Appendix 3

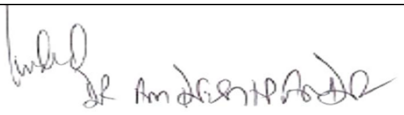
THURROCK BETTER CARE FUND PLAN

1) PLAN DETAILS

a) Summary of Plan

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

b) Authorisation and signoff

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

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

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

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

c) Related documentation

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

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

Introduction and Executive Summary

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

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

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

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

The proposed focus of the BCF

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

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

Building on our experience of integrated services – building on what works

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

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

Future vision for health and social care in Thurrock

In essence, the overarching vision for our health and care services involves:

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

And for residents, our vision should mean:

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

2) VISION FOR HEALTH AND CARE SERVICES

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

Introduction

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

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

Context

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

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

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

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

In addition to the over 75s analysis, NHS England's Essex Area Team are in the process of developing a Primary Care Strategy. Robust primary care, particularly GP services, are critical to early identification of those at risk of developing a health condition and those individuals whose health is deteriorating and reaching crisis point. Thurrock is currently under-doctored, and 30% of the current Thurrock CCG GP workforce is over the age of 60. A number of the areas with a shortage of GPs are also in Thurrock's most deprived areas. Scheme 1 aims to maximise primary care capacity by providing an integrated health and care offer that builds on four GP cluster areas.

What our Stakeholders tell us

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

JRT and RRAS – the platform for developing more integrated services

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

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

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

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

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

Approach

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and has a number of strands:

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

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

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

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

Integration

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

The future – 2018/19

Our future, delivered through the BCF and related programmes (Building Positive

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

Healthy, active ageing and supporting independence

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

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

Living well with simple or stable long-term conditions

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

Living well with complex co-morbidities, dementia and frailty

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

Rapid support close to home in times of crisis

- Further development of our integrated Rapid Response and Assessment Service (RRAS) as part of our developing Frailty Model

Good rehabilitation and re-ablement after acute illness or injury

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

High quality nursing and residential care for those who need it

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

Choice, control and support towards the end of life

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

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

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

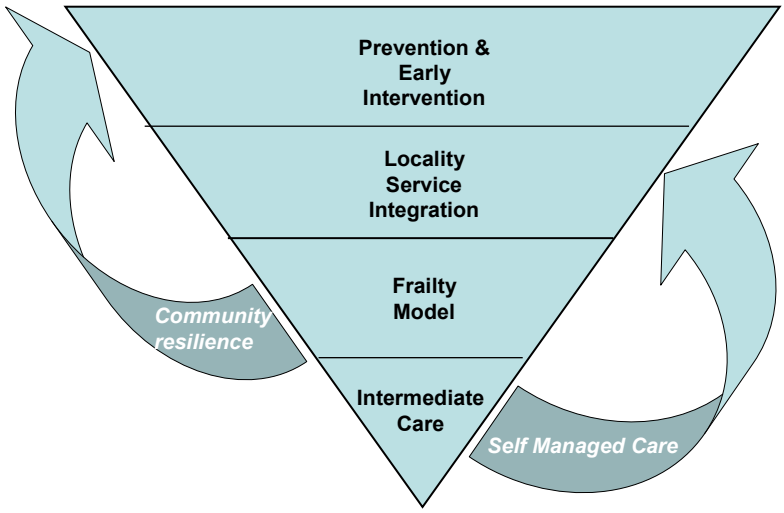
Alignment

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

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

Better Care in Thurrock

Right time, right place, right solution



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

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

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

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

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

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

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

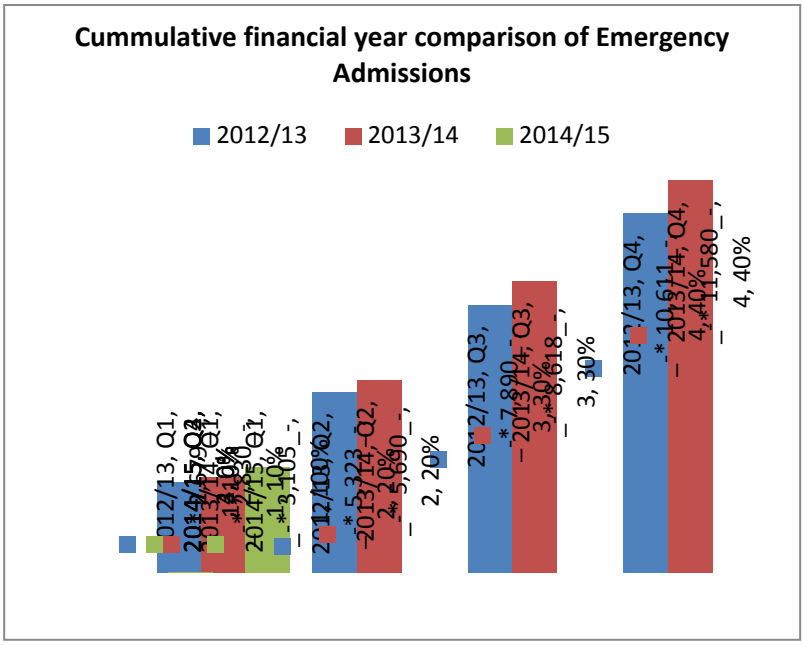
Our short-term ambition is as follows:

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

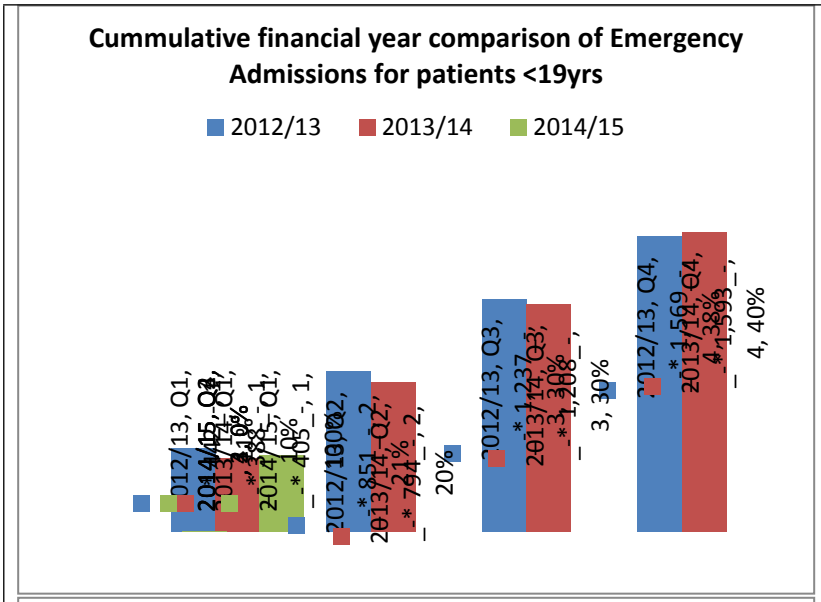
3) CASE FOR CHANGE

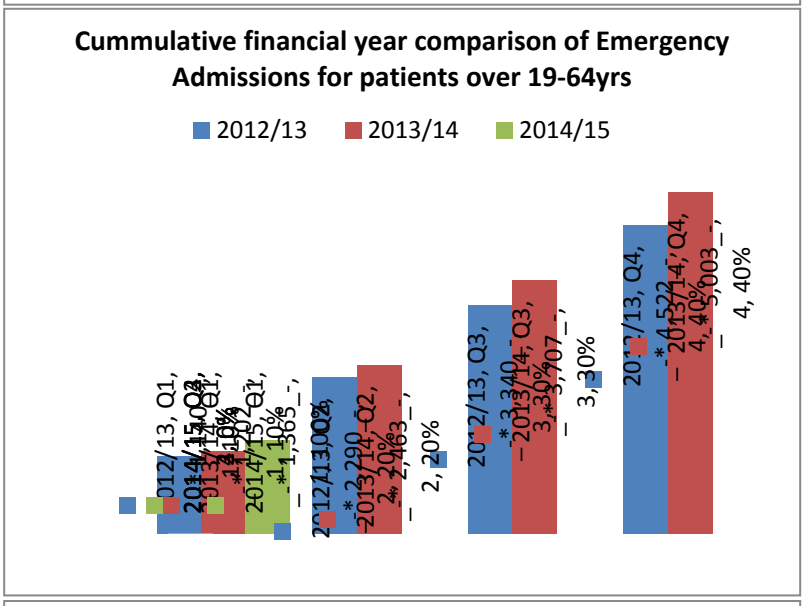
Why have we focused on people age 65 and over?

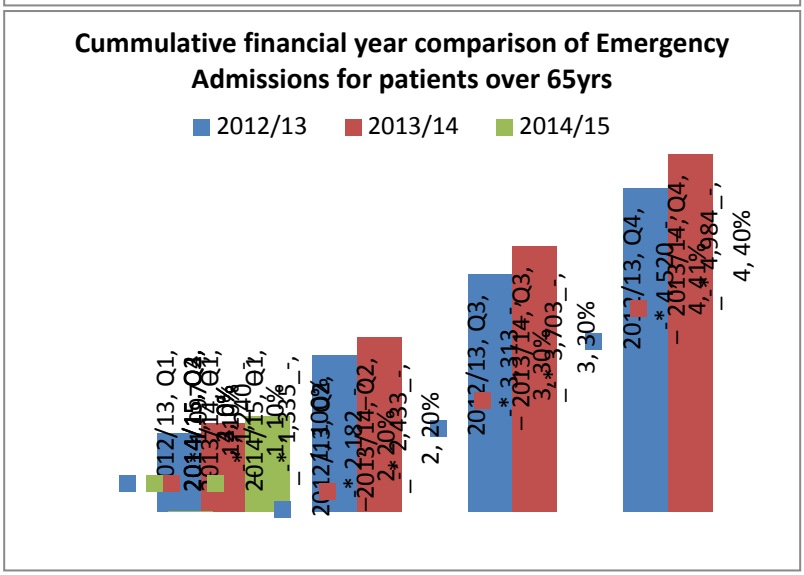
Thurrock CCG had 11,580 emergency admissions in 2013/14. As demonstrated in the graph below this represented a 9.1% growth on the previous year. Furthermore, activity in the first quarter of 2014/15 indicated a 9.7% growth on 13/14.



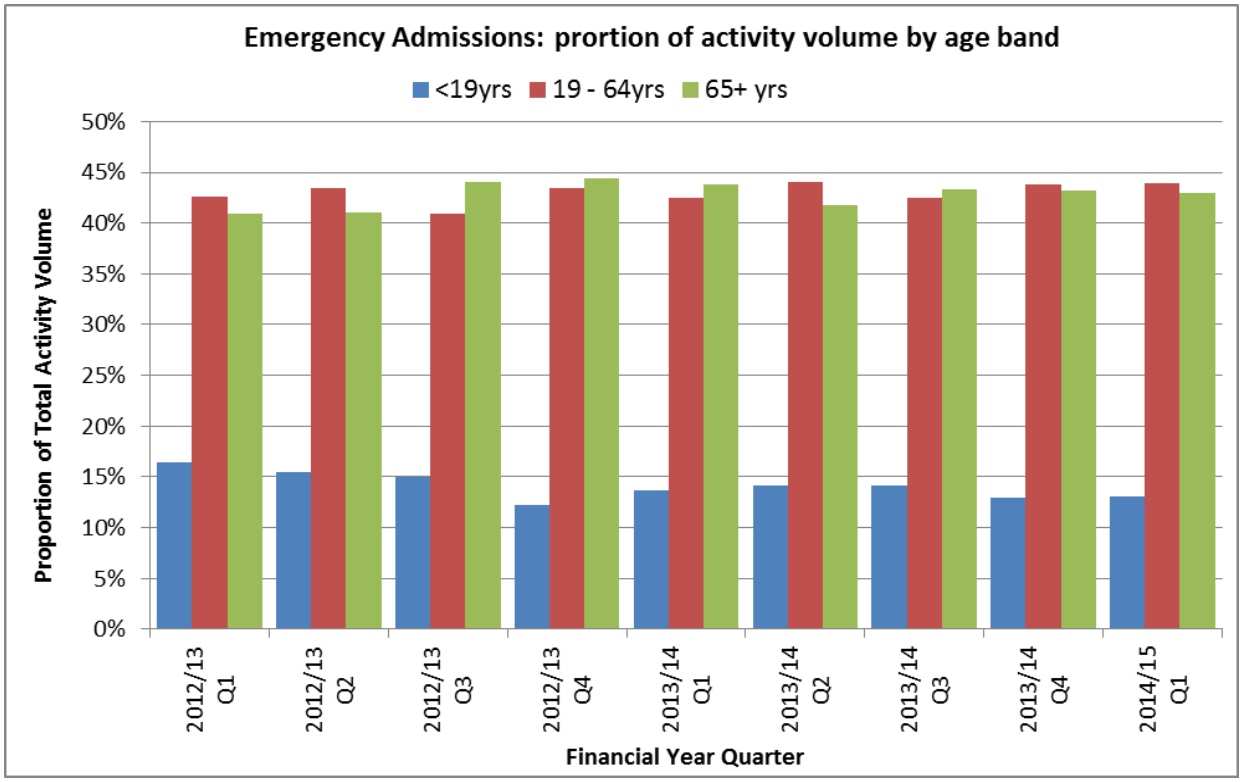
This level of growth presents a substantial challenge to both the CCG and Council. In order to meet the requirements of the BCF, our ability to use a risk based approach to identify the opportunities for avoiding admissions is paramount. In order to identify the opportunity, we have stratified total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

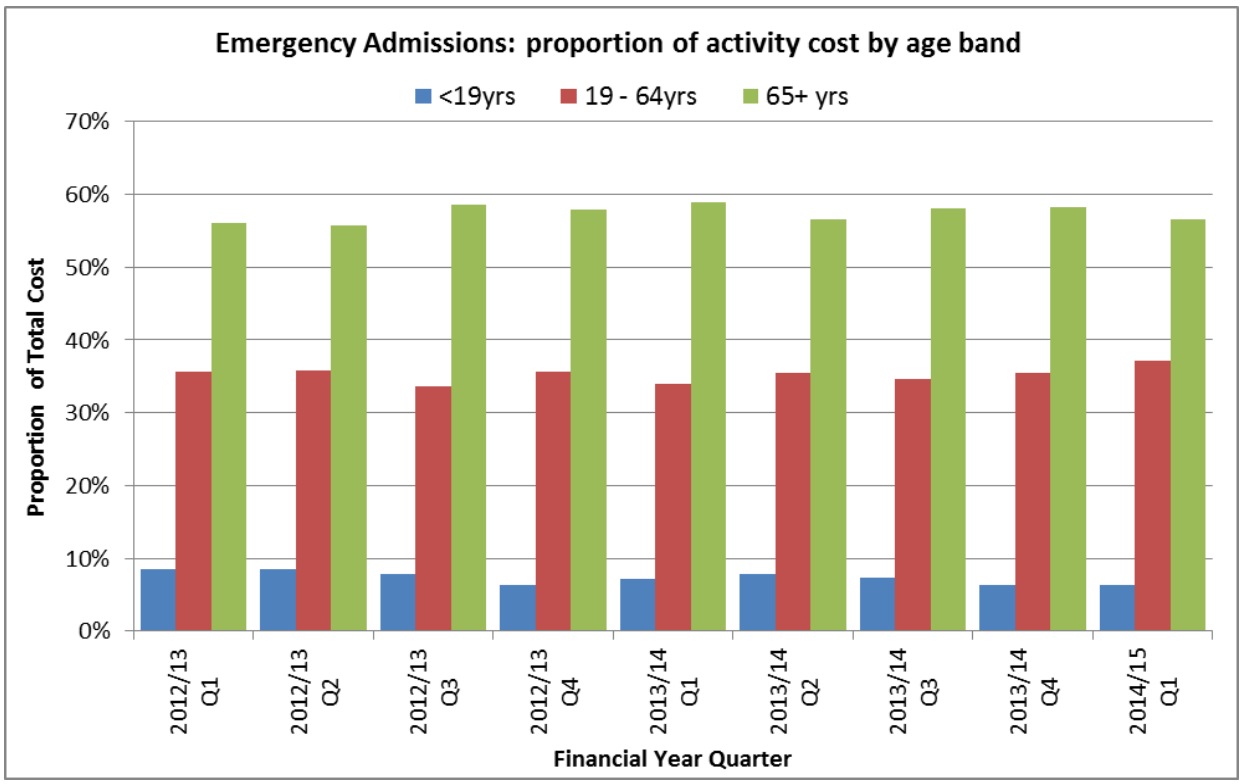






Based purely on total activity, the two age ranges with the greatest opportunity are 19-65 and 65+. Based on activity cost, the age range of greatest opportunity that far outweighs the other two age ranges is the 65+ cohort. In order to identify the focus of the BCF, further analysis was undertaken at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


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


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

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

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

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

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

This demonstrates significantly greater admission avoidance potential.

