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

Health and Wellbeing Board

The meeting will be held at **2.00 pm** on **9 February 2015**

Committee Room 1, Civic Offices, New Road, Grays, Essex, RM17 6SL.

Membership:

Councillors Barbara Rice (Chair), John Kent, Tunde Ojetola and Joycelyn Redsell

Mandy Ansell, (Chief Operating Officer, Thurrock NHS Clinical Commissioning Group)
Dr Andrea Atherton, (Director of Public Health, Southend and Thurrock Councils)
Dr Anand Deshpande, (Chair, Thurrock NHS Clinical Commissioning Group)
Len Green, (Lay member, Clinical Commissioning Group)
Barbara Brownlee, (Director of Housing, Thurrock Council)
Roger Harris, (Director of Adults, Health and Commissioning, Thurrock Council)
Kim James, (Chief Operating Officer, Healthwatch Thurrock)
Carmel Littleton, (Director of Children's Services, Thurrock Council)
Lucy Magill, (Chair of Thurrock Community Safety Partnership)
Andrew Pike, (Director, Essex Area Team of NHS England)
Ian Stidston, (Director of Primary Care & Partnership Commissioning Essex Area Team of NHS England)
Dawn Scrafield, (Director of Finance, Essex Area Team of NHS England)

Agenda

Open to Public and Press

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1	**Apologies for Absence**	
2	**Minutes** To approve as a correct record the minutes of the Health and Wellbeing Board meeting held on 8th January 2015	**5 - 12**
3	**Urgent Items** To receive additional items that the Chair is of the opinion should be considered as a matter of urgency, in accordance with Section 100B (4) (b) of the Local Government Act 1972.	

4	**Declaration of Interests**	
5	**Developments in Primary Care Thurrock CCG report**	**13 - 18**
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Queries regarding this Agenda or notification of apologies:

Please contact Ceri Armstrong, Strategy Officer by sending an email to Direct.Democracy@thurrock.gov.uk

Agenda published on: **30 January 2015**

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DECLARING INTERESTS FLOWCHART – QUESTIONS TO ASK YOURSELF

Breaching those parts identified as a pecuniary interest is potentially a criminal offence

Helpful Reminders for Members

- *Is your register of interests up to date?*
- *In particular have you declared to the Monitoring Officer all disclosable pecuniary interests?*
- *Have you checked the register to ensure that they have been recorded correctly?*

When should you declare an interest *at a meeting?*

- **What matters are being discussed at the meeting?** (including Council, Cabinet, Committees, Subs, Joint Committees and Joint Subs); or
- If you are a Cabinet Member making decisions other than in Cabinet **what matter is before you for single member decision?**

Does the business to be transacted at the meeting

- **relate to; or**
- **likely to affect**

any of your registered interests and in particular any of your Disclosable Pecuniary Interests?

Disclosable Pecuniary Interests shall include your interests or those of:

- your spouse or civil partner's
- a person you are living with as husband/ wife
- a person you are living with as if you were civil partners

where you are aware that this other person has the interest.

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What is a Non-Pecuniary interest? – this is an interest which is not pecuniary (as defined) but is nonetheless so significant that a member of the public with knowledge of the relevant facts, would reasonably regard to be so significant that it would materially impact upon your judgement of the public interest.

Pecuniary

If the interest is not already in the register you must (unless the interest has been agreed by the Monitoring Officer to be sensitive) disclose the existence and nature of the interest to the meeting

If the Interest is not entered in the register and is not the subject of a pending notification you must within 28 days notify the Monitoring Officer of the interest for inclusion in the register

Unless you have received dispensation upon previous application from the Monitoring Officer, you must:

- **Not participate or participate further in any discussion of the matter at a meeting;**
- **Not participate in any vote or further vote taken at the meeting; and**
- **leave the room while the item is being considered/voted upon**

If you are a Cabinet Member you may make arrangements for the matter to be dealt with by a third person but take no further steps

Non- pecuniary

Declare the nature and extent of your interest including enough detail to allow a member of the public to understand its nature

You may participate and vote in the usual way but you should seek advice on Predetermination and Bias from the Monitoring Officer.

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

To achieve our vision, we have identified five strategic priorities:

1. Create a great place for learning and opportunity

- Ensure that every place of learning is rated “Good” or better
- Raise levels of aspirations and attainment so that local residents can take advantage of job opportunities in the local area
- Support families to give children the best possible start in life

2. Encourage and promote job creation and economic prosperity

- Provide the infrastructure to promote and sustain growth and prosperity
- Support local businesses and develop the skilled workforce they will require
- Work with communities to regenerate Thurrock’s physical environment

3. Build pride, responsibility and respect to create safer communities

- Create safer welcoming communities who value diversity and respect cultural heritage
- Involve communities in shaping where they live and their quality of life
- Reduce crime, anti-social behaviour and safeguard the vulnerable

4. Improve health and well-being

- Ensure people stay healthy longer, adding years to life and life to years
- Reduce inequalities in health and well-being
- Empower communities to take responsibility for their own health and wellbeing

5. Protect and promote our clean and green environment

- Enhance access to Thurrock’s river frontage, cultural assets and leisure opportunities
- Promote Thurrock’s natural environment and biodiversity
- Ensure Thurrock’s streets and parks and open spaces are clean and well maintained

Minutes of the Meeting of the Health and Wellbeing Board held on 8 January 2015 at 2.00 pm

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Present: Councillors Barbara Rice (Chair) and Joycelyn Redsell

Mandy Ansell, (Chief Operating Officer, Thurrock NHS Clinical Commissioning Group)
Dr Andrea Atherton, (Director of Public Health, Southend and Thurrock Councils)
Dr Anand Deshpande, (Chair, Thurrock NHS Clinical Commissioning Group)
Len Green, (Lay member, Clinical Commissioning Group)
Barbara Brownlee, (Director of Housing, Thurrock Council)
Roger Harris, (Director of Adults, Health and Commissioning, Thurrock Council)
Kim James, (Chief Operating Officer, Healthwatch Thurrock)
Carmel Littleton, (Director of Children's Services, Thurrock Council)
Lucy Magill, (Chair of Thurrock Community Safety Partnership)
Andrew Pike, (Director, Essex Area Team of NHS England)

Apologies: Councillors John Kent and Tunde Ojetola

In attendance: Catherine Wilson – Thurrock Council, Strategic Lead, Commissioning and Procurement
Jill Moorman – Thurrock Council, Safeguarding Adult Manager
Allison Hall – Thurrock Council, Commissioning Officer
Graham Carey – Safeguarding Adults Board (Chair)
Ceri Armstrong – Thurrock Council, Strategy Officer
Sharon Grimmond – Thurrock Council, HWBB Business Manager

Before the start of the Meeting, all present were advised that the meeting may be filmed and was being recorded, with the audio recording to be made available on the Council's website.

33. Minutes

The Minutes of the Health and Wellbeing Board, held on 13th November 2014 were approved as a correct record. BR welcomed new Board member Dr Anjan Bose who replaced Dr Pro Mallik.

The following comments and updates were received:

Actions: from last minutes

Item 5: pg. 7 Pharmaceutical Needs Assessment
LG highlighted that this item is not noted correctly – Thurrock Council do provide a collection service if you pay, but there is not a service for the collection of needles from any other exchange area e.g. pharmacies. This correction was noted.

Item 9: Better Care Fund (BCF) Section 75 agreement
RH noted that the BCF is not on the agenda as a special HWBB Meeting will be held on 9th February for the Board to agree the Better Care Fund Section 75 agreement.

34. Urgent Items

There were no items of urgent business

35. Declaration of Interests

There were no declarations of interest declared.

36. Thurrock Adult Autism Strategy Report

CW provided an overview of the Thurrock Adult Autism Strategy. The Strategy has been revised and a request was made for this to be brought back to the HWBB after consultation had taken place.

The draft Strategy is aligned to the Government's 'Think Autism' publication published in April 2014. The Strategy also takes into account Thurrock's Autism self-assessment carried out last year.

The original action plan has been updated with clear objectives of what needs to be achieved. The action plan responds to the Adult Autism event that was held at the end of 2014.

The Strategy and Action Plan will be consulted on as part of a 6 week consultation process.

An Autism Steering Group has been established and had its inaugural meeting in December.

CW explained that at least 57 young people will be going through transition from children's services to adult services, with 54% of those on the autism spectrum. Over the next 4 years through the transition process support will continue for autistic young. There are 16 service users with complex needs and would require costly specialist services e.g. residential or school placements.

CW made the Board aware of the cost of those who would transition from children's to adult services.

Weekly residential placement costs are between £2,900 - £ 5,600 The total weekly cost of all placements is around £59,000. The annual cost is £3.1millon.

AH clarified that the £59,000 figure came from a combination of sources – Education and Health. Of the £3.1 million spent £2.5 million was on Adult Social Care.

BB said she would consider how Housing could contribute to providing accommodation solutions for young people through the supported living programme.

JR asked if priority for Treetops school places were given to local people.

CL informed the Board that Treetops had received a third outstanding Ofsted judgement. CL advised that there is a myth that people move to Thurrock from elsewhere in the country to attend Treetops, when this only applies to a small number of people..

JR commented on the chance to include younger children at Treetops. CL responded that there is pre-school specialist provision already and that plans were in place to expand and offer a bigger pre-school offer at Treetops.

RH commented on the joint working that had taken place with partners and health colleagues to work closely with parents and the schools at an earlier stage – looking at work opportunities, travel training, supported living. This would help to manage expectations of what adult services could provide and help to reduce the cost required.

BR supported these comments and mentioned the cuts to Adult Social Care Services. BR also asked CW if parents sat on the Autism Steering Group.

CW said that parents and carers participated in the Autism Steering Group and Autism Transitions Steering Group for parents of younger children. CW explained that there is currently a major piece of work being carried out in commissioning about autism and day opportunities, supported living and how they all interlink to start these conversations earlier. JR asked about the opportunity to share expertise and experiences from parents and children.. CW provided an example where a parent with a child going through transition had been involved with the Borough's Winterbourne work and that this had been of real benefit.

BR suggested that maybe we should undertake a media campaign to support and promote the public consultation.

CL advised that it may be worth mentioning the percentage of children with autism within the document. There may be undiagnosed autism in adults due to historic practices but diagnosing autism in children has improved and is accurate and would provide a good indicator of future demand.

RESOLVED

Recommendations agreed.

37. Safeguarding Adults Partnership Board Annual Report

JM presented the report to raise awareness of the work of the Safeguarding Adults Partnership Board. The Board congratulated JM on her Silver Award for Team Leader of the Year, in recognition of the work in Social work, championing the services and the impact on the lives of people who uses the services.

M provided an overview of the report which included: safeguarding referrals and outcomes, statistics, and partnership working with colleagues such as the Police and Ambulance Service.

BR said that Thurrock has not been involved in any serious national safeguarding issues which is reassuring and that safeguarding is taken very seriously. She also asked about the training of staff and contractors.

JM explained that at least 450 went through the training, 300 of whom were not Thurrock employees. She also informed the Board that awareness training is undertaken with all contractors and staff. RH highlighted the work carried out by the CCG and asked if future Safeguarding reports could be presented to the HWBB within 6 months of the end of the year.

MA added that Jane Foster-Taylor has been working on safeguarding on behalf of the CCG as the Executive Nurse, and that the CCG are really committed to safeguarding. AB summarised stated that it is mandatory for the safeguarding of Adults and Children to be followed through for clinical staff. GC added that work for clinical staff had been carried out by the Safeguarding Board.

RESOLVED

Recommendations agreed.

38. Public Health Commissioning 2015 16

AA presented the Public Health Commissioning Report and provided an overview of the current work done.

AA wanted to draw the Board's attention to the Public Health Team's work which is aligned to the priorities in the Joint Strategic Needs Assessments (JSNA) and Public Health Strategy.

AA explained that significant public consultation and benchmarking work has been carried out. The Benson's model has been used to identify the required skills mix for commissioned services.

BR acknowledged the difference made to services since the Public Health Team joined the Council.

BR called for GPs to get involved in the engagement and promotion of local health services being provided and asked AB to comment on this.

AB agreed that GPs do need to do more and that he would support in any way he could to get GPs to promote and engage more.

JR commented on individuals smoking outside health premises in the Borough e.g. Long Lane.

BR mentioned that she is an advocate for the Sugar Swap initiative and more needs to be done to ensure the Council's building is healthy with vending machines.

LG commended staff health and wellbeing initiatives in the Council, but was concerned the initiative should be expanded to other businesses. AA stated that there will be a strategy for 'healthy businesses'.

RH mentioned that the 'Beat the Street' campaign had been nominated for an award.

0-5 responsibilities will transfer from NHS England to Local Authority from April 2015. AA mentioned that clarity on the cost was required and that she was in discussions with NHS England.

CL also commended the Public Health Team with the support and the work it had carried out to dovetail in to effective initiatives e.g. portion control plates and beat the street. She added that this had made an impact in schools.

RESOLVED

Recommendation agreed.

39. Housing Strategy Report

BB provided a report on the Housing Strategy which is at an early stage. BB suggested that autism and dementia should be added to the Strategy.

BB highlighted the importance of the input of the HWBB to the Strategy. She added that the Housing Team wanted to empower local people, capture growth in the community, and ensure excellence in service.

The Strategy aimed to deliver high quality housing in both the Council and private housing arenas. The Strategy fitted with the priorities of the Council and would span 5 years but be extend to 30 years in terms of the action and business plan.

The Strategy will gather and respond to data concerning health and wellbeing.

A Housing Needs Survey, Strategic Market Assessment with Planning colleagues and a new Homelessness Survey leading to a Homelessness Strategy will be commissioned as part of the Strategy. Consultation will be carried out until March.

JR discussed the downsizing of properties for local people and that alternatives to flats needed to be offered - e.g. bungalows.

BR thanked BB for her approach. BR added that she was unclear about the direction of sheltered housing.

BB added that she is aware of the requests for bungalows for older people. Housing is also currently working with Public Health on intervention on improving health for older people in sheltered homes.

BR mentioned that we have Local Area Coordinators and Estate Officers and we need to ensure they work together effectively and do not overlap.

CL commented that consideration needed to be made to ensuring accommodation was suitable for young people – adequate space for studying. CL recommended the Housing Strategy was taken to the Youth Cabinet.

RH welcomed the Housing Strategy and stated it needed to be aligned to the Market Position Statement. Elizabeth Gardens should be used as a good model for other areas across the borough.

RESOLVED

BR asked for the recommendation to be altered to state 'to help develop the Strategy's vision'

40. The Forward Plan

The forward plan for February and March was discussed.

BR added a note: to confirm that the Board has signed up to the Disabled Children Charter and that this is being overseen by the Children and Young People's Partnership.

Reminder of the HWB special meeting on 9th February.

The meeting finished at 3.55 pm

Approved as a true and correct record

CHAIR

DATE

Any queries regarding these Minutes, please contact Democratic Services at Direct.Democracy@thurrock.gov.uk

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9 February 2015	ITEM: 5
Health and Wellbeing Board	
Developments in Primary Care	
Wards and communities affected: All	**Key Decision:** Not applicable
Report of: Lisa Henschen, Assistant Director, Primary Care - Primary Care support to Thurrock CCG.	
Accountable Head of Service: Mandy Ansell, Acting (Interim) Accountable Officer, Thurrock CCG	
Accountable Director: Mandy Ansell, Acting (Interim) Accountable Officer, Thurrock CCG	
This report is Public	

Executive Summary

The purpose of this report is to provide an overview of developments in Primary Care underway in Thurrock. The report provides an overview of the following areas:

Primary Care Transformation Bid: This details that Primary care in Thurrock has been successfully awarded £248,996 through a bid that they made to NHS England for extending access to Primary Care in Thurrock. The extended access provision will be provided on a locality basis, through four locality based hubs, offering access to a GP and Practice nurse on Saturday and Sunday mornings (9am – 12.30pm).

Primary Care Strategy: An overview is provided in this paper of progress that Thurrock CCG is making in implementation of the Primary Care Strategy.

Health Care provision and the Purfleet redevelopment: This paper provides details of the scoping work that has been completed to date to map the requirements of a healthcare offer that will result from the population increase in Purfleet from the current redevelopment programme.

National developments in primary care commissioning and implications for Thurrock: NHS England have issued guidance to CCGs regarding the future of primary care commissioning. This guidance sets out the three primary care co-commissioning models CCGs could take forward. This paper describes these options and the one that Thurrock CCG have put forward to NHS England: Greater Involvement in Primary Care Decision Making.

1. Recommendation(s)

1.1 To note the development of four locality hubs for extended primary care access in Thurrock and provide any comment on their progression.

1.2 To note the progression of implementation of the primary care strategy.

1.3 To note the development of a health care offer for Purfleet as a result of the regeneration programme and provide advice on the best way to engage the Health and Wellbeing Board on the ongoing development of this work.

1.4 To note the intention of Thurrock CCG in relation to primary care commissioning.

2. Introduction and Background

The purpose of this paper is to provide an update against key developments in primary care in Thurrock. The introduction and background to these developments is as follows:

2.1 In August 2014, NHS England invited primary care providers to bid for additional primary care funding to support better access to primary care. Applications for funding were open to all primary care providers across Essex. Primary Care providers in Thurrock developed a Thurrock wide application to support weekend access to primary care, through a locality model, with one hub providing access to General Practice for patients registered in that locality.

Thurrock were successful in their application and have been awarded £248,996, which will allow the provision of a GP and a Nurse session (9am – 12.30pm) on both a Saturday and a Sunday within the four hub locations.

2.3 In March 2013, NHS England published, *The Heart of Patient Care: Transforming Primary Care in Essex* which sets out the vision for a strong and sustainable primary care community, as well as high quality and accessible primary care provision for patients. Thurrock CCG will lead the local implementation of this strategy. The key areas of focus for Thurrock are integration, improving quality, addressing demand, workforce development, estates development and shifting activity from secondary care to primary care.

2.4 A 10 year programme for regeneration of the Purfleet area is commencing, with a range of proposals, including over 3,000 new homes through a range of developments. As a result of these developments, it is estimated that the total number of patients registered in Purfleet by 2026 will be 16,545. This includes the 5,345 patients currently registered at the Purfleet Health Centre.

It is clear from this significant population increase that additional healthcare provision will be needed for Purfleet, both to address the population increase

and to use this as an opportunity to enhance the healthcare offer for the existing community. In order to start shaping what this offer might look like, a healthcare needs assessment has been undertaken by Thurrock CCG to inform a service offer, as well as a stock-take of existing provision in Purfleet, including benchmarking quality, performance and access.

2.5 In November 2014, NHS England issued guidance to CCGs on the next steps for primary care co-commissioning in 2015/16. This guidance sets out the three primary care co-commissioning models CCGs could take forward. These models are (1) Greater involvement in primary care decision-making, (2) Joint Commissioning arrangements and (3) Delegated Commissioning.

3. Issues, Options and Analysis of Options

3.1 **Primary Care Transformation Bid:** Thurrock CCG have been supporting the primary care community in Thurrock to implement the hub arrangements for extended access in primary care and *c*onfirm the four locations for the hubs. Discussions with the four potential hub locations are underway with the aim of confirming the locations in early 2015.

An implementation group comprising of clinical leads and supported by project management, are working to the opening the extended hubs by April 2015. The hubs will then continue to be opened on a phased basis, with two opening in February 2015 and the final one in March 2015. This is to allow identification of any operational issues early and for learning to be applied.

In relation to communication and engagement with the population on the opening of the hubs, a “soft launch” approach is being taken until the demand for the service can be fully ascertained. We will, however, be specifically raising awareness of the service through voluntary and community sector groups who work with communities who traditionally experience challenges in primary care access.

3.2 **Primary Care Strategy**: The development of the extended access hubs has a strong relationship to the progress that is being made against the implementation of the primary care strategy in Thurrock. It is well recognised that in order to meet both current and future challenges, General Practice needs to move towards a more federated model of service delivery, in order to take a population needs based approach and to create efficiencies through working at scale.

The development of the extended access hubs are providing a catalyst to collaboration in primary care. This is a key step towards Practices working together on a locality basis to provide “at scale” extended access to primary care. A key component of the evaluation of this implementation will be to focus on how this model can develop and extend to meet the broader primary care agenda.

In addition to the development of the collaboration working Practices, Thurrock CCG are also co-funding with NHS England an incentive scheme to encourage GPs into Thurrock. This will be an important measure to address the workforce challenges that are faced locally.

The next stage for the primary care strategy development will focus on estates to ensure that they are fit for purpose and have the capacity to meet the population growth experienced in the borough.

3.3. **Health Care provision and the Purfleet redevelopment**: Thurrock CCG has been asked to give an indicative position in relation to a potential new health centre as part of the Purfleet redevelopment. Thurrock CCG has put forward an initial draft figure for a potential new health centre space which is based on the population growth, analysis of the health needs of the current population of Purfleet and the associated health offer that should be provided. A potential vision for future healthcare provision in Purfleet has also been developed in line with the direction of local primary care strategy to deliver greater service integration.

Important discussions in this area will progress over coming months that will relate particularly to existing Primary Care Contractors in the Purfleet area and how the current and potential new health care services will best deliver increased quality and accessibility of services.

3.4 **National developments in primary care commissioning and implications for Thurrock:** In relation to the changes in Primary Care Commissioning arrangements, the three options that have been offered to Thurrock CCG, and an overview of their implications are:

Option 1: Greater involvement in primary care decision-making

This option is simply an invitation to CCGs to collaborate more closely with their area teams to ensure that decisions taken about healthcare services are strategically aligned across the local health economy.

This option will assist CCGs in fulfilling their duty to improve the quality of primary medical care. There are no new Governance arrangements associated with this option.

Option 2: Joint commissioning arrangements

This option would involve the creation of a “joint committee” with the local area team that would address General Practice functions including GMS, PMS and APMS Contracts (design, monitoring and contractual action), newly designed enhanced services, design of a local incentive scheme as an alternative to QOF and approving Practice mergers.

This function could be carried out in collaboration with other CCGs.

This option would exclude individual GP performance management as well as pharmacy and optometry commissioning. CCGs wishing to take forward this option are required to complete a proposal if this is their preferred option and submit this by 30 January 2015.

Option 3: Delegated commissioning

Delegated commissioning offers an opportunity for CCGs to assume full responsibility for commissioning General Practice services. The functions would be the same as the examples cited under option 2, but would be assumed fully by the CCG.
This option would exclude individual GP performance management as well as pharmacy and optometry commissioning. CCGs wishing to take this forward as their preferred option are required to complete a proposal and submit by the 9th January 2015.

Thurrock CCGs position

Thurrock CCG has decided to choose option 1: greater involvement in primary care decision making, as this fits strategically with CCG developments at this current time. It is acknowledge however, that the role in commissioning of primary care may not be a choice for CCGs in the future. The CCG is also aware that these changes will impact on the form and capacity of the NHS England team support primary care and will continue conversations through the Primary Care Strategy Group to ensure that both Statutory Duties, as well as strategic priorities continue to be taken forward.

4. Reasons for Recommendation

4.1 This is a report for the Health and Wellbeing Board to note and provide comment. No recommendations are made.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 There has been extensive clinical and patient engagement in all of these primary care developments.

5.2 This paper was presented to the Overview and Scrutiny Committee on Tuesday 13th January 2015.

6. Impact on corporate policies, priorities, performance and community impact

6.1 None

7. Implications

7.1 **Financial**

Implications verified by: Kay Goodacre
01375 652466
Kgoodacre@thurrock.gov.uk

Financial Implications are contained within the body of the report.

7.2 **Legal**

Implications verified by: Dawn Pelle
Legal and Democratic Services
dawn.pelle@BDTLegal.org.uk

There are no legal implications.

7.3 **Diversity and Equality**

Implications verified by: Natalie Warren
Equalities Manager
nwarren@thurrock.gov.uk

There are no implications.

However the increased access to primary care will have a positive impact on communities in meeting their health needs.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- None

9. Appendices to the report

- none

Report Author:

Lisa Henschen
Assistant Director – Primary Care
NELCSU on behalf of Thurrock CCG

9 February 2015	ITEM: 6
Health and Wellbeing Board	
The future of the Thurrock Walk-in Service	
Wards and communities affected: All	**Key Decision:** N/A
Report of: Beata Malinowska, Senior Consultant, NEL CSU – Walk In Service project lead for Thurrock CCG.	
Accountable Head of Service: Mandy Ansell, Acting (Interim) Accountable Officer, Thurrock CCG	
Accountable Director: Mandy Ansell, Acting (Interim) Accountable Officer, Thurrock CCG	
This report is Public	

Executive Summary

This report outlines the progress of work that Thurrock CCG has conducted so far to facilitate the decision-making process for the future of the walk-in service at Thurrock Health Centre in Grays.

Through a robust engagement and data gathering process, Thurrock CCG has identified three options for the future of the Walk-in Service (WiS):

1. Re-tender for the service on the current specification
2. Re-tender with a new specification for service
3. Decommission the Walk-in Service with a view to fully or partially reinvest in four hubs.

These options were considered and appraised by a selected scoring panel of clinicians, GPs, commissioners, patients and the public on 18 November 2014 (a fourth option was considered – to decommission the service and do nothing, but that was considered by the panel and rejected as an option). The panel scored Option 3 the highest and the CCG has accepted that option: *To decommission the Walk-In Service and fully or partially reinvest in the four hubs'* as its preferred option, and is looking to proceed to an eight-week consultation period, subject to a decision-making meeting of its governing body on 28 February.

The proposed change is only to the Walk-in Service at Thurrock Health Centre, not the GP practice whose patients will still be able to see their GP there.
We have plans to provide increased access to local GPs on Saturdays and Sundays more widely across Thurrock in four existing GP practices (which we are calling

hubs), and local GP services will absorb the rest of the capacity provided at the Walk-in Service.

Whilst the change is not significant, Thurrock CCG recommended an eight-week period of consultation under section 14Z2, Health and Social Care Act 2012, which will see a consultation document produced, a questionnaire for residents to complete, opportunities to discuss the proposals with clinicians, and engagement with people who currently access the Walk-in service.

This recommendation has been supported by the Thurrock Health Overview and Scrutiny Committee which considered the report on 13 January 2015.

This report includes a consultation plan and stakeholder framework for Health and Wellbeing Board members' information.

1. Recommendation(s)

1.1 To note the consultation process, including its duration proposed as an eight-week consultation under section 14Z2, Health and Social Care Act 2012, starting in February 2015.

1.2 To note the public consultation plan attached to this report.

2. Introduction and Background

2.1 Thurrock CCG currently commissions one Walk-in Service based in Thurrock Health Centre, Grays, to serve its population of 158,000. The contractual arrangements for this Walk-in Service are tied with the provision of services for the GP practice registered list which is commissioned by NHS England.

Thurrock Health Centre opened in March 2010 as part of the then national programme which required each Primary Care Trust (PCT) area to open a GP-led Health Centre (GPLHC). Each GPLHC was required to have two core elements:

- A registered list similar to existing GMS and PMS practices, but with extended opening hours, and
- A walk-in service for non-registered patients open 365 days per year from 8am to 8pm.

Following changes to the NHS set out in the Health and Social Care Act 2012, the CCG is now responsible for the walk-in element of the contract at Thurrock Health Centre, whilst NHS England retains responsibility for the GP practice registered list.

Total spend in 2013/14 for the Walk-in Service was £568,539 which is less than the allocated budget of £626,000.

With the Walk-in Service contract expiring in September 2015, this provided the CCG with an opportunity to review the model of care as to whether it is the

most appropriate service for all the people of Thurrock, as well as its overall alignment with CCG and national strategies for both urgent and primary care.

To capitalise on this opportunity, Thurrock CCG has conducted a robust analysis of the current use of, cost of, and patient satisfaction with the walk-in service at Thurrock Health Centre. In addition, local access to primary care and attendance rates at the A&E at Basildon Hospital were also examined to set some context to the landscape in which the Walk-in Service operates.

The approach adopted was designed to collate sufficient amount of relevant data to allow a robust options development process followed by an appraisal conducted by a carefully selected scoring panel. The outcome was to identify and recommend a preferred option for the future of the Walk-in Service.

The methodology employed included a rigorous data collection process, underpinned by qualitative and quantitative data gathering. Both processes highlighted current key issues related to provision of services at the Walk-in which were presented to the scoring panel.

One of the key documents that guided the approach and methodology employed for this process was Monitor's "Walk-in Centre Review" report (February 2014). This report sets out best practice for conducting such reviews, including the following key considerations for commissioners when developing and assessing options for the future of Walk-in Services:

1. Patient need
2. Transparency in decision-making and procurement
3. Integration of services
4. Managing conflicts of interest
5. Ensuring transparency in decision-making.

These considerations were applied by Thurrock CCG throughout the process of identifying and assessing options for the future of its Walk-in Service.

3. Issues, Options and Analysis of Options

3.1 Data underpinning the options appraisal process

To enhance the understanding of the current Walk-in Service provision, both qualitative and quantitative data on the current use, cost and patient satisfaction with the walk-in service was collected and analysed. The data was sought to gain the understanding of the following dimensions:

- Strategic alignment with relation to patient need
- Patient need data including:
    - Who uses the Walk-In Service?
    - Why do our patients attend the Walk-In Service?
- Impact of the Walk-In Service on usage of other services including:

    - Use of A&E
    - Use of out of hours' services
    - Use of the Minor Injuries Unit
    - Summary of quantitative analysis of usage
- Patient survey
- GP patient survey
- Practice capacity survey.

The data covers the financial year 2013/14. The table demonstrates total attendances and indicates that most patients who attend the Thurrock walk-in service come from Grays. This data does not include the attendances from patients who are also registered at the GP practice at Thurrock Health Centre which account for approximately 723 further attendances per month, which over the year would mean another 8,400 attendances by patients local to Grays.

Total attendances by locality for 2013/14 (Thurrock registered patients only)

Locality	Total
Corringham	571
Grays	**8,094**
South Ockendon	4,264
Tilbury	4,668
Grand Total	**17,597**

3.2 Key findings and issues

- We need to make sure we provide the right services in the right place for the people of Thurrock
    - At the moment, it is mainly people from Grays and Tilbury who use the walk-in service

- We need to ensure value for money given our limited resources
    - The current walk-in service duplicates services
    - We need to make services more efficient and use the money we've got more appropriately

- We need to promote resilient communities and self-management
    - People use the service because they find it convenient; they don't want to wait for an appointment with their GP, they want reassurance, or they don't know where else to go
    - People should use their GP as their first point of contact which is essential if we are to help patients keep healthier and manage long-term conditions better
    - People can use pharmacists or treat themselves for most of the complaints they go to the Walk-in Service

3.3 Engagement process leading to the development of options

In advance of the development of the options appraisal process, a comprehensive engagement plan was drawn up and the CCG Commissioning Reference Group was consulted to identify any gaps.

The purpose of this engagement was twofold; to ensure the CCG met its obligation for transparency and secondly to enable the development of options for this options appraisal process.

The engagement process included the opinions sought from the following groups:

- Healthwatch Thurrock
- Thurrock Council for Voluntary Service
- Thurrock Council Health Overview and Scrutiny Committee
- South West Essex System Resilience Group
- Basildon and Thurrock University Hospitals NHS Foundation Trust
- North East London NHS Foundation Trust
- South Essex Emergency Doctors Surgeries
- Thurrock GPs through the CCG Clinical Engagement Group and visits to GPs in their practices
- Thurrock CCG's Commissioning Reference Group
- Thurrock CCG's Primary Care Development Working Group
- Thurrock CCG's Annual General Meeting
- Thurrock Health and Care: working together for a better future – public engagement event.

When we have been discussing possible changes to the walk-in service, people have told us that the three things they are most concerned about are:

1. the **need for greater access to primary care** in Thurrock,
2. that the **walk-in service does not provide a borough-wide service**, and
3. that while the four GP 'hubs' would **provide more access to GPs across Thurrock**, they would be open for fewer hours than the walk-in service.

3.3 Options development process

As a result of the engagement process, the following options were identified:

1. Re-tender for the service on the current specification
2. Re-tender with a new specification for service
3. Decommission the Walk-in Service with a view to fully or partially reinvest in four hubs.

These options with the relevant underpinning data available were presented to the options appraisal scoring panel on 18 November 2014. (A fourth option–

to decommission the service and do nothing - was considered by the panel and rejected as an option).

3.4 Assessment process

The Primary Care Development Working Group (PCDWG) developed and agreed a scoring criteria to enable an objective view of the options presented:

Criteria	Weighting	Maximum score possible
Qualitative	50%	1
Risk	30%	0.6
Finance	20%	0.4
Total	100%	2

3.5 Scoring panel

The PCDWG also nominated the following members for the scoring panel, as follows:

Name	Role	Attended on 18th November 2014 Y/N
Dr Raja	GP – CCG Board Member	Y
Dr Deshpande	GP – CCG Chair	Y
Femi Otukoya	CCG Finance	N
Len Green	Lay member for patient and public engagement	Y
Kim James	Healthwatch Thurrock	N
Mark Tebbs	CCG Commissioner for Integrated Care	Y
Les Billingham	Local Authority, Lead for Adults	Y

It was noted that a possible conflict of interest may exist for the GP members of the panel, who could be seen to benefit from the decisions made, even if indirectly, as providers of future primary care services.

However, it is important to point out that GP panel members were taking part in the scoring process in their capacity as clinical experts. Therefore, this possible conflict of interest was noted at the PCDWG and the decision taken that to retain them as members of the panel as clinical input and local clinical knowledge held by CCG Board member GPs was very important and needed for the evaluation purposes.

3.6 Outcome of the scoring panel's assessment process

As a result of the assessment work conducted by the scoring panel which took place on 18 November 2014, option 3, '*Decommission the Walk-In*

Service with a view to fully or partially reinvest in four hubs' gained a total of 1.54 points which constituted the highest score out of all four assessed options. Option 3 "Re-tender with a new specification for service scored second highest".

Total Scores	Weighting	Option 1[1]	Option 2	Option 3	Option 4
Qualitative	50%	0.04	0.16	0.26	0.84
Risk	30%	0.12	0.285	0.33	0.42
Finance	20%	0.2	0.17	0.2	0.28
Total	**100%**	**0.36**	**0.615**	**0.79**	**1.54**

Thurrock CCG position

The scoring panel identified a preferred option: *Decommission the Walk-in Service with a view to fully or partially reinvest in four hubs.*

The outcome, along with the underpinning engagement and data evidence, was presented at the CCG's Finance and Performance Committee on 19 November.

The Thurrock CCG Governing Body met on 26 November and agreed in principle to go out to consultation, subject to discussion by the HOSC.

The case for change along with the consultation approach were presented and discussed at the HOSC meeting on 13 January 2015. The HOSC supported an eight-week consultation, under section 14Z2, Health and Social Care Act 2012, starting on 2 February 2015 and noted the consultation plan.

4. Reasons for Recommendation

4.1 Given the wide ranging engagement process that has been adhered to on an ongoing basis by Thurrock CCG and with the HOSC's support, the Health and Wellbeing Board is asked to note the consultation process, including its duration as an eight-week consultation, under section 14Z2, Health and Social Care Act 2012, starting on 2 February 2015,

In addition, the Health and Wellbeing Board is asked to note the consultation plan which is to be delivered during the consultation period.

5. Consultation (including Overview and Scrutiny, if applicable)

[1] Option 1 – To decommission the service and do nothing - was considered by the panel and rejected as an option.

5.1 Engagement has already been undertaken in developing the options for the future of the Walk-in Service, and included the opinions sought from, but not limited to, the groups listed at 3.2.

The views on the undertaking of an eight-week consultation (which is the next phase of the process) were received from the HOSC on 13 January 2015.

The views of the Health and Wellbeing Board are now being sought through the submission of this report.

The views of the wider public including patients, patient representatives and groups, CVS and other community groups will be encouraged during the period of the consultation.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The process of identifying options for the future of the Walk-in service conducted by Thurrock CCG aligns with the Council's priority of improving health and wellbeing of the population.

7. Implications

7.1 Financial

Implications verified by: Kay Goodacre
Interim Finance Manager
Kgoodacre@thurrock.gov.uk

Financial Implications are contained within the body of the report.

7.2 Legal

Implications verified by: Dawn Pelle
Legal and Democratic Services
dawn.pelle@BDTLegal.org.uk

There are no legal implications.

7.3 Diversity and Equality

Implications verified by: Rebecca Price
Community Development Officer
r.price@thurrock.gov.uk

An Equality Impact Assessment has been developed for the launch of the consultation – nothing to add at this time.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

N/A

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

None

9. Appendices to the report

- Consultation plan and stakeholder framework

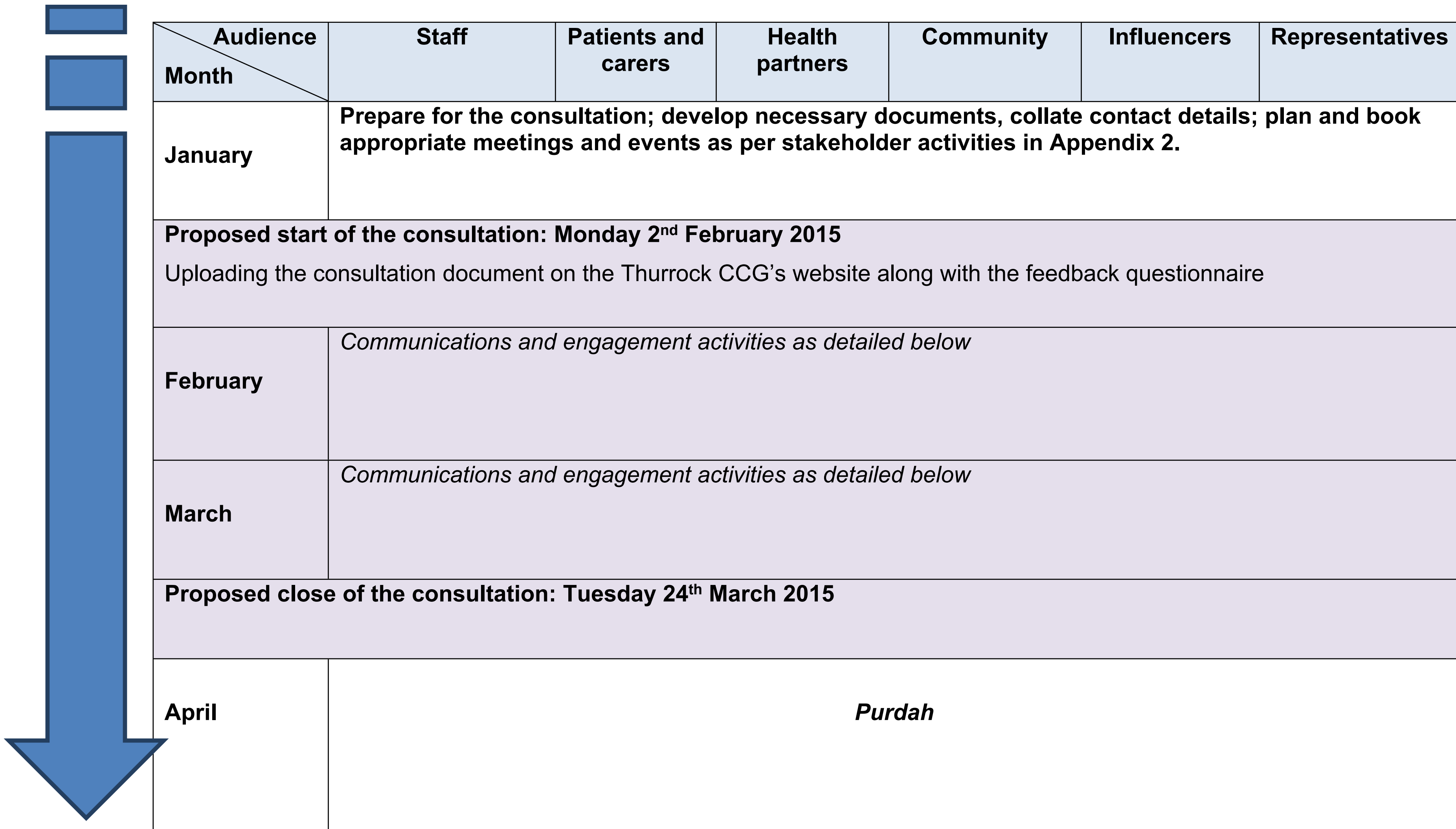
Report Author:

Beata Malinowska

Senior Consultant

NEL CSU on behalf of Thurrock CCG

Appendix 1 - Consultation plan and stakeholder framework



Audience / Month	Staff	Patients and carers	Health partners	Community	Influencers	Representatives
January	**Prepare for the consultation; develop necessary documents, collate contact details; plan and book appropriate meetings and events as per stakeholder activities in Appendix 2.**					
Proposed start of the consultation: Monday 2nd February 2015 Uploading the consultation document on the Thurrock CCG's website along with the feedback questionnaire						
February	*Communications and engagement activities as detailed below*					
March	*Communications and engagement activities as detailed below*					
Proposed close of the consultation: Tuesday 24th March 2015						
April	***Purdah***					

Audience	Communication objectives	Communication activities	Timescale	Who
1. NHS staff, internal stakeholders e.g: Includes: • College Health group • Thurrock Walk-in Service • Thurrock CCG • North East London Foundation Trust staff • SEPT staff • BUHT staff • EEAST staff • Care UK staff • GPs • GP practice managers and staff • SEEDs • Other Clinical Commissioning Groups • Community pharmacists • Other staff working at the same location • NEL CSU	• to develop NHS staff as potential ambassadors and drivers for change • to ensure awareness of the aims of the consultation • to ask staff their views in order to inform our understanding and to improve and develop the proposals • to enable staff to understand the impact of any proposals on their roles or professional groups, and what it means for them – and help allay any fears about their jobs and future careers	• Develop proposals in partnership • Draft letters/emails to keep informed • Emails and links to consultation website • Make formal proposal document available • Produce information for staff briefings and articles in stakeholders newsletters • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above As above End of consultation	Comms/ Prog office Comms Comms Comms Comms / GPs Comms/Prog office

Audience	Communication objectives	Communication activities	Timescale	Who
2. Patients/carers Includes: • patients/carers with experience of walk-in services • patients using the location to access other services (e.g. GP patients) • people with a long-term conditions • people with mental health problems or dementia • PALS and Friends • patient groups • carers of patients	• to ensure awareness of the aims of the consultation and ask people to respond to the consultation • to explain the benefits and issues around quality, equalities, travel, patient pathways • to be open and create understanding • to provide reassurance of the NHS commitment to clinical quality and patient care • to encourage informed debate • to understand the needs of patients • to help prevent ill health and improve the health of residents	• Develop proposals in partnership • Draft letters/emails to keep informed • Emails and links to consultation website • make formal proposal document available • Public drop-in event for Thurrock-based patients and carers • Media releases • Leaflet door drop • Newspaper advertising • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above As above As above As above As above As above End consultation	Comms/Prog Office Comms Comms Comms Comms / GPs and Programme office Comms /Prog office

Audience	Communication objectives	Communication activities	Timescale	Who
3. Health and related partners Includes: • Dept of Health; NHS England; other CCGs – in particular Basildon and Brentwood • Health and Wellbeing Board • Thurrock Council • London Ambulance Service • local partnerships; groups/boards • private providers • Voluntary groups – especially associated with the locations	• as section 2, plus: • to ensure any impacts on health partners are fully explored • to utilise specialist knowledge of issues and opportunities • to ensure synergy with partners' developments and announcements	• Develop proposals in partnership • Draft letters/emails to keep informed • produce information for staff briefings and articles in stakeholders newsletters • emails and links to consultation website • encourage local organisations to create and publicise a link from their website home page to website and include information in their publications • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above End consultation	Comms/Prog office Comms Comms Comms /Prog office

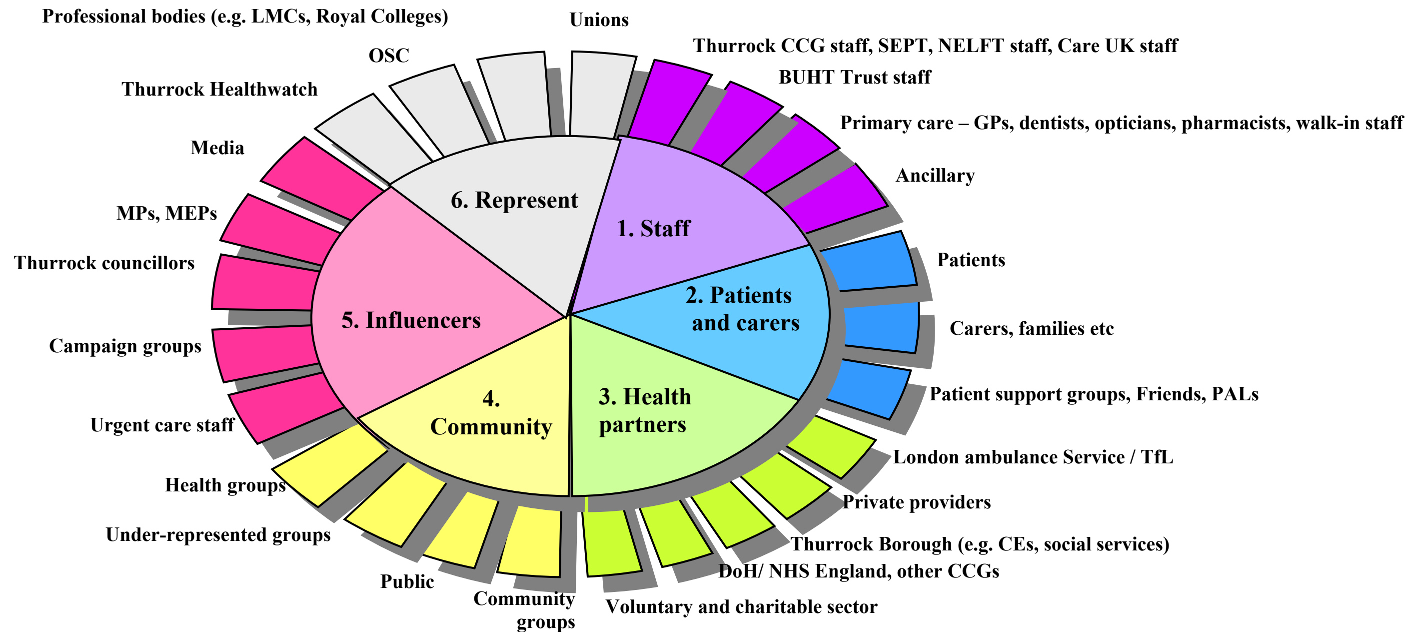
Audience	Communication objectives	Communication activities	Timescale	Who
4. Community • public • community groups e.g. schools, faith communities and leaders, residents associations, • traditionally excluded groups • health groups	• as section 2, plus: • to build trust in the Trust and the NHS as effective caretakers of the health of local population • for the community to understand how the NHS works and the services on offer • to understand the needs of residents	• develop proposals in partnership • Draft letters/emails to keep informed • emails and links to consultation website • make formal proposal document available media releases • Leaflet door drop • Newspaper advertising • Communicate to all following decision	Ongoing Start of consultation and throughout consultation As above Throughout consultation Start and end of consultation End of consultation	Comms/ Prog office Comms Comms Comms Comms/ GPs and Prog office Comms Comms/ Prog office

Audience	Communication objectives	Communication activities	Timescale	Who
5. Influencers • MPs • Media • Councillors	• as section 2, plus: • to listen to their views • to facilitate influencers in providing reliable information to constituents	• develop proposals in partnership • Draft letters/emails to keep informed • distribute copies of proposals, but face-to-face meetings are key for this audience: one-to-one meetings or roundtable discussions • media releases • press advertisements • Communicate to all following decision	Ongoing Start of consultation and throughout consultation Start and end of consultation Start and end of consultation End of consultation	Comms/Prog office Comms Comms Comms Comms Comms /Prog office

Audience	Communication objectives	Communication activities	Timescale	Who
6. Representatives • HOSCs • Local Medical Committees • Thurrock Healthwatch • Unions • professional bodies / royal colleges	• as section 2, plus: • to provide information as required under the NHS Act (OSCs) • receive independent endorsement for proposals and thereby reassure relevant audiences • to receive critical challenge and objective examination	• develop proposals in partnership where appropriate • distribute proposals, but face-to-face meetings are key for this audience • presentations • respond to OSC/ submission • Communicate to all following decision	Ongoing Start of consultation and throughout consultation Ongoing TBA Start and end of consultation	Comms/Prog office Comms Programme office Comms/Prog office Comms/Prog office

Stakeholder framework

This stakeholder framework details the communications and engagement responsibilities of Thurrock CCG. It is based on the understanding that staff work in collaboration to avoid duplication of effort; and to ensure the most effective use of professional resources.



