Updated July 2014

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Thurrock Council**
Clinical Commissioning Group	**NHS Thurrock Clinical Commissioning Group**
Boundary Differences	**None**
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**19/09/2014**
Minimum required value of BCF pooled budget: 2014/15	**£2,861,506**
2015/16	**£10,565,000**
Total agreed value of pooled budget: 2014/15	**£3,723,506**
2015/16	**£0.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS Thurrock Clinical Commissioning Group

By	Dr Anand Deshpande
Position	Chair
Date	TBC

By	Mandy Ansell
Position	Acting Interim Accountable Officer
Date	TBC

Signed on behalf of the Council	Thurrock Council
By	Roger Harris
Position	Director of Adults, Health and Commissioning
Date	TBC

<Insert extra rows for additional Councils as required>

Signed on behalf of the Health and Wellbeing Board	Thurrock Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Barbara Rice
Date	TBC

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

Document or information title	**Synopsis and links**

2) VISION FOR HEALTH AND CARE SERVICES

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

Introduction
The initial focus for Thurrock's Better Care Fund is on adults aged 65 and over who are most at risk of hospital admission or residential home admission. In line with the Care Act guidance on 'preventing, reducing or delaying needs', our aim is to develop integrated approaches that target 'individuals who have an increased risk of developing needs, where the provision of services, resources or facilities may help slow down any further deterioration or prevent other needs from developing'; and to develop integrated approaches aimed at 'minimising the effect of disability or deterioration of people with established health conditions, complex care and support needs or caring responsibilities'. Although our focus for this iteration of the BCF is the 65+ agre group, we know that whole system transformation aimed and reducing and preventing individuals from reaching crisis point will require a focus on health and wellbeing for the whole population – e.g. initiatives aimed at 'individuals who have no current particular health or care and support needs'.

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

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

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

In addition to the over 75s analysis, NHS England's Essex Area Team are in the process of developing a Primary Care Strategy. Robust primary care, particularly GP services, are critical to early identification of those at risk of developing a health condition and those individuals who are deteriorating and reaching crisis point. Thurrock is currently under-doctored, and 30% of the current Thurrock CCG GP workforce is over the age of 60. A number of the areas with a shortage of GPs are also in Thurrock's most deprived areas.

Approach
The Council and CCG have established as part of their Health and Social Care Transformation Programme a Whole System Redesign Project Group. The Group, guided by data and intelligence and also patient and service user experience, is reviewing how and what requires redesign – with the focus on reducing hospital and residential home admission for adults 65 and over. The Group are working in accordance with a set of principles jointly agreed by Thurrock Council and Thurrock CCG:

- Empowered citizens who have choice and independence and take personal responsibility for their health and wellbeing;
- Health and care solutions that can be accessed close to home;
- High quality services tailored around the outcomes the individual wishes to achieve;
- A focus on prevention and timely intervention that supports people to be healthy and live independently for as long as possible; and
- Systems and structures that enable and deliver a coordinated and seamless response.

In addition to the recommendations contained within the over 75s analysis and the principles outlined above, our approach will incorporate the Kings Fund recommendations for reducing avoidable admissions which includes:

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

Service User and Public Engagement
As part of our approach to redesign, we have established an Engagement Group which has been meeting for a number of months. The Group includes representatives from Thurrock's Voluntary and Community Sector – those with the greatest reach to users of services (refer to section 8 for more detail).

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

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

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

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

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

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

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

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

The future – 2018/19
Our future, delivered through the BCF and related programmes (BPF, Care Act implementation, Primary Care Strategy etc.) will reflect the following:

Healthy, active ageing and supporting independence

- Further development of 'well homes' initiatives that builds on the work with Housing partners – recognising that over half those aged 75 years and over own their own property but that a number of those people will be both cash poor and equity poor;
- Further development and implementation of housing schemes that support older people as their frailty increases – e.g. HAPPI standard homes;
- Community-run hubs that provide information and advice, and allow individuals to get the support they need to remain independent;
- Development of health improvement initiatives for older people – particularly recognising the impact of loneliness;
- Focus on maintaining the health and wellbeing of carers – e.g. via increased carers assessments, provision and availability of respite, support within the community etc.

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

Living well with simple or stable long-term conditions

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

Living well with complex co-morbidities, dementia and frailty

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

Good rehabilitation and re-ablement after acute illness or injury

- Significant numbers of those aged 75 and over are unable to complete one domestic task or self-care activity on their own, and lack of capacity in post-acute rehabilitation is most probably a key factor behind the high numbers of older

people who go straight from hospital stay into long-term care;
- Greater number of housing schemes that support older people as their frailty increases – including extra care housing;
- Through DFG being part of the BCF, review the role of Housing in ensuring homes of those people coming out of hospital enable rather than disable people;
- Development of existing Joint Reablement Team, and also increased capacity in step down beds – e.g. Collins House Residential Home;
- Good multi-disciplinary coordination for people being discharged from hospital – building on the role of the successful social care hospital team;

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

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

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

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

- Users of services will have an improved experience through multi-disciplinary teams and services that operate around the whole person;
- Individuals will be able to achieve the outcomes they want through personal health budgets and personal care budgets;
- Risk-based approaches will enable individuals to remain out of hospital and residential care;
- Fewer people will require a service as they will be able to self-serve and gain access to the information and advice and support they need within the community they live in;
- Proactive approaches to 'ageing well' will enable people to remain healthy, independent and in control for longer;
- Federations of GP practices aligned with community health, mental health, and

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

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

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

In summary, this will mean:

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

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

Rhodri/Phillip

- **A clear and quantified understanding of the precise issues that the Better Care Fund will be used to address in the local area**
- **Risk stratification of the entire population and segmentation of the opportunity to improve quality and reduce costs**
- **A narrative that is bespoke to the local area – i.e. not a generic narrative about the need for integration that could be relevant to any local area**
- **Data that supports the case for change, e.g. data that quantifies levels of unmet need, issues of service quality, or inefficiencies in service delivery**
- **Visualisations of data if appropriate – e.g. graphs or diagrams that illustrate the local issues**
- **An articulation, at a high level, of how integration (of systems, processes, teams, budgets) could be used to improve the issues – i.e. set out in broad terms the theory of change or logic that supports the Better Care Fund Plan.**

Whilst Thurrock has a relatively low percentage *(21.1%)* of patients aged 65 and over, those patients equated to 52.5% of emergency admissions spend and 19.6% of A&E attendance spend; with a combined annual cost total of £13,466,657 to the CCG *(A&E and NEL Admissions: 12 month period ending December 2012).*

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

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

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

There were 11,521 emergency admissions from March 2013 – February 2014 in Thurrock. 30% of emergency admissions were among patients aged 75 and over. The overall rate of A&E admissions for those aged 75 years and over is over two times higher than the under 75 population. The most common Healthcare Resource Group (HRG) code is category 2 investigations with category 1 treatment.

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

- 18% diseases of the respiratory system
- 17% diseases of the circulatory system

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

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

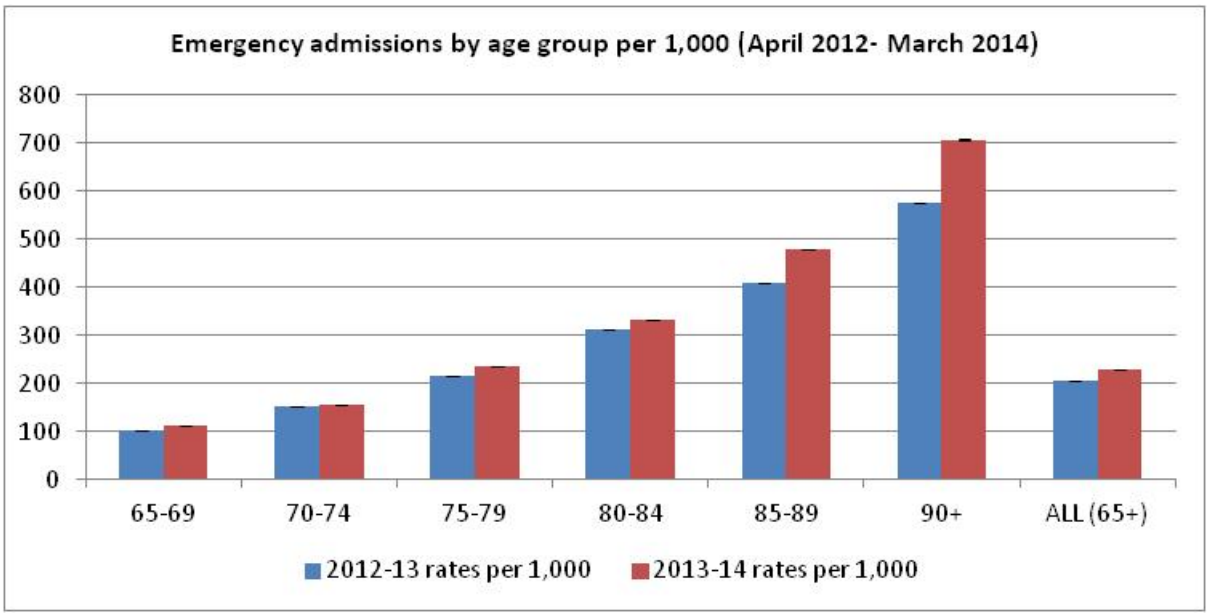


Table 1 - Top 10 HRG codes for those aged 65 years or more in Thurrock CCG (April 2012-March 2014)