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

Age Band	Population	Number of Admissions	Admissions per ‘000 population

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

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

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

Needs Assessment of the target population

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

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

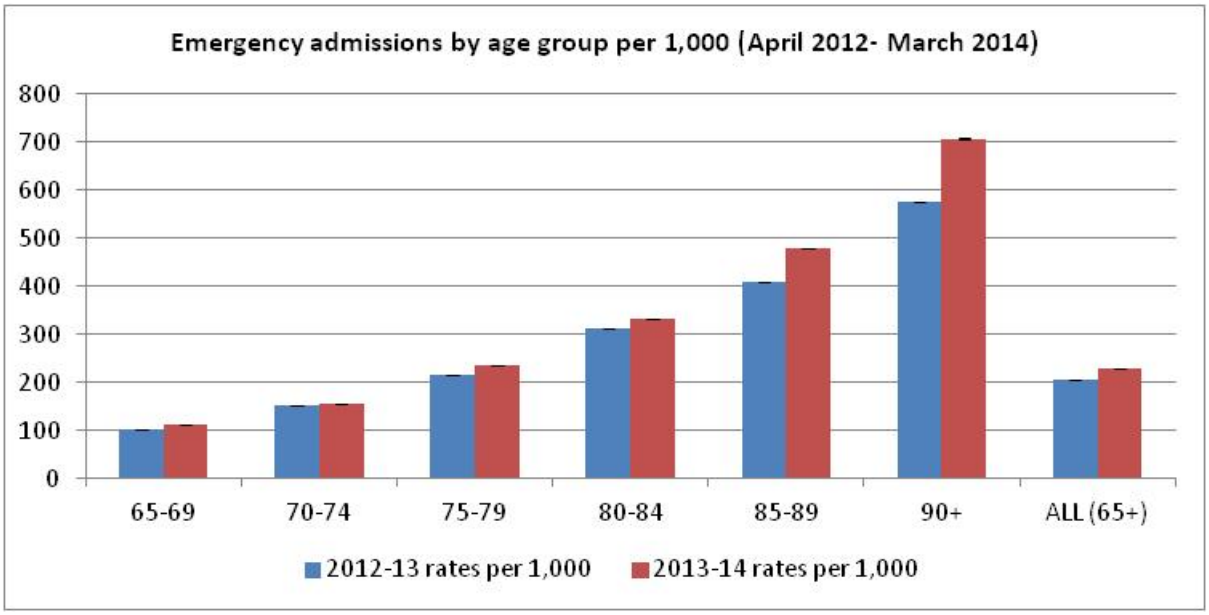


Table 1 - Top 10 HRG codes for those aged 65 years and over in Thurrock CCG (April 2012-March 2014)

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

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

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

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

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

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

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

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

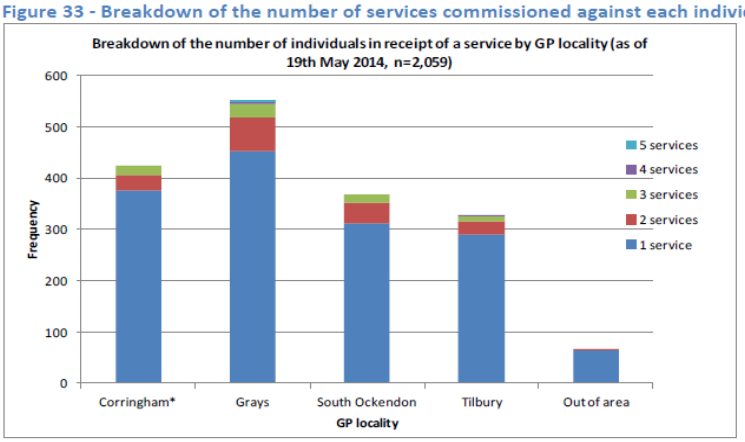
- 18% diseases of the respiratory system
- 17% diseases of the circulatory system
- 13% symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- 12% injury, poisoning and certain other consequences of external causes
- 10% diseases of the genitourinary system
- 10% diseases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

Social Care Demand & Spend

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

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

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



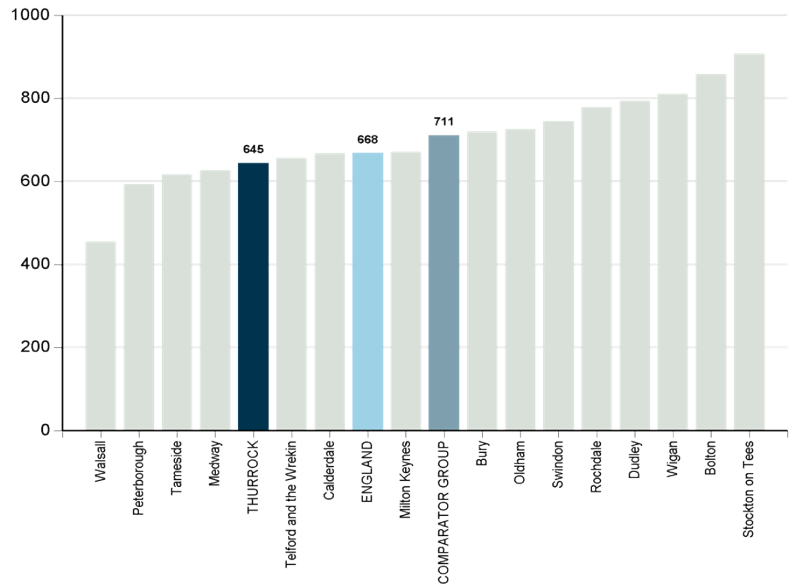
Source: Thurrock council adult social care.

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

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

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

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



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

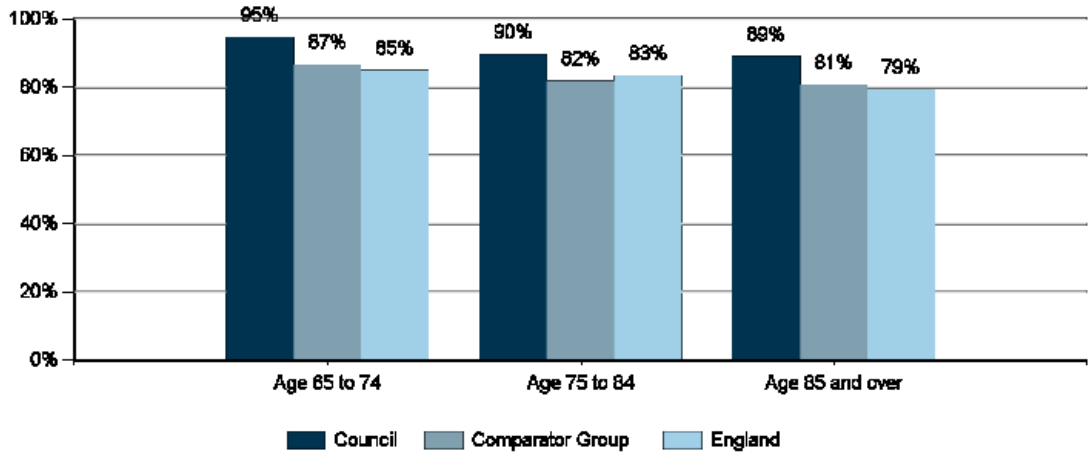
	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Standard Placements	286	299	308	317	323	330
Dementia Placements	70	77	80	82	84	85
Nursing Placements	25	25	26	27	27	28
TOTAL	381	402	414	425	434	443

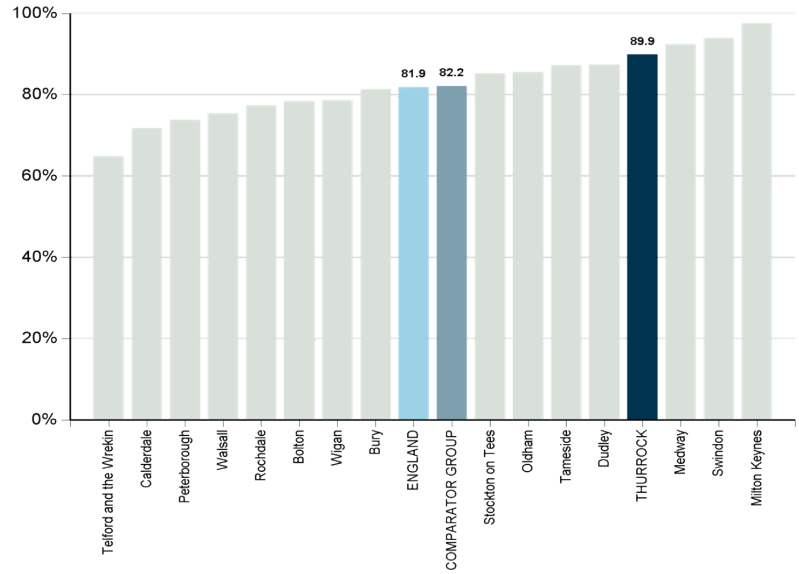
Supporting people to achieve and maintain independence at home through effective discharge from hospital and inappropriate care home admissions into re-ablement and rehabilitation services is a priority for Thurrock. Overall, Thurrock performs comparatively well on this key measure. 89% of people discharged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

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

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

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





Integration to improve outcomes

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

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

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

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

Service Quality and Efficiency

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

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

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

Integrated Commissioning

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

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

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

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

PLAN OF ACTION

Schemes for 15/16

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

Evidence review and initiative impact analysis

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

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

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

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

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

below.

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

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

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

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

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

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

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

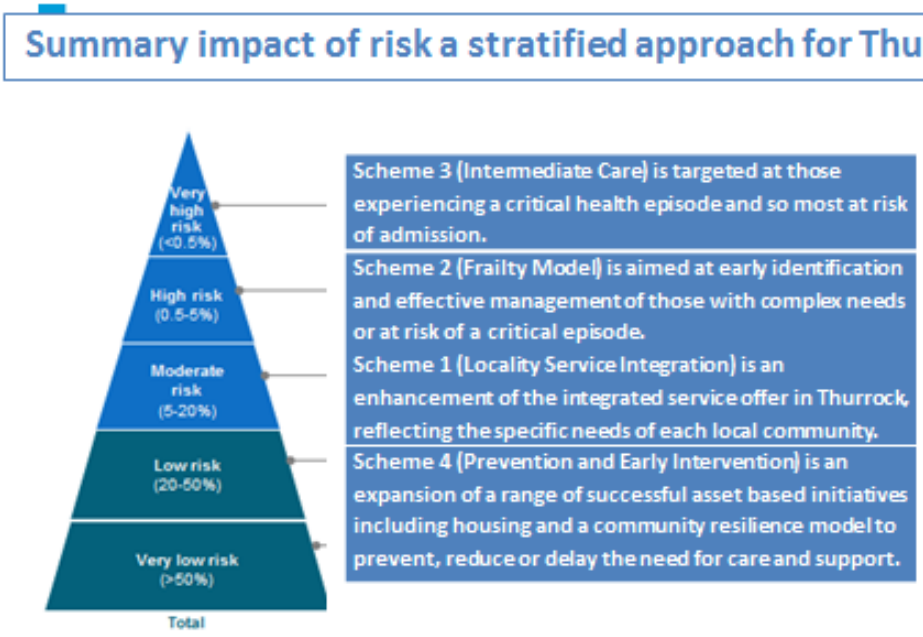
- In Scheme 1 (pg 71) we have identified a number of key milestones for the development of the Locality Service Integration model:
  - Development of integration governance arrangements and working groups – March 2015
  - Enhancing the current risk stratification approach with an aim to developing an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

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

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

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

Risk Segmentation and Next Steps



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

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

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

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

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

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

In addition the Transformation Programme Board will work closely together:

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

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

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

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

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

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

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

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

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

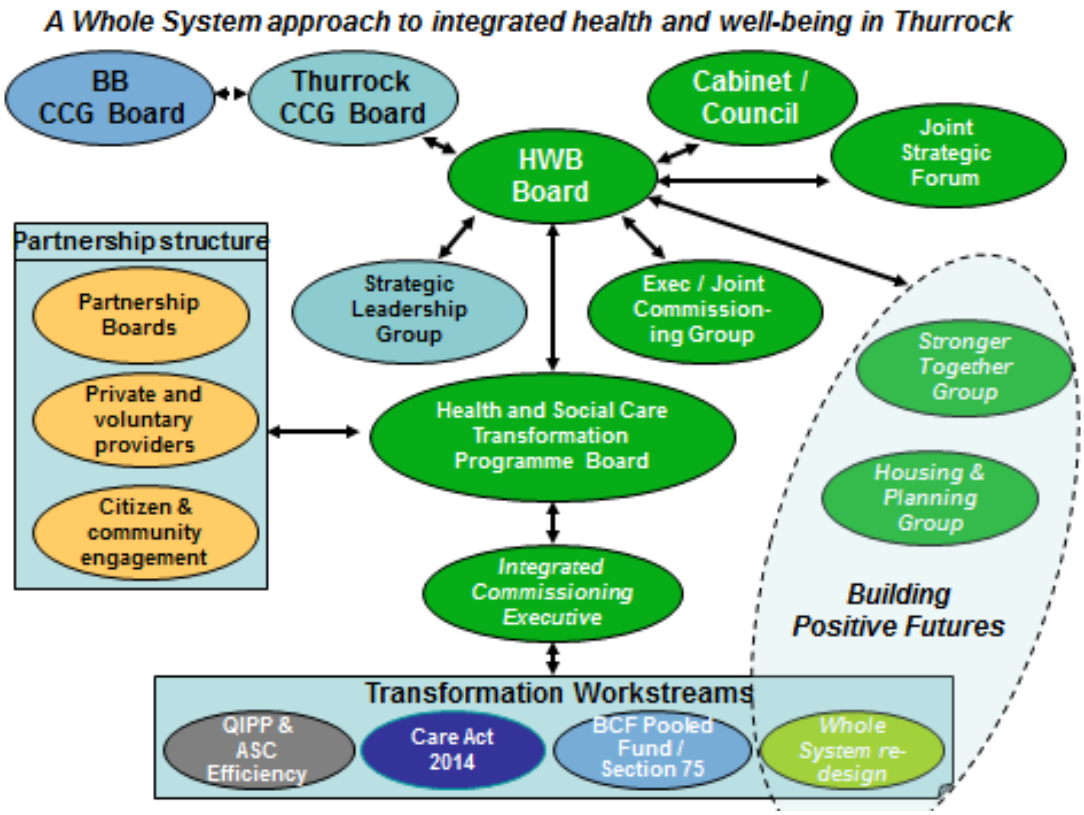
Scheme	Milestones
Scheme 1	• By June 2015 enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care • By March 2015 development of an integration governance arrangements and working groups • By September 2015 full integration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

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

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

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

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



In relation to the Governance of the BCF Pooled Fund the following is a summary of the main workstreams

- ***Whole System Re-design*** *– undertaking asset based reviews of care pathways (including the contribution of housing and communities) and developing the business case for change*
- ***BCF Pooled Fund*** *– undertaking the procurement of health and social care services (with BCF schemes annexed to S 75 Agreement) to implement changes*
- ***Integrated Commissioning Executive*** *– approving (under delegation from HWB Board) investment plans, including changes to services, overseeing the BCF pooled fund, together with oversight of Care Act implementation and wider efficiency initiatives*

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

As noted above, the Better Care Fund Section 75 Agreement Group is overseeing implementation of all the arrangements for the Council to host the pooled fund from 2015. From April 2015 the Group will report to the Integrated Commissioning Executive (a Partnership Board with responsibility for oversight of the management of the BCF).

The Executive will report to the Health and Well-Being Board on its commissioning decisions as set out from time to time in the Better Care Fund Section 75 Agreement between the Council and the CCG. The Executive will also oversee the operation of the Better Care Fund, managing performance and risks within the Fund, and reporting these to the Health and Wellbeing Board. In order to avoid conflicts of interest, any discussions related to commissioning decisions, or payment, price or the performance of the pooled fund, or any other element of the whole system which may involve matters which are commercially sensitive, will be dealt with exclusively by the Integrated Commissioning

Executive.

Membership of the Executive is:
Acting Interim Accountable Officer, Thurrock CCG
Director of Adults, Health and Commissioning, Thurrock Council
Chief Finance Officer, Thurrock CCG
Strategic Lead for Commissioning and Service Development, Thurrock Council
Head of Integrated Commissioning, Thurrock CCG
Head of Finance, Thurrock Council

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

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

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

The Integrated Commissioning Executive will meet on a bi-monthly basis (or more frequently if issues are escalated by the Pooled Fund Manager) to review performance against the Plan. The Transformation Programme Board (of which the Integrated Commissioning Executive forms part) will have delegated authority from the Health and Wellbeing Board to modify the plan, and the focus and funding for individual schemes, where both the Council and the CCG agree to do so.

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

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

Performance Management

As noted above the Pooled Fund Manager will monitor financial and activity information on a monthly basis, escalating any issues/off-target performance to the Clinical Executive Group as necessary. In addition, and at least quarterly, the Pooled Fund Manager will provide a full report to the Programme Board to enable it to:

- provide strategic direction to schemes
- receive finance and activity information
- escalate any unresolved issues/off-target performance
- agree variations to the agreement and plan as required
- authorise the Pooled Fund Manager to approve expenditure

The key performance metrics which will be monitored by the Pooled Fund Manager are detailed within part 2 of the Plan.

In relation to how strategic and operational issues are dealt with - as part of the established governance structure - the following points should also be noted:
The Approach on page 10 of the Plan states:
"The Council and CCG have established as part of their Health and Social Care Transformation Programme a Whole System Redesign Project Group. The Group, guided by data and intelligence, and also patient and service user experience, is reviewing what requires redesign – with the focus on reducing hospital and residential home admissions for adults aged 65 and over. The Group will be responsible for shaping and ensuring delivery of the schemes attached as annexes to the Plan, ensuring that they deliver the expected benefits."

As an example of the management of operational issues, the Plan includes the following Milestones on pages 31/32

- "By March 2015 development of integration governance arrangements and working groups
- By April 2015 embed the performance management framework as part of Thurrock's BCF governance arrangements – through the Integrated Commissioning Executive"

And In relation to the feedback loop for scheme 2 on page 81
"The impact of this scheme will be monitored through the Whole System Redesign Project Group. This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive. "

Other points relevant to the governance arrangements for strategic and operational issues are set out in Section 5) RISKS AND CONTINGENCY on page 40
"In the case of new services or major variations to existing services, business cases will be developed to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the Health and Wellbeing Board on the recommendation of the Integrated Commissioning Executive which is the partnership Board for the pooled fund. These plans will include robust programme plans for each project, including key milestones, impacts and risks."

In terms of the Council and the CCGs demonstrating a track record of the delivery of integrated health and social care services, for example our Rapid Response and Assessment Service and Joint Reablement Team, the following points are relevant.

For example, in the Introduction and Executive Summary on page 5
"In relation to the delivery of integrated care and health services, we have established highly effective joint working arrangements with health partners in relation to the delivery of Rapid Response and Assessment Services (RRAS) and Joint Re-ablement (JRT) delivering services jointly through a combined budget of £1.75m. Both performance levels against targets and service user feedback demonstrate a solid base from which to extend integrated working."

And on page 9
"The RRAS is a joint service between social care and NELFT to provide a rapid response and assessment for people over 18 in crisis or pending crisis. The aim is to assess the situation and avoid where appropriate, unplanned emergency admissions to hospital and

residential care, redirecting to intermediate care in the right place, right time and by the right team. The service is also a support service for carers. 84% of people are seen within 1-2 hours of a referral being made. On average 200 referrals are received per month. 70% of referrals are seen once but there are some cases where people are seen numerous times as they enter further crisis. The majority of referrals are from GPs (18%). RRAS is also available to care homes.

And In the overview of scheme 2 – page 83
"As part of the scheme, we will continue to build on the successful integrated RRAS service. Our service is aimed at those individuals who we think are likely to reach crisis point within 72 hours and co-ordinates and redirects care to the appropriate intermediate care provider or service. The service has recently been evaluated and the recommendations from the evaluation will be considered as part of the work to be carried out during 15/16."

And in terms of the contingency arrangements in place should partnership working break down, .
Section 5) RISKS AND CONTINGENCY on page 40 notes:
"To deliver the vision in Thurrock's BCF plan, under the direction of the Health and Well-Being Board, the Council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which will determine the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment will be undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks."

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

Scheme Ref	Scheme Name	Amount £000s
1	Locality Service Integration	4,551
2	Frailty Model	4,379
3	Intermediate Care Review	5,036
4	Prevention and Early Intervention	1,965
5	Disabled Facilities Grant and Social Care Capital Grant	845
6	Care Act Implementation	522
7	Payment for Performance	722
		18,019

5) RISKS AND CONTINGENCY

a) Risk log - Top 10 Risks

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

The Risk Register for the Thurrock Better Care Fund provides an overview of the top 10 risks identified to date. It has been developed in conjunction with the Council's Corporate Risk Officer and the CCG's Head of Corporate Governance and agreed with key partners. The risks will be reviewed on a monthly basis by the relevant Project Group (S75 Governance; Whole System Redesign; Care Act; Engagement; Efficiency) with oversight provided by Thurrock's Health and Adult Social Care Transformation Programme Board on a bi-monthly basis.

A number of the services within the BCF Plan are currently operational, and risks already assessed and owned. In the case of new services or major variations to existing services, business cases will be developed by the Whole System Redesign Group to ensure that they are fully costed, outcomes clearly stated and risks fully assessed. Business plans will be agreed by both the Health and Wellbeing Board on the recommendation of the Integrated Commissioning Executive which is the partnership Board for the pooled fund. These plans will include robust programme plans for each project, including key milestones, impacts and risks.