KEY:

1. Staff - Purple
2. Patients / Carers - Blue
3. Health Partners – Green
4. Community - Yellow
5. Influencers – Pink
6. Represents - Grey

9 February 2015	ITEM: 7
Thurrock Health and Wellbeing Board	
The Better Care Fund pooled fund Section 75 Agreement	
Wards and communities affected: All	**Key Decision:** Key
Report of: Mandy Ansell, (Acting) Interim Accountable Officer, NHS Thurrock CCG and Roger Harris, Director of Adults, Health and Commissioning, Thurrock Council	
Accountable Head of Service: Not applicable	
Accountable Directors: As above	
This report is public	

Executive Summary

This report concerns the establishment of the Better Care Fund pooled fund to promote integrated care and support services. As reported previously, the pooled fund will be operated in line with the conditions set out in a Section 75 agreement to between the Board of NHS Thurrock CCG and the Cabinet of Thurrock Council.

Approval for the Better Care Fund Plan for Thurrock has now been received from the Department of Health. Accordingly the Health and Wellbeing Board is asked to support the Section 75 agreement (attached as Appendix 1) which will enable the pooled fund to be established.

A report with a recommendation to approve the agreement will be considered by the Board of NHS Thurrock Clinical Commissioning Group on 25 February and the Cabinet of Thurrock Council on 11 March. Following approval by both bodies the agreement can then be signed and sealed by the parties, and contracts for the delivery of the health and social care services commissioned from the fund can be entered into by the Council as host of the pooled fund.

The pooled fund will be overseen by an Integrated Commissioning Executive which will receive regular reports on expenditure, quality and activity. The Executive will report on the performance of the fund to the Health and Wellbeing Board.

1. Recommendation(s)

1.1 The Health and Wellbeing Board is asked to support the Better Care Fund Section 75 Agreement between NHS Thurrock CCG and Thurrock Council.

2. Introduction and Background

2.1 As reported to the Board on 11 September and 13 November 2014, Central Government is placing £3.8 billion of existing health and social care funding into a single pooled budget, to enable health and social care services to work more closely together. Locally, a pooled fund will need to be established by April 2015 and administered in line with a Section 75 agreement between NHS Thurrock Clinical Commissioning Group and Thurrock Council.

2.2 The Better Care Fund Plan for Thurrock was approved by the Board on 11 September and submitted to the Department of Health on 19 September. On 29 October 2014 the CCG and the Chair of the Health and Wellbeing Board received a letter which stated that the Department of Health had determined that Thurrock's Better Care Fund Plan was "Approved Subject to Conditions". The Department of Health's conditions related to certain narrative and financial aspects of the plan. In line with advice from advisors from the Department, a revised plan was submitted on 28 November. On 21 January 2015 Dame Barbara Hakin, National Director Commissioning Operations NHS England, wrote to the Board advising that the resubmitted plan has been classified as "**Approved**".

2.3 Dame Barbara's letter also advised that the Better Care Fund will be made available to the Board subject to the following standard conditions:

- "The Fund being used in accordance with your final approved plan and through a section 75 agreement;
- The full value of the element of the Fund linked to non-elective admissions reduction target will be paid over to CCGs at the start of the financial year. However, CCGs may only release the full value of this funding into the pool if the admissions reduction target is met as detailed in the BCF Technical Guidance[1]. If the target is not met, the CCG(s) may only release into the pool a part of that funding proportionate to the partial achievement of the target. Any part of this funding that is not released into the pool due to the target not being met must be dealt with in accordance with NHS England requirements. Full details are set out in the BCF Technical Guidance"

2.4 This report outlines the terms of the section 75 agreement and the arrangements for commissioning services from the pooled fund.

3. Issues, Options and Analysis of Options

The value of the Better Care Fund

3.1 As reported in September, the Better Care Fund Plan for Thurrock will establish a pooled fund of £18,019,336 made up of a £14,766,142 contribution from the CCG and a £3,253,194 contribution from the Council.

The focus of the Better Care Fund for Thurrock

[1] http://www.england.nhs.uk/wp-content/uploads/2014/08/bcf-technical-guidance-v2.pdf

3.2 The initial focus for Thurrock's Better Care Fund is on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes chosen for the BCF reflect this focus and the rationale for this is set out in the Case for Change section of the Better Care Fund Plan. The aim is to have a single pooled fund across health and social care for all older people's services by April 2017. In line with the Care Act guidance on 'preventing, reducing or delaying needs', our aim is to develop integrated approaches that target 'individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing'; and to develop integrated approaches aimed at 'minimising the effect of disability or deterioration of people with established health conditions, complex care and support needs or caring responsibilities'. These themes run throughout our Better Care Fund Schemes.

The investment in Schemes for 2015/16

3.3 In terms of investment, the fund will be used to commission 7 schemes which combined will enable us to transform our service and support to the population aged 65 and over:

- Locality Service Integration - £4,551,113
- Frailty Model - £4,378,980
- Intermediate Care - £5,035,665
- Prevention and Early Intervention - £1,964,509
- Disabled Facilities Grant and Social Care Capital Grant - £845,000
- Care Act Implementation - £522,000
- Payment for Performance - £722,069

Full details of each of the Schemes are contained in the Better Care Fund Plan which is included as Schedule 8 of the Section 75 Agreement (attached). It should be noted that contract negotiations have yet to be concluded and so the contract values shown in the Section 75 agreement are provisional.

The National Conditions to be met

3.4 As noted in previous reports, the Better Care Fund is to be established, and a reduction in total emergency admissions achieved, within existing Council and NHS funding – there is no new money. In addition to the challenge of driving through significant change in our health and social care system there are a set of national "must dos", including 7 day working, better data sharing, an accountable professional for people over 75, and protection for adult social care services.

The costs of implementing the Care Act 2014

3.5 Further, it was announced as part of the Spending Round that the Better Care Fund would include £135m of revenue funding for costs to councils resulting from Care Act implementation in 2015/16. Again this is not new money but £522,000 has been set aside in the local pooled fund for this purpose.

Payment for Performance

3.6 While the initial focus of the Better Care Fund when it was launched in August 2013 was on integration, the revised guidance places a specific requirement for a minimum target reduction in total emergency admissions. The guidance makes it clear this should be 3.5% for all Health and Wellbeing Board areas, unless an area can make a credible case as to why it should be lower. Thurrock has accepted this challenging target (amounting to some £722,000 locally). In order to manage the risk of under-performance, the Council and CCG propose that funds related to the performance element will only be paid by the CCG into the pooled fund in relation to the performance achieved. Commitments related to the performance element will likewise only be made following conformation of performance against the target.

Overspends/ Underspends in the Better Care Fund

3.7. The issue of treatment of overspends has been examined and, with a view to limiting the risk to the CCG and Council, expenditure in each scheme within the pooled fund will be monitored closely, and any virement between schemes will be subject to approval by both parties. Further, it is proposed that any expenditure over and above the value of the fund should fall to the Council or the CGG depending on whether the expenditure is incurred on social care functions or health related functions. The arrangements for monitoring expenditure and managing any overspend in an individual scheme is set out in detail in the Section 75 Agreement. Any underspends at the year end will stay within the Pooled Fund as a restricted reserve – unless otherwise agreed by both parties.

Governance arrangements

3.8 The management of the pooled fund will require regular oversight by both parties and accordingly an Integrated Commissioning Executive comprising officers of the CCG and Council is being established – this Executive will report directly into the Health and Well-Being Board. A Pooled Fund Manager will also be appointed to provide regular reports, (including an Annual Review) to the Executive which will provide strategic direction on the individual schemes and manage risks. The Pooled Fund Manager will also prepare reports for the Health and Well-Being Board.

Contracting arrangements

3.9 The Council as host of the pooled fund, will need to enter into contracts with third party providers, and service level agreements for services the Council itself provides, and to make payments for these from the fund from April 2015. Accordingly, the report to Cabinet on 11 March will recommend approval of waiver requests and contract award requests for these contracts. For the first year the Council will become a party alongside the CCG for those contracts where the CCG already has an existing arrangement e.g. North East London NHS Foundation Trust. This will allow for more effective integrated commissioning and establish a single, joint contract management framework. It is proposed that the standard NHS contract is used for these services with the Council becoming an equal commissioning partner with the CCG.

Performance Framework

3.10 A new health and social care performance scorecard has been agreed for the Better Care Fund. The primary aim of the scorecard will be to monitor the BCF core measures and related health, social care and public health measures contained within local strategies. It will also ensure a clear alignment with national outcomes frameworks. The scorecard will provide a regular update to the Thurrock Integrated Commissioning Executive (ICE) and Council / CCG Boards on the performance of the BCF and related priorities. It is also proposed that the report be presented to the Health and Well-Being Board to enable a line of sight into health and social care performance.

Management or risks

3.11 A Risk Register for the Better Care Fund has been established and a Project Group comprising senior officers from the CCG and the Council is meeting monthly to actively manage the risks identified. The Project Group reports to the Integrated Commissioning Group so that linkages with the implementation of the Care Act, and QIPP and corporate efficiency initiatives are also actively managed.

Clinical Liability

3.12 The Partners agree that the Council will not be liable for Losses or Default Liability arising from the performing or overseeing certain clinical tasks, such as [clinical/medical diagnosis, or the prescription of medicine (‘Clinical Liability`). It is recognised by the Partners that the Council is not able to source appropriate insurance for Clinical Liability. Clinical Liability, if it arises, will be met by the contractor or provider performing or overseeing these tasks, or failing that it will be met by the CCG, which will ensure appropriate insurance is in place to cover any such liability.

4. Reasons for Recommendation

4.1 The “Approved” status of the Better care Fund Plan, now permits the Council and the CCG to enter into a Section 75 Agreement to administer the pooled fund from April 2015.

5. Consultation (including Overview and Scrutiny, if applicable)

5.1 As noted in the previous reports, the process of community engagement in the redesign of health and social care services in Thurrock is being undertaken in conjunction with Thurrock Healthwatch, Thurrock Coalition, Thurrock CVS and the Thurrock Commissioning Reference Group.

5.2 A specific consultation on the establishment of the pooled fund to drive through the integration of health and social care services, as required under the terms of the Health and Social Care Act 2012, was undertaken in September and October 2014. This was undertaken through the Thurrock consultation portal as well as the CCG website.

6. Impact on corporate policies, priorities, performance and community impact

6.1 The planned reduction in emergency admissions, which brings with it the potential to invest in services closer to home, will help prevent, reduce or delay the need for health and social care services. This will help deliver the Community Strategy priority to improve health and wellbeing.

6.2 Achieving closer integration and improved outcomes for patients, service users and carers is also seen to being a significant way of managing demand for health and social care services, and so manage financial pressures on both the CCG and the Council.

7. Implications

7.1 Financial

Implications verified by: **Sean Clark**
Head of Corporate Finance
Thurrock Council

Femi Otukoya
Head of Finance
NHS Thurrock CCG

Total Better Care Fund pooled budget for 2015/16 of **£18,019,336;**
Thurrock CCG contribution **£14,766,142;**
Thurrock Council contribution **£3,253,194.**

The above report outlines the arrangements for the administration of a pooled fund for the Better Care Fund in 2015/16. The pooled fund is to be with created with contributions from both Thurrock Council and NHS Thurrock Clinical Commissioning Group and will be administered by the Council in line with the Better Care Fund Plan. As noted in the previous report, the complexity of the health and social care system presents a major challenge and the Health and Well-Being Board will receive regular reports on the performance of the Better Care Fund.

7.2 Legal

Implications verified by: **Daniel Toohey**
Principal Solicitor - Contracts & Procurement
Thurrock Council

Andrew Stride
Head of Corporate Governance
NHS Thurrock CCG

By virtue of Section 75 of the NHS Act 2006 and related regulations, the Council may enter into prescribed arrangements, including the establishment of pooled funds, with NHS bodies, such as clinical commissioning groups. Such arrangements are often referred to in short as "Section 75 agreements".

It is a requirement of the terms of the Better Care Fund programme that local authorities and the respective clinical commissioning groups enter into a Section 75 agreement.

The governance arrangements for the Better Care Fund, as set out in the Section 75 Agreement, will need to be approved by the Cabinet of Thurrock Council and the Board of NHS Thurrock CCG before the pooled fund can be established.

Legal Services, in conjunction with the Council's finance, procurement and risk-management teams have been available to advise and assist in the preparation of the attached Section 75 agreement and will be on hand to assist with legal issues arising during the sign off, and delivery phase of the programme.

7.3 **Diversity and Equality**

Implications verified by: **Teresa Evans**
Equalities and Cohesion officer
Thurrock Council

Andrew Stride
Head of Corporate Governance
NHS Thurrock CCG

The vision of the Better Care Fund is improved outcomes for patients, service users and carers through the provision of better co-ordinated health and social care services. The commissioning plans developed to realise this vision will need to be developed with due regard to equality and diversity considerations. This will include adherence to the relevant 'Equality' Codes of Practice on Procurement. These require consideration of the equality arrangements of all such providers, such as relevant policies on equal opportunities and the ability to demonstrate a commitment to equality and diversity. These arrangements will also be subject to a full review as part of the contract management of the services to be provided.

7.4 **Other implications** (where significant) – i.e. Staff, Health, Sustainability, Crime and Disorder)

None identified at this time.

8. Background papers used in preparing the report (including their location on the Council's website or identification whether any are exempt or protected by copyright):

- Better Care Fund Revised Planning Guidance Contractual 25 July 2014
- Better Care Fund – Revised technical guidance (version 2 – August 2014)

9. Appendices to the report

- Section 75 Agreement between NHS Thurrock Clinical Commissioning Group and Thurrock Council

Report Author: Christopher Smith
Programme Manager, Adults, Health and Commissioning

Appendix 1

Dated 2014

THURROCK BOROUGH COUNCIL

and

NHS THURROCK CLINICAL COMMISSIONING GROUP

FRAMEWORK PARTNERSHIP AGREEMENT RELATING TO THE COMMISSIONING OF HEALTH AND SOCIAL CARE SERVICES BETTER CARE FUND PROGRAMME

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THIS AGREEMENT is made on day of 2014

PARTIES

(1) **THURROCK COUNCIL** of Civic Offices, New Road Grays, Essex, RM17 6SL (the "**Council**")

(2) **NHS THURROCK CLINICAL COMMISSIONING GROUP** of 2nd Floor Civic Offices, New Road Grays, Essex, RM17 6SL(the "**CCG**")

BACKGROUND

(A) The Council has responsibility for commissioning and/or providing social care services on behalf of the population of the borough of Thurrock.

(B) The CCG has the responsibility for commissioning health services pursuant to the 2006 Act in the borough of Thurrock.

(C) The Better Care Fund has been established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that the CCG and the Council establish a pooled fund for this purpose.

(D) Section 75 of the 2006 Act gives powers to local authorities and clinical commissioning groups to establish and maintain pooled funds out of which payment may be made towards expenditure incurred in the exercise of prescribed local authority functions and prescribed NHS functions.

(E) The purpose of this Agreement is to set out the terms on which the Partners have agreed to collaborate and to establish a framework through which the Partners can secure the future provision of health and social care services. It is also the means through which the Partners will pool funds.

(F) The aims and benefits of the Partners in entering in to this Agreement are to:

a) improve the quality and efficiency of the Services;

b) meet the National Conditions and Local Objectives;

c) make more effective use of resources through the establishment and maintenance of a pooled fund for revenue expenditure on the Services;

d) In the first instance, to focus on people aged 65 years and over, in particular those at risk of hospital admission and permanent admission to residential care or nursing care;

e) Empower citizens who have choice and independence and take personal responsibility for their health and wellbeing;

DRAFT

f) Present health and care solutions that can be accessed close to home;

g) Commission and provide health care services tailored around the outcomes the individual wishes to achieve;

h) Focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible, and

i) Develop systems and structures that enable and deliver a co-ordinated and seamless response [CP to confirm to DT if there is any further wording here]

(G) The Partners have jointly carried out consultations on the proposals for this Agreement with all those persons likely to be affected by the arrangements.

(H) The Partners are entering into this Agreement in exercise of the powers referred to in Section 75 of the 2006 Act and/or Section 13Z(2) and 14Z(3) of the 2006 Act as applicable, to the extent that exercise of these powers is required for this Agreement.

1 DEFINED TERMS AND INTERPRETATION

1.1 In this Agreement, save where the context requires otherwise, the following words, terms and expressions shall have the following meanings:

1998 Act means the Data Protection Act 1998.

2000 Act means the Freedom of Information Act 2000.

2004 Regulations means the Environmental Information Regulations 2004.

2006 Act means the National Health Service Act 2006.

Affected Partner means, in the context of Clause 24, the Partner whose obligations under the Agreement have been affected by the occurrence of a Force Majeure Event

Agreement means this agreement including its Schedules and Appendices.

Approved Expenditure means any additional expenditure approved by the Partners in relation to an Individual Service above any Contract Price and Performance Payments.

Authorised Officers means an officer of each Partner appointed to be that Partner's representative for the purpose of this Agreement.

Better Care Fund means the Better Care Fund as described in NHS England Publications Gateway Ref. No.00314 and NHS England Publications Gateway Ref. No.00535 as relevant to the Partners.

Better Care Fund Plan means the plan attached at Schedule 6 setting out the Partners plan for the use of the Better Care Fund.

CCG Statutory Duties means the Duties of the CCG pursuant to Sections 14P to 14Z2 of the 2006 Act

Change in Law means the coming into effect or repeal (without re-enactment or consolidation) in England of any Law, or any amendment or variation to any Law, or any judgment of a relevant court of law which changes binding precedent in England after the date of this Agreement

Commencement Date means 00:01 hrs on 1 April 2015

Confidential Information means information, data and/or material of any nature which any Partner may receive or obtain in connection with the operation of this Agreement and the Services and:

(a) which comprises Personal Data or Sensitive Personal Data or which relates to any patient or his treatment or medical history;

(b) the release of which is likely to prejudice the commercial interests of a Partner or the interests of a Service User respectively; or

(c) which is a trade secret.

Contract Price means any sum payable to a Provider under a Service Contract as consideration for the provision of Services and which, for the avoidance of doubt, does not include any Default Liability or Performance Payment

Default Liability *means any sum which is agreed or determined by Law or in accordance with the terms of a Services Contract) to be payable by any Partner(s) to the Provider as a consequence of (i) breach by any or all of the Partners of an obligation(s) in whole or in part) under the relevant Services Contract or (ii) any act or omission of a third party for which any or all of the Partners are, under the terms of the relevant Services Contract, liable to the Provider.*

Financial Contributions means the financial contributions made by each Partner to the Pooled Fund in any Financial Year.

Financial Year means each financial year running from 1 April in any year to 31 March in the following calendar year.

Force Majeure Event means one or more of the following:

(a) war, civil war (whether declared or undeclared), riot or armed conflict;

(b) acts of terrorism;

(c) acts of God;

(d) fire or flood;

(e) industrial action;

(f) prevention from or hindrance in obtaining raw materials, energy or other supplies;

(g) any form of contamination or virus outbreak; and

(h) any other event,

in each case where such event is beyond the reasonable control of the Partner claiming relief

Functions means the NHS Functions and the Health Related Functions

Health Related Functions means those of the health related functions of the Council, specified in Regulation 6 of the Regulations as relevant to the commissioning of the Services and which may be further described in the relevant Scheme Specification.

Host Partner means for the Pooled Fund the Partner that will host the Pooled Fund

Health and Wellbeing Board means the Health and Wellbeing Board established by the Council pursuant to Section 194 of the Health and Social Care Act 2012.

Indirect Losses means loss of profits, loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis.

Individual Scheme means one of the schemes which is agreed by the Partners to be included within this Agreement using the powers under Section 75 as documented in a Scheme Specification in Schedule 2.

Law means:

(d) any statute or proclamation or any delegated or subordinate legislation;

(e) any enforceable community right within the meaning of Section 2(1) European Communities Act 1972;

(f) any guidance, direction or determination with which the Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the Partner(s) or relevant third party (as applicable); and

(g) any judgment of a relevant court of law which is a binding precedent in England.

Losses means all damage, loss, liabilities, claims, actions, costs, expenses (including the cost of legal and/or professional services), proceedings, demands and charges whether arising under statute, contract or at common law but excluding Indirect Losses and "Loss" shall be interpreted accordingly.

Month means a calendar month.

National Conditions mean the national conditions as set out in the NHS England Planning Guidance as are amended or replaced from time to time.

NHS Functions means those of the NHS functions listed in Regulation 5 of the Regulations as are exercisable by the CCG as are relevant to the commissioning of the Services and which may be further described in each Scheme Specification.

Non-Recurrent Payments means funding provided by a Partner to the Pooled Fund in addition to the Financial Contributions pursuant to arrangements agreed in accordance with Clause [8.4].

Overspend means any expenditure from the Pooled Fund in relation to an Individual Scheme in a Financial Year which exceeds the Financial Contributions for that Individual Scheme for that Financial Year.

Partner means each of the CCG and the Council, and references to "**Partners**" shall be construed accordingly.

Integrated Commissioning Executive means the partnership board responsible for review of performance and oversight of this Agreement as set out in Schedule 2.

Performance Payment Arrangement means any arrangement agreed with a Provider and one of more Partners in relation to the cost of providing Services on such terms as agreed in writing by all Partners.

Performance Payments means any sum over and above the relevant Contract Price which is payable to the Provider in accordance with a Performance Payment Arrangement.

Permitted Budget means in relation to a Service where the Council is the Provider, the budget that the Partners have set in relation to the particular Service.

Permitted Expenditure has the meaning given in Clause [7.3].

Personal Data means Personal Data as defined by the 1998 Act.

Pooled Fund means any pooled fund established and maintained by the Partners as a pooled fund in accordance with the Regulations, and as set out in the relevant Scheme Specification.

Pooled Fund Manager means such officer of the Host Partner which includes a Section 113 Officer for the Pooled Fund established under an Individual Scheme as is nominated by the Host Partner from time to time to manage the Pooled Fund in accordance with Clause [10].

Provider means a provider of any Services commissioned under the arrangements set out in this Agreement.

Provider Contracts means those contracts entered into by a Partner in order to deliver the Individual Schemes

Public Health England means the SOSH trading as Public Health England.

Quarter means each of the following periods in a Financial Year:

1 April to 30 June

1 July to 30 September

1 October to 31 December

1 January to 31 March

and "**Quarterly**" shall be interpreted accordingly.

Regulations means the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 No 617 (as amended).

Scheme Specification means a specification setting out the arrangements for an Individual Scheme agreed by the Partners to be commissioned under this Agreement.

Sensitive Personal Data means Sensitive Personal Data as defined in the 1998 Act.

Services means such health and social care services as agreed from time to time by the Partners as commissioned under the arrangements set out in this Agreement and more specifically defined in each Scheme Specification.

Services Contract means an agreement for the provision of Services entered into with a Provider by one or more of the Partners in accordance with the relevant Individual Scheme.

Service Users means those individual for whom the Partners have a responsibility to commission the Services.

SOSH means the Secretary of State for Health.

Third Party Costs means all such third party costs (including legal and other professional fees) in respect of each Individual Scheme as a Partner reasonably and properly incurs in the proper performance of its obligations under this Agreement and as agreed by the Integrated Commissioning Executive.

TUPE means the Transfer of Undertakings (Protection of Employment) Regulations 2006

Working Day means 8.00am to 6.00pm on any day except Saturday, Sunday, Christmas Day, Good Friday or a day which is a bank holiday (in England) under the Banking & Financial Dealings Act 1971.

1.2 In this Agreement, all references to any statute or statutory provision shall be deemed to include references to any statute or statutory provision which amends, extends, consolidates or replaces the same and shall include any orders, regulations, codes of practice, instruments or other subordinate legislation made thereunder and any conditions attaching thereto. Where relevant, references to English statutes and statutory provisions shall be construed as references also to equivalent statutes, statutory provisions and rules of law in other jurisdictions.

1.3 Any headings to Clauses, together with the front cover and the index are for convenience only and shall not affect the meaning of this Agreement. Unless the contrary is stated, references to Clauses and Schedules shall mean the clauses and schedules of this Agreement.

1.4 Any reference to the Partners shall include their respective statutory successors, employees and agents.

1.5 In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.

1.6 Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

1.7 In this Agreement, words importing any particular gender include all other genders, and the term "person" includes any individual, partnership, firm, trust, body corporate, government, governmental body, trust, agency, unincorporated body of persons or association and a reference to a person includes a reference to that person's successors and permitted assigns.

1.8 In this Agreement, words importing the singular only shall include the plural and vice versa.

1.9 In this Agreement, "staff" and "employees" shall have the same meaning and shall include reference to any full or part time employee or officer, director, manager and agent.

1.10 Subject to the contrary being stated expressly or implied from the context in these terms and conditions, all communication between the Partners shall be in writing.

1.11 Unless expressly stated otherwise, all monetary amounts are expressed in pounds sterling but in the event that pounds sterling is replaced as legal tender in the United Kingdom by a different currency then all monetary amounts shall be converted into such other currency at the rate prevailing on the date such other currency first became legal tender in the United Kingdom.

1.12 All references to the Agreement include (subject to all relevant approvals) a reference to the Agreement as amended, supplemented, substituted, novated or assigned from time to time.

2 TERM

2.1 This Agreement shall come into force on the Commencement Date.

2.2 This Agreement shall continue until it is terminated in accordance with Clause [22].

2.3 The duration of the arrangements for each Individual Scheme shall be as set out in the relevant Scheme Specification.

3 GENERAL PRINCIPLES

3.1 Nothing in this Agreement shall affect:

3.1.1 the liabilities of the Partners to each other or to any third parties for the exercise of their respective functions and obligations (including the Functions); or

3.1.2 any power or duty to recover charges for the provision of any services (including the Services) in the exercise of any local authority function.

3.2 The Partners agree to:

3.2.1 treat each other with respect and an equality of esteem;

3.2.2 be open with information about the performance and financial status of each; and

3.2.3 provide early information and notice about relevant problems.

3.3 For the avoidance of doubt, the aims and outcomes relating to an Individual Scheme may be set out in the relevant Scheme specification.

4 PARTNERSHIP FLEXIBILITIES

4.1 This Agreement sets out the mechanism through which the Partners will work together to establish the Pooled Fund in relation to the Individual Schemes ("the Flexibilities")

4.2 The Council delegates to the CCG and the CCG agrees to exercise, on the Council's behalf, the Health Related Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the NHS Functions.

4.3 The CCG delegates to the Council and the Council agrees to exercise on the CCG's behalf the NHS Functions to the extent necessary for the purpose of performing its obligations under this Agreement in conjunction with the Health Related Functions.

4.4 Where the powers of a Partner to delegate any of its statutory powers or functions are restricted, such limitations will automatically be deemed to apply to the relevant Scheme Specification and the Partners shall agree arrangements designed to achieve the greatest degree of delegation to the other Partner necessary for the purposes of this Agreement which is consistent with the statutory constraints.

5 FUNCTIONS

5.1 The purpose of this Agreement is to establish a framework through which the Partners can secure the provision of health and social care services in accordance with the terms of this Agreement.

5.2 This Agreement shall include such functions as shall be agreed from time to time by the Partners.

5.3 Where the Partners add a new Individual Scheme to this Agreement a Scheme Specification for each Individual Scheme shall be in the form set out in Schedule 1 shall be shall be completed and agreed between the Partners. The initial scheme specifications are set out in schedule 1 part 2.

5.4 The Partners shall not enter into a Scheme Specification in respect of an Individual Scheme unless they are satisfied that the Individual Scheme in question will improve health and well-being in accordance with this Agreement.

5.5 The introduction of any Individual Scheme will be subject to business case approval by the Integrated Commissioning Executive, [subject to any further requirement to report back to the Health and Wellbeing Board as set out in Schedule 2.

6 COMMISSIONING ARRANGEMENTS

6.1 The Partners shall comply with the arrangements in respect of commissioning as set out in the relevant Scheme Specification.

6.2 The Integrated Commissioning Executive will report back to the Health and Wellbeing Board as required by its terms of reference.

7 ESTABLISHMENT OF A POOLED FUND

7.1 In exercise of their respective powers under Section 75 of the 2006 Act, the Partners have agreed to establish and maintain such pooled funds for revenue expenditure as set out in the Scheme Specifications.

7.2 Pooled Fund shall be managed and maintained in accordance with the terms of this Agreement.

7.3 It is agreed that the monies held in a Pooled Fund may only be expended on the following:

7.3.1 *the Contract Price;*

7.3.2 where the Council is to be the Provider, the Permitted Budget;

7.3.3 *Performance Payments*;

7.3.4 *Third Party Costs;*

7.3.5 *Approved Expenditure*

("Permitted Expenditure")

7.4 The Partners may only depart from the definition of Permitted Expenditure to include or exclude other revenue expenditure with the express written agreement of each Partner.

7.5 For the avoidance of doubt, monies held in the Pooled Fund may not be expended on Default Liabilities unless this is agreed by all Partners.

7.6 Pursuant to this Agreement, the Partners agree to appoint a Host Partner for the Pooled Fund as set out in the Scheme Specifications. The Host Partner shall be the Partner responsible for:

7.6.1 holding all monies contributed to the Pooled Fund on behalf of itself and the other Partners;

7.6.2 providing the financial administrative systems for the Pooled Fund; and

7.6.3 appointing the Pooled Fund Manager;

7.6.4 ensuring that the Pooled Fund Manager complies with its obligations under this Agreement.

8 POOLED FUND MANAGEMENT

8.1 When introducing a Pooled Fund in respect of an Individual Scheme, the Partners shall agree:

8.1.1 which of the Partners shall act as Host Partner for the purposes of Regulations 7(4) and 7(5) and shall provide the financial administrative systems for the Pooled Fund;

8.1.2 which officer of the Host Partner shall act as the Pooled Fund Manager for the purposes of Regulation 7(4) of the Regulations.

8.2 The Pooled Fund Manager in respect of each Individual Scheme where there is a Pooled Fund shall have the following duties and responsibilities:

8.2.1 the day to day operation and management of the Pooled Fund;

8.2.2 ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of this Agreement and the relevant Scheme Specification;

8.2.3 maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund;

8.2.4 ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund;

8.2.5 reporting to the Integrated Commissioning Executive as required by the Integrated Commissioning Executive and the relevant Scheme Specification;

8.2.6 ensuring action is taken to manage any projected under or overspends relating to the Scheme Specifications in accordance with this Agreement;

8.2.7 preparing and submitting to the Integrated Commissioning Executive Quarterly reports (or more frequent reports if required by the Integrated Commissioning Executive) and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Integrated Commissioning

Executive to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met.

8.2.8 preparing and submitting reports to the Health and Wellbeing Board as required by it.

8.3 In carrying out their responsibilities as provided under Clause [8.2] the Pooled Fund Manager shall have regard to the recommendations of the Integrated Commissioning Executive and shall be accountable to the Partners.

8.4 The Integrated Commissioning Executive may agree to the virement of funds between Individual Schemes.

9 NON POOLED FUNDS - NOTE THIS CLAUSE HAS BEEN DELETED AS NON-POOLED FUNDS WILL NOT BE UTILISED

10 FINANCIAL CONTRIBUTIONS

10.1 The Financial Contribution of the CCG and the Council to the Pooled Fund for the first Financial Year of operation of each Individual Scheme shall be as set out in the relevant Scheme Specification.

10.2 The Financial Contributions in each Financial Year, excluding NHS acute Payment 4 performance financial contributions, as set out in section 7 shall be paid to the fund quarterly in advance receivable the first day of the month commencing 1st April 2015.

10.3 The NHS acute Payment 4 Performance financial contributions shall be paid to the fund quarterly in arrears receivable on 1st day of the quarter commencing 1st July in accordance with the release of payment for performance to non-acute NHS commissioning as set out in the National Guidance.

10.4 The Financial Contributions of the Council will be made as set out in the each Scheme Specification.

10.5 With the exception of Clause [13], no provision of this Agreement shall preclude the Partners from making additional contributions of Non-Recurrent Payments to the Pooled Fund from time to time by mutual agreement. Any such additional contributions of Non-Recurrent Payments shall be explicitly recorded in Integrated Commissioning Executive minutes and recorded in the budget statement as a separate item.

11 FURTHER CONTRIBUTIONS

11.1 The Scheme Specification shall set out any further contributions of each Partner to cover including staff (including the Pooled Fund Manager), premises, IT support and other non-financial resources necessary to perform its obligations pursuant to this Agreement (including, but not limited to, management of service contracts and the Pooled Fund).

12 RISK SHARE ARRANGMENTS, OVERSPENDS AND UNDERSPENDS

Risk share arrangements

12.1 The partners have agreed risk share arrangements as set out in schedule 3, which provide for financial risks arising within the Individual Schemes of the Pooled Fund and the financial risk to the pool arising from the payment for performance element of the Better Care Fund.

Overspends in Pooled Fund

12.2 Subject to Clause [12.2], the Host Partner for the Pooled Fund shall manage expenditure from the Pooled Fund within the Financial Contributions and shall ensure that the expenditure is limited to Permitted Expenditure.

12.3 The Host Partner shall not be in breach of its obligations under this Agreement if an Overspend of an Individual Scheme occurs PROVIDED THAT the only expenditure from that Individual Scheme has been in accordance with Permitted Expenditure and it has informed the Integrated Commissioning Executive in accordance with Clause 12.4.

12.4 In the event that the Pooled Fund Manager identifies an actual or projected Overspend the Pooled Fund Manager must ensure that the Integrated Commissioning Executive is informed as soon as reasonably possible and the provisions of the relevant Scheme Specification and Schedule 3 shall apply.

Underspend

12.5 In the event that expenditure from the Pooled Fund in any Financial Year is less than the aggregate value of the Financial Contributions made for that Financial Year the Partners shall agree how the surplus monies shall be spent, carried forward and/or returned to the Partners. Such arrangements shall be subject to the Law and the Standing Orders and Standing Financial Instructions (or equivalent) of the Partners and the terms of the Performance Payment Arrangement.

13 CAPITAL EXPENDITURE

The Pooled Fund shall not normally be applied towards any one-off expenditure on goods and/or services, which will provide continuing benefit and would historically have been funded from the capital budgets of one of the Partners. If a need for capital expenditure is identified this must be agreed by the Partners.

14 VAT

The Partners shall agree the treatment of the Pooled Fund for VAT purposes in accordance with any relevant guidance from HM Customs and Excise.

15 AUDIT AND RIGHT OF ACCESS

15.1 All Partners shall promote a culture of probity and sound financial discipline and control. The Host Partner shall arrange for the audit of the accounts of the Pooled

Fund, taking note that external audit processes will change when Audit Commission is dissolved on 31 March 2015.

15.2 All internal and external auditors and all other persons authorised by the Partners will be given the right of access by them to any document, information or explanation they require from any employee, member of the Partner in order to carry out their duties. This right is not limited to financial information or accounting records and applies equally to premises or equipment used in connection with this Agreement. Access may be at any time without notice, provided there is good cause for access without notice.

16 LIABILITIES AND INSURANCE AND INDEMNITY

16.1 [Subject to Clause 16.2, and 163, if a Partner ("First Partner") incurs a Loss arising out of or in connection with this Agreement or the Services Contract as a consequence of any act or omission of another Partner ("Other Partner") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or the Services Contract then the Other Partner shall be liable to the First Partner for that Loss and shall indemnify the First Partner accordingly.

16.2 Clause 16.1 shall only apply to the extent that the acts or omissions of the Other Partner contributed to the relevant Loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other Partner acting in accordance with the instructions or requests of the First Partner or the Integrated Commissioning Executive.

16.3 If any third party makes a claim or intimates an intention to make a claim against either Partner, which may reasonably be considered as likely to give rise to liability under this Clause 16. the Partner that may claim against the other indemnifying Partner will:

16.3.1 as soon as reasonably practicable give written notice of that matter to the Other Partner specifying in reasonable detail the nature of the relevant claim;

16.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other Partner (such consent not to be unreasonably conditioned, withheld or delayed);

16.3.3 give the Other Partner and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

16.4 Each Partner shall ensure that they maintain policies of insurance (or equivalent arrangements through schemes operated by the National Health Service Litigation Authority) in respect of all potential liabilities arising from this Agreement.

16.5 Each Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

17 STANDARDS OF CONDUCT AND SERVICE

17.1 The Partners will at all times comply with Law and ensure good corporate governance in respect of each Partner (including the Partners respective Standing Orders and Standing Financial Instructions).

17.2 The Council is subject to the duty of Best Value under the Local Government Act 1999. This Agreement and the operation of the Pooled Fund is therefore subject to the Council's obligations for Best Value and the other Partners will co-operate with all reasonable requests from the Council which the Council considers necessary in order to fulfil its Best Value obligations.

17.3 The CCG is subject to the CCG Statutory Duties and these incorporate a duty of clinical governance, which is a framework through which they are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. This Agreement and the operation of the Pooled Fund is therefore subject to ensuring compliance with the CCG Statutory Duties and clinical governance obligations.

17.4 The Partners are committed to an approach to equality and equal opportunities as represented in their respective policies. The Partners will maintain and develop these policies as applied to service provision, with the aim of developing a joint strategy for all elements of the service.

18 CONFLICTS OF INTEREST

The Partners shall comply with the agreed policy for identifying and managing conflicts of interest as set out in schedule 7.

19 GOVERNANCE

19.1 Overall strategic oversight of partnership working between the partners is vested in the Health and Wellbeing Board, which for these purposes shall make recommendations to the Partners as to any action it considers necessary.

19.2 The Partners have established a Integrated Commissioning Executive to meet the roles and obligations set out in schedule 2.

19.3 The Integrated Commissioning Executive is based on a joint working group structure. Each member of the Integrated Commissioning Executive shall be an officer of one of the Partners and will have individual delegated responsibility from the Partner employing them to make decisions which enable the Integrated Commissioning Executive to carry out its objects, roles, duties and functions as set out in this Clause 19 and Schedule 2.

19.4 The terms of reference of the Integrated Commissioning Executive shall be as set out in Schedule 2.

19.5 Each Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each Partner's own statutory duties and organisation are complied with.

19.6 The Integrated Commissioning Executive shall be responsible for the overall approval of the Individual Scheme and Services, ensuring compliance with the Better Care Fund Plan and the strategic direction of the Better Care Fund.

19.7 Each Scheme Schedule shall confirm the governance arrangements in respect of the Individual Scheme (and related Service) and how that Individual Scheme (and related Service) is reported to the Integrated Commissioning Executive and Health and Wellbeing Board.

19.8 Each Scheme Schedule shall confirm the governance arrangements in respect of the Individual Scheme (and related Service) and how that Individual Scheme (and related Service) is reported to the Integrated Commissioning Executive and Health and Wellbeing Board.

20 REVIEW

20.1 Save where the Integrated Commissioning Executive agree alternative arrangements (including alternative frequencies) the Partners shall undertake an annual review ("**Annual Review**") of the operation of this Agreement, the Pooled Fund, and the provision of the Services within 3 Months of the end of each Financial Year.

20.2 Subject to any variations to this process required by the Integrated Commissioning Executive, Annual Reviews shall be conducted in good faith and, where applicable, in accordance with the governance arrangements set out in Schedule 2.

20.3 The Partners shall within 20 Working Days of the Annual Review prepare a joint annual report documenting the matters referred to in this Clause 20. A copy of this report shall be provided to the Integrated Commissioning Executive.

20.4 In the event that the Partners fail to meet the requirements of the Better Care Fund Plan and NHS England the Partners shall provide full co-operation with NHS England to agree a recovery plan.

21 COMPLAINTS

The Partners' own complaints procedures shall apply to this Agreement. The Partners agree to assist one another in the management of complaints arising from this Agreement or the provision of the Services, in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

22 TERMINATION & DEFAULT

22.1 This Agreement may be terminated by any Partner giving not less than 3 Months' notice in writing to terminate this Agreement provided that such termination shall not take effect prior to the termination or expiry of all Individual Schemes.

22.2 Each Individual Scheme may be terminated in accordance with the terms set out in the relevant Scheme Specification provided that the Partners ensure that the Better Care Fund requirements continue to be met.

22.3 If any Partner (“Relevant Partner”) fails to meet any of its obligations under this Agreement, the other Partner may by notice require the Relevant Partner to take such reasonable action within a reasonable timescale as the other Partner may specify to rectify such failure. Should the Relevant Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 23.

