Thurrock Integration and Better Care Fund

Narrative Plan 2017-19

Area	Thurrock
Constituent Health and Wellbeing Boards	Thurrock Health and Wellbeing Board
Constituent CCGs	NHS Thurrock Clinical Commissioning Group

AUTHORISATION AND SIGN-OFF

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Date	

1. Local vision for health and social care

1a) Our vision for health and social care services

Thurrock's Better Care Fund is the main delivery vehicle for achieving adult health and social care integration in Thurrock. The focus of the Plan as in previous years is adults aged 65 and over. Our ambition to have a fully pooled budget across adult social care and community health services for this cohort by 2017-18 has been achieved and is reflected within the Plan for 2017-19.

The rationale behind the ambition to have a pooled budget for those aged 65 and over is that health and social care spend the greatest proportion of their resources on older people. The greatest proportion of the resource spent on the over 65 age group is used by a fraction of people in the group. We also know that the greatest pressures in the system now and in the future will come from this group. People in that group use a range of services across the whole system – historically in a disjointed way. Consultation that we have carried out reflects the frustrations people have in finding the system difficult to navigate. We think that bringing budgets together through the BCF will enable us to develop and deliver a whole population and system-wide response that manages available resource to best effect, ultimately enabling us to achieve the best outcomes for our residents.

Whilst our Plan's focus has been and remains to be on people aged 65 and over, our commitment as partners representing the health and care system is to ensure that it improves the health and wellbeing of the whole population. Many of the elements of this Plan are not exclusive to the over 65s and have a far greater reach. We are clear that in order to improve the health and wellbeing of those aged 65 and over, we need to ensure we improve the outcomes of all Thurrock residents. This reflects the vision contained within our Health and Wellbeing Strategy 2016-2021.

Our first Better Care Fund Plan in 2015-16 set out our vision for integrated adult health and care services – linked by a golden thread to the Essex Success Regime (our local Sustainability and Transformation Plan), our Health and Wellbeing strategy and NHS Thurrock CCG Operational / Transformation Plan. The 2016-17 Plan reinforced that vision, building on the work that had taken place during 2015-16 to prevent, reduce and delay the number of people aged 65 and over requiring health and social care services – including unplanned admissions to hospital. The focus enabled us to achieve a 3.2% reduction in unplanned admissions which meant we could invest further during 2016-17 in initiatives that advanced our achievements.

Our 2016-17 Plan clearly set out what achieving our Vision would require:

- More joint programmes designed to support people to stay well and strongly connected within their own communities – for example through the Local Area Coordination Service (LAC) and community building initiatives (via our Stronger Together Partnership);
- 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-agency, multi-disciplinary working which puts the individual at the centre – building on our collaborative work with General Practitioners (GPs), LAC, 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 involving the community geriatrician with a single pathway and incorporating end of life care; an enhanced intermediate care offer; and a shift towards prevention and early intervention led by LAC; and
- A greater range of small-scale care services to enhance choice and control – driven by our Market Position Statement which promotes innovative approaches such as community micro-enterprises, and initiatives such as Shared Lives.

Our 2016-17 Plan moved us a considerable way towards achieving our vision, embedding many of the foundations required to be able to deliver system change. This included the implementation of a Social Prescribing pilot, restructuring of intermediate care beds, development of an integrated data set and analytical tool, establishment of an integrated adults health and wellbeing service, and further investment in integrated teams such as the Rapid Response and Assessment Team and Joint Reablement Team. The Council and CCG also brought their transformation programmes together in to one integrated programme known as 'For Thurrock in Thurrock'. As part of For Thurrock in Thurrock, significant work took place to outline the development of an Accountable Care Partnership and to redesign an integrated Out of Hospital system which would initially be delivered as a pilot in one area of the Borough but act as the blueprint for health and care across Thurrock. The agreement of these significant programmes is evidence of the distance travelled by commissioners and providers to deliver the vision outlined in this Plan. The commitment to continue to deliver system-wide change as reflected by these programmes will feature prominently within our 2017-19 Plan and take us considerably further still towards delivering our Vision.

To ensure that any system change reflects our agreed Direction of Travel, we have developed a set of principles and success factors. The principles and success factors were informed by service users and their advocates. In addition, we carried out a public consultation for three months starting in April and finishing in June. There was overwhelming agreement with what was proposed.

Our key principles

- We are focused on supporting you to achieve the outcomes that are most important to you;
- The amount of resource we spend on bureaucracy is kept to a minimum – ensuring that the maximum amount is available to provide you with the solution you require;
- We work in partnership with you to identify and provide the best solution for you;
- Our solutions look to utilise the assets available within the local area and not just made up of the services we provide;
- We are flexible enough to respond and adapt to your and your neighbourhood's changing circumstances;
- Responsibility for maintaining and improving your health and wellbeing is

shared with you and with your neighbourhood;

- Our starting point will always be to prevent, reduce and delay you from requiring a social care and health service; but….
- If a service is the best solution for you, we will ensure it is appropriate, easy to access, of high quality and provided in a timely manner.

Our key success factors

- You are less isolated and have the opportunity to be well connected where you live;
- You are able to get the majority of the support you need from within your neighbourhood and as a result you access health and care services less frequently;
- Our health and care system treats you as an individual and does not define you by your illness or condition;
- You take responsibility for staying as healthy as possible;
- We all take responsibility for using health and care resources appropriately and responsibly;
- You can get the support and care you need at the right place and the right time;
- By bringing health and social care services and resources together we will reduce duplication, provide a better response, and ensure that you have only had to tell your story once;
- We act before you reach crisis point; and
- You are enabled to live a healthy and happy life.

1b) Expected changes to patient and service user experience

Through the significant amount of consultation and engagement that has taken place, we know that our residents find the current system fragmented and have frustrations with both quality and ease of access.

Achieving our vision will signify the change in the current system we all wish to see take place, which will reduce fragmentation, improve quality and ease of access, and reduce the need for residents to access services through providing viable alternatives within the community that focus on prevention and self-management.

The changes we have put in place to date are already having an impact on patient and service user experience. For example:

- Our review of intermediate care beds means that Thurrock residents will be placed in an intermediate care bed in Thurrock;
- Additional Rapid Response and Assessment Team and Joint Reablement Team capacity means that Thurrock residents can be kept out of hospital or a residential care home setting where appropriate;
- Our social prescribing pilot has meant that a number of people have been helped to get the support they need – which isn't always a clinical solution;
- Our increased Local Area Coordinator capacity has meant that an increased number of residents have been helped to avoid or reduce service intervention

and have been given increased opportunities to connect within the communities they live in; and

- Our Integrated Health and Wellbeing Older People's Service has enabled proactive work to take place with Care Homes in the Borough that includes falls, medication review, and a multi-disciplinary team approach. The work has undoubtedly contributed towards prevention – including reduced admissions.

Through the work of the Plan in 2017-19, customer experience will be further enhanced. For example:

- Development and implementation of out of hospital system redesign pilot – focusing on primary care transformation, integration and workforce development, and identification and management of Long-Term Conditions;
- Further development of four Integrated Medical Centres in the Borough that will provide state of the art health and care centres tailored and responsive to the communities they are located to and including the provision of outpatient services;
- Market diversification and stability – ensuring residents accessing services have a greater level of choice from a stable market place, particularly domiciliary care; and
- Continuation of initiatives that improve capacity and build on strengths within communities to divert individuals away from services or to enable them to better manage and achieve the outcomes that matter most to them – for example through Local Area Coordination

In relation to the development of four Integrated Medical Centres across the Borough, we have a commitment from partners to achieve:

- An enhanced and more resilient Primary Care that attracts the best clinicians to Thurrock.
- Bringing outpatient, diagnostic and other hospital services closer to the communities they serve
- An integrated care model that encompasses primary, secondary, community and mental health care together with social care and community and third sector organisations
- A reduction on avoidable demand for hospital and residential care services

We have consulted with the public on the principles and success factors that should underpin the health and care system in Thurrock. These outline how patients and service users should see the system change to deliver the best customer experience.

1c) How the BCF Plan contributes to the local implementation of the Five Year Forward View and the move towards fully integrated health and social care services by 2020

Thurrock's Better Care Fund Plan is aligned with the local implementation of the Five Year Forward View and the move towards fully integrated health and social care services by 2020. Local plans are set out within Thurrock Clinical Commissioning Group and Thurrock Council's Transformation Plan (For Thurrock in Thurrock) and Operational Plan, and also contribute to the Sustainability and Transformation Plan which covers the same footprint as the Essex Success Regime. The objective of the transformation plan is for short term wins to support urgent system performance issues as well as moving to a longer term sustainable position. The years 2015-16 and 2016-17 have seen significant steps being made towards the integration of health and social care through the delivery of BCF schemes. System integration will be developed further during the course of 2017-19 as documented within this Plan and its respective schemes. This Plan reflects and integrated vision for health and social care in Thurrock.

For all organisations involved with the Essex Success Regime, there is no requirement to produce a separate Sustainability and Transformation Plan.