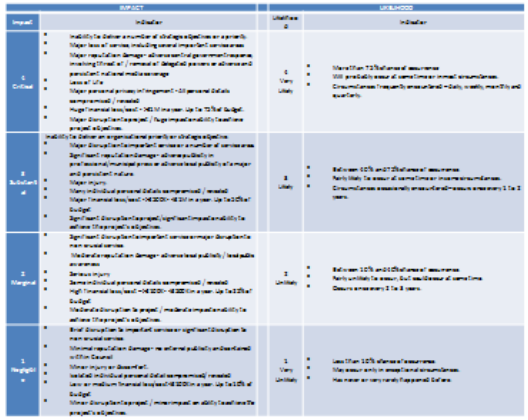
To deliver the vision in Thurrock's BCF plan, under the direction of the Health and Wellbeing Board, the Council and the CCG will be need to delegate a number of functions. A risk sharing arrangement has been agreed by the two parties and this is set out in the Section 75 agreement which will determine the administrative arrangements for the pooled fund and the basis for contracting for the provision of services commissioned by the fund. Additionally a specific risk assessment will be undertaken on the Section 75 agreement to cover: strategic, financial, reputation and political risks.

H&SC Transformation - Risk Register as at 26th November 2014

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
1	The failure to reduce demand for acute services by 3.5% places does not release funds (a value of £722k in 2015/16) for investment in community services/ results in failure to achieve performance target.	1. Initial mpact of each BCF scheme has been assessed. 2. Metrics for monitoring performance of each service are being developed together with reporting arrangements.	4	3	12	1. Close liaison with acute providers on performance against QIPP Plans. 2. Co-ordinated action across the whole system to secure investment in out of hospital services and reduce demands on emergency admissions. 3. Arrangements for remedial action agreed if required.	9	April 2015	Head of Integrated Commissioning Thurrock CCG
2	Changes to eligibility criteria, introduction of care accounts, assessment of self funders will all bring new challenges for IT, the workforce, finance and information and advice services, communications and housing.	Care Act Project Group meeting monthly to assess impact of guidance and to determine how risks should be managed.	3	3	9	1. A change programme with appropriate governance, resources (both people and financial) to implement the Care Act reforms and to monitor impacts on service quality and user satisfaction, and all with multiple interfaces with Better Care Fund initiatives.	6	April 2015	Director of Adults Heath and Commissioning
3	Difficulties in sharing of patient / service user level data may frustrate commissioning plans or performance and financial management.	1. Initial meeting with BB CCG Head of Information Governance to agree strategy. 2. Close links with Southend Pioneer maintained	2	3	6	1. An Information Governance strategy for commissioning and providing integrated care, using the NHS number and with the required technical solutions is required. However, there is a clear dependence on legislation and regulatory changes before this can be achieved.	4	On-going	Service Manager (Performance, Quality & Information)
4	The changes required for the configuration of practices my make it difficult to engage GPs in integrated care programmes.	1. Strong early engagement of GP practices and timely implementation of the Primary Care strategy to involve GPs in change, and to ensure a common understanding of risks,	2	2	4	1. Close Liaison with NHS England Essex Area Team regarding cluster arrangements	4	On-going	Acting (Interim) Accountable Officer Thurrock

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
		opportunities and incentives.							
5	Uncertainty about the changing offer from ASC and Health may result in or late or low take up of community services, and a failure of the system to prevent crisis or intervene in a timely way.	1. Initial scoping of comms plan completed. 2. Dependency on DH/NHS England comms noted and detailed plans awaited	2	2	4	1. Strong campaigns to engage citizens and professionals across the system in the plans for integrated care, and reviews of the effectiveness of those campaigns. 2. A joint formal CCG, Council and Provider launch for Better Care Fund in Thurrock to initiate this campaign.	4	Januar y 2015	Manager Corporate Communicati ons
6	Implementation and operational costs for BCF and Care Act may exceed budget plans.	1. Integrated Commissioning Executive established to monitor performance of the pooled fund. 2. Financial analysis of the Care Act changes completed.	2	2	4	1. Financial contingency plan to estimate and alleviate cost pressures that may arise during implementation or benefits realisation.	4	April 2015	1. Pooled Fund Manager 2. Interim Customer Finance Team Manager
7	Change may take longer or may be more difficult to achieve if a provider faced significant operational difference in neighbouring CCG areas.	1. Links made to Essex BCF Technical Group regarding commissioning intentions and procurement plans	2	2	4	1. Liaison with B&B, CCG and ECC about the impact of our respective emerging commissioning plans to agree common principles, to identify variances and, where necessary, plan contingencies.		On-going	Directorate Strategy Officer, Adults Health and Commissioni ng
8	NHS provider may experience difficulties in delivering QIPP plan efficiencies or face unexpected costs in delivering integrated services.	1. Agreement for joint Council CCG monitoring of contract performance to be in place from April 2015. 2. Scorecard for monitoring performance against pooled fund tagerts being developed	2	2	4	Regular oversight of performance by Integrated Commissioning Executive	4	April 2015	Head of Integrated Commissioni ng Thurrock CCG/ Service Manager Contracts & Commissioni ng

Ref	Risk Heading & Description	Summary of Existing Actions (including dates implemented)	Impact Score	Likeli-hood Score	Resid-ual Rating	Summary of Further Action (including implementation dates)	Target Rating	Target Date	Owner / Lead
9	Public engagement related to adopting healthier life styles, developing greater community resilience, and the importance of accessing service in the community take longer to gain traction.	1. Linkages between Stronger Together programme maintained. 2. Link to healthy lifestyles campaigns (linked to DH NHS England campaigns) scoped.	2	2	4	1. Campaign to promote community solutions to be planned	4	Januar y 2015	Community Development and Equalities Manager
10	The impact, risks and benefits of commissioning integrated health and social care are not sufficiently understood.	1. Initial research and impact modelling of the benefits of integration undertaken. 2. BCF Plan schemes amended to highlight benefits where these can be quantified	2	2	4	1. Further impact assessment of all commissioning plans to be undertaken using: • A common assessment tool • A joint sign off process • An agreed review period • A joint service restriction policy	2	April 2015	Head of Integrated Commissioni ng Thurrock CCG/ Service Manager Contracts & Commissioni ng



b) Contingency plan and risk sharing

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

The total value of the Better Care Fund in Thurrock is £18,019k and the amount of the Better Care Fund described as 'at risk' is the performance element of £722k.

The Council and CCG, working with its providers BTUH, NELFT and SEPT, have agreed to assume strategic responsibility for the whole health and social care system economy. They accept collective responsibility for overspends, working together, and with providers, to pre-empt or minimise their occurrence. (The governance diagram on page 35 shows the relationship between the various interests in the whole system, and the part played by the Integrated Commissioning Executive – the executive arm of the wider Transformation Programme Board, which reports to the Health and Wellbeing Board.)

The Health and Wellbeing Board has specifically considered the risk of financial underperformance against the total emergency admissions target set locally. The Board has been involved in the arrangements for managing the pooled fund section 75 agreement which includes consideration of how financial underperformance will be managed. This includes the £722k payment for performance element linked to a 3.5% reduction in emergency admissions. Following the decision to create an Integrated Commissioning Executive (as part of the Transformation Programme Board - which has already been established) it can be demonstrated that the Boards have close involvement with the management of the risk of financial underperformance. Section 75 performance reports for each BCF scheme will be provided to Integrated Commissioning Executive and reported to the Health and Wellbeing Board from April 2015.

The Health and Wellbeing Board has agreed that the risk of underperformance is to be managed by delaying expenditure commitments for a number of services until the payment for performance target is achieved, and payment of the target sum can be released into the pooled fund by NHS Thurrock CCG. When the target is achieved It is anticipated that the payment for performance element of the fund will make a contribution to the protection of adult social care.

The issue of treatment of overspends in the BCF schemes has also been agreed and the Health and Well-being Board have proposed that the Better Care Fund for 2015/16 should be fixed at the agreed value of the Pooled Fund. The effect of this is that any expenditure over and above the value of the fund will fall to the Council or the CGG depending on whether the expenditure is incurred on the social care functions or health care related functions. For the avoidance of doubt, the use of block contracts for the BCF schemes in 2015/16 means that there is no new financial risk for the commissioners – with the only risk relating to the achievement of the 3.5% reduction in emergency admissions performance target (£722k). Accordingly, the focus of the Pooled Fund will be on improving service delivery and exploring with providers, including the Acute service providers, how investment in future years can be managed to provide more treatment closer to home/ away from hospital settings.

The Section 75 Agreement will stipulate that Financial Contributions in each Financial Year, excluding NHS acute Payment 4 performance financial contributions, will be paid to the fund monthly[1] in advance receivable on the first day of the month commencing 1st

April 2015. The NHS acute Payment 4 Performance financial contributions shall be paid to the fund quarterly in arrears receivable on 1st day of the quarter commencing 1st July in accordance with the release of payment for performance to non-acute NHS commissioning as set out in the National Guidance.

In terms of management arrangements, the Section 75 agreement will specify that, if during the course of monthly monitoring of activity and expenditure, a risk of overspend is identified in any of the Schemes, the Pooled Fund Manager will require a Remedial Action Plan to be produced by the provider and this will be presented to the Integrated Commissioning Executive within 21 days. The Integrated Commissioning Executive, where appropriate in consultation with the Health and Wellbeing Board will then consider whether it needs to agree the action plan in order to reduce expenditure.

[1] Revised, from quarterly to monthly, because CCGs funded monthly by DH.

6) ALIGNMENT

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

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

Building Positive Futures

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

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

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

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

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

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

Local Area Coordination

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

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

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

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

LAC was originally piloted in three learning sites. Due to the success of the pilots, the initiative has been expanded and is now Borough-wide.

We have just completed our 14 Month Evaluation which reflects some promising results to build on:

300 people have been introduced to the LACs
Of the people currently receiving support:

- 12% have learning disabilities,
- 27% have mental health issues,
- 31% are older people,
- 15% have physical disabilities,
- 4% have sensory impairments and
- 11% "other"

To date introductions are from a wide variety of sources including:

- The Council's initial contact service - Community Solutions

- Social workers and support planners across all services including mental health teams
- Third Sector organisations
- Multi-disciplinary meetings (MDT's) based around GP surgeries
- The Mayor of Thurrock Council and ward Councillors
- Direct from the community and meeting people at Community Events
- Community Hubs
- Housing
- Police and Fire Services

Analysis of people supported by the LACs shows significant savings to both health, social care (as well as other statutory services including fire). Examples are included here:

Costs associated with depression: Over 75 people introduced to LAC have identified depression as one of the main challenges they face. A very high percentage have reported an improvement in their depression and none have been readmitted since the LAC has been introduced. However, two people have needed the ongoing expertise of Mental Health services
If 75 people have seen an improvement in their depression and avoided or delayed the need for mental health services this is a potential saving of: £71,700

Mental Health community provision: Individuals and professionals have fed back that the need for mental health professionals has reduced and this includes regular weekly support groups where community alternatives have been found.
There are approximately 6 cases where people previously attended a support group. This will give a saving of: £101k pa (based on 6 people attending 2 hr session per week)

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

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

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

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

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

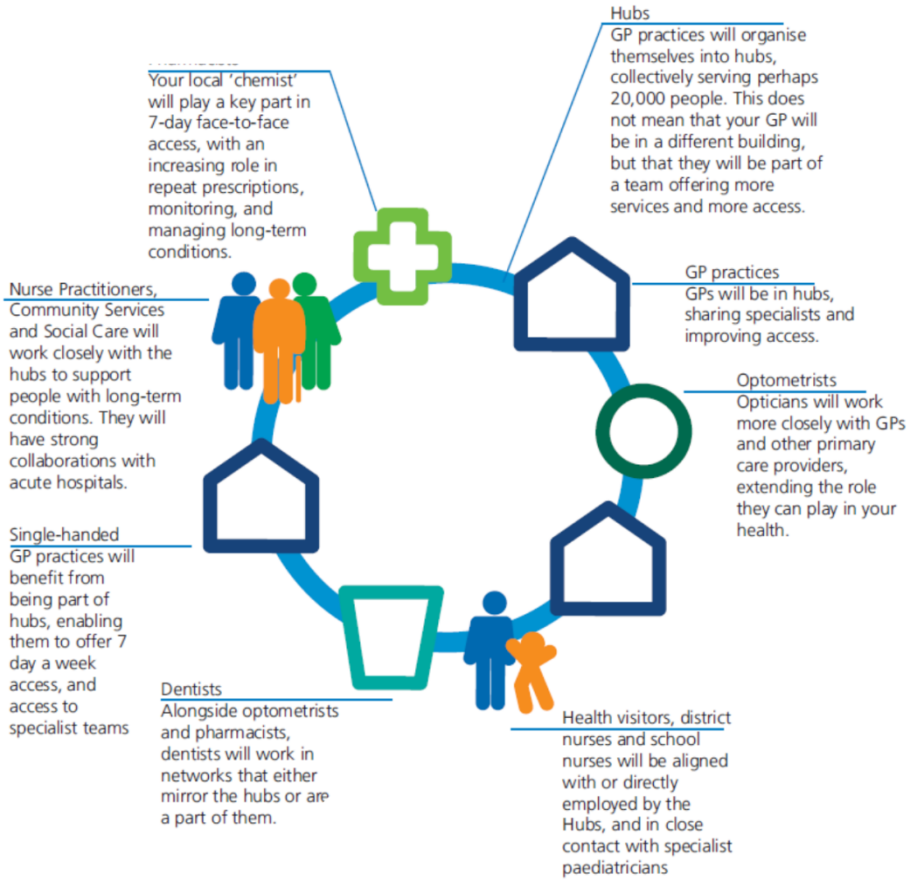
'People with dementia stay far longer in hospital than other people admitted for the same

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

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

Delivering Co-ordinated Care

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

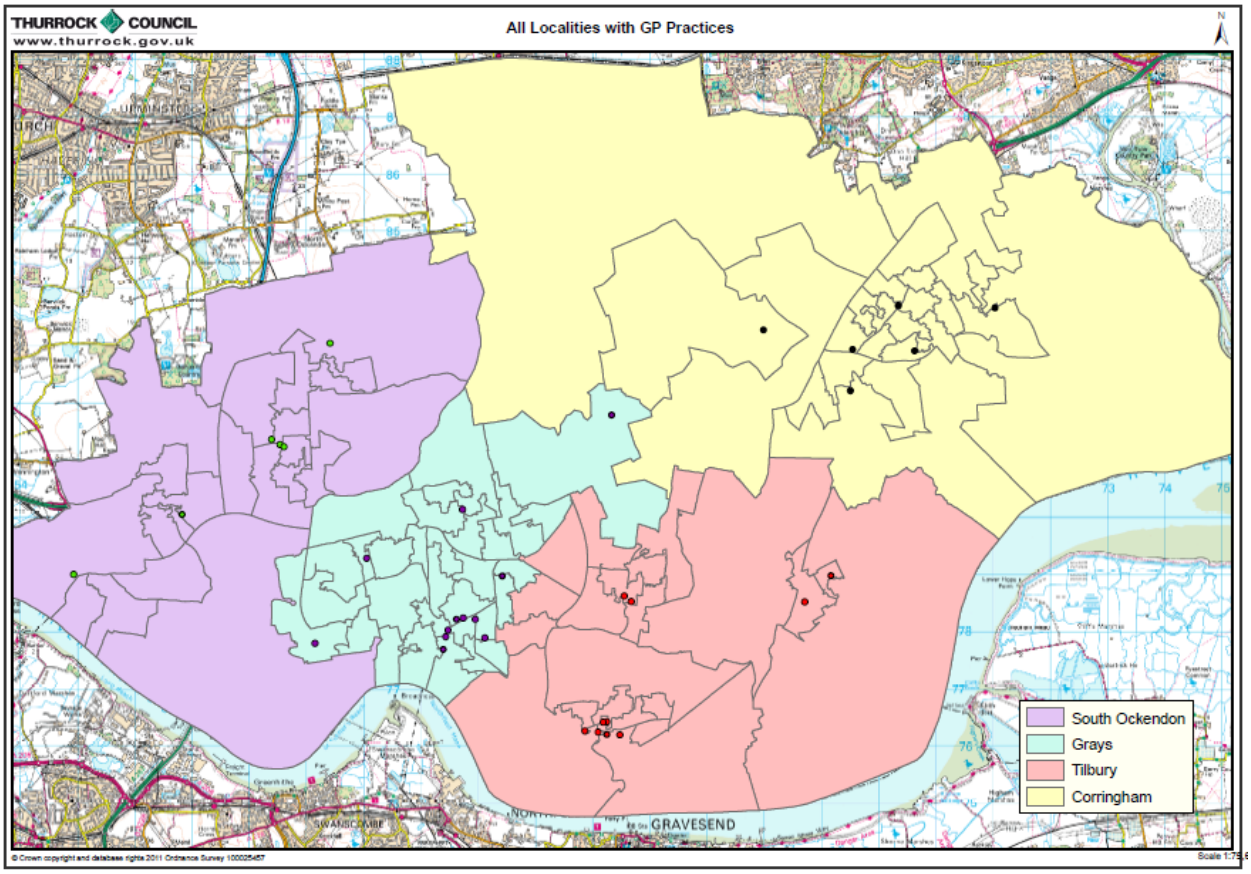


A system-wide Operational Resilience and Capacity Plan is in place. Whilst these focus on short term initiatives to manage day to day pressures in the system, the plans enabled by the BCF are seen as the longer term solution to managing fluctuations and growing demand across the unplanned care system.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

The monies identified through the Call to Action programme (£5 per head) and the CCG endorsement of the NHS England Direct Enhanced Service for Avoiding Admissions, have been aligned to the longer term integrated commissioning and delivery

programmes. For example, developing integrated health and social care co-ordination for high risk patients supporting the role of the Accountable GP for the 75s and over age group.

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



This map indicates the proposed localities for the integrated service model outlined within BCF Scheme 1.

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

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

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

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

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

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

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

The vision for integration is set out in the CCG 5 year strategy and 2 year operating plan. Therefore, the BCF is an important step in a pre-existing journey towards integration. Primary care clinicians have been at the heart of this journey. Over the last 12 months we have engaged with primary care on a number of different occasions including:

- In December 2013, a workshop was held with GPs and the local authority to set out the vision for integration.
- Include work at Clinical Executive Group (which is the key engagement route for all GP practices in Thurrock) on developing locality hubs
- In September and November 2014, presentation at the Finance and performance committee
- In December 2014, BCF presentation at Board seminar

The comments from primary care re-enforced the sense of a shared vision for Thurrock based on the understanding that we are ‘stronger together’. Colleagues articulated the

need to deliver value for money by working smarter, removing hierarchy [where this impedes decision making], encouraging active citizenship, focusing on prevention and rehabilitation and sharing responsibility/risk.

We have recently undertaken an extensive engagement process regarding primary care access and, in particular, the Grays Walk In Centre. A theme from this engagement was the need to improve equitable access across Thurrock, and the limitations of one walk in centre for the whole of Thurrock. This has further confirmed the support for improved access based on a locality model.

The CCG has been successful in bidding for primary care transformation funding. The funding has been awarded to provide one session: 9am – 12.30pm, on a Saturday and a Sunday in four "hubs" in Thurrock – which will be aligned to our locality models. The hubs will be providing urgent care services for patients through one GP, one Practice Nurse and one receptionist in each of the four services.

The move to community hubs will also be the focus for our upcoming application for the Prime Minister Challenge Fund. This will build of the successful primary care transformation bid so that we can continue to extend primary care access based on the locality model described in scheme 1. If successful the bid will allow us to open up additional sessions in each locality.