HRG code	Total
Lobar, Atypical or Viral Pneumonia with Major CC	560
Non-Interventional Acquired Cardiac Conditions	395
Kidney or Urinary Tract Infections with length of stay 2 days or more with Major CC	369
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with Major CC	190
Arrhythmia or Conduction Disorders without CC	161
Heart Failure or Shock with CC	157
Unspecified Acute Lower Respiratory Infection with Major CC	146
Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy	140
Non-Transient Stroke or Cerebrovascular Accident, Nervous System Infections or Encephalopathy with CC	130
Chronic Obstructive Pulmonary Disease or Bronchitis without NIV without Intubation with CC	130

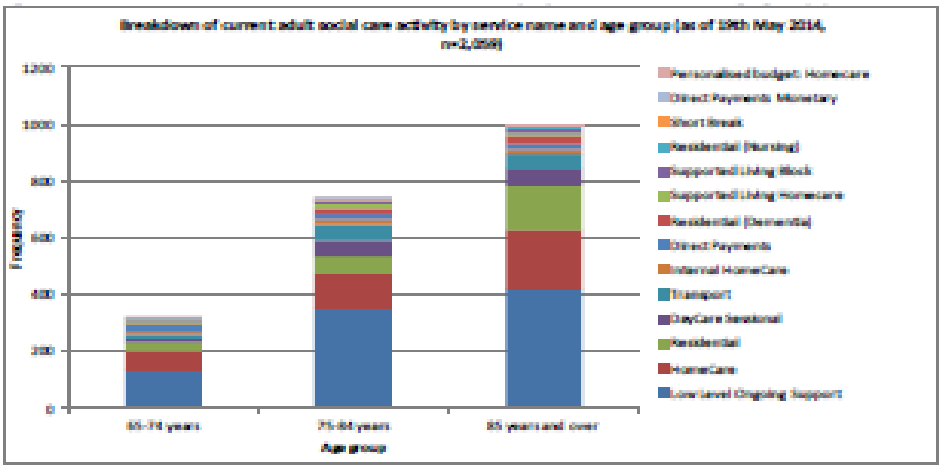
Table 2 - Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

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

Social Care Demand & Spend

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

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



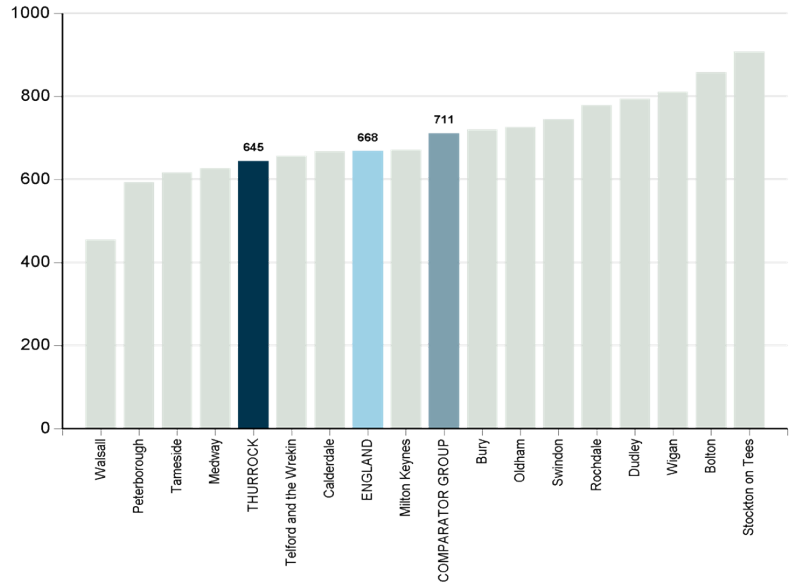
Source: Thurrock council adult social care.

In line with our existing commissioning intentions and strategies to enable people requiring care and support to access alternative arrangements to permanent residential or nursing care and to maintain independence at home, the number of people in residential or nursing care shows a trend of reduction over three years as does the rate of admissions into permanent placements.

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

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

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



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

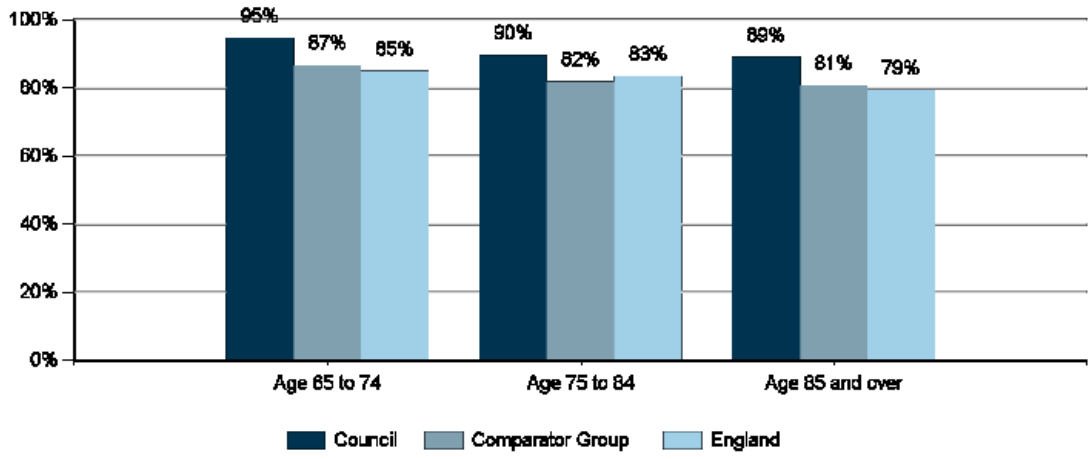
	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Standard Placements	286	299	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	381	402	414	425	434	443

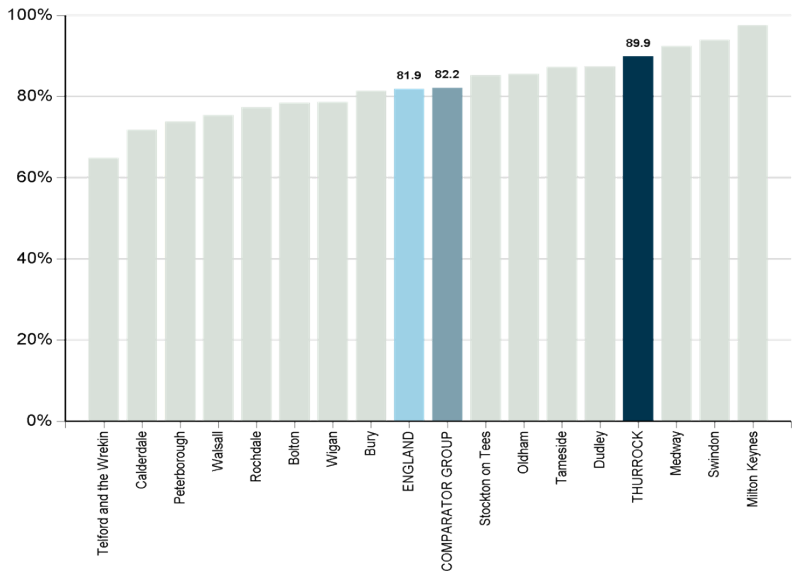
Supporting people to achieve and maintain independence at home through effective discharge from hospital into reablement / rehabilitation services is a priority for Thurrock. Overall, Thurrock performs comparatively well on this key measure. 89% of people discharged into these services were still at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

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

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

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





4) PLAN OF ACTION

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

The Council's Transformation Planning Groups, assisted where appropriate by Officers from the CCG and a dedicated programme management resource, has scoped out and commissioned work packages to ensure the Council and CCG are able to address the requirements of the following *inter-dependent* work streams:

- Efficiency – identifying initiatives that in the short term offer cashable efficiencies to contribute towards the Council's £37m savings target, and ensuring opportunities for joint working and reducing duplication are maximised;
- The Care Act (2014) – preparation and implementation arrangements for the new duties;
- Better Care Fund Section 75 Agreement - preparation of the Better Care Fund Plan and implementation of all the arrangements for the Council to hosting the pooled fund from 2015 including, where necessary, contract novation;
- Whole systems Re-design as part of the Building Positive Futures programme – to determine the best model for commissioning and delivery of specialised housing, health and adult social care services in conjunction with the citizens of Thurrock and in consultation with providers, citizens, and other stakeholders.