The CCG's (and Council's) Transformation Plan (and Operational Plan) outlines plans for providing health and care closer to or at home (as reflected within this Plan). The plans include a new model of care and a commitment to improve the quality and accessibility of service for the local population with a view to providing a more holistic model of locality based care closer to home. This work was started in 2016-17 and will be taken further during 2017-19. The work includes the development of an Accountable Care Partnership, an Out of Hospital system redesign project to be piloted initially in one area (quadrant) of the Borough, and the development of four Integrated Medical Centres (one per quadrant) across the Borough.

When carrying out engagement on the development of Thurrock's refreshed Health and Wellbeing Strategy, many people raised concerns on aspects of the quality and accessibility of health services – community health services in particular. The CCG and Council's Transformation Plan is part of the response to improving both quality and accessibility of community services – including an expansion of hospital services offered in the community. The schemes within this Plan are consistent with the contents of the Transformation Plan.

Successful delivery of the Plan will require a range of out of hospital services which will be able to flex during changes in demand and that are based around the person. New models of care will be locality based and will be delivered through Multi-Disciplinary Teams spanning both health and social care.

Locality based teams will align with existing health hubs, taking a 'virtual ward' approach to providing care closer to or at home within each locality, and with new developments in the primary care estate – as outlined within the Primary Care Estate Strategy.

Individuals will be identified by risk stratification and will receive wider support to remain well – including through the Council's LAC service and local voluntary services based on a social prescription model.

The new model means that teams will work together to develop person-centred holistic care plans.

The changes set out within the CCG's Transformation Plan – which is now part of the jointly owned health and social care transformation plan 'For Thurrock in Thurrock' are integral to the Better Care Fund Plan. Delivery of the model will require joint and integrated working across a range of partners including health, housing, social care and the voluntary and community sector.

The schemes contained within this year's Better Care Fund Plan have been revised to reflect the development achieved in 2016-17, and the next steps required during 2017-19.

1d) How progress will continue to be made against the former national conditions 3, 4 and 5 in the 2016/17 BCF policy framework

National Condition 3
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective admissions and support timely discharge

A number of steps have been taken in Thurrock over recent months to improve the delivery of 7-day services. This includes working with Thurrock care homes so that they accept admissions at the weekend, developing an improved offer through the Rapid Response and Assessment Team and introducing seven-day working for mental health, community health and adult social care as part of the new Single Point of Access Service: Thurrock First.

An analysis has been undertaken of seven-day working in the South West Essex area as part of an assessment against the relevant high impact change model. Further detail concerning the assessment and planned action is shown under the High Impact Change Model section further in this plan (refer to section 6d).

National Condition 4 Public Health
Better data sharing between health and social care, based on the NHS number

Our 16-17 Plan detailed the arrangements in place for data sharing based on the NHS number. This detailed that our main focus was on progressing the development of an integrated data set. Work has taken place over the last year to procure a system which based on the NHS number as an identifier will highlight risk areas and also key areas for further integration work.

The Council and CCG have procured the integrated data set through an external supplier called Mede Analytics. The model will integrate a number of different health and social care datasets in order to form a *population health system*. Establishment

of a system will demonstrate new ways of working in Thurrock in that it will support pro-active early intervention – identifying patients before they are likely to need a specialist service based on population segmentation. It will also promote and facilitate information sharing, and look to amalgamate information governance issues – the concept is that different parties will have different permissions available depending on their role and requirements. This will also promote a new way of working in that a population health system would encourage viewing a person in a more holistic way, rather than just as a user of each separate service; thereby aiming to reduce professionals working 'in silo' and working more closely together to support their residents.

We have agreed to develop this in a phased approach, with the first phase looking to link and integrate Adult Social Care data with local hospital data. Work is underway with the providers of both datasets (the Council for Adult Social Care and Basildon and Thurrock University Hospitals Foundation Trust for hospital data) to agree the fields for the initial extracts, ensure all information governance protocols are followed, and to install and configure Mede Analytics' *Pseudonymisation at Source* on the relevant systems to enable the uploads. It is hoped that this will be in place imminently. After a period of user testing, it is envisaged that the integrated dataset will be used to look at programmes of work related to topics such as:

- Characteristics of those experiencing delayed transfers of care;
- Those going to hospital following a fall and whether they are known to social care also;
- Analyses of the top few reasons for admissions and development of risk stratification models based on patient characteristics; and
- Analyses of those admitted to residential care following a hospital stay.

Following successful integration of these datasets, steps would be taken to start integrating other datasets in further phases, including primary care data, community health service data and mental health service data. Other datasets could be included in the future as appropriate.

National Condition 5
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

We have increased and will continue to increase our approach to joint assessments and care planning. For example, as a result of investment through the BCF, we have increased capacity within the Dementia Crisis Team – and joined the team with the already integrated Rapid Response and Assessment Team. We have also rolled out the Electronic Frailty Index so we can better manage those who the frailest in the best way.

We have implemented a Multi-Disciplinary Team approach across mental health – including for dementia and this has enabled people with dementia to ensure they are included on their GP's dementia register.

During 2017-19, we will continue to embed the approach mentioned above, as well as developing and implementing initiatives that will further ensure a joint approach to assessments and care planning. This will include work via the High Impact Change Models assessment to implement the approach to Trusted Assessors, and the implementation via the BCF of a Discharge to Assess Model.

1e) Progress to date

In our 2016-17 Plan, we said that its delivery would mean:

- Many more opportunities for people to stay connected and supported within their own communities, so preventing or reducing the need for care and support services;
- Where services were needed, they would be coordinated around the individual – preferably at home and with the individual in control and able to exercise real choice;
- Following diagnosis (of any condition), pro-active support and coordination of care and support services linked to the person's home would reduce incidence of crisis; and
- Where acute services are needed, appropriate reablement support and intermediate care would be put in place to prevent readmission and enable timely and effective discharge.

Whilst there remain significant challenges to the health and care system, substantial progress has been made. A summary of key achievements and progress against each of the schemes is detailed below:

Scheme	Progress
1 - Prevention and Early Intervention	• **Local Area Coordination:** Supporting the development and delivery of the Local Area Coordination team (LAC), which is part funded by the Better Care Fund. Now consisting of 14 LACs and a manager to provide Borough-wide coverage, the team continue to identify and work with individuals at risk of 'getting lost in the system' to identify the outcomes that matter best to them (via the question 'what does a good life look like to you?' and to help those outcomes get delivered. There are numerous case studies to evidence how the LAC team are reducing service reliance and improving outcomes for individuals. The LAC team have also worked to strengthen communities and to promote community-based networks and initiatives that provide an alternative to clinical solutions. • **Social Prescribing:** through the BCF, Thurrock was

	able to invest in a social prescribing pilot. This consisted of two social prescribers operating out of four GP practices. As a result of the impact of the pilot, it has been agreed that a further £100k will be invested in increasing the initiative's coverage. In the five months the project had been in place, social prescribers had received 84 referrals and carried out 160 sessions. GPs involved have reported a reduction in repeat GP appointments from those individuals. A review is being carried out in September and will analyse further the impact of the work carried out to date. • **E-Consult:** Thurrock is trialling e-consult in some of its GP practices. A review is to be carried out to identify impact but is a key element of transforming Primary Care. • **Integrated Data Set:** the BCF has funded an integrated data set (via Medeanalytics) to enable us to better identify patients who are at risk – but who may have been missed through other parts of the system. The system is now in place and will be operational throughout 2017-18 (early detail regarding information sharing refers). • **Exercise Referral:** as part of its focus on prevention and early intervention, the BCF has invested in an exercise referral scheme. A number of conditions are preventable or manageable through exercise – with a significant saving for the health and care system. In the first year of the programme, there were 585 participants, referred for a range of reasons and conditions. All participants went from being inactive to moderately inactive. Increasing activity levels of particular cohorts of the population will return significant benefits for health and social care.
Out of Hospital Community Integration	• **Integrated Adults Health and Wellbeing Service:** a significant amount of the payment for performance money achieved through reducing unplanned admissions during 2015-16 was used to invest in an integrated adult's health and wellbeing service. The funding contributed towards a service that brought together a community geriatrician, pharmacist, falls prevention service, care home support, and a community geriatrician support team. The service has enabled a MDT approach to complex cases – including weekly visits to care homes where residents rated as red or amber using the EFI or community MDT are focused on. A review of the service will be carried out to evaluate its impact. • **Investment in Rapid Response and Assessment**

	and Dementia Crisis: during 2016-17, we used the BCF to invest in expanding the capacity of our integrated Rapid Response and Assessment Service and Dementia Crisis Team. The increased capacity as well as both teams working together has led to fewer people being admitted to hospital. • **Out of Hospital System Redesign:** a significant piece of work was carried out during 2016-17 to identify the approach required to deliver whole system change in Thurrock. The proposal was to pilot the approach in one part of the Borough in the first instance. The pilot will transform how health and care is delivered in Thurrock and will form a significant part of the BCF Plan for 2017-19.
Intermediate Care	• **Intermediate Care – For Thurrock in Thurrock:** the focus of the Intermediate Care scheme was to ensure that any Thurrock resident discharged from hospital to an intermediate care bed would be placed in Thurrock. The situation was that residents were finding themselves in one of any six locations across South West Essex. Work carried out now means that there is sufficient capacity to ensure that Thurrock residents can be placed in Thurrock intermediate care beds. Work has also taken place to ensure that only those residents requiring an intermediate care bed are placed in that bed. An audit suggested that this was not the case. The additional investment in the community through the development of the Adult Health and Wellbeing Service has enabled communication solutions to be found.
Disabled Facilities Grant	As detailed in the 2016-17 Plan, we used the DFG to help pay for major adaptions for owner occupiers, private tenants or housing association tenants. 61 applications were completed during 2016-17, and a post has been recruited to so that applications can be accelerated during 2017-19. In line with Department of Health guidance and through the local planning process, we have invested some of the funding in broader strategic capital projects. In Thurrock, this investment has allowed us to support our broader ambition of supporting people to live at home. We will continue to review how we use the DFG to ensure that we remain as innovative as possible.