A team has now been established to oversee the implementation of this arrangement, with the first hub planned for opening in mid-January. This team includes four clinical leads, one for each of the localities as follows:

Dr Anil Kallil: Grays Locality
Dr Bhatt: Tilbury Locality
Dr Verghes: South Ockendon Locality
Dr Deshpande: Stanford-le-Hope Locality

This team will be working with the General Practice community in Thurrock to identify suitable premises for the hubs to operate from, as well as establishing the rota for weekend working. We will be keeping Practices up to date when this programme commences, through a dedicated page on the CCG intranet, email and our regular engagement forums, including CEG.

The CCG is committed to improving the capacity and quality of Primary Care in Thurrock. We are currently supporting the development of a local Primary Care Strategy. The key issues we are seeking to address in the primary care strategy are an ageing workforce, poor provision of GPs in comparison to the population and growing population.
The development of primary care firmly aligns with the Better Care Fund. The CCG is working with the Area Team on the co-commissioning agenda but has not expressed an initial interest in co-commissioning services with NHS England.

The whole system redesign group and the primary care transformation group will continue to work seamlessly to deliver the vision for integration set out within our strategy and the BCF.

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

Reducing Overall Demand

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

Fig 1 – Adult Social Care Residential Home Placement Numbers

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

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

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

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

- Joint commissioning of integrated health, public health, social care and housing services;
- A mixed economy of locally run care services; and
- Social prescribing – linking people up to activities in the community that they might benefit from (there is increasing evidence to support the use of social interventions for people with mild to moderate depression and anxiety, and people who are frequent attendees in primary care).

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

Shifting Resource

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

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

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

Thurrock applies the eligibility criteria of substantial and critical – this will remain as a result of the Care Act's implementation from 2015 and the National Minimum Eligibility

Standard.

Through the BCF, the local authority and the CCG have identified investments that will contribute towards the protection of adult social care. These are contained within the schemes as shown below:

Scheme	**Contribution £000**
2	2,217
3	240
4	72
Total	**2,529**

All of this funding is in addition to the mandated allocation for the Care Act of £ 522k.

In addition, we are taking a number of practical steps to be able to maintain eligibility levels which includes:

- Our approach to prevention and early intervention as expressed within Scheme 4 – we are expanding our community-based prevention and early intervention approach as part of the BCF to ensure that we reduce the need for care and support. We will have full Borough coverage of our Local Area Coordination initiative which is key to this approach
- Through the application of the Care Act (scheme 5) we are enhancing our information and advice offer to better signpost individuals and their carers to support; expanding our provision of advocacy and reaching out to self-funders who will be our responsibility from April 2016.
- We have restructured our social care fieldwork teams so that they align with community health services and around the four GP clusters to ensure a multi-agency approach that identifies those people at risk of crisis at the earliest opportunity and navigates those individuals to receive an appropriate service (scheme 1)
- We have and are enhancing our intermediate care offer to ensure that we offer a menu of options that assists with enabling individuals to stay out of hospital or reables that individual to live as independently as possible within their own home (scheme 3)
- We are working towards an integrated frailty model that will identify people at the earliest opportunity and ensure that they enter the right part of an integrated model (scheme 2).

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

We have identified £522k as part of our approach to implement and deliver the Care Act. Delivery of the Care Act will also help to support our ambition to protect social care services – e.g. through a focus on reducing, preventing and delaying needs.

We are taking a whole-system approach to the protection of adult social care services and have identified a figure of £2 million. We aim to achieve this in a number of ways that include:

- Review of existing schemes;
- Reallocation of resource;
- Contribution of the 'pay for performance' element of the BCF – whilst acknowledging that the amount to be achieved is an unknown quantity.

With regards to the pay for performance monies, we see any money secured as supporting efficiencies and transformation across the system, and not solely the protection of social care services.

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

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

Key elements are as follows:

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

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

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

Within the BCF, we have identified £178k for investment into carers' support. We are keen to ensure that the provision of carers support is integrated within our overarching service model and therefore have included the development of our carer's services into BCF 2. Frailty Model. The key elements of this part of the programme are the identification and recording of carers within a central list, improving the provision of carers support within generic services e.g. COPD specialist nursing providing carer support through education and telephone support, commissioning of specific carer support interventions e.g. carers breaks, support groups. Additionally, we will be using the resource available to support the sitting service for older people currently provided by Adult Social Care.

Through the BCF, the Council and CCG are keen to ensure that we use the available evidence to commission the right range of support packages available. The Systematic Review of Interventions for Carers in the UK study (Victor, 2009) identified the following interventions as having a significant impact on wellbeing of the carer and the individual cared for;

- Ensuring that the quality of carer assessments is as important as the numbers assessed
- Provision of carer support groups that are both specific to a presenting condition and more generic

- Improving the level of education to carers on the specific conditions of those they care for
- Provision of carers breaks

Ensuring providers consider the needs of less assertive carers and put in place proactive approaches to supporting those carers.

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

We are taking a whole-system approach to the protection of adult social care services and have identified a figure of £2 million.

b) 7 day services to support discharge

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

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

We have already made significant progress towards this vision. For example:

- Rapid Response and Assessment Service (RRAS) – extended weekday hours (9am – 5pm);
- One Response Service (End of Life SPOR model) – 24 hours, 7 days a week
- Thurrock Social Workers – 7 day hospital cover including on-site provision 6 days per week;
- Intermediate Care (health and social care) – provision for admission and discharge on Saturdays and Sundays;
- Nursing Homes – premium payments for homes that can admit at short notice/weekends; and
- The Right Place, right Time Programme (RPRT) at Basildon Hospital (BTUH) focused on 7-day services.

The Whole System Redesign Group will drive the next steps towards further integrated 7 day a week working. This forum is a multi-agency group including health commissioners, social care commissioners, mental health service providers, community service providers, local authority service managers and patient and service user representative groups. The Group has organised a system workshop for early January to consolidate the work to date and build consensus on the next steps. This is an important milestone for the Group so that we can engage with wider stakeholders to build consensus. The collaborative approach will ensure that we are able to work together to manage concerns and risks.

The timing of the workshop is important because we shall reflect the principles of integrated 7 day working within the upcoming contract negotiation round. This will be a key component of Service Development and Improvement Plans (SDIP) over the next two years and beyond. Health and Social Care commissioners across Thurrock will expect providers to ensure the same standards of services are provided across seven days. We will be commissioning for outcomes with the expectations of the same level of interventions being in place at weekends as during the week to prevent unnecessary

admissions and support discharge. We are fortunate that the whole system is committed to this direction of travel and will continue to collaborate on the development of these action plans.

Clearly, this vision is aligned with the NHS Outcomes Framework, two year operational plan, five year strategy and the Primary Care Strategy (see primary care section). This will be critical to meeting the ambition of delivering 7-day services. Over the next five years, work will continue to explore innovative solutions – including optimising primary care provision, pharmacists, optometrists and dentists to support 7-day services based on the community hub model championed in Thurrock'.

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

In Thurrock, the NHS number is already used as the primary identifier for correspondence across health systems.

In adult social care strong progress has been made in adopting this practice and improving the proportion of social care clients with their NHS number matched and recorded on the adult social care LAS system. Adult social care have carried out a number of data matching exercises and utilised the national number matching service to support this. This has realised a match of some 85% to date -, this foundation gives us confidence as we aim towards 100% of clients being identified in this way.

In addition, the council, together with health partners have signed up to be a second wave follower on the national Child Protection-Information Sharing (CP-IS) project. The supplier of the children's social care IT system is an approved provider for the project. To support the project, children's social care are also working to capture NHS number within the system. We anticipate going live with this project in summer 2015. The learning from this process will be adopted into our approach and strategy for adults to ensure consistency.

Thurrock Council and Thurrock CCG are developing an IM&T Strategy that will set out the future direction of travel for information, governance and systems development. This is a key focus in the next financial year. The strategy will include a specific focus on the following:

- Consent models
- Data sharing and information governance
- Recording management
- Risk stratification
- Systems development and architecture

The strategy will underpin and support the delivery of key priorities and schemes within the BCF including the extension of MDT, single care coordinator and single assessment.

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

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

- System One is widely used across health services and provides a strong foundation for future development.

- Social Care uses an IT system (LAS) that provides an electronic record across all social care services. It also allows health partners and staff to view information, contribute to information and to support the provision of support and services e.g. joint re-ablement and RRAS teams. The system also enables data and information to be shared with and interfaced with other systems where required. The system and developments meet requirements outlined in the IG Toolkit and are fully compliant with an open set of APIs.

- Social care are working with the mental health trust (SEPT) to ensure the interface and sharing of appropriate information between the LAS and eCPA system. Progress is being made, though work is ongoing. This will significantly improve the productivity of staff and reduce the requirement for dual entry to systems and dual recording of care information. In addition, this will also deliver the added benefit of improved performance and financial monitoring.

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

- In doing so we are engaging with a neighbouring area – Southend. Southend are a Pioneer for BCF and are implementing the same system. The Department of Health have assigned an information governance resource to support Southend with the development of the system and Thurrock will work with both to obtain assurance in respect of our approach.

- In preparation for the implementation of this system (Care and Healthtrak) Thurrock has undertaken a number of a number of preliminary exercises have including:
  - Consent to share sought from all known Thurrock adult social care clients;
  - Changes to operational policies to ensure consent is sought upon first contact with adult social care clients; with confirmation of decision sought annually;
  - Review and alignment of social care information architecture for alignment to acute health data;
  - Thurrock LA and CCG have created a suite of reporting templates with Pi Benchmark to realise a joint risk-stratification tool once Information Governance allows.

Thurrock actively awaits the results from the Southend Pioneer project on how they

have utilised Health & CareTrak; within the current limitations of Information Governance. We are committed to adopting an approach and practice that meets the approach and recommendations that may flow from this.

- Thurrock has recently reviewed options to improve the functionality of its systems to support service user access to view information and to undertake elements of self-assessment, planning and commissioning via an online platform.

The development of an IM&T Strategy (as outlined above) will provide the future basis upon which systems development, procurement, architecture will be based.

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

Thurrock is fully committed to ensuring compliance with all information governance, confidentiality and data protection requirements.

Thurrock is compliant to level 2 of the Information Governance Toolkit for the period April 2014 to 31 March 2015 and meets all requirements in respect of existing practice and operation (see follows). There are no specific risks requiring mitigation in year.

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

Internally within the council, a project group leads work on the IG Toolkit. This includes adult social care, children's social care, public health, IT and information governance.

The priority areas to be addressed for submission in the 2015-16 IG Toolkit (by 31 March 2015) and forming the work plan for this Group relate to the following areas:

- Evidencing PSN Certificate of compliance;
- Formalisation of Information Management and Governance Strategy;
- Reviews of staff compliance with IG guidelines as audit trail
- Information Assett management;Details on the role of Caldicott Guardian, review of Caldicott Issues log and evidence to support;

Social Care has amended its service user information governance statement to incorporate sharing of information with health partners on an electronic basis in support of the preparatory work for the implementation of Care and Healthtrak. As highlighted above, we have engaged with Southend (as a Pioneer) to seek and share the DH IG advice and recommendations that emerge in respect of IG.
The development of our data sharing arrangements will be in keeping with the Data Protection Act 1998, particularly principle 7 (security measures taken to protect data), and Article 8 of the European Convention on Human Rights (the right to a private an family life).

The NHS Standard Contract and Community Contract includes all required provisions.

Initial contracting arrangements for BCF will see Thurrock LA become a commissioning associate to the CCG's existing NHS Standard Community Contract arrangements for all services part or fully commissioned from healthcare *(public or private sector).* We anticipate the portfolio of non-healthcare services will gradually transfer over to the NHS Standard Community Contract as we see the development of integrated health and social care services; thus recognising the need for heightened governance arrangements and processes.

The Director for Adults, Health and Commissioning is the Caldicott Guardian and oversees governance for adult social care. The Director for Children's Services is the Caldicott Guardian and oversees governance in respect of children's social care. Together, these roles ensure compliance with the principles and requirements supported by the Information Manager (Council).

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

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

Thurrock is in the process of developing a joint-risk stratification strategy to identify when and how patients should be assessed; with the identification of associated benefits for each cohort of patients. We anticipate the risk-stratification will take into account: social and physiological indicators: e.g. a recent local review of our district general hospital admissions identified a relationship between inappropriate hospital attendance and admissions with those patients living alone.

A precursor to this initiative has been the development of:

- **Primary Care MDT reviews**; with health and social care parties identifying patients for review. Patients within this programme are largely those already known to the system i.e. under active review by GP, community nursing or social care.

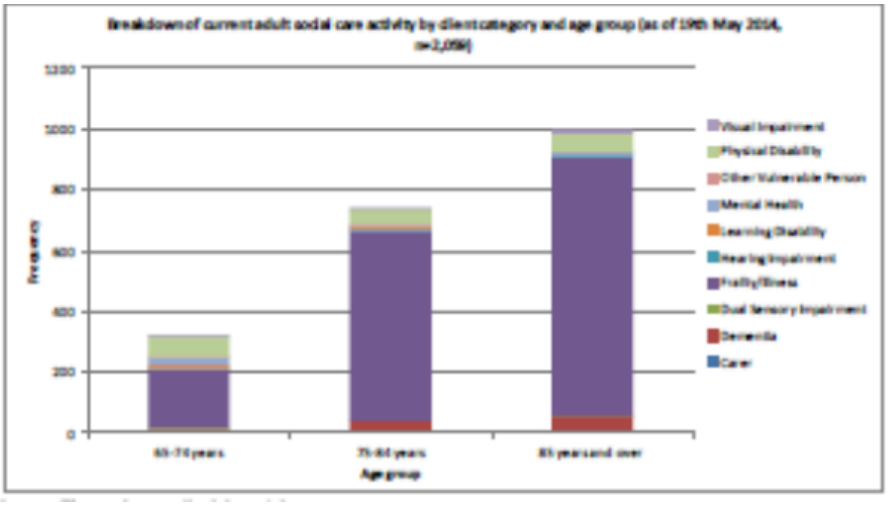
- **Unplanned Care Directly Enhanced Service:** Within 2014/15 practices in Thurrock have carried out risk-stratification of their registered population; identifying those at most risk of a non-elective admission into hospital. This has seen 2% of the population receiving joint integrated care plans c.3,400 patients; with a proportion of these being reviewed within the Primary Care MDT reviews.

- **End of Life Register & GSF:** Over and above those patients identified for Primary Care MDT reviews and this year's Unplanned Care DES, all practices in Thurrock have signed-up to undertaking GSF reviews. In partnership with this we have incentivised our community provider *(through CQUINs)* to aid the further development of the existing End of Life register. We anticipate that with these measures Thurrock's End of Life register should be nearing the 1% national benchmark by 2017; with integrated care-plans, anticipatory prescribing and key contacts.

- **Long Term Conditions:** Work continues to improve the long-term condition registers and the pro-active management of conditions e.g. introduction of patient passports for COPD.

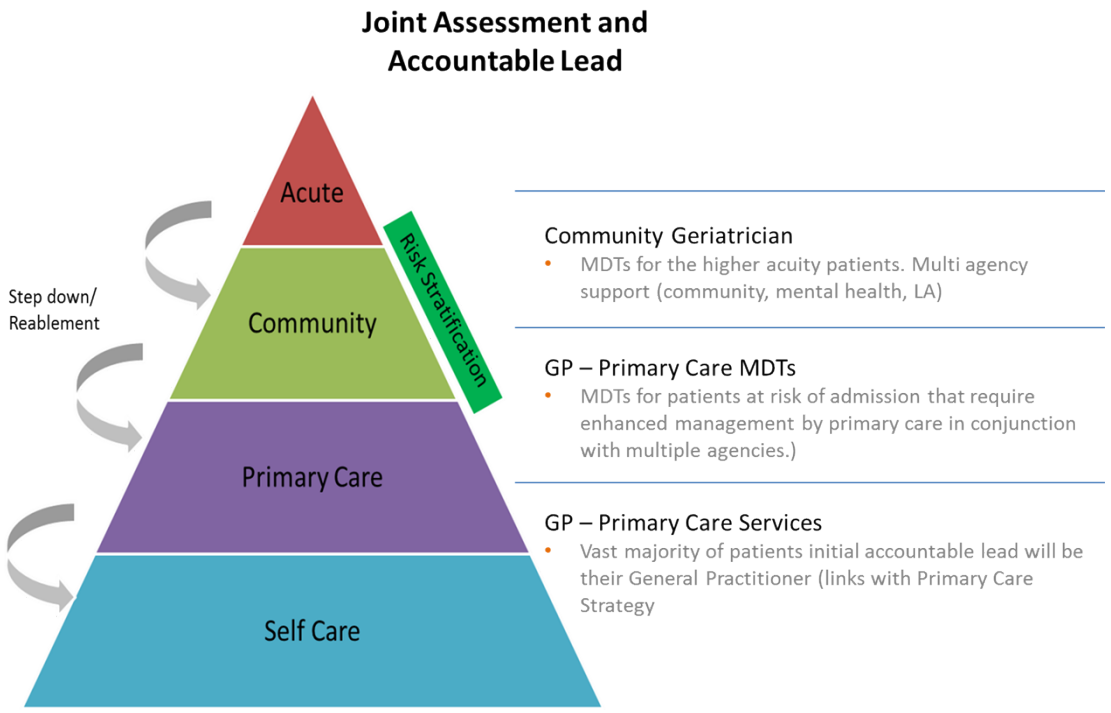
Patients identified within the above work-streams are recorded on SystmOne *(through use of Special Patient Notes)*; to inform services coming in contact with each patient e.g. NHS 111, and thereby ensure care is managed accordingly. Moving forward we will need to ensure patients identified as being at risk of admission due to their social indicators are flagged in a similar fashion to inform their care package including support measures *(where required).*

Adult Social Care Analysis *(p32 HNA)*



Thurrock's position in terms of risk stratification and risk segmentation and future approach is included earlier in this document (refer to Case for Change and Plan of Action)

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



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

Actions and Milestones

Our actions and milestones for joint assessment and accountable lead are as follows:

Work Programme Initiative	**Start Date**	**End Date**
Primary Care Multi-Disciplinary Teams *(H&SC)*	Apr 2012	On-going
End of Life GSF Reviews *(H&SC)*	Sept 2014	On-going
Health & Caretrak Development & Implementation: Risk Stratification of patients *(H&SC)*	Apr 2012	On-going
Long Term Conditions *(LTC)* dashboard Development: LTC management in practice inc. anticipated/reported prevalence, utilisation of services, QOF.	Nov 2014	Mar 2015
Development of improved LTC pathways to address inequalities across the local health economy *(inc. variation in practice/pt outcomes)*	Mar 2015	Sept 2015
Development of locality integrated service model *(H&SC)*	Jun 2014	Jan 2015
Implementation of the four integrated service areas *(H&SC)*	Apr 2015	On-going
Central case management *(by each four locality)* of patients identified as having a high risk-scoring including alignment of Care Homes to each area.	Apr 2015	On-going
Review & development of co-morbidity clinics *(H)*	Dec 2014	Mar 2015

Implementation of the co-morbidity clinical model *(H)*	Sept 2015	On-going
Review & Utilisation of accessibility mapping software to inform future service development and commissioning arrangements *(rurality and accessibility to services encompassing transport).*	Jan 2015	Apr 2015

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

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

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

We expect that by March 2015, at least 70% of the expected 3,100-3,400 patients requiring a joint care plan will have a plan in place.