In addition the Transformation Programme Board will work closely together:

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

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

Health and Well-Being Board to agree the draft Better Care Fund Plan, the delegated authority for sign off and the approach to the Section 75 agreement	11 September 2014
Submission of Better Care Fund Plan following sign of by the Chair of HWB Board	19 September 2014
Agree Commissioning Intentions with NHS providers	by end September 2014
Amendments to plan following Assurance Reviews and Moderation	by 10 October 2014
6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16	End October 2014
Health and Well-Being Board agreement to Section 75 agreement including Annual Development Plan	13 November 2014
NHS Thurrock CCG Board approval of Section 75 agreement	26 November 2014
Cabinet of Thurrock Council approval of Section 75 agreement	3 December 2014
Waiver requests and contract awards	From January 2015
Purchase to pay arrangement	From January 2015
Contract and Performance management arrangements in place	From January 2015
Payments of providers from the BCF pooled fund	From April 2015

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

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

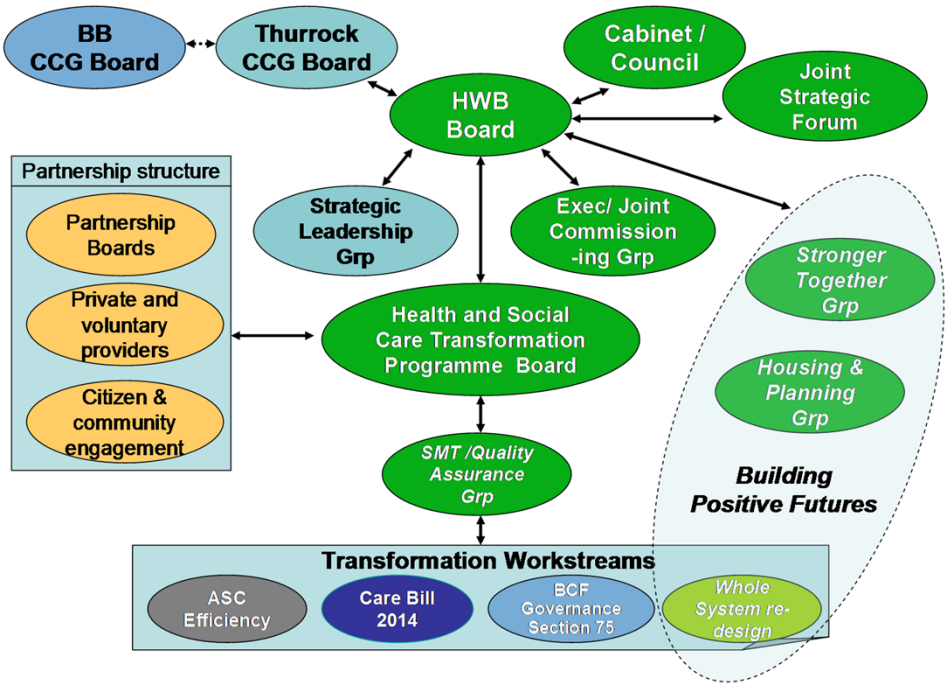
6 month Review of performance of 2014/15 BCF schemes completed and commissioning plans developed for 2015/16	End October 2014
Clinical Analysis of patient records to determine the likely causes of emergency admissions of patients aged 65 and over in a sample area	October/November 2014
Semi structured interviews with a sample of the cohort to assess patient and service user experience	December/January 2014
Subgroup of acute and community health and care providers to review findings and model improved clinical pathways and the wider determinants of health and well-being	Jan - March 2015
6 month trial of new pathways	April - September 2015
Agree Commissioning Intentions with NHS providers	by end September 2015

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

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

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

The reporting lines are as follows:



c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

As noted above, the Better Care Fund Section 75 Agreement Group is overseeing

implementation of all the arrangements for the Council to host the pooled fund from 2015. From 2015 the Group will be reconstituted as a Partnership Board with responsibility for oversight of the management of the BCF.

The arrangements which are currently being developed will be set out in detail in the governance section of the Section 75 Agreement and cover:

- The Membership of the Partnership Board
- Role and responsibilities
- Conduct of meetings
- Delegated authority
- Reporting arrangements
- Risk sharing arrangements
- Joint working obligations
- Performance arrangements
- Information Governance Protocol
- Dispute Resolution

The Partnership Board will be services by a dedicated team led by the Pooled Fund Manager which will provide financial and activity information at least quarterly.

The Partnership Board will meet on a monthly basis to review performance against the Plan and will have delegated authority to modify the plan whether there is full agreement to do so.

The Partnership Board will report progress against the plan to the Health and Wellbeing Board.

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

d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	BCF1 – Co Terminous Services Review
2	BCF2 – Frailty – Extended Service Model
3	BCF 3 – Frailty – Public Health Initiatives
4	
5	
6	
etc	

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

No.	Risk	Score	Supporting Actions	Lead Assurance
Strategic				
1.1	Consequent policy changes may delay implementation	1	Both National and Local – analysis of opposition policy proposals and the development of contingency plans in the case of potential material changes to policy	
1.2	There may be a higher level of demand on service solutions with a consequential impact of budgets	1	Comparison of Annual Mid-year Population Estimates with strategic and commissioning plans to identify variances and, where necessary, plan contingencies	
1.3	Decisions are not made, or are not made in a timely way or do not have the necessary authority to effect change	1	Clear governance arrangements including statutory accountability, schemes of delegation, dispute resolution processes and risk management are required	
1.4	Implementation and operation costs may exceed budget plans	2	Financial contingency plan to alleviate cost pressures that may arise during implementation or benefits realisation	
1.5	The changes required for the configuration of practices my make it difficult to engage GPs in co-ordinated care	2	Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve them in change, and to ensure a common understanding of risks,	

	programmes		opportunities and incentives	
1.6	The failure to reduce demand for acute services places does not release funds for investment in community services and results in overspend	2	Close liaison with acute providers on performance against QIPP Plans and co-ordinated action across the whole system to reduce demands on acute services.	
1.7	Difficulty transforming care pathways and pace of change too slow to realise required financial benefits.	1	a) Strong early engagement to involve providers in change, and analysis of their business risks and opportunities to ensure they are incentivised to deliver co-ordinated care in Thurrock. b) Liaison with neighbouring CCG to avoid conflict in transformation plans.	c)
1.8	The failure to reduce demand for acute services places does not release funds for investment in community services and results in overspend and poor care.	1	Strong early engagement to involve GPs in change, and analysis of their business risks and opportunities to ensure they are incentivised to deliver improved primary care.	
1.9	The failure to reduce demand for A&E services does not release funds for investment in community services and results in overspend and poor care	2	Strong campaigns to engage citizens in managing their health needs and presenting at appropriate times/places.	
1.10	Pace of change too slow to realise financial	1	Strong early engagement to involve them in change, and analysis of their	

	benefit.		business risks and opportunities to ensure they can be incentivised	
1.11	There may be a higher level of demand on service solutions with a consequential impact of budgets	2	Strong campaigns to engage citizens in lifestyle improvements and to strengthen communities	
1.12	There may be a higher level of demand on service solutions with a consequential impact of budgets	2	Strong campaigns to support the management of long term conditions, and reviews of the effectiveness of those campaigns	
1.13	Higher levels of demand on service solutions than assumed	2	Investment in asset based community development will be required together with an evaluation programme to determine its effectiveness and the reliance that can be placed on resilience in each community	
1.14	Uncertainty about the offer from ASC and Health may result in or late or low take up of services and a failure of the system to prevent crisis or intervene in a timely way	1	Strong campaigns to engage citizens and professionals across the system in the plans for co-ordinated care, and reviews of the effectiveness of those campaigns. A formal launch for Better Care in Thurrock may be needed to initiate this campaign	
1.15	Public confidence in services is adversely affected and public opinion swings against the changes		As above	
2.1	Changes to funding criteria, introduction of care accounts, assessment of self	3	A change programme with appropriate governance, resources (both people and financial) to implement the reforms and to monitor impacts on service	

	funders will all bring new challenges for IT, the workforce, finance and information and advice services, communications and housing		quality and user satisfaction, and all with multiple interfaces with Better Care	
2.2	May make it harder or take longer to introduce change if a provider has significant operational difference in the two CCG areas	2	Liaison with B&B CCG and ECC about the impact of our respective emerging plans to identify variances and, where necessary, plan contingencies	
2.3	Commissioning strategies and implementation plans for co-ordinated care may lack coherence or ambition	2	A single commissioning structure, from the HWB Board down, will be needed to ensure goals, roles, processes, values, communications practices, attitudes and assumptions are consistent across the better care programme.	
2.4	Organisations' business strategies and objectives may conflict resulting in delayed or problematic implementation	2	Strong early engagement of all entities involved in commissioning in change programme, and analysis of their business risks and opportunities to ensure they can be incentivised to commission co-ordinated care	
2.5	Access to the required health care services in community settings may be frustrated or delayed	2	Strong early engagement to involve the Hospital Trust in change, and analysis of their business risks and opportunities to ensure they can be incentivised to provide co-ordinated health care in the community in Thurrock	

