efficiencies, or benefits take longer to realise than planned	Implementation and operation costs may exceed budget plans	2	3	Financial contingency plan to alleviate cost pressures that may arise during implementation or benefits realisation
	Delays or difficulties with the implementation of initiatives to address under doctoring and the quality of Primary Care	The changes required to the configuration of practices my make it difficult to engage GPs in co-ordinated care programmes	2	2	Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve them in change, and to ensure a common understanding of risks, opportunities and incentives
	Demand management initiatives (such as Public Health campaigns, Local	There may be a higher level of demand on service solutions with a	2	2	Strong campaigns to engage citizens in lifestyle improvements and to strengthen communities

	Area Co-ordination etc) do not result in healthier lifestyles or more mutually supportive communities.	consequential impact of budgets			
	Personal ASC and health budgets do result in the better management of long term conditions	There may be a higher level of demand on service solutions with a consequential impact of budgets	2	2	Strong campaigns to support the management of long term conditions, and reviews of the effectiveness of those campaigns
	Communities fail to develop expected levels of resilience or take longer than anticipated to do so	Higher levels of demand on service solutions than assumed	2	3	Investment in asset based community development will be required together with an evaluation programme to determine its effectiveness and the reliance that can be placed on resilience in each community
	The general public does not understand the purpose of the Better Care programme and there is an undue emphasis on minor perturbations resulting from implementation	Public confidence in services is adversely affected and public opinion swings against the changes			As above
OPERATIONAL / TECHNICAL					
	Mobilising the whole Council in implementing the care and support reforms in parallel with the implementing Better Care in partnership with	Changes to funding criteria, introduction of care accounts, assessment of self funders will all bring new challenges for IT, the	3	2	A change programme with appropriate governance, resources (both people and financial) to implement the reforms and to monitor impacts on service quality and user

	the CCG	workforce, finance and information and advice services, communications and housing			satisfaction, and all with multiple interfaces with Better Care
	Differences in policy and practice between Thurrock and B&B CCG and or ECC	May make it harder or take longer to introduce change if a provider has significant operational difference in the two CCG areas	2	2	Liaison with B&B CCG and ECC about the impact of our respective emerging plans to identify variances and, where necessary, plan contingencies
	The different organisational cultures in Health, and the LA, history and standing of the CCG and LA make it difficult to provide effective leadership for the system	Commissioning strategies and implementation plans for co-ordinated care may lack coherence or ambition	2	2	A single leadership structure, from the HWB Board down, will be needed to ensure goals, roles, processes, values, communications practices, attitudes and assumptions are consistent across the better care programme.
	Difficulty in changing hospital contracts and or tariffs to enable greater investment in community based solutions	Access to the required health care services in community settings may be frustrated or delayed	2	2	Strong early engagement to involve the Hospital Trust in change, and analysis of their business risks and opportunities to ensure they can be incentivised to provide co-ordinated health care in the community in Thurrock
	The management of change (in relation to commissioning strategies, contracts and procurement, and	Change is ineffectively or incompletely implemented with consequential impacts on individual service users/patients,	1	3	The development of an Benefits Realisation strategy together with communications and training programmes to ensure change is planned, implemented and

	operations and services) is not planned or executed effectively	budgets and organisational reputations			managed effectively
	The incompatibility of Information systems (including for example those related to contracts and commissioning, service provision, personal data, performance and finance and charging).	If strategic, personal, operational or performance and financial information cannot be shared in a timely manner the necessary controls to deliver co-ordinated care will not be in place	2	3	An information strategy for commissioning and providing co-ordinated care, using the NHS number and with the required governance and technical solutions is required at an early stage
IMPLEMENTATION					
	Lack of capacity and/or capability requirements for an integrated programme.	A dedicated resource will be required to plan and implement better care while existing programmes for health and ASC are maintained and care and support reforms implemented	1	3	A resource plan for an integration team with roles and responsibilities specified, and clear interfaces with business as usual and care and support reform will need to be developed and agreed so that posts can be filled from early 2014/15
	The precise scope and scale of the changes required to achieve pooled funding and co-ordinated care is presently unknown	Until the programme is defined it will not be possible to match resources or plan delivery effectively	1	3	A Programme plan which defined the programmes and workstreams required to deliver Better Care, (and the interfaces to care and support reform and business as usual) and estimates the resource requirements and the manner in which those resources should be deployed, is required to manage implementation