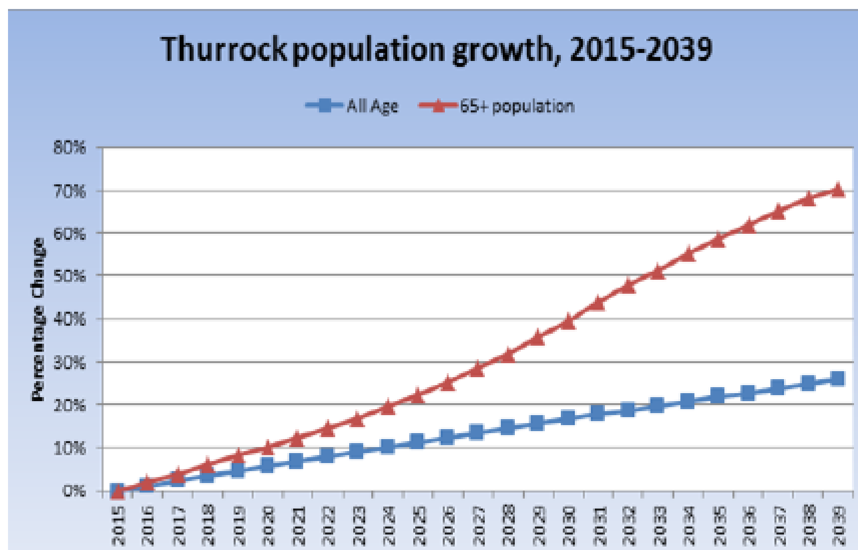
2. Plan of action to contribute to delivering the vision for social and health integration

2a) Action Plan to address the challenges of delivering our vision

1. Quantified understanding of the current issues that the BCF Plan aims to resolve

The focus of the Director of Public Health's Annual Public Health report 2016 was 'A Sustainable Health and Social Care System for Thurrock'. Not dissimilar to other areas, this identified that:

- As a population, we were living longer but not necessarily healthier lives;
- The rate of growth in the population aged 65+ locally was increasing at a rate that far exceeded that of the general population;
- Older patients were more likely to develop multiple long-term conditions; and
- That the combination of the above was resulting in increased demand for health and social care services with fewer working age people to pay through taxation for this increased demand.

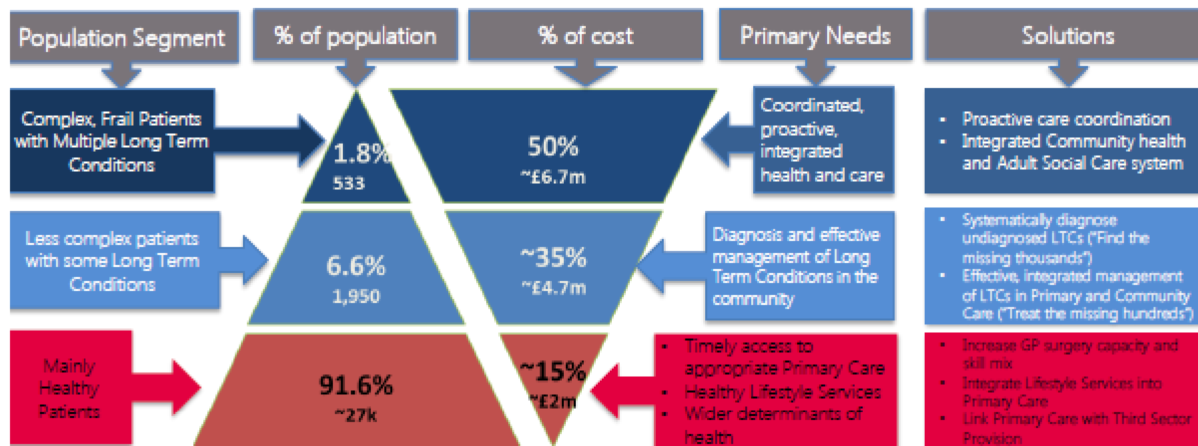


In addition, the report set out that:

- 70% of all health and social care funding was now spent on caring for people with long-term conditions;
- Effective demand management to create an operationally and sustainable Adult Health and Social Care System required a system approach; and
- Actions taken by one organisation alone in isolation of others could not achieve system sustainability.

The diagram below demonstrates the proportion of spend in the local hospital against service users and how system-wide solutions will enable resource to be released to primary and community services – including prevention and early intervention.

Figure X: Percentage of population and cost of Hospital Services use. (A&E, Outpatients and Inpatients)



The DPH report identified system issues and solutions as follows and provides a case for change in Thurrock that this BCF Plan contributes towards solving through the delivery of its schemes:

a) Improving Primary Care Capacity

The report calculated that if Thurrock was to bring Full-Time Equivalent GP:patient ratios in line with the England average, an additional 45 GPs would be needed. Understanding the national shortage of GPs and difficulties recruiting GPs, we are working jointly to deliver four Integrated Medical Centres (IMCs) that will provide coverage across the Borough. Work is taking place to identify how the IMCs will operate and to ensure that they respond to local requirements. IMCs will bring together primary, community and mental health together with diagnostics, hospital outpatients and community hubs. The implementation of a more diverse sills mix within existing Primary Care provision will also free up GP time. This Plan also identifies how activity can be diverted away from primary care – for example through the work of social prescribing, e-consult, and sign-posting within communities. IMCs are a key element of Thurrock's Out of Hospital strategy and will link to the Out of Hospital project being delivered in Tilbury and Chadwell.

For every one percentage point increase in the availability of GP appointments, we estimate a reduction in:

- **6543 emergency hospital admissions for COPD**
- **109 emergency hospital admissions for Heart Failure**
- **A saving to the NHS in Thurrock of £2.9m**

b) Prevalence of Long-Term Conditions

There is a significant variation between GP practice populations in terms of the prevalence of diagnosed different long-term conditions between different populations – particularly in diagnosed rates of Hypertension, Coronary Heart Disease (CHD) and Heart Failure. Initiatives that focus on both preventing and increasing the diagnoses rates of certain Long-Term Conditions will contribute to reducing pressure on the system – particularly preventing emergency admissions and treatment at the most expensive part of the system – i.e. acute care.

- **The vast majority of long-term conditions are highly preventable through lifestyle changes**
- **Preventing and improving identification of long-term conditions will ensure that money is kept in the right place**

c) 'Find the missing thousands'
Thousands of people in Thurrock are living with long-term health conditions that are yet to be diagnosed, and identifying these people is a key priority. Improving case finding of long-term conditions means that far more people can be identified and treated at an early stage – avoiding the need for expensive treatment and the development of potentially life-threatening and life-changing events.

- **For every 1% complete hypertension registers are, 65 strokes will be prevented over 3 years**
- **Increasing the completeness of hypertension registers by just 10% would save the NHS locally £2.38m in stroke treatment costs**

d) 'Treat the missing hundreds'
Once diagnosed with a Long-Term Condition, effective clinical management of patients is absolutely vital in order to reduce the risk of their wellbeing and independence deteriorating and to prevent them being admitted to hospital or requiring social care packages. Variations in the management of long-term conditions need to be addressed which will both improve health and wellbeing and reduce demand and cost.

In 2015-16 there were 247 patients in Thurrock with a diagnosis of AF who were assessed at being at high risk of a stroke but who were not prescribed an anti-coagulant to reduce their risk nor exception reported

In 2014-15, 1,075 patients with COPD were eligible for Pulmonary Rehabilitation but were not referred by their GP practice

Currently, GP practices are not financially incentivised to treat all high risk patients. Work is taking place to consider implementing a stretched 'QOF' programme to provide clinical interventions to 100% of patients that require and desire them – which in turn will contribute to significant system savings and capacity.

e) Reduce preventable emergency hospital admissions
Preventable emergency hospital admissions are a symptom of inadequate capacity and missed opportunity to intervene in the management of long-term conditions within Primary and Community Care, together with at times inadequate self-care by patients themselves. A range of measures can be put in place to prevent and reduce the likelihood of emergency admissions – which includes focused work with high risk groups including care homes.

f) Reduce avoidable A&E attendances
Through analysis undertaken, we have concluded that the vast majority of Accident and Emergency attendances are inappropriate. Out of 59,675 attendances in 2014/15, 24,424 did not require any medical intervention or treatment at all. A

number of recommendations have been made which include the ability to shift resource from secondary care to primary care – particularly with regard to minor clinical conditions; increasing the skill mix of staff in the community; and development of four Integrated Medical Centres.