2.6	Knowledge of the organisation, programmes and systems may be lost resulting in delayed or problematic implementation	3	The development of knowledge management strategy to ensure all essential information about the implementation and operation of Better Care is systematically collected and stored to ensure it remains available to relevant parts of the organisation	
2.7	Change is ineffectively or incompletely implemented with consequential impacts on individual service users/patients, budgets and organisational reputations	1	The development of a Benefits Realisation strategy together with communications and training programmes to ensure change is planned, implemented and managed effectively	
2.8	If strategic, personal, operational or performance and financial information cannot be shared in a timely manner the necessary controls to deliver co-ordinated care will not be in place	2	An information strategy for commissioning and providing co-ordinated care, using the NHS number and with the required governance and technical solutions is required at an early stage	
2.9	The requirement for changes to the system in the medium term undermines securing cashable efficiency gains in the short term		Regular monitoring of the impact of implementing Better Care alongside the achievement of savings targets will be required	
3.1	A dedicated resource will be required to plan and implement better care while existing programmes for health	1	A resource plan for an integration team with roles and responsibilities specified, and clear interfaces with business as usual and care and support reform will need to be developed and agreed so	

	and ASC are maintained and care and support reforms implemented		that posts can be filled from early 2014/15	
3.2	Until the programme is defined it will not be possible to match resources or plan delivery effectively	1	A Programme plan which defined the programmes and workstreams required to deliver Better Care, (and the interfaces to care and support reform and business as usual) and estimates the resource requirements and the manner in which those resources should be deployed, is required to manage implementation	
3.3	If issue are not resolved in a timely way implementation may be delayed or halted	1	Specialist legal advice needs to be procured and briefed on the legal issues and then commissioned in line with the Programme plan	
3.4	Change is ineffectively or incompletely implemented with consequential impacts on individual service users/patients, budgets and organisational reputations	1	A plan for reviewing the portfolio of existing health and ASC services against Thurrock's Vision for Better Care and the care pathways to deliver co-ordinated care is required and in order to inform a managed change programme for those services	
3.5	Joint Impact Assessment for <u>all</u> health and social care commissioning decisions:		Common Assessment Tool Joint Process for Sign-off Agree review period of potential impact Formalise within a joint service restrictio	
3.6	Review of lead funding Responsibilities taking into account:		Primarily Social Care / Health *(against n* Main Beneficiary Prior Commissioning Responsibility *(i.e.*	
3.7	Clarification on		Existing joint commissioning/provider st	

	workforce split between provider / commissioning functions		Identification of core statutory skills / fu structures Identification of dual social/health skill-s assessment undertaken by nursing staff	
3.8	Each existing and newly commissioned services will need to identify:		Funding Split Lead Commissioner Funding implications if not commissione pressures	
3.9	Review of contract management arrangements to include:		Identification of revised commissioning s Revised Terms of Reference to Contract Agreed quorate principles and criteria	
4.0	Creation of a Joint 5yr IMNT strategy to inform future service modelling / commissioning decisions.			
4.1	To mitigate against national benchmarking data (as service models are locally determined) commissioning parties will need to:		Audit trail of workforce assumptions at transfer to BCF or inception of new integrated teams.	
4.2	Review of commissioning landscape to identify commissioning stakeholders to include:		Full health and social care commissionin commissioning stakeholders for each se *(including funding % for each);* Mapping of service interdependencies.	

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place i) between commissioners across health and social care and ii) between providers and commissioners

It is proposed that the risk of underperformance against the total emergency admissions target set locally is managed by delaying expenditure commitments equivalent to the target for some services until the target is achieved, and payment of the target sum can be released into the pooled fund by NHS Thurrock CCG.

The issue of treatment of overspends is currently being examined with a view to limiting the risk to the CCG and Council. One proposal being considered is that any expenditure over and above the value of the fund should fall to the Council or the CGG depending on whether the expenditure is incurred on social care functions or health related functions. The arrangements for managing the risk of overspend will be set out in detail in the Section 75 agreement.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

- **References to links with other initiatives**
- **An articulation of how these initiatives can support the delivery of the Better Care Fund and where there are any arrangements to share resources**
- **Identification of any inter-dependencies, demonstrating an understanding of how one initiative impacts or depends on another**
- **Clear responsibilities for bringing together and ensuring ongoing communications between the related initiatives**
- **Evidence that the local area has considered alignment with local plans for housing and plans for the use of technology**

For the ambition set out within this Plan to be advanced and delivered, there needs to be alignment with a range of existing plans and initiatives. These are summarised below:

Building Positive Futures
Building Positive Futures is Thurrock's programme to support older and vulnerable people to live well. The Programme reflects good health and wellbeing being dependent upon a number of factors including:

- The neighbourhoods we live in;
- The opportunities we have to connect with others;
- Safe and accessible paths and parks;
- Access to shops, health clinics and other facilities; and
- The opportunity to give as well as receive help – to feel needed and useful.

BCF recognises the value and impact that partners beyond health and social care have on creating communities that foster good health and wellbeing.

The Programme centres on three main themes under which sit a number of related initiatives:

- Better health and wellbeing: so people stay strong and independent
  - Dementia Friendly Communities
  - Integration of Health and Social Care (Whole System Redesign)
- Improved housing and neighbourhoods: to give people more – and better – choice over how and where they live as they grow older
  - Health and Wellbeing Housing and Planning Advisory Group
  - Flagship housing schemes for older people – based on design recommendations of the HAPPI
  - Sheltered Housing Review
  - Thurrock Well Homes - a scheme to improve the housing conditions and health and wellbeing of residents in private properties
- Stronger local networks: to create more hospitable, age-friendly communities
  - Local Area Coordination
  - Asset Based Community Development
  - Strength-based approaches to commissioning and social work practice

The BPF Programme is a key and fundamental part of our Health and Social Care Transformation Programme. The Programme's success will result in people growing older in better health, and older people being better supported and more resilient within the communities they live in. A key element of the Programme is that individuals are less likely to require formal 'services', but are able to find the support they need to remain healthy and independent from within their own communities. As such, the Programme is a vital part of this Plan's ambition to reduce the number of people aged 65 and over who are admitted to hospital or a residential setting.

Local Area Coordination

Whilst an initiative that has been developed as part of our BPF Programme, Local Area Coordination requires a mention in its own right.

Initiated by Adult Social Care, Local Area Coordination is a partnership programme with:

- Public Health;
- Housing;
- Essex County Fire and Rescue Service;
- North East London Foundation Trust;
- Thurrock Council for Voluntary Service;
- Healthwatch;
- South Essex Partnership Foundation Trust; and
- Thurrock Clinical Commissioning Group.

Starting with a strength-based question about 'what a good life looks like', coordinators help vulnerable people to find their own local solutions. Solutions pursued do not often lie with services – but in the community. Where a service is the right solution, the LACs are able to co-ordinate a response which invariably crosses service and organisational boundaries. This in itself is a great help for people who are vulnerable and do not have the knowledge, expertise or emotional resilience to navigate the complexities of service offers.

LAC was originally piloted in three learning sites. Due to the success of the pilots, the initiative has been expanded and is now Borough-wide. Whilst much of the evidence at such an early stage of the initiative is anecdotal, there are a number of case studies showing how people have been identified and prevented from requiring a service or from

reaching crisis point. GPs in the pilot areas gave some very positive feedback on how the LAC service had helped patients.

The LAC initiative is a key approach in reducing the number of people who end up in crisis.

Timely Intervention and Prevention Service

We recognise that the key to developing sustainable health and social care services is by reducing demand on already stretched services. Our approach to redesign is therefore focused on how we can prevent individuals from not only reaching crisis point, but from requiring a service altogether.