8) ENGAGEMENT

a) Patient, service user and public engagement

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

As part of the Council's and CCG's Health and Social Care Transformation Programme, we have established an Engagement Group. The Group is comprised of key representatives of the voluntary and community sector, including Thurrock Healthwatch. The Group's purpose is to advise on engagement with users of services, carers, and the general public. The representatives on the Group are able to facilitate engagement with patients and service users due to their reach with groups and individuals across Thurrock. This includes seldom heard from groups within Thurrock's community. Engagement takes place through a variety of means, e.g. sign posting to specific individuals or groups, bespoke events, or utilising existing meetings and events – e.g. via Thurrock's Commissioning Reference Group bi-monthly meetings. The Group has developed an Engagement Plan, and has also developed a process for involving users of services, carers and the public in commissioning and service development (signed off by the Health and Wellbeing Board at its July 2014 meeting).

Extracts from the Health and Social Care Engagement Plan

> Thurrock Council (the Council) and Thurrock Clinical Commissioning Group (the CCG) are committed to engaging and involving citizens and community groups in developing a vision of what integration will look like, and the principles that will underpin that vision.
>
> Together with Thurrock Council for Voluntary Services (the VCS), Thurrock Healthwatch, Thurrock Commissioning Reference Group (the CRG) and Thurrock

Coalition we have already developed the high level principles that will frame our joint vision. These are:

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

In pursuing our vision, Thurrock CVS, Thurrock Healthwatch, Thurrock CRG and Thurrock Coalition have also agreed to work with Thurrock Council and the CCG in a process by which:

a) citizens will be involved, at the earliest stage, in conversations to refine and confirm the vision and the high level principles for integrated health and social care services, and

b) the manner in which the principles should be applied across the whole health and social care system to ensure better care for the people of Thurrock will be jointly determined - with the initial focus being the health and wellbeing of older adults.

This Plan will be delivered in agreement with the principles of the Thurrock Joint Compact 2012 and the Thurrock Community Engagement Toolkit

To enable citizens and community groups to participate fully in the co-production process, we recognise that clear and accessible information about the challenges and choices facing them must be made available in a timely manner.

From the outset engagement will be::

- Honest and transparent about the scope of change, and the enablers and constraints in the change process;
- On terms, in places and at times which suit citizens and communities;
- Two way, with information being imparted and received, and delivered in a manner which encourages questions and constructive criticism; and
- Responsive to what we hear, where ever possible giving an account of what will be done with what we learn and the likely outcomes.

That way that the Health and Social Care Transformation Programme communicates will

- demonstrate integrity and public accountability;
- be clear and easy to understand;
- Provide feedback where people have engaged using the ‘you said, we did’ methodology; and
- be appropriately targeted to the communication needs of our various audiences.

Governance arrangements

This Communication and Engagement Plan forms part of the Programme Initiation Document for the Health and Social Care Transformation Programme Board. The arrangements for engaging citizens and communities will be overseen by the Health and Social Care Transformation Programme Board, reporting to the Health and Wellbeing Board.

The Health and Social Care Transformation Engagement Group is responsible for developing and overseeing the detailed programme of engagement activity. The Group's membership includes:

- Thurrock Healthwatch
- Thurrock Coalition
- Thurrock Commissioning Reference Group (CCG Lay Member for Public and Patient Involvement)
- Thurrock Council for Voluntary Services
- Thurrock CCG
- Thurrock Council

Components of the Engagement Plan include:

Information Exchange:

- A range of briefing sessions at public meetings such as the community fora
- A presence at community events
- Briefings with representative and special interest groups
- Specially convened listening events

In-depth soundings including:

- Focus groups – i.e. people with Long Term Conditions
- Individual interviews with experts by experience
- Joint Strategic Forum

Working groups:

- Citizen involvement in whole system reviews of care-pathways, commencing with the care-pathway for older people.

Locality based conversations:

- Building on the local presence of Community Fora, community organisers, local area coordinators and Asset Based Community Development - community builders.

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

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

Considerable community engagement has already taken place on some of the elements that are incorporated within and aligned to this plan – e.g. Local Area Coordination. An innovative recruitment process involving community representatives, designed by Thurrock CVS and the Thurrock Coalition has been used for all LAC appointments and is increasingly used for other social care appointments.

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

The success of engagement will be measured via the Engagement Group and its representatives, but in addition, Thurrock has chosen a service user satisfaction metric as part of its Better Care Fund metrics to measure the impact that service redesign has had on the quality of service provision. – '% of Adult Social Care Service Users who are satisfied with their services and support'.

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

i) NHS Foundation Trusts and NHS Trusts

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

Thurrock's Strategic Leadership Group has been in existence for a year and has already met a number of times. The focus of the Group is managing demand across the health and care system. An extract from the Group's Terms of Reference which shows focus and membership is shown below:

Membership of the Strategic Leadership Group includes:

- Thurrock Council – responsible for commissioning and providing adult and children's social care services
- Thurrock NHS Clinical Commissioning Group – responsible for commissioning a range of acute and community health care services
- North East London Foundation Trust (NELFT) which provides community services,
- South Essex Partnership Foundation Trust (SEPT) which provides mental health services,
- Basildon and Thurrock University Hospitals Foundation Trust (BTUH) which provides acute and secondary care services

In recognition of the important role, both now and in the future, of the voluntary and community sector, Thurrock CVS will be a member of the Group.

Remit of the Group:

- Receive and scrutinise national policy, best practice and independent investigation reports, as well as reports on the application of policies and performance locally, and agree at an early stage to jointly plan change to address any issues identified.
- Consider and advise on whether:
    - commissioning strategies reflect all elements of quality (experience, effectiveness, economy and safety) for service users and patients,
    - commissioned services ensure that the service user/patient sits at the heart of plans and decisions related to their care, and that services are being delivered in a high quality and safe manner.
- Advise on the effective management of risk for co-ordinated service delivery, market stability and sustainability, whether or not specific services are delivered jointly or not.
- Ensure a clear escalation process is in place to enable appropriate engagement of the relevant decisions makers within their organisations on any areas of concern related to the delivery of quality.
- Demonstrate clear commitment to the delivery of quality outcomes for the citizens of Thurrock, even where their interests cover a wider geographical area.

Commissioning intentions for 2015/16 have recently been sent to each of the main local NHS providers and detailed negotiations on the 2015/16 operational plans and contracts are currently taking place. This will include consideration of the delivery of QIPP plans, and their inter-relationship with the BCF Plan and the target reduction in emergency admissions. Provider risk management will be undertaken via contract negotiations and then through regular contract monitoring arrangements.

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

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

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

Both Health and social care providers were closely involved in the revisions to the Plan resubmitted on 28th November. They were also part of the impact assessment workshop that was provided by McKinsey as part of the support arranged by the BCF task force. Additionally, the further development of the Plan prior to re-submission was discussed and endorsed at Thurrock's Strategic Leadership Group meeting on the 27th November. This included senior executives from the key health providers (NELFT, SEPT, and BTUH) as well as the Council and CCG.

ii) primary care providers

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

A workshop took place with the CCG Board and Health and Wellbeing Board in December 2013 to develop the five principles that underpin health and social care transformation in Thurrock, and therefore Thurrock's Better Care Fund.

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

The Voluntary and Community Sector have and are being engaged through the Health and Social Care Transformation Programme – in particular through the Engagement Group. Members of the Voluntary and Community Sector are also members of key project groups:

- Care Act Implementation Project Group;
- Whole System Redesign Project Group;
- Health and Social Care Transformation Programme Board; and
- Thurrock Strategic Leadership Group (as described in ii above).

Please also note that Essex Area Team's deputy Chief Executive (Dawn Scrafield) has stated 'Thurrock is an interesting area as, based on my experience, they are one of the few areas that really are living the values of integration between Health and Social Care'.

c) Implications for acute providers

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

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

Basildon and Thurrock University Hospital NHS Foundation Trust seek to reduce the bed base they currently commit for unplanned care activity. The Trust recognise that the current numbers of beds are unsustainable and are not the optimal way to deliver care to patients. Through the implementation of the BCF schemes and resultant reduction in unplanned care admissions the Trust will be able to reduce their bed base or convert the beds to an alternative use.

The target for reducing total emergency admissions contained within Thurrock's BCF Plan has been set at 3.5%. Whilst this is an ambition, given the history of activity related to unplanned admissions, achieving a 3.5% reduction will provide Thurrock with a significant challenge.

Thurrock has established a Strategic Leadership Group with membership comprising of the main NHS providers, Thurrock Council, Thurrock CCG, Thurrock HealthWatch, and Thurrock Council for Voluntary Services. How the system can work together to achieve significant reduction in unplanned admissions is one of the main agenda items.

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

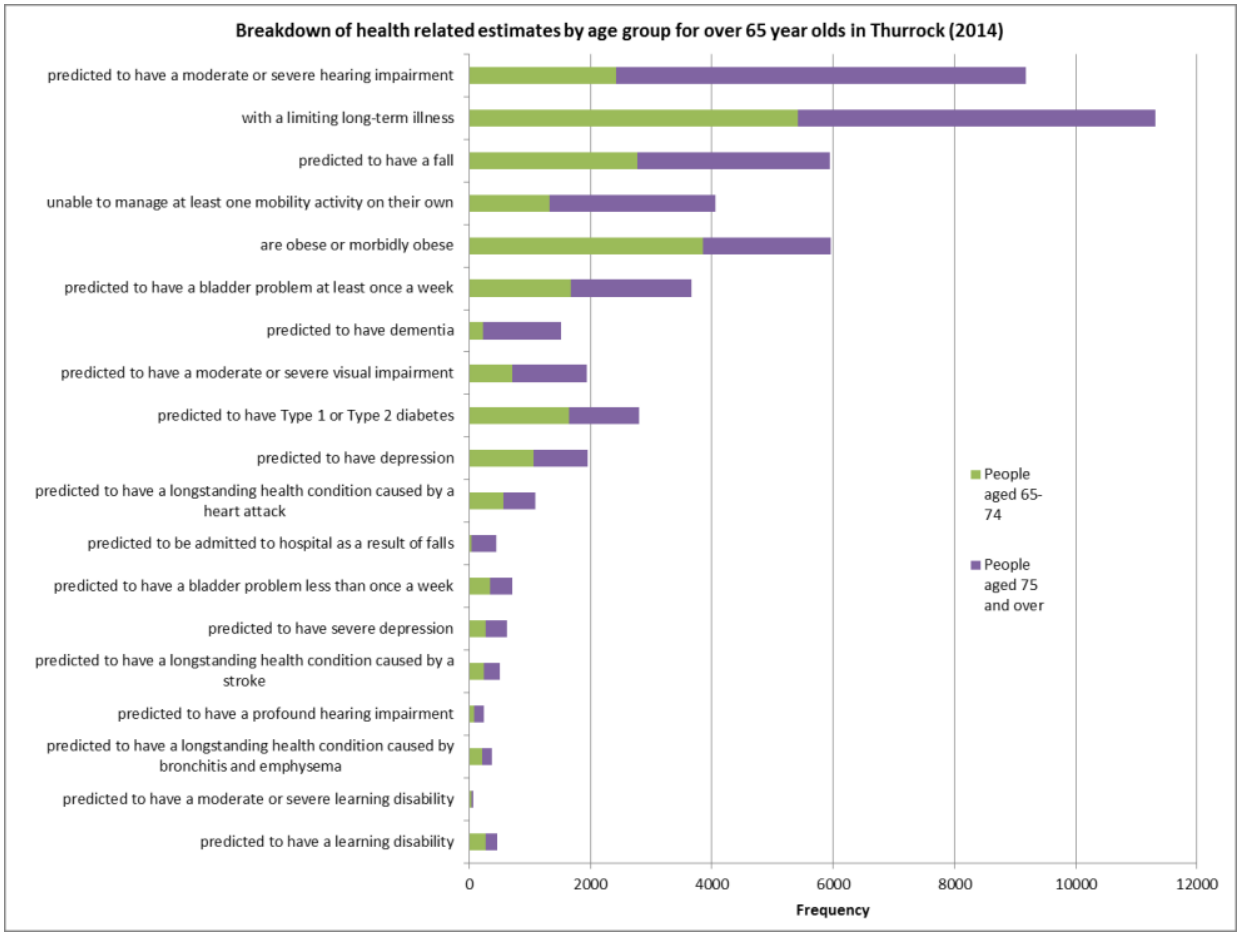
ANNEX 1 – Detailed Scheme Description

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

Scheme ref no.
BCF Scheme 1
Scheme name
Locality Service Integration
What is the strategic objective of this scheme?
The aim of Locality Service Integration is to integrate service delivery in Thurrock around 4 community hubs. Our aim will be to define an integrated service offer for the people of Thurrock based on detailed understanding of the local needs of each community. The Locality Service Integration Scheme forms part of the universal community offer for adults in Thurrock. However, the majority of people using the service will be adults aged 65 and over. The scheme will support people with stable long term conditions to live well with simple or stable long-term conditions so that they avoid unnecessary complications and acute crises. The scheme builds on the successes of the integrated Rapid Response and Assessment Service and the Joint Re-ablement Team. It will scale up the integration of health and adult social care services in broader integrated service model linked housing and a range of non service solutions including more responsive and resilient communities. The Locality Service Integration Scheme will integrate community health services, mental health services, housing and adult social care with primary care. It will be organised around the developing GP clusters to create a locality offer which addresses the strengths and needs of the diverse communities in Thurrock. The integrated offer will use risk stratification to target people who are most at risk of admission to hospital or a care home, providing solutions which will promote health and well-being, and ensure unplanned interventions are avoided. The scheme will generate efficiencies by reducing duplication, by improving service user and patient experience and satisfaction, and by providing solutions closer to home. As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a moderate or high risk of admission.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The Locality Service Integration Scheme is primarily focused at adults aged 65 years and over. Evidence from the King's Fund (2013 Making Integration Happen at Pace and Scale) which makes it clear that integration is most effective where the target population is older people living with chronic conditions including mental ill health. The 65 and over cohort which numbers in Thurrock approximately 20,000 people will benefit from the prevention and early intervention services as set out in Scheme 4. The subgroup will be people with relatively simple and stable long term conditions. (BCF2 focuses on the frailty

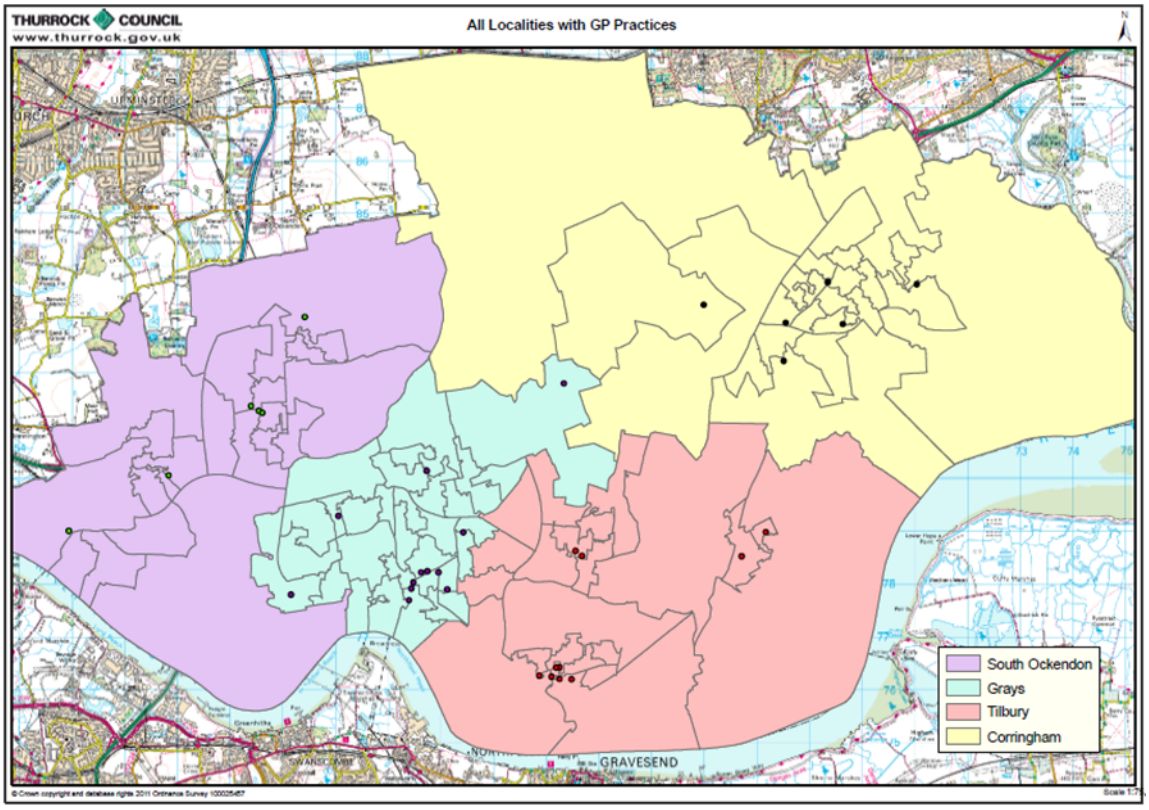
model and people with complex co-morbidities, BCF 3 focuses on those with re-ablement and rehabilitation needs and BCF 4 focuses on prevention and keeping people active)

The following table provides a summary of health related indicators for people aged 65 and over in Thurrock in 2014.



The model of integration for the Locality Service Integration Scheme was piloted with a Joint Re-ablement Team and extended through the Rapid Response Assessment Service, an integrated health and social care team which provides crisis management for service users in a timely manner, typically within 1-2 hours of the referral being received. This scheme takes integration further by organising health and social care service responses around clusters of GP practices. This will allow services to take advantage of a range of community assets for the delivery of care including GP surgeries and the community hubs currently being rolled our across the borough. To maximise financial and operational efficiencies electoral-ward based commissioning solutions are also being developed; responding to the disparate population needs. This will mean services responding to the specific needs of the local-ward population; with GPs working in conjunction with local community service providers, public health and social care. The BCF is strategically aligned to our primary care strategy. We have recently been successful in bidding for a primary care transformation fund. This bid will enable us to deliver improved GP access 7 days a week from community hubs. We aim to build on this success through our application to the prime minister challenge fund bid.