22.4 Termination of this Agreement (whether by effluxion of time or otherwise) shall be without prejudice to the Partners’ rights in respect of any antecedent breach and the provisions of Clauses [to be inserted at signing]

22.5 In the event of termination of this Agreement, the Partners agree to cooperate to ensure an orderly wind down of their joint activities and to use their best endeavours to minimise disruption to the health and social care which is provided to the Service Users.

22.6 Upon termination of this Agreement for any reason whatsoever the following shall apply:

22.6.1 the Partners agree that they will work together and co-operate to ensure that the winding down and disaggregation of any integrated and joint activities to the separate responsibilities of the Partners is carried out smoothly and with as little disruption as possible to service users, employees, the Partners and third parties, so as to minimise costs and liabilities of each Partner in doing so;

22.6.2 where either Partner has entered into a Service Contract which continues after the termination of this Agreement, both Partners shall continue to contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this;

22.6.3 the Host Partner shall make reasonable endeavours to amend or terminate a Service Contract (which shall for the avoidance of doubt not include any act or omission that would place the Host Partner in breach of the Service Contract) where the other Partner requests the same in writing Provided that the Host Partner shall not be required to make any payments to the Provider for such amendment or termination unless the Partners shall have agreed in advance who shall be responsible for any such payment.

22.6.4 where a Service Contract held by a Host Partner relates all or partially to services which relate to the other Partner's Functions then provided that the Service Contract allows the other Partner may request that the Host Partner assigns the Service Contract in whole or part upon the same terms mutatis mutandis as the original contract.

22.6.5 the Integrated Commissioning Executive shall continue to operate for the purposes of functions associated with this Agreement for the remainder of any contracts and commitments relating to this Agreement; and

22.6.6 Termination of this Agreement shall have no effect on the liability of any rights or remedies of either Partner already accrued, prior to the date upon which such termination takes effect.

22.7 In the event of termination in relation to an Individual Scheme or Service the provisions of Clause 22.6 shall apply mutatis mutandis in relation to the Individual Scheme or Service (as though references as to this Agreement were to that Individual Scheme or Service).

23 DISPUTE RESOLUTION

23.1 In the event of a dispute between the Partners arising out of this Agreement, either Partner may serve written notice of the dispute on the other Partner, setting out full details of the dispute.

23.2 The Authorised Officers shall meet in good faith as soon as possible and in any event within seven (7) days of notice of the dispute being served pursuant to Clause 23.1, at a meeting convened for the purpose of resolving the dispute.

23.3 If the dispute remains after the meeting detailed in Clause 23.1 has taken place, the Chief Executive of the Council (or nominee) and the Accountable Officer of the CCG (or nominee) shall meet in good faith as soon as possible after the relevant meeting and in any event with fourteen (14) days of the date of the meeting, for the purpose of resolving the dispute.

23.4 If the dispute remains after the meeting detailed in Clause 23.3 has taken place, then the Partners will attempt to settle such dispute by mediation in accordance with the CEDR Model Mediation Procedure or any other model mediation procedure as agreed by the Partners. To initiate a mediation, either Partner may give notice in writing (a **"Mediation Notice"**) to the other requesting mediation of the dispute and shall send a copy thereof to CEDR or an equivalent mediation organisation as agreed by the Partners asking them to nominate a mediator. The mediation shall commence within twenty (20) Working Days of the Mediation Notice being served. Neither Partner will terminate such mediation until each of them has made its opening presentation and the mediator has met each of them separately for at least one (1) hour. Thereafter, paragraph 14 of the Model Mediation Procedure will apply (or the equivalent paragraph of any other model mediation procedure agreed by the Partners). The Partners will co-operate with any person appointed as mediator, providing him with such information and other assistance as he shall require and will pay his costs as he shall determine or in the absence of such determination such costs will be shared equally.

23.5 Nothing in the procedure set out in this Clause 23 shall in any way affect either Partner's right to terminate this Agreement in accordance with any of its terms or take immediate legal action.

24 FORCE MAJEURE

24.1 Neither Partner shall be entitled to bring a claim for a breach of obligations under this Agreement by the other Partner or incur any liability to the other Partner for any losses or damages incurred by that Partner to the extent that a Force Majeure Event occurs and it is prevented from carrying out its obligations by that Force Majeure Event.

24.2 On the occurrence of a Force Majeure Event, the Affected Partner shall notify the other Partner as soon as practicable. Such notification shall include details of the Force Majeure Event, including evidence of its effect on the obligations of the Affected Partner and any action proposed to mitigate its effect.

24.3 As soon as practicable, following notification as detailed in Clause 24.2, the Partners shall consult with each other in good faith and use all best endeavours to agree appropriate terms to mitigate the effects of the Force Majeure Event and, subject to Clause 24.4, facilitate the continued performance of the Agreement.

24.4 If the Force Majeure Event continues for a period of more than sixty (60) days, either Partner shall have the right to terminate the Agreement by giving fourteen (14) days written notice of termination to the other Partner. For the avoidance of doubt, no compensation shall be payable by either Partner as a direct consequence of this Agreement being terminated in accordance with this Clause.

25 CONFIDENTIALITY

25.1 In respect of any Confidential Information a Partner receives from another Partner (the "**Discloser**") and subject always to the remainder of this Clause 25, each Partner (the "**Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

25.1.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the Commencement Date; and

25.1.2 the provisions of this Clause 25 shall not apply to any Confidential Information which:

(a) is in or enters the public domain other than by breach of the Agreement or other act or omission of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information.

25.2 Nothing in this Clause 25 shall prevent the Recipient from disclosing Confidential Information where it is required to do so in fulfilment of statutory obligations or by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable Law.

25.3 Each Partner:

25.3.1 may only disclose Confidential Information to its employees and professional advisors to the extent strictly necessary for such employees to carry out their duties under the Agreement; and

25.3.2 will ensure that, where Confidential Information is disclosed in accordance with Clause 25.3.1, the recipient(s) of that information is made subject to a duty of confidentiality equivalent to that contained in this Clause 25;

25.3.3 shall not use Confidential Information other than strictly for the performance of its obligations under this Agreement.

26 FREEDOM OF INFORMATION AND ENVIRONMENTAL PROTECTION REGULATIONS

26.1 The Partners agree that they will each cooperate with each other to enable any Partner receiving a request for information under the 2000 Act or the 2004 Act to respond to a request promptly and within the statutory timescales. This cooperation shall include but not be limited to finding, retrieving and supplying information held, directing requests to other Partners as appropriate and responding to any requests by the Partner receiving a request for comments or other assistance.

26.2 Any and all agreements between the Partners as to confidentiality shall be subject to their duties under the 2000 Act and 2004 Act. No Partner shall be in breach of Clause 26 if it makes disclosures of information in accordance with the 2000 Act and/or 2004 Act.

27 OMBUDSMEN

The Partners will co-operate with any investigation undertaken by the Health Service Commissioner for England or the Local Government Commissioner for England (or both of them) in connection with this Agreement.

28 INFORMATION SHARING

The Partners will follow the Information Governance Protocol set out in schedule 8, and in so doing will ensure that the operation this Agreement complies comply with Law, in particular the 1998 Act**.**

29 NOTICES

29.1 Any notice to be given under this Agreement shall either be delivered personally or sent by facsimile or sent by first class post or electronic mail. The address for service of each Partner shall be as set out in Clause 29.3 or such other address as each Partner may previously have notified to the other Partner in writing. A notice shall be deemed to have been served if:

29.1.1 personally delivered, at the time of delivery;

29.1.2 sent by facsimile, at the time of transmission;

29.1.3 posted, at the expiration of forty eight (48) hours after the envelope containing the same was delivered into the custody of the postal authorities; and

29.1.4 if sent by electronic mail, at the time of transmission and a telephone call must be made to the recipient warning the recipient that an electronic mail message has been sent to him (as evidenced by a contemporaneous note of the Partner sending the notice) and a hard copy of such notice is also sent by first class recorded delivery post (airmail if overseas) on the same day as that on which the electronic mail is sent.

29.2 In proving such service, it shall be sufficient to prove that personal delivery was made, or that the envelope containing such notice was properly addressed and delivered into the custody of the postal authority as prepaid first class or airmail letter (as appropriate), or that the facsimile was transmitted on a tested line or that the correct transmission report was received from the facsimile machine sending the notice, or that the electronic mail was properly addressed and no message was received informing the sender that it had not been received by the recipient (as the case may be).

29.3 The address for service of notices as referred to in Clause 29.1 shall be as follows unless otherwise notified to the other Partner in writing:

29.3.1 if to the Council, addressed to the Director of Adults, Health and Commissioning, Thurrock Borough Council, Civic Offices, New Road Grays, Essex, RM17 6SL;

Tel: 01375 364029
E.Mail: rharris@thurrock.gov.uk

and

29.3.2 if to the CCG, addressed to the Chief Operating Officer, Thurrock CCG, 2nd Floor Civic Offices, New Road Grays, Essex, RM17 6SL;

Tel: 01375 365810
Email: thurrock.ccg@nhs.net

30 VARIATION

No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each of the Partners.

31 CHANGE IN LAW

31.1 The Partners shall ascertain, observe, perform and comply with all relevant Laws, and shall do and execute or cause to be done and executed all acts required to be done under or by virtue of any Laws.

31.2 On the occurrence of any Change in Law, the Partners shall agree in good faith any amendment required to this Agreement as a result of the Change in Law subject to the Partners using all reasonable endeavours to mitigate the adverse effects of such Change in Law and taking all reasonable steps to minimise any increase in costs arising from such Change in Law.

31.3 In the event of failure by the Partners to agree the relevant amendments to the Agreement (as appropriate), the Clause 23 (Dispute Resolution) shall apply.

32 WAIVER

No failure or delay by any Partner to exercise any right, power or remedy will operate as a waiver of it nor will any partial exercise preclude any further exercise of the same or of some other right to remedy.

33 SEVERANCE

If any provision of this Agreement, not being of a fundamental nature, shall be held to be illegal or unenforceable, the enforceability of the remainder of this Agreement shall not thereby be affected.

34 ASSIGNMENT AND SUB CONTRACTING

The Partners shall not sub contract, assign or transfer the whole or any part of this Agreement, without the prior written consent of the other Partners, which shall not be unreasonably withheld or delayed. This shall not apply to any assignment to a statutory successor of all or part of a Partner's statutory functions.

35 EXCLUSION OF PARTNERSHIP AND AGENCY

35.1 Nothing in this Agreement shall create or be deemed to create a partnership under the Partnership Act 1890 or the Limited Partnership Act 1907, a joint venture or the relationship of employer and employee between the Partners or render either Partner directly liable to any third party for the debts, liabilities or obligations of the other.

35.2 Except as expressly provided otherwise in this Agreement or where the context or any statutory provision otherwise necessarily requires, neither Partner will have authority to, or hold itself out as having authority to:

35.2.1 act as an agent of the other;

35.2.2 make any representations or give any warranties to third parties on behalf of or in respect of the other; or

35.2.3 bind the other in any way.

36 THIRD PARTY RIGHTS

Unless the right of enforcement is expressly provided, no third party shall have the right to pursue any right under this Contract pursuant to the Contracts (Rights of Third Parties) Act 1999 or otherwise.

37 ENTIRE AGREEMENT

37.1 The terms herein contained together with the contents of the Schedules constitute the complete agreement between the Partners with respect to the subject matter hereof and supersede all previous communications representations understandings and agreement and any representation promise or condition not incorporated herein shall not be binding on any Partner.

37.2 No agreement or understanding varying or extending or pursuant to any of the terms or provisions hereof shall be binding upon any Partner unless in writing and signed by a duly authorised officer or representative of the parties.

38 COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all Partners shall constitute a full original of this Agreement for all purposes.

39 GOVERNING LAW AND JURISDICTION

39.1 This Agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the laws of England and Wales.

39.2 Subject to Clause 23 (Dispute Resolution), the Partners irrevocably agree that the courts of England and Wales shall have exclusive jurisdiction to hear and settle any action, suit, proceedings, dispute or claim, which may arises out of, or in connection with, this Agreement, its subject matter or formation (including non-contractual disputes or claims).

IN WITNESS WHEREOF this Agreement has been executed by the Partners on the date of this Agreement

THE CORPORATE SEAL of)
THURROCK COUNCIL)
was hereunto affixed in the)
presence of:

Signed for on behalf of **THURROCK CLINICAL COMMISSIONING GROUP**

____

Authorised Signatory

SCHEDULE 1 – SCHEME SPECIFICATION

– Template Scheme Schedule

TEMPLATE SCHEME SCHEDULE

Unless the context otherwise requires, the defined terms used in this Scheme Specification shall have the meanings set out in the Agreement.

1 OVERVIEW OF INDIVIDUAL SCHEME

Insert details including:

(a) Name of the Individual Scheme
(b) Relevant context and background information
(c) Whether there are Pooled Funds:

The Host Partner for Pooled Fund X is [ ] and the Pooled Fund Manager, being an officer of the Host Partner is [ ]

2 AIMS AND OUTCOMES

Insert agreed aims of the Individual Scheme

3 THE ARRANGEMENTS

Set out which of the following applies in relation to the Individual Scheme:

(1) Lead Commissioning;
(2) Integrated Commissioning;
(3) Joint (Aligned) Commissioning;
(4) the establishment of one or more Pooled Funds as may be required.

4 FUNCTIONS

Set out the Council's Functions and the CCG's Functions which are the subject of the Individual Scheme including where appropriate the delegation of such functions for the commissioning of the relevant service.

Consider whether there are any exclusions from the standard functions included (see definition of NHS Functions and Council Health Related Functions)

5 SERVICES

What Services are going to be provided within this Scheme. ?
Are there contracts already in place?
Are there any plans or agreed actions to change the Services?
Who are the beneficiaries of the Services? [1]

[1] This may be limited by service line –i.e. individuals with a diagnosis of dementia. There is also a significant issue around individuals who are the responsibility of the local authority but not the CCG and Vice versa See note [ ] above

6 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

Set out what arrangements will be in place in relation to Lead Commissioning/Joint (Aligned) commissioning. How will these arrangements work?

Contracting Arrangements

Insert the following information about the Individual Scheme:

relevant contracts

arrangements for contracting. Will terms be agreed by both partners or will the Lead Commissioner have authority to agree terms

what contract management arrangements have been agreed?
What happens if the Agreement terminates? Can the partner terminate the Contract in full/part?
Can the Contract be assigned in full/part to the other Partner?

Access
Set out details of the Service Users to whom the Individual Scheme relates. How will individuals be assessed as eligible.

7 FINANCIAL CONTRIBUTIONS

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		
Pooled Fund Y		

Financial Year 201…./201

	CCG contribution	Council Contribution
Non-Pooled Fund A		
Non-Pooled Fund B		
Non-Pooled Fund C		
Pooled Fund X		

	CCG contribution	Council Contribution
Pooled Fund Y		

Financial resources in subsequent years to be determined in accordance with the Agreement

8 FINANCIAL GOVERNANCE ARRANGEMENTS

[(1) As in the Agreement with the following changes:

(2) Management of the Pooled Fund

Are any amendments required to the Agreement in relation to the management of Pooled Fund
Have the levels of contributions been agreed?
How will changes to the levels of contributions be implemented?
Have eligibility criteria been established?
What are the rules about access to the pooled budget?
Does the pooled fund manager require training?
Have the pooled fund managers delegated powers been determined?
Is there a protocol for disputes?

(3) Audit Arrangements

What Audit arrangements are needed?
Has an internal auditor been appointed?
Who will liaise with/manage the auditors?
Whose external audit regime will apply?

(4) Financial Management

Which financial systems will be used?
What monitoring arrangements are in place?
Who will produce monitoring reports?
Has the scale of contributions to the pool been agreed?
What is the frequency of monitoring reports?
What are the rules for managing overspends?
Do budget managers have delegated powers to overspend?
Will delegated powers allow underspends recurring or non-recurring, to be transferred between budgets?
How will overspends and underspends be treated at year end?
Will there be a facility to carry forward funds?
How will pay and non pay inflation be financed?
Will a contingency reserve be maintained, and if so by whom?
How will efficiency savings be managed?
How will revenue and capital investment be managed?
Who is responsible for means testing?
Who will own capital assets?
How will capital investments be financed?

What management costs can legitimately be charged to pool?
What re the arrangement for overheads?
What will happen to the existing capital programme?
What will happen on transfer where if resources exceed current liability (i.e. commitments exceed budget) immediate overspend secure?
Has the calculation methodology for recharges been defined?
*What closure of accounts arrangement need to be applied?]*2

9 VAT

Set out details of the treatment of VAT in respect of the Individual Service consider the following:

- *Which partner's VAT regime will apply?*
- *Is one partner acting as 'agent' for another?*
- *Have partners confirmed the format of documentation, reporting and*
- *accounting to be used?*

10 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

Will there be a relevant Committee/Board/Group that reviews this Individual Scheme?
Who does that group report to?
Who will report to that Group?

Pending arrangements agreed in the Partnership Agreement, including the role of the Health & Wellbeing Board, Partners to confirm any bespoke management arrangements for the Individual Scheme

11 FURTHER RESOURCES

Council contribution

	Details	Charging arrangements[3]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

CCG Contribution

[2] We note that some of the information overlaps with the information that is included in the main body of Agreement, however, we consider it is appropriate that this is considered for each Scheme in order to determine whether the overarching arrangements should apply.

[3] Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no "mixing" of resources

	Details	Charging arrangements[4]	Comments
Premises			
Assets and equipment			
Contracts			
Central support services			

12 STAFF

Consider:

- *Who will employ the staff in the partnership?*
- *Is a TUPE transfer secondment required?*
- *How will staff increments be managed?*
- *Have pension arrangements been considered?*

Council staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the CCG.

If the staff are being seconded to the CCG this should be made clear

CCG staff to be made available to the arrangements

Please make it clear if these are staff that are transferring under TUPE to the Council.

If the staff are being seconded to the Council this should be made clear.

13 ASSURANCE AND MONITORING

Set out the assurance framework in relation to the Individual Scheme. What are the arrangements for the management of performance? Will this be through the agreed performance measures in relation to the Individual Scheme.
In relation to the Better Care Fund you will need to include the relevant performance outcomes. Consider the following:

- *What is the overarching assurance framework in relation to the Individual Scheme?*
- *Has a risk management strategy been drawn up?*
- *Have performance measures been set up?*
- *Who will monitor performance?*
- *Have the form and frequency of monitoring information been agreed?*
- *Who will provide the monitoring information? Who will receive it?*

4 Are these to be provided free of charge or is there to a charge made to a relevant fund. Where there are aligned budgets any recharge will need to be allocated between the CCG Budget and the Council Budget on such a basis that there is no “mixing” of resources

14 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council					
CCG					

15 INTERNAL APPROVALS

- *Consider the levels of authority from the Council's Constitution and the CCG's standing orders, scheme of delegation and standing financial instructions in relation to the Individual Scheme;*
- *Consider the scope of authority of the Pool Manager and the Lead Officers*
- *Has an agreement been approved by cabinet bodies and signed?*

16 RISK AND BENEFIT SHARE ARRANGEMENTS

Has a risk management strategy been drawn up?
Set out arrangements, if any, for the sharing of risk and benefit in relation to the Individual Scheme.

17 REGULATORY REQUIREMENTS

Are there any regulatory requirements that should be noted in respect of this particular Individual Scheme?

18 INFORMATION SHARING AND COMMUNICATION

What are the information/data sharing arrangements?
How will charges be managed (which should be referred to in Part 2 above)
What data systems will be used?

Consultation – staff, people supported by the Partners, unions, providers, public, other agency
Printed stationary

19 DURATION AND EXIT STRATEGY

What are the arrangements for the variation or termination of the Individual Scheme.
Can part/all of the Individual Scheme be terminated on notice by a party? Can part/all of the Individual Scheme be terminated as a result of breach by either Partner?
What is the duration of these arrangements?

Set out what arrangements will apply upon termination of the Individual Service, including without limitation the following matters addressed in the main body of the Agreement

(1) maintaining continuity of Services;

(2) allocation and/or disposal of any equipment relating to the Individual Scheme;

(3) responsibility for debts and on-going contracts;

(4) responsibility for the continuance of contract arrangements with Service Providers (subject to the agreement of any Partner to continue contributing to the costs of the contract arrangements);

(5) where appropriate, the responsibility for the sharing of the liabilities incurred by the Partners with the responsibility for commissioning the Services and/or the Host Partners.

Consider also arrangements for dealing with premises, records, information sharing (and the connection with staffing provisions set out in the Agreement.

20 OTHER PROVISIONS

Consider, for example:

- *Any variations to the provisions of the Agreement*
- *Bespoke arrangements for the treatment of records*
- *Safeguarding arrangements*

PART 2 – AGREED SCHEME SPECIFICATIONS

[Scheme Specifications will be prepared in line with the Better Care Fund Plan]

SCHEDULE 2 – GOVERNANCE

1 Integrated Commissioning Executive

The membership of the Integrated Commissioning Executive will be as follows:

CCG:

- Mandy Ansell (Chief Operating Officer(CCG)) or her successor
- Ade Olarinde (Chief Finance Officer) or his successor
- Mark Tebbs (Head of Integrated Commissioning) or his successor

or a deputy to be notified to the other members in advance of any meeting;

the Council:

- Roger Harris (Director of Adult Health and Commissioning) or his successor
- Sean Clark (Head of Finance) or his successor
- Catherine Wilson (Strategic Lead for Commissioning) or her successor

or a deputy to be notified in writing to Chair in advance of any meeting;

2 Role of Integrated Commissioning Executive

3 The Integrated Commissioning Executive shall:

Provide strategic direction on the Individual Schemes

receive the financial and activity information;

review the operation of this Agreement, including by way of formal Annual Review, and performance manage the Individual Services;

agree such variations to this Agreement from time to time as it thinks fit;

review risks Quarterly and agree annually a risk assessment and a Performance Payment protocol;

review and agree annually revised Schedules as necessary; and

request such protocols and guidance as it may consider necessary in order to enable the Pooled Fund Manager to approve expenditure from the Pooled Fund;

4 Integrated Commissioning Executive Support

The Integrated Commissioning Executive will be supported by officers from the Partners from time to time.

5 Meetings

The Integrated Commissioning Executive will meet at least Quarterly at a time to be agreed within following receipt of each Quarterly report or other reports of the Pooled Fund Manager.

The quorum for meetings of the Integrated Commissioning Executive shall be a minimum of two representatives from each of the Partner organisations. Attendees may attend meetings via telephone or teleconference facility.

Decisions of the Integrated Commissioning Executive shall be made unanimously. Where unanimity is not reached then the item in question will in the first instance be referred to the next meeting of the Integrated Commissioning Executive. If no unanimity is reached on the second occasion it is discussed then the matter shall be dealt with in accordance with the dispute resolution procedure set out in the Agreement.

Minutes of all decisions shall be kept and copied to the Authorised Officers within seven (7) days of every meeting.

6 Delegated Authority

The Integrated Commissioning Executive is authorised within the limit of delegated authority for its members (which is received through their respective organisation's own financial scheme of delegation) to authorise an officer of the Host Partner to enter into any contract for services necessary for the provision of Services under an Individual Scheme.

7 Information and Reports

The Pooled Fund Manager shall supply to the Integrated Commissioning Executive on a Quarterly basis the financial and activity information as required under the Agreement.

8 Post-termination

The Integrated Commissioning Executive shall continue to operate in accordance with this Schedule following any termination of this Agreement but shall endeavour to ensure that the benefits of any contracts are received by the Partners in the same proportions as their respective contributions at that time.

9 Extra-Ordinary or Urgent Meetings

If there are urgent or extra-ordinary matters to be considered the Integrated Commissioning Executive may choose to meet between the Quarterly interval in order to take decisions on urgent issues.

10. Annual Governance Statement

The Integrated Commissioning Executive will prepare an annual governance statement, which will be included in a report to the Health and Wellbeing Board, on an annual basis.

SCHEDULE 3 – RISK SHARE AND OVERSPENDS

Pooled Fund Management

Overspend

1 The Integrated Commissioning Executive shall consider what action to take in respect of any actual or potential Overspends

2 The Integrated Commissioning Executive shall acting reasonably having taken into consideration all relevant factors including, where appropriate the Better Care Fund Plan and any agreed outcomes and any other budgetary constraints agree appropriate action in relation to Overspends which may include the following:

whether there is any action that can be taken in order to contain expenditure;

whether there are any underspends that can be dealt with by virement to or from any Individual Scheme maintained under this Agreement;

Subject to clause [3] below, how any Overspend shall be apportioned between the Partners, such apportionment to be just and equitable taking into consideration all relevant factors.

3 The Partners will adopt the position agreed by the Health and Wellbeing Board, that the Better Care Fund for 2015/16 (and any subsequent years if extended) should be fixed at the agreed value of the Pooled Fund (as set out in the Scheme Specifications), with the effect that any expenditure above the value of the Pooled Fund should fall to the Council or the CCG depending on whether the expenditure is incurred on the Health Related Functions (in which case the Council will be liable) or NHS Functions (in which case the CCG will be liable).

Payment for Performance

4 The Partners will manage the risk of under-performance against the total emergency admissions target set locally, in accordance with the approach agreed by the Health and Wellbeing Board, and set out in the Thurrock BCF Plan. In particular the approach will be that it is managed by delaying expenditure commitments in relation to the BCF Scheme 7 (Payment for Performance), equivalent to the target, until the target is achieved, and payment of the target sum can be released into the Pooled Fund by NHS Thurrock CCG. Where the target is achieved, the payment for performance element of the fund will be used as a contribution to the protection of adult social care.

5 **Reputational Risk**

Both Partners have plans and policies in place to manage reputational issues. Each Partner will co-operate with the other in managing any reputational risk that may arise with that other Partner.

6. **Clinical Liability**

For the avoidance of doubt, the Partners agree that the Council will not be liable for Losses or Default Liability arising from the performing or overseeing of certain clinical tasks, such as clinical/medical diagnosis, or the prescription of medicine ("Clinical Liability"). It is recognised by the Partners that the Council is not able to source appropriate insurance for Clinical Liability. Clinical Liability will be met by the contractor or provider performing or overseeing these tasks, if there is one, or failing same it will be met by the CCG, which will ensure appropriate insurance is in place for same.

SCHEDULE 4 – JOINT WORKING OBLIGATIONS

– CO-ORDINATING COMMISSIONER OBLIGATIONS

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

1 The Co-ordinating Commissioner shall notify the other Partners if it receives or serves:

a Change in Control Notice;
a Notice of a Event of Force Majeure;
a Contract Query;
Exception Reports

and provide copies of the same.

2 The Co-ordinating Commissioner shall provide the other Partners with copies of any and all:

CQUIN Performance Reports;
Monthly Activity Reports;
Review Records; and
Remedial Action Plans;
JI Reports;
Service Quality Performance Report
;

3 The Co-ordinating Commissioner shall invite the other Partners to attend any and all:

Activity Management Meetings;
Contract Management Meetings;
Review Meetings;

and, ,to raise issues reasonably at those meetings in line with the objectives of this agreement.

4 The Co-ordinating Commissioner shall not:

vary any Provider Plans (excluding Remedial Action Plans);
agree (or vary) the terms of a Joint Investigation or a Joint Action Plan;
give any approvals under the Service Contract;
agree to or propose any variation to the Service Contract (including any Schedule or Appendices);
suspend all or part of the Services;
serve any notice to terminate the Service Contract (in whole or in part);
serve any notice;
agree (or vary) the terms of a Succession Plan;

without the prior approval of the other Partners (acting through the Integrated Commissioning Executive) such approval not to be unreasonably withheld or delayed.

5 The Co-ordinating Commissioner shall advise the other Partners of any matter which has been referred for dispute and agree what (if any) matters will require the prior approval of one or more of the other Partners as part of that process.

6 The Co-ordinating Commissioner shall notify the other Partners of the outcome of any Dispute that is agreed or determined by Dispute Resolution.

7 The Co-ordinating Commissioner shall share copies of any reports submitted by the Service Provider to the Lead Commissioner pursuant to the Service Contract (including audit reports).

8 The Co-ordinating Commissioner shall report to the other Partners on the performance of the Individual Schemes in relation to:

reduction in non-elective activity (general and acute)
admissions to residential care homes
effectiveness of reablement
delayed transfers of care
patient/ service user experience

– OBLIGATIONS OF THE OTHER PARTNER

Terminology used in this Schedule shall have the meaning attributed to it in the NHS Standard Form Contract save where this Agreement or the context requires otherwise.

9 The other Partner shall (at its own cost) provide such cooperation, assistance and support to the Co-ordinating Commissioner (including the provision of data and other information) as is reasonably necessary to enable the Co-ordinating Commissioner to:

resolve disputes pursuant to a Service Contract;
comply with its obligations pursuant to a Service Contract and this Agreement;
ensure continuity and a smooth transfer of any Services that have been suspended, expired or terminated pursuant to the terms of the relevant Service Contract;

10 No Partner shall unreasonably withhold or delay consent requested by the Co-ordinating Commissioner.

11 Each Partner (other than the Co-ordinating Commissioner) shall:

comply with the requirements imposed on the Co-ordinating Commissioner pursuant to the relevant Service Contract in relation to any information disclosed to the other Partners;
notify the Co-ordinating Commissioner of any matters that might prevent the Co-ordinating Commissioner from giving any of the warranties set out in a Services Contract or which might cause the Co-ordinating Commissioner to be in breach of warranty.

SCHEDULE 5 – PERFORMANCE ARRANGMENTS

1. Introduction and context

Thurrock Council and Thurrock Clinical Commissioning Group (CCG) have expressed a clear intention to develop a more integrated approach to performance that encompasses the achievement of key objectives contained within the Better Care Fund (BCF) and other related enabling strategies.

This schedule outlines the approach to implementing a new health and social care performance scorecard. The primary aim of the scorecard will be to monitor the BCF core measures and related health, social care and public health measures contained within local strategies. It will also ensure a clear alignment with national outcomes frameworks.

The scorecard will provide a regular update to the Thurrock Integrated Commissioning Executive (ICE) and Council / CCG Boards on the performance of the BCF and related priorities. It will also be presented to the Health and Well-Being Board to enable a line of sight into health and social care performance.

2. Principles

- The Integrated Commissioning Executive (ICE) will be accountable for the scorecard and report
- Clear ownership and accountability will be established for performance measures
- Main performance monitoring tool for the Better Care Fund – replacing those currently in use
- Support integration between social care, health and public health performance measures
- Collaboration in production of the scorecard to facilitate provision of insightful commentary
- Accessible and proportionate
- Enable benchmarking with other areas

3. Alignment with national outcomes frameworks

The health and social care scorecard adopts relevant measures from the NHS, ASC and Public Health outcome frameworks where these align with local priorities. The core BCF measures also correlate with the outcome frameworks.

4. Commissioned services

Clear expectations for commissioned services and schemes post April 2015 will be set out in formal performance specifications as part of contract agreements (s75). Services / providers will be held to account for delivery of key performance measures and outcomes in relation to relevant schemes/services. Where appropriate and of benefit, these will link into the reporting process. Further detail on this is expected following the planned Whole System Re-Design Workshop in January 2015 and the outputs of the review of existing s256 schemes.

5. Suggested content and measures

Provisional scorecards are attached in appendix 1. The worksheet format is not final and is merely illustrative for the purposes of this agreement. The first worksheet is the BCF core measures scorecard. The second worksheet brings together related health, social care and public health measures. These are shown as an initial foundation for their links to both local and national priorities. Further discussion is needed with the ICE and relevant officers to firm up measures for inclusion.

The first four Schemes of the BCF relate to health and social transformation and scaling up integration between health and social care. These are Locality Service Integration, Frailty Model, Intermediate Care and Prevention and Early Intervention.

Consideration has been given to aligning indicators to these Schemes. However, given the cross-cutting nature of the objectives and planned outcomes this has proved difficult – the majority of measures can be used to measure success in all four Schemes.

Instead we intend to use the outcomes themes of the national NHS, adult social care and public health outcomes frameworks. However, this can be reconsidered.

6. Proposed reporting structure and process

The proposed reporting process is set out in the table below. The Data and Intelligence Group (DIG) (or similar group incorporating performance leads) will be responsible for the design, collation, updating and compiling of the scorecard and supporting reports.

Service leads will be responsible for provision of commentary.

Thurrock ICE will be responsible for review and sign off scorecard and reports.

The DIG will also support the ongoing development of the scorecard and report e.g. ensuring it continues to meet local priorities and supporting ad-hoc analysis into particular issues and questions (resource allowing).

The ICE and DIG will work together to facilitate collaborative working on performance issues, areas of shared interest and additional in-depth analysis activity.

Reporting process

When	What	Where
Monthly	• BCF core measures scorecard • Key health, adult social care and public health measures • Monthly progress/highlights plus commentary on core measures	• Integrated Commissioning Executive (ICE)

Quarterly	• BCF core measures scorecard
	• Key health, adult social care and public health measures
	• Expanded report taking into account:
	  • Additional commentary and analysis
	  • Improvement actions e.g. scope for more detailed service input
	  • Supplementary information e.g. from commissioned services
		• Integrated Commissioning Executive (ICE)
		• ASC DMT
		• CCG Board
		• Health & Well-Being Board

Mid Year / Annual	• BCF core measures scorecard
	• Key health, adult social care and public health measures
	• Expanded report taking into account:
	  • Nationally available data
	  • Benchmarking and comparative analysis e.g. trends
	  • Additional commentary and analysis
	  • Improvement actions e.g. scope for more detailed service input
	  • Supplementary information e.g. from commissioned services
		• Integrated Commissioning Executive (ICE)
		• ASC DMT
		• CCG Board
		• Health & Well-Being Board

Health and Social Care Performance Scorecard - Better Care Fund Measures

Performance Measure	Previous Outturn	Target / Plan	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Year To Date	RAG Against Target	Direction of Travel
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	13,846 (Jan 14-Dec 14)	3.5% reduction on 2014 outturn (13,361)															
Comments:																	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	644.9 (13-14)	603.5 (14-15) 587.6 (15-16)															
Comments:																	
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	622.7 (13-14) calc. from quarterly outturns)	622.6 (14-15) calc. from quarterly outturns)															
Comments:																	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	89.9 (13-14)	90.3 (14-15) 90.9 (15-16)															
Comments:																	
Reduction in the proportion of people (aged 65+) assesssed by RRAS that require immediate hospital admission per 10,000 population aged 65+	41.3 (13-14)	35.7 (14-15) 34.8 (15-16)															
Comments:																	

DRAFT

Health and Social Care Performance Scorecard (Draft Only)																			
Ref	Indicator	Freq.	Previous Outturn	Current England Avg	14/15 Target / Plan	Quarter 4			Quarter 1			Quarter 2			Quarter 3			RAG Against Target	DOT
						Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15		
Adult Social Care Outcome 1 - Quality of life for people with care and support needs / NHS Outcome 2 - Quality of life for people with long term conditions / Public Health Outcome 1 - Improving the wider determinants of health																			
ASC1B	% of people who use ASC services who reported that they have control over their daily life	A																	
NHS2	Health related quality of life for people with long term conditions	A																	
NHS2.1	% of people feeling supported to manage their long term condition	A																	
ASC1D / NHS2.4	Carer reported quality of life	A																	
ASC1C	% of people receiving self directed support	M																	
ASC1Ca	% of people receiving direct payments	M																	
ASC1Cb	% of carers receiving direct payments	M																	
Adult Social Care Outcome 2 - Delaying and reducing the need for care and support / NHS Outcome 3 - Helping people to recover from episodes of ill-health or following injury / Public Health Outcome 1 - Improving the wider determinants of health																			
ASC2Aa	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	M																	
ASC2Ab	Permanent admissions of older people (aged 18-64) to residential and nursing care homes, per 100,000 population	M																	
NHS3a	Emergency admissions for acute conditions that should not usually require hospital admission																		
NHS3b / PH4.11	Emergency readmissions within 30 days of discharge from hospital																		
	% reduction in the average length of stay for patients >75 compared to 2013/14 baseline.																		
ASC2B / NHS3.6	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Q																	
	% of reablement completions which resulted in a reduction or end in care package	M																	
2Ca	Delayed transfers of care from hospital per 100,000 population	M																	
2Cb	Delayed transfers of care from hospital per 100,000 population (attributable to ASC)	M																	
	Reduction in the proportion of people (aged 65+) assesssed by RRAS that require immediate hospital admission per 10,000 population aged 65+	M																	
	% of people supported by LACs who became volunteers	Q																	
	Number of people receiving long term support services (SALT)	M																	
	% of interim care bed departures to a) residential care, b) hospital, c) community	M																	
Adult Social Care Outcome 3 / NHS Outcome 4 - Ensuring that people have a positive experience of care and support																			
ASC3a	% of ASC service users who reported that they are satisfied with their services and support	A																	
ASC3b	% of carers who reported that they are satisfied with their services and support	A																	
ASC1I / PH1.18	% of ASC service users who reported that they have as much social contact as they would like	A																	
	% of people receiving reablement who felt the quality of their day to day life had improved following support	Q																	
	Friends and family test																		

Health and Social Care Performance Scorecard - Better Care Fund Measures

Performance Measure	Previous Outturn	Target / Plan	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Year To Date	RAG Against Target	Direction of Travel
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	13,846 (Jan 14-Dec 14)	3.5% reduction on 2014 outturn (13,361)															
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Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	622.7 (13-14) calc. from quarterly outturns)	622.6 (14-15) calc. from quarterly outturns)															
Comments:																	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	89.9 (13-14)	90.3 (14-15) 90.9 (15-16)															
Comments:																	
Reduction in the proportion of people (aged 65+) assesssed by RRAS that require immediate hospital admission per 10,000 population aged 65+	41.3 (13-14)	35.7 (14-15) 34.8 (15-16)															
Comments:																	

SCHEDULE 6– BETTER CARE FUND PLAN

[Note the Better Care Fund Plan will be inserted here]

DRAFT

SCHEDULE 8 – INFORMATION GOVERNANCE PROTOCOL

[Note – the Council is advised that the Department of Health is currently concluding a draft protocol which may be utilised in this schedule, and inserted shortly.]

Appendix 3

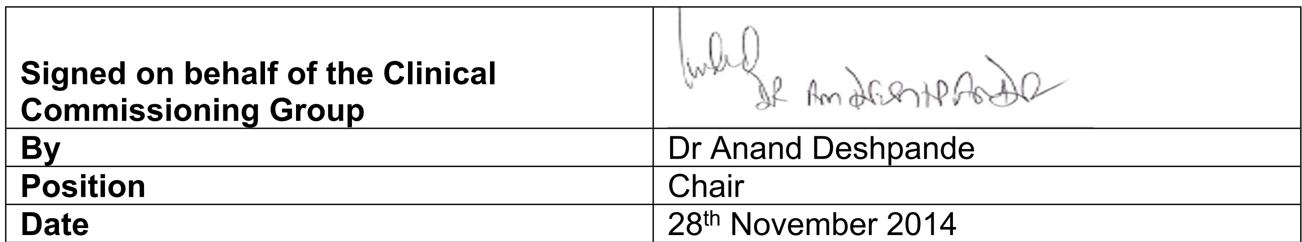
THURROCK BETTER CARE FUND PLAN

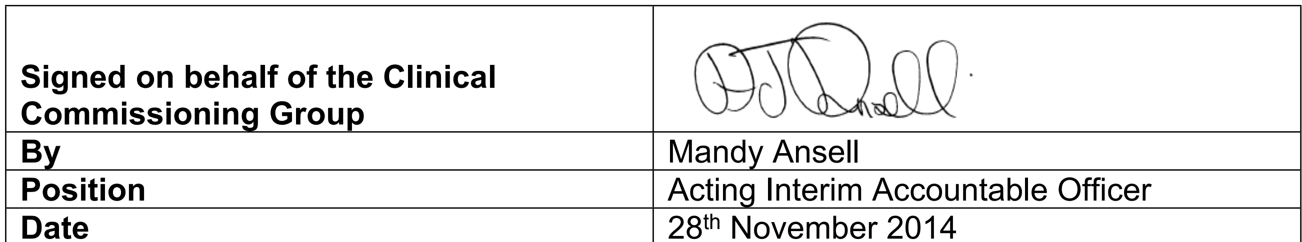
1) PLAN DETAILS

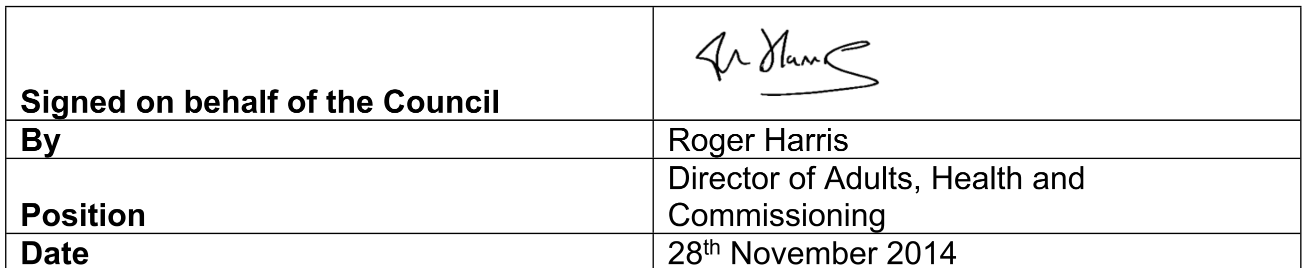
a) Summary of Plan

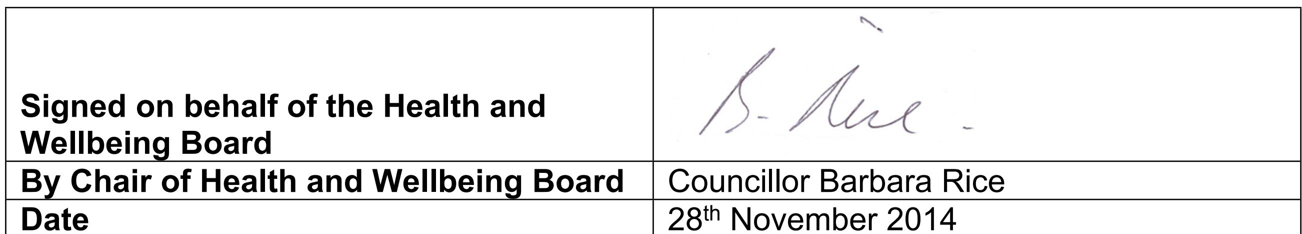
Local Authority	**Thurrock Council**
Clinical Commissioning Group	**NHS Thurrock Clinical Commissioning Group**
Boundary Differences	**None**
Date agreed at Health and Wellbeing Board:	**11/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£3,860k**
2015/16	**£10,565k**
Total agreed value of pooled budget: 2014/15	**£3,860k**
2015/16	**£18,019k**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Anand Deshpande
Position	Chair
Date	28th November 2014

Signed on behalf of the Clinical Commissioning Group	
By	Mandy Ansell
Position	Acting Interim Accountable Officer
Date	28th November 2014

Signed on behalf of the Council	
By	Roger Harris
Position	Director of Adults, Health and Commissioning
Date	28th November 2014

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Councillor Barbara Rice
Date	28th November 2014

c) 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.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	Analysis of the needs of Thurrock's residents to inform planning and commissioning.
Health Needs Assessment for the over 75 year old Thurrock Population	Analysis of the health needs of people aged 75 and over in Thurrock
CCG Operational Plan	Thurrock CCG's two year operational plan.
CCG Strategic Plan	Thurrock CCG's five year strategic plan
Joint Health and Wellbeing Strategy	A partnership document detailing the vision and aims for improving health and wellbeing in Thurrock.
Delivering Seven Day Services	Describes how seven day services across health and social care will be delivered
Building Positive Futures Programme	Building Positive Futures is the Council's transformation programme for Adult Social Care, and leads the Council-wide work on 'Ageing Well', as well as integration with Health.

Introduction and Executive Summary

Thurrock's Joint Health and Wellbeing Strategy is built around a vision for: Resourceful and resilient people in resourceful and resilient communities. The vision recognises that first and foremost, health and well-being is created by active, connected individuals living in healthy, inclusive and connected communities.

Thurrock is an area of major regeneration to the east of London and the job opportunities and economic growth will lead to a more diverse and prosperous population in the coming years. However, there are still major health inequalities in Thurrock with a gap of life expectancy of 8 years between the most and least prosperous areas. And, whilst our population is relatively young in comparison with south Essex, the over 65 population is increasing to an extent that demands on the acute services need to be managed carefully.