2014/15

- 83% of all A&E attendances needed no medical intervention or treatment, or the most minor category of medical intervention and treatment
- 27% of these attendances were conveyed to A&E by ambulance
- Treating these patients in Primary or Community Care would deliver £1.57m net savings in Thurrock
- Treating 'excess' A&E attendances in Primary or Community Care settings would saving approximately £2m over three years

g) Reduce Delayed Transfers of Care

The South West Essex area has carried out an assessment against the High Impact Change Models. This is in response to the rising increased delayed transfers of care – as is the national picture. This has resulted in an understanding of a) where the area is against each of the models; and b) identification of actions that need to be taken. In addition, the Better Care Fund contributes significantly towards the delivery of reductions in DTOC through its scheme on 'delivering good discharge'. The BCF has enabled additional investment in initiatives that will enhance the good discharge of Thurrock patients. Further detail of the work carried out is documented later in this Plan within scheme 3 and also as part of 6d.

h) Adult Social Care

Whilst analysis shows that the number of new service packages is reducing (based on 2014-15 to 2015-16), the mean cost per service package is increasing. This suggests that the investment that has been made in prevention and early intervention is having an impact, and that the acuity of the packages provided is increasing. We have shifted and invested resource in a number of prevention and early intervention initiatives, including through investments made by the Better Care Fund. This includes Local Area Coordination, Rapid Response and Assessment Service, Joint Reablement Team, Intermediate Care bed capacity, outcome-based assessment.

2. The BCF Plan responds to the current challenges in the system as detailed above by:

1. Prevention and Early Intervention

We believe that a focus on preventing, reducing and delaying the need for health and care support and services is the best chance we have of both managing demand and ensuring that Thurrock people are able to achieve the outcomes that matter most to them. As such, much of the focus of this Plan is on how we can prevent the need for service intervention and intervene at the earliest opportunity to ensure that people have the best chance to maintaining a good quality of life. We have used the BCF in the past to invest in our Local Area Coordination service and also in introducing initiatives such as Social Prescribing. This is bolstered by our work to support the development of stronger communities through the Stronger

Together Thurrock partnership between the CCG, Council and the Voluntary and Community Sector.

We will use our BCF during 2017-19 to continue to support the development and delivery of prevention and early intervention – with some focus on increasing identification, case management and self-management of Long-Term Conditions.

Our system redesign project detailed below (see scheme 2 'Out of Hospital Community Integration') will look at how the current system can shift away from a typical focus on 'treating an illness or condition'.

2. Out of Hospital Community Integration

In 2016-17, our focus was on using extra investment to build an integrated health and wellbeing team to better manage those individuals at risk of admission to a hospital or residential care home. This included a community geriatrician-led multi-disciplinary team approach that included a pharmacist, GP, and falls clinic. This has led to some good early results – particularly targeted work that has taken place with residential care homes. We also continued work on the development of four Integrated Medical Centres that would serve the population of Thurrock and provide additional Primary Care capacity.

Following the Director of Public Health's Annual Report 2016 on achieving system sustainability, it was agreed that the health and care system in one part of the Borough (Tilbury and Chadwell) would be remodelled. A further piece of work has been carried out to detail the system change that needs to take place. The paper developed (case for change) proposes a transformation in the way care is delivered, including a new offer from Primary Care, an integrated workforce based around a locality and some more immediate initiatives that will lead to improved management and identification of Long Term Conditions – and also early intervention and prevention.

A project (known as 'New Models of Care'), led by the Director of Integrated Care for Thurrock Council and North East London Foundation Trust (NELFT), has been established to develop and take forward the recommendations within the Tilbury and Chadwell Case for Change. This will be the main focus of the 'Out of Hospital Community Integration' scheme during 2017-19 and sits as part of Thurrock's health and care transformation programme 'For Thurrock in Thurrock'. The project will provide the blueprint for the future health and care system in Thurrock.

As part of this scheme, work will continue on the development of the four Integrated Medical Centres. This will enable people to access a range of services and support close to where they live. This includes the delivery of a range of outpatient services currently delivered in a hospital setting.

We have used a substantial amount of our iBCF to support a stable market place. This includes enabling an uplift in hourly rates for our domiciliary care providers, and an increase rate for residential care providers. Over the last 18 months, we have had an increasingly unstable domiciliary care market place, and we see additional investment as essential to our ability to provide a sound 'out of hospital' offer.

In addition, we have agreed to use funding from the iBCF to provide additional investment in our Rapid Response and Assessment Service, Home from Hospital Service, and to increase capacity within the Hospital Social Work Team.

The Out of Hospital Community Integration scheme will continue to support the main elements included in the 2016-17 Plan, but the size of the scheme as grown significantly to incorporate the aforementioned elements.

3. Discharge Pathway

During 2015-16 and 2016-17 the focus of scheme 3 was on reviewing and refocusing intermediate care provision across the Borough. This scheme was successful and was implemented in 2016-17. As a result, this scheme has been refocused to delivering good discharge and will contribute significantly to the management of Delayed Transfers of Care.

As part of the High Impact Change Model assessment undertaken by the South West Essex area, those actions that relate to delivering good discharge will form the outline of this scheme.

3. Approach to programme delivery and control

3a) Governance and Accountability (a description of the specifics of the overarching governance and accountability structures and management oversight in place locally to support integrated care and the delivery of the BCF Plan)

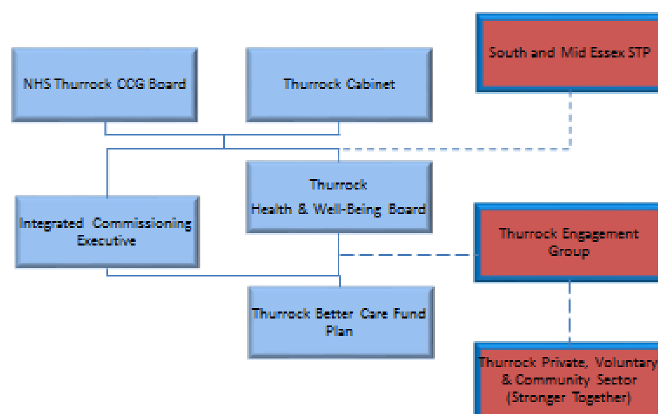
The Integrated Commissioning Executive was established by Thurrock Council and NHS Thurrock Clinical Commissioning Group in April 2015 to oversee and sign off the development of all policy, commissioning and procurement, market engagement, efficiency, performance and processes related to the integration of adult social care and health care in the Borough.

Where relevant the change programmes managed by the Essex Success Regime (which is the footprint for the local Sustainability and Transformation Plan) are also considered by the Integrated Commissioning Executive.

There is also oversight by the Integrated Commissioning Executive of progress against relevant aspects of the QIPP challenge, the Primary Care and Estates Strategies, and the Council's transformation programme for adult social care.

The links to the integrated For Thurrock in Thurrock transformation programme – which is focused on developing solutions, strengthening communities and the designing a built environment to promote health and well-being – ensures that due regard is given to the impact of the wider determinants of health.

The Integrated Commissioning Executive reports to the Health and Wellbeing Board and its terms of reference are set out in the Section 75 Agreement for the Better Care Fund. The reporting lines are as follows:



In relation to the Better Care Fund a joint Council and CCG Section 75 Agreement Project Group established the arrangements for the Council to host the pooled fund.

Responsibility and accountability for the Better Care Fund pooled fund was assumed by the Integrated Commissioning Executive from April 2015.

The Integrated Commissioning Executive reports to the Health and Wellbeing Board (and the Cabinet of Thurrock Council, the Board of NHS Thurrock CCG and relevant sub-committees) on its commissioning decisions, as set out in the Better Care Fund plan, and the associated Section 75 Agreement between the Council and the CCG. The Integrated Commissioning Executive also oversees 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, are also dealt with exclusively by the Integrated Commissioning Executive.

The arrangements are set out in detail in the governance section of the Section 75 Agreement and cover:
- 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

Membership of the Executive is:
- Accountable Officer, NHS Thurrock CCG
- Corporate Director Adults, Housing and Health, Thurrock Council
- Director of Public Health, Thurrock Council
- Chief Finance Officer, NHS Thurrock CCG
- Strategic Lead for Commissioning and Service Development, Thurrock Council
- Director of Commissioning, NHS Thurrock CCG
- Director of Finance and Information Technology, Thurrock Council

The Integrated Commissioning Executive is serviced by a dedicated team led by the Pooled Fund Manager which reports financial and activity information at least quarterly.

The Integrated Commissioning Executive meets on a monthly basis to review performance against the Plan. It has 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 this is appropriate.

The Integrated Commissioning Executive reports progress against the plan to the Health and Wellbeing Board.

Financial and performance reports are also made on a quarterly basis to the Cabinet of the Council, and to the Board of NHS Thurrock Clinical Commissioning Group.