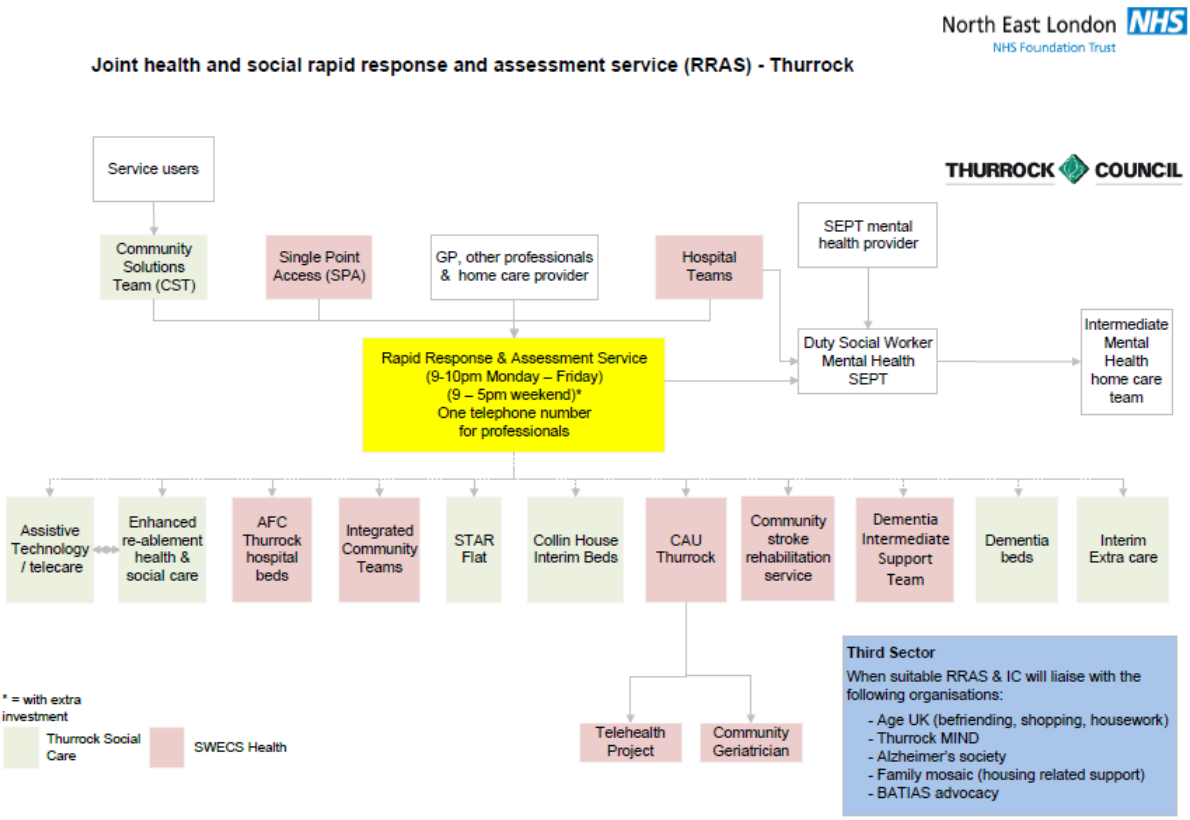
The GP clusters are shown on the following map:



The Locality Service Integration Scheme will be a partnership between Thurrock's adult social care services, and the community health providers (North East London Foundation Trust and South Essex Partnership Trust). It will have a Single Point of Access through referral from GPs, a wide range of community organisations or through Community Solutions – the triage service for adult social care in Thurrock. The initial response around each patient will involve a multi-disciplinary approach to risk stratification, facilitating the delivery of a wide range of solutions ranging from, for example, referrals to housing services where there is a need for adaptations or to the Frailty Model for those in acute need.

Thurrock recognises that carers are crucial partners in promoting health and well-being and believes they should not pay a penalty for the valuable contribution they make. The application of the carer's grant will be directed as part of this scheme as will the two carer support posts provided by South Essex Partnership NHS Foundation Trust (SEPT), and funded from the Mental Health Grant.

The integrated model of care will ensure a single care plan for each service user/patient so ensuring co-ordinated care and removing wasteful duplication. The service will provide a seamless pathway of care and support led by a care co-ordinator. The health and social care offer will be linked to health related services including housing (via Thurrock's tenancy services or Well Homes programme) and non service solutions through Local Area Co-ordination. The full menu of options is illustrated in the following diagram:



The costs associated with developing the Locality Service Integration Scheme and managing the changes will be borne by the providers within their existing budgets, and Primary Care Transformation monies will be used to enhance the primary care offer including the extension to 7 day.

A project implementation plan is being developed through our Whole System Redesign Group, this Group will ensure that the outcome of the reviews of all relevant current services will inform the design of the care pathway. The Governance arrangements for the Whole System ,Redesign as well as arrangements for engaging service users, patients and carers are described elsewhere within the BCF Plan.

The cost per case for the Locality Service Integration Scheme will be modelled in detail during the course of the first year to refine our understanding about the most effective, efficient and economic approaches to the management of long term conditions, and to promoting health and wellbeing for those with two or more morbidities.

The key milestones for the Locality Service Integration Scheme include:

- Development of integration governance arrangements and working groups – March 2015
- Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
- Full integration of the team, care coordination model, and sharing of information to enable management of risk – September 2015
- Cost benefit analysis of the first 6 month's operation – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Well established relationships exist between providers and commissioners and commitment to partnership working at all levels – e.g. Health and Wellbeing Board, Strategic Leadership Group, as well as at an operational level. We will build on the trust that has developed from our successes.

The delivery chain for this scheme is wide and interlinked with the other schemes that have been identified by Thurrock. The Whole System Redesign Group will closely manage the review and design of the care pathway ensuring that this is commissioned in partnership by housing, health and social care.

The integration of the commissioning approach will reflect the integration of the service delivery. The Care Act 2014 places a responsibility on all public organisations to work together and co-operate where needed to ensure a focus on the needs of their local population, and this is supporting our thinking in developing Locality Service Integration.

The Commissioners supporting the development of the Locality Service Integration scheme are:

NHS England - Primary Care
Thurrock CCG - Acute and Community Care
Thurrock Council - Social Care, Public Health, and Housing

As we shape the market to move to Locality Service Integration in Thurrock we build on the positive relationships that currently exist with providers and we will work in partnership to develop the model of care and support. There will be a range of providers involved in this approach including:

General Practice:

- Undertake routine Primary Care Multi-Disciplinary Team Reviews *(for patients identified as vulnerable / at risk of hospital admission)*;
- Gain patient consent *(for sharing and review of their needs with social care)* ahead of each multi-disciplinary team review;
- Participate and facilitate End of Life GSF Reviews *(for improved identification, review and care management);*
- Create and review integrated care plans for all patients with complex conditions;
- Adoption of standardised read-codes for locally agreed cohorts of patients e.g. coding of patients residing in a Care Home;
- Review and respond to any identified gaps in the detection and/or management of Long Term Conditions *(from the new CCG performance dashboard);*
- Repatriation of patients from secondary care management into the locality-integrated service model of care.

Basildon and Thurrock University Hospital NHS Foundation Trust:

- Continued delivery and development of Ambulatory Emergency Care Unit, Frailty Ward *(in partnership with community services);*
- Utilisation of 'Special Patient Notes' featured on SystmOne to improve assessment and management of presenting conditions;
- Facilitation of improved discharge arrangements including the implementation of an improved Comprehensive Discharge Plan;
- On-going reporting of inappropriate referrals / patient redirections *(for feedback to provider / identification of gaps in service);*

- Work in partnership with Community Services and the CCG to realise improved interface with acute-tiered services in a community-setting.

North East London Foundation Trust *(Community Services):*

- Development and on-going production of a performance dashboard for long-term condition management *(in partnership with the CCG, NHS England, and Public Health);*
- Development and implementation of the four locality integrated service boundaries *(health and social care provision);*
- Implementation of comorbidity clinics;
- Continued attendance and facilitation of Primary Care MDT reviews within general practice;
- Facilitation of End of Life GSF reviews in primary care including training in of general practice and care home staff;
- Continued delivery of Ambulatory Emergency Care programme *(in partnership with BTUHFT);*
- Continued provider-lead delivery of the Rapid Response Assessment Service *(RRAS) (in partnership with Thurrock social care);*
- Development and implementation of a rehab and convalescence model of care *(to realise optimal patient outcomes and reduce premature admission into care home)*.

South Essex Partnership Foundation

- Development and implementation of an integrated Single Point of Referral model for the population of Thurrock *(in partnership with NELFT);*
- Continued delivery of improving detection, assessment and care management of patients with Dementia;
- Continued improvements to timely responses and integration with non-elective acute and community services;
- Participation in Primary Care Multi-Disciplinary Team Reviews including the identification of patients requiring MDT review.

Thurrock Council & Clinical Commissioning Group

- Development and implementation of the four integrated service hubs *(in partnership with NELFT);*
- Implementation of a risk-stratification tool for the identification of patients in need, not already known to the service;
- Commission and implementation of a Falls Prevention service which is compliant with latest NICE guidance *(Public Health);*
- Review and rationalisation of estates to ensure a single point of care *(hub)* model is realised for each of the identified four localities.

St Lukes Hospice

- Implementation and delivery of a Single Point of Referral model for End of Life care in the form of 'One Response' service *(in partnership with NELFT / Social Care);*
- Delivery and review of a Fast Track Pilot to improve assessment and delivery of Preferred Place of Care;
- Support and participation in End of Life GSF Reviews.

Other smaller Private and Voluntary Sector providers

- Continued support and delivery service within agreed arrangements.

As the Council is leading a number of major regeneration schemes, including building a new town centre in Purfleet, the partnership will also have the potential to deliver new

and better health care facilities to further enhance the Locality Service Integration Scheme.

The budgets that are included within this scheme will be

- Integrated community teams
- Long term conditions
- Carers' Grant
- Primary Care MDT Co-ordinator

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Locally Thurrock has a coterminous Local Authority and Clinical Commissioning Group which facilitates a co-ordinated local response to health and social care needs. Utilising the approach to create federations of GP practices will align the response identified within our ageing well strategy, Building Positive Futures, this strategy focuses on key areas:

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

Aligned to the strategy the evidence base we have drawn on is:

- The Health Needs Assessment for the population in Thurrock over 75, undertaken by Public Health
- The data regarding numbers of patients over 75 registered with GP Practices
- The numbers of people aged 65 and over in receipt of care packages from social care (covering Critical and Substantial need)
- Those in receipt of re-ablement services from health and social care
- The number of people attending Accident and Emergency over 65
- The number of hospital admissions for those aged 65 and over and lengths of stay
- Data gathered from our Local Area Coordination
- Housing Data – e.g. from our Well Homes initiative

Ref BCF narrative re: case for change

The above has provided the evidence for us to focus on the implementation of this scheme. Although the number of A&E attendances and hospital admissions for those aged 65 and over may be less than for those aged under 65, the length of stay and the cost of support to the health and social care economy after discharge is far greater.

We will develop the Thurrock model based upon the learning of other pilot sites across the country such as:

- The Torbay Model – which saw reduced use of hospital beds, low rates of admissions for those over 65 and minimal delayed transfers of care (Thistlehwaite 2011)

- The North Somerset Model – which created four fully integrated MDTs to provide

case management and promote self care. This model integrated community health and social care works, community nurses, adult social care and mental health professionals (Windle et al 2010)

- The Hereford Model – this saw eight health and social care neighbourhood teams created that focused on chronic illness management such as diabetes, stroke, COPD and lower back pain. (Woodford 2011)

While drawing on other successful models of integrated care this scheme will ensure a focus on the specific needs of the residents of Thurrock and the assets of the communities within the borough.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Investments	Current Service Provider	HWB Total £
Integrated Community Teams	NELFT	3,906,301
Long Term Conditions	NELFT	415,682
Primary Care MDT Coordinator	NELFT	51,130
Carers Grant	Various	178,000
		4,551,113

Scheme total: £4,551k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Co-location of Health and Social Care will have an impact for the patient with a single point of entry resulting in the correct intervention to support the patient to remain in the community and out of hospital. It will reduce duplication and enhance communication between different service responses.

The various pilot schemes that have been undertaken across the country have seen varying impacts for both health and social care services including (but not limited to);

- Reduced usage of acute beds for those patients under the care of the integrated teams
- Reduced usage of acute beds in the 65 years and over population as a whole
- Reduced admissions and A&E attendances for those under the care of the integrated teams
- Reduced average length of stay for medical non elective admissions
- Reduced delayed transfers of care
- Reduced admissions to long term residential or nursing home care packages

Research by the Buildings Research Establishment has shown the potential to prevent of falls by close working better with housing. The importance of good hydration is also recognised in the Prevention of Urinary Tract Infections.

Through this scheme, we would expect to see a combination of these indicators being delivered. In terms of reduced admissions, there are a number of commonly presenting conditions that we would expect to impact upon through the integration of services (highlighted green). It should be noted that other schemes will also contribute towards this impact – e.g. Frailty Model

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

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

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Wellbeing Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Robust data regarding the interventions of the teams within each morbidity cohort will be gathered. This data will support monitoring of effectiveness and outcomes and should include:

- Referral rates
- Outcomes of referrals, health, social care, joint or other interventions
- Length of time maintained out of hospital
- Follow up to ascertain re-entry points to the services

Comparative data form 2012-13 and 2013-14 regarding numbers of admissions to hospital for those patients over 65 to support analysis of effectiveness.

What are the key success factors for implementation of this scheme?

The following factors will be measured to determine the success of the scheme and used in the feedback loop to improve delivery:

Proactive management of their disease or condition in the right environment with the right solution

Fewer professionals involved in the delivery of care

Service user satisfaction

Ability to manage and utilise capacity across the system appropriately across the locality

Reduction of unplanned admissions to hospital and care homes

Creation of MDT approach to targeting patients aged 65 and over at risk of admission to hospital

Creation of a more integrated RRAS/Rehabilitation service

Good Partnership working

Integrated commissioning approaches

Our local metric is a key measure of success:
'Prevention of admission of older people aged 65+ to hospital by providing effective urgent and crisis response (RRAS) and community/other support interventions. Reductions in the proportion of people (aged 65+) assessed by RRAS that require immediate hospital admission per 10,000 population aged 65+'.

Scheme ref no.
BCF Scheme 2
Scheme name
Frailty Model
What is the strategic objective of this scheme?
The Frailty Model aims to provide an enhanced tier of services to The Frailty Model aims to provide an enhanced tier of services to people who live with complex co-morbidities, including dementia and frailty. Health and care services will support older people with complex multiple co-morbidities, including frailty and dementia, to remain as well and independent as possible and to avoid deterioration or complications. The key element focuses on proactively identifying and supporting frail/older people and their carers who are at the greatest risk to prevent deterioration, and proactively supporting frail/older people and their carers to self-care and remain independent. The scheme consists of two key workstreams: I. Pre-emptive identification – as identified through the Locality Single Point of Access as described in scheme 1, treatment and co-ordination of service-users and/or their carers who have social and/or health risk factors through the development of a localised risk stratification tool and furthermore the use of a frailty risk stratification tool to identify the response required for those who present with complex needs – e.g. more than two long-term conditions. II. Enhanced community provision for frail, elderly clients to improve their health and social care outcomes whilst realising the ethos of 'Right Time, Right Place, Right Solution' in accordance with each person's preference of care and treatment as denoted in their electronic integrated care record. As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a moderate or high risk of admission.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
In Thurrock, we are developing a frailty model based on the principles of: • care wrapped around the patient, whatever the setting of care and which is experienced by them as a single delivery system through multi-disciplinary, multi-organisational integrated care teams • risk stratification to target the right services, at the right level, to the right people, reducing inequalities by delivering the best possible outcome • high quality pathways for people to maintain and maximise independence, to live in their own homes and where inappropriate admission to an acute hospital is seen as a system failure • a sustainable and cost effective system across health and social care, supported by the right financial framework

- transformed services through a seamless and integrated approach to health and social care

As we have said, this scheme is focussed on helping people live with complex co-morbidities, including dementia and frailty. The older people JSNA (attached) provides a detailed analysis of this population within Thurrock. We have targeted this population because we know that people with 2 or more long term conditions are some of the highest users of health and social care services.

As described within Scheme 1, Thurrock already has a number of integrated services in place between the Council and Community Health Provider (NELFT). These services are aimed at targeting those most at risk of Hospital or residential home admission through a 'right time, right place, right solution' principle, or ensuring that those in Hospital are able to leave hospital and are supported to live as independently as possible in the community whilst at the same time avoiding unnecessary readmissions.

There is a need for this scheme as Thurrock does not currently have a clear frailty model that is inclusive of all of the pathways that older service users may use. The frailty model will also enable evaluation of how services work together to provide support.

The scheme will aim to bring services together into a single integrated service framework that will enable service users to access the appropriate solution and for care to be joined up across providers and systems – including with mental health.

If the scheme was not taken forward then the current service provision would mostly operate in isolation – with the exception of those areas already integrated (e.g. Joint Re-ablement Team, Rapid Response and Assessment Service).

Risk Stratification – Frailty
In addition to an initial risk stratification exercise (ref. scheme 1), once an individual has been identified as having complex needs, a frailty risk stratification exercise will be carried out to ensure that the individual is able to access the appropriate part of the pathway. The improvement of this approach as part of the scheme is linked to the integration of the Community Geriatrician as described below.

Community Geriatrician
The scheme will build on the learning from the community geriatrician to develop a locality focused community geriatrician offer. Following an initial review, we will be integrating community geriatrician services into the frailty model to better meet the needs of the community. Also, as part of the risk stratification process (as described in scheme 1) to identify individuals with complex needs, the community geriatrician will be positioned at the single point of access. This will ensure that individuals will be referred to the right part of the pathway quicker as a result and will also be identified as complex at the earliest opportunity. This will be a distinct difference to what happens currently and will have an impact as a result.

Single Care Plan and Care Co-ordination
The benefit of the community geriatrician being at the Single Point of Access (SPA) will enable individuals with complex needs to be identified earlier and ensure that they access the right part of the pathway. A key element of this will be the development of a single care plan and a co-ordinated approach to that individual's care. A key impact of

this will be a reduction in the number of professionals that the individual sees in addition to an improved experience.

Rapid Response and Assessment Service (RRAS)
As part of the scheme, we will continue to build on the successful integrated RRAS service. Our service is aimed at those individuals who we think are likely to reach crisis point within 72 hours and co-ordinates and redirects care to the appropriate intermediate provider or service. The service has recently been evaluated and the recommendations from the evaluation will be considered as part of the work to be carried out during 15/16.

Menu of Choices
The success of the scheme is reliant to a great extent on the menu of choice that exists – which offers choice other than admission to hospital. A number of existing and developing services will be integrated within the approach which includes:

- Interim beds
- Step up beds and step down beds
- Extra care housing

The menu of choices as part of the frailty scheme link closely with scheme 3 – 'Intermediate Care' and should be read in conjunction with that scheme.

End of Life
Our model includes our desire to build on a good 'end of life' which we will aim to further enhance across the frailty pathway. Building upon the proactive end of life care coordination within Thurrock, we would aim to strengthen the identification and prognostic indicators for the monitoring of patients reaching the final year of life. This would include: maintaining the coordinated care register for end of life; ensuring advance care planning takes place; and embedding the delivery of end of life education across all care providers. Currently, 100% of all patients added to the coordinated care register all have an advanced care plan within 3 months.

Assistive Technology
Whilst we have used assistive technology solutions for some time, as part of the scheme, we will be building on the evaluation of the successes the community provider has had with telehealth – e.g. disease specific heart failure patients to facilitate discharge from acute and has improved quality of life and empowered patient to know more about their disease research project, successful management of Long Term Conditions through telehealth. Evaluation has shown that proactive telecare has reduced non-elective admissions(as contained within QIPP)

Older People with Mental Health
We have a very well established Older People Mental Health team, which as part of our social care fieldwork restructure has been strengthened. We plan to integrate further with other health colleagues, and we are looking towards the single point of access for GPs to include mental health to ensure a quick response in crisis. Co-location of this service will further enhance joint working with other services. Thurrock Council's Dementia Strategy has been recognised as an exemplar and this involves all services working together to meet the needs of people with dementia in the community currently being driven forward through our dementia friends training programme. A weakness at present is that we do not have a single pathway for people with dementia. Creating a pathway, including mental health will be a distinct improvement as part of the development and implementation of the BCF scheme.