Building social capital, investing in local community social/care enterprises, strengthening communities are embedded in Thurrock's health and wellbeing strategy as a key element of overcoming health inequality and responding to the growing demands of an ageing population. Our focus on strengthening communities brings together the resources of housing, public health, adult social care and the CCG. Another feature is co-production – working with individuals and communities to create their own health and well-being solutions. These features naturally appear in our BCF proposals and, we think make our approach unique.

We recognise that these community-building initiatives need to be backed up by a suite of community based care and health responses that prevent or delay the need for services in the acute sector. Consultation events with key stakeholders – residents, patient representative groups, providers, commissioners held in December 2013 and April 2014 have enabled us to formulate a set of guiding principles for health and social care, and understand important messages from our stakeholders about Better Care and the future direction of primary care in Thurrock.

The proposed focus of the BCF
Through the BCF, we intend to expand or accelerate certain programmes already underway such as Local Area Coordination and the Rapid Response and Assessment Service (RRAS) as well as use the BCF as the catalyst to new initiatives such as an integrated single frailty pathway. BCF is therefore being used to enhance service innovations that we know are working well and providing us with the opportunity to re-design other areas that we recognise could benefit from review. The focus for our BCF will initially be on people over 65 for reasons we set out in the Case for Change – but in essence, the selection of this age group reflects the spiralling rates of non elective admissions but also the opportunities to avoid such admissions through concerted action by health and social care services operating at community level building on successful working practice to date.

As a relatively small unitary, with operating costs that compare well with comparable authorities, and with a number of health and well-being programmes aimed at the adult population already underway, we feel that focusing BCF work streams onto one segment of the population commanding the highest spending, will yield the best returns – but also reflecting the capacity of the CCG and council to achieve radical transformation in a way that is sustainable and maximises the opportunities for change. The learning from this approach can then be applied across other areas.

Building on our experience of integrated services – building on what works
In relation to the delivery of integrated care and health services, we have established highly effective joint working arrangements with health partners in relation to the delivery of Rapid Response and Assessment Services (RRAS) and Joint Re-ablement (JRT) delivering services jointly through a combined budget of £1.75m. Both performance levels against targets and service user feedback demonstrate a solid base from which to extend integrated working.

Our Local Area Coordination programme, currently funded through social care, public health and fire service resources will be extended to cover the whole Borough through the use of BCF funds. Feedback from people supported by LAC and the professionals referring people demonstrate significant results in terms of diverting people away from crisis services.

Future vision for health and social care in Thurrock
In essence, the overarching vision for our health and care services involves:

- More jointly commissioned programmes designed to support people to stay strong, well and connected within their own communities – for example our local area coordination and community building initiatives
- New, jointly commissioned, integrated services that support people, post diagnosis, to manage their conditions – for example specialist dementia support workers and increased use of assistive technology
- Enhanced multi-disciplinary working which puts the individual at the centre – building on our collaborative work with GPs, local area coordination, hospital social work teams and mental health professionals
- Expanded community based responses that reduce reliance on the acute sector – supported by locality service integration based around four GP cluster areas, an integrated frailty model integrating the community geriatrician within a single pathway and incorporating end of life care, a further developed intermediate care offer, and a shift towards prevention and early intervention majoring on Local Area Coordination
- Greater range of small-scale care services to enhance choice and control – driven by our Market Position Statement which promotes innovative approaches such as micro-care enterprises and initiative such as Shared Lives

And for residents, our vision should mean:

- Many more opportunities to stay connected and supported within their own communities
- Where services are needed, these will be coordinated around the individual – preferably at home and with the individual in control and able to exercise real choice
- Post diagnosis of any condition, pro-active support and coordination of care and support service linked to the person's home
- Where acute services are needed, appropriate re-ablement support and intermediate care to prevent readmission

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Introduction

The initial focus for Thurrock's Better Care Fund is on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes we have chosen for the BCF reflect this focus and the rationale for this are set out in the Case for Change section. We aim to have a single pooled fund across health and social care for all older people's services by April 2017. In line with the Care Act guidance on 'preventing, reducing or delaying needs', our aim is to develop integrated approaches that target 'individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing'; and to develop integrated approaches aimed at 'minimising the effect of disability or deterioration of people with established health conditions, complex care and support needs or caring responsibilities'. These themes run throughout our schemes (refer to schemes 1 – 4 in particular).

Although our focus for this iteration of the BCF is the 65 and over age group, we know that whole system transformation aimed at reducing and preventing individuals from reaching crisis point will require a focus on health and wellbeing for the whole population – e.g. initiatives aimed at 'individuals who have no current particular health or care and support needs'. Our strength based approaches such as Local Area Coordination and Asset Based Community development have a clear role to play in keeping individuals strong and connected – scheme 4 refers.

Context

Thurrock's current population, which is now estimated to be in excess of 160,000, has increased by over 10% since 2001, and 22% since 1991. It is projected to be 207,300 by 2033. The population group aged 85 and over is projected to double. With the expected ageing and growth of the population, we can expect a rise in age-related disease prevalence and additional demand on health and social care services. As an example, dementia is expected to increase steeply in Thurrock.

Lifestyle factors are having a significant impact on the demand for health and social care services in Thurrock. 20.7% of adults in Thurrock smoke, and 31.4% of adults are obese (significantly higher than national average), and 70.8% of adults have excess weight (significantly higher than national average) - 2014 Health Profile. A preventative approach as well as interventions for those individuals who have already entered the health and care system is therefore paramount to the long-term sustainability of Thurrock's health and care services. Local Area Coordination is proving to be very effective in this regard and for this reason is being expanded in support of the BCF objectives.

To assist with the focus of Thurrock's BCF Plan, we carried out a recent 'Health Needs Assessment for the over 75 year old Thurrock population. This is a focused piece of work and builds on Thurrock's JSNA which was published in 2012. The Assessment made a number of recommendations which will assist with the development of initiatives as part of the BCF. Further detail has already been provided in the 'Case for Change' section and has already influenced a number of our schemes – for example the frailty

model (scheme 4) and locality service integration (scheme 1).

In addition to the over 75s analysis, NHS England's Essex Area Team are in the process of developing a Primary Care Strategy. Robust primary care, particularly GP services, are critical to early identification of those at risk of developing a health condition and those individuals whose health is deteriorating and reaching crisis point. 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 in Thurrock's most deprived areas. Scheme 1 aims to maximise primary care capacity by providing an integrated health and care offer that builds on four GP cluster areas.

What our Stakeholders tell us

Two key events in December 2013 and April 2014 have provided a rich picture of stakeholder perspectives. Patient, carer and community representatives, perhaps reflecting the success of our strength based initiatives to date see the potential to mobilise commissioning and services around community hubs so that support services and carer support are locally based. The Local Area Coordinators, again reflecting the impact made even in the early stages of our pilot programme are seen as having the potential to work directly with GPs, coordinating care and support around the person. Single assessments, single plans and clear pathways as well as clear, accessible information are key themes. The home is seen as the place where assessments should take place with personalised care packages developed around the person. Commissioners and providers similarly reflected a commitment to coordination around the whole person's needs, assessed at home and also saw the potential of local solutions rooted in the local community. Our chosen schemes and the initiatives within them respond to these messages – e.g. the use of telehealth and assistive technology.

Central to the future direction of health and social care in Thurrock, our stakeholders identified themes that highlighted the importance of: the home, coordination around the whole person and the community as the source of solutions. These themes are again picked up in our evaluation of Local Area Coordination; feedback from people supported, health and social care professionals all highlight the importance of seeing the whole person and finding the best possible solutions at home, connected with the wider community.

Informed by the December event a set of joint principles was subsequently developed and agreed by Thurrock Council and the CCG:

- 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; and
- Systems and structures that enable and deliver a coordinated and seamless response.

How Local Area Coordination is driving service reform and its contribution to the BCF

Local Area Coordination has been selected for acceleration under the BCF as it is proving to be a very powerful approach to supporting people who often have complex issues which are not readily remedied by a single service approach. Whilst the age range of people supported runs from 18-98 years old, there is a significant pattern of older people, who are isolated and who have a range of health issues exacerbated by depression and isolation. Referrals from the Older People Mental Health Team demonstrate the value of the LAC approach which starts with a question about what makes a good life and working outwards to find local and usually informal solutions.
An example of this is one individual who required interventions from RRAS, Out of Hours or NHS 111 service 41 times over a 7 month period, which consequently reduced after LAC intervention to 3 calls over a 4 month period. Another individual supported by a LAC to find local, informal supports had a long history of mental health service interventions – such was the impact on this individual's well-being, his psychiatrist rang to thank the LAC personally for making such a significant impact.

Local Area Coordination with its emphasis on the whole person, local solutions and diverting people away from service dependency is perhaps the best possible example of joint commissioning to achieve a whole-person approach to health and wellbeing – in our case the roles are funded by social care, public health, the fire service and now through the BCF. Police support is also anticipated as the police service can see the great potential offered by LAC of supporting vulnerable people who they encounter day and night. The feedback from people supported by the LACs as well as the professional services is testament to power of the approach :

LAC Evaluation – feedback from individuals supported, health professionals and Steering Group members:

Mr A:
"Francis grabbed my ears and dragged me up from the grave."
"Everything good in my life started from the time the very clever hospital social worker made a plan and then introduced me to Francis."
"Francis has been the right man, in the right place at the right time".

From Adult Safeguarding:
"Since Martin's involvement my visits have reduced to the point where the safeguarding concern has been closed. It is my opinion that without LAC involvement there was a high possibility that the individual's life was at risk due to self neglect, falls and injury."

From an Individual supported by LAC:
The LAC is genuinely interested in me and does not have an agenda. I feel completely in control and that the LAC is on my side. There are things that I have done that I wouldn't have been able to do without the support of the LAC.

From MDT coordinator (NEFLT)
"From a health perspective it links in well with the Primary Care MDT's as we identify patients who would benefit from LAC intervention and can do direct referrals. It is an effective way of supporting people to be independent but with the benefit of having local knowledge as the LACs are embedded in the Community, and are able to give them advice and information about the local area, making it more inclusive of health conditions. They are also supporting with navigating the complex systems and referral processes for

more formal support due to LACs being part of Thurrock Council."

Regular meetings between MDT Coordinator and the LAC's help to provide up to date feedback and ensure patients' best interests are maintained.

Daniel Gatehouse – Strengthening Communities Manager (Fire Service)
The LAC's have achieved astounding results in the relatively short time they have been in existence, changing the lives of people that had the potential to become dependent on public sector services or worse still become a fatal statistic.

Sue Bradish – Public Health Manager (Thurrock Council)
We have been pleased to support their work on an individual and community level that has addressed some of the Public Health expected outcomes around increasing health improving behaviours

We are therefore very confident that in extending the LAC programme to provide cover across Thurrock, we are in a good position to support people to stay well who are 'under the radar' but also to steer people away from crisis who are at significant risk. In relation to the focus of our BCF, the LACs are making a major contribution to older people who are isolated, have mental health or physical disabilities, helping them to remain safe, independent at home. With that level of support in place across our communities, the BCF allows us to re-think how we deliver health and social care services to the over 65s.

JRT and RRAS – the platform for developing more integrated services

The RRAS is a joint service between social care and NELFT to provide a rapid response and assessment for people over 18 in crisis or pending crisis. The aim is to assess the situation and avoid where appropriate, unplanned emergency admissions to hospital and residential care, redirecting to intermediate care in the right place, right time and by the right team. The service is also a support service for carers. 84% of people are seen within 1-2 hours of a referral being made. On average 200 referrals are received per month. RRAS is also available to care homes 70% of referrals are seen once but there are some cases where people are seen numerous times as they enter further crisis. The majority of referrals are from GPs (18%).

Outcomes are as follows for Jul-Sept 2014: 2.9% (36) of service users assessed had an immediate admission to hospital. This is under the 7% target and is continuing to reduce.

JRT is a joint service between social care and NELFT (our community health provider) and provides rehabilitation services appropriate to the individual's needs with the aim of preventing a readmission to hospital and enabling the individual to live as independently as possible in their own home.
Service user satisfaction levels with the JRT are very high. :A quarterly survey (Jul-Sept 2014) has the following positive results:

- 94% state that they are always treated with respect and dignity.
- 94.5 state that all or most of their care needs are met.
- 93% report that the range of care and health workers work well together at a team.
- 86% state that the service has helped them to be more independent and stay in their own home.
- 95% state that the quality of life has completely or mostly improved following

- support from the team.
- 98% are completely or quite satisfied with the service overall.

Approach

BCF offers Thurrock Council and the CCG the catalyst to transform how we work together, what we deliver, how we deliver it and where we deliver it. The timing is ideal, coming as it does at the point when our community building, strength based approaches are taking root and BCF is welcomed because it helps to deliver our Building Positive Futures programme. We therefore approach BCF with an openness to change and challenge and want to set up a process which is inclusive and transparent. Having fixed ideas at the beginning of the process about what will change and how, is therefore counterproductive. We intend to embark on this transformation in the same spirit as we embarked on Local Area Coordination – as a learning experience which needs to be captured throughout the development. The key deliverables that will inform this process are national conditions and the reduction in non-elective admissions, but how these deliverables are met will be designed in partnership will all key stakeholders.

We have identified distinct work streams that we believe, combined will enable us to transform our service and supports to the over 65 population:

- Locality Service Integration
- Frailty Model
- Intermediate Care
- Prevention and Early Intervention
- Disabled Facilities Grant and Social Care Capital Grant
- Care Act Implementation
- Payment for Performance

The first four schemes are primarily about key whole systems transformation – building on what has already been described and scaling up the level of integration between health and social care.

The difference we expect the BCF to make is described within each of the schemes, along with what will change as a result of their implementation. For example:

- Integrated single frailty pathway that identifies individuals with complex needs at an earlier stage, ensures they access the right part of the pathway via a single point of access, and then ensures that the care and support they receive is co-ordinated across the system; and
- An integrated locality service that offers a flexible range of multi-agency solutions at a locality level tailored to the needs of that particular area – including community and non-service based solutions to emphasis the 'right place, right time, right solution' principle.

The Council and CCG have established as part of their Health and Social Care Transformation Programme a Whole System Redesign Project Group. The Group, guided by data and intelligence, and also patient and service user experience, is reviewing what requires redesign – with the focus on reducing hospital and residential home admissions for adults aged 65 and over. The Group will be responsible for shaping and ensuring delivery of the schemes attached as part of this document ensuring that they deliver the expected benefits.

The Group is working in accordance with the set of principles jointly agreed by Thurrock Council and Thurrock CCG – see above. In addition to the recommendations contained within the over 75s analysis and the principles outlined above, our approach will incorporate the Kings Fund recommendations for reducing avoidable admissions which includes:

- Healthy, active ageing and supporting independence;
- Living well with simple or stable long-term conditions;
- Living well with complex co-morbidities, dementia and frailty;
- Rapid support close to home in times of crisis;
- Good acute hospital care when needed;
- Good discharge planning and post-discharge support;
- Good rehabilitation and re-ablement after acute illness or injury;
- High quality nursing and residential care for those who need it;
- Choice, control and support towards end of life; and
- Integration to provide person-centred co-ordinated care.

Service User and Public Engagement
Following on from the consultation events in December 2013 and April 2014, as part of our approach to redesign, we have established an Engagement Group which has been meeting for a number of months. The Group includes representatives from Thurrock's Voluntary and Community Sector including Thurrock Healthwatch, the local user-led coalition, Council for Voluntary Services, Commissioning Reference Group – i.e. those with the greatest reach to users of services (refer to section 8 for more detail).

The Engagement Group has developed an Engagement Plan, and also identified how users of services and their carers should be engaged and involved with the commissioning and service development process. The Plan was agreed by the Health and Wellbeing Board on 17 July 2014.

Members of the Group are already playing an active part by reviewing how existing services are engaging and whether this is sufficient, and recommending changes. The Group has also developed an approach to involvement and engagement in commissioning which was agreed by the Health and Wellbeing Board and ensures that patients, service users and carers are appropriately involved in service development, commissioning, re-commissioning, and de-commissioning.

The Group will play an active role in identifying those groups and individuals who should be invited to be part of engagement activity – for example through the development of the schemes that are part of this BCF Plan.

Key members of the voluntary and community sector are also represented on the Whole System Redesign Group and are therefore ensuring that any service review or system redesign incorporates the experience and views of users of those services, their carers, the voluntary sector and the wider public.

Starting Position
Thurrock has already started on its journey towards reducing admissions through its overarching strategy to ensure that people age well. Thurrock's ageing well strategy ensures a focus on solutions and not services – recognising that a service response is not the only response. Our ageing well strategy is known as Building Positive Futures

and has a number of strands:

- Create the homes and neighbourhoods the support independence;
- Create the communities that support health and wellbeing; and
- Creating the social care and health infrastructure to manage demand.

Building Positive Futures has already had a number of successes that reflect Thurrock's vision for the future of health and social care, and establishes a new relationship between citizens and the public sector. These include:

- Development of 'strength-based' approaches such as the introduction of Local Area Coordination – with full coverage across the Borough after a successful pilot, LACs work with individuals who are at risk of crisis to prevent them from increased service intervention or reaching a crisis situation – e.g. unplanned admission to hospital (includes signposting by GPs). We have also introduced Asset Based Community Development, which is ensuring that rather than focusing on what someone cannot do and in essence further disabling them, we focus on what someone can do – their strengths;
- Community Hubs – a community based and community run initiative which allows individuals to receive the information, advice, and support they need and ensures people living in Thurrock's communities remain connected. Building community resilience and reducing service reliance is the underlying aim of this and our other community-based initiatives;
- Housing as a key partner – we have and are continuing to work with housing colleagues to provide and develop suitable accommodation to support older adults as they age. Early successes include a 'HAPPI' standard (Housing our Ageing Population Panel for Innovation) specialised housing scheme in Derry Avenue, South Ockendon, where 25 flats for older people are being developed. We have also just received approval for Government funding for another HAPPI scheme in Tilbury;
- Development of a 'Thurrock Well Homes' index and mapping tool – so that Lower Super Output Areas with the most housing-related need are identified.

The success of Building Positive Futures is inextricably linked to our ability to reduce service demand through improving health and wellbeing, and building resilience communities and individuals. Building Positive Futures is a key element of Thurrock's Health and Social Care Transformation Programme. The Better Care Fund will help to continue the shift towards prevention and early and timely intervention.

Integration
The Council and NHS already work closely in a number of areas linked to reducing admissions for the over 65s. This includes the Rapid Response and Assessment Service – an integrated service between adult social care and the NHS community health provider aimed at identifying individuals who are at risk of hospital admission and preventing that admission. The service relies heavily on GPs recognising those at risk and linking in to the service. The Council also has an integrated Joint Re-ablement Team with the NHS community service provider aimed at preventing readmission to hospital through proactive re-ablement. This work will be progressed further as part of the BCF.

The future – 2018/19
Our future, delivered through the BCF and related programmes (Building Positive

Futures, Care Act implementation, Primary Care Strategy etc.) will reflect the following:

Healthy, active ageing and supporting independence
- Further development of 'well homes' initiatives that builds on the work with Housing partners – recognising that over half those aged 75 years and over own their own property but that a number of those people will be both cash poor and equity poor – this also links to identifying and reducing hazards such as falls which relate to unplanned admissions;
- Further development and implementation of housing schemes that support older people as their frailty increases – e.g. Housing Ageing Population Panel for Innovation (HAPPI) standard homes;
- Community-run hubs that provide information and advice, and allow individuals to get the support they need to remain independent;
- Development of health improvement initiatives for older people – particularly recognising the impact of loneliness;
- Focus on maintaining the health and wellbeing of carers – e.g. via an increased number of carers assessments, provision and availability of respite care, support within the community etc.

It is envisaged that a number of these initiatives will not be 'services' in the traditional sense of the word, but community-run initiatives with support from public services.

Living well with simple or stable long-term conditions
- Improving self-management of long-term conditions to prevent further ill-health – e.g. through Whole System Redesign;
- Multi-disciplinary teams focused on the person – rather than the condition – via GP hubs, and including social care;
- Proactive case management of at-risk patients;
- Increase 'expert patient' initiatives;
- Increased use of assistive technology and telecare to maintain independence.

Living well with complex co-morbidities, dementia and frailty
- Reflects that those aged 75 years and over experience considerable co-morbidities, and consequently increased rates of emergency and A&E urgent admissions;
- Increased use of assistive technology and telecare to maintain independence;
- Multi-disciplinary teams focused on the person – rather than the condition – via GP hubs, and including social care;
- Over 75 GP lead;
- Further development of multi-disciplinary Rapid Response and Re-ablement Service and of the Joint Re-ablement Team – including development of a Timely Intervention Service;
- Robust multi-agency falls strategy in place;
- Development of 'hospital at home' type initiatives;
- Implementation of Thurrock's Dementia-Friendly Communities initiatives – helping to support and maintain those with dementia in their own communities;
- Provision of support for carers – e.g. via carers' assessment and promotion of carer health and wellbeing.

Rapid support close to home in times of crisis
- Further development of our integrated Rapid Response and Assessment Service (RRAS) as part of our developing Frailty Model

Good rehabilitation and re-ablement after acute illness or injury

- Significant numbers of those aged 75 and over are unable to complete one domestic task or self-care activity on their own, and lack of capacity in post-acute rehabilitation is considered to be a key factor behind the high numbers of older people who go straight from hospital stay into long-term care;
- Greater number of housing schemes that support older people as their frailty increases – including extra care housing;
- Through the Disabled Facilities Grant being part of the BCF, review the role of Housing in ensuring homes of those people coming out of hospital enable rather than disable people;
- Development of existing Joint Re-ablement Team, and also increased capacity in step down beds – e.g. Collins House Residential Home;
- Good multi-disciplinary coordination for people being discharged from hospital – building on the role of the successful Hospital Social Work Team;

High quality nursing and residential care for those who need it

- Continued work with private, voluntary and independent sector so that the health and social care workforce are empowered to deliver better care – resulting in fewer emergency admissions;
- Private, voluntary and independent Sector workforce development agreement implemented – contains a number of pledges aimed at ensuring the conditions are in place to promote a high quality workforce;
- Robust quality assurance and monitoring arrangements that ensure high standards are maintained, and that issues are picked up and resolved early;
- Robust relationship between GPs and nursing/residential homes – including medication reviews, continuity of care, proactive end of life planning

Choice, control and support towards the end of life

- Currently, significantly high proportions of older people die in hospital – which may not have been that person's desired place of death;
- Multi-agency approach to supporting those with a terminal illness to die in their place of choice – e.g. implementation of NICE quality standard and also RCGP guidance for commissioning end of life care

The Council and CCG's Whole System Redesign Project Group will be responsible for the review of existing and the development of new schemes and initiatives as part of the BCF to deliver what has been described above. Due to the embryonic nature of this work, what has been described within this section is likely to be further refined as thinking progresses. The overriding objective will be to ensure that any change improves the experience of the individual, and that the individual is at the centre of all planning at all times.

Our short-term ambition and related milestones are described in following sections of this template and the schemes themselves.

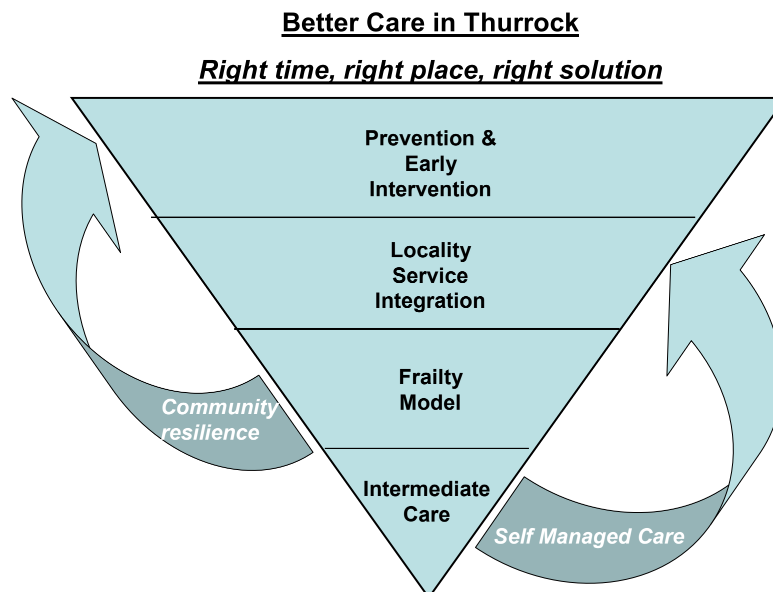
Alignment

For ease of reference, the following table reflects the alignment of the objectives for the future (as expressed by the Kings Fund and localised throughout our document) with the relevant scheme(s).

Objective	Dominant Scheme
Healthy, active ageing and supporting independence	Scheme 4
Living well with simple or stable long-term conditions	Scheme 1
Living well with complex co-morbidities, dementia and frailty	Scheme 2
Rapid support close to home in times of crisis	Scheme 2
Good rehabilitation and re-ablement after acute illness or injury	Scheme 3
High quality nursing and residential care for those who need it	Quality of care and support is an underlying principle relating to most schemes
Choice, control and support towards the end of life	Scheme 2

Better Care in Thurrock

Right time, right place, right solution



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

- Users of services will have an improved experience through multi-disciplinary teams and services that operate around the whole person;
- Individuals will be able to achieve the outcomes they want through personal health budgets and personal care budgets;
- Risk-based approaches to target those most at risk will enable individuals to remain out of hospital and residential care;
- Fewer people will require a service as they will be able to self-serve and gain access to the information and advice and support they need from the community

they live in;

- Proactive approaches to 'ageing well' will enable people to remain healthy, independent and in control for longer;
- Clusters of GP practices aligned with community health, mental health, and social care services will ensure whole person approaches;
- Long-term conditions will be identified at the earliest opportunity with individuals supported to self-manage those conditions – including through technological solutions in the home;
- Multi-agency/disciplinary teams linked to hospital discharge will ensure that individuals receive co-ordinated care when they leave hospital and reduce readmission rates;
- Close work with partners beyond health and social care – e.g. community, voluntary sector, housing, leisure and transport – will ensure a holistic approach to preventing, reducing and delaying an individual's need for care;
- The market will be sufficiently developed to enable individuals to have choice and control;
- Carers will feel supported and sustained in their caring role.

We have established an Engagement Group as part of our Health and Social Care Transformation Programme, and already work closely with the user-led Thurrock Coalition. We will work with these groups to ensure that we can effectively performance manage the impact of the changes we make on the patient, service-user, and carer experience.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

As explained in a), we are implementing Whole System Redesign to ensure interventions and approaches move 'up stream'. This means the reconfiguration of resource to sit with prevention and early intervention offers. Achieving a reduction in admissions means supporting individuals to age well. Reconfiguring the system to ensure individuals can age well, means more than the reconfiguration of services – it means a completely different offer, and a completely different relationship between the community, individual, and the state. This is described in detail in section 2a).

In summary, this will mean:

- Greater support available within the community via the community hubs offer – particularly in terms of information and advice;
- Further development and embedding of Local Area Coordination;
- Risk stratification enabling effective targeting through multi-disciplinary teams based around the four clusters of GP practices – particularly long-term conditions as identified in the July 2014 Health Needs Assessment for the over 75 year old Thurrock Population;
- Development of an early and timely intervention offer – building on the success of the Rapid Response and Assessment Service and Joint Re-ablement Team;
- Integrated commissioning approach across health, public health and social care;
- Further development of the 'well homes' housing initiative – targeting vulnerable people living in conditions that are detrimental to health and wellbeing;
- Build on Primary Care Multi-Disciplinary Teams to ensure pro-active case management.

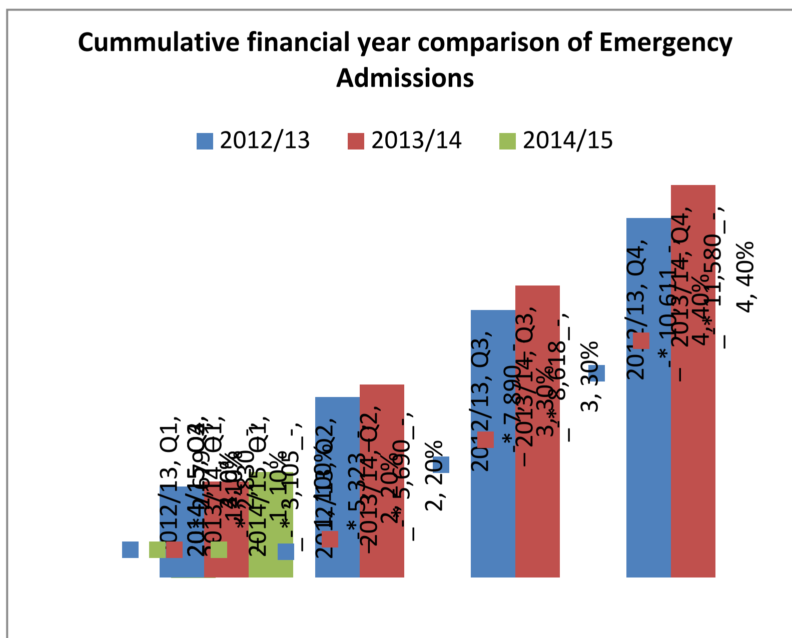
Our short-term ambition is as follows:

- By April 2015 we will have developed our local risk stratification tool for those aged 65 and over most at risk of hospital or care home admission;
- During 2015-16 we will establish a network of health and social care hubs that will integrate GPs, social care and community services as part of our new early intervention and prevention services;
- April 2016 – we will have established a single commissioning team across the Council and the CCG; and
- April 2017 – we will have established a single pooled budget across health and social care for all services for people aged 65 and over.

3) CASE FOR CHANGE

Why have we focused on people age 65 and over?

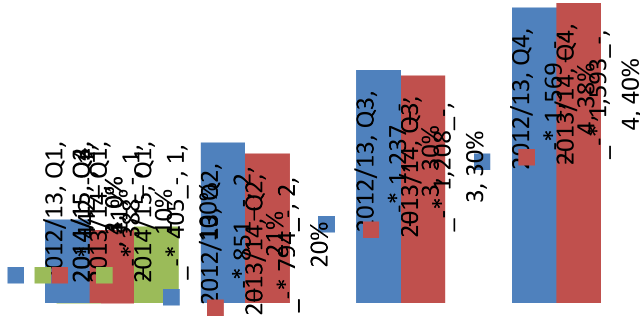
Thurrock CCG had 11,580 emergency admissions in 2013/14. As demonstrated in the graph below this represented a 9.1% growth on the previous year. Furthermore, activity in the first quarter of 2014/15 indicated a 9.7% growth on 13/14.



This level of growth presents a substantial challenge to both the CCG and Council. In order to meet the requirements of the BCF, our ability to use a risk based approach to identify the opportunities for avoiding admissions is paramount. In order to identify the opportunity, we have stratified total activity by an age profile of 0-19, 19-65 and 65+. The graphs below summarise activity by this age range profile;

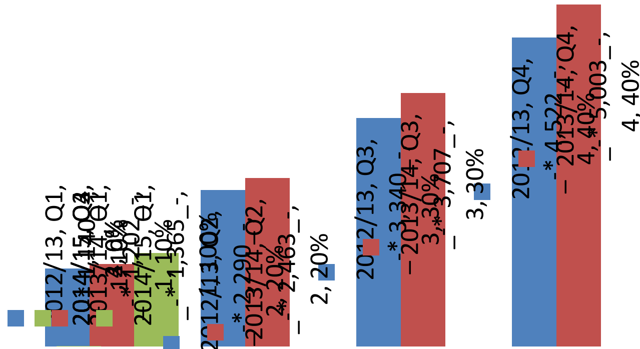
Cummulative financial year comparison of Emergency Admissions for patients <19yrs

2012/13 2013/14 2014/15



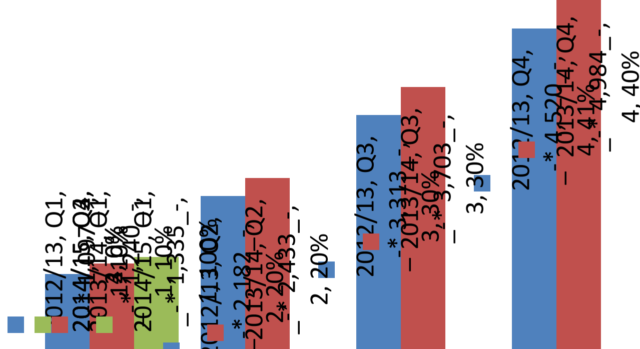
Cummulative financial year comparison of Emergency Admissions for patients over 19-64yrs

2012/13 2013/14 2014/15

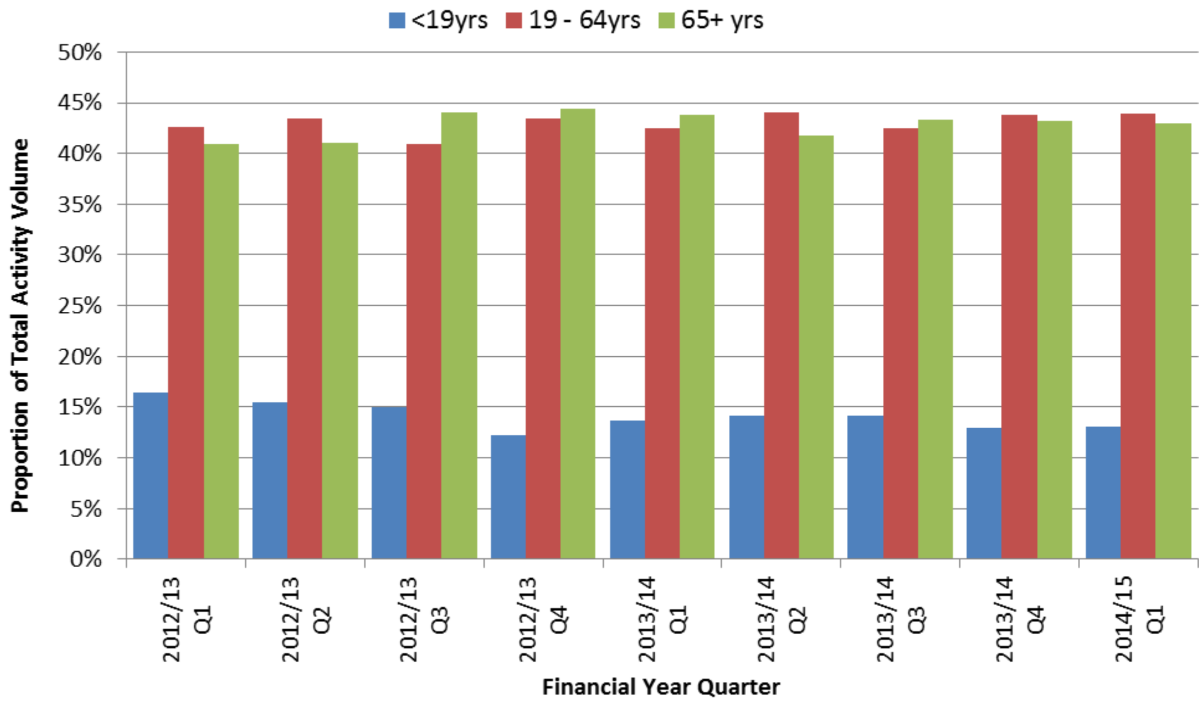


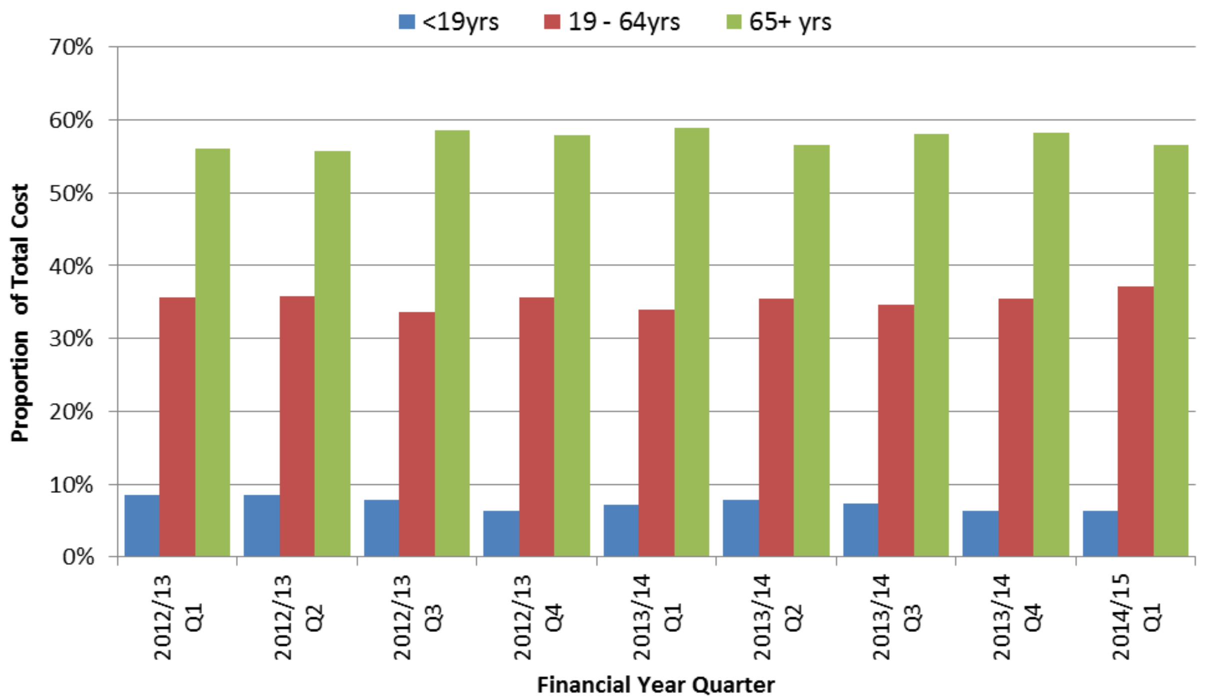
Cummulative financial year comparison of Emergency Admissions for patients over 65yrs

2012/13 2013/14 2014/15



Based purely on total activity, the two age ranges with the greatest opportunity are 19-65 and 65+. Based on activity cost, the age range of greatest opportunity that far outweighs the other two age ranges is the 65+ cohort. In order to identify the focus of the BCF, further analysis was undertaken at Specialty level. The following table indicates the top 15 specialties for Emergency Admissions in the 19-65 age range;


Emergency Admissions: prortion of activity volume by age band
<19yrs
19 - 64yrs
65+ yrs
Proportion of Total Activity Volume
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
2012/13 Q1
2012/13 Q2
2012/13 Q3
2012/13 Q4
2013/14 Q1
2013/14 Q2
2013/14 Q3
2013/14 Q4
2014/15 Q1
Financial Year Quarter


Emergency Admissions: proportion of activity cost by age band
<19yrs
19 - 64yrs
65+ yrs
Proportion of Total Cost
70%
60%
50%
40%
30%
20%
10%
0%
2012/13 Q1
2012/13 Q2
2012/13 Q3
2012/13 Q4
2013/14 Q1
2013/14 Q2
2013/14 Q3
2013/14 Q4
2014/15 Q1
Financial Year Quarter

HRG Sub Chapter	2013/14				
	Q1	Q2	Q3	Q4	Total
Digestive System Procedures and Disorders	216	204	223	208	851
Thoracic Procedures and Disorders	98	89	95	100	382
Cardiac Disorders	71	79	96	86	332
Nervous System Procedures and Disorders	69	80	77	94	320
Immunology infectious diseases poisoning shock special examinations screening and othe	69	65	64	68	266
Urological and Male Reproductive System Procedures and Disorders	36	35	50	48	169
Orthopaedic Trauma Procedures	39	51	32	31	153
Renal Procedures and Disorders	26	45	39	40	150
Hepatobiliary and Pancreatic System Disorders	34	38	41	30	143
Cardiac Procedures	31	24	32	31	118
Female Reproductive System Procedures	25	44	16	29	114
Female Reproductive System Disorders	35	30	21	26	112
Obstetric Medicine	19	27	33	31	110
Skin Disorders	25	27	25	32	109
Mouth Head Neck and Ears Procedures and Disorders	15	17	16	22	70

As demonstrated by the highlighted specialities, a significant volume of admissions in this age range are either surgical admissions, gynaecological/obstetric or specialities where the opportunity to avoid admissions is limited.

This compares to the following specialty level overview for the over 65 age range;

HRG Sub Chapter	2013/14				
	Q1	Q2	Q3	Q4	Total
Thoracic Procedures and Disorders	220	177	239	252	888
Cardiac Disorders	160	140	155	165	620
Digestive System Procedures and Disorders	153	151	168	140	612
Renal Procedures and Disorders	80	84	84	109	357
Nervous System Procedures and Disorders	76	85	97	92	350
Immunology infectious diseases poisoning shock special examinations screening and othe	55	67	68	72	262
Orthopaedic Trauma Procedures	70	54	64	58	246
Urological and Male Reproductive System Procedures and Disorders	35	43	34	56	168
Cardiac Procedures	40	39	49	31	159
Skin Disorders	29	25	31	41	126
Musculoskeletal Disorders	22	21	20	25	88
Haematological Procedures and Disorders	26	21	14	24	85
Mouth Head Neck and Ears Procedures and Disorders	24	20	20	20	84
Hepatobiliary and Pancreatic System Disorders	21	19	23	19	82
Orthopaedic Non-Trauma Procedures	13	15	21	10	59

This demonstrates significantly greater admission avoidance potential.

A further rationale for focusing of the over 65 population is the rate of non elective admissions per ‘000 population. The table below provides an overview of these comparative rates by age band;

Age Band	Population	Number of Admissions	Admissions per ‘000 population

0-19	40,355	1,593	39.47
19-65	98,597	5,003	50.74
65+	18,753	4,984	265.77

The comparative rate of admissions for the 65 and over group is five times that of the 19-65 age group.

Therefore, on the basis of the type of admissions and rate of admissions, the BCF is focusing on the 65+ population as this is where we feel we have the greatest opportunity to influence overall non elective admission rates.

Needs Assessment of the target population

Following the decision to focus on the over 65 age range, a provisional needs assessment has been undertaken to identify underlying trends and stratify some of the opportunity for improving outcomes. The following is an extract of that information.

Figure 1 - breakdown of emergency admission rates by age group for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

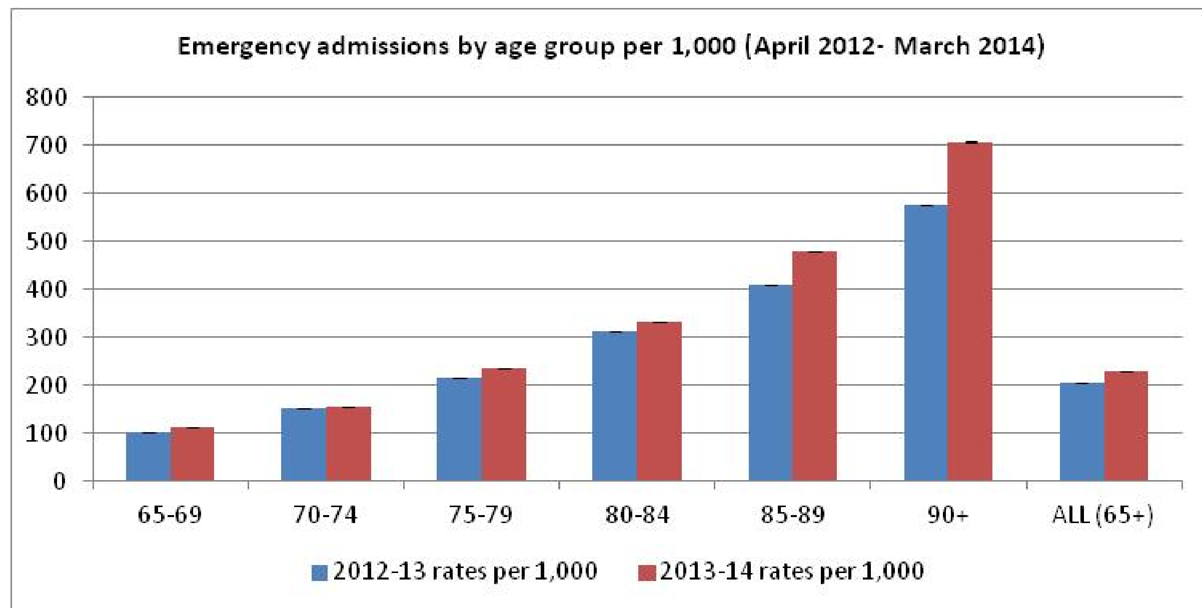


Table 1 - Top 10 HRG codes for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

HRG code	Total
Lobar, Atypical or Viral Pneumonia with Major CC	560
Non-Interventional Acquired Cardiac Conditions	395
Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC	369
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC	190
Arrhythmia or Conduction Disorders without CC	161
Heart Failure or Shock with CC	157
Unspecified Acute Lower Respiratory Infection with Major CC	146
Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	140

Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	130
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with CC	130

Table 2 - Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212	**Urinary tract infection, site not specified**	230
Congestive heart failure	207	**Respiratory failure, unspecified**	164
Atrial fibrillation and flutter	181	**Volume depletion**	146
Fracture of neck of femur: closed	178	**Chronic ischaemic heart disease, unspecified**	145
Tendency to fall, not elsewhere classified	173	**NOT CODED**	138
Acute renal failure, unspecified	164	**Pleural effusion, not elsewhere classified**	135

2011/12 analysis indicated 53% of >75s emergency admissions could be attributed to 35 presenting conditions which are generally amenable to community-based interventions.