As part of our BCF Programme for ageing well in Thurrock, we identified a need for a Timely Intervention Service – aimed at better community management of a number of conditions to prevent crisis and manage demand.

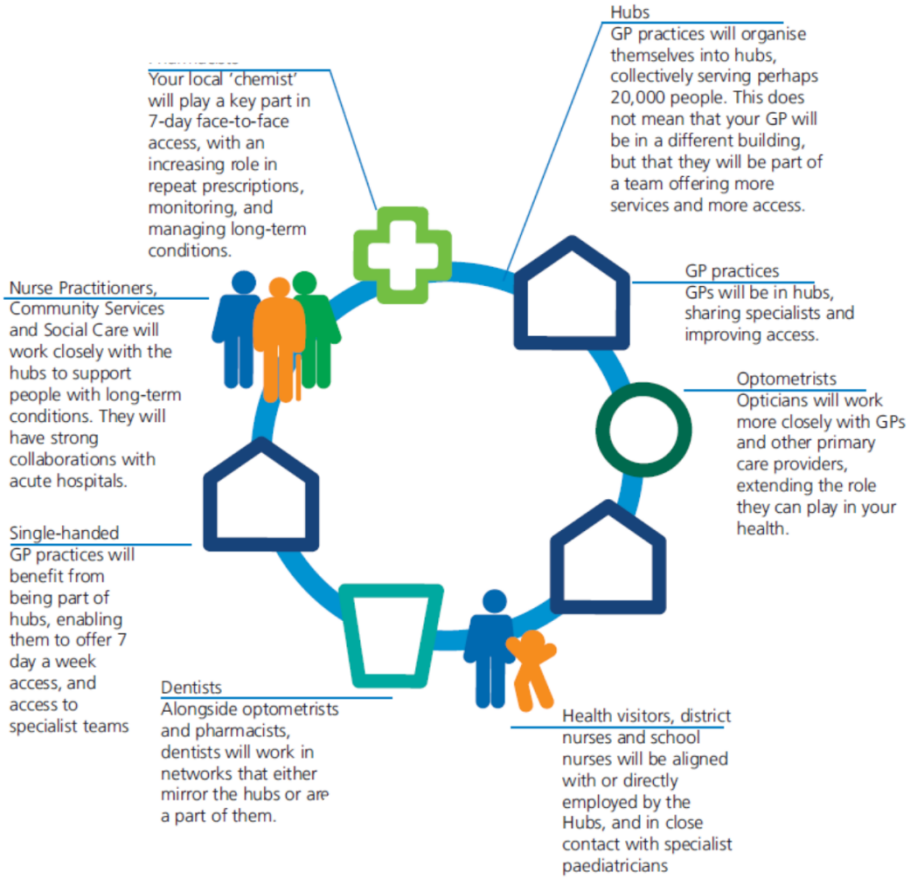
Concurrent with the desire to provide an early intervention response, and greater local emphasis upon whole systems and community collaboration, is also a growing awareness of the need to improve support to people who have been diagnosed with dementia and their carers.

The current offer provides support and advice at the time of diagnosis, but typically little ongoing support until crisis is reached – a situation that often results in premature reliance of more intensive models of care and support. The 2011 House of Commons Select Committee report on dementia stated:

'People with dementia stay far longer in hospital than other people admitted for the same procedure, often unnecessarily. The National Audit Office study in Lincolnshire found that more than two-thirds of people with dementia no longer needed to be there. This represented a total of £6.5 million that could be invested more appropriately in other services. The King's Fund extrapolated from this finding that over the whole of England, this would equate to more than £300 million that could be allocated more productively.'

Although not already in existence, as part of this BCF Plan and aligned to it will be the development of our Timely Intervention and Prevention Service focused initially on dementia for the reasons outlined above.

The delivery of other key work streams e.g. seven day services and the primary care strategy are also echoed within the BCF approach. Part of the proposed future model of primary care is the co-location of appropriate services around confederations of GPs. This is also a key work stream within the BCF.



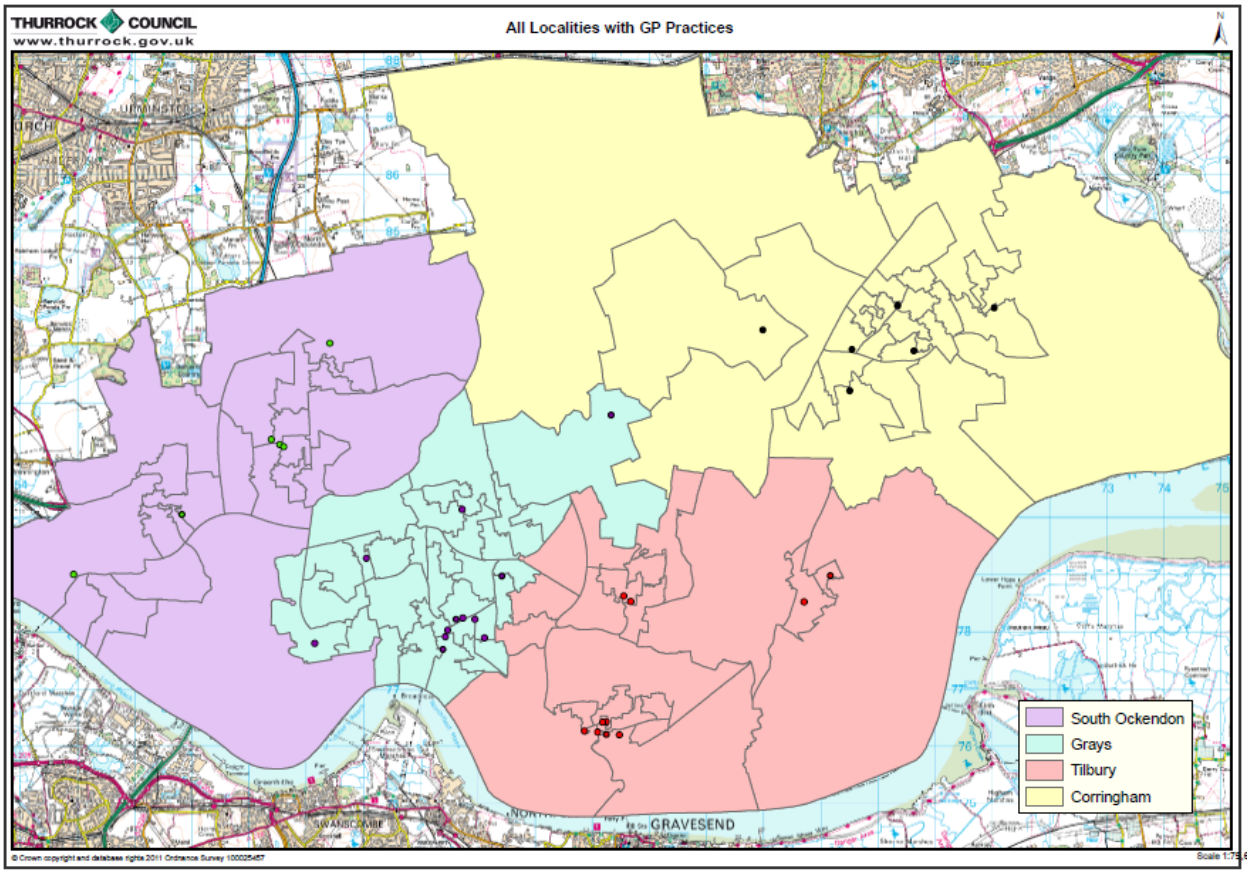
System wide Operational Resilience and Capacity Plans are in place for all five of the sub-economy areas. Whilst these focus on short term initiatives to manage day to day pressures in the system, the plans enabled by the BCF are seen as the longer term solution to managing fluctuations and growing demand across the unplanned care system. The projects funded through the 14/15 Resilience Monies have been targeted to help inform and/or pump prime BCF related initiatives.

The monies identified through the Call to Action programme (£5 per head) and the CCG endorsement of the NHS England Direct Enhanced Service for Avoiding Admissions, have been aligned to the longer term integrated commissioning and delivery programmes. For example, developing integrated health and social care co-ordination for high risk patients supporting the role of the Accountable GP for the over 75s.

Everyone Counts

Thurrock CCG and Thurrock Council have a close working relationship and already have a joint post. Further work is being undertaken to align commissioning arrangements to ensure a truly joint approach going forward.

To facilitate improved access and integration the CCG has been working in partnership with social and primary care providers to realise co-terminous health and social care hubs; helping shape decisions being made as part of the wider primary care transformation programme.