Care Homes
As part of our plans to build on an integrated frailty pathway and reduce unnecessary admissions to Hospital, we recognise the need to support individuals residing in residential and nursing homes to ensure that they receive a timely response from RRAS and community teams. We have initiated Multi Disciplinary Team meetings in care homes via the community geriatrician reviewing all patients to identify those most at risk. Fewer people are going into hospital as a result. We have also undertaken training for care home staff and employed a dedicated Community Psychiatric Nurse to work with care homes to ensure mental health needs are identified. Further integration and development as part of this scheme will further strengthen our approach.

Ambulance Service
The frailty model's success relies on an integrated approach across all partners. This includes the local ambulance service. Work has and continues to be carried out with the ambulance service so that they understand the 'menu of choice' that exists over and above hospital admission. We are confident that this is preventing some unnecessary admissions to hospital.

The key milestones for the Frailty Model Scheme include:

- Enhancing the current risk stratification approach with an aim to developing an integrated approach across health and adult social care – June 2015
- Single Care Plan and Care Co-ordination– September 2015
- RRAS Service development – September 2015
- Assistive Technology forward plan – January 2016
- End of Life strategy – January 2016

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This primarily affects the following commissioners;
NHS England (Primary Care)
Thurrock CCG (Acute and Community Care)
Thurrock Council (Social Care Services)

And following providers;
General Practice:

- Undertake routine Primary Care Multi-Disciplinary Team Reviews *(for patients identified as vulnerable / at risk of hospital admission)*;
- Gain patient consent *(for sharing and review of their needs with social care)* ahead of each multi-disciplinary team review;
- Participate and facilitate End of Life GSF Reviews *(for improved identification, review and care management);*
- Create and review integrated care plans for all patients with complex conditions;
- Adoption of standardised read-codes for locally agreed cohorts of patients e.g. coding of patients residing in a Care Home;
- Review and respond to any identified gaps in the detection and/or management of Long Term Conditions *(from the new CCG performance dashboard);*
- Repatriation of patients from secondary care management into the locality-integrated service model of care.

Basildon and Thurrock University Hospital NHS Foundation Trust:

- Continued delivery and development of Ambulatory Emergency Care Unit, Frailty Ward *(in partnership with community services);*
- Utilisation of 'Special Patient Notes' featured on SystmOne to improve assessment and management of presenting conditions;
- Facilitation of improved discharge arrangements including the implementation of an improved Comprehensive Discharge Plan;
- On-going reporting of inappropriate referrals / patient redirections *(for feedback to provider / identification of gaps in service);*
- Work in partnership with Community Services and the CCG to realise improved interface with acute-tiered services in a community-setting.

North East London Foundation Trust *(Community Services):*

- Development and on-going production of a performance dashboard for long-term condition management *(in partnership with the CCG, NHS England, and Public Health);*
- Development and implementation of the four locality integrated service boundaries *(health and social care provision);*
- Implementation of comorbidity clinics;
- Continued attendance and facilitation of Primary Care MDT reviews within general practice;
- Facilitation of End of Life GSF reviews in primary care including training in of general practice and care home staff;
- Continued delivery of Ambulatory Emergency Care programme *(in partnership with BTUHFT);*
- Continued provider-lead delivery of the Rapid Response Assessment Service *(RRAS) (in partnership with Thurrock social care);*
- Development and implementation of a rehab and convalescence model of care *(to realise optimal patient outcomes and reduce premature admission into care home)*.

South Essex Partnership Foundation

- Development and implementation of an integrated Single Point of Referral model for the population of Thurrock *(in partnership with NELFT);*
- Continued delivery of improving detection, assessment and care management of patients with Dementia;
- Continued improvements to timely responses and integration with non-elective acute and community services;
- Participation in Primary Care Multi-Disciplinary Team Reviews including the identification of patients requiring MDT review.

Thurrock Council & Clinical Commissioning Group

- Development and implementation of the four integrated service hubs *(in partnership with NELFT);*
- Implementation of a risk-stratification tool for the identification of patients in need, not already known to the service;
- Commission and implementation of a Falls Prevention service which is compliant with latest NICE guidance *(Public Health);*
- Review and rationalisation of estates to ensure a single point of care *(hub)* model is realised for each of the identified four localities.

St Lukes Hospice

- Implementation and delivery of a Single Point of Referral model for End of Life care in the form of 'One Response' service *(in partnership with NELFT / Social*

Care);
- Delivery and review of a Fast Track Pilot to improve assessment and delivery of Preferred Place of Care;
- Support and participation in End of Life GSF Reviews.

Other smaller Private and Voluntary Sector providers
- Continued support and delivery service within agreed arrangements.

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Community Geriatrician Service

The introduction of the community geriatrician service has already shown evidence of success – for example the cost of geriatric medicine remained static from 2011/12 to 2012/13 (Thurrock CCG QIPP workbook). We feel that the impact of the service can only improve with the community geriatrician being at the forefront of the Single Point of Access as described within the scheme.

Telehealth

The use of telehealth has led to some noticeable improvements. This included a 33% reduction in the number of patients having an acute admission, and 48% reduction in acute activity costs between pre-telehealth and post-telehealth use (Thurrock CCG QIPP workbook).

Primary Care MDT

Although only limited evidence is available for the effectiveness of primary care MDTs, there are some good examples of where interventions on specific disease areas have improved outcomes. For example, the Kwok, Rice and Module review of MDTs identified the following benefits in heart failure and COPD:

Heart Failure:
- A lower rate of readmissions (7.8% vs. 25.5% over 3 months);
- Reduced Hospital stay; and
- 6 patients required to be part of a MDT to reduce hospital admissions by 1.

COPD:
- A lower rate of readmissions (51% vs. 69% at 12 months);
- Better patient knowledge (81% vs. 44% inhaler compliance, 71% vs. 37% for earlier treatment during exacerbation); and
- Reduced hospital bed stay and improved physical and emotional aspect of COPD.

Early indications are that patients who have a Primary Care MD accumulate on average 34% less on non-elective activity 3 months post review compared to 3 months prior to review (Thurrock CCG QIPP workbook)

End of Life

A 2014 review of providing palliative care (Picken and Cakmak) stated that 'nationally 63% of people would rather die at home. This contrasts sharply with 2012 statistics for England showing only 42.4% of deaths at usual residents with 52% in hospital'.

RRAS

Analysis of RRAS performance data April-October 2014 shows 1917 referrals and 1429 interventions/visits. Only 2.8% of people visited and assessed went into hospital (this is below the operating target of 7%). In particular, RRAS has an impact on non-elective attendances linked to COPD and UTIs in particular.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total:

£4,379k

Investments	Current Service Provider	HWB Total £ 000
End of Life Team	NELFT	389
Day Hospital Assessment and Treatment	NELFT	389
Admission Avoidance	NELFT	126
Continence Service	SEPT	62
Community Geriatrician	NELFT	84
Rapid Response and Assessment Service (RRAS)	NELFT & Local Authority	606
Risk Stratification Tool	PA Benchmark	50
Telehealth	Docobo	30
Various Other	Local Authority	158
Hospital Social Work Team	Local Authority	507
External Purchasing	Various	1,803
Elizabeth Gardens	Local Authority	175

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The cohorts of patients that would be identified and managed through this programme are similar to those in the locality integration project. Therefore, we would expect to impact of the similar range of presenting conditions – in particular those conditions/diagnoses linked to COPD and UTIs;

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

Primary diagnoses	Total	Secondary diagnoses	Total
Urinary tract infection, site not specified	523	**Essential (primary) hypertension**	348
Lobar pneumonia, unspecified	398	**Chronic obstructive pulmonary disease with acute lower respiratory infection**	296
Chronic obstructive pulmonary disease with acute lower respiratory infection	347	**Acute renal failure, unspecified**	287
Unspecified acute lower respiratory infection	229	**Atrial fibrillation and flutter**	279
Pneumonia, unspecified	212	**Urinary tract infection, site not specified**	230

Congestive heart failure	207	**Respiratory failure, unspecified**	164
Atrial fibrillation and flutter	181	**Volume depletion**	146
Fracture of neck of femur: closed	178	**Chronic ischaemic heart disease, unspecified**	145
Tendency to fall, not elsewhere classified	173	**NOT CODED**	138
Acute renal failure, unspecified	164	**Pleural effusion, not elsewhere classified**	135

Impact Assessment - RRAS

- Assuming the average cost of an A&E attendance is £114 (2012/13 NHS reference cost data)
- Assuming that 25% of RRAS cases that proceeded to assessment had potential for hospital admission that was subsequently avoided by RRAS intervention
- In the year to date, this would mean 357 cases (from a base of 1429) at a cost of £114 per case = £40,726
- Assuming the standard day rate for residential care placement is £425.84
- Potential residential care services avoided by RRAS interventions is estimated by workers to be 227 in year to date which equates to 453 over a full year period
- Assuming a conservative estimate that only 25% of these cases would in fact have required a minimum of a day residential care means a saving of £24,272 in year to date with a projected year end saving of £48,119

We have already described within the supporting evidence section the impacts we expect the scheme to make based upon existing evidence:

- Early indications are that patients who have a Primary Care MD accumulate on average 34% less on non-elective activity 3 months post review compared to 3 months prior to review (Thurrock CCG QIPP workbook)
- The use of telehealth has led to some noticeable improvements. This included a 33% reduction in the number of patients having an acute admission, and 48% reduction in acute activity costs between pre-telehealth and post-telehealth (Thurrock CCG QIPP workbook).
- RRAS impact as above

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Well-being Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Additionally, performance related to the scheme is already collated via existing arrangements – e.g. via the re-ablement scorecard and provider monitoring.

What are the key success factors for implementation of this scheme?

- Reduction of unplanned admissions to hospital and care homes
- Admission avoidance
- Increased use of community solutions
- Increased numbers of people ending their life in a setting of their choice
- Increased use of telecare – knowing that 33% of users avoid an acute admission as a result

The key performance indicators that relate to this scheme are:

- Non-elective admissions
- Residential admissions
- Patient and Service User Satisfaction

Our local metric is a key measure of success as is our patient and service user satisfaction metric as detailed below:

- 'Prevention of admission of older people aged 65+ to hospital by providing effective urgent and crisis response (RRAS) and community/other support interventions. Reductions in the proportion of people (aged 65+) assessed by RRAS that require immediate hospital admission per 10,000 population aged 65+'.

- '% of Adult Social Care service users who are satisfied with their services and support'

Scheme ref no.

BCF Scheme 3

Scheme name

Intermediate Care

What is the strategic objective of this scheme?

The focus of Intermediate Care is admission avoidance with a clear remit to ensure that robust discharge planning is in place, that effective rehabilitation and re-ablement take place before CHC assessments, and that any long term support is put in place in a person centred way to make sure each individual has as much choice and control as possible.

This scheme will enhance the provision of care and support that is delivered away from the persons home but is but of hospital care. The scheme will increase the range of settings in which re-ablement, and physical and mental health care can be provided. It will also extend the range of people who use those settings. The scheme aims to achieve the following objectives;

- providing a discharge to assess model for continuing healthcare (CHC) which will ensure patients achieve their optimal re-ablement capability prior to a CHC assessment being undertaken
- Reducing readmissions to hospital from care homes
- Increasing the availability of step up provision (to avoid acute admissions).
- Improving the contractual efficiency of bed based intermediate care services commissioned by the NHS Thurrock CCG and the Council.

As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a very high risk of admission.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

There is considerable investment by both the CCG and LA in Thurrock for intermediate care and support. The focus of the scheme is to develop this investment further by realigning the current mainly bed based provision to afford the opportunity in year to make better use of and change existing services.

The scheme consists of several components;

a) Establishing a non acute rehabilitation/assessment pathway (pilot)
This will be a pilot project to Commissioning an intermediate care rehabilitation and assessment pathway across Collins House the LA residential provision and the NELFT Community Hospital together with part of the Mount Nessing Court provision for rehabilitative dementia care and support. The focus of this element of the project is to create a far more effective and responsive pathway to move people into the long term solution more effectively reducing the time frame for bed use.

- To support this the scheme will commission an enhanced domiciliary provision to enable service users/ patients to be discharged to where they live so that a

detailed assessment can be carried out focusing on the outcome of maintaining them where they live This will mean that people will move on more quickly either from hospital or bed based rehabilitation services back to where they live this could be residential support, sheltered accommodation or their own home.

b) Establishing a non acute rehabilitation/assessment pathway (pilot)

- Commissioning an intermediate care rehabilitation and assessment pathway across Collins House/NELFT Community Hospitals and part of Mount Nessing Court (specifically for dementia care)
- Commissioning an enhanced domiciliary provision to enable service users/ patients to be discharged to assess within their normal place of residence
- Reviewing placements to identify opportunities/challenges associated with the provision of out of hospital health care
- significantly reducing the number of CHC assessments undertaken in BTUH. The new pathway would improve patient experience through a package of re-ablement/rehabilitation so reducing long term care needs and improving outcomes.

c) Promotion of step up and step down facilities

- Working with GPs, Community Staff and East of England Ambulance Service to promote the usage of step up/step down to facilitate discharge and reduce non elective admissions.

d) Contract review of bed based services

- Joint review of all existing commissioned services to identify contractual efficiency opportunities. This resource will be reinvested in supporting the implementation of the Care Act.

e) Supporting carers

- Carers are seen as a key part of the multi-disciplinary approach to timely discharge and admissions avoidance (as in Scheme 1) and so identifying the requirements of carers will be a central part of our intermediate care offer.

f) The Joint Re-ablement Team

1. Council provided adult social care integrated with the NHS community service provider aimed at preventing readmission to hospital through proactive re-ablement.

Intermediate Care offer will also be used to explore the fullest range of care and support options available to patients / service users, including self funders through our information, advice and guidance service (see diagram in BCF Scheme 1 for more detail)..

The key milestones for the Intermediate Care Scheme include:

- New rehabilitation/assessment pathway pilot - April 2015
- Roll out Carer Support – April 2015
- Contract Review of bed based services –June 2015
- Review of rehabilitation/assessment pathway pilot including Step Up and Step Down facilities – January 2016

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme affects the following commissioners and providers;

Provision	Commissioner	Provider
Acute Based Care	NHS Thurrock CCG (alongside Basildon and Brentwood CCG as the lead commissioner)	Basildon and Thurrock University Hospital NHS Foundation Trust
Out of Hospital health care	NHS Thurrock CCG Thurrock Council Jointly Commissioned (Better Care Fund)	North East London Foundation Trust (Thurrock Community Hospital) South Essex Partnership NHS Foundation Trust (Mount Nessing Court Thurrock Council (Housing – extra care housing and Adult Social Care – Collins House care home) Private and voluntary care home and extra care housing providers

The providers will be expected to deliver broadly the same offer as shown in schemes 1 and 2 above.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There have been a series of similar pilots across the country looking at the discharge to assess model notably Cambridge and Peterborough, Sheffield Frailty Unit and Wakefield. These have all influenced the proposal to develop and improve intermediate care in Thurrock.

Re-ablement Performance:

- 280 people completed re-ablement with the Joint Re-ablement Team in the year to end Sept 2014. Average of 47 per month
- Projecting this over a full year estimates 564 people completing – a rate of 46 per 10,000 population aged 18+
- Around 75-80% of people tend to be 65+. Assuming a fixed rate of 75% over a year this would 423 people aged 65+ completing – a rate of 200 per 10,000 population 65+
- 66% of completers in the year to date resulted in a reduction or end in support (185 cases)
- The number of people completing re-ablement continues to show an increasing trend and the proportion of people completing with a reduction or end in support is rising on previous years
- Projecting this over a full year period estimates 372 people ending with a reduction or end in support
- 96.7% of people receiving re-ablement self-report that 'their quality of day to day life had improved following support'.

In Quarter 2 2014/15 (July-August) there were 16 departures from the Collins House Interim Residential Care beds. In the year to date there have been 28 departures. The destination of these individuals are as follows:

	Quarter 2	Year to Date
Returned to the Community	7 (43.8%)	11 (39.3%)
Moved to Extra Care	1 (6.3%)	3 (10.7%)
Moved to Residential Care	6 (37.5%)	11 (39.3%)
Admitted to Hospital	2 (12.5%)	3 (10.7%)
Total Departures	16	28

It is assumed that by providing re-ablement services and enhanced health care services in a wider range of out of hospital settings more service user/ patients will regain skills and confidence for independent living.

A recent review of existing step up and step down provision in Thurrock has identified a gap – people who do not need rehabilitation or re-ablement but who have health care needs which cannot at the time be met in their own home. Too frequently these cases use beds within BTUH when hospital care is not what they need. In other cases, health care away from home is required until the patient/ service users home is adapted or their informal care arrangements are available (this includes intermediate care to provide respite to carers)

The scheme will use available funding to meet the costs of accommodating the service user/patient ranging from residential care to extra care housing. The accommodation will be commissioned from within the Council's housing and care home estate, and through the private and voluntary sector. The market position statement will be used to help shape this offer.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total: £5,035k

Investments	Current Service Provider	HWB Total £
Joint Re-ablement Team	NELFT & LA	1,168,794
Mount Nessing Court	SEPT	704,800
Intermediate Care Beds	NELFT	2,585,738
Collins Hse Intermediate Care Beds	LA	576,333
Total		5,035,665

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Whilst this scheme is likely to have a limited impact on overall numbers of admissions, we would expect there to be an impact on both readmissions and admissions into residential care placements.

Below is a summary of the projected growth of social care admissions into standard, dementia and nursing placements without any interventions. Through this scheme we would expect to stem the growth across all placement types.

	Actual	Projected				
	Sep-13	Apr-14	Apr-15	Apr-16	Apr-17	Apr-18
Residential & Nursing Placements	311	324	334	344	350	358
Dementia Placements	70	77	80	82	84	85
TOTAL	381	401	414	426	434	443

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop

and sign off project plans, monitor implementation and review impact, reporting to the Health and Well-being Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Provider engagement will be through specific pathway development meetings, formal contract management, the Strategic Leader's Group and the Market Position Statement.

What are the key success factors for implementation of this scheme?

The key success factors in relation to this scheme are;

a) successful implementation of a discharge to assess model
b) enhancement of capacity for health care away from home in an out of hospital setting
c) reduction in the number of cases requiring continuing healthcare and a reduction in the needs/case mix for those who are eligible for CHC.
d) Increase in the volume of step up/step down cases
e) A reduction in the cost of commissioned bed based care
f) A reduction in the requirement for care and support services after re-ablement.