The most common health problems (predicted) for those aged 75 years and over are summarised below:

- 69% with moderate or severe hearing impairment
- 60% limiting long-term illness
- 32% predicted to have a fall – and 4% admitted to hospital as a result of a fall
- 28% are unable to manage at least one mobility activity on their own
- 22% are obese or morbidly obese
- 20% have a bladder problem at least once a week

The top 6 chapter codes for emergency admissions for those aged 75 years and over are:

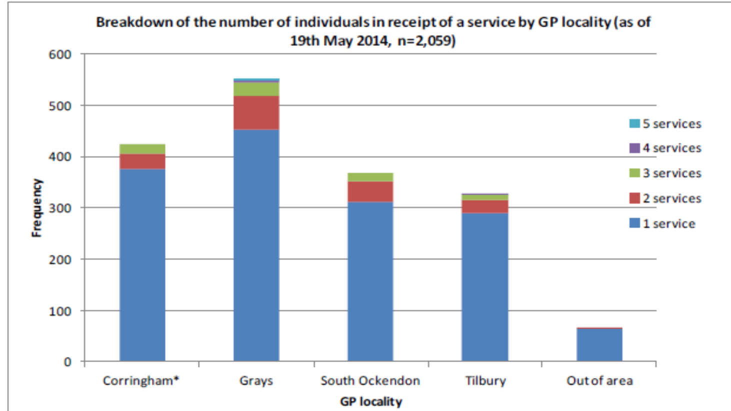
- 18% diseases of the respiratory system
- 17% diseases of the circulatory system
- 13% symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- 12% injury, poisoning and certain other consequences of external causes
- 10% diseases of the genitourinary system
- 10% diseases of the digestive system.

Social Care Demand & Spend

Thurrock Council spends £42 million annually on adult social care services. The area of highest spend is residential care – 50% of total spend in 2012/13. Of this, the greatest proportion of expenditure was on people aged 65+ - 55% of spend (an increase of some 3% since 2011).

The proportion of people using services and receiving residential or nursing care rises with age. People aged 85+ often receiving the most expensive and complex care.

Figure 33 - Breakdown of the number of services commissioned against each individual by ward (as of 19th May 2014, n=2,059)



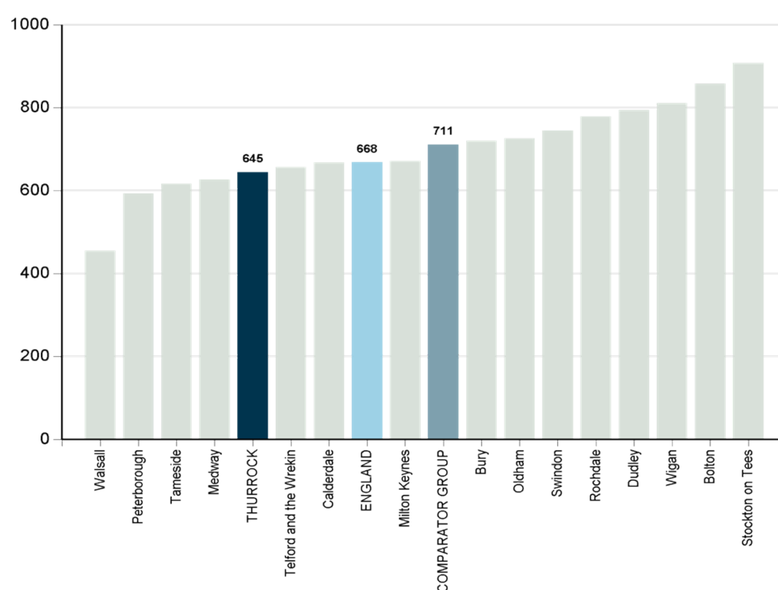
Source: Thurrock council adult social care.

In line with our existing commissioning intentions and strategies to enable people requiring care and support to access alternative arrangements to permanent residential or nursing care and to maintain independence at home, the number of people in residential or nursing care shows a trend of reduction over three years as does the rate of admissions into permanent placements. The reduction reflects the impact that existing initiatives are having on admissions to residential or nursing care – something we wish to build on through the schemes contained within this Plan.

This can in part be attributed to the impact of developing alternative supported living arrangements. However, some of this reduction can be attributed to more robust application of CHC and categorisation of clients who become full-cost payers.

As at the end of 2013/14 there were 335 people aged 65+ in residential or nursing care placements. 62% of these were aged 85+. In 2013/14 there were 645 older people (65+) admissions to permanent residential care or nursing care per 100,000 This compares to a national average of 668 and comparator group average of 711.

Series	Year	Residential Care	Nursing Care	Total Of Residential Care and Nursing Care
Council	2011-12	519	40	558
	2012-13	797	62	858
	2013-14	607	38	645
Comparator Average	2011-12	508	183	690
	2012-13	524	181	705
	2013-14	536	175	711
England	2011-12	468	228	696
	2012-13	467	230	697
	2013-14	451	218	668



However, without continued and further focus to minimise admissions the demographic pressures projected in coming years, together with increased complexity of people's conditions will see projected rise in numbers – see below.

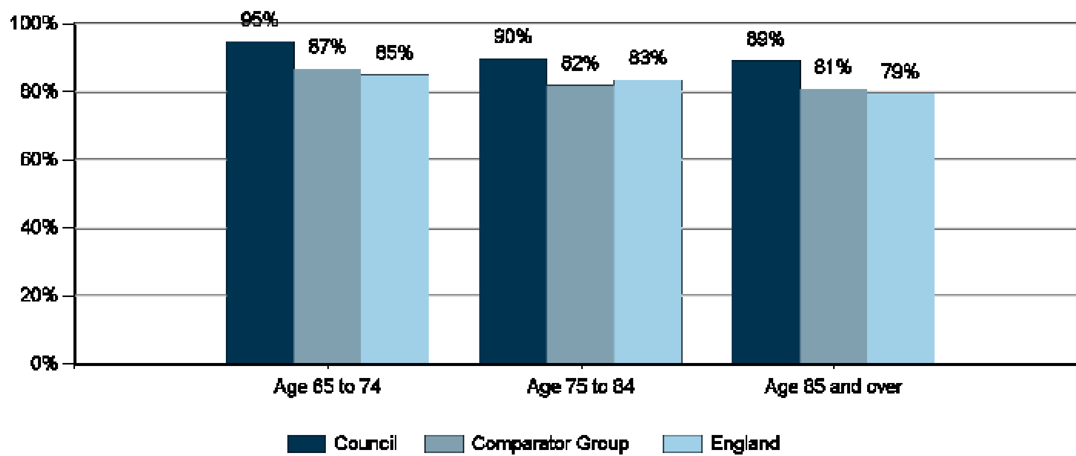
	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Standard Placements	286	299	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	381	402	414	425	434	443

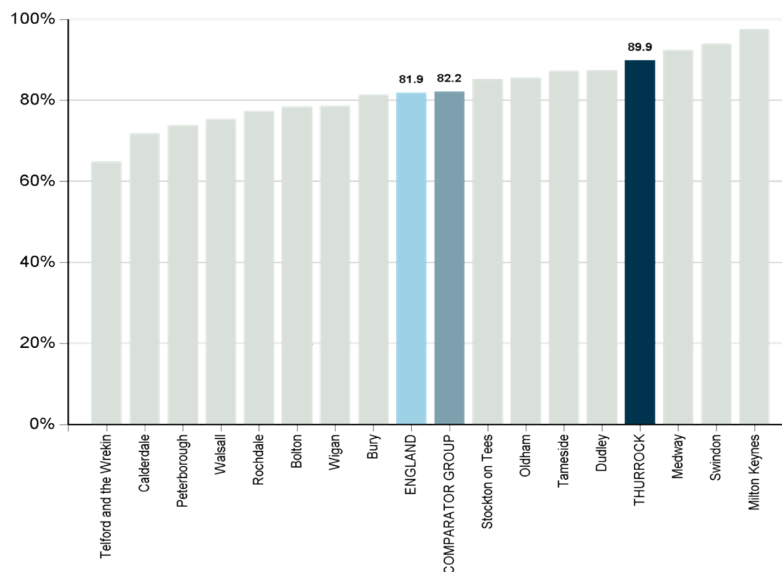
Supporting people to achieve and maintain independence at home through effective discharge from hospital and inappropriate care home admissions into re-ablement and rehabilitation services is a priority for Thurrock. Overall, Thurrock performs comparatively well on this key measure. 89% of people discharged into these services were still at home 91 days after. Performance also appears consistent across the key age groups for people aged 65+, with less variation than that nationally and among our comparator councils.

This can be attributed to continued focus on effective and timely hospital discharge planning to avoid delays and a jointly provided re-ablement service.

While performance appears strong, continued improvements are needed to ensure that this remains effective and also that independence is maintained and sustained over time, with subsequent reduced pressures or potential for admission to hospital or residential care.

9. Acheiving independence indicator (ASCOF measure 2B), by age group, 2013-14





Integration to improve outcomes

The rationale behind developing our pooled fund has been to identify those commitments that currently support older people's services and that would potentially benefit from integration. As a result, and to ensure that the BCF in Thurrock is large enough to support significant redesign, our BCF is considerably greater than the minimum amount.

The work that is and will continue to be carried out by our Whole System Redesign Project Group includes reviewing existing evidence of what works and therefore what will deliver better outcomes for users of services – including reducing the probability of admissions for those most at risk.

Part of the work being carried out includes a review of existing services and schemes – starting with those funded by section 256 monies and included within our BCF – e.g. our integrated Rapid Response and Assessment Service aimed at admission avoidance, and our Joint Re-ablement Team. Throughout the year, this will be expanded to include all services funded by BCF monies with a view to redesign based upon evidence of what improves outcomes for users and potential users of services.

Our 'Health Needs Assessment for the over 75 year old Thurrock population' published in June 2014 made a number of recommendations that are contained within our Vision. These recommendations will support our plans for 15/16 as taken forwards by the Whole System Redesign Project Group. The recommendations are made as a result of and in response to existing evidence of what works. The Health Needs Assessment also suggests that a more detailed review of evidence 'to determine which interventions may have greatest impact in the longer term for those aged 65-74 years and under 65 years' is required.

Service Quality and Efficiency
Our Health and Wellbeing Strategy has a focus on improving the quality of health and social care. This focuses on the quality of primary care. Issues in Thurrock, particularly in relation to GP practices, concern the number of GPs at or over retirement age, the number of single handed or small practices, and difficulties with recruitment and retention of GPs to the area.

The BCF responds to this through the development of schemes such as the Locality Service Integration. This scheme and others build on commissioning and provision of services and solutions through four GP cluster areas. Social Care Fieldwork Teams and Community Service Teams have restructured to ensure alignment.

This allows capacity to be maximised and also allows the development of solutions tailored to an area need as opposed to a Borough-wide solution. Plans also enable the involvement and further development of community solutions such as the Local Area Coordination initiative (scheme 4) and also Community Hubs. The four areas are already meeting to identify needs associated with that particular area. This will enhance quality and how we target capacity effectively and efficiently.

Integrated Commissioning

We have agreed as part of our BCF to have an aligned commissioning team across health and social care in place from April 2016. This will support our ambition to deliver an integrated commissioning approach.

Currently, the CCG has a commissioning team, and the Council's Adult Social Care has a commissioning team. Steps will be taken to move towards a fully aligned commissioning team by April 2016. This will mean:

- Establishment of joint posts – moving from one joint commissioning officer in 2014/15, to three joint posts by April 2015, to a fully aligned team by April 2016;

- The development of an integrated commissioning strategy and integrated commissioning intentions;
- The development and delivery of jointly commissioned services and solutions based upon the development of integrated solutions (as defined within the BCF schemes and the Whole System Redesign programme); and
- The establishment of joint contract and performance monitoring from April 2015.

PLAN OF ACTION

Schemes for 15/16

Scheme Ref	Scheme Name	Amount £000s
1	Locality Service Integration	4,551
2	Frailty Model	4,379
3	Intermediate Care Review	5,035
4	Prevention and Early Intervention	1,965
5	Disabled Facilities Grant and Social Care Capital Grant	845
6	Care Act Implementation	522
7	Payment for Performance	722
		18,019

Evidence review and initiative impact analysis

We have very deliberately identified the services that contribute to our BCF dependent upon their opportunity for redesign and impact on reducing emergency admissions and admissions to a care home.

We believe that the schemes we have identified will drive the transformation of health and care towards improving outcomes for users of services and their carers.

Our benefit mapping in the first instance has focused on reducing total emergency admissions – e.g. the target of 3.5%, and also on maintaining the level of residential admissions whilst demand increases. However we acknowledge that there will be a range of other related benefits across the system as a result of the delivery of our schemes. For example:

- Quicker identification of those with complex needs and those individuals accessing the appropriate element of the frailty pathway sooner;
- Greater access to appropriate parts of the system through the access of 7 day working;
- Increased co-ordination of care removing duplication and enhancing outcomes; and
- A greater percentage of people identifying and supported to die in the setting of their choice.

We have detailed evidence as to why we feel the chosen schemes will also have the desired impact. This is contained within the schemes themselves and also summarised

below.

We believe that the impact of our BCF will come from the collective impact of our schemes. Each scheme, and the initiatives within them, is interdependent on at least one other, and for this reason a scheme by scheme impact assessment would not demonstrate how a reduction in emergency admissions would be achieved – vulnerable adults receive services from more than one area. Our narrative describes how our operational framework builds on a number of successful initiatives that are already in place, and our ambition through the BCF to scale-up the extent to which these initiatives are integrated and aligned. The impact examples given within this document are all contained within Thurrock's BCF (schemes 1 – 4).

We had an impact assessment workshop as part of the support provided through the BCF team on the 25th November. Following the workshop, we redrafted our schemes to incorporate the key discussion points – e.g. to strengthen the narrative of each of the key schemes and to articulate how from implementing the schemes benefits would be realised in terms of total contribution as opposed to individual contribution.

We have demonstrated several examples of the work we have achieved on our journey towards integration.

- Benefit of having the community geriatrician as part of the risk stratification process and single point of access – identifying those with complex needs earlier and ensuring they access the appropriate part of the frailty pathway
- Local Area Coordination – as part of our prevention and early intervention approach aimed at building resilience within the community, positive results are showing the impact of our Local Area Coordinators on people's lives – including critically reducing the need for a service. As part of the BCF, the number of LACs with increase to 9 to ensure Borough-wide coverage. Scheme 4 details a list of the impacts the LACs are having based on recent evaluation. The benefits and impacts of the scheme are wide-ranging. There is a growing body of evidence to support both short and medium term initiatives around prevention; that is interventions that can prevent immediate crisis such as our RRAS service and interventions that enable people to manage their individual circumstances more effectively, including the need for support, be it medical, social or, as in most cases both in origin.
- Building on the Primary Care Multi-Disciplinary Team, which we know from research (as quoted in scheme 2) has significant impacts on patients with COPD and heart failure in terms of lower rates of readmission - those who have a Primary Care MDT accumulate on average 34% less on non-elective activity
- Impact of the Rapid Response and Assessment Service – as a result of performance monitoring and also our 15 month review, we know that less than 3% of individuals seen by the RRAS end up in hospital. Based on an assumption that 25% of those seen by the RRAS would have ended up as an admission, this equates to a saving of over £40k and over 350 avoidances of hospital admission (our 3.5% total admissions reduction target = 485 change in activity, so the RRAS as part of the frailty scheme would have a significant impact)
- Joint Reablement Team – we estimate from current data that 75% of people completing reablement are 65 years and over, with 66% either reducing the level of or ending support received (372 people)

- End of Life – we know that a significant number of people end their life in hospital but would rather have died in a home or hospice. Our frailty model builds on ensuring that all terminally ill people identified are on the co-ordinated care register and have an advanced care plan within 3 months. The multi-agency approach to end of life in Thurrock will have an impact on reducing unwanted hospital admissions
- Part of our frailty model builds on carrying out community geriatrician-led Multi-Disciplinary Team meetings in Thurrock's care homes – this is already having an impact on reducing the numbers of people in care homes being admitted to hospital
- Interim Beds show that 44% of people who used Interim Beds went home or into extra care/sheltered housing in 2013/14 thus avoiding long term residential care. These beds have grown from 2 to 18 due to demand. These beds are key to the Council's zero delays (due to social care) in acute beds for the past three years and also are used to avoid acute admissions. Extra Care Interim and respite flats have recently been introduced part of the intermediate menu of options to avoid permanent residential care and provide care needed to avoid crisis (and potential admission to hospital).
- Use of telecare – we will continue to embed the use of telecare. National evidence shows that telecare impacts on hospital admissions.
- Use of telehealth – our QIPP workbook 2013/14 shows a 33% reduction in the number of patients having an acute admission (12 patients pre-telehealth to 8 patients post-telehealth usage).

In Thurrock we feel that we have only just begun the journey towards integration and that there is a lot more than can be achieved. We feel we have provided a strong case for why our schemes – in particular schemes 1 – 4 – will, collectively, contribute to our ability to achieve the 3.5% reduction in total emergency admissions, and also the additional benefit of maintaining the current level of admissions to residential/nursing home care – we aim to keep admissions static whilst demographic pressures are increasing.

In each of the scheme descriptions we highlight the key milestones which will enable us to integrate further and deliver the reduction in unplanned care:

- In Scheme 1 (pg 71) we have identified a number of key milestones for the development of the Locality Service Integration model:
    - Development of integration governance arrangements and working groups – March 2015
    - Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
    - Full integration of the team, care coordination model, and sharing of information to enable management of risk – September 2015
    - Cost benefit analysis of the first 6 month's operation – January 2016

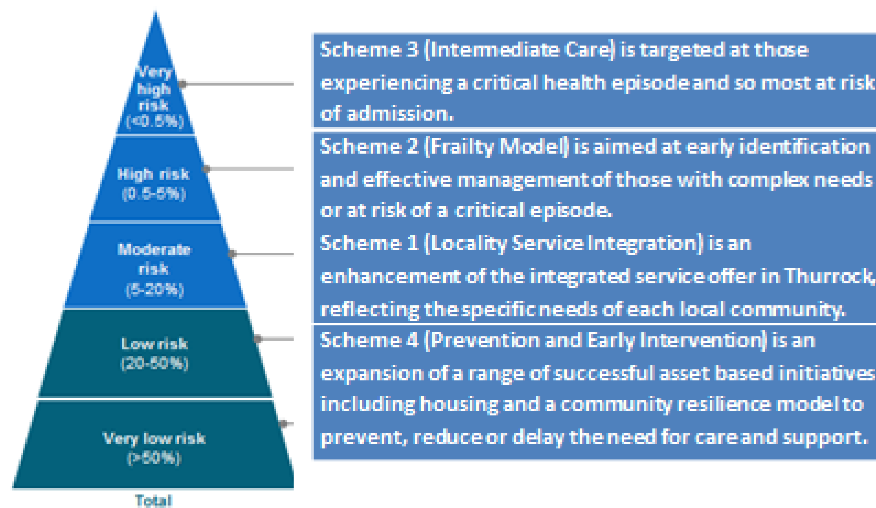
- In Scheme 2 (pg. 81), we highlight the following key milestones in developing our Frailty Model Scheme:
    - Single Care Plan and Care Co-ordination– September 2015
    - RRAS Service development – September 2015
    - Assistive Technology forward plan – January 2016
    - End of Life strategy – January 2016

- In Scheme 3 (pg 90) The key milestones for the Intermediate Care Scheme include:
    - New rehabilitation/assessment pathway pilot - April 2015
    - Roll out Carer Support – April 2015
    - Contract Review of bed based services –June 2015
    - Review of rehabilitation/assessment pathway pilot including Step Up and Step Down facilities – January 2016

- In Scheme 4 (pg 96) the key milestones are described as:
    - Pathways review – access to equipment – April 2015
    - Options Appraisal for Retail Model & Implementation – June 2015
    - Conduct Public Health-led review of emergency admissions – June 2015
    - Falls Prevention programme review and development – June 2015
    - Recruitment of further 3 LACs – April 2015
    - Local Area Coordination – 2 year evaluation July 2015
    - Local Area Coordination & GP initiative to target frequent users of A&E, ambulance services as part of public health-led review of unplanned admissions – September 2015

Risk Segmentation and Next Steps

Summary impact of risk a stratified approach for Thurrock



As a critical part of our plan of action, we have agreed to undertake clinical analysis of patient records with the aim of identifying a) inappropriate admissions and how they can be avoided; and b) where unplanned admissions have occurred, what could have been done to reduce the probability of that admission from taking place. Our case review will focus on an area of our Borough with a high admission rate. The results of this review will allow us to identify a cohort most at risk and enable us to refine our approach to reducing the probability of admission. Although we will pilot our approach in one area of the Borough, we will then look to refine and roll out to all areas based upon an evaluation

of the exercise. We aim to have finalised our pilot prior to April 2015. The results will inform our approach to service redesign and integration.

Whilst we have been able to undertake a very high level risk stratification based on existing data analysis, current information governance challenges have prevented us from developing any level of sophistication with regards to risk segmentation or stratification at a patient level. A key milestone for us and this plan will be to agree our approach to pseudonymised data in lieu of having the legal framework to use patient-identifiable data.

Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The joint CCG and Council Transformation Project Groups, assisted by a dedicated programme management resource, has scoped out and commissioned work packages to ensure the Council and CCG are able to address the requirements of the following *inter-dependent* work streams:

- Efficiency – identifying initiatives that in the short term offer cashable efficiencies to contribute towards the Council's £37m savings target, and ensuring opportunities for joint working and reducing duplication are maximised;
- The Care Act (2014) – preparation and implementation arrangements for the new duties;
- Better Care Fund Section 75 Agreement - preparation of the Better Care Fund Plan and implementation of all the arrangements for the Council to host the pooled fund from 2015 including, where necessary, contract novation;
- Whole systems Re-design as part of the Building Positive Futures programme – to determine the most effective models of care to reduce unplanned admissions and deliver co-ordinated care in conjunction with the citizens of Thurrock, and in consultation with patients, service users, carers, providers and other stakeholders.

In addition the Transformation Programme Board will work closely together:

- to engage with NHS England in the development of the Primary Care Strategy – to determine in particular, how the Essex Strategy can bring improvements to GP services across Thurrock;
- to address relevant aspects of the CCG's QIPP Programme where they affect both health and adult social care.

The key milestones for delivering the Better Care Fund for 2015/16 are as follows:

Health and Well-Being Board agreed the draft Better Care Fund Plan, the delegated authority for sign off and the approach to the Section 75 agreement	11 September 2014
Submission of Better Care Fund Plan following sign of by the CCG, the Council and the Chair of HWB Board	19 September 2014
Agree Commissioning Intentions with NHS providers	by end September 2014

Amendments to plan following Assurance Reviews and Moderation	by 10 October 2014
6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16 schemes	End October 2014
Health and Well-Being Board agreement to Section 75 agreement including Annual Development Plan	to be confirmed
NHS Thurrock CCG Board approval of Section 75 agreement	to be confirmed
Cabinet of Thurrock Council approval of Section 75 agreement	to be confirmed
Waiver requests and contract awards	From January 2015
Purchase to pay arrangements	From January 2015
Contract and Performance management arrangements in place	From January 2015
Pooled Fund Manager to monitor financial and activity information each month, escalating any issues/off-target performance to the Clinical Executive Group	From April 2015
At least quarterly meetings of Partnership Board to: o provide strategic direction to schemes o receive finance and activity information o escalate any unresolved issues/off-target performance o agree variations to the agreement and plan as required o authorise the Pooled Fund Manager to approve expenditure	From April 2015
Payments of providers from the BCF pooled fund	From April 2015
Review the operation of the agreement and the performance of individual services	October 2015

In parallel with the development and implementation of the Better Care Fund Plan for 2015/16 the Whole Service Redesign Group in taking forward a range of initiatives aimed at older adults (aged 65 and over) and most at risk of admission to hospital or care homes. This builds on work undertaken in the Urgent Care Deep Dive undertaken with BB CCG in May 2014, and the Thurrock Health Needs Assessment completed in July 2014 for the 75 and over age group. As noted elsewhere, these reports highlight the importance of also focusing on the 65-54 year old cohort in order to manage conditions at an earlier stage and so prevent or delay the need for care.

The Milestones for the Whole Service Redesign Group are as follows:

6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16 Develop detailed descriptions of the schemes • Locality Service Integration • Frailty Model • Intermediate Care • Prevention and Early Intervention • Disabled facilities Grant and Social Care Capital Grant • Care Act Implementation • Payment for Performance	End October 2014

Clinical Analysis of patient records to determine the likely causes of emergency admissions of patients aged 65 and over in a sample area; semi structured interviews with a sample of the cohort to assess patient and service user experience	October/November 2014
Semi structured interviews with a sample of the cohort to assess patient and service user experience	December/January 2014
Subgroup of acute and community health and care providers with Clinical Leads to review findings and model improved clinical interventions as well as community solutions impacting the wider determinants of health and wellbeing	Jan - March 2015
6 month trial of new models or care and community solutions	April - September 2015
Agree Commissioning Intentions with NHS providers and social care providers	by end September 2015
Review after 6 month trial of new models of care and community solutions	October 2015
6 month review of performance of 2015/16 BCF schemes completed and commissioning plans developed for 2015/16	End October 2015
Health and Wellbeing Board agreement to Section 75 agreement including Annual Development Plan for 2016/17	November 2015
NHS Thurrock CCG Board approval of Section 75 agreement	November 2015
Cabinet of Thurrock Council approval of Section 75 agreement	December 2015
Re-commissioning and decommissioning activity including procurement	From January 2016
Contract and Performance management arrangements in place	From January 2016
Implementation of commissioning changes in line with the BCF pooled fund Plan	From April 2016

Key delivery milestones related to the schemes (these cross reference with each scheme):

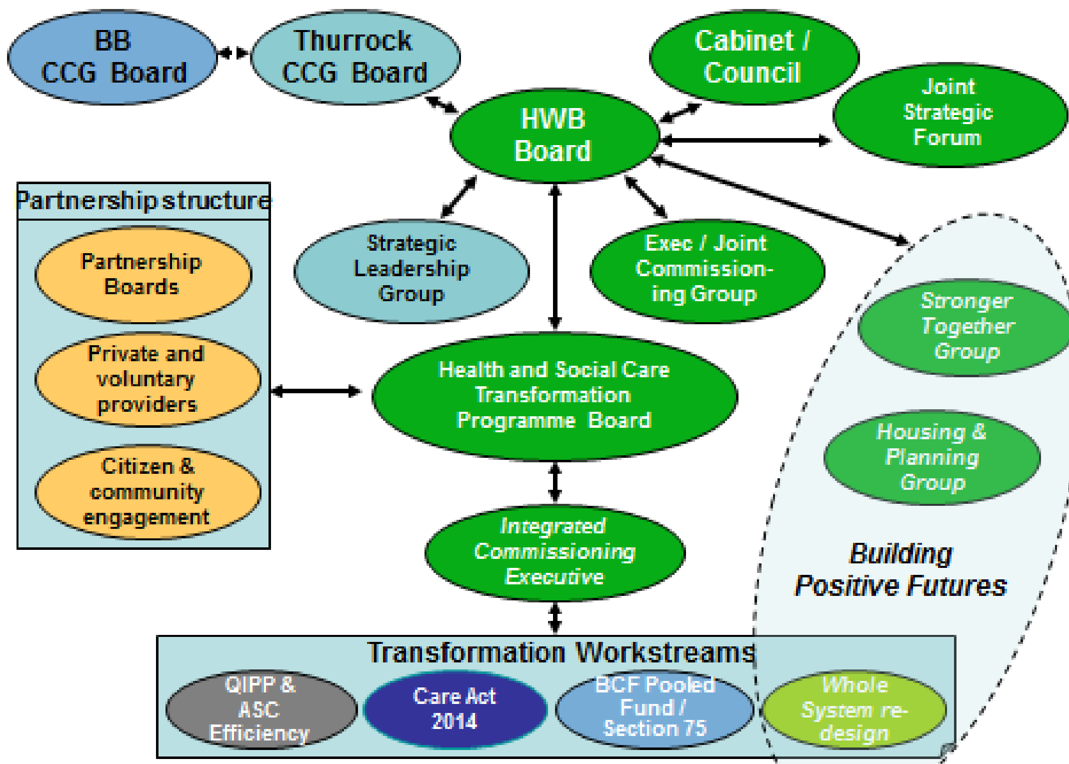
Scheme	**Milestones**
Scheme 1	• By June 2015 enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care • By March 2015 development of an integration governance arrangements and working groups • By September 2015 full integration of the team, care co-ordination model, and sharing of information to enable management of risks • By January 2016 cost benefit analysis of the first 6 months operation
Scheme 2	• By June 2015 enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care • By September 2015 developing a single care plan and care co-ordination • By September 2015 – further review and development of the RRAS based on evaluation

Scheme 3	• By April 2015 a new rehabilitation and assessment pathway pilot • By June 2015 a contract review of bed based services • By January 2016 a review of rehabilitation/assessment pathway pilot including Step Up and Step Down facilities
Scheme 4	• By April 2015 a pathways review of access to equipment • By June 2015 an options appraisal for retail model and implementation • By June 2015 conduct Public Health-led review of emergency admissions • By September 2015 LAC and GP initiative to target frequent users of A&E, ambulance services as part of the public health review • By June 2015 review of falls prevention programme • By April 2015 recruitment of further 3 LACs • By July 2015 LAC 2 year evaluation
Scheme 5	• By March 2016 deployment of DFG and review how DFG is used to prevent, reduce and delay • By March 2015 development of plan for social care capital fund
Scheme 6	• By April 2015 invest in areas as identified through ready reckoner and internal Care Act Implementation Group to ensure compliance with Care Act
Scheme 7	• By April 2015 embed the performance management framework as part of Thurrock's BCF governance arrangements – through the Integrated Commissioning Executive • By December 2015 based on likely outturn of reduction in total admissions, review evidence and agree areas of investment

b) Please articulate the overarching governance arrangements for integrated care locally

A joint Council and CCG Transformation Programme Board has been established to oversee and sign off the development of all policy, commissioning and procurement, market engagement, efficiency, performance and governance documentation and processes related to the integration of adult social care and health, and, where relevant the changes to be introduced by the Care Act. Because of the cross cutting nature of these changes, there will also be oversight by the joint Transformation Board of progress against relevant aspects of the QIPP challenge, the Primary Care Strategy and the Council's efficiency programmes for social care.

The Governance arrangements for the Transformation Programme Board are set out in the Programme Initiation Document and the Board itself has agreed the Terms of Reference for each of the Sub-groups. The reporting lines are as follows:



In relation to the Governance of the BCF Pooled Fund the following is a summary of the main workstreams

- ***Whole System Re-design** – undertaking asset based reviews of care pathways (including the contribution of housing and communities) and developing the business case for change*
- ***BCF Pooled Fund** – undertaking the procurement of health and social care services (with BCF schemes annexed to S 75 Agreement) to implement changes*
- ***Integrated Commissioning Executive** – approving (under delegation from HWB Board) investment plans, including changes to services, overseeing the BCF pooled fund, together with oversight of Care Act implementation and wider efficiency initiatives*

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

As noted above, the Better Care Fund Section 75 Agreement Group is overseeing implementation of all the arrangements for the Council to host the pooled fund from 2015. From April 2015 the Group will report to the Integrated Commissioning Executive (a Partnership Board with responsibility for oversight of the management of the BCF).

The Executive will report to the Health and Well-Being Board on its commissioning decisions as set out from time to time in the Better Care Fund Section 75 Agreement between the Council and the CCG. The Executive will also oversee the operation of the Better Care Fund, managing performance and risks within the Fund, and reporting these to the Health and Wellbeing Board. In order to avoid conflicts of interest, any discussions related to commissioning decisions, or payment, price or the performance of the pooled fund, or any other element of the whole system which may involve matters which are commercially sensitive, will be dealt with exclusively by the Integrated Commissioning

Executive.

Membership of the Executive is:
Acting Interim Accountable Officer, Thurrock CCG
Director of Adults, Health and Commissioning, Thurrock Council
Chief Finance Officer, Thurrock CCG
Strategic Lead for Commissioning and Service Development, Thurrock Council
Head of Integrated Commissioning, Thurrock CCG
Head of Finance, Thurrock Council

The arrangements which are currently being developed will be set out in detail in the governance section of the Section 75 Agreement and cover:

- The Membership of the Partnership Board
- Role and responsibilities
- Conduct of meetings
- Delegated authority
- Reporting arrangements
- Risk sharing arrangements
- Joint working obligations
- Performance arrangements
- Information Governance Protocol
- Dispute Resolution

The Integrated Commissioning Executive will be serviced by a dedicated team led by the Pooled Fund Manager which will provide financial and activity information at least quarterly.

The Integrated Commissioning Executive will meet on a bi-monthly basis (or more frequently if issues are escalated by the Pooled Fund Manager) to review performance against the Plan. The Transformation Programme Board (of which the Integrated Commissioning Executive forms part) will have delegated authority from the Health and Wellbeing Board to modify the plan, and the focus and funding for individual schemes, where both the Council and the CCG agree to do so.

The Programme Board will report progress against the plan to the Health and Wellbeing Board.

Financial and performance reports will be made on a quarterly basis to the Cabinet of Thurrock Council and to the Thurrock NHS Clinical Commissioning Group Board.

Performance Management

As noted above the Pooled Fund Manager will monitor financial and activity information on a monthly basis, escalating any issues/off-target performance to the Clinical Executive Group as necessary. In addition, and at least quarterly, the Pooled Fund Manager will provide a full report to the Programme Board to enable it to:

- provide strategic direction to schemes
- receive finance and activity information
- escalate any unresolved issues/off-target performance
- agree variations to the agreement and plan as required
- authorise the Pooled Fund Manager to approve expenditure

The key performance metrics which will be monitored by the Pooled Fund Manager are detailed within part 2 of the Plan.

In relation to how strategic and operational issues are dealt with - as part of the established governance structure - the following points should also be noted:
The Approach on page 10 of the Plan states:
"The Council and CCG have established as part of their Health and Social Care Transformation Programme a Whole System Redesign Project Group. The Group, guided by data and intelligence, and also patient and service user experience, is reviewing what requires redesign – with the focus on reducing hospital and residential home admissions for adults aged 65 and over. The Group will be responsible for shaping and ensuring delivery of the schemes attached as annexes to the Plan, ensuring that they deliver the expected benefits."

As an example of the management of operational issues, the Plan includes the following Milestones on pages 31/32

- "By March 2015 development of integration governance arrangements and working groups
- By April 2015 embed the performance management framework as part of Thurrock's BCF governance arrangements – through the Integrated Commissioning Executive"

And In relation to the feedback loop for scheme 2 on page 81
"The impact of this scheme will be monitored through the Whole System Redesign Project Group. This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive. "

Other points relevant to the governance arrangements for strategic and operational issues are set out in Section 5) RISKS AND CONTINGENCY on page 40
"In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the Health and Wellbeing Board on the recommendation of the Integrated Commissioning Executive which is the partnership Board for the pooled fund. These plans will include robust programme plans for each project, including key milestones, impacts and risks."

In terms of the Council and the CCGs demonstrating a track record of the delivery of integrated health and social care services, for example our Rapid Response and Assessment Service and Joint Reablement Team, the following points are relevant.

For example, in the Introduction and Executive Summary on page 5
"In relation to the delivery of integrated care and health services, we have established highly effective joint working arrangements with health partners in relation to the delivery of Rapid Response and Assessment Services (RRAS) and Joint Re-ablement (JRT) delivering services jointly through a combined budget of £1.75m. Both performance levels against targets and service user feedback demonstrate a solid base from which to extend integrated working."

And on page 9
"The RRAS is a joint service between social care and NELFT to provide a rapid response and assessment for people over 18 in crisis or pending crisis. The aim is to assess the situation and avoid where appropriate, unplanned emergency admissions to hospital and

residential care, redirecting to intermediate care in the right place, right time and by the right team. The service is also a support service for carers. 84% of people are seen within 1-2 hours of a referral being made. On average 200 referrals are received per month. 70% of referrals are seen once but there are some cases where people are seen numerous times as they enter further crisis. The majority of referrals are from GPs (18%). RRAS is also available to care homes.

And In the overview of scheme 2 – page 83
"As part of the scheme, we will continue to build on the successful integrated RRAS service. Our service is aimed at those individuals who we think are likely to reach crisis point within 72 hours and co-ordinates and redirects care to the appropriate intermediate care provider or service. The service has recently been evaluated and the recommendations from the evaluation will be considered as part of the work to be carried out during 15/16."

And in terms of the contingency arrangements in place should partnership working break down, .
Section 5) RISKS AND CONTINGENCY on page 40 notes:
"To deliver the vision in Thurrock's BCF plan, under the direction of the Health and Well-Being Board, the Council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which will determine the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment will be undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks."

d) List of planned BCF schemes
Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Scheme Ref	Scheme Name	Amount £000s
1	Locality Service Integration	4,551
2	Frailty Model	4,379
3	Intermediate Care Review	5,036
4	Prevention and Early Intervention	1,965
5	Disabled Facilities Grant and Social Care Capital Grant	845
6	Care Act Implementation	522
7	Payment for Performance	722
		18,019

5) RISKS AND CONTINGENCY

a) Risk log - Top 10 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 and any financial risks for both the NHS and local government.

The Risk Register for the Thurrock Better Care Fund provides an overview of the top 10 risks identified to date. It has been developed in conjunction with the Council's Corporate Risk Officer and the CCG's Head of Corporate Governance and agreed with key partners. The risks will be reviewed on a monthly basis by the relevant Project Group (S75 Governance; Whole System Redesign; Care Act; Engagement; Efficiency) with oversight provided by Thurrock's Health and Adult Social Care Transformation Programme Board on a bi-monthly basis.

A number of the services within the BCF Plan are currently operational, and risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed by the Whole System Redesign Group to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the Health and Wellbeing Board on the recommendation of the Integrated Commissioning Executive which is the partnership Board for the pooled fund. These plans will include robust programme plans for each project, including key milestones, impacts and risks.

To deliver the vision in Thurrock's BCF plan, under the direction of the Health and Wellbeing Board, the Council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which will determine the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment will be undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks.

H&SC Transformation - Risk Register as at 26th November 2014

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
1	The failure to reduce demand for acute services by 3.5% places does not release funds (a value of £722k in 2015/16) for investment in community services/ results in failure to achieve performance target.	1. Initial mpact of each BCF scheme has been assessed. 2. Metrics for monitoring performance of each service are being developed together with reporting arrangements.	4	3	12	1. Close liaison with acute providers on performance against QIPP Plans. 2. Co-ordinated action across the whole system to secure investment in out of hospital services and reduce demands on emergency admissions. 3. Arrangements for remedial action agreed if required.	9	April 2015	Head of Integrated Commissioning Thurrock CCG
2	Changes to eligibility criteria, introduction of care accounts, assessment of self funders will all bring new challenges for IT, the workforce, finance and information and advice services, communications and housing.	Care Act Project Group meeting monthly to assess impact of guidance and to determine how risks should be managed.	3	3	9	1. A change programme with appropriate governance, resources (both people and financial) to implement the Care Act reforms and to monitor impacts on service quality and user satisfaction, and all with multiple interfaces with Better Care Fund initiatives.	6	April 2015	Director of Adults Heath and Commissioning
3	Difficulties in sharing of patient / service user level data may frustrate commissioning plans or performance and financial management.	1. Initial meeting with BB CCG Head of Information Governance to agree strategy. 2. Close links with Southend Pioneer maintained	2	3	6	1. An Information Governance strategy for commissioning and providing integrated care, using the NHS number and with the required technical solutions is required. However, there is a clear dependence on legislation and regulatory changes before this can be achieved.	4	On-going	Service Manager (Performance, Quality & Information)
4	The changes required for the configuration of practices my make it difficult to engage GPs in integrated care programmes.	1. Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve GPs in change, and to ensure a common understanding of risks,	2	2	4	1. Close Liaison with NHS England Essex Area Team regarding cluster arrangements	4	On-going	Acting (Interim) Accountable Officer Thurrock

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
		opportunities and incentives.							
5	Uncertainty about the changing offer from ASC and Health may result in or late or low take up of community services, and a failure of the system to prevent crisis or intervene in a timely way.	1. Initial scoping of comms plan completed. 2. Dependency on DH/NHS England comms noted and detailed plans awaited	2	2	4	1. Strong campaigns to engage citizens and professionals across the system in the plans for integrated care, and reviews of the effectiveness of those campaigns. 2. A joint formal CCG, Council and Provider launch for Better Care Fund in Thurrock to initiate this campaign.	4	January 2015	Manager Corporate Communications
6	Implementation and operational costs for BCF and Care Act may exceed budget plans.	1. Integrated Commissioning Executive established to monitor performance of the pooled fund. 2. Financial analysis of the Care Act changes completed.	2	2	4	1. Financial contingency plan to estimate and alleviate cost pressures that may arise during implementation or benefits realisation.	4	April 2015	1. Pooled Fund Manager 2. Interim Customer Finance Team Manager
7	Change may take longer or may be more difficult to achieve if a provider faced significant operational difference in neighbouring CCG areas.	1. Links made to Essex BCF Technical Group regarding commissioning intentions and procurement plans	2	2	4	1. Liaison with B&B, CCG and ECC about the impact of our respective emerging commissioning plans to agree common principles, to identify variances and, where necessary, plan contingencies.		On-going	Directorate Strategy Officer, Adults Health and Commissioning
8	NHS provider may experience difficulties in delivering QIPP plan efficiencies or face unexpected costs in delivering integrated services.	1. Agreement for joint Council CCG monitoring of contract performance to be in place from April 2015. 2. Scorecard for monitoring performance against pooled fund tagerts being developed	2	2	4	Regular oversight of performance by Integrated Commissioning Executive	4	April 2015	Head of Integrated Commissioning Thurrock CCG/ Service Manager Contracts & Commissioning

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
9	Public engagement related to adopting healthier life styles, developing greater community resilience, and the importance of accessing service in the community take longer to gain traction.	1. Linkages between Stronger Together programme maintained. 2. Link to healthy lifestyles campaigns (linked to DH NHS England campaigns) scoped.	2	2	4	1. Campaign to promote community solutions to be planned	4	January 2015	Community Development and Equalities Manager
10	The impact, risks and benefits of commissioning integrated health and social care are not sufficiently understood.	1. Initial research and impact modelling of the benefits of integration undertaken. 2. BCF Plan schemes amended to highlight benefits where these can be quantified	2	2	4	1. Further impact assessment of all commissioning plans to be undertaken using: • A common assessment tool • A joint sign off process • An agreed review period • A joint service restriction policy	2	April 2015	Head of Integrated Commissioning Thurrock CCG/ Service Manager Contracts & Commissioning

b) Contingency plan and risk sharing
Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

The total value of the Better Care Fund in Thurrock is £18,019k and the amount of the Better Care Fund described as 'at risk' is the performance element of £722k.

The Council and CCG, working with its providers BTUH, NELFT and SEPT, have agreed to assume strategic responsibility for the whole health and social care system economy. They accept collective responsibility for overspends, working together, and with providers, to pre-empt or minimise their occurrence. (The governance diagram on page 35 shows the relationship between the various interests in the whole system, and the part played by the Integrated Commissioning Executive – the executive arm of the wider Transformation Programme Board, which reports to the Health and Wellbeing Board.)

The Health and Wellbeing Board has specifically considered the risk of financial underperformance against the total emergency admissions target set locally. The Board has been involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. This includes the £722k payment for performance element linked to a 3.5% reduction in emergency admissions. Following the decision to create an Integrated Commissioning Executive (as part of the Transformation Programme Board - which has already been established) it can be demonstrated that the Boards have close involvement with the management of the risk of financial underperformance. Section 75 performance reports for each BCF scheme will be provided to Integrated Commissioning Executive and reported to the Health and Wellbeing Board from April 2015.