Seamless Single Contact Service Solutions
A key feature in the newly commissioned services in Thurrock is their ability to reduce the number of patient transfers between services; aiming to operate as Single Point of Access Services. These include:

- **Rapid Response Assessment Service *(RRAS)***
  RRAS is an integrated health and social care team who provide a rapid response and assessment of service users in crisis, within their own home setting. The service trai, co-ordination and redirection of their care to the most appropriate intermediate care provider/service. The service does not deliver
- **Support, Assessment & Advice Service (SAAS)**
  Text
- **NHS 111**
  Text

Core to the success in both of these models is equipping patients, and/or their carer with the telephone number; where this has been identified within their care-plan or as a targeted marketing campaign.

Expanding on the development of the four community hubs, commissioners are working with the

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

William

- **Confirmation that the schemes described in the plan are all included as part of the 2 year operating plans for 2014-16 and aligned with 5 year strategic plans**
- **Highlighting any schemes that are not part of the 2 year plans and describes how this will be managed, and how these plans be included in any refreshed CCG plans or in CCG plans for 16-18**
- **Any risks that emerge as a result of differences or discrepancies between the BCF plans and the 2 year plans and how these can be addressed**

Thurrock CCG's 5 Year Plan identifies a number of areas of focus (under pinned by the JSNA). These developments span health and social care. The principles outlined within this document are also the principles within the five year plan. The work programme within the two year operational plan is geared towards the delivery of these principles;

Principles	CVD - Cardiology	CVD - Stroke	CVD - Heart Failure	Haematology	Respiratory Review	Cancer Services	Diabetes Service Review	LTCs in patients w/ MH cond.	Continence Service Redesign	Personal Health Budgets	Under 19 High Impact Pathways	Ambulatory Emergency Care	Dementia Screening	IAPT	Community Geriatrician Model	MSK Pathway	RRAS and Reablement	Continuing Healthcare Review	Community Bed Provision	Parity of Esteem	BCF Programme	Improving Quality	Acute Service Review
1) Empowered citizens who have the choice and independence and take personal responsibility for their health and wellbeing																							
2) Health and care solutions that can be accessed close to home																							
3) High quality services tailored around the outcomes the individual wishes to achieve																							
4) A focus on prevention and timely intervention that supports people to be health and live independently for as long as possible																							
5) Systems and structures that enable and deliver a co-ordinated and seamless response																							

The key schemes within the BCF are all included within the CCGs two year operational plan.

The key risk associated with differences between the two year plan and BCF that has been identified is a variation between primary care federation boundaries/community health boundaries and social care operational boundaries. A key requirement of the two year plan and BCF is the colocation/alignment of services into the federation model however, from an operational delivery perspective this may require significant change. Work is being undertaken to understand the differences and how we could mitigate any issues.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Our plans for co-commissioning align entirely with our plans in the BCF and the CCGs' wider strategic direction. Whilst the CCG has not expressed an initial interest co-commissioning services with NHS England, a key aim of the CCG is improve to the capacity and quality of primary care, in particular addressing issues of an ageing workforce, under provision and growing population. We are seeking to work with primary care to develop clinical practice, provide better care management, and integrated delivery through the alignment of health and social care teams (initially through our deployment of £5/head funding as proof of concept).

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

Our approach to protecting social care services, and therefore our definition, is as follows:

Reducing Overall Demand
The client number projections from September 2013 up until April 2018 in Figure 1 below shows the expected natural increase via demographic pressures the Authority will face from now up until April 2018. This is an expected trend due to the nature of the population mix, coupled with an ageing population.

Fig 1

Actual	**Projected**

	Sep – 13	**Apr-14**	**Apr-15**	**Apr-16**	**Apr-17**	**Apr-18**
Standard placements	286	300	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	**381**	**402**	**414**	**425**	**434**	**443**

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

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

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

- Joint commissioning of integrated health, public health, social care and housing services;
- A mixed economy of locally run care services; and

- Social prescribing – linking people up to activities in the community that they might benefit from (there is increasing evidence to support the use of social interventions for people with mild to moderate depression and anxiety, and people who are frequent attendees in primary care).

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

Shifting Resource

We will look at the BCF in its entirety with a view to placing resource where it will have the greatest impact. This approach will help to manage the demand for both health and social care services, but also ensure that we are able to continue to provide services for those who meet our eligibility criteria. We estimate that pressures on external placements will increase by at least 20%. We have reflected the increase on external placements in our spending plans. We will also be identifying how the BCF can help to support existing social care services – these will be detailed within our Section 75 agreement. The review of services and pathways that we will undertake as part of developing and delivering our approach to integration will help to ensure that resource is in the right place – and help to identify where the resource should be shifted to.

Our approach to investing in early intervention and prevention solutions will assist with ensuring that resource is used as effectively and efficiently as possible.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

We have identified above the projected demographic pressures the Authority will face. We will identify within the BCF how existing social care services can be supported. Our approach will also be to review existing schemes and release efficiencies that can then be used to contribute towards sustaining social care.

Schemes and initiatives contained within the BCF are part of our broader Whole System Redesign work and will focus on timely intervention and prevention, and integrated and better coordinated services across the health and social care system. This approach will reduce the numbers of people being admitted to hospital or a residential setting. Effective reablement services, which are part of this BCF, will help to prevent readmissions.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£521k - Ade

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The Council, as part of the Health and Social Care Transformation Programme, has established a Care Act Implementation Project Group. The Group has assessed the Council's readiness against the Care Act's requirements and identified the work that needs to take place between now and April.

Key elements are as follows:

- Carers – assessment and support;
- Information and Advice – system/material development;
- Safeguarding – implementation of new responsibilities;
- Assessment and Eligibility – primarily change in eligibility;
- Capital investment funding – e.g. IT systems for personal budgets.

The Care Act implementation funding will be used to ensure readiness for April 2015. A full readiness assessment and related action plan is available.

v) Please specify the level of resource that will be dedicated to carer-specific support

Ade/William?

An articulation of how this funding will be used to support improved outcomes for carers: including: what types of services are being commissioned and how will the experience be different from the perspective of a carer

Evidence based consideration of how carer support will impact on patient level outcomes

Highlighting any risks relating to the delivery of carer-specific support, and ensure that these are cross referenced in the risk log alongside appropriate mitigating actions

Attach any support documents that evidence the approach to carer-specific support

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The amount of funding that has been affected within the LA's budget if any – n/a

b) 7 day services to support discharge

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

We are committed to improving the quality of services provided for our population and see the BCF and integration as the vehicle through which we will continue to seek new ideas and opportunities for advancing 7-day services in partnership with our providers.

Thurrock CCG is working with all of its relevant providers to develop action plans to support their response to the 10 clinical standards for 7 day working. This will be a key component of Service Development and Improvement Plans (SDIP) over the next two years and beyond. We will engage closely with our providers to ensure, once action plans are developed, that they are rolled out across the system over the plan period in line with contract commitments.

Health and Social Care commissioners across Thurrock will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary admissions and support discharge.

This vision is aligned with the NHS Outcomes Framework, two year operational plan and five year strategy.
The delivery of the Primary Care Strategy will be critical to meeting the ambition of delivering 7-day services. The Primary Care Transformation Fund bid is focussing on the delivery of a seven day primary care service.

To support the acute trusts in their transition to 7-day services through their Right Place Right Time Programme (RPRT), the CCG and Council have committed to the following developments (several through the BCF Plan):

- Rapid Response and Assessment Service (RRAS) – extended weekday hours (9am – 7pm) and weekend cover (9am – 5pm);
- Thurrock Social Workers – 7-day hospital cover including on-site provision 6 days per week;
- Intermediate Care (health and social care) – provision for admission and discharge on Saturdays and Sundays; and
- Nursing Homes – premium payments for homes that can admit at short notice.

Over the next five years, work will continue to explore innovative solutions – including optimising primary care provision, pharmacists, optometrists and dentists to support 7-day services based on the community hub model championed in Thurrock.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

Rhodri/Phillip

NHS Number

The use of the NHS number is to a large extent governed by the rules around Information Governance and until some of these issues are resolved all organisations will continue to work with NHSE to ensure that we are ready and able to implement the use of the NHS number as soon as possible following authorisation to do so.

- **Preparatory Work**
  In preparation for undertaking advanced risk-stratification of health, social care and electoral roll data; a number of preliminary exercises have been undertaken by the CCG and social care including:
  - Consent to share sought from all known Thurrock adult social care clients;
  - Changes to operational policies to ensure consent is sought upon first contact with adult social care clients; with confirmation of decision sought annually;
  - Review and alignment of social care information architecture for alignment to acute health data;
  - Thurrock LA and CCG have created a suite of reporting templates with Pi Benchmark to realise a joint risk-stratification tool once Information Governance allows.

  The resultant impact of these actions have realised a significant improvement in the capture of NHS numbers for adults; with only 2% of all social care clients not providing consent to share.