3b) Contribution towards health inequalities (a description of how the plan will contribute to reducing health inequalities as per section 4 of the Health and Social Care Act and to reduce inequalities for people with protected characteristics under the Equality Act 2010)

The principles and success factors that underpin the vision set out within this Plan detail the delivery of a health and care system equitable to all and a health and care system that contributes to the reduction of health inequality. This is consistent with Thurrock's Health and Wellbeing Strategy 2016-2021.

The work being carried out to deliver a population-based health and care system (scheme 2 refers) will pilot the approach in one of the most deprived areas of the Borough. The change being delivered through this pilot will not only ensure services are responsive and person-centred, but focus on prevention and the delivery of outcomes that are most important to the individual. This includes making strong linkages to and building on community strengths through the Stronger Together Thurrock Partnership. The health and care system pilot will respond to a needs assessment that has been carried out at a neighbourhood level. This enables any change required to take in to account the requirements of different cohorts within the population. As the work is scaled-up across the Borough, it will avoid a 'one size fits all' approach and flex according to local requirements.

Thurrock has already signified its commitment to reducing inequalities within its population. This includes investment made through the BCF in previous years to initiatives that deliver prevention and early intervention at a community-level – for example through Local Area Coordination, Social Prescribing, Micro Enterprises. Thurrock's integrated health and social care transformation programme also focuses on influencing the wider determinants of health – e.g. through influencing the built environment.

3c) Does the narrative plan have a clear approach for the management and control of the schemes?

As noted in section 3 above (Approach to programme management and control), the Pooled Fund Manager monitors financial and activity information on a monthly basis, escalating any issues/off-target performance to the Integrated Commissioning Executive as necessary. In addition, and at least quarterly, the Pooled Fund Manager provides a full report to the Integrated Commissioning Executive 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 monitored by the Pooled Fund Manager are detailed within the Better Care Fund planning template submitted alongside this plan.

In the case of the introduction of new services or de-commissioning 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 the Health and Wellbeing Board on the recommendation of the Integrated Commissioning Executive. These plans will include robust mobilisation plans for each service or initiative, including key milestones, impacts and risks.

In terms of capturing and sharing learning, Thurrock is part of a regional East of England Local Government Association Health Integration Network which meets on a monthly basis and also holds a number of peer-to-peer learning workshops on topical themes.

4. Management of risk

The Risk Register for the Thurrock Better Care Fund provides an overview of the top 10 risks identified for the period 2017-19 and can be found in Appendix 1 of this Plan. 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 Pooled Fund Manager, with oversight by the Integrated Commissioning Executive.

The majority of 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 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. These plans will include robust mobilisation plans for each project, including key milestones, impacts and risks.

As well as the majority of services within the BCF Plan being operational, the majority are also commissioned by the Council or CCG. As a result, the quality of the services to be provided is secured through both the procurement process and contract monitoring process. As such, the risk of poor service quality is reduced.

To deliver the vision in Thurrock's Better Care Fund 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 is in place between the two parties and this is set out in the Section 75 agreement which determines 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 has been undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks.

THURROCK'S AGREED APPROACH TO FINANCIAL RISK SHARING AND CONTINGENCY

The Thurrock Better Care Fund needs to be understood within the context of the Essex Success Regime and the Sustainability and Transformation Plan (STP) for mid and south Essex. The STP sets out the overall strategic planning framework for the whole of Essex, including Thurrock and Southend on Sea. It is focussed on both financial and clinical sustainability across Essex. It has brought together leaders (both providers and commissioners) in Essex to develop a plan which will achieve these goals over the next 3 years. This is within the backdrop of a potential NHS financial deficit within the Essex system of approaching £200m.

The STP has developed two core work streams; the acute work stream and the out of hospital work stream. There has been significant investment into the national programme and its governance. This has included investment into Business intelligence to monitor its delivery. The programme reports directly to senior national NHS leaders.

The STP system partners have decided that the best way to achieve system sustainability is to agree NHS block contracts for total activity across the 3 acute Trusts in Essex. This allows the system to focus on the transformation and integration of acute services whilst providing assurance on income for individual trusts. The acute work stream includes urgent and acute configurations, back office efficiencies, and clinical support service efficiencies. The three trusts are developing a network structure and have appointed a joint CEO. The trusts support this approach and accept the risk on over activity in non-electives. There is no financial risk in 2017-19 to the BCF on increased non-elective admissions.

The second work stream is focused on developing the out of hospital services and shifting appropriate activity out of the acute hospital. In Thurrock we have worked hard with local partners to ensure that the Better Care Fund, Health and Wellbeing Strategy and the STP Out of Hospital work stream are aligned. The aim is not to use the financial security of a block contract to diminish our ambition to improving out of hospital community integration. In fact, the opposite is true. There is a hugely ambitious programme of work to transform community services. The delivery of this programme of work will allow the terms of the block contract to be renegotiated and reduced in size as sustained reductions in acute activity are achieved.

The STP is trying to deliver sustainability and manage risk by balancing these two work streams. The BCF sits within and supports this risk sharing approach.

The total value of the Better Care Fund in Thurrock is circa £40m and for the year 2017-19 no amount of the Better Care Fund is described as 'at risk'.

The Health and Wellbeing Board has specifically considered performance against the total emergency admissions target set locally for 2016-17 and determined that in the light of the solid performance in the last year, together with the close working with the Essex Success Regime in the context of agreeing a new Block Contract with the Acute Provider BTUH, no "at risk" contingency is required in 2017-19.

The Health and Wellbeing Board remains closely involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. Section 75 performance reports for each BCF Scheme will continue to be provided to the Integrated Commissioning Executive and reported to the Health and Wellbeing Board.

The issue of treatment of overspends in the BCF Schemes has also been agreed and the Health and Wellbeing Board have determined that the Better Care Fund for 2017-19 should again 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.

The Section 75 Agreement stipulates that Financial Contributions in each Financial Year will be paid to the fund monthly in advance receivable on the first day of the month commencing 1st April 2017.

In terms of management arrangements, the Section 75 agreement stipulates 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.

5. Funding contributions and BCF schemes

The Planned investment in Better Care Fund Schemes in 2017-19

Scheme Ref	Scheme Name
1	Prevention and Early Intervention
2	Out of Hospital Community Integration
3	Intermediate Care Review
4	Disabled Facilities Grant

Further details on each of the schemes are given below.

BCF Scheme 1 Prevention and Early Intervention

Scheme Aims and Objectives

The objective of the Scheme is to develop a whole system approach to prevention and early intervention. The result will be a cohesive prevention and early intervention offer spanning the community, public health, health and adult 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;
- to be fully coordinated around the individual needing a solution bringing together all interventions designed to manage demand and prevent crisis;
- to have the "right place, right time, right solution".

The aims and outcomes associated with this Scheme are focused on preventing illness and maintaining good health. There are a number of benefits including reducing pressure on the system – both in terms of demand and cost for health and social care services. The focus will help to shift the system towards maintaining good health and well-being rather than a system geared up to treat disease at a point where good health and well-being cannot be achieved.

Scheme Overview

The Health and Wellbeing Board has refreshed its Health and Wellbeing Strategy 2016-2021. This has brought with it a stronger focus on preventing ill-health and reducing and delaying the need for increased health and care interventions.

In addition, though our Stronger Together Thurrock partnership, we continue to focus on how we can build on the strengths that exist within communities and how these in themselves can underpin the ability for people to achieve the outcomes that are most

important to them. Our ability to achieve this means the continued support and development of the following initiatives – many of which are part or fully funded through the BCF:

- Local Area Coordination;
- Social Prescribing;
- Time Banking;
- Community Hubs;
- Community Micro Enterprises; and
- Community Asset Mapping.

BCF Achivements to date

Since the 2015-16 Plan was written, the BCF has delivered a number of significant successes:

- Developing a Borough-wide Local Area Coordination service;
- Procurement of an integrated data set across health and social care to enable early identification of those at risk. The system enables the linking of patient and client records to allow risk stratification, mapping of patient and client flow, enabling remote call-recall and clinical audit, and the development of predictive models to identify residents most at risk and intervene early;
- Investment into a Falls prevention service which is linked to the Well Homes initiative;
- Stroke prevention – increased identification of those at risk of a stroke through increased and targeted health checks;
- Diabetes prevention – implementation of the national diabetes prevention programme;
- Piloting Social Prescribing a number of GP practices; and
- Voluntary Sector Grants – introducing a joined-up approach across health and social care to how voluntary sector grants for the 65 and above cohort are awarded.

Next steps

The 'case for change' underpinning the 'New Models of Care' project (see scheme 2 Out of Hospital Community Integration) identified a number of 'quick wins' that would help deliver system-wide change. This scheme will focus on developing and delivering the following initiatives identified as part of that case for change:

- Development of Mede-Analytics – The Mede-Analytic tool was successfully procured in December 2016 and began initial roll out in March 2017. The next steps are to complete the roll out of the system, develop the Mede user group to drive the strategic direction and embed the data reports into the BCF work streams;
- Roll-out of E-consult pilot to GP surgeries – following the success of the initial pilot, further work will be carried out to make E-consult available for a greater number of surgeries enabling greater choice and flexibility and improving primary care capacity;
- Hypertension and Atrial Fibrillation case finding and improved clinical management – to test the model in a number of community settings and roll out across Thurrock by March 2018

- Stretched QoF for Cardio-Vascular Disease Management and COPD;
- Improved targeting of NHS Health Checks to increase uptake from those most likely to be at risk;
- Improving the coverage rate of flu vaccination – with a particular focus on those people with respiratory disease; and
- Roll out of social prescribing – to review the pilot project and roll out across Thurrock by the March 2018.