The Health and Wellbeing Board has agreed that the risk of underperformance is to be managed by delaying expenditure commitments for a number of services until the payment for performance target is achieved, and payment of the target sum can be released into the pooled fund by NHS Thurrock CCG. When the target is achieved It is anticipated that the payment for performance element of the fund will make a contribution to the protection of adult social care.

The issue of treatment of overspends in the BCF schemes has also been agreed and the Health and Well-being Board have proposed that the Better Care Fund for 2015/16 should be fixed at the agreed value of the Pooled Fund. The effect of this is that any expenditure over and above the value of the fund will fall to the Council or the CGG depending on whether the expenditure is incurred on the social care functions or health care related functions. For the avoidance of doubt, the use of block contracts for the BCF schemes in 2015/16 means that there is no new financial risk for the commissioners – with the only risk relating to the achievement of the 3.5% reduction in emergency admissions performance target (£722k). Accordingly, the focus of the Pooled Fund will be on improving service delivery and exploring with providers, including the Acute service providers, how investment in future years can be managed to provide more treatment closer to home/ away from hospital settings.

The Section 75 Agreement will stipulate that Financial Contributions in each Financial Year, excluding NHS acute Payment 4 performance financial contributions, will be paid to the fund monthly[1] in advance receivable on the first day of the month commencing 1st

April 2015. The NHS acute Payment 4 Performance financial contributions shall be paid to the fund quarterly in arrears receivable on 1st day of the quarter commencing 1st July in accordance with the release of payment for performance to non-acute NHS commissioning as set out in the National Guidance.

In terms of management arrangements, the Section 75 agreement will specify that, if during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

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[1] Revised, from quarterly to monthly, because CCGs funded monthly by DH.

6) ALIGNMENT
a) Please describe how these plans align with other initiatives related to care and support underway in your area

For the ambition set out within this Plan to be advanced and delivered, there needs to be alignment with a range of existing plans and initiatives. These are summarised below:

Building Positive Futures
Building Positive Futures is Thurrock's programme to support older and vulnerable people to live well. The Programme reflects good health and wellbeing being dependent upon a number of factors including:

- The neighbourhoods we live in;
- The opportunities we have to connect with others;
- Safe and accessible paths and parks;
- Access to shops, health clinics and other facilities; and
- The opportunity to give as well as receive help – to feel needed and useful.

BCF recognises the value and impact that partners beyond health and social care have on creating communities that foster good health and wellbeing.

The Programme centres on three main themes under which sit a number of related initiatives:

- Better health and wellbeing: so people stay strong and independent
  Dementia Friendly Communities
  Integration of Health and Social Care (Whole System Redesign)
- Improved housing and neighbourhoods: to give people more – and better – choice over how and where they live as they grow older
  Health and Wellbeing Housing and Planning Advisory Group
  Flagship housing schemes for older people – based on design recommendations of the HAPPI
  Sheltered Housing Review
  Thurrock Well Homes - a scheme to improve the housing conditions and health and wellbeing of residents in private properties
- Stronger local networks: to create more hospitable, age-friendly communities
  Local Area Coordination
  Asset Based Community Development
  Strength-based approaches to commissioning and social work practice

The BPF Programme is a key and fundamental part of our Health and Social Care Transformation Programme. The Programme's success will result in people growing older in better health, and older people being better supported and more resilient within the communities they live in. A key element of the Programme is that individuals are less likely to require formal 'services', but are able to find the support they need to remain healthy and independent from within their own communities. As such, the Programme is a vital part of this Plan's ambition to reduce the number of people aged 65 and over who are admitted to hospital or a residential care home.

Local Area Coordination
Whilst an initiative that has been developed as part of our BPF Programme, Local Area Coordination requires a mention in its own right.

Initiated by Adult Social Care, Local Area Coordination is a partnership programme with:

- Public Health;
- Housing;
- Essex County Fire and Rescue Service;
- North East London Foundation Trust;
- Thurrock Council for Voluntary Service;
- Healthwatch;
- South Essex Partnership Foundation Trust; and
- Thurrock Clinical Commissioning Group.

Starting with a strength-based question about 'what a good life looks like', coordinators help vulnerable people to find their own local solutions. Solutions pursued often do not lie with services – but in the community. Where a service is the right solution, the LACs are able to co-ordinate a response which invariably crosses service and organisational boundaries. This in itself is a great help for people who are vulnerable and do not have the knowledge, expertise or emotional resilience to navigate the complexities of service offers.

LAC was originally piloted in three learning sites. Due to the success of the pilots, the initiative has been expanded and is now Borough-wide.

We have just completed our 14 Month Evaluation which reflects some promising results to build on:
300 people have been introduced to the LACs
Of the people currently receiving support:

- 12% have learning disabilities,
- 27% have mental health issues,
- 31% are older people,
- 15% have physical disabilities,
- 4% have sensory impairments and
- 11% "other"

To date introductions are from a wide variety of sources including:

- The Council's initial contact service - Community Solutions

- Social workers and support planners across all services including mental health teams
- Third Sector organisations
- Multi-disciplinary meetings (MDT’s) based around GP surgeries
- The Mayor of Thurrock Council and ward Councillors
- Direct from the community and meeting people at Community Events
- Community Hubs
- Housing
- Police and Fire Services

Analysis of people supported by the LACs shows significant savings to both health, social care (as well as other statutory services including fire). Examples are included here:

Costs associated with depression: Over 75 people introduced to LAC have identified depression as one of the main challenges they face. A very high percentage have reported an improvement in their depression and none have been readmitted since the LAC has been introduced. However, two people have needed the ongoing expertise of Mental Health services
If 75 people have seen an improvement in their depression and avoided or delayed the need for mental health services this is a potential saving of: £71,700

Mental Health community provision: Individuals and professionals have fed back that the need for mental health professionals has reduced and this includes regular weekly support groups where community alternatives have been found.
There are approximately 6 cases where people previously attended a support group. This will give a saving of: £101k pa (based on 6 people attending 2 hr session per week)

The LAC initiative is a key approach in reducing the number of people who end up in crisis.

Timely Intervention and Prevention Service
We recognise that the key to developing sustainable health and social care services is by reducing demand on already stretched services. Our approach to redesign is therefore focused on how we can prevent individuals from not only reaching crisis point, but from requiring a service altogether.

As part of our BCF Programme for ageing well in Thurrock, we identified a need for a Timely Intervention Service – aimed at better community management of a number of conditions to prevent crisis and manage demand.

In keeping with the desire to provide an early intervention response, and greater local emphasis upon whole systems and community collaboration, is a growing awareness of the need to improve support to people who have been diagnosed with dementia and their carers.

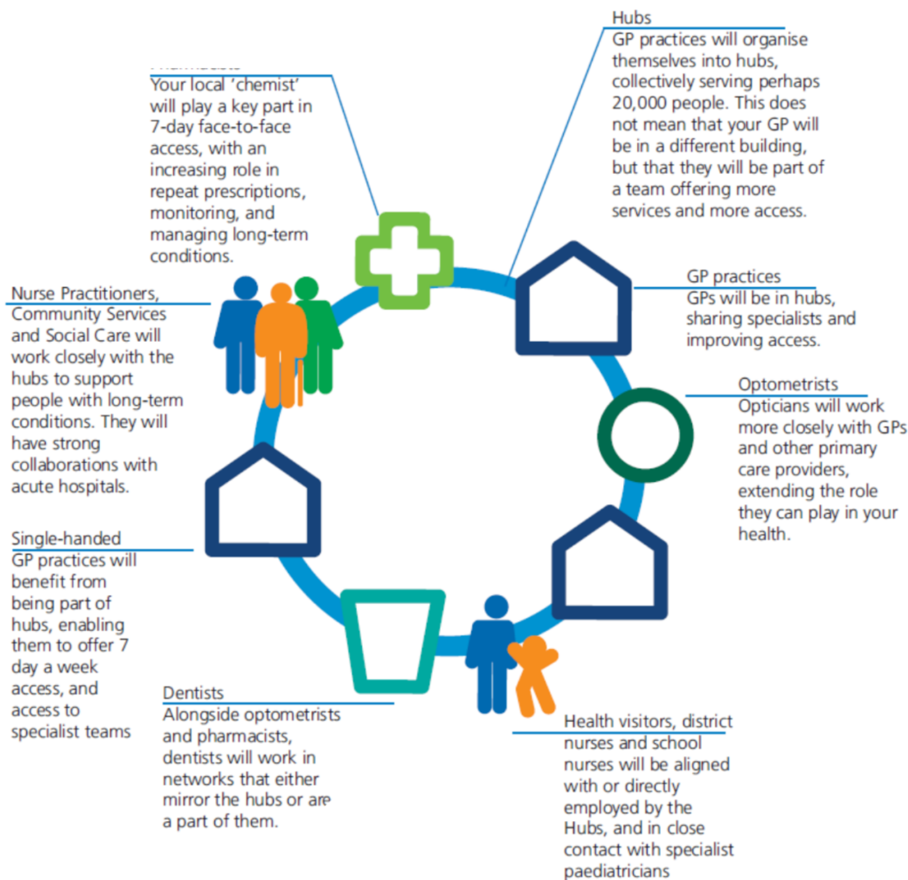
The current offer provides support and advice at the time of diagnosis, but typically little ongoing support until crisis is reached – a situation that often results in premature reliance of more intensive models of care and support. The 2011 House of Commons Select Committee report on dementia stated:

‘People with dementia stay far longer in hospital than other people admitted for the same

procedure, often unnecessarily. The National Audit Office study in Lincolnshire found that more than two-thirds of people with dementia no longer needed to be there. This represented a total of £6.5 million that could be invested more appropriately in other services. The King's Fund extrapolated from this finding that over the whole of England, this would equate to more than £300 million that could be allocated more productively.'

Although not already in existence, as part of this BCF Plan and aligned to it will be the development of our Timely Intervention and Prevention Service focused initially on dementia for the reasons outlined above.

Delivering Co-ordinated Care
The delivery of other key work streams e.g. seven day services and the primary care strategy are also echoed within the BCF approach. Part of the proposed future model of primary care is the co-location of relevant services around confederations of GPs. This is also a key work stream within the BCF.

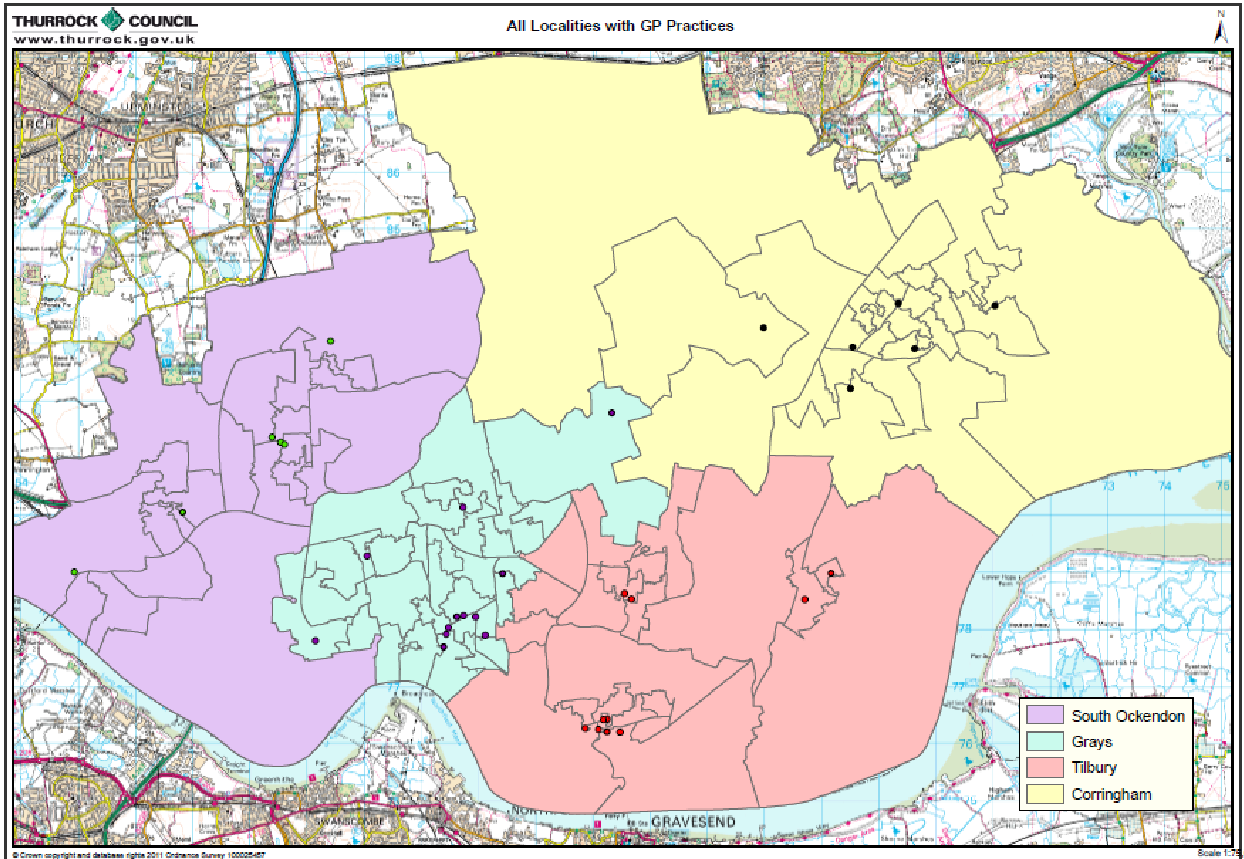


A system-wide Operational Resilience and Capacity Plan is in place. Whilst these focus on short term initiatives to manage day to day pressures in the system, the plans enabled by the BCF are seen as the longer term solution to managing fluctuations and growing demand across the unplanned care system. The projects funded through the 14/15 Resilience Monies have been targeted to help inform and/or pump prime BCF related initiatives.

The monies identified through the Call to Action programme (£5 per head) and the CCG endorsement of the NHS England Direct Enhanced Service for Avoiding Admissions, have been aligned to the longer term integrated commissioning and delivery

programmes. For example, developing integrated health and social care co-ordination for high risk patients supporting the role of the Accountable GP for the 75s and over age group.

To facilitate improved access and integration the CCG has been working in partnership with social and primary care providers to realise co-terminous health and social care hubs, linked to the Community Hubs in the Borough; helping shape decisions being made as part of the wider primary care transformation programme.



This map indicates the proposed localities for the integrated service model outlined within BCF Scheme 1.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

Thurrock CCG's 5 Year Plan identifies a number of areas of focus (under pinned by the JSNA). These developments span health and social care. The principles outlined within this document are also the principles within the five year plan. The work programme within the two year operational plan is geared towards the delivery of these principles;

Principles	CVD - Cardiology	CVD - Stroke	CVD - Heart Failure	Haematology	Respiratory Review	Cancer Services	Diabetes Service Review	LTCs in patients w/ MH cond.	Continence Service Redesign	Personal Health Budgets	Under 19 High Impact Pathways	Ambulatory Emergency Care	Dementia Screening	IAPT	Community Geriatrician Model	MSK Pathway	RRAS and Reablement	Continuing Healthcare Review	Community Bed Provision	Parity of Esteem	BCF Programme	Improving Quality	Acute Service Review
1) Empowered citizens who have the 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 health and live independently for as long as possible																							
5) Systems and structures that enable and deliver a co-ordinated and seamless response																							

The key schemes within the BCF are all included within the CCGs two year operational plan.

The key risk associated with differences between the two year plan and BCF that has been identified is a variation between primary care federation boundaries/community health boundaries and social care operational boundaries. A key requirement of the two year plan and BCF is the co-location/alignment of services into the federation model however, from an operational delivery perspective this may require significant change. Work is being undertaken to understand the differences and how we could mitigate any issues.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

The vision for integration is set out in the CCG 5 year strategy and 2 year operating plan. Therefore, the BCF is an important step in a pre-existing journey towards integration. Primary care clinicians have been at the heart of this journey. Over the last 12 months we have engaged with primary care on a number of different occasions including:

- In December 2013, a workshop was held with GPs and the local authority to set out the vision for integration.
- Include work at Clinical Executive Group (which is the key engagement route for all GP practices in Thurrock) on developing locality hubs
- In September and November 2014, presentation at the Finance and performance committee
- In December 2014, BCF presentation at Board seminar

The comments from primary care re-enforced the sense of a shared vision for Thurrock based on the understanding that we are ‘stronger together’. Colleagues articulated the

need to deliver value for money by working smarter, removing hierarchy [where this impedes decision making], encouraging active citizenship, focusing on prevention and rehabilitation and sharing responsibility/risk.

We have recently undertaken an extensive engagement process regarding primary care access and, in particular, the Grays Walk In Centre. A theme from this engagement was the need to improve equitable access across Thurrock, and the limitations of one walk in centre for the whole of Thurrock. This has further confirmed the support for improved access based on a locality model.

The CCG has been successful in bidding for primary care transformation funding. The funding has been awarded to provide one session: 9am – 12.30pm, on a Saturday and a Sunday in four "hubs" in Thurrock – which will be aligned to our locality models. The hubs will be providing urgent care services for patients through one GP, one Practice Nurse and one receptionist in each of the four services.

The move to community hubs will also be the focus for our upcoming application for the Prime Minister Challenge Fund. This will build of the successful primary care transformation bid so that we can continue to extend primary care access based on the locality model described in scheme 1. If successful the bid will allow us to open up additional sessions in each locality.

A team has now been established to oversee the implementation of this arrangement, with the first hub planned for opening in mid-January. This team includes four clinical leads, one for each of the localities as follows:

Dr Anil Kallil: Grays Locality
Dr Bhatt: Tilbury Locality
Dr Verghes: South Ockendon Locality
Dr Deshpande: Stanford-le-Hope Locality

This team will be working with the General Practice community in Thurrock to identify suitable premises for the hubs to operate from, as well as establishing the rota for weekend working. We will be keeping Practices up to date when this programme commences, through a dedicated page on the CCG intranet, email and our regular engagement forums, including CEG.

The CCG is committed to improving the capacity and quality of Primary Care in Thurrock. We are currently supporting the development of a local Primary Care Strategy. The key issues we are seeking to address in the primary care strategy are an ageing workforce, poor provision of GPs in comparison to the population and growing population.
The development of primary care firmly aligns with the Better Care Fund. The CCG is working with the Area Team on the co-commissioning agenda but has not expressed an initial interest in co-commissioning services with NHS England.

The whole system redesign group and the primary care transformation group will continue to work seamlessly to deliver the vision for integration set out within our strategy and the BCF.

7) NATIONAL CONDITIONS
Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Our approach to protecting social care services, and therefore our definition, is as follows:

Reducing Overall Demand
The client number projections from September 2013 up until April 2018 in Figure 1 below shows the expected natural increase via demographic pressures the Authority will face from now up until April 2018. This is an expected trend due to the nature of the population mix, coupled with an ageing population.

Fig 1 – Adult Social Care Residential Home Placement Numbers

	Actual	Projected				
	Sep – 13	**Apr-14**	**Apr-15**	**Apr-16**	**Apr-17**	**Apr-18**
Standard placements	286	300	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	**381**	**402**	**414**	**425**	**434**	**443**

Efficient, effective social care services are essential in reducing demand for 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 system, 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-orientated – re-focusing services and re-commissioning services as necessary;
- Opportunities for out-sourcing to local community-based providers (CIEs, micro-enterprises etc.)

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

- Joint commissioning of integrated health, public health, social care and housing services;
- A mixed economy of locally run care services; and
- Social prescribing – linking people up to activities in the community that they might benefit from (there is increasing evidence to support the use of social interventions for people with mild to moderate depression and anxiety, and people who are frequent attendees in primary care).

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. In addition to our Well Homes initiative, we have embarked on a housing development programme to develop HAPPI housing for older and vulnerable people (partly funded by the Homes and Community Agency and our own Housing Revenue Account); we have successfully piloted Local Area Coordination and have extended the approach in order to divert people away from formal services and find informal local solutions; and 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.

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 estimate that pressures on external placements will increase by at least 20%. We have reflected the increase on external placements in our spending plans. We will also be identifying how the BCF can help to support existing social care services – these will be detailed within our Section 75 agreement. 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 the resource should be shifted to.

Our approach to investing in early intervention and prevention solutions will assist with ensuring that resource is used as effectively and efficiently as possible.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Thurrock applies the eligibility criteria of substantial and critical – this will remain as a result of the Care Act’s implementation from 2015 and the National Minimum Eligibility

Standard.

Through the BCF, the local authority and the CCG have identified investments that will contribute towards the protection of adult social care. These are contained within the schemes as shown below:

Scheme	Contribution £000
2	2,217
3	240
4	72
Total	**2,529**

All of this funding is in addition to the mandated allocation for the Care Act of £ 522k.

In addition, we are taking a number of practical steps to be able to maintain eligibility levels which includes:

- Our approach to prevention and early intervention as expressed within Scheme 4 – we are expanding our community-based prevention and early intervention approach as part of the BCF to ensure that we reduce the need for care and support. We will have full Borough coverage of our Local Area Coordination initiative which is key to this approach
- Through the application of the Care Act (scheme 5) we are enhancing our information and advice offer to better signpost individuals and their carers to support; expanding our provision of advocacy and reaching out to self-funders who will be our responsibility from April 2016.
- We have restructured our social care fieldwork teams so that they align with community health services and around the four GP clusters to ensure a multi-agency approach that identifies those people at risk of crisis at the earliest opportunity and navigates those individuals to receive an appropriate service (scheme 1)
- We have and are enhancing our intermediate care offer to ensure that we offer a menu of options that assists with enabling individuals to stay out of hospital or reables that individual to live as independently as possible within their own home (scheme 3)
- We are working towards an integrated frailty model that will identify people at the earliest opportunity and ensure that they enter the right part of an integrated model (scheme 2).

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

We have identified £522k as part of our approach to implement and deliver the Care Act. Delivery of the Care Act will also help to support our ambition to protect social care services – e.g. through a focus on reducing, preventing and delaying needs.

We are taking a whole-system approach to the protection of adult social care services and have identified a figure of £2 million. We aim to achieve this in a number of ways that include:

- Review of existing schemes;
- Reallocation of resource;
- Contribution of the 'pay for performance' element of the BCF – whilst acknowledging that the amount to be achieved is an unknown quantity.

With regards to the pay for performance monies, we see any money secured as supporting efficiencies and transformation across the system, and not solely the protection of social care services.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Council, as part of the Health and Social Care Transformation Programme, has established a Care Act Implementation Project Group. The Group has assessed the Council's readiness against the Care Act's requirements and identified the work that needs to take place between now and April.

Key elements are as follows:

- Carers – assessment and support;
- Information and Advice – system/material development;
- Safeguarding – implementation of new responsibilities;
- Assessment and Eligibility – primarily change in eligibility;
- Capital investment funding – e.g. IT systems for personal budgets.

The Care Act implementation funding will be used to ensure readiness for April 2015. A full readiness assessment and related action plan is available.

v) Please specify the level of resource that will be dedicated to carer-specific support

Within the BCF, we have identified £178k for investment into carers' support. We are keen to ensure that the provision of carers support is integrated within our overarching service model and therefore have included the development of our carer's services into BCF 2. Frailty Model. The key elements of this part of the programme are the identification and recording of carers within a central list, improving the provision of carers support within generic services e.g. COPD specialist nursing providing carer support through education and telephone support, commissioning of specific carer support interventions e.g. carers breaks, support groups. Additionally, we will be using the resource available to support the sitting service for older people currently provided by Adult Social Care.

Through the BCF, the Council and CCG are keen to ensure that we use the available evidence to commission the right range of support packages available. The Systematic Review of Interventions for Carers in the UK study (Victor, 2009) identified the following interventions as having a significant impact on wellbeing of the carer and the individual cared for;

- Ensuring that the quality of carer assessments is as important as the numbers assessed
- Provision of carer support groups that are both specific to a presenting condition and more generic

- Improving the level of education to carers on the specific conditions of those they care for
- Provision of carers breaks

Ensuring providers consider the needs of less assertive carers and put in place proactive approaches to supporting those carers.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

We are taking a whole-system approach to the protection of adult social care services and have identified a figure of £2 million.

b) 7 day services to support discharge

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

We are committed to improving the quality of services provided for our population and see the BCF and integration as the vehicle through which we will continue to seek new ideas and opportunities for advancing 7-day services I partnership with our providers.

We have already made significant progress towards this vision. For example:

- Rapid Response and Assessment Service (RRAS) – extended weekday hours (9am – 5pm);
- One Response Service (End of Life SPOR model) – 24 hours, 7 days a week
- Thurrock Social Workers – 7 day hospital cover including on-site provision 6 days per week;
- Intermediate Care (health and social care) – provision for admission and discharge on Saturdays and Sundays;
- Nursing Homes – premium payments for homes that can admit at short notice/weekends; and
- The Right Place, right Time Programme (RPRT) at Basildon Hospital (BTUH) focused on 7-day services.

The Whole System Redesign Group will drive the next steps towards further integrated 7 day a week working. This forum is a multi-agency group including health commissioners, social care commissioners, mental health service providers, community service providers, local authority service managers and patient and service user representative groups. The Group has organised a system workshop for early January to consolidate the work to date and build consensus on the next steps. This is an important milestone for the Group so that we can engage with wider stakeholders to build consensus. The collaborative approach will ensure that we are able to work together to manage concerns and risks.

The timing of the workshop is important because we shall reflect the principles of integrated 7 day working within the upcoming contract negotiation round. This will be a key component of Service Development and Improvement Plans (SDIP) over the next two years and beyond. Health and Social Care commissioners across Thurrock will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary

admissions and support discharge. We are fortunate that the whole system is committed to this direction of travel and will continue to collaborate on the development of these action plans.

Clearly, this vision is aligned with the NHS Outcomes Framework, two year operational plan, five year strategy and the Primary Care Strategy (see primary care section). This will be critical to meeting the ambition of delivering 7-day services. Over the next five years, work will continue to explore innovative solutions – including optimising primary care provision, pharmacists, optometrists and dentists to support 7-day services based on the community hub model championed in Thurrock'.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

In Thurrock, the NHS number is already used as the primary identifier for correspondence across health systems.

In adult social care strong progress has been made in adopting this practice and improving the proportion of social care clients with their NHS number matched and recorded on the adult social care LAS system. Adult social care have carried out a number of data matching exercises and utilised the national number matching service to support this. This has realised a match of some 85% to date -, this foundation gives us confidence as we aim towards 100% of clients being identified in this way.

In addition, the council, together with health partners have signed up to be a second wave follower on the national Child Protection-Information Sharing (CP-IS) project. The supplier of the children's social care IT system is an approved provider for the project. To support the project, children's social care are also working to capture NHS number within the system. We anticipate going live with this project in summer 2015. The learning from this process will be adopted into our approach and strategy for adults to ensure consistency.

Thurrock Council and Thurrock CCG are developing an IM&T Strategy that will set out the future direction of travel for information, governance and systems development. This is a key focus in the next financial year. The strategy will include a specific focus on the following:

- Consent models
- Data sharing and information governance
- Recording management
- Risk stratification
- Systems development and architecture

The strategy will underpin and support the delivery of key priorities and schemes within the BCF including the extension of MDT, single care coordinator and single assessment.

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

- System One is widely used across health services and provides a strong foundation for future development.

- Social Care uses an IT system (LAS) that provides an electronic record across all social care services. It also allows health partners and staff to view information, contribute to information and to support the provision of support and services e.g. joint re-ablement and RRAS teams. 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 and are fully compliant with an open set of APIs.

- Social care are working with the mental health trust (SEPT) to ensure the interface and sharing of appropriate information between the LAS and eCPA system. Progress is being made, though work is ongoing. This will significantly improve the productivity of staff and reduce the requirement for dual entry to systems and dual recording of care information. In addition, this will also deliver the added benefit of improved performance and financial monitoring.

- 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, provision of targeted interventions and resources where needed and support shared performance reporting. This will be supported by use of the NHS Number.

- In doing so we are engaging with a neighbouring area – Southend. Southend are a Pioneer for BCF and are implementing the same system. The Department of Health have assigned an information governance resource to support Southend with the development of the system and Thurrock will work with both to obtain assurance in respect of our approach.

- In preparation for the implementation of this system (Care and Healthtrak) Thurrock has undertaken a number of a number of preliminary exercises have including:
  - Consent to share sought from all known Thurrock adult social care clients;
  - Changes to operational policies to ensure consent is sought upon first contact with adult social care clients; with confirmation of decision sought annually;
  - Review and alignment of social care information architecture for alignment to acute health data;
  - Thurrock LA and CCG have created a suite of reporting templates with Pi Benchmark to realise a joint risk-stratification tool once Information Governance allows.

Thurrock actively awaits the results from the Southend Pioneer project on how they

have utilised Health & CareTrak; within the current limitations of Information Governance. We are committed to adopting an approach and practice that meets the approach and recommendations that may flow from this.

- Thurrock has recently reviewed options 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.

The development of an IM&T Strategy (as outlined above) will provide the future basis upon which systems development, procurement, architecture will be based.

Please explain your approach for 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 Caldicott 2.

Thurrock is fully committed to ensuring compliance with all information governance, confidentiality and data protection requirements.

Thurrock is compliant to level 2 of the Information Governance Toolkit for the period April 2014 to 31 March 2015 and meets all requirements in respect of existing practice and operation (see follows). There are no specific risks requiring mitigation in year.

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

Internally within the council, a project group leads work on the IG Toolkit. This includes adult social care, children's social care, public health, IT and information governance.

The priority areas to be addressed for submission in the 2015-16 IG Toolkit (by 31 March 2015) and forming the work plan for this Group relate to the following areas:

- Evidencing PSN Certificate of compliance;
- Formalisation of Information Management and Governance Strategy;
- Reviews of staff compliance with IG guidelines as audit trail
- Information Assett management;Details on the role of Caldicott Guardian, review of Caldicott Issues log and evidence to support;

Social Care has amended its service user information governance statement to incorporate sharing of information with health partners on an electronic basis in support of the preparatory work for the implementation of Care and Healthtrak. As highlighted above, we have engaged with Southend (as a Pioneer) to seek and share the DH IG advice and recommendations that emerge in respect of IG.
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).

The NHS Standard Contract and Community Contract includes all required provisions.

Initial contracting arrangements for BCF will see Thurrock LA become a commissioning associate to the CCG's existing NHS Standard Community Contract arrangements for all services part or fully commissioned from healthcare *(public or private sector).* We anticipate the portfolio of non-healthcare services will gradually transfer over to the NHS Standard Community Contract as we see the development of integrated health and social care services; thus recognising the need for heightened governance arrangements and processes.

The Director for Adults, Health and Commissioning is the Caldicott Guardian and oversees governance for adult social care. The Director for Children's Services is the Caldicott Guardian and oversees governance in respect of children's social care. Together, these roles ensure compliance with the principles and requirements supported by the Information Manager (Council).

d) Joint assessment and accountable lead professional for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

Thurrock is in the process of developing a joint-risk stratification strategy to identify when and how patients should be assessed; with the identification of associated benefits for each cohort of patients. We anticipate the risk-stratification will take into account: social and physiological indicators: e.g. a recent local review of our district general hospital admissions identified a relationship between inappropriate hospital attendance and admissions with those patients living alone.

A precursor to this initiative has been the development of:

- **Primary Care MDT reviews**; with health and social care parties identifying patients for review. Patients within this programme are largely those already known to the system i.e. under active review by GP, community nursing or social care.

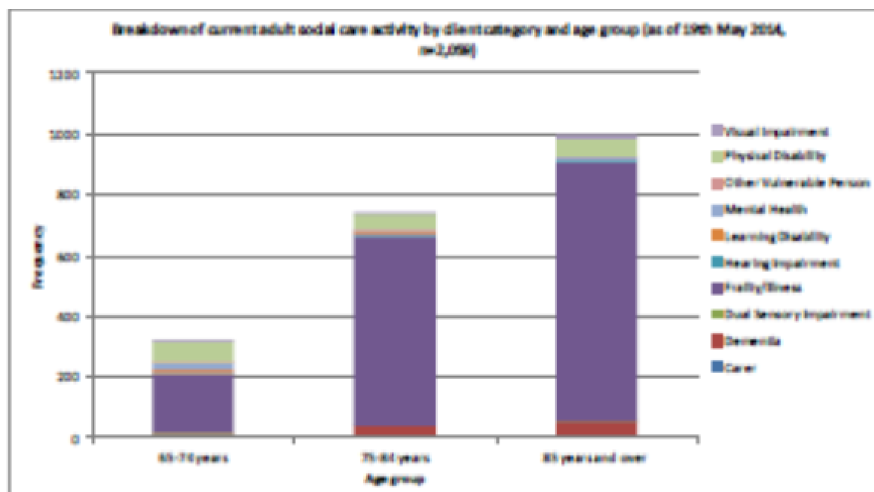
- **Unplanned Care Directly Enhanced Service:** Within 2014/15 practices in Thurrock have carried out risk-stratification of their registered population; identifying those at most risk of a non-elective admission into hospital. This has seen 2% of the population receiving joint integrated care plans c.3,400 patients; with a proportion of these being reviewed within the Primary Care MDT reviews.

- **End of Life Register & GSF:** Over and above those patients identified for Primary Care MDT reviews and this year's Unplanned Care DES, all practices in Thurrock have signed-up to undertaking GSF reviews. In partnership with this we have incentivised our community provider *(through CQUINs)* to aid the further development of the existing End of Life register. We anticipate that with these measures Thurrock's End of Life register should be nearing the 1% national benchmark by 2017; with integrated care-plans, anticipatory prescribing and key contacts.

- **Long Term Conditions:** Work continues to improve the long-term condition registers and the pro-active management of conditions e.g. introduction of patient passports for COPD.

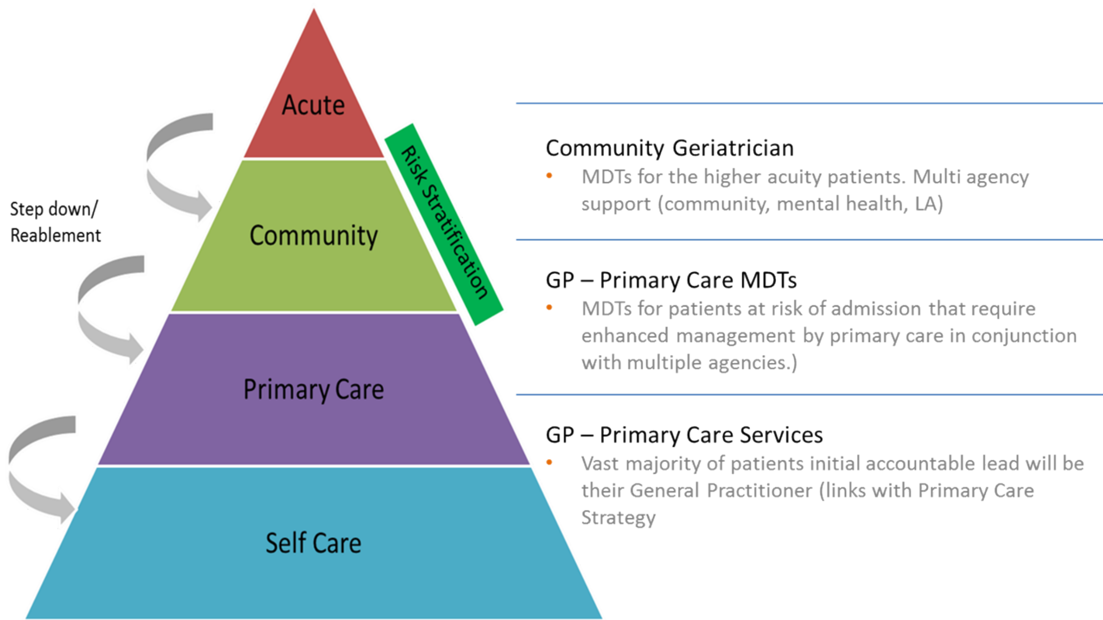
Patients identified within the above work-streams are recorded on SystmOne *(through use of Special Patient Notes)*; to inform services coming in contact with each patient e.g. NHS 111, and thereby ensure care is managed accordingly. Moving forward we will need to ensure patients identified as being at risk of admission due to their social indicators are flagged in a similar fashion to inform their care package including support measures *(where required).*

Adult Social Care Analysis *(p32 HNA)*



Thurrock's position in terms of risk stratification and risk segmentation and future approach is included earlier in this document (refer to Case for Change and Plan of Action)

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population



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.

Actions and Milestones

Our actions and milestones for joint assessment and accountable lead are as follows:

Work Programme Initiative	**Start Date**	**End Date**
Primary Care Multi-Disciplinary Teams *(H&SC)*	Apr 2012	On-going
End of Life GSF Reviews *(H&SC)*	Sept 2014	On-going
Health & Caretrak Development & Implementation: Risk Stratification of patients *(H&SC)*	Apr 2012	On-going
Long Term Conditions *(LTC)* dashboard Development: LTC management in practice inc. anticipated/reported prevalence, utilisation of services, QOF.	Nov 2014	Mar 2015
Development of improved LTC pathways to address inequalities across the local health economy *(inc. variation in practice/pt outcomes)*	Mar 2015	Sept 2015
Development of locality integrated service model *(H&SC)*	Jun 2014	Jan 2015
Implementation of the four integrated service areas *(H&SC)*	Apr 2015	On-going
Central case management *(by each four locality)* of patients identified as having a high risk-scoring including alignment of Care Homes to each area.	Apr 2015	On-going
Review & development of co-morbidity clinics *(H)*	Dec 2014	Mar 2015

Implementation of the co-morbidity clinical model *(H)*	Sept 2015	On-going
Review & Utilisation of accessibility mapping software to inform future service development and commissioning arrangements *(rurality and accessibility to services encompassing transport).*	Jan 2015	Apr 2015

The Role of Primary Care
This model is underpinned by the Primary Care Strategy which seeks to strengthen primary care and improve capacity and sustainability.

The Clinical Commissioning Group will be supporting GPs to utilise the £5 per head to support the development of primary care capacity and quality that will enable the GP to be the Accountable Lead Professional in the vast majority of patients.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

We expect that by March 2015, at least 70% of the expected 3,100-3,400 patients requiring a joint care plan will have a plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

As part of the Council's and CCG's Health and Social Care Transformation Programme, we have established an Engagement Group. The Group is comprised of key representatives of the voluntary and community sector, including Thurrock Healthwatch. The Group's purpose is to advise on engagement with users of services, carers, and the general public. The representatives on the Group are able to facilitate engagement with patients and service users due to their reach with groups and individuals across Thurrock. This includes seldom heard from groups within Thurrock's community. Engagement takes place through a variety of means, e.g. sign posting to specific individuals or groups, bespoke events, or utilising existing meetings and events – e.g. via Thurrock's Commissioning Reference Group bi-monthly meetings. The Group has developed an Engagement Plan, and has also developed a process for involving users of services, carers and the public in commissioning and service development (signed off by the Health and Wellbeing Board at its July 2014 meeting).

Extracts from the Health and Social Care Engagement Plan

Thurrock Council (the Council) and Thurrock Clinical Commissioning Group (the CCG) are committed to engaging and involving citizens and community groups in developing a vision of what integration will look like, and the principles that will underpin that vision.

Together with Thurrock Council for Voluntary Services (the VCS), Thurrock Healthwatch, Thurrock Commissioning Reference Group (the CRG) and Thurrock

Coalition we have already developed the high level principles that will frame our joint vision. These 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

In pursuing our vision, Thurrock CVS, Thurrock Healthwatch, Thurrock CRG and Thurrock Coalition have also agreed to work with Thurrock Council and the CCG in a process by which:

a) citizens will be involved, at the earliest stage, in conversations to refine and confirm the vision and the high level principles for integrated health and social care services, and

b) the manner in which the principles should be applied across the whole health and social care system to ensure better care for the people of Thurrock will be jointly determined - with the initial focus being the health and wellbeing of older adults.

This Plan will be delivered in agreement with the principles of the Thurrock Joint Compact 2012 and the Thurrock Community Engagement Toolkit

To enable citizens and community groups to participate fully in the co-production process, we recognise that clear and accessible information about the challenges and choices facing them must be made available in a timely manner.

From the outset engagement will be::
- Honest and transparent about the scope of change, and the enablers and constraints in the change process;
- On terms, in places and at times which suit citizens and communities;
- Two way, with information being imparted and received, and delivered in a manner which encourages questions and constructive criticism; and
- Responsive to what we hear, where ever possible giving an account of what will be done with what we learn and the likely outcomes.

That way that the Health and Social Care Transformation Programme communicates will
- demonstrate integrity and public accountability;
- be clear and easy to understand;
- Provide feedback where people have engaged using the ‘you said, we did’ methodology; and
- be appropriately targeted to the communication needs of our various audiences.

Governance arrangements

This Communication and Engagement Plan forms part of the Programme Initiation Document for the Health and Social Care Transformation Programme Board. The arrangements for engaging citizens and communities will be overseen by the Health and Social Care Transformation Programme Board, reporting to the Health and Wellbeing Board.

The Health and Social Care Transformation Engagement Group is responsible for developing and overseeing the detailed programme of engagement activity. The Group's membership includes:

- Thurrock Healthwatch
- Thurrock Coalition
- Thurrock Commissioning Reference Group (CCG Lay Member for Public and Patient Involvement)
- Thurrock Council for Voluntary Services
- Thurrock CCG
- Thurrock Council

Components of the Engagement Plan include:

Information Exchange:
- A range of briefing sessions at public meetings such as the community fora
- A presence at community events
- Briefings with representative and special interest groups
- Specially convened listening events

In-depth soundings including:
- Focus groups – i.e. people with Long Term Conditions
- Individual interviews with experts by experience
- Joint Strategic Forum

Working groups:
- Citizen involvement in whole system reviews of care-pathways, commencing with the care-pathway for older people.

Locality based conversations:
- Building on the local presence of Community Fora, community organisers, local area coordinators and Asset Based Community Development - community builders.

The Engagement Group recently met to agree their role in the review of existing Better Care Fund schemes. They are also represented on the Whole System Redesign Project Group, Care Act Implementation Project Group, and Health and Social Care Transformation Programme Board.

In April, the Council and CCG held a stakeholder event to gauge stakeholder feedback – including users of services, carers and the public – on the principles that underpin the vision for Health and Social Care. The Better Care Fund has also been discussed at Thurrock's Clinical Reference Group.

Considerable community engagement has already taken place on some of the elements that are incorporated within and aligned to this plan – e.g. Local Area Coordination. An innovative recruitment process involving community representatives, designed by Thurrock CVS and the Thurrock Coalition has been used for all LAC appointments and is increasingly used for other social care appointments.

Future engagement activity as part of developing and delivering this Plan will be guided by existing arrangements – i.e. the Engagement Group.

The success of engagement will be measured via the Engagement Group and its representatives, but in addition, Thurrock has chosen a service user satisfaction metric as part of its Better Care Fund metrics to measure the impact that service redesign has had on the quality of service provision. – '% of Adult Social Care Service Users who are satisfied with their services and support'.

b) Service provider engagement
Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Thurrock CCG is engaging with their main acute provider (Basildon and Thurrock University Trust), main community provider (North East London Foundation Trust) and main mental health services provider (South Essex Partnership Trust). Updates on the development of the BCF and the strategic direction of the BCF have been shared through a variety of forums including Thurrock's Strategic Leadership Group, contract management meetings and specific workshops.

Thurrock's Strategic Leadership Group has been in existence for a year and has already met a number of times. The focus of the Group is managing demand across the health and care system. An extract from the Group's Terms of Reference which shows focus and membership is shown below:

Membership of the Strategic Leadership Group includes:

- Thurrock Council – responsible for commissioning and providing adult and children's social care services
- Thurrock NHS Clinical Commissioning Group – responsible for commissioning a range of acute and community health care services
- North East London Foundation Trust (NELFT) which provides community services,
- South Essex Partnership Foundation Trust (SEPT) which provides mental health services,
- Basildon and Thurrock University Hospitals Foundation Trust (BTUH) which provides acute and secondary care services

In recognition of the important role, both now and in the future, of the voluntary and community sector, Thurrock CVS will be a member of the Group.