  Thurrock actively awaits the results from the Southend Pioneer project on how they have utilised Health & CareTrak; within the current limitations of Information Governance.

- **Active Work Programmes**

  - **Primary Care Multi-Disciplinary Team Reviews**
    In 2012/13 the newly formed CCG introduced Primary Care MDT reviews in 32 of its 34 practices; for the improved detection and care co-ordination of frail, vulnerable, complex patients at risk of decline in health and/or risk of avoidable admission into hospital or premature care home placement.

    All health and social care providers identify patients

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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

- Social Care uses an IT system that allows health partners and staff to view information, contribute to information and to support the provision of support and services e.g. joint reabelement and RRAS teams. The system also enables data and information to be shared with and interfaced with other systems where required. The system and developments meet requirements outlined in the IG Toolkit and are fully compliant with an open set of APIs.

- To enable integrated working, we will review and improve systems - either through use of a single shared system or through enhanced interfaces, connections and access across systems. This will improve data sharing and enable practitioners across health and social care to view and contribute to an individual's information and records. This will also support enhanced and more accurate data quality assurance by earlier identification of gaps or inconsistent records. This will be underpinned by use of the NHS Number.

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

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

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

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

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

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

Social Care has amended its service user information governance statement to incorporate sharing of information with health partners on an electronic basis
The development of our data sharing arrangements will be in keeping with the Data Protection Act 1998, particularly principle 7 (security measures taken to protect data), and Article 8 of the European Convention on Human Rights (the right to a private an family life).

As part of our governance arrangements for the BCF Plan, a Section 75 Group will oversee compliance supported by a Data and Intelligence Group.

d) Joint assessment and accountable lead professional for high risk populations

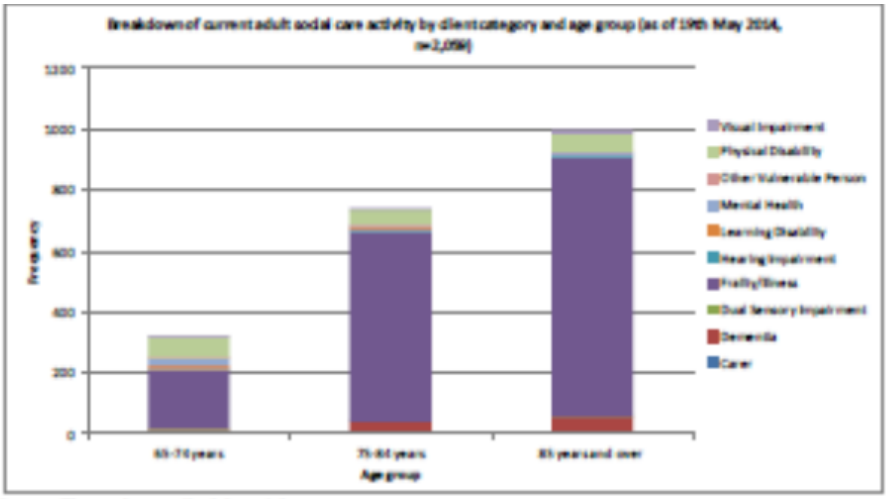
i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

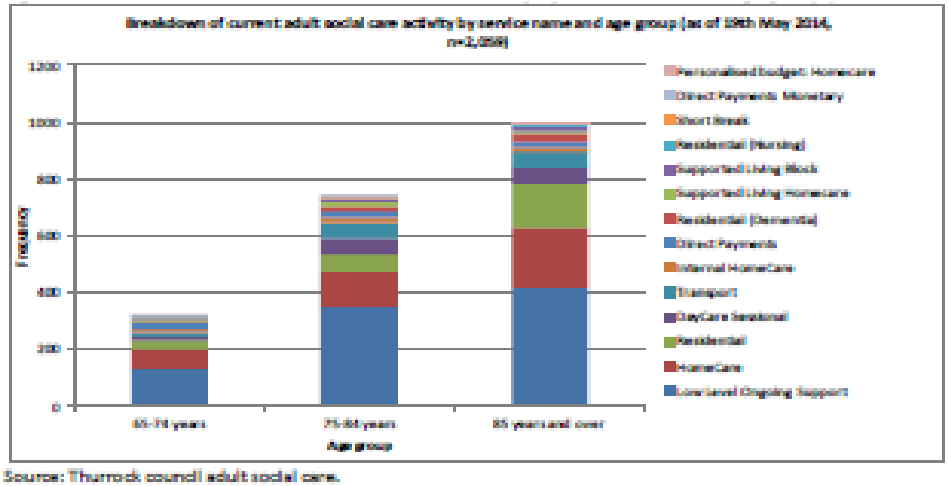
Phillip/William/Rhodri?

In line with the Unplanned Care Directly Enhanced Service, Thurrock are expecting 2% of the population to fall within the “frail at risk” population. This equates to approximately 3,100 – 3,400 people.

1% Benchmark – EOL Register

Adult Social Care Analysis *(p32 HNA)*

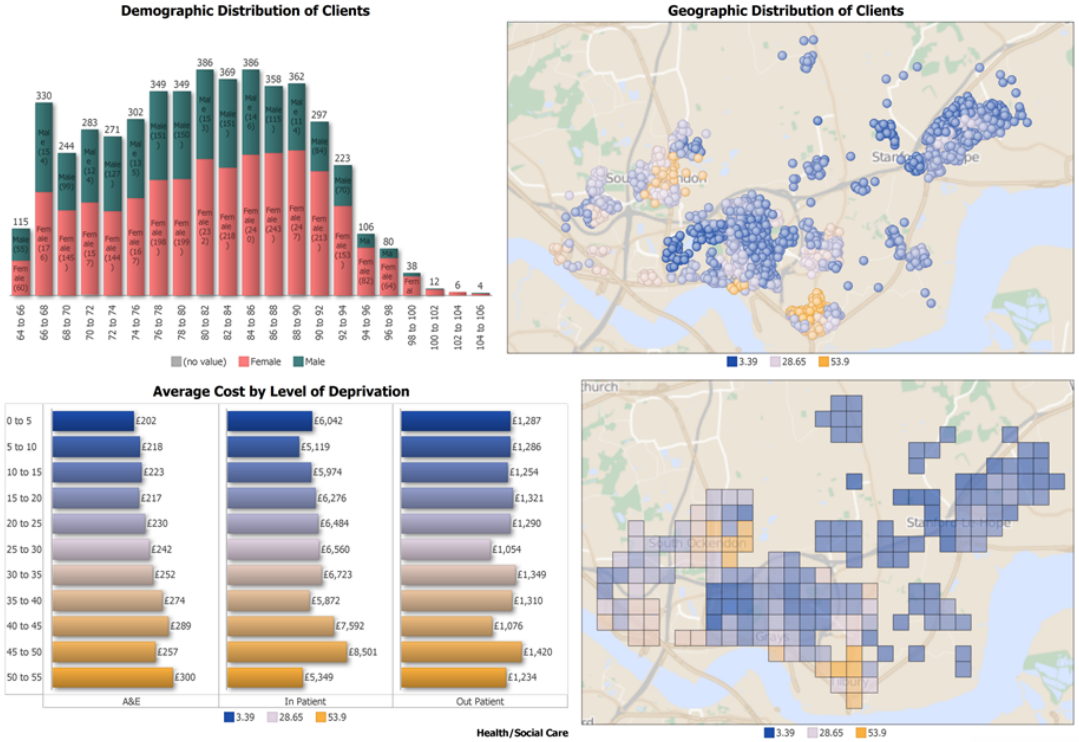




Source: Thurrock council adult social care.

Safeguarding Adults >65 Number

Preparatory slides from Healthtrak



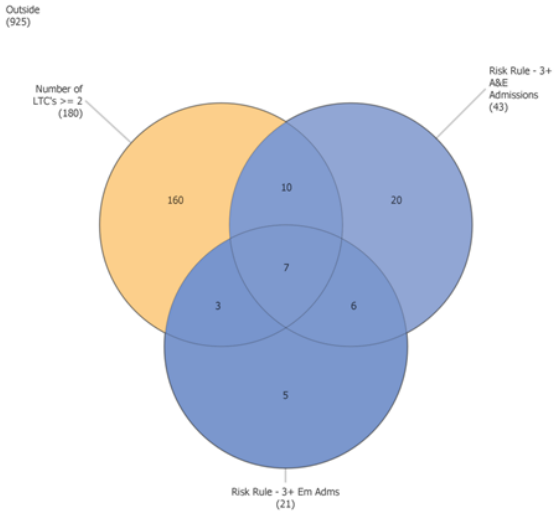
Health spend and activity and deprivation overview – local challenge areas – do they align with local knowledge?