Better Care Fund investments related to Prevention and Early Intervention

INSERT HERE

BCF Scheme 2 Out of Hospital Community Integration

Aims and Objectives

The aim of this scheme is, through system redesign, to improve the coordination of community health and adult social care services so that care delivered in the community is person-centred whatever the provider or nature of the service required. The aim of the scheme is also to improve available capacity within the community to ensure that the individual can find community-based solutions to suit their requirements – including the relocation of services currently provide in hospital as appropriate.

Scheme Overview

In Thurrock, there is a long standing journey towards greater integration of health and social care. This includes the development of an Older Adults Integrated Wellbeing Service – supported through investment from the BCF, and providers agreeing to develop an Accountable Care Partnership and lead provider arrangements through Mental Health provider EPUT. Linked to this is the agreement to develop and implement new models of care that effectively redesign how health and care is provided in Thurrock.

Thurrock has also taken the lead for the Frailty work stream for the Mid and South Essex Sustainable Transformation Plan and Essex Success Regime. This is as a result of the plans it has in place to transform the health and care system in Thurrock through its For Thurrock in Thurrock transformation programme.

MH STP leadership and parity of esteem

GP FYFV
Following several Care Quality Commission inspections of local practices and subsequent poor ratings, a successful bid enabled the funding of a Primary Care Development team to work with General Practice. The team oversees a programme of works - initially focusing on improving the quality of primary care delivery.

Thurrock now has twenty-three practices with a 'Good' CQC rating (72%). Three practices were rated as 'Requires Improvement' and it is expected that these ratings will improve at the next CQC inspection. Two practices currently have an

'Inadequate' rating: One of these is closing in September 17 with the list being dispersed and one is part of a re-procurement. Four practices have yet to be inspected due to partnership registration changes - these practices have recently undergone re-procurement and the new Provider is expected to achieve a 'Good' rating as a minimum.

More recently, the team has been involved in supporting the implementation of the GPFV. Plans have been developed and agreed to support the Tilbury and Chadwell locality to progress as an Accountable Care Partnership

CCG DM plan – INSERT HERE

Part of the plans include the development of four Integrated Medical Centres (IMC) across the Borough which will enable services currently run in a hospital setting to be delivered in the community. Each IMC will be tailored to meet the needs of the community it serves.

The BCF plan is also aligned the CCG Demand Management Plan. The CCG Demand management plan focuses on the 8 high impact changes:

- Peer to peer review
- Shared decision making
- Choice
- Alternatives to outpatients
- Direct access to diagnostics
- Referral diversion
- Advice and guidance
- Ambulatory emergency care
- Emergency admission avoidance

Achievements to date

Since the 2015-16 Plan was written, significant progress has been made towards identifying and redesigning health and care in Thurrock. This includes:

Thurrock First
Thurrock First has brought together Adult Social Care, Community Health provider NELFT, and Mental Health provider EPUT in to a Single Point of Access. The new service launched in early July and enables members of the public to ring one number in order to access information and advice, including referrals and Rapid Response and Assessment, across all three providers. The aim of the integrated service is to reduce duplication and to provide a more seamless experience for service users – particularly those who are known to more than one provider. The service also provides sign-posting to assist with preventing, reducing and delaying the need for health and care intervention. A review will be carried out within a year of the new service's launch.

Joint Strategic Needs Assessment
Area-specific JSNA have been carried out to support the development of locality-

based system redesign. The first of these are to support the development of new models of care in one area of the Borough – Tilbury and Chadwell. The JSNA ensure that the health and care 'offer' is specific to and responsive to the need of the population it spans. As a result of the JSNA, and Case for Change is being developed and a number of recommendations have been made that not only include what is on offer and how it is offered, but that aim to prevent, reduce and delay the need for health and care intervention.

Case for change
A Case for Change is being prepared that will underpin the development and delivery of the health and care system in Tilbury and Chadwell. Whilst the Case for Change is still being refined, a number of recommendations have been made – driven by the JSNA. The recommendations include a number of quick wins, suggestions concerning the development of an integrated workforce, and also suggestions that improve the primary care offer and capacity. Scheme 2 is the result of the JSNA and Case for Change and identifies areas of investment to ensure that the recommendations made to date can be delivered alongside anticipated outcomes.

Executive and steering groups
Linked to the commitment to develop an Accountable Care Partnership and deliver new models of care in one area of the Borough, new governance arrangements have been established. This includes the implementation of an ACP Executive, and also a new models of care project steering group. Both groups will link in to the existing Integrated Commissioning Executive which is responsible for overseeing the BCF Plan.

Next steps
The Plan for 2017-19 takes the development of Out of Hospital Community Integration further still. Following a 'case for change' prepared by the Director of Public Health, Thurrock has established a 'New Models of Care' project in one part of the Borough (Tilbury and Chadwell). The Project aims to develop and deliver system change based on the development and introduction of a population-health model - incorporating prevention and early intervention (see scheme 1). The project will link with several other initiatives so that it delivers system-wide redesign. This will include the development of four Integrated Medical Centres and the development of Wellbeing Teams (self-managed teams delivering domiciliary care). Should the project be successful, it will provide a blue print for the rest of the Borough – ensuring sufficient flexibility to adjust to local requirements. The project will consist of three specific work streams:

- **Primary Care Transformation** – to increase the capacity and quality of Primary Care provision and reduce variation in current provision;
- **Integration and Workforce Development** – development of an integrated community health and wellbeing team including community health, mental health, primary care, specialist services, adult social care, and linking to the community and voluntary sector to encourage self-care and prevention;
- **Delivery of 'quick wins' for LTC identification and early intervention** (see scheme 1 for detail).

Better Care Fund investments related Out of Hospital Community Integration

INSERT HERE

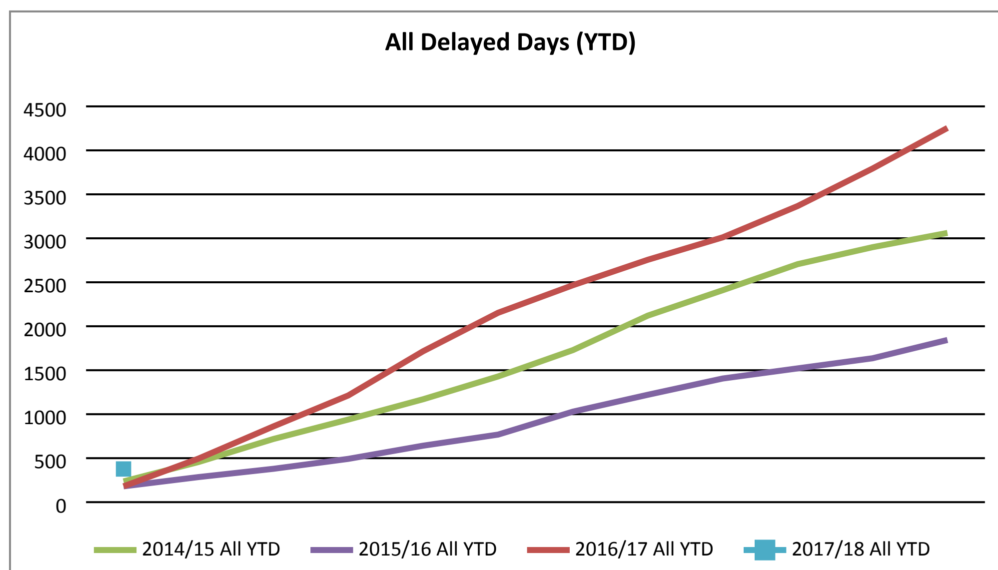
BCF Scheme 3 Good Discharge

Aims and Objectives

Scheme 3 focuses on the development and delivery of 'good discharge'. It is a critical part of our action plan to reduce delayed transfers of care and to meet our targets. A number of new investments have been made to accelerate work linked to this scheme. Actions have been identified as a result of an assessment against the 8 High Impact Change Models.

Scheme Overview

In Thurrock as across the Country, Delayed Transfers of Care have been on the increase.



Analysis has been carried out across the South West Essex region to identify actions set to reduce the number of delays. Key risks continue to be the stability of the domiciliary care market, intermediate care capacity, and the fragility of the workforce across the health and care system (risk register at appendix 1 refers). Delivering good discharge arrangements is key to the ability to reduce and manage delayed transfers.

The improvement actions linked to delivering 'good discharge' form part of the Accident and Emergency Delivery Board's 'out flow' action plan. The action plan covers South West Essex.

Key objectives of the action plan relating to 'out flow' are:

- Delivery of a Trusted Assessor scheme;

- Effective discharge to assess pathways in place;
- Provision of additional capacity to enable movement of patients;
- Review of intermediate care referrals process;
- Development of neighbourhood teams to support improved discharge planning and admission avoidance;
- Effective discharge to assess pathways in place;
- Enable care homes to manage patients.