Remit of the Group:

- Receive and scrutinise national policy, best practice and independent investigation reports, as well as reports on the application of policies and performance locally, and agree at an early stage to jointly plan change to address any issues identified.
- Consider and advise on whether:
  - commissioning strategies reflect all elements of quality (experience, effectiveness, economy and safety) for service users and patients,
  - commissioned services ensure that the service user/patient sits at the heart of plans and decisions related to their care, and that services are being delivered in a high quality and safe manner.
- Advise on the effective management of risk for co-ordinated service delivery, market stability and sustainability, whether or not specific services are delivered jointly or not.
- Ensure a clear escalation process is in place to enable appropriate engagement of the relevant decisions makers within their organisations on any areas of concern related to the delivery of quality.
- Demonstrate clear commitment to the delivery of quality outcomes for the citizens of Thurrock, even where their interests cover a wider geographical area.

Commissioning intentions for 2015/16 have recently been sent to each of the main local NHS providers and detailed negotiations on the 2015/16 operational plans and contracts are currently taking place. This will include consideration of the delivery of QIPP plans, and their inter-relationship with the BCF Plan and the target reduction in emergency admissions. Provider risk management will be undertaken via contract negotiations and then through regular contract monitoring arrangements.

In addition, there will be regular dialogue with all providers through the System Resilience meetings (fortnightly) with the main providers and other key partners (OOHs, Ambulance Service, 111 etc). This forum is sub economy wide and so includes Thurrock CCG (a Lead or Associate to all the aforementioned providers' contracts). Therefore, the interface between the Thurrock BCF and the Essex BCF will be subject to provider scrutiny.

Within our Executive to Executive Contract Negotiations for 15/16, the BCF developments and their impact (for both 15/16 and beyond) will be a standing item to ensure that any contractual (activity, finance, specification, service development plan) requirements are agreed well in advance of signing contracts.

As part of the work streams identified, there will also be specific market development work both with incumbent and potential service providers

Both Health and social care providers were closely involved in the revisions to the Plan resubmitted on 28th November. They were also part of the impact assessment workshop that was provided by McKinsey as part of the support arranged by the BCF task force. Additionally, the further development of the Plan prior to re-submission was discussed and endorsed at Thurrock's Strategic Leadership Group meeting on the 27th November. This included senior executives from the key health providers (NELFT, SEPT, and BTUH) as well as the Council and CCG.

ii) primary care providers

There has been specific engagement on the Better Care Fund with GPs through the CCGs governance committees. In addition, through the Clinical Executive Group (all GP practices and other forums, GP members have been kept updated on the development of the BCF. More explicit engagement has been pathway related on the development of the co-location model, frailty services, mental health services and the interface between primary care and community (health and social services).

A workshop took place with the CCG Board and Health and Wellbeing Board in December 2013 to develop the five principles that underpin health and social care transformation in Thurrock, and therefore Thurrock's Better Care Fund.

iii) social care and providers from the voluntary and community sector

The Voluntary and Community Sector have and are being engaged through the Health and Social Care Transformation Programme – in particular through the Engagement Group. Members of the Voluntary and Community Sector are also members of key project groups:

- Care Act Implementation Project Group;
- Whole System Redesign Project Group;
- Health and Social Care Transformation Programme Board; and
- Thurrock Strategic Leadership Group (as described in ii above).

Please also note that Essex Area Team's deputy Chief Executive (Dawn Scrafield) has stated 'Thurrock is an interesting area as, based on my experience, they are one of the few areas that really are living the values of integration between Health and Social Care'.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Basildon and Thurrock University Hospital NHS Foundation Trust seek to reduce the bed base they currently commit for unplanned care activity. The Trust recognise that the current numbers of beds are unsustainable and are not the optimal way to deliver care to patients. Through the implementation of the BCF schemes and resultant reduction in unplanned care admissions the Trust will be able to reduce their bed base or convert the beds to an alternative use.

The target for reducing total emergency admissions contained within Thurrock's BCF Plan has been set at 3.5%. Whilst this is an ambition, given the history of activity related to unplanned admissions, achieving a 3.5% reduction will provide Thurrock with a significant challenge.

Thurrock has established a Strategic Leadership Group with membership comprising of the main NHS providers, Thurrock Council, Thurrock CCG, Thurrock HealthWatch, and Thurrock Council for Voluntary Services. How the system can work together to achieve significant reduction in unplanned admissions is one of the main agenda items.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

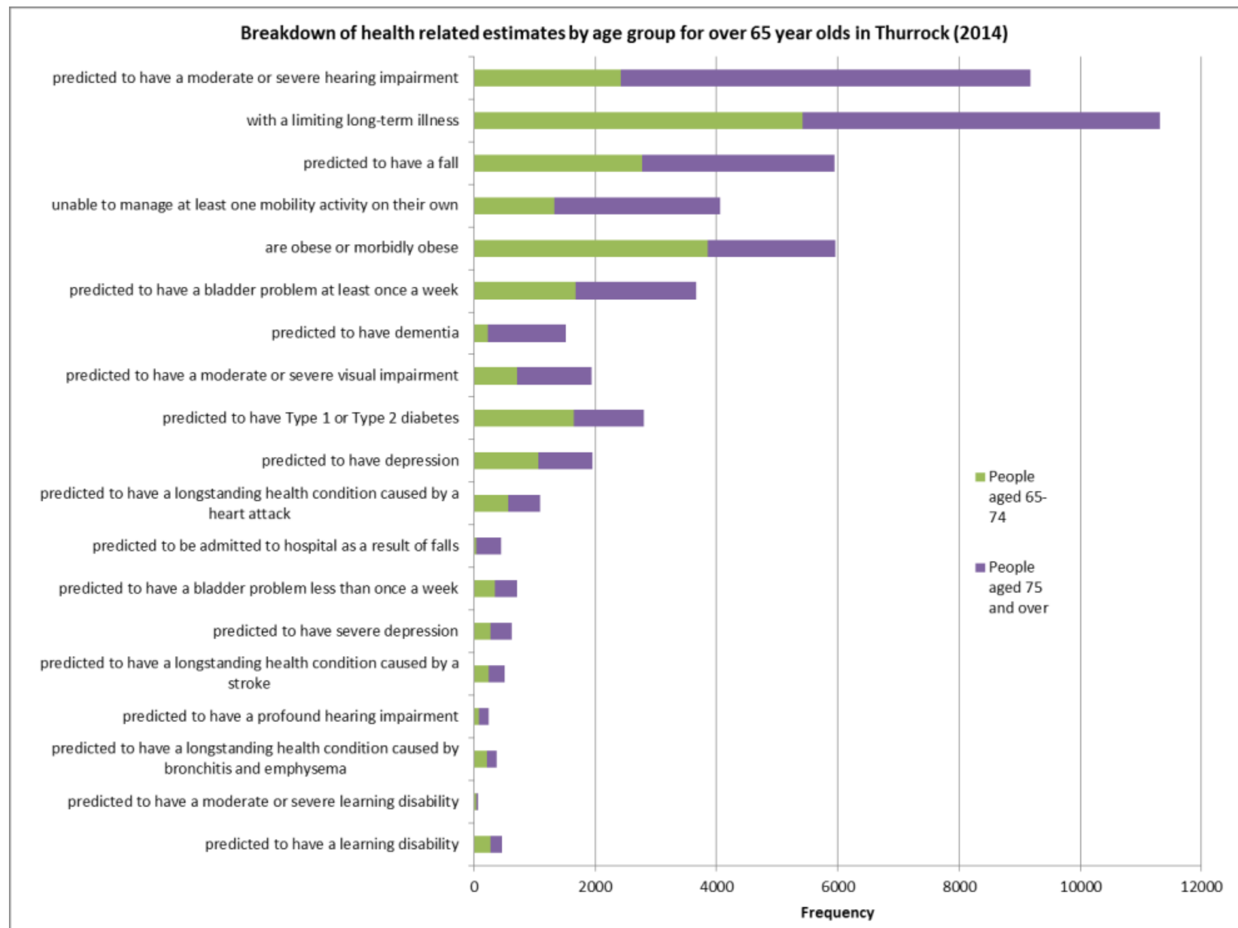
ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
BCF Scheme 1
Scheme name
Locality Service Integration
What is the strategic objective of this scheme?
The aim of Locality Service Integration is to integrate service delivery in Thurrock around 4 community hubs. Our aim will be to define an integrated service offer for the people of Thurrock based on detailed understanding of the local needs of each community. The Locality Service Integration Scheme forms part of the universal community offer for adults in Thurrock. However, the majority of people using the service will be adults aged 65 and over. The scheme will support people with stable long term conditions to live well with simple or stable long-term conditions so that they avoid unnecessary complications and acute crises. The scheme builds on the successes of the integrated Rapid Response and Assessment Service and the Joint Re-ablement Team. It will scale up the integration of health and adult social care services in broader integrated service model linked housing and a range of non service solutions including more responsive and resilient communities. The Locality Service Integration Scheme will integrate community health services, mental health services, housing and adult social care with primary care. It will be organised around the developing GP clusters to create a locality offer which addresses the strengths and needs of the diverse communities in Thurrock. The integrated offer will use risk stratification to target people who are most at risk of admission to hospital or a care home, providing solutions which will promote health and well-being, and ensure unplanned interventions are avoided. The scheme will generate efficiencies by reducing duplication, by improving service user and patient experience and satisfaction, and by providing solutions closer to home. As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a moderate or high risk of admission.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Locality Service Integration Scheme is primarily focused at adults aged 65 years and over. Evidence from the King's Fund (2013 Making Integration Happen at Pace and Scale) which makes it clear that integration is most effective where the target population is older people living with chronic conditions including mental ill health. The 65 and over cohort which numbers in Thurrock approximately 20,000 people will benefit from the prevention and early intervention services as set out in Scheme 4. The subgroup will be people with relatively simple and stable long term conditions. (BCF2 focuses on the frailty

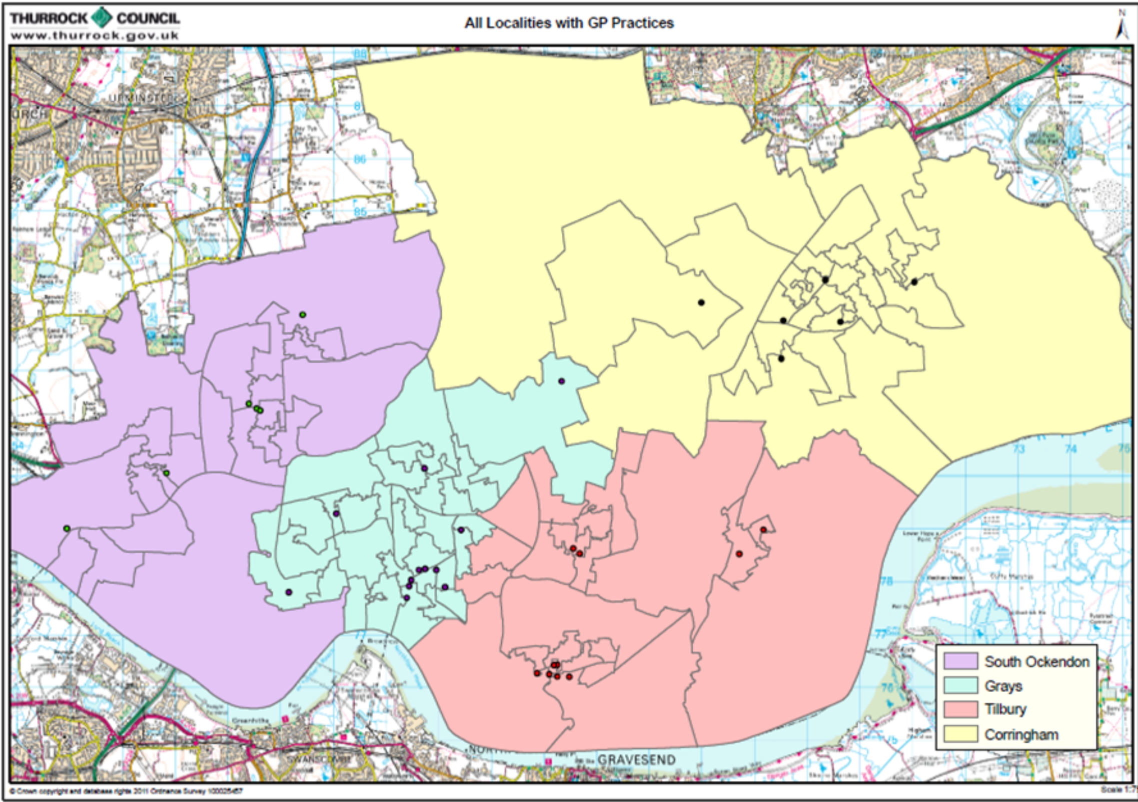
model and people with complex co-morbidities, BCF 3 focuses on those with re-ablement and rehabilitation needs and BCF 4 focuses on prevention and keeping people active)

The following table provides a summary of health related indicators for people aged 65 and over in Thurrock in 2014.



The model of integration for the Locality Service Integration Scheme was piloted with a Joint Re-ablement Team and extended through the Rapid Response Assessment Service, an integrated health and social care team which provides crisis management for service users in a timely manner, typically within 1-2 hours of the referral being received. This scheme takes integration further by organising health and social care service responses around clusters of GP practices. This will allow services to take advantage of a range of community assets for the delivery of care including GP surgeries and the community hubs currently being rolled our across the borough. To maximise financial and operational efficiencies electoral-ward based commissioning solutions are also being developed; responding to the disparate population needs. This will mean services responding to the specific needs of the local-ward population; with GPs working in conjunction with local community service providers, public health and social care. The BCF is strategically aligned to our primary care strategy. We have recently been successful in bidding for a primary care transformation fund. This bid will enable us to deliver improved GP access 7 days a week from community hubs. We aim to build on this success through our application to the prime minister challenge fund bid.

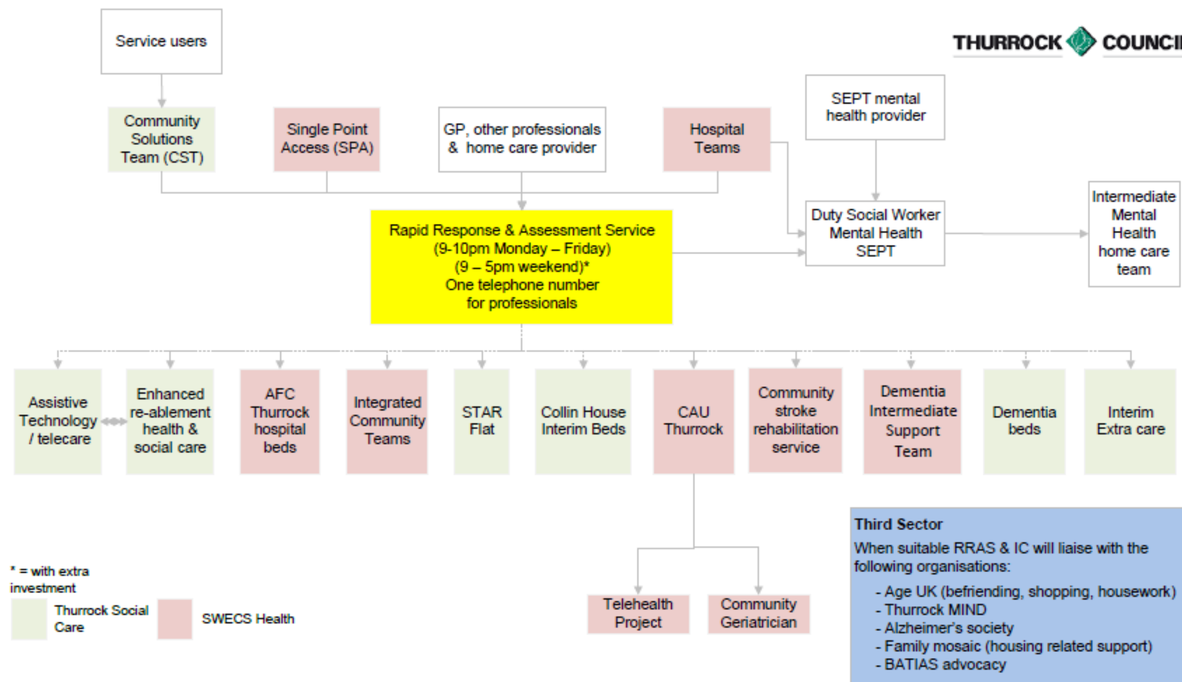
The GP clusters are shown on the following map:



The Locality Service Integration Scheme will be a partnership between Thurrock's adult social care services, and the community health providers (North East London Foundation Trust and South Essex Partnership Trust). It will have a Single Point of Access through referral from GPs, a wide range of community organisations or through Community Solutions – the triage service for adult social care in Thurrock. The initial response around each patient will involve a multi-disciplinary approach to risk stratification, facilitating the delivery of a wide range of solutions ranging from, for example, referrals to housing services where there is a need for adaptations or to the Frailty Model for those in acute need.

Thurrock recognises that carers are crucial partners in promoting health and well-being and believes they should not pay a penalty for the valuable contribution they make. The application of the carer's grant will be directed as part of this scheme as will the two carer support posts provided by South Essex Partnership NHS Foundation Trust (SEPT), and funded from the Mental Health Grant.

The integrated model of care will ensure a single care plan for each service user/patient so ensuring co-ordinated care and removing wasteful duplication. The service will provide a seamless pathway of care and support led by a care co-ordinator. The health and social care offer will be linked to health related services including housing (via Thurrock's tenancy services or Well Homes programme) and non service solutions through Local Area Co-ordination. The full menu of options is illustrated in the following diagram:



The costs associated with developing the Locality Service Integration Scheme and managing the changes will be borne by the providers within their existing budgets, and Primary Care Transformation monies will be used to enhance the primary care offer including the extension to 7 day.

A project implementation plan is being developed through our Whole System Redesign Group, this Group will ensure that the outcome of the reviews of all relevant current services will inform the design of the care pathway. The Governance arrangements for the Whole System ,Redesign as well as arrangements for engaging service users, patients and carers are described elsewhere within the BCF Plan.

The cost per case for the Locality Service Integration Scheme will be modelled in detail during the course of the first year to refine our understanding about the most effective, efficient and economic approaches to the management of long term conditions, and to promoting health and wellbeing for those with two or more morbidities.

The key milestones for the Locality Service Integration Scheme include:

- Development of integration governance arrangements and working groups – March 2015
- Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
- Full integration of the team, care coordination model, and sharing of information to enable management of risk – September 2015
- Cost benefit analysis of the first 6 month's operation – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Well established relationships exist between providers and commissioners and commitment to partnership working at all levels – e.g. Health and Wellbeing Board, Strategic Leadership Group, as well as at an operational level. We will build on the trust that has developed from our successes.

The delivery chain for this scheme is wide and interlinked with the other schemes that have been identified by Thurrock. The Whole System Redesign Group will closely manage the review and design of the care pathway ensuring that this is commissioned in partnership by housing, health and social care.

The integration of the commissioning approach will reflect the integration of the service delivery. The Care Act 2014 places a responsibility on all public organisations to work together and co-operate where needed to ensure a focus on the needs of their local population, and this is supporting our thinking in developing Locality Service Integration.

The Commissioners supporting the development of the Locality Service Integration scheme are:

NHS England - Primary Care
Thurrock CCG - Acute and Community Care
Thurrock Council - Social Care, Public Health, and Housing

As we shape the market to move to Locality Service Integration in Thurrock we build on the positive relationships that currently exist with providers and we will work in partnership to develop the model of care and support. There will be a range of providers involved in this approach including:

General Practice:

- Undertake routine Primary Care Multi-Disciplinary Team Reviews *(for patients identified as vulnerable / at risk of hospital admission)*;
- Gain patient consent *(for sharing and review of their needs with social care)* ahead of each multi-disciplinary team review;
- Participate and facilitate End of Life GSF Reviews *(for improved identification, review and care management);*
- Create and review integrated care plans for all patients with complex conditions;
- Adoption of standardised read-codes for locally agreed cohorts of patients e.g. coding of patients residing in a Care Home;
- Review and respond to any identified gaps in the detection and/or management of Long Term Conditions *(from the new CCG performance dashboard);*
- Repatriation of patients from secondary care management into the locality-integrated service model of care.

Basildon and Thurrock University Hospital NHS Foundation Trust:

- Continued delivery and development of Ambulatory Emergency Care Unit, Frailty Ward *(in partnership with community services);*
- Utilisation of 'Special Patient Notes' featured on SystmOne to improve assessment and management of presenting conditions;
- Facilitation of improved discharge arrangements including the implementation of an improved Comprehensive Discharge Plan;
- On-going reporting of inappropriate referrals / patient redirections *(for feedback to provider / identification of gaps in service);*

- Work in partnership with Community Services and the CCG to realise improved interface with acute-tiered services in a community-setting.

North East London Foundation Trust *(Community Services):*

- Development and on-going production of a performance dashboard for long-term condition management *(in partnership with the CCG, NHS England, and Public Health);*
- Development and implementation of the four locality integrated service boundaries *(health and social care provision);*
- Implementation of comorbidity clinics;
- Continued attendance and facilitation of Primary Care MDT reviews within general practice;
- Facilitation of End of Life GSF reviews in primary care including training in of general practice and care home staff;
- Continued delivery of Ambulatory Emergency Care programme *(in partnership with BTUHFT);*
- Continued provider-lead delivery of the Rapid Response Assessment Service *(RRAS) (in partnership with Thurrock social care);*
- Development and implementation of a rehab and convalescence model of care *(to realise optimal patient outcomes and reduce premature admission into care home)*.

South Essex Partnership Foundation

- Development and implementation of an integrated Single Point of Referral model for the population of Thurrock *(in partnership with NELFT);*
- Continued delivery of improving detection, assessment and care management of patients with Dementia;
- Continued improvements to timely responses and integration with non-elective acute and community services;
- Participation in Primary Care Multi-Disciplinary Team Reviews including the identification of patients requiring MDT review.

Thurrock Council & Clinical Commissioning Group

- Development and implementation of the four integrated service hubs *(in partnership with NELFT);*
- Implementation of a risk-stratification tool for the identification of patients in need, not already known to the service;
- Commission and implementation of a Falls Prevention service which is compliant with latest NICE guidance *(Public Health);*
- Review and rationalisation of estates to ensure a single point of care *(hub)* model is realised for each of the identified four localities.

St Lukes Hospice

- Implementation and delivery of a Single Point of Referral model for End of Life care in the form of 'One Response' service *(in partnership with NELFT / Social Care);*
- Delivery and review of a Fast Track Pilot to improve assessment and delivery of Preferred Place of Care;
- Support and participation in End of Life GSF Reviews.

Other smaller Private and Voluntary Sector providers

- Continued support and delivery service within agreed arrangements.

As the Council is leading a number of major regeneration schemes, including building a new town centre in Purfleet, the partnership will also have the potential to deliver new

and better health care facilities to further enhance the Locality Service Integration Scheme.

The budgets that are included within this scheme will be
- Integrated community teams
- Long term conditions
- Carers' Grant
- Primary Care MDT Co-ordinator

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Locally Thurrock has a coterminous Local Authority and Clinical Commissioning Group which facilitates a co-ordinated local response to health and social care needs. Utilising the approach to create federations of GP practices will align the response identified within our ageing well strategy, Building Positive Futures, this strategy focuses on key areas:

- Creating homes and neighbourhoods that support independence
- Creating communities that support health and wellbeing; and
- Creating the social care and health infrastructure to manage demand.

Aligned to the strategy the evidence base we have drawn on is:
- The Health Needs Assessment for the population in Thurrock over 75, undertaken by Public Health
- The data regarding numbers of patients over 75 registered with GP Practices
- The numbers of people aged 65 and over in receipt of care packages from social care (covering Critical and Substantial need)
- Those in receipt of re-ablement services from health and social care
- The number of people attending Accident and Emergency over 65
- The number of hospital admissions for those aged 65 and over and lengths of stay
- Data gathered from our Local Area Coordination
- Housing Data – e.g. from our Well Homes initiative

Ref BCF narrative re: case for change

The above has provided the evidence for us to focus on the implementation of this scheme. Although the number of A&E attendances and hospital admissions for those aged 65 and over may be less than for those aged under 65, the length of stay and the cost of support to the health and social care economy after discharge is far greater.

We will develop the Thurrock model based upon the learning of other pilot sites across the country such as:

- The Torbay Model – which saw reduced use of hospital beds, low rates of admissions for those over 65 and minimal delayed transfers of care (Thistlehwaite 2011)

- The North Somerset Model – which created four fully integrated MDTs to provide

case management and promote self care. This model integrated community health and social care works, community nurses, adult social care and mental health professionals (Windle et al 2010)

- The Hereford Model – this saw eight health and social care neighbourhood teams created that focused on chronic illness management such as diabetes, stroke, COPD and lower back pain. (Woodford 2011)

While drawing on other successful models of integrated care this scheme will ensure a focus on the specific needs of the residents of Thurrock and the assets of the communities within the borough.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investments	Current Service Provider	HWB Total £
Integrated Community Teams	NELFT	3,906,301
Long Term Conditions	NELFT	415,682
Primary Care MDT Coordinator	NELFT	51,130
Carers Grant	Various	178,000
		4,551,113

Scheme total: £4,551k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Co-location of Health and Social Care will have an impact for the patient with a single point of entry resulting in the correct intervention to support the patient to remain in the community and out of hospital. It will reduce duplication and enhance communication between different service responses.

The various pilot schemes that have been undertaken across the country have seen varying impacts for both health and social care services including (but not limited to);

- Reduced usage of acute beds for those patients under the care of the integrated teams
- Reduced usage of acute beds in the 65 years and over population as a whole
- Reduced admissions and A&E attendances for those under the care of the integrated teams
- Reduced average length of stay for medical non elective admissions
- Reduced delayed transfers of care
- Reduced admissions to long term residential or nursing home care packages

Research by the Buildings Research Establishment has shown the potential to prevent of falls by close working better with housing. The importance of good hydration is also recognised in the Prevention of Urinary Tract Infections.

Through this scheme, we would expect to see a combination of these indicators being delivered. In terms of reduced admissions, there are a number of commonly presenting conditions that we would expect to impact upon through the integration of services (highlighted green). It should be noted that other schemes will also contribute towards this impact – e.g. Frailty Model

Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212	**Urinary tract infection, site not specified**	230
Congestive heart failure	207	**Respiratory failure, unspecified**	164
Atrial fibrillation and flutter	181	**Volume depletion**	146
Fracture of neck of femur: closed	178	**Chronic ischaemic heart disease, unspecified**	145
Tendency to fall, not elsewhere classified	173	**NOT CODED**	138
Acute renal failure, unspecified	164	**Pleural effusion, not elsewhere classified**	135

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Wellbeing Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Robust data regarding the interventions of the teams within each morbidity cohort will be gathered. This data will support monitoring of effectiveness and outcomes and should include:

- Referral rates
- Outcomes of referrals, health, social care, joint or other interventions
- Length of time maintained out of hospital
- Follow up to ascertain re-entry points to the services

Comparative data form 2012-13 and 2013-14 regarding numbers of admissions to hospital for those patients over 65 to support analysis of effectiveness.

What are the key success factors for implementation of this scheme?
The following factors will be measured to determine the success of the scheme and used in the feedback loop to improve delivery: Proactive management of their disease or condition in the right environment with the right solution Fewer professionals involved in the delivery of care Service user satisfaction Ability to manage and utilise capacity across the system appropriately across the locality Reduction of unplanned admissions to hospital and care homes Creation of MDT approach to targeting patients aged 65 and over at risk of admission to hospital Creation of a more integrated RRAS/Rehabilitation service Good Partnership working Integrated commissioning approaches Our local metric is a key measure of success: ‘Prevention of admission of older people aged 65+ to hospital by providing effective urgent and crisis response (RRAS) and community/other support interventions. Reductions in the proportion of people (aged 65+) assessed by RRAS that require immediate hospital admission per 10,000 population aged 65+’.

Scheme ref no.
BCF Scheme 2
Scheme name
Frailty Model
What is the strategic objective of this scheme?

The Frailty Model aims to provide an enhanced tier of services to The Frailty Model aims to provide an enhanced tier of services to people who live with complex co-morbidities, including dementia and frailty. Health and care services will support older people with complex multiple co-morbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications.

The key element focuses on proactively identifying and supporting frail/older people and their carers who are at the greatest risk to prevent deterioration, and proactively supporting frail/older people and their carers to self-care and remain independent.

The scheme consists of two key workstreams:

I. Pre-emptive identification – as identified through the Locality Single Point of Access as described in scheme 1, treatment and co-ordination of service-users and/or their carers who have social and/or health risk factors through the development of a localised risk stratification tool and furthermore the use of a frailty risk stratification tool to identify the response required for those who present with complex needs – e.g. more than two long-term conditions.
II. Enhanced community provision for frail, elderly clients to improve their health and social care outcomes whilst realising the ethos of 'Right Time, Right Place, Right Solution' in accordance with each person's preference of care and treatment as denoted in their electronic integrated care record.

As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a moderate or high risk of admission.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

In Thurrock, we are developing a frailty model based on the principles of:

- care wrapped around the patient, whatever the setting of care and which is experienced by them as a single delivery system through multi-disciplinary, multi-organisational integrated care teams
- risk stratification to target the right services, at the right level, to the right people, reducing inequalities by delivering the best possible outcome
- high quality pathways for people to maintain and maximise independence, to live in their own homes and where inappropriate admission to an acute hospital is seen as a system failure
- a sustainable and cost effective system across health and social care, supported by the right financial framework

- transformed services through a seamless and integrated approach to health and social care

As we have said, this scheme is focussed on helping people live with complex co-morbidities, including dementia and frailty. The older people JSNA (attached) provides a detailed analysis of this population within Thurrock. We have targeted this population because we know that people with 2 or more long term conditions are some of the highest users of health and social care services.

As described within Scheme 1, Thurrock already has a number of integrated services in place between the Council and Community Health Provider (NELFT). These services are aimed at targeting those most at risk of Hospital or residential home admission through a 'right time, right place, right solution' principle, or ensuring that those in Hospital are able to leave hospital and are supported to live as independently as possible in the community whilst at the same time avoiding unnecessary readmissions.

There is a need for this scheme as Thurrock does not currently have a clear frailty model that is inclusive of all of the pathways that older service users may use. The frailty model will also enable evaluation of how services work together to provide support.

The scheme will aim to bring services together into a single integrated service framework that will enable service users to access the appropriate solution and for care to be joined up across providers and systems – including with mental health.

If the scheme was not taken forward then the current service provision would mostly operate in isolation – with the exception of those areas already integrated (e.g. Joint Re-ablement Team, Rapid Response and Assessment Service).

Risk Stratification – Frailty
In addition to an initial risk stratification exercise (ref. scheme 1), once an individual has been identified as having complex needs, a frailty risk stratification exercise will be carried out to ensure that the individual is able to access the appropriate part of the pathway. The improvement of this approach as part of the scheme is linked to the integration of the Community Geriatrician as described below.

Community Geriatrician
The scheme will build on the learning from the community geriatrician to develop a locality focused community geriatrician offer. Following an initial review, we will be integrating community geriatrician services into the frailty model to better meet the needs of the community. Also, as part of the risk stratification process (as described in scheme 1) to identify individuals with complex needs, the community geriatrician will be positioned at the single point of access. This will ensure that individuals will be referred to the right part of the pathway quicker as a result and will also be identified as complex at the earliest opportunity. This will be a distinct difference to what happens currently and will have an impact as a result.

Single Care Plan and Care Co-ordination
The benefit of the community geriatrician being at the Single Point of Access (SPA) will enable individuals with complex needs to be identified earlier and ensure that they access the right part of the pathway. A key element of this will be the development of a single care plan and a co-ordinated approach to that individual's care. A key impact of

this will be a reduction in the number of professionals that the individual sees in addition to an improved experience.

Rapid Response and Assessment Service (RRAS)
As part of the scheme, we will continue to build on the successful integrated RRAS service. Our service is aimed at those individuals who we think are likely to reach crisis point within 72 hours and co-ordinates and redirects care to the appropriate intermediate provider or service. The service has recently been evaluated and the recommendations from the evaluation will be considered as part of the work to be carried out during 15/16.

Menu of Choices
The success of the scheme is reliant to a great extent on the menu of choice that exists – which offers choice other than admission to hospital. A number of existing and developing services will be integrated within the approach which includes:

- Interim beds
- Step up beds and step down beds
- Extra care housing

The menu of choices as part of the frailty scheme link closely with scheme 3 – 'Intermediate Care' and should be read in conjunction with that scheme.

End of Life
Our model includes our desire to build on a good 'end of life' which we will aim to further enhance across the frailty pathway. Building upon the proactive end of life care coordination within Thurrock, we would aim to strengthen the identification and prognostic indicators for the monitoring of patients reaching the final year of life. This would include: maintaining the coordinated care register for end of life; ensuring advance care planning takes place; and embedding the delivery of end of life education across all care providers. Currently, 100% of all patients added to the coordinated care register all have an advanced care plan within 3 months.

Assistive Technology
Whilst we have used assistive technology solutions for some time, as part of the scheme, we will be building on the evaluation of the successes the community provider has had with telehealth – e.g. disease specific heart failure patients to facilitate discharge from acute and has improved quality of life and empowered patient to know more about their disease research project, successful management of Long Term Conditions through telehealth. Evaluation has shown that proactive telecare has reduced non-elective admissions(as contained within QIPP)

Older People with Mental Health
We have a very well established Older People Mental Health team, which as part of our social care fieldwork restructure has been strengthened. We plan to integrate further with other health colleagues, and we are looking towards the single point of access for GPs to include mental health to ensure a quick response in crisis. Co-location of this service will further enhance joint working with other services. Thurrock Council's Dementia Strategy has been recognised as an exemplar and this involves all services working together to meet the needs of people with dementia in the community currently being driven forward through our dementia friends training programme. A weakness at present is that we do not have a single pathway for people with dementia. Creating a pathway, including mental health will be a distinct improvement as part of the development and implementation of the BCF scheme.

Care Homes
As part of our plans to build on an integrated frailty pathway and reduce unnecessary admissions to Hospital, we recognise the need to support individuals residing in residential and nursing homes to ensure that they receive a timely response from RRAS and community teams. We have initiated Multi Disciplinary Team meetings in care homes via the community geriatrician reviewing all patients to identify those most at risk. Fewer people are going into hospital as a result. We have also undertaken training for care home staff and employed a dedicated Community Psychiatric Nurse to work with care homes to ensure mental health needs are identified. Further integration and development as part of this scheme will further strengthen our approach.

Ambulance Service
The frailty model's success relies on an integrated approach across all partners. This includes the local ambulance service. Work has and continues to be carried out with the ambulance service so that they understand the 'menu of choice' that exists over and above hospital admission. We are confident that this is preventing some unnecessary admissions to hospital.

The key milestones for the Frailty Model Scheme include:

- Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
- Single Care Plan and Care Co-ordination– September 2015
- RRAS Service development – September 2015
- Assistive Technology forward plan – January 2016
- End of Life strategy – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This primarily affects the following commissioners;
NHS England (Primary Care)
Thurrock CCG (Acute and Community Care)
Thurrock Council (Social Care Services)

And following providers;
General Practice:

- Undertake routine Primary Care Multi-Disciplinary Team Reviews *(for patients identified as vulnerable / at risk of hospital admission)*;
- Gain patient consent *(for sharing and review of their needs with social care)* ahead of each multi-disciplinary team review;
- Participate and facilitate End of Life GSF Reviews *(for improved identification, review and care management);*
- Create and review integrated care plans for all patients with complex conditions;
- Adoption of standardised read-codes for locally agreed cohorts of patients e.g. coding of patients residing in a Care Home;
- Review and respond to any identified gaps in the detection and/or management of Long Term Conditions *(from the new CCG performance dashboard);*
- Repatriation of patients from secondary care management into the locality-integrated service model of care.

Basildon and Thurrock University Hospital NHS Foundation Trust:

- Continued delivery and development of Ambulatory Emergency Care Unit, Frailty Ward *(in partnership with community services);*
- Utilisation of 'Special Patient Notes' featured on SystmOne to improve assessment and management of presenting conditions;
- Facilitation of improved discharge arrangements including the implementation of an improved Comprehensive Discharge Plan;
- On-going reporting of inappropriate referrals / patient redirections *(for feedback to provider / identification of gaps in service);*
- Work in partnership with Community Services and the CCG to realise improved interface with acute-tiered services in a community-setting.

North East London Foundation Trust *(Community Services):*

- Development and on-going production of a performance dashboard for long-term condition management *(in partnership with the CCG, NHS England, and Public Health);*
- Development and implementation of the four locality integrated service boundaries *(health and social care provision);*
- Implementation of comorbidity clinics;
- Continued attendance and facilitation of Primary Care MDT reviews within general practice;
- Facilitation of End of Life GSF reviews in primary care including training in of general practice and care home staff;
- Continued delivery of Ambulatory Emergency Care programme *(in partnership with BTUHFT);*
- Continued provider-lead delivery of the Rapid Response Assessment Service *(RRAS) (in partnership with Thurrock social care);*
- Development and implementation of a rehab and convalescence model of care *(to realise optimal patient outcomes and reduce premature admission into care home)*.

South Essex Partnership Foundation

- Development and implementation of an integrated Single Point of Referral model for the population of Thurrock *(in partnership with NELFT);*
- Continued delivery of improving detection, assessment and care management of patients with Dementia;
- Continued improvements to timely responses and integration with non-elective acute and community services;
- Participation in Primary Care Multi-Disciplinary Team Reviews including the identification of patients requiring MDT review.

Thurrock Council & Clinical Commissioning Group

- Development and implementation of the four integrated service hubs *(in partnership with NELFT);*
- Implementation of a risk-stratification tool for the identification of patients in need, not already known to the service;
- Commission and implementation of a Falls Prevention service which is compliant with latest NICE guidance *(Public Health);*
- Review and rationalisation of estates to ensure a single point of care *(hub)* model is realised for each of the identified four localities.

St Lukes Hospice

- Implementation and delivery of a Single Point of Referral model for End of Life care in the form of 'One Response' service *(in partnership with NELFT / Social*

Care);

- Delivery and review of a Fast Track Pilot to improve assessment and delivery of Preferred Place of Care;
- Support and participation in End of Life GSF Reviews.

Other smaller Private and Voluntary Sector providers

- Continued support and delivery service within agreed arrangements.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Community Geriatrician Service

The introduction of the community geriatrician service has already shown evidence of success – for example the cost of geriatric medicine remained static from 2011/12 to 2012/13 (Thurrock CCG QIPP workbook). We feel that the impact of the service can only improve with the community geriatrician being at the forefront of the Single Point of Access as described within the scheme.

Telehealth

The use of telehealth has led to some noticeable improvements. This included a 33% reduction in the number of patients having an acute admission, and 48% reduction in acute activity costs between pre-telehealth and post-telehealth use (Thurrock CCG QIPP workbook).

Primary Care MDT

Although only limited evidence is available for the effectiveness of primary care MDTs, there are some good examples of where interventions on specific disease areas have improved outcomes. For example, the Kwok, Rice and Module review of MDTs identified the following benefits in heart failure and COPD:

Heart Failure:

- A lower rate of readmissions (7.8% vs. 25.5% over 3 months);
- Reduced Hospital stay; and
- 6 patients required to be part of a MDT to reduce hospital admissions by 1.

COPD:

- A lower rate of readmissions (51% vs. 69% at 12 months);
- Better patient knowledge (81% vs. 44% inhaler compliance, 71% vs. 37% for earlier treatment during exacerbation); and
- Reduced hospital bed stay and improved physical and emotional aspect of COPD.

Early indications are that patients who have a Primary Care MD accumulate on average 34% less on non-elective activity 3 months post review compared to 3 months prior to review (Thurrock CCG QIPP workbook)

End of Life

A 2014 review of providing palliative care (Picken and Cakmak) stated that 'nationally 63% of people would rather die at home. This contrasts sharply with 2012 statistics for England showing only 42.4% of deaths at usual residents with 52% in hospital'.

RRAS

Analysis of RRAS performance data April-October 2014 shows 1917 referrals and 1429 interventions/visits. Only 2.8% of people visited and assessed went into hospital (this is below the operating target of 7%). In particular, RRAS has an impact on non-elective attendances linked to COPD and UTIs in particular.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total:
£4,379k

Investments	Current Service Provider	HWB Total £ 000
End of Life Team	NELFT	389
Day Hospital Assessment and Treatment	NELFT	389
Admission Avoidance	NELFT	126
Continence Service	SEPT	62
Community Geriatrician	NELFT	84
Rapid Response and Assessment Service (RRAS)	NELFT & Local Authority	606
Risk Stratification Tool	PA Benchmark	50
Telehealth	Docobo	30
Various Other	Local Authority	158
Hospital Social Work Team	Local Authority	507
External Purchasing	Various	1,803
Elizabeth Gardens	Local Authority	175

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The cohorts of patients that would be identified and managed through this programme are similar to those in the locality integration project. Therefore, we would expect to impact of the similar range of presenting conditions – in particular those conditions/diagnoses linked to COPD and UTIs;

Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212	**Urinary tract infection, site not specified**	230

Congestive heart failure	207	Respiratory failure, unspecified	164
Atrial fibrillation and flutter	181	Volume depletion	146
Fracture of neck of femur: closed	178	Chronic ischaemic heart disease, unspecified	145
Tendency to fall, not elsewhere classified	173	NOT CODED	138
Acute renal failure, unspecified	164	Pleural effusion, not elsewhere classified	135

Impact Assessment - RRAS

- Assuming the average cost of an A&E attendance is £114 (2012/13 NHS reference cost data)
- Assuming that 25% of RRAS cases that proceeded to assessment had potential for hospital admission that was subsequently avoided by RRAS intervention
- In the year to date, this would mean 357 cases (from a base of 1429) at a cost of £114 per case = £40,726
- Assuming the standard day rate for residential care placement is £425.84
- Potential residential care services avoided by RRAS interventions is estimated by workers to be 227 in year to date which equates to 453 over a full year period
- Assuming a conservative estimate that only 25% of these cases would in fact have required a minimum of a day residential care means a saving of £24,272 in year to date with a projected year end saving of £48,119

We have already described within the supporting evidence section the impacts we expect the scheme to make based upon existing evidence:

- Early indications are that patients who have a Primary Care MD accumulate on average 34% less on non-elective activity 3 months post review compared to 3 months prior to review (Thurrock CCG QIPP workbook)
- The use of telehealth has led to some noticeable improvements. This included a 33% reduction in the number of patients having an acute admission, and 48% reduction in acute activity costs between pre-telehealth and post-telehealth (Thurrock CCG QIPP workbook).
- RRAS impact as above

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Well-being Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Additionally, performance related to the scheme is already collated via existing arrangements – e.g. via the re-ablement scorecard and provider monitoring.

What are the key success factors for implementation of this scheme?

- Reduction of unplanned admissions to hospital and care homes
- Admission avoidance
- Increased use of community solutions
- Increased numbers of people ending their life in a setting of their choice
- Increased use of telecare – knowing that 33% of users avoid an acute admission as a result

The key performance indicators that relate to this scheme are:

- Non-elective admissions
- Residential admissions
- Patient and Service User Satisfaction

Our local metric is a key measure of success as is our patient and service user satisfaction metric as detailed below:

- 'Prevention of admission of older people aged 65+ to hospital by providing effective urgent and crisis response (RRAS) and community/other support interventions. Reductions in the proportion of people (aged 65+) assessed by RRAS that require immediate hospital admission per 10,000 population aged 65+'.