	The decommissioning and commissioning processes could introduce an element of double running and/or confusion about who had the lead responsibility for the provision of care at points of transition	Change is ineffectively or incompletely implemented with consequential impacts on individual service users/patients, budgets and organisational reputations	1	3	A plan for reviewing the portfolio of existing health and ASC services against Thurrock's Vision for Better Care and the care pathways to deliver co-ordinated care is required and in order to inform a managed change programme for those services

Key: 1 = Low / 3 = High

Outcomes and Finances

Outcomes and Metrics

1. Permanent admissions of older people (aged 65 and over) into residential and nursing care homes per 100,000 population

Outcomes

- Reduction in the number of older people placed into permanent residential or nursing care
- Increase in rates of older people supported to live independently in alternative settings such as supported living placements, extra care housing
- Evidence of local interventions and strategy delaying dependency, increasing effectiveness of short-term support and alternatives to more costly residential and nursing care to reduce admissions
- Evidence of social care budgets 'stretching further' through shift to greater use of preventative and community based support rather than higher cost longer-term support

Measurement

- Metric to be measured and tracked applying existing national definition as defined in the Adult Social Care Outcomes Framework (ASCOF)
- Progress to be monitored monthly at respective Council / CCG governance bodies
- Quarterly reporting to HWB Board to enable progress to be tracked

2. Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Outcomes

- Increase in effectiveness of reablement / rehabilitation services in supporting more people to regain and retain independence
- Ensuring that the proportion of people that reablement / rehabilitation services are offered to does not decrease
- Evidence of the impact of preventative and shorter-term reablement / rehabilitation services delaying dependency, preventing avoidable admissions into residential or nursing care or hospital readmission and reducing costs associated with these

Measurement

- Metric to be measured and tracked applying existing national definition as defined in the Adult Social Care Outcomes Framework (ASCOF)
- Progress to be monitored quarterly at respective Council / CCG governance bodies
- Quarterly reporting (based on proxy measurement) to HWB Board to enable progress to be tracked
- Local customer satisfaction and experience survey to be used to assist measurement of effectiveness

3. Delayed transfers of care from hospital per 100,000 population

Outcomes

- Effective joint management of discharges across acute, mental health, non-acute and community services to facilitate timely and appropriate transfer from all hospitals for all adults
- Delayed transfers of care reduced and minimised
- Evidence of effective joint working and effective discharge planning across the sector supporting people to live independently at home
- Evidence of continuity of care that supports people before, during and after admission to hospital

Measurement

- Metric to be measured and tracked applying national definition for DTOCs as defined by NHS England
- Progress to be monitored quarterly at respective Council / CCG governance bodies
- Progress tracked through regular multi-agency MDTs
- Quarterly reporting (based on proxy measurement) to HWB Board to enable progress to be tracked

LOCAL??

Assurance Process

- Performance metrics, targets and performance plans to be signed off by the Integration Leadership Group and Health and Wellbeing Board
- Performance metrics, targets and performance plans to be signed off by Council and CCG respective governance bodies – Cabinet and CCG Board
- The Plan has also been to the Health and Wellbeing Overview and Scrutiny Committee
- Performance metrics and plans to be incorporated into Council / CCG performance management and monitoring frameworks. To include regular reporting to the Integration Finance and Performance Group, reporting to the Integration Leadership Group
- Performance targets informed by comparative analysis against national and statistical comparators and historical trend patterns
- Performance metrics and agreement of local metric(s) assessed against local priorities and ambitions as set out in HWB Plan to ensure clear and demonstrable links