Text

Comparison of patients with LTC's and multiple admissions, Cost of Care Pathway, Cost of Placment and Admissions

Filterd by GP practice - currently showing: **Dr Colburn M Practice**

Venn showing number of individuals with multiple LTC's and multiple Emergency and A&E admissions

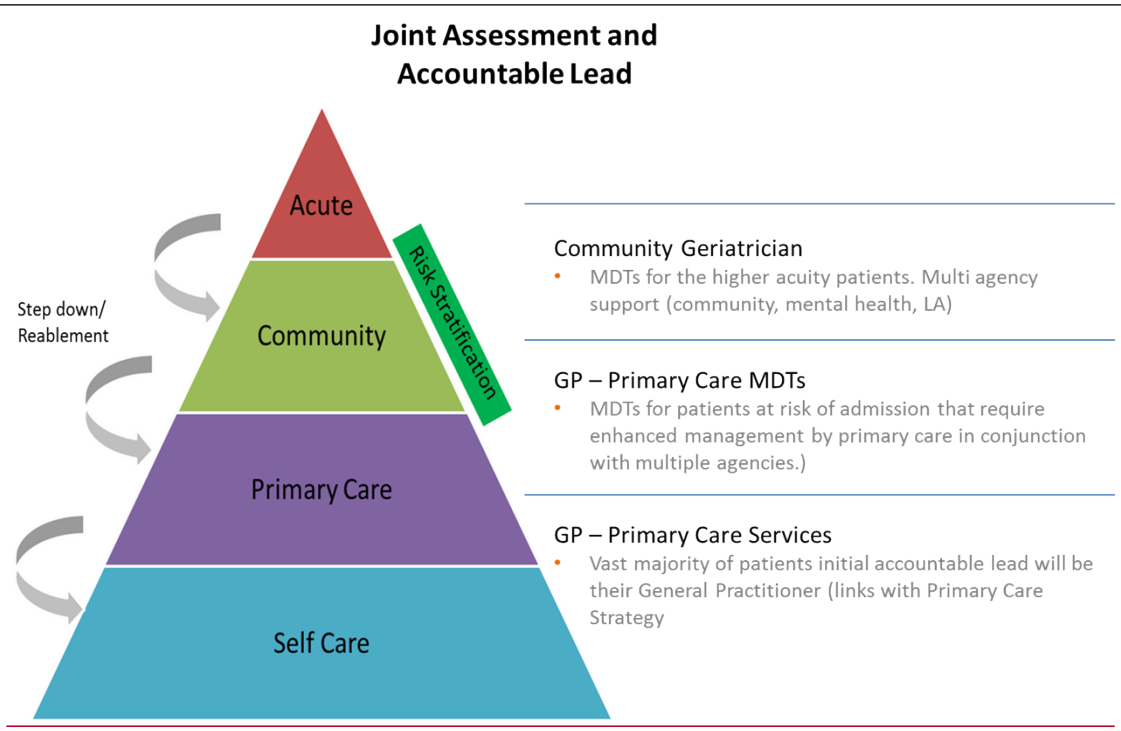


Bar view to show the top 100 patients in terms of the cost of their care compared to their usage

Cost and activity breakdown by Risk Strat groups

Measures

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population



We are currently refining our proposals for the Joint Assessment and Accountable Lead process. The above diagram is the basis of the system that we have begun to implement and are starting to refine across the locality. Within this model, General Practice plays the strongest accountable role for the majority of patients.

The Role of Primary Care
This model is underpinned by the Primary Care Strategy which seeks to strengthen primary care and improve capacity and sustainability.

The Clinical Commissioning Group will be supporting GPs to utilise the £5 per head to support the development of primary care capacity and quality that will enable the GP to be the Accountable Lead Professional in the vast majority of patients.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

As part of the Council's and CCG's Health and Social Care Transformation Programme, we have established an Engagement Group. The Group's purpose is to advise on engagement with users of services, carers, and the public. The Group has developed an Engagement Plan for this purpose, and has also developed a process for involving users of services, carers and the public in commissioning and service development (signed off by the Health and Wellbeing Board at its July 2014) meeting.

The Engagement Group recently met to agree their role in the review of existing Better Care Fund schemes. They are also represented on the Whole System Redesign Project Group, Care Act Implementation Project Group, and Health and Social Care Transformation Programme Board.

In April, the Council and CCG held a stakeholder event to gauge stakeholder feedback – including users of services, carers and the public – on the principles that underpin the vision for Health and Social Care. The Better Care Fund has also been discussed at Thurrock's Clinical Reference Group.

Considerable community engagement has already taken place on some of the elements that are incorporated within and aligned to this plan – e.g. Local Area Coordination.

Future engagement activity as part of developing and delivering this Plan will be guided by existing arrangements – i.e. the Engagement Group.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

Thurrock CCG are engaging with their main acute provider (Basildon and Thurrock University Trust), main community provider (North East London Foundation Trust) and main mental health services provider (South Essex Partnership Trust). Updates on the development of the BCF and the strategic direction of the BCF have been shared through a variety of forums including system leadership meetings, contract management meetings and specific workshops.

In addition, there will be regular dialogue with all providers through the System Resilience meetings (fortnightly) with the main providers and other key partners (OOHs, Ambulance Service, 111 etc). This forum is sub economy wide and so includes Thurrock CCG (a Lead or Associate to all the aforementioned contracts). Therefore, the interface between the Thurrock BCF and the Essex BCF will be subject to provider scrutiny.

Within our Executive to Executive Contract Negotiations for 15/16, the BCF developments and their impact (for both 15/16 and beyond) will be a standing item to ensure that any contractual (activity, finance, specification, service development plan) requirements are agreed well in advance of signing contracts.

As part of the work streams identified, there will also be specific market development work both with incumbent and potential service providers

ii) primary care providers

There has been specific engagement on the Better Care Fund with GPs through the CCGs governance committees. In addition, through the Clinical Executive Group (all GP practices and other forums, GP members have been kept updated on the development of the BCF. More explicit engagement has been pathway related on the development of the colocation model, frailty services, mental health services and the interface between primary care and community (health and social services).

iii) social care and providers from the voluntary and community sector

TBC

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Ade/William

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

William/Catherine

Scheme ref no.
BCF1
Scheme name
CO-TERMINOUS SERVICES REVIEW
What is the strategic objective of this scheme?
The aim of this scheme is to review health and social care provision with a view to align appropriate services around federations of GP practices.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme will see the alignment of primary (GP, Pharmacy) care services with community health (community nursing, matrons and others to be determined) alongside social care and other non-statutory services. This cohesive working arrangement will aim to manage care out of hospitals and reduce the level of unplanned admissions.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This primarily affects the following commissioners; NHS England (Primary Care) Thurrock CCG (Acute and Community Care) Thurrock Council (Social Care Services) And following providers; General Practice Basildon and Thurrock University Hospital NHS Foundation Trust North East London Foundation Trust Thurrock Council Other smaller providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Scheme ref no.
BCF2
Scheme name
Frailty – Extended Services Model
What is the strategic objective of this scheme?
The aim of this scheme is to review pathways for frail patients to ensure we are meeting local need and delivering best practice.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme covers a wide range of initiatives including; - Review of existing Reablement and protection of social cares services - Implementation of a frailty pathway across primary, community and acute providers - End of Life Care - Review of dementia services - Review of falls services - Development of carers services
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This primarily affects the following commissioners; NHS England (Primary Care) Thurrock CCG (Acute and Community Care) Thurrock Council (Social Care Services) And following providers; General Practice Basildon and Thurrock University Hospital NHS Foundation Trust North East London Foundation Trust Thurrock Council Other smaller providers

The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

Scheme ref no.
BCF3
Scheme name
Frailty – Public Health Initiatives
What is the strategic objective of this scheme?
The aim of this scheme is to ensure population wide scheme are in place for reducing risk for over 65 patients and identifying at risk patients for proactive management.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
This scheme covers a wide range of initiatives including; - Identification of population wide schemes to reduce risk - Development of a risk stratification tool
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
This primarily affects the following commissioners; Thurrock CCG Thurrock Council And following providers;

North East London Foundation Trust Thurrock Council
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
What are the key success factors for implementation of this scheme?

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	
Name of Provider organisation	
Name of Provider CEO	
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	
	2014/15 Plan	
	2015/16 Plan	
	14/15 Change compared to 13/14 outturn	
	15/16 Change compared to planned 14/15 outturn	
	How many non-elective admissions is the BCF planned to prevent in 14-15?	
	How many non-elective admissions is the BCF planned to prevent in 15-16?	

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	