- '% of Adult Social Care service users who are satisfied with their services and support'

Scheme ref no.
BCF Scheme 3
Scheme name
Intermediate Care
What is the strategic objective of this scheme?
The focus of Intermediate Care is admission avoidance with a clear remit to ensure that robust discharge planning is in place, that effective rehabilitation and re-ablement take place before CHC assessments, and that any long term support is put in place in a person centred way to make sure each individual has as much choice and control as possible. This scheme will enhance the provision of care and support that is delivered away from the persons home but is but of hospital care. The scheme will increase the range of settings in which re-ablement, and physical and mental health care can be provided. It will also extend the range of people who use those settings. The scheme aims to achieve the following objectives; - providing a discharge to assess model for continuing healthcare (CHC) which will ensure patients achieve their optimal re-ablement capability prior to a CHC assessment being undertaken - Reducing readmissions to hospital from care homes - Increasing the availability of step up provision (to avoid acute admissions). - Improving the contractual efficiency of bed based intermediate care services commissioned by the NHS Thurrock CCG and the Council. As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a very high risk of admission.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
There is considerable investment by both the CCG and LA in Thurrock for intermediate care and support. The focus of the scheme is to develop this investment further by realigning the current mainly bed based provision to afford the opportunity in year to make better use of and change existing services. The scheme consists of several components; a) Establishing a non acute rehabilitation/assessment pathway (pilot) This will be a pilot project to Commissioning an intermediate care rehabilitation and assessment pathway across Collins House the LA residential provision and the NELFT Community Hospital together with part of the Mount Nessing Court provision for rehabilitative dementia care and support. The focus of this element of the project is to create a far more effective and responsive pathway to move people into the long term solution more effectively reducing the time frame for bed use. - To support this the scheme will commission an enhanced domiciliary provision to enable service users/ patients to be discharged to where they live so that a

detailed assessment can be carried out focusing on the outcome of maintaining them where they live This will mean that people will move on more quickly either from hospital or bed based rehabilitation services back to where they live this could be residential support, sheltered accommodation or their own home.

b) *Establishing a non acute rehabilitation/assessment pathway (pilot)*
- Commissioning an intermediate care rehabilitation and assessment pathway across Collins House/NELFT Community Hospitals and part of Mount Nessing Court (specifically for dementia care)
- Commissioning an enhanced domiciliary provision to enable service users/ patients to be discharged to assess within their normal place of residence
- Reviewing placements to identify opportunities/challenges associated with the provision of out of hospital health care
- significantly reducing the number of CHC assessments undertaken in BTUH. The new pathway would improve patient experience through a package of re-ablement/rehabilitation so reducing long term care needs and improving outcomes.

c) *Promotion of step up and step down facilities*
- Working with GPs, Community Staff and East of England Ambulance Service to promote the usage of step up/step down to facilitate discharge and reduce non elective admissions.

d) *Contract review of bed based services*
- Joint review of all existing commissioned services to identify contractual efficiency opportunities. This resource will be reinvested in supporting the implementation of the Care Act.

e) *Supporting carers*
- Carers are seen as a key part of the multi-disciplinary approach to timely discharge and admissions avoidance (as in Scheme 1) and so identifying the requirements of carers will be a central part of our intermediate care offer.

f) *The Joint Re-ablement Team*
1. Council provided adult social care integrated with the NHS community service provider aimed at preventing readmission to hospital through proactive re-ablement.

Intermediate Care offer will also be used to explore the fullest range of care and support options available to patients / service users, including self funders through our information, advice and guidance service (see diagram in BCF Scheme 1 for more detail)..

The key milestones for the Intermediate Care Scheme include:
- New rehabilitation/assessment pathway pilot - April 2015
- Roll out Carer Support – April 2015
- Contract Review of bed based services –June 2015
- Review of rehabilitation/assessment pathway pilot including Step Up and Step Down facilities – January 2016

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme affects the following commissioners and providers;

Provision	Commissioner	Provider
Acute Based Care	NHS Thurrock CCG (alongside Basildon and Brentwood CCG as the lead commissioner)	Basildon and Thurrock University Hospital NHS Foundation Trust
Out of Hospital health care	NHS Thurrock CCG	North East London Foundation Trust (Thurrock Community Hospital)
	Thurrock Council	South Essex Partnership NHS Foundation Trust (Mount Nessing Court
		Thurrock Council (Housing – extra care housing and Adult Social Care – Collins House care home)
	Jointly Commissioned (Better Care Fund)	Private and voluntary care home and extra care housing providers

The providers will be expected to deliver broadly the same offer as shown in schemes 1 and 2 above.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There have been a series of similar pilots across the country looking at the discharge to assess model notably Cambridge and Peterborough, Sheffield Frailty Unit and Wakefield. These have all influenced the proposal to develop and improve intermediate care in Thurrock.

Re-ablement Performance:

- 280 people completed re-ablement with the Joint Re-ablement Team in the year to end Sept 2014. Average of 47 per month
- Projecting this over a full year estimates 564 people completing – a rate of 46 per 10,000 population aged 18+
- Around 75-80% of people tend to be 65+. Assuming a fixed rate of 75% over a year this would 423 people aged 65+ completing – a rate of 200 per 10,000 population 65+
- 66% of completers in the year to date resulted in a reduction or end in support (185 cases)
- The number of people completing re-ablement continues to show an increasing trend and the proportion of people completing with a reduction or end in support is rising on previous years
- Projecting this over a full year period estimates 372 people ending with a reduction or end in support
- 96.7% of people receiving re-ablement self-report that 'their quality of day to day life had improved following support'.

In Quarter 2 2014/15 (July-August) there were 16 departures from the Collins House Interim Residential Care beds. In the year to date there have been 28 departures. The destination of these individuals are as follows:

	Quarter 2	Year to Date
Returned to the Community	7 (43.8%)	11 (39.3%)
Moved to Extra Care	1 (6.3%)	3 (10.7%)
Moved to Residential Care	6 (37.5%)	11 (39.3%)
Admitted to Hospital	2 (12.5%)	3 (10.7%)
Total Departures	16	28

It is assumed that by providing re-ablement services and enhanced health care services in a wider range of out of hospital settings more service user/ patients will regain skills and confidence for independent living.

A recent review of existing step up and step down provision in Thurrock has identified a gap – people who do not need rehabilitation or re-ablement but who have health care needs which cannot at the time be met in their own home. Too frequently these cases use beds within BTUH when hospital care is not what they need. In other cases, health care away from home is required until the patient/ service users home is adapted or their informal care arrangements are available (this includes intermediate care to provide respite to carers)

The scheme will use available funding to meet the costs of accommodating the service user/patient ranging from residential care to extra care housing. The accommodation will be commissioned from within the Council's housing and care home estate, and through the private and voluntary sector. The market position statement will be used to help shape this offer.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total: £5,035k

Investments	Current Service Provider	HWB Total £
Joint Re-ablement Team	NELFT & LA	1,168,794
Mount Nessing Court	SEPT	704,800
Intermediate Care Beds	NELFT	2,585,738
Collins Hse Intermediate Care Beds	LA	576,333
Total		5,035,665

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Whilst this scheme is likely to have a limited impact on overall numbers of admissions, we would expect there to be an impact on both readmissions and admissions into residential care placements.

Below is a summary of the projected growth of social care admissions into standard, dementia and nursing placements without any interventions. Through this scheme we would expect to stem the growth across all placement types.

	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Residential & Nursing Placements	311	324	334	344	350	358
Dementia Placements	70	77	80	82	84	85
TOTAL	381	401	414	426	434	443

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop

and sign off project plans, monitor implementation and review impact, reporting to the Health and Well-being Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Provider engagement will be through specific pathway development meetings, formal contract management, the Strategic Leader's Group and the Market Position Statement.

What are the key success factors for implementation of this scheme?

The key success factors in relation to this scheme are;

a) successful implementation of a discharge to assess model
b) enhancement of capacity for health care away from home in an out of hospital setting
c) reduction in the number of cases requiring continuing healthcare and a reduction in the needs/case mix for those who are eligible for CHC.
d) Increase in the volume of step up/step down cases
e) A reduction in the cost of commissioned bed based care
f) A reduction in the requirement for care and support services after re-ablement.

Scheme ref no.
BCF Scheme 4
Scheme name
Prevention and Early Intervention
What is the strategic objective of this scheme?
The objective of the scheme is to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health and social care system. Ultimately our vision is for prevention and early intervention to become embedded within our locality approach (working within and alongside the communities they serve), and to be fully unified around the individual needing a solution (bringing together all interventions designed to manage demand and prevent crisis); Thurrock's vision for whole system re-design being predicated on the concept, "right place, right time, right solution". Through utilising the opportunities created for pooling resources within the Better Care Fund, we are confident that this transformation can be accelerated. The scheme initially focuses predominantly on embedding and further developing our Local Area Coordination (LAC) offer. The LAC offer is open to everyone over the age of 18 who has the potential to place demand on a service. LAC has already had notable evidence of success – including admission avoidance – in the 14 months it has been established, and this scheme aims to build on and further that success. As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a very low through to moderate risk of admission.
Overview of the scheme **Please provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
Thurrock is engaged in a whole system transformation focused upon a shift of resources towards timely intervention and prevention, part of which has been captured within the BCF to enable the pooling of key resources. The overarching vision for the system, places 'right time, right place, right solution' at the heart of the design. The redesign features three key aspects: - Right Time – ensuring people receive the intervention most likely to support wellbeing at the point at which it will have most impact; - Right Place – ensuring the homes that people live in and the communities in which they reside support their health and active ageing; and - Right Solution – either service or other support designed to promote independence and maintain quality of life. The broad transformation includes significant activity currently outside the BCF (for example work with our housing colleagues and private developers to drive up the quality of older people's housing designed to Housing our Ageing Population Panel for Innovation (HAPPI) standards, bringing forward a Council - wide programme of community hubs) and our work within communities building resilience using a strength-

based approach under the Council's 'Stronger Together' programme. We are also working with Housing on a Well Homes initiative. Finally, a number of other key initiatives are currently in development and will feature in future pooled fund arrangements as the programme develops – for example a post-diagnosis community based integrated dementia service.

The scheme consists of several components which includes:

Local Area Coordination
Thurrock successfully implemented a pilot Local Area Coordination initiative (LAC) in July 2013, beginning with 3 LAC's funded through the deletion of three social work posts. An initial evaluation 4 months into the pilot already showed clear evidence of the impact of working in this way upon marginalised people, most of whom were previously unknown to social care services. Because referral routes, eligibility criteria and assessment and care management techniques were not a feature of the entry point into receiving support, this model represents a 'new front door to services', ensuring people who were outside of the care system, or who had fallen between various "siloed" services received comprehensive support. The LAC model is based upon a western Australian scheme that over the past 25 plus years has proved its effectiveness in supporting marginalised groups in becoming more resilient and self-managing.

Recognising that the initiative is about supporting vulnerable and marginalized people and acknowledging the high percentage of fire deaths that impact this group, the Fire Service have seconded a senior fire officer in to the team, seeing the LAC role as fundamental to their shift from an emergency response service and towards a prevention model of delivery . Early successes with specific groups such as hoarders provide clear evidence of the impact on fire prevention. However, because of the way LAC's provide support, there is also significant proof of impact across a very broad range of support needs for this group.

The initial success evidenced by the 4 month report enabled the LAC programme to be expanded through the agreement for public health to fund an additional three posts as part of their prevention and reducing health inequalities programmes. The six LACs have now been working in Thurrock for the past 14 months and a more in-depth analysis has been recently produced. Key findings that allow us to evidence the potential impact of this initiative are included within the 'evidence base' section.

Because of the compelling evidence provided from a number of key professionals including GPs, psychiatrists etc., the BCF identifies CCG funding to further expand the programme by recruiting 3 additional LACs, who once in place, will provide full coverage across Thurrock. It is recognised that cost benefit analysis around prevention and early intervention, especially where the intervention impact may be longer term, is remarkably difficult to prove. With this in mind, Thurrock Council with Derby City Council is engaged with the University of Birmingham to develop an academically accredited evaluation tool. We are confident that the evidence provided will establish very clear cost benefit analysis supporting the financial case for deploying Local Area Coordination and that in the future additional integrated funding may be approved to further expand the service.

Falls Prevention Programme
The review and further development of a comprehensive falls prevention programme that provides multidisciplinary assessment, a programme of falls risk reduction (including exercise programmes, adaptations, prescribing interventions etc.) and on-going follow up

(to maintain compliance and benefit). This will target patients that have experienced falls (to reduce recurrence) in addition to those identified as at risk by primary care, community services (health and social) and acute services. Work will align with the Housing-based Well Homes project which works with private sector housing to ensure that homes promote health and wellbeing – including the identification and rectification of trip hazards. This is an initiative funded through the Public Health resource within this scheme.

Public Health-led review of emergency admissions
Through the Whole System Redesign Project Group, public health are leading work in conjunction with the CCG, social care, and primary care to review cases of emergency admissions in certain practices with high levels of admissions over a 12 month period. The review hopes to identify those patients that could be avoided from accessing unplanned care by better management in the community.

Given the potential that exists to build upon a strong local community, part of the work will include improving connectivity and further enhancing resilience to explore the possibility of neighbourhood solutions to key causal factors for poor wellbeing such as bereavement and loneliness - there is a clear link with those bereaved and/or lonely and avoidable admissions.

The findings of the work will be used to inform system changes aimed at preventing admissions.

Improved Efficiency of Commissioning of Equipment including: promotion of self-care, prevention, integration of services, and improved accessibility and public education
Though pooling our resources in a single place with our community health provider, we are hoping to drive efficiencies through the following approach.

Single Integrated Service Model for Community Equipment
Health and social care currently operate two separate models for the provision of community equipment; according to their statutory obligations. Part of this initiative that will see the emergence of a fully integrated community equipment model of care. The revised model will see a seamless pathway for each patient, irrespective of traditional organisational responsibilities or point of entry. This part of the scheme's initiative will realise improved efficiencies across existing service provision (currently responding to substantive and critical needs).

Improved self-care, prevention and accessibility of equipment
The second part of the scheme's initiative has ambition to promote self-care prevention; and thereby increasing the number of patients taking individual responsibility for fulfilling their moderate equipment needs (not currently funded). To facilitate these benefits the pathway will introduce improved accessibility to equipment informed on the national retail model, improve public education of need and promotion of self-assessment.

This model will also interface with the risk stratification of Thurrock residence (encompassing physiological and social indicators) to ensure targeted promotion and uptake is facilitated.

We will review and redesign existing and new initiatives and pathways as part of our

Whole System Redesign Group.

The key milestones for the Prevention and Early Intervention Scheme include:

- Pathways review – access to equipment – April 2015
- Options Appraisal for Retail Model & Implementation – June 2015
- Conduct Public Health-led review of emergency admissions – June 2015
- Falls Prevention programme review and development – June 2015
- Recruitment of further 3 LACs – April 2015
- Local Area Coordination – 2 year evaluation July 2015
- Local Area Coordination & GP initiative to target frequent users of A&E, ambulance services as part of public health-led review of unplanned admissions – September 2015

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme affects the following commissioners and providers:

Provision	Commissioner	Provider
Essex Equipment Services	Thurrock CCG (through a Section 75 agreement managed on our behalf by North East London Foundation Trust) Thurrock Council (direct 75)	Essex Cares (provider arm of Essex County Council).
Local Area Coordination	Thurrock Council, Essex Fire and Rescue Service, Thurrock CCG	Thurrock Council
Public Health Commissioning	Thurrock Council	NELFT Voluntary and Community Sector
Falls Prevention	Thurrock Council	NELFT
Stroke	Thurrock Council	Thurrock Council

The providers will be expected to deliver broadly the same offer as shown in schemes 1 and 2 above.

The evidence base
Please reference the evidence base which you have drawn on

- **to support the selection and design of this scheme**
- **to drive assumptions about impact and outcomes**

We have carried out a fourteen month evaluation report of our Local Area Coordination project. We have also made some assumptions based on existing LAC caseload that has allowed us to model the impact of this initiative. The facts and assumptions we have made are as follows:

- The post-18 population in Thurrock is 120,200

- We believe that the potential cohort for Local Area Coordination in Thurrock as a percentage of the over 18 population could be as high as 10% - approximately 12,000 people
- However in reality each LAC works with an average caseload of 60 people (based upon experience from Western Australia) which equates to 450 people at any one time (60 x 9 LACs)
- 31% of the caseload relates to older people which is the primary focus of our BCF

The financial cost of the LAC initiative is between £150k (initial period of three LAC's p.a.) - £300k (6 LAC's) in total to date. Current agreed deployment (utilising BCF funding) is £450k with 9 LACs recruited and full coverage of the Borough. (because the model is completely "agile" in terms of working pattern and utilising community assets, there is no estates costs attached to the scheme and very little capital funding required apart from equipment to support mobile working)

The unit cost of supporting 256 people (total number of people supported to date) by approx £200k over 14 months (the £200k takes in to account the variance in cost over the life over the initiative to provide an approximate average cost - started with 3 LACs and £150k investment rising to 9 LACs at the end of the fourteen months) = £780 cost per person over 14 months.

Therefore the average caseload per LAC = 60 people x £780 = £46,800

The fourteen month review has allowed us to make some assumptions on what the LAC initiative has and can save – based on the number of people who have been supported to avoid a service intervention and evidence from professionals, LACs, and those supported. The impact of the initiative includes the following unit of prevention cost:

Cost	Unit of prevention cost	Impact
£125	Per hour GP visit	Fewer people seeing a GP as a result of LAC involvement – particularly regarding social isolation
£956	Annual cost of depression	Over 75 people introduced to LAC have identified depression as one of the main challenges they face, with a high percentage having reported an improvement in their depression
£445	Mental Health overnight stay in hospital	Reports of people who have avoided a potential admission to hospital
£162	Mental Health Community Provision	Reduced need for mental health professionals
£1779	Episode of inpatient care	Individuals supported who are likely to be admitted to hospital without support
£510	Adult Social Care assessment	A number of individuals have been referred to the LAC who would otherwise have

		received a social care assessment
£65	Day care provision	A number of individuals have avoided Day Care services due to alternatives in the community being found – on average people attend day care for 2 days a week at £65 approximately per day
£7095	Complex eviction case	At least one individual supported to date has avoided eviction as a result of support received
£1962	Annual cost of alcohol abuse to NHS	A number supported have reduced or stopped their alcohol intake
£7744	Income support claimant entering work	At least one example of an individual being supported back in to work – with a number of others working towards this goal
£3568	Average response to a fire	A number of people are supported to make their home safer – with 3 individuals to date at high risk of fire due to their environment and lifestyle
£10.50	Volunteering per hour contribution	13 people have been supported in to volunteering

Our evaluation report reflects clear evidence of how we have kept people out of services and equates that to potential savings made.

With regards to our Falls initiative, our 'Health Needs Assessment for the over 75 year old Thurrock population' written in July 2014 predicted that 32% of that cohort were predicted to have a fall, with 4% likely to be admitted to hospital as a result of a fall.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total:
£1,965k

Investments	**Current Service Provider**	**HWB Total £000**
Community Equipment	NELFT	1,533
Local Area Coordination	Local Authority	147
Stroke Prevention	Local Authority	35
Public Health	NELFT	250

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of the scheme with reference to the LAC initiative has already been demonstrated in the 'evidence base' section. We have also commissioned Birmingham University to develop an accredited evaluation tool to enable us to more accurately measure the true benefits and impact of this important initiative.

We recognise that community equipment is key to prevention and early intervention. We will work with our community health provider to evaluate further efficiencies and improvements in the way in which we provide community equipment.

We know that falls is a key reason for people aged 65 and over having an unplanned admission. We will look to review and further develop the programme so that it continues to identify and focus on the cohort most likely to have a fall. We are already working with housing colleagues through the Public Health funded 'Well Homes' project to help improve private sector accommodation including the reduction of fall hazards.

Based on the evidence, we would expect that the falls programme would directly impact upon the highlighted diagnoses categories below as well as having a indirect impact on other reasons for admission. A discussed in the 'evidence' section, it is estimated that 32% of people aged 75 and over will have a fall, with 4% of those being admitted to hospital. We know that the average cost of an admission for someone aged 75 and over at Basildon Hospital is £3419, therefore just 1% of those aged 75 and above being prevented from being admitted to Hospital would equate to a saving of £351,302 and reduce attendances by over 100 (4% of 75 and over = 411).
Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014) X indicates those areas we believe LAC and other timely intervention support could reduce admissions.

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523 ***X***	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398 ***X***	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229 ***X***	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212 ***X***	**Urinary tract infection, site not specified**	230
Congestive heart failure	207	**Respiratory failure, unspecified**	164
Atrial fibrillation and flutter	181	**Volume depletion**	146
Fracture of neck of femur: closed	178 ***X***	**Chronic ischaemic heart disease, unspecified**	145
Tendency to fall, not elsewhere classified	173 ***X***	**NOT CODED**	138
Acute renal failure, unspecified	164	**Pleural effusion, not elsewhere classified**	135

Therefore we believe more timely and local interventions could have a significant impact upon 6 of the top 10 most common presenting conditions amongst the over 65 population in Thurrock; with the other 4 being more likely to be improved through much longer term preventative measures. There is already evidence that joining up all prevention activity will lead to improved outcomes. For example it is acknowledged that campaigns around

smoking cessation and obesity which provide the general population with information and advice have limited impact. There is already some local evidence that providing such advice through the LAC (which offers individual, trust based style of support), improves the likelihood of take up of rehabilitation in cases of substance misuse; it seems logical to combine such an approach with broader cessation and management programmes to improve take up and sustainability.

We would expect this scheme to contribute to our key metrics of:

- Non-elective admissions
- Residential admissions
- Service User/Patient Satisfaction

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Wellbeing Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Provider engagement will be through specific pathway development meetings, formal contract management and the Strategic Leadership Group.

Additionally, we have a fully developed performance management framework for our Local Area Coordination initiative.

What are the key success factors for implementation of this scheme?

Commissioning of Equipment:
The key success factors in relation to this scheme are;

a) Delivery of efficiencies from the integrated commissioning hub for equipment (reduction in price for commonly ordered items)
b) Implementation of retail model
c) Access to equipment for all key admission avoidance pathways

With regards to the LAC initiative:

- Number of people supported by LAC which leads to an individual avoiding need for a service (both acute or community based) or reducing demand for service
- Conversion rates of service users to volunteers
- Socially isolated people reconnected with their community
- Prevention of homelessness
- Number of people receiving equipment that require a reduced level of service or no service
- Reduction in use of medication for people supported by LAC
- Reduction in alcohol dependency or drug misuse

- Fire prevention

As previously mentioned, the Council has commissioned Birmingham University to develop a method of measuring the impact of the LAC.

Scheme ref no.
BCF Scheme 5
Scheme name
Disabled Facilities Grant and Social Care Capital Grant
What is the strategic objective of this scheme?
Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants. The Community Capacity Grant to local authorities, provides capital funding to support development in three key areas: personalisation, reform and efficiency.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Mandatory DFGs are available from local authorities, subject to a means test, for essential adaptations to give disabled people better freedom of movement into and around their homes and to give access to essential facilities within the home. The Community Capacity Grant is a principal component of our work to promote Asset Based Community Development. It is an approach to community building which transforms the way communities are seen, focusing on strengths and assets and connecting people and networks around common interests and concerns. This contrasts with the deficit model which typically characterises communities in terms of needs and deprivation.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Council's Private Housing & Adaptation Service is working closely with Adult Social Care, Health and Public Health to improve independence at home. DFGs are delivered in partnership with our local home improvement agency the Papworth Trust. Asset Based Community Development is being used to re-engineer our fieldwork services to be community facing, working in conjunction with Primary Care MDTs and community hubs. It also supports our work to raise the profile of attractive, high-quality housing for older people, and the benefits this can bring to health and wellbeing.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Disabled Facilities Grants provide an important mechanism for supporting people with disabilities to live independently. When delivered early, alongside other preventative measures, they may contribute to preventing admissions to hospital and residential care. Asset Based Community Development complements the ambition of the Better Care Fund to deliver services that:

- are built around people and their communities
- work together effectively to achieve outcomes, including an integrated health and social care system
- prioritise timely intervention and prevention, reducing inequalities and promoting equalities
- improve performance and reduce costs and are open and accountable, including investment in leadership and workforce development
- are person-centred and offer flexibility and choice.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Disabled Facilities Grant £481,000

Capital Grant (provisional allocation): £358,902

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Our aim is to use DFGs to maximise a resident's independence and quality of life.

Asset Based Community Development is focused on communities, strengthening the connections between people and informal associations around common interests and concerns.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The performance of services funded by these grants will be monitored by the Pooled Fund Manager and reported to the Partnership Board on a quarterly basis.

What are the key success factors for implementation of this scheme?

The scheme will be monitored for its contribution to the reduction in total emergency admissions and the reduction in admissions to residential care homes.

Scheme ref no.
BCF Scheme 6
Scheme name
Care Act Implementation
Overview of the scheme
The Schemes purpose is to deliver the requirements of the Care Act, ensuring that the Council are compliant and that existing services are not adversely affected by increased costs.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Scheme total: £522k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The scheme will allow the following themed requirements in particular to be delivered: • Carers – placing carers on a par with users for assessment; and introducing a new duty to provide support for carers; • Information advice and support – provision of advice and support to access and plan care, including rights to advocacy; • Safeguarding – implementing new statutory responsibilities; • Assessment and Eligibility – Setting a national minimum eligibility threshold, providing continuity of care for people moving in to the area until reassessment; and • Capital funding – capital investment funding including IT systems.
What are the key success factors for implementation of this scheme?
The key success factors in relation to this scheme will relate to our ability to implement the requirements of the Act seamlessly and without impacting negatively on user experience.

Scheme ref no.
BCF Scheme 7
Scheme name
Payment for Performance
What is the strategic objective of this scheme?
This scheme is the provision for the payment for performance. As such, the provision is two fold (dependent on the performance of the system in 2015/16). a) In the event of the required reduction in unplanned care admissions failing to be delivered, this resource will be utilised to fund commensurate activity in local acute trusts. b) In the event of the required reduction in unplanned care occurring, this resource will instead be utilised to fund a series of initiatives (currently being identified) that further improve out of hospitals care to our population.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
a) Transaction with acute providers to cover the cost of unplanned care episodes (primarily Basildon and Thurrock University Hospital NHS Foundation Trust). b) If the target is achieved, this resource will be invested into schemes that align with the other schemes outlined within this document (i.e. BCF1-6). The concise detail of the investments is to be determined.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Scenario A – target not achieved Commissioner – Thurrock Clinical Commissioning Group Provider – Acute Trusts (primarily Basildon and Thurrock Hospital NHS Foundation Trust) Scenario B – target achieved Commissioner Thurrock Clinical Commissioning Group Thurrock Council Providers To be determined but from the following; General Practice Basildon and Thurrock University Hospital NHS Foundation Trust North East London Foundation Trust Thurrock Council

Other smaller Private and Voluntary Sector providers

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Scenario A – this is a transactional process and therefore no evidence based is required

Scenario B – the evidence base for each proposed investment will be identified as part of the business case developments.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

£722k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Scenario A – no impact,
Scenario B – the precise impact will be identified as part of the business case development process. However, the investments will reinforce the aforementioned impacts within BCF Schemes 1-6

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. The role of this group will be to develop and sign off project plans, monitor implementation and review impact.
Provider engagement will be through specific pathway development meetings, formal contract management and the strategic leaders forum.

What are the key success factors for implementation of this scheme?

Scenario A – Transactional process, not applicable
Scenario B
- clearly defined business cases for investment
- clearly defined expected outcomes that align with the BCF's objectives
- clearly defined outcome measures
- implementation of an effective prioritisation and approval process for the business cases
- implementation and delivery of the service changes proposed in the business cases

- review

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	Basildon and Thurrock University Hospital Trust
Name of Provider CEO	Claire Panniker
Signature (electronic or typed)	Claire Panniker

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Thurrock Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by the Trust in order to reduce our emergency bed base allowing either closure or alternative use.

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	North East London Foundation Trust
Name of Provider CEO	John Brouder
Signature (electronic or typed)	John Brouder

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	Not fully – NELFT would like to fully understand the forecasting and how the final outturn was agreed. Would be helpful to align to schemes also
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	NELFT have not had the opportunity to be able to review and analyse the detailed impact of the schemes which are described in the BCF but NELFT are fully committed to work with Thurrock Health and social care partners in order to achieve a consensus and agree joints plans
3.	Can you confirm that you have considered the resultant implications on services provided by your organisation?	NELFT are committed to seeing a reduction in unplanned care admissions and welcome the opportunity to develop services which enable the people of Thurrock to be cared for appropriately in their community

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	South Essex Partnership Trust
Name of Provider CEO	Sally Morris
Signature (electronic or typed)	Sally Morris

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	**Response**
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No.
2.	**If you answered ‘no’ to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Thurrock Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by SEPT.

Appendix 2

SCHEDULE 1 – PART 2 AGREED Scheme specification

BCF SCHEME 1 LOCALITY SERVICE INTEGRATION

1 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 1 Locality Service Integration** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) The Locality Service Integration Scheme is primarily focused at adults aged 65 years and over. Evidence from the King's Fund (2013 Making Integration Happen at Pace and Scale) makes it clear that integration is most effective where the target population is older people living with chronic conditions including mental ill health. The 65 and over cohort which numbers in Thurrock approximately 20,000 people will benefit from the prevention and early intervention services as set out in Scheme 4. The subgroup will be people with relatively simple and stable long term conditions. (BCF2 focuses on the frailty model and people with complex co-morbidities, BCF 3 focuses on those with re-ablement and rehabilitation needs and BCF 4 focuses on prevention and keeping people active).

Further details are contained in pages 71-74 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

AIMS AND OUTCOMES

The aim of Locality Service Integration is to integrate service delivery in Thurrock around 4 community hubs. Our aim will be to define an integrated service offer for the people of Thurrock based on detailed understanding of the local needs of each community.

2 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A variation to the Standard NHS Contract for 2015/16 with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and
- A Service Level Agreement for Thurrock Council's Provider Services.

3 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

4 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.

5 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- Thurrock Council Provider Services

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

6 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
Integrated Community Teams	£3,906,301		£3,906,301
Long Term Conditions	£415,682		£415,682
Primary Care MDT Coordinator	£51,130		£51,130
Carers Grant	£178,000		£178,000
Total	£4,551,113		£4,551,113

Financial resources in subsequent years are to be determined in accordance with the Agreement.

7 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

8 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

9 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

10 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

11 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer
- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

12 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

13 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

14 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

15 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

16 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

17 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

18 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

19 OTHER PROVISIONS

- There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 2 FRAILTY MODEL

20 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 2 Frailty Model** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) In Thurrock, we are developing a frailty model based on the principles of:

- care wrapped around the patient, whatever the setting of care and which is experienced by them as a single delivery system through multi-disciplinary, multi-organisational integrated care teams
- risk stratification to target the right services, at the right level, to the right people, reducing inequalities by delivering the best possible outcome
- high quality pathways for people to maintain and maximise independence, to live in their own homes and where inappropriate admission to an acute hospital is seen as a system failure
- a sustainable and cost effective system across health and social care, supported by the right financial framework
- transformed services through a seamless and integrated approach to health and social care

Further details are contained in pages 81-84 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

21 AIMS AND OUTCOMES

The Frailty Model aims to provide an enhanced tier of services to The Frailty Model aims to provide an enhanced tier of services to people who live with complex co-morbidities, including dementia and frailty. Health and care services will support older people with complex multiple co-morbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications.

22 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

A variation to the Standard NHS Contracts for 2015/16 with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and for South Essex Partnership Trust for which Castle Point and Rochford CCG is a Co-ordinating Commissioner, and

A Service Level Agreement for Thurrock Council's Provider Services.

23 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

24 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.

25 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- South Essex Partnership Trust
- Thurrock Council Provider Services

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

26 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
End of Life Team	£388,795		£388,795
Day Hospital Assessment & Treatment	£388,947		£388,947
Admission Avoidance	£125,910		£125,910
Continence Service	£62,000		£62,000
Community Geriatricians	£84,079		£84,079
Rapid Response & Assessment Service (RRAS)	£605,580		£605,580
Risk Stratification Tool	£50,000		£50,000
Telehealth	£30,000		£30,000
Various other - Sensory Worker; Stroke, MH Support; Direct Payments Officer	£158,329		£158,329
Hospital Social Work Team	£80,000	£427,000	£507,000
External Purchasing	£1,803,340		£1,803,340
Elizabeth Gardens	£175,000		£175,000
Total	£3,951,980	£427,000	£4,378,980

Financial resources in subsequent years are to be determined in accordance with the Agreement.

27 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Well-being Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

28 VAT

- The Council's VAT regime will apply to Provider Contracts
- The Council is not acting as 'agent' for NHS Thurrock CCG

29 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

30 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

31 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer
- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse

- Head of Performance
- Senior Commissioning Manager

32 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

33 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

34 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

35 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

36 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

37 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

38 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

39 OTHER PROVISIONS

- There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 3 INTERMEDIATE CARE

40 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 3 Intermediate Care** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) There is considerable investment by both the CCG and LA in Thurrock for intermediate care and support. The focus of the scheme is to develop this investment further by realigning the current mainly bed based provision to afford the opportunity in year to make better use of and change existing services.

Further details are contained in pages 90-91 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

41 AIMS AND OUTCOMES

The focus of Intermediate Care is admission avoidance with a clear remit to ensure that robust discharge planning is in place, that effective rehabilitation and re-ablement take place before CHC assessments, and that any long term support is put in place in a person centred way to make sure each individual has as much choice and control as possible.

42 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A variation to the Standard NHS Contracts for 2015/16 with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and for South Essex Partnership Trust for which Castle Point and Rochford CCG is a Co-ordinating Commissioner, and
- A Service Level Agreement for Thurrock Council's Provider Services.

43 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

44 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.

45 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts

- North East London Foundation Trust
- South Essex Partnership Trust
- Thurrock Council Provider Services

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

(i) contract management arrangements
(ii) termination
(iii) assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

46 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
Joint Reablement Team	£420,000	£748,794	£1,168,794
Mount Nessing Court	£704,800		£704,800
Intermediate Care Beds	£2,585,738		£2,585,738
Collins Hse Intermediate Care Beds	£240,000	£336,333	£576,333
Total	£3,950,538	£1,085,127	£5,035,665

Financial resources in subsequent years are to be determined in accordance with the Agreement.

47 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

48 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

49 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

50 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

51 STAFF

TUPE transfers and secondments are not expected to be required In order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer
- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

52 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

53 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

54 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

55 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

56 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

57 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

58 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

59 OTHER PROVISIONS

There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 4 PREVENTION AND EARLY INTERVENTION

60 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 4 Prevention and Early Intervention** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) Thurrock is engaged in a whole system transformation focused upon a shift of resources towards timely intervention and prevention, part of which has been captured within the BCF to enable the pooling of key resources. The overarching vision for the system, places 'right time, right place, right solution' at the heart of the design. The redesign features three key aspects:

- Right Time – ensuring people receive the intervention most likely to support wellbeing at the point at which it will have most impact;
- Right Place – ensuring the homes that people live in and the communities in which they reside support their health and active ageing; and
- Right Solution – either service or other support designed to promote independence and maintain quality of life.

Further details are contained in pages 90-91 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

61 AIMS AND OUTCOMES

The objective of the scheme is to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health and social care system.

62 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A variation to the Standard NHS Contracts for 2015/16 with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner, and

- A Service Level Agreement for Thurrock Council's Provider Services.

63 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

64 SERVICES

The Services are set out in the Provider Contracts and the Service Level Agreement with Thurrock Council Provider Services.:

65 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will become an associate to the CCG Health Contract with North London Foundation Trust for the first year to allow for continuity and the opportunity to develop an integrated commissioning model and approach for subsequent years

Contracting Arrangements

relevant contracts
North East London Foundation Trust
Thurrock Council Provider Services

The Commissioners have authority to agree contract terms in line with the terms of this agreement including
(iv) contract management arrangements
(v) termination
(vi) assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Provider's contract and Operational Guidelines for services provided by Thurrock Council Provider Services.

66 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
Community Equipment	**£921,385**	**£611,352**	**£1,532.737**
Local Area Co-ordination	**£147,057**		**£147,057**
Stroke Prevention		**£34,715**	**£34,715**
Public Health		**£250,000**	**£250,000**
Total	**£1,068,442**	**896,067**	**£1,964,509**

Financial resources in subsequent years are to be determined in accordance with the Agreement.

67 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

68 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

69 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

70 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

71 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer
- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

72 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

73 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

74 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

75 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

76 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

77 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

78 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

79 OTHER PROVISIONS

There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 5 DISABLED FACILITIES GRANT AND SOCIAL CARE CAPITAL GRANT

80 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 5 Disabled Facilities Grant and Social Care Capital Grant** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) Mandatory DFGs are available from local authorities, subject to a means test, for essential adaptations to give disabled people better freedom of movement into and around their homes and to give access to essential facilities within the home.

The Community Capacity Grant is a principal component of our work to promote Asset Based Community Development. It is an approach to community building which transforms the way communities are seen, focusing on strengths and assets and connecting people and networks around common interests and concerns. This contrasts with the deficit model which typically characterises communities in terms of needs and deprivation.

Further details are contained in page 105 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

81 AIMS AND OUTCOMES

Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants.

The Community Capacity Grant to local authorities provides capital funding to support development in three key areas: personalisation, reform and efficiency.

82 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A Service Level Agreement for Thurrock Council's Housing Services and Adults Health and Commissioning.

83 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

84 SERVICES

The Services are set out in the Service Level Agreement with Thurrock Council Housing Services and Adults, Health and Commissioning.

85 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will put in place Service Level Agreements to specify the services to be delivered.

Contracting Arrangements

relevant contracts

Thurrock Council Housing Services and Adults, Health and Commissioning

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

Access

Details of how Patients and Service Users will be assessed as eligible for services will be as set out in the Operational Guidelines for services provided by Thurrock Council Housing Services.

86 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
DFG		£481,000	£481,000
Capital Grant		£364,000	£364,000
Total		£845,000	£845,000

Financial resources in subsequent years are to be determined in accordance with the Agreement.

87 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

88 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

89 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

90 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

91 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer
- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

92 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

93 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

94 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

95 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

96 REGULATORY REQUIREMENTS

The regulatory requirements for NHS services are set out within the NHS standard contract and the intention is therefore to continue to use the NHS contract.

The regulatory requirements for local authority provided services are as set out within the Care Act.

97 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

98 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

99 OTHER PROVISIONS

There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF 6 CARE ACT IMPLEMENTATION

100 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF 6 Care Act Implementation** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) Further details are contained in pages 107 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

101 AIMS AND OUTCOMES

The Scheme's purpose is to deliver the requirements of the Care Act, ensuring that the Council are compliant and that existing services are not adversely affected by increased costs.

102 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A Service Level Agreement for Thurrock Council's Adults Health and Commissioning.

103 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

104 SERVICES

The Services are set out in the Service Level Agreement with Thurrock Council Adults, Health and Commissioning.

105 COMMISSIONING, CONTRACTING, ACCESS
Commissioning Arrangements

The Council will put in place Service Level Agreements to specify the services to be delivered.

Contracting Arrangements

relevant contracts
Thurrock Council Adults, Health and Commissioning

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination
- assignment

Access

Not applicable.

106 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
Not applicable	£522,000		£522,000
Total			£522,000

Financial resources in subsequent years are to be determined in accordance with the Agreement.

107 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

108 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

109 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

110 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

111 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer

- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

112 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

113 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

114 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

115 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

116 REGULATORY REQUIREMENTS

The regulatory requirements for local authority provided services are as set out within the Care Act.

117 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

118 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

119 OTHER PROVISIONS

There are none.

SCHEDULE 1 – PART 2 AGREED SCHEME SPECIFICATION

BCF SCHEME 7 PAYMENT FOR PERFORMANCE

120 OVERVIEW OF INDIVIDUAL SCHEME

(a) **BCF Scheme 7 Payment for Performance** (as set out in Annex 1 of Schedule 6 Thurrock Better Care Fund Plan)

(b) Further details are contained in pages 109 of the Better Care Fund Plan (Schedule 6 of this agreement).

(c) This Scheme is funded by the Thurrock BCF Pooled Fund in 2015/16.

121 AIMS AND OUTCOMES

This scheme is the provision for the payment for performance. As such, the provision is twofold (dependent on the performance of the system in 2015/16).

- In the event of the required reduction in unplanned care admissions failing to be delivered, this resource will be utilised to fund commensurate activity in local acute trusts.
- In the event of the required reduction in unplanned care occurring, this resource will instead be utilised to fund a series of initiatives (currently being identified) that further improve out of hospitals care to our population.

122 THE ARRANGEMENTS

The Council as Host Partner will commission Services in relation to the Scheme, in exercise of both NHS Functions and Council Functions under the terms of the Pooled Fund by means of:

- A variation to the Standard NHS Contracts for 2015/16 with North East London Foundation Trust for which Thurrock Clinical Commissioning Group is a Co-ordinating Commissioner and for South Essex Partnership Trust for which Castle Point and Rochford CCG is a Co-ordinating Commissioner, and

- A Service Level Agreement for Thurrock Council's Provider Services.

123 FUNCTIONS

See Section 4 PARTNERSHIP FLEXIBILITIES PARAGRAPH 4.3 and 4.5

124 SERVICES

The Services to be provided under this scheme will be determined by the Commissioning Partners.

125 COMMISSIONING, CONTRACTING, ACCESS

Commissioning Arrangements

The Council will put in place Contracts and Service Level Agreements to specify the services to be delivered.

Contracting Arrangements

relevant contracts

To be determined by the Commissioning Partners

The Commissioners have authority to agree contract terms in line with the terms of this agreement including

- contract management arrangements
- termination

- assignment

Access

Not applicable.

126 FINANCIAL CONTRIBUTIONS

Financial Year 2015 / 2016

Budgets Included	CCG contribution £	Council contribution £	Total £
	£722,069		£722,069
	£722,069		£722,069

Financial resources in subsequent years are to be determined in accordance with the Agreement.

127 FINANCIAL GOVERNANCE ARRANGEMENTS

The total value of the Better Care Fund in Thurrock is £18,019,000 and the amount of the Better Care Fund described as 'at risk' is the performance element of £722,000.

If during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

128 VAT

The Council's VAT regime will apply to Provider Contracts

The Council is not acting as 'agent' for NHS Thurrock CCG

129 GOVERNANCE ARRANGEMENTS FOR THE PARTNERSHIP

See Schedule 2 - Governance

130 NON FINANCIAL RESOURCES

Council contribution – Not Applicable

CCG Contribution – Not Applicable

131 STAFF

TUPE transfers and secondments are not expected to be required in order to deliver this Scheme.

Staff increments and pension arrangements of employees of the Partners will be administered in line with the relevant terms and conditions of employment under the existing contract of employment of the particular staff member.

Council staff to be made available to the arrangements

- Strategic Lead - Commissioning and Procurement
- Joint Unplanned Care Commissioning Officer
- Commissioner for dementia and older people
- Service Manager - Contract compliance & Brokerage

CCG staff to be made available to the arrangements

- Head of Integrated Commissioning
- Joint Unplanned Care Commissioning Officer
- Chief Finance Officer
- Executive Nurse
- Head of Performance
- Senior Commissioning Manager

132 ASSURANCE AND MONITORING

See Schedule 5 – Performance arrangements

133 LEAD OFFICERS

Partner	Name of Lead Officer	Address	Telephone Number	Email Address	Fax Number
Council	Catherine Wilson	Thurrock Council, Civic Offices	01375 652068	cwilson@thurrock.gov.uk	
CCG	Mark Tebbs	Thurrock CCG, Civic Offices	01375 365810	Mark.tebbs@nhs.net	

134 INTERNAL APPROVALS

The Pooled Fund will be administered in accordance with the Better Care Fund Plan, this Agreement and the Constitution of the Council. In relation to this Individual Scheme and the Services it contains; the levels of authority from the Council's Constitution, scheme of delegation and standing financial instructions will apply.

135 RISK AND BENEFIT SHARE ARRANGEMENTS

See Schedule 3 – Risk Share and Overspends

136 REGULATORY REQUIREMENTS

The regulatory requirements for local authority provided services are as set out within the Care Act.

137 INFORMATION SHARING AND COMMUNICATION

In addition to the general Better Care Fund consultation and engagement process, the Partners will engage with stakeholders as part of each scheme. The purpose of this work is to promote integrated services and therefore communication and engagement is at the heart of the redesign work.

Both the Partners will be involved in contract negotiations for these services and will therefore develop the required activity and performance schedules. These will be shared via the Partners' contract management teams.

Further details are contained in page 58 of the Better Care Fund Plan (Schedule 6 of this agreement).

138 DURATION AND EXIT STRATEGY

Subject to the provisions of Section 22 of this agreement this scheme or any service contained within in it may be terminated with the agreement of both the Partners.

139 OTHER PROVISIONS

There are none.

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Health and Wellbeing Board Forward Plan

Date	Agenda	Lead
12/03/15	• Joint Health and Social Care Self-Assessment (Learning Disabilities) • Health and Social Care Transformation Update Report • Joint Commissioning Statement Special Educational Needs • Annual Public Health Report • Troubled Families Report • Charter for Older People • Children's and Demographics JSNA Reports	Kelly Jenkins Ceri/Christopher Malcom/Claire Andrea Andrew Carter Sarah Turner Debbie / Maria Payne
05/2015	• Mental Health Crisis Care Concordat • Health and Wellbeing Board Development Session Report and Action Plan • Homelessness Strategy Review	Mark Tebbs/ Catherine Wilson Sharon Grimmond Dawn Shepherd

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