Achievements to date
Intermediate Care Review - during 2016-17, the scheme focused on redeploying intermediate care beds to ensure there were Thurrock beds for Thurrock residents. This piece of work was completed during that period of time.

Joint Reablement Team – additional investment for the JRT to provide the capacity required to provide sufficient reablement to those who qualify.

Next steps

- **21st Century Residential Care –** the development of proposals to redevelop in-house residential care in Thurrock. This will include consideration of intermediate care capacity and potential for integration or join up with primary and community care services on the same site. Proposals will respond to recent reports that a significant increase in residential care capacity will be required in response to people living longer.

- **Bridging Service –** investment from the iBCF will enable Thurrock to access the Hospital's Bridging Service, which involves Healthcare Assistances from Basildon Hospital supporting patients to leave hospital and move safely back home during the winter period until a home care package to support the service users can be put in place.

- **Winter Pressure –** investment will allow the ability to mobilise and provide additional capacity wherever it is required to avoid bottle necks from developing and to ensure continued discharge from hospital to home or to an intermediate care setting.

In addition, we have used integrated Better Care Fund (iBCF) monies to further the scheme's objectives by investing in the following initiatives:

- **Market Stability** – it has been well reported that the adult social care provider market is extremely fragile. In Thurrock over the last 18 months this has led to home care providers either handing back contacts or failing. A significant proportion of the iBCF has been used to provide market stability – either through a rates uplift or through investing initiatives that provide greater market choice.

- **Home from Hospital** – delivering home from hospital support for people discharged from hospital who have no support close by. Working in

partnership with the hospital and adult social care to facilitate discharge and stop readmission to the hospital.

- **Red Bag –** to deliver the integrated pathway (Red Bag Pathway) to support care homes, ambulance services and the local hospital meet the requirements of NICE guideline NG27: Transition between inpatient hospital setting and community or care homes.

- **Rapid Response and Assessment Service –** The additional investment will increase capacity in the Rapid Response and Assessment Service which in turn will help to relieve pressure on home care services.

- **Hospital Social Work Team –** This will increase capacity in the hospital team to assist patients who do not require admission but who may have social care needs.

- **Community Based social Work –** This will increase the capacity in the community team providing support for older people.

- **Night Service –** Investment from the BCF will enable increased capacity and support to enable the service to provide nursing assessments for housebound patients with a physical healthcare need from 2000 – 0800. The purpose of the service will be to encourage people with disabilities and long-term conditions to be able to live independent lives and to avoid reaching crisis leading to avoidable admissions.

Section 6d shows how we have assessed ourselves against each of the High Impact Change Models, and the actions we have agreed to take forward as part of the Accident and Emergency Delivery Plan. This will be taken forward on a South West Essex geographical basis. The elements in this scheme reflect Thurrock's contribution to the 'out flow' element of that plan.

Better Care Fund investments related to Intermediate Care

INSERT HERE

<u>BCF Scheme 4 Disabled Facilities Grant</u>

Scheme Overview

The Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants.

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. A responsive service is crucial to ensuring those who have no clinical need for care in acute settings to move to a home which safely meets their mobility and other needs.

In addition to the provision of adaptations, Thurrock is investing significant sums in assistive technology to meet the care needs of the 21st Century. This includes a

programme over the next 6 months of replacing all the pull cord alarm systems in the Borough which mobile pendant based technology. As part of its preventative strategy, and in order to encourage the take up of assistive technologies, the Council has agreed to make it's community alarm service free of charge to all users of social care services, and also to all those who are aged 75 years and over and who live alone.

In recognitions that there is now a well-established body of evidence that telecare and telemedicine can bring significant improvements in outcomes for service users, and efficiencies for commissioners Thurrock is currently embarking on a new programme to embed Technology Enabled Care in all parts of its community based systems. This programme, led jointly by adult social care and health commissioners and providers will make available a range of digital technologies that support prevention and early intervention. Solutions may include overcoming social isolation by connecting people to the wider community and family, helping people manage their own conditions and co-produce their care arrangements, assisting care services to monitor health and identify symptoms.

Better Care Fund investments related to Disabled Facilities Grant

INSERT HERE

6. National Conditions

6a) National condition 1: jointly agreed plan

The Plan is aligned with and supports the delivery of Thurrock's refreshed Health and Wellbeing Strategy. The Strategy has been developed through discussions with all key partners – including providers of health and care services, and has been agreed by the Health and Wellbeing Board. Thurrock's Health and Wellbeing Board includes NHS providers as full Board members.

The Plan builds on the one agreed in 2016-17 and has been updated to reflect progress made and next steps. Providers have been involved in the development of the initiatives that form those refreshed Schemes.

6b) National condition 2: social care maintenance

Our first Plan in 2015-16 set out our approach to protecting social care services and how the BCF would assist. This included:

- Ability to reduce overall demand – e.g. responding to increased demographic pressures;
- Strengthening social care provision – reviewing existing services to ensure that they are value for money and person centred – re-commissioning and re-modelling where required (ASC Transformation Plan);
- Reviewing the way we commission and procure services; and
- Shifting resource to ensure that it has the best possible impact.

We encompassed all of the above in an Adult Social Care Transformation Plan with is now a joint plan with Thurrock CCG called For Thurrock in Thurrock. The elements of our approach to protecting social care services remain as set out above.

The Better Care Fund Plan further aided the protection of social care through its ambition to shift the health and care system towards prevention and early intervention – aiming to keep people well rather than focusing on treating them when they became unwell.

Our 2016-17 Plan built on this approach as does our Plan for 17-19.

For 2017-19, we have agreed that the BCF's contribution towards maintaining the provision of social care services will be £xm which represents an increase of x on 16-17. As already documented, the Plan will further contribute toward maintaining social care services by focusing on prevention and early identification.

Adult Social Care continues to face a number of challenges. Over the last 18 months, we have seen a number of our domiciliary care providers either handing back contracts or failing. This has placed significant pressure on the system as a whole and contributed to increased Delayed Transfers of Care and for the first time the implementation of waiting lists for domiciliary care. There has also been an impact on our ability to provide preventative services such as reablement, with capacity in our Joint Reablement Team being temporarily diverted to provide additional homecare capacity. Being able to provide additional investment in

domiciliary and residential care services, as well as initiatives to look at how we can provide domiciliary care differently, means we are able to provide a greater degree of stability within the market place – and reduce the impact on the system as a whole.

6c) National condition 3: NHS commissioned out-of-hospital services

Within this Plan, we have set aside £x for NHS commissioned out-of-hospital services. The funding will contribute to the following:

- Detail what the OOH funding is being spent on and how this links to reducing/maintaining NEAs – see p11 of the BCF planning – add from planning template when available

6d) National Condition 4: Managing Transfers of Care

We have worked with partners across the South West Essex sub-economy to assess our progress against each of the eight high impact models. A copy of the assessment is attached. From the assessment, a number of key actions have been identified. The actions have been integrated in to the local Accident and Emergency Delivery Board work programme (see attached) under 'in-flow', 'flow', and 'out-flow' programmes of work. Arrangements are in place to oversee progress through the monthly Accident and Emergency Delivery Board, and in addition Thurrock's Integrated Commissioning Executive will monitor progress via overseeing the implementation of the Better Care Fund Plan.

Scheme 3 of this Better Care Fund Plan (Good Discharge) contributes towards the delivery of managing transfers of care in Thurrock and relates to the 'out flow' element of the Delivery Board's work programme. Key initiatives in Thurrock and as part of this Plan are:

- Home from Hospital;
- Bridging Services;
- Rapid Response and Assessment Service;
- Increased capacity of the Hospital Social Work Team;
- Discharge to Assess; and
- Enhancing health in care homes via the continued work of the Older Adults Integrated Wellbeing Team.

Details of the investment being made are included within the respective schemes.

The South West Essex self-assessment against the High Impact Care Models has resulted in the following high level assessment and key actions against each of the models:

1. Early Discharge Planning

Where are we now?	What actions do we need to take forward
Inconsistent. Across Elective Surgery, planning is relatively good (particularly orthopaedics). In general discharge dates are set within 48 hours, however, it was felt that these dates are not always accurate nor necessarily worked to and are adjusted regularly. It was noted that in the main, social are is not involved in planning discharge until the point in which someone was medically fit for discharge. There is little or no proactive involvement of primary or community services in both planned and unplanned admissions.	1. Ensure choice letter is issued and that policy is signed off and followed by all departments. 2. Through the aligned teams/neighbourhood development, understand the opportunity for proactive involvement of community and primary care in supporting discharge planning for both elective/non elective admissions. Put in place necessary arrangements to enable this to happen.