Outcomes and metrics

Please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metrics		Current Baseline (as at….)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	899	N/A	597 **(1)**
	Numerator	180		135
	Denominator	21,090		22,600 **(2)**
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services (%)	*Metric Value*	89.8	N/A	93 **(3)**
	Numerator	95		205
	Denominator	110		220 **(4)**
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*			
	Numerator			
	Denominator			
		(insert time period)	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		(TBC)	(April - September 2014)	(October 2014 - March 2015)

Option 1: Patient / service user experience - Overall satisfaction of people who use social care with their care and support (%)	*Metric Value*	59.6	N/A	64.5% **(5)**
		April 2012-March 2013		*April 2014 - March 2015*
Option 2: Patient / service user experience - Overall satisfaction of carers with their social care(%)	*Metric Value*	45.4	N/A	48.5% **(6)**
		April 2012-March 2013		*April 2014 - March 2015*
Option 3: Patient / service user experience - Social care related quality of life	*Metric Value*	18.7	N/A	19 **(7)**
		April 2012-March 2013		*April 2014 - March 2015*

1. Target based on reduction in placements from March 2013 baseline of 180 to 135 by March 2015. Factors in improvement trend and accurate reporting of CHC and full-cost payers through 2013-14 and would bring Thurrock in below 2012/13 national average of 708.

2. Denominator estimated as 22,600 based on ONS Sub National Population Projections, September 2012.

3. Target based on a proposed ratio of 205 out of 220 people remaining settled and independent 91 days after discharge into reablement/rehab services.

4. Denominator based on a proposed increase of 100% on the number of people offered reablement/rehab services on discharge - 220 in 2014/15 from 110 in 2012/13. 220 would represent 7.7% of people discharged compared to 3.8% in 2012/13 and the national average of 3.3%

5. Target set based on assumed confidence interval of 3.5% required for statistical significant change and upward trend beyond the national average for 2012/13 of 63.7%

6. Target based on assumed confidence interval of 3.5% required for statistical significant change and upward trend improvement on 2012/13 outturn of 45.4 - already above national average of 42.7%

7. Target set based on improved performance above the national average of 18.8 for 2012/13. Indicator is based on an aggregated score of service user satisfaction with a series of quality of life domains. It is therefore difficult to attain a significant shift in performance.

Finance

Please summarise the total health and care spend for each commissioner in (£000s)

Organisation	2013/14 spend	2014/15 spend	2015/16 spend
Local Authority Adult Social			

Care			
Thurrock CCG			
Primary Care			
Specialised commissioning			
Local Authority Public Health			
Total			

Finance (to be confirmed/developed)

Please summarise where your pooled budget will be spent. NB the total must be equal to or more than our total BCF allocation.

BCF Investment (£000s)	**2014/15 Spend**		**2014/15 benefits**					
	Min	**Max**	**Min**	**Max**	**Min**	**Max**	**Min**	**Max**
BCF01 – Empowering Citizens	£214							

BCF02 – Voluntary Services	£0	£0						
BCF03 – Caretrak – integrated health and care data	£25	£25						
BCF04 – Primary Care MDT	£51	£51						
BCF05 – Stroke Services	£75	£75						
BCF06 – Community Equipment	£0	£0						
BCF07 – Community Bed Provision	£435	£435						
BCF08 – Rapid Response Assessment Service and Reablement	£862							
BCF09 – Protection of Social Care	£1,388	£1,664						
BCF10 – Hospital Social Care Team	£80	£80						
BCF11 – Telehealth and Assistive Technology	£75	£75						
BCF12 – Transition Worker	£31	£31						
BCF13 – Programme Management Fund and Transformation Fund								
BCF14 – Care Bill Requirements								
Carers' Funding					£178			
ASC Capital Grant					£364			
Disabled Facilities Grant					£481			
Mainstream NHS Funding					£5,818			
Mainstream Adult Social Care Funding					£10,410			