BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Thurrock

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The Health and Wellbeing Board has agreed a memorandum of understanding between the locality and place and the wider Mid and South Essex Health and Care Partnership. The purpose of this MOU is to establish the governance framework covering the delivery roles and commissioning functions across the three distinct population geographies in order to create an effective Population Health System:

- System - Mid and South Essex
- Place - Thurrock Health and Wellbeing Board area
- Locality - Thurrock footprint/Primary Care Networks

Alignment with Primary Care Services (PCNs)
Our 'Case for Change' set out how capability and capacity could be built in to Primary Care, with Thurrock having some of the most under-doctored areas in the Country which was undoubtedly adding pressure to an already stretched health and care system. As a result, the Primary Care Networks were established and a number of additional practitioners were employed - including pharmacists, physiotherapists, community psychiatric nurse, advanced nurse practitioners and paramedics. The enhanced Primary Care Networks align with and complement our social care transformation programme which included Wellbeing Teams and also the Community-Led Support Social Care Team.

Alignment of services and the approach to partnership with the VCS
Thurrock Community and Voluntary Sector (CVS) is an equal partner on our social care transformation programme and our health and care infrastructure. They also lead on the Stronger Communities element of the programme via Stronger Together Thurrock. CVS facilitated the development of Thurrock's vision, aims and objectives for health and care via running Theory of Change workshops. CVS, representing Thurrock's Third Sector has influenced our agenda to ensure that it is focused on delivering the outcomes that matter most to people. This means growing community resilience and enabling the community to play a key part in ensuring that people can achieve their version of a 'good life'.

To deliver this vision with Providers we work with them to ensure they are able to play their full part in Better Care Together. This means that services and support will be

- personalised and reflect the outcomes that are most important for each person

- deeply rooted in the local community, and able to make use of community assets

- increasingly geared up to respond to the integrated commissioning of social care and health in Thurrock, and better able to provide holistic services

- able to make the most of Technology Enabled Care Services

- equipping service users to have more choice and take more control over their lives and working to reduce dependence of services.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The focus of the Better Care Fund to date has been on adults aged 65 and over who are most at risk of hospital admission or residential home admission. The schemes chosen for the Fund reflect this focus. The future plans are likely to continue this focus, and will include elements that are population wide including initiatives linked to preventing, reducing and delaying the need for health and social care intervention.

Priorities for 2021/22 include a focused review of our schemes with a view to ensuring they:

- Continue to have maximum impact
- Reflect the changes in patterns of health and care needs which have resulted from the pandemic
- Reflect the needs of our communities in the face of unprecedented demand for half and social care services and reducing resources in real terms.

Integration

- The BCF part funds two integrated posts Director and Assistant Director across NELFT and the Council to support integrated health and social care service delivery in the community within PCN footprints.
- The Community Response Team (which used to be called RASS) is an integrated team dedicated to maintaining people in the community with health and social care interventions supporting discharge from acute settings and also preventing admission.
- The Joint Reablement team provides reablement with therapist and social workers supporting carers to deliver reablement to those discharged from hospital.
- The primary care MDT co-ordinator is funded to ensure that all professionals are brought together to support individuals in a meaningful way.
- By Your Side is a key service offering a settling at home service and welfare checks that support timely discharge.

Prevention - there are a number of services within the BCF that support admission avoidance and discharge from hospital

- Stroke prevention services offer information and practical support.
- The Community Response Team enable people to remain in their own homes and prevent the need for emergency intervention.
- The Bridging service supports timely hospital discharge and our plan going forward is to start discussions in early 2022 with Health colleagues to explore the model and consider moving to change the model to a wider discharge to assess approach across the MSE footprint.
- The voluntary organisation budgets sit with this area offering a range of support to enable people to stay in their own homes.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

Governance arrangements for the health and car transformation programme at Thurrock have developed over time and have recently been reviewed and approved by the Health and Wellbeing Board and Thurrock Integrated Care Partnership. The arrangements include:
- a single Thurrock Integrated Care Partnership Board that has overall strategic oversight of the health and care transformation agenda - including the Better Care Fund (the plan is synonymous with the transformation agenda), the commissioning agenda and acting as the financial delivery mechanisms for health and care integration;
- a finance group reporting to the Partnership which has responsibility for financial monitoring and oversight of the BCF and other system level financial modelling, integration of health and care budgets, and identification of system-level savings which could inform issues such as risk and reward in an alliance contract
- a Better Care Together Thurrock Operations Delivery Board that sits under the Partnership - with responsibility for the overall delivery of the transformation programme
- to support integrated working at locality level, a Locality Working Programme Board - which oversees a combined strategic programme of integrated health and care at locality level. This includes scaling up across the Borough Primary Care Networks' mixed skill workforce, Wellbeing Teams, and Community Led Support Teams
- four Locality Delivery Groups where clinicians, Adult Social Care professionals and other front line staff can refine individual locality integrated models. Locality Groups have a key function in driving the priorities of the ICP by identifying and communicating upwards key local priorities.