2. Systems to monitor patient flow

Where are we now?	What actions do we need to take forward
Inconsistent - there is some demand and capacity work that is undertaken and in part applied to planning. There is some flexing of capacity to support peaks in demand e.g. additional staff on Mondays, additional staff to enable escalation etc. However, fundamentally, we are still bedding patients in A&E which creates a bottleneck at the beginning of the day. Whilst there is senior management involvement and flexing to some level of capacity outside of hospital (community and social), there is no real ability to flex capacity to any significant degree. For social care, this is largely reflective of the fragile market. It was felt that we make best use of the available capacity but don't really have the ability to proactively flex capacity. It was noted that referrals to social care seem to peak on Thursday and Fridays and thus do not enable best use of assessor capacity. Whilst some work is undertaken on capacity and demand, this isn't fully built into system resilience planning.	1. Complete FourEyes demand and capacity planning exercise and apply similar methodology to community services. 2. Implementation of Red to Green/Safer across the acute (and I/C) 3. Understand opportunity for improving the flow of social care assessment requests 4. Work with ECC and Thurrock Council to understand opportunities for improving the flexibility of the care market

3. Multi-disciplinary, multi-agency discharge teams

Where are we now?	What actions do we need to take forward
Where cases are referred into the Single Point (CCMT/Social Care) it was felt that there is a strong approach to multidisciplinary working across health, social and the voluntary sector (in particular St Luke's). The teams are co-located which encourages joint working. The CHC Discharge To Assess models are showing strong early signs of success and demonstrate joint working between in and out of hospital teams. However, it was noted that overall, there is no single IT system and no single form of paperwork. This could strengthen joint working. It was also noted that the involvement of community services could be strengthened albeit that having specific roles would not necessarily serve the purpose.	1. Through the development of aligned teams/neighbourhoods, there will be greater involvement in discharge planning arrangements and pulling people through the system. This could include a form of Discharge to Assess. 2. Review of Intermediate Care pathway to understand opportunities for refining (Discharge Sub Group) 3. Receive paper from NELFT following Sue Burke's secondment into BTUH and understand opportunities for closer working etc.

4. Discharge Planning

Where are we now?	What actions do we need to take forward
It was noted that there are a broad number of "discharge to assess" pathways in operation across the sub economy e.g. reablement, reablement beds, I/C beds, CHC DTA pathway and bridging. In addition, there are a number of planned developments that support this approach e.g. Affletts and Pickwick. It was noted that in the main, our focus of discharge to assess is largely to bed based care and further developments could be made to support managing patients in their homes. In addition, it was noted that a large proportion of social care assessment is undertaken in the acute environment. Thurrock have considered and developed the pathway for the implementation of a "Shortened Assessment" which will enable the full assessment to be undertaken in an alternative environment, however, this has been delayed due to the fragility of the care market (Bridging is being considered as an alternative source of capacity to take this development forward).	1. Establish pathways into Affletts and Pickwick 2. Ensure that all stakeholders understand the various discharge to assess pathways and that they are used effectively 3. Work with Thurrock Council to consider how the "Shortened Assessment" could be put in place and understand whether this could be mirrored in ECC. 4. Understand the pathway for discharge to assess into a patient's normal place of residence and understand what is currently preventing this (? night sitting). Embed changes into the neighbourhood/aligned teams development to try and increase the proportion of assessments that are done in a domiciliary setting.

5. Seven-Day Services

Where are we now?	What actions do we need to take forward
It was felt that although a providers do have in place seven day services, weekend and out of hour provision is often skeletal and doesn't have the full functionality of Monday - Friday 9-5 services. This can increase delays and bottlenecks and potentially warps the usage of weekday capacity. Key areas of limited provision at weekends include; medical capacity to support discharging at weekends, pharmacy capacity after 12pm at weekends, equipment capacity after 2pm on Fridays until Tuesdays, weekend admissions into intermediate care, weekend restarts/admissions into care homes.	1. As part of Red to Green programme, review the capacity for medical reviews at weekends to support discharges and pharmacy capacity to ensure TTAs are available after midday at weekends (and in general). 2. Review community equipment provision to understand weekend cover and whether an improved system can be put in place that is more responsive to seven day demands. 3. Continue work with care homes (lead by CCMT) to improve working relationship between homes and hospital/community to build up trust that will then enable weekend restarts 4. Review I/C pathway to ensure weekend admissions (as part of Intermediate Care Review (Discharge Sub group)

6. Trusted Assessor

Where are we now?	What actions do we need to take forward
There is strong examples of trusted assessor working practice within the local sub economy e.g. the discharge to asses CHC pathways, joint working between CCMT and social care. There is not a single assessment process undertaken as the norm. There are also examples of where assessment is undertaken multiple times e.g. intermediate care pathways, IRS, care homes	1. Continue work with care homes (lead by CCMT) to improve working relationship between homes and hospital/community to build up trust that will then enable weekend restarts 2. Review I/C pathway to ensure reduction in duplicate assessments etc. 3. Define Trusted Assessor Role through the Frailty Programme

7. Focus on Choice

Where are we now?	What actions do we need to take forward
Significant work has been undertaken to agree a choice policy/protocol and common letter across the acute and community system. This is now requiring organisational sign off and implementation across all providers. There is established voluntary sector involvement for patients that are self funders.	1. Sign off choice protocols/policies. Embed policies across normal working practice e.g. issue choice letters to all patients in acute and community beds. Monitoring of impact

8. Enhancing health in care homes

Where are we now?	What actions do we need to take forward
Significant work is being undertaken with care homes locally e.g. development of the neighbourhood model, significant seven, CCMT lead work, Fish and Chips. However, it was agreed that there needs to be greater coordination of this work to ensure a systematic approach to supporting care homes is in place.	1. Bring programme of work supporting homes together to have a single plan

APPENDIX 1 – Thurrock Better Care Fund Risk Register as at 1 August 2017

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
1	*Workforce and capacity issues mean providers are unable to meet demand or provide good quality health and care services*	*Integrated Commissioning Executive established to monitor activity, performance and market conditions, and to develop alternative and more sustainable models of care closer to home.*	*4*	*3*	*16*	*1. Development of key worker housing* *2. Consider incentivising certain roles* *3. Growing the market to offer greater choice and flexibility for both service users and also for employees*	*12*	*On-going 2017-19*	*Strategic Lead (Commissioning and Procurement) & Director of Commissioning Thurrock CCG*
2	*Failure to check and reduce Delayed Transfers of Care (DTOC).*	*1. The impact of each BCF Scheme has been reviewed with regard to risks of DTOC.* *2. New investment (from the IBCF) agreed to tackle issues related to DTOC.* *3. Metrics for monitoring performance of each service are in development together with*	*4*	*3*	*12*	*1. Close liaison with acute and community providers, and social care provision against DTOC target.* *2. Co-ordinated action across the whole system to secure investment in out of hospital services and reduce DTOC.* *3. Arrangements for remedial action agreed if required.*	*9*	*On-going 2017-19*	*Strategic Lead (Commissioning and Procurement) & Director of Commissioning Thurrock CCG*

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
		reporting arrangements.							
3	*STP alignment – the BCF delivery plan sits within an STP context which will impact on system prioritisation and capacity.*	*1. HWB presentations from STP* *2 Thurrock presence at joint committee* *3. Thurrock attendance at STP programme board*	*4*	*3*	*12*	*Continuation of existing actions*	*9*	*On-going 2017-19*	*ICE*
4	*Cost pressures in social care impact on the quality and availability of the services in Care Homes.*	*1. ASC Precept agreed by Thurrock Council.* *2.Enhanced care for care home residents including Complex Care Premium agreed as part of BCF*	*3*	*3*	*9*	*1. Close monitoring of the effectiveness of the arrangements for enhanced health care for care home residents.*	*6*	*On-going 2017-19*	*Strategic Lead (Commissioning and Procurement)*
5	*Difficulties in sharing patient / service user level data may frustrate commissioning plans or performance and financial management.*	*1. Close liaison with 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 fully achieved.*	*4*	*On-going*	*Strategic Lead (Performance, Quality & Business Support)*

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
6	*The changes required for the configuration of practices and estates strategy may 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, opportunities and incentives.*	*2*	*2*	*4*	*1. Close Liaison with NHS England Essex Area Team regarding cluster arrangements*	*4*	*On-going 2016-17*	*(Acting) Interim Accountable Officer Thurrock*
7	*Uncertainty about the changing offer from ASC and Health may result in late or low take up of community services, and a failure of the system to prevent crisis or intervene in a timely way.*	*1. Strategy and communications plan completed.* *2. Dependency on DH/NHS England communications regarding STP 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 promotion of integrated health and care service in Thurrock to initiate this campaign.*	*4*	*On-going 2017-19*	*Manager Corporate Communications*
8	*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 Success Regime/STP regarding commissioning intentions and procurement plans*	*2*	*2*	*4*	*1. Liaison with B&B, CPR, Mid Essex, CCGs 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*

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
9	*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 2016.* *2. Scorecard for monitoring performance against pooled fund targets being developed*	*2*	*2*	*4*	*Regular oversight of performance by Integrated Commissioning Executive*	*4*	*On-going 2017-19*	*Director of Commissioning Thurrock CCG/ Strategic Lead (Commissioning and Procurement)*
10	*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 with 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*	*On-going 2017-19*	*Community Development and Equalities Manager*
11	*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*	*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*	*On-going 2017-19*	*Director of Commissioning Thurrock CCG/ Strategic Lead (Commissioning and*

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likelihood Score	Residual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
		be quantified							*Procurement)*