The Health and Wellbeing Board, as the highest level strategic board remains responsible for delivery of the Health and Wellbeing Strategy including place and wider determinants of health.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.

- How BCF funded services are supporting your approach to integration. Briefly

Our approach to integrated services at a HWB level has been developed, delivered and overseen by the Better Care Together programme. Our entire approach to system redesign is integrated and includes a number of elements:
a) An integrated vision;
b) An integrated set of principles and success factors, co-designed by the community;
c) An integrated approach to developing and delivering the vision - through a steering group and four work streams.

Joint Commissioning Arrangements
The budgets for Adult Social Care and Community Health are contained within the Better Care Fund. Decisions as to how the Fund is used is taken through the Thurrock Integrated Care Partnership which meets monthly and includes the Corporate Director of Adults, Housing and Health, Accountable Officer and Chief Finance Officer for the Clinical Commissioning Group, Director of Public Health, Director of Commissioning for the CCG and Strategic Lead for Commissioning for Adult Social Care. This includes developing and piloting arrangements for place-based commissioning, community-led commissioning, and community-led priority setting.

The Integrated Care Partnership includes executive officers from commissioning and provider organisations across health and social care. It has overall responsibility for the development of the Better Care Together health and care transformation programme

The aim is for 80% of activity to be commissioned to take place on a Thurrock footprint or smaller (e.g. locality-based) in line with the King's Fund evaluation of integrated care systems, and by our understanding of the proportion of the population requiring a community-based solution.

Key achievements include:

• The development of a Shared Lives Scheme which was delivered in collaboration with Social Finance an entrepreneurial group of businesses wanting to invest in social support. This 5 year contract aims to deliver 75 matches to offer positive alternatives to more traditional service responses.

• The implementation of Individual Service Funds which support people to have more control of their service provision without having the full responsibility of a direct payment. • The development of over 50 micro enterprises. We recognised the need to diversify the market in the last Market Position Statement. As such we undertook a two year project to develop this segment of the market.

• Accommodation and support is key and a great deal has been achieved through the development of a refurbished complex of flats for people with learning disabilities, the agreement between the Council and Peabody Housing Association to develop 6 specialist units of accommodation for people with autism in Medina Road and the expansion of capacity for people requiring support who have dementia.

The attached report – Integrating Health and Care in Thurrock – tells the story of our integration journey. In addition, the following Integration Priorities have been agreed by the Thurrock Integrated Care Partnership:

1. Strengths-led and integrated public-facing workforce
2. Integrated support in the home
3. New Generation Integrated Care Facilities
4. Improving access and quality and reducing variation
5. Population health management – preventing ill health and promoting good health

describe any changes to the services you are commissioning through the BCF from 2020-21.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Our Better Care Fund Plan focuses on:

Early discharge planning - working with Southend Council to act as Trusted Assessors when Southend residents are at Basildon Hospital and when Thurrock residents are at Southend Hospital. We have implemented a new information portal to allow trusted assessors to upload assessment information on to the Council's system. We also carry out discharge planning pre-admission to enable early discharge.

Systems to monitor patient flow - we have extracted information from our information system Mede Analytics which allows us to monitor patient flow and to analyse activity
Trusted Assessors - we are broadening our approach to Trusted Assessors. We are piloting Domiciliary Care providers as trusted assessors and also working with Southend Council as a trusted assessor

The key schemes and initiatives contributing to supporting discharge are as follows:
- Bridging Service - which is enabling people to be discharged from hospital when they are medically fit to do so but unable to go home;
- Additional investment in domiciliary care to build sufficient capacity and reduce the likelihood of people waiting for care;
- The provision of intermediate care beds;
- Investment in a scheme known as 'By Your Side' which ensures people's homes are ready for them when they come out of hospital
- Recruitment of a DTOC coordinator
- implementation of 7 day working - for example the Hospital Social Work Team.

The attached proposal - Extended Enhanced Discharge to Assess (EED2A) Pathway – was approved by the Thurrock Integrated Care Partnership (which includes the Council, CCG, the Hospital Trust - MSE Group, as well as community and mental health providers NELFT and EPUT) in April 2021, and the scheme forms part of the Better Care Fund Plan for Thurrock. The proposal sets out the local approach to safe and timely discharge, as well as home first. Funding began in April 2021 and the BCF Delivery Group meets monthly to review the performance of this and other schemes.

The CHC team in Thurrock CCG, currently do not have any delay transfer of care from the hospital for the home first health lead enhanced discharge to assess pathway. All therapy and care support are implemented within 24 hours of the referral indicating the patient is medically fit to leave hospital. (If a patient requires interim 24 hour care placement there may be a delay in sourcing the appropriate care /nursing home but this is when home is no longer an option).

The metrics around admission avoidance is ambitious and stretching as with most systems we are experiencing extremely high levels of demand and the acute hospitals are struggling to maintain flow however the schemes within our BCF Plan offer a range of responses which we consider will enable those targets to be reached. The integration and transformation work is supporting joint solutions utilising our preventative and integrated services. The metrics have been discussed and agreed with the Hospital Trust.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to

The Council has adopted a strength-based approach to delivering Disabled Facilities Grants to enhance independence and improve health and wellbeing for tenants and owner occupiers. In line with the Royal College guide to adaptations, our newly introduced pathway means DGF applicants can do more for themselves with a self-serve approach providing significant benefits for all. Completed cases and overall expenditure has doubled since 2016.

Transformation of the DFG services continues with a greater understanding and promotion of health equality. It is acknowledged that there is a primary focus to support people through home adaptations via the mandatory grant; recognising the home environment can have a considerable bearing on people's safety, independence and overall health and wellbeing. However, it is also recognised that an integrated and holistic approach across health, social care and housing is essential to not only realise the benefits of accessible housing, but also achieve an understanding of, and subsequent approach to, meeting an individual's needs and the needs of the wider community in which they live.

The Council has completed a review of the DFG service and implemented a strength-based approach to service delivery, which has greatly enhanced the support available for the residents of Thurrock. Inclusive in this approach is improved awareness and accessibility, with our newly introduced pathway meaning DGF applicants can do more for themselves with a self-serve approach, which in turn provides significant benefits for all. The service is now hosted alongside the Occupational Therapy Service within Adult Social Care. This has enabled the DFG service to be more assessable and compliment integrated approaches already established across health, social care and housing, such as the integrated first point of contact service, placed based support services across health, social care and housing, and the established Integrated Community Equipment Service.

The Council is currently in the process of finalising, and implementing phase two of the intended transformation of the DFG Service. This includes greater opportunities to support wider services within health, social care and housing, especially where there is a recognised crossover with DFG services in supporting individuals to remain in their home and meet their wider housing needs. Furthermore, the Council intends to provide additional support by virtue of the Regulatory Reform (Housing Assistance) (England & Wales) Order 2002, which would enable the Council to provide Thurrock residents with financial assistance from a range of discretionary grants. Examples include:

- 'top up' to a mandatory grant and / or to fund unforeseen works
- adaptations for a child's second home where the parent's live separately
- adaptations for a child / young person in foster care
- adaptations for an adult supported in "shared lives" or similar supported living scheme
- assist a disabled person or their family to move to more suitable accommodation
- dispense financial assessment for works below £5000
- facilitate timely discharge from hospital or other non-residential settings (individual and schemes)
- avoid unnecessary hospital admission or other non-residential settings
- facilitate fast track adaptations for end of life / life limiting conditions
- improve accommodation of a nature that supports residents in supported living and step down / rehabilitation services, or in need of interim support
- provide non-fixed solutions, including, but not limited to Tech Enabled Care and ICES
- explore and provide innovative housing solutions / schemes for a range of client groups, such as dementia, autism etc (purpose build housing solutions)
- support safe / warm homes initiatives
- support complimentary services in meeting an individual's wider housing needs
- support handyman / minor adaptations schemes

support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

The prevailing ethos of our approach remains to ensure all individuals and communities have a health and care system that is equitable and designed around their specific requirements. For example, ensuring that the system looks to deliver a broad range of solutions that meet the outcomes most important to the individual. The focus on shifting the system upstream by redesigning it around principles relating to early intervention and prevention ensures that significantly more activity takes place within the community. This in itself will not only reduce health inequalities, but increase the health and wellbeing of the population. The approach is whole-population meaning that all protected characteristics (Equalities Act 2010) will benefit from the principles of redesign.