Scheme ref no.
BCF Scheme 4
Scheme name
Prevention and Early Intervention
What is the strategic objective of this scheme?
The objective of the scheme is to provide an integrated response to a number of successful existing and developing initiatives that result in a cohesive prevention and early intervention offer spanning the community, public health and social care system. Ultimately our vision is for prevention and early intervention to become embedded within our locality approach (working within and alongside the communities they serve), and to be fully unified around the individual needing a solution (bringing together all interventions designed to manage demand and prevent crisis); Thurrock's vision for whole system re-design being predicated on the concept, "right place, right time, right solution". Through utilising the opportunities created for pooling resources within the Better Care Fund, we are confident that this transformation can be accelerated. The scheme initially focuses predominantly on embedding and further developing our Local Area Coordination (LAC) offer. The LAC offer is open to everyone over the age of 18 who has the potential to place demand on a service. LAC has already had notable evidence of success – including admission avoidance – in the 14 months it has been established, and this scheme aims to build on and further that success. As shown in the diagram on page 30 (Summary impact of risk stratified approach) this scheme is aimed at those who have a very low through to moderate risk of admission.
Overview of the scheme **Please provide a brief description of what you are proposing to do including:** - **What is the model of care and support?** - **Which patient cohorts are being targeted?**
Thurrock is engaged in a whole system transformation focused upon a shift of resources towards timely intervention and prevention, part of which has been captured within the BCF to enable the pooling of key resources. The overarching vision for the system, places 'right time, right place, right solution' at the heart of the design. The redesign features three key aspects: - Right Time – ensuring people receive the intervention most likely to support wellbeing at the point at which it will have most impact; - Right Place – ensuring the homes that people live in and the communities in which they reside support their health and active ageing; and - Right Solution – either service or other support designed to promote independence and maintain quality of life. The broad transformation includes significant activity currently outside the BCF (for example work with our housing colleagues and private developers to drive up the quality of older people's housing designed to Housing our Ageing Population Panel for Innovation (HAPPI) standards, bringing forward a Council - wide programme of community hubs) and our work within communities building resilience using a strength-

based approach under the Council's 'Stronger Together' programme. We are also working with Housing on a Well Homes initiative. Finally, a number of other key initiatives are currently in development and will feature in future pooled fund arrangements as the programme develops – for example a post-diagnosis community based integrated dementia service.

The scheme consists of several components which includes:

Local Area Coordination
Thurrock successfully implemented a pilot Local Area Coordination initiative (LAC) in July 2013, beginning with 3 LAC's funded through the deletion of three social work posts. An initial evaluation 4 months into the pilot already showed clear evidence of the impact of working in this way upon marginalised people, most of whom were previously unknown to social care services. Because referral routes, eligibility criteria and assessment and care management techniques were not a feature of the entry point into receiving support, this model represents a 'new front door to services', ensuring people who were outside of the care system, or who had fallen between various "siloed" services received comprehensive support. The LAC model is based upon a western Australian scheme that over the past 25 plus years has proved its effectiveness in supporting marginalised groups in becoming more resilient and self-managing.

Recognising that the initiative is about supporting vulnerable and marginalized people and acknowledging the high percentage of fire deaths that impact this group, the Fire Service have seconded a senior fire officer in to the team, seeing the LAC role as fundamental to their shift from an emergency response service and towards a prevention model of delivery . Early successes with specific groups such as hoarders provide clear evidence of the impact on fire prevention. However, because of the way LAC's provide support, there is also significant proof of impact across a very broad range of support needs for this group.

The initial success evidenced by the 4 month report enabled the LAC programme to be expanded through the agreement for public health to fund an additional three posts as part of their prevention and reducing health inequalities programmes. The six LACs have now been working in Thurrock for the past 14 months and a more in-depth analysis has been recently produced. Key findings that allow us to evidence the potential impact of this initiative are included within the 'evidence base' section.

Because of the compelling evidence provided from a number of key professionals including GPs, psychiatrists etc., the BCF identifies CCG funding to further expand the programme by recruiting 3 additional LACs, who once in place, will provide full coverage across Thurrock. It is recognised that cost benefit analysis around prevention and early intervention, especially where the intervention impact may be longer term, is remarkably difficult to prove. With this in mind, Thurrock Council with Derby City Council is engaged with the University of Birmingham to develop an academically accredited evaluation tool. We are confident that the evidence provided will establish very clear cost benefit analysis supporting the financial case for deploying Local Area Coordination and that in the future additional integrated funding may be approved to further expand the service.

Falls Prevention Programme
The review and further development of a comprehensive falls prevention programme that provides multidisciplinary assessment, a programme of falls risk reduction (including exercise programmes, adaptations, prescribing interventions etc.) and on-going follow up

(to maintain compliance and benefit). This will target patients that have experienced falls (to reduce recurrence) in addition to those identified as at risk by primary care, community services (health and social) and acute services. Work will align with the Housing-based Well Homes project which works with private sector housing to ensure that homes promote health and wellbeing – including the identification and rectification of trip hazards. This is an initiative funded through the Public Health resource within this scheme.

Public Health-led review of emergency admissions
Through the Whole System Redesign Project Group, public health are leading work in conjunction with the CCG, social care, and primary care to review cases of emergency admissions in certain practices with high levels of admissions over a 12 month period. The review hopes to identify those patients that could be avoided from accessing unplanned care by better management in the community.

Given the potential that exists to build upon a strong local community, part of the work will include improving connectivity and further enhancing resilience to explore the possibility of neighbourhood solutions to key causal factors for poor wellbeing such as bereavement and loneliness - there is a clear link with those bereaved and/or lonely and avoidable admissions.

The findings of the work will be used to inform system changes aimed at preventing admissions.

Improved Efficiency of Commissioning of Equipment including: promotion of self-care, prevention, integration of services, and improved accessibility and public education
Though pooling our resources in a single place with our community health provider, we are hoping to drive efficiencies through the following approach.

Single Integrated Service Model for Community Equipment
Health and social care currently operate two separate models for the provision of community equipment; according to their statutory obligations. Part of this initiative that will see the emergence of a fully integrated community equipment model of care. The revised model will see a seamless pathway for each patient, irrespective of traditional organisational responsibilities or point of entry. This part of the scheme's initiative will realise improved efficiencies across existing service provision (currently responding to substantive and critical needs).

Improved self-care, prevention and accessibility of equipment
The second part of the scheme's initiative has ambition to promote self-care prevention; and thereby increasing the number of patients taking individual responsibility for fulfilling their moderate equipment needs (not currently funded). To facilitate these benefits the pathway will introduce improved accessibility to equipment informed on the national retail model, improve public education of need and promotion of self-assessment.

This model will also interface with the risk stratification of Thurrock residence (encompassing physiological and social indicators) to ensure targeted promotion and uptake is facilitated.

We will review and redesign existing and new initiatives and pathways as part of our

Whole System Redesign Group.

The key milestones for the Prevention and Early Intervention Scheme include:

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

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

This scheme affects the following commissioners and providers:

Provision	Commissioner	Provider
Essex Equipment Services	Thurrock CCG (through a Section 75 agreement managed on our behalf by North East London Foundation Trust) Thurrock Council (direct 75)	Essex Cares (provider arm of Essex County Council).
Local Area Coordination	Thurrock Council, Essex Fire and Rescue Service, Thurrock CCG	Thurrock Council
Public Health Commissioning	Thurrock Council	NELFT Voluntary and Community Sector
Falls Prevention	Thurrock Council	NELFT
Stroke	Thurrock Council	Thurrock Council

The providers will be expected to deliver broadly the same offer as shown in schemes 1 and 2 above.

The evidence base
Please reference the evidence base which you have drawn on

- **to support the selection and design of this scheme**
- **to drive assumptions about impact and outcomes**

We have carried out a fourteen month evaluation report of our Local Area Coordination project. We have also made some assumptions based on existing LAC caseload that has allowed us to model the impact of this initiative. The facts and assumptions we have made are as follows:

- The post-18 population in Thurrock is 120,200

- We believe that the potential cohort for Local Area Coordination in Thurrock as a percentage of the over 18 population could be as high as 10% - approximately 12,000 people
- However in reality each LAC works with an average caseload of 60 people (based upon experience from Western Australia) which equates to 450 people at any one time (60 x 9 LACs)
- 31% of the caseload relates to older people which is the primary focus of our BCF

The financial cost of the LAC initiative is between £150k (initial period of three LAC's p.a.) - £300k (6 LAC's) in total to date. Current agreed deployment (utilising BCF funding) is £450k with 9 LACs recruited and full coverage of the Borough. (because the model is completely "agile" in terms of working pattern and utilising community assets, there is no estates costs attached to the scheme and very little capital funding required apart from equipment to support mobile working)

The unit cost of supporting 256 people (total number of people supported to date) by approx £200k over 14 months (the £200k takes in to account the variance in cost over the life over the initiative to provide an approximate average cost - started with 3 LACs and £150k investment rising to 9 LACs at the end of the fourteen months) = £780 cost per person over 14 months.

Therefore the average caseload per LAC = 60 people x £780 = £46,800

The fourteen month review has allowed us to make some assumptions on what the LAC initiative has and can save – based on the number of people who have been supported to avoid a service intervention and evidence from professionals, LACs, and those supported. The impact of the initiative includes the following unit of prevention cost:

Cost	Unit of prevention cost	Impact
£125	Per hour GP visit	Fewer people seeing a GP as a result of LAC involvement – particularly regarding social isolation
£956	Annual cost of depression	Over 75 people introduced to LAC have identified depression as one of the main challenges they face, with a high percentage having reported an improvement in their depression
£445	Mental Health overnight stay in hospital	Reports of people who have avoided a potential admission to hospital
£162	Mental Health Community Provision	Reduced need for mental health professionals
£1779	Episode of inpatient care	Individuals supported who are likely to be admitted to hospital without support
£510	Adult Social Care assessment	A number of individuals have been referred to the LAC who would otherwise have

		received a social care assessment
£65	Day care provision	A number of individuals have avoided Day Care services due to alternatives in the community being found – on average people attend day care for 2 days a week at £65 approximately per day
£7095	Complex eviction case	At least one individual supported to date has avoided eviction as a result of support received
£1962	Annual cost of alcohol abuse to NHS	A number supported have reduced or stopped their alcohol intake
£7744	Income support claimant entering work	At least one example of an individual being supported back in to work – with a number of others working towards this goal
£3568	Average response to a fire	A number of people are supported to make their home safer – with 3 individuals to date at high risk of fire due to their environment and lifestyle
£10.50	Volunteering per hour contribution	13 people have been supported in to volunteering

Our evaluation report reflects clear evidence of how we have kept people out of services and equates that to potential savings made.

With regards to our Falls initiative, our 'Health Needs Assessment for the over 75 year old Thurrock population' written in July 2014 predicted that 32% of that cohort were predicted to have a fall, with 4% likely to be admitted to hospital as a result of a fall.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Scheme total:
£1,965k

Investments	**Current Service Provider**	**HWB Total £000**
Community Equipment	NELFT	1,533
Local Area Coordination	Local Authority	147
Stroke Prevention	Local Authority	35
Public Health	NELFT	250

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of the scheme with reference to the LAC initiative has already been demonstrated in the 'evidence base' section. We have also commissioned Birmingham University to develop an accredited evaluation tool to enable us to more accurately measure the true benefits and impact of this important initiative.

We recognise that community equipment is key to prevention and early intervention. We will work with our community health provider to evaluate further efficiencies and improvements in the way in which we provide community equipment.

We know that falls is a key reason for people aged 65 and over having an unplanned admission. We will look to review and further develop the programme so that it continues to identify and focus on the cohort most likely to have a fall. We are already working with housing colleagues through the Public Health funded 'Well Homes' project to help improve private sector accommodation including the reduction of fall hazards.

Based on the evidence, we would expect that the falls programme would directly impact upon the highlighted diagnoses categories below as well as having a indirect impact on other reasons for admission. A discussed in the 'evidence' section, it is estimated that 32% of people aged 75 and over will have a fall, with 4% of those being admitted to hospital. We know that the average cost of an admission for someone aged 75 and over at Basildon Hospital is £3419, therefore just 1% of those aged 75 and above being prevented from being admitted to Hospital would equate to a saving of £351,302 and reduce attendances by over 100 (4% of 75 and over = 411).
Top 10 primary and secondary diagnoses for those aged 65 years and over in Thurrock CCG (April 2012-March 2014) X indicates those areas we believe LAC and other timely intervention support could reduce admissions.

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

Therefore we believe more timely and local interventions could have a significant impact upon 6 of the top 10 most common presenting conditions amongst the over 65 population in Thurrock; with the other 4 being more likely to be improved through much longer term preventative measures. There is already evidence that joining up all prevention activity will lead to improved outcomes. For example it is acknowledged that campaigns around

smoking cessation and obesity which provide the general population with information and advice have limited impact. There is already some local evidence that providing such advice through the LAC (which offers individual, trust based style of support), improves the likelihood of take up of rehabilitation in cases of substance misuse; it seems logical to combine such an approach with broader cessation and management programmes to improve take up and sustainability.

We would expect this scheme to contribute to our key metrics of:

- Non-elective admissions
- Residential admissions
- Service User/Patient Satisfaction

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The impact of this scheme will be monitored through the Whole System Redesign Project Group. As set out in the Governance arrangements the role of this group is to develop and sign off project plans, monitor implementation and review impact, reporting to the Health and Wellbeing Board.

This Group sits as part of the Health and Wellbeing Board's Governance Structure and reports to the Integrated Commissioning Executive (as set out in page 35 of our Plan of Action).

Provider engagement will be through specific pathway development meetings, formal contract management and the Strategic Leadership Group.

Additionally, we have a fully developed performance management framework for our Local Area Coordination initiative.

What are the key success factors for implementation of this scheme?

Commissioning of Equipment:
The key success factors in relation to this scheme are;

a) Delivery of efficiencies from the integrated commissioning hub for equipment (reduction in price for commonly ordered items)
b) Implementation of retail model
c) Access to equipment for all key admission avoidance pathways

With regards to the LAC initiative:

- Number of people supported by LAC which leads to an individual avoiding need for a service (both acute or community based) or reducing demand for service
- Conversion rates of service users to volunteers
- Socially isolated people reconnected with their community
- Prevention of homelessness
- Number of people receiving equipment that require a reduced level of service or no service
- Reduction in use of medication for people supported by LAC
- Reduction in alcohol dependency or drug misuse

- Fire prevention

As previously mentioned, the Council has commissioned Birmingham University to develop a method of measuring the impact of the LAC.

Scheme ref no.
BCF Scheme 5
Scheme name
Disabled Facilities Grant and Social Care Capital Grant
What is the strategic objective of this scheme?
Disabled Facilities Grant (DFGs) helps to pay for major adaptations for owner occupiers, private tenants or housing association tenants. The Community Capacity Grant to local authorities, provides capital funding to support development in three key areas: personalisation, reform and efficiency.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Mandatory DFGs are available from local authorities, subject to a means test, for essential adaptations to give disabled people better freedom of movement into and around their homes and to give access to essential facilities within the home. The Community Capacity Grant is a principal component of our work to promote Asset Based Community Development. It is an approach to community building which transforms the way communities are seen, focusing on strengths and assets and connecting people and networks around common interests and concerns. This contrasts with the deficit model which typically characterises communities in terms of needs and deprivation.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
The Council's Private Housing & Adaptation Service is working closely with Adult Social Care, Health and Public Health to improve independence at home. DFGs are delivered in partnership with our local home improvement agency the Papworth Trust. Asset Based Community Development is being used to re-engineer our fieldwork services to be community facing, working in conjunction with Primary Care MDTs and community hubs. It also supports our work to raise the profile of attractive, high-quality housing for older people, and the benefits this can bring to health and wellbeing.
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Disabled Facilities Grants provide an important mechanism for supporting people with disabilities to live independently. When delivered early, alongside other preventative measures, they may contribute to preventing admissions to hospital and residential care. Asset Based Community Development complements the ambition of the Better Care Fund to deliver services that:

- are built around people and their communities
- work together effectively to achieve outcomes, including an integrated health and social care system
- prioritise timely intervention and prevention, reducing inequalities and promoting equalities
- improve performance and reduce costs and are open and accountable, including investment in leadership and workforce development
- are person-centred and offer flexibility and choice.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Disabled Facilities Grant £481,000

Capital Grant (provisional allocation): £358,902

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Our aim is to use DFGs to maximise a resident's independence and quality of life.

Asset Based Community Development is focused on communities, strengthening the connections between people and informal associations around common interests and concerns.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The performance of services funded by these grants will be monitored by the Pooled Fund Manager and reported to the Partnership Board on a quarterly basis.

What are the key success factors for implementation of this scheme?

The scheme will be monitored for its contribution to the reduction in total emergency admissions and the reduction in admissions to residential care homes.

Scheme ref no.
BCF Scheme 6
Scheme name
Care Act Implementation
Overview of the scheme
The Schemes purpose is to deliver the requirements of the Care Act, ensuring that the Council are compliant and that existing services are not adversely affected by increased costs.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
Scheme total: £522k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
The scheme will allow the following themed requirements in particular to be delivered: • Carers – placing carers on a par with users for assessment; and introducing a new duty to provide support for carers; • Information advice and support – provision of advice and support to access and plan care, including rights to advocacy; • Safeguarding – implementing new statutory responsibilities; • Assessment and Eligibility – Setting a national minimum eligibility threshold, providing continuity of care for people moving in to the area until reassessment; and • Capital funding – capital investment funding including IT systems.
What are the key success factors for implementation of this scheme?
The key success factors in relation to this scheme will relate to our ability to implement the requirements of the Act seamlessly and without impacting negatively on user experience.

Scheme ref no.
BCF Scheme 7
Scheme name
Payment for Performance
What is the strategic objective of this scheme?
This scheme is the provision for the payment for performance. As such, the provision is two fold (dependent on the performance of the system in 2015/16). a) In the event of the required reduction in unplanned care admissions failing to be delivered, this resource will be utilised to fund commensurate activity in local acute trusts. b) In the event of the required reduction in unplanned care occurring, this resource will instead be utilised to fund a series of initiatives (currently being identified) that further improve out of hospitals care to our population.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
a) Transaction with acute providers to cover the cost of unplanned care episodes (primarily Basildon and Thurrock University Hospital NHS Foundation Trust). b) If the target is achieved, this resource will be invested into schemes that align with the other schemes outlined within this document (i.e. BCF1-6). The concise detail of the investments is to be determined.
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Scenario A – target not achieved Commissioner – Thurrock Clinical Commissioning Group Provider – Acute Trusts (primarily Basildon and Thurrock Hospital NHS Foundation Trust) Scenario B – target achieved Commissioner Thurrock Clinical Commissioning Group Thurrock Council Providers To be determined but from the following; General Practice Basildon and Thurrock University Hospital NHS Foundation Trust North East London Foundation Trust Thurrock Council

Other smaller Private and Voluntary Sector providers
The evidence base Please reference the evidence base which you have drawn on - to support the selection and design of this scheme - to drive assumptions about impact and outcomes
Scenario A – this is a transactional process and therefore no evidence based is required Scenario B – the evidence base for each proposed investment will be identified as part of the business case developments.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£722k
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Scenario A – no impact,
Scenario B – the precise impact will be identified as part of the business case development process. However, the investments will reinforce the aforementioned impacts within BCF Schemes 1-6

Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The impact of this scheme will be monitored through the Whole System Redesign Project Group. The role of this group will be to develop and sign off project plans, monitor implementation and review impact. Provider engagement will be through specific pathway development meetings, formal contract management and the strategic leaders forum.
What are the key success factors for implementation of this scheme?
Scenario A – Transactional process, not applicable Scenario B - clearly defined business cases for investment - clearly defined expected outcomes that align with the BCF's objectives - clearly defined outcome measures - implementation of an effective prioritisation and approval process for the business cases - implementation and delivery of the service changes proposed in the business cases

- review

ANNEX 2 – Provider commentary

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

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	Basildon and Thurrock University Hospital Trust
Name of Provider CEO	Claire Panniker
Signature (electronic or typed)	Claire Panniker

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Thurrock Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by the Trust in order to reduce our emergency bed base allowing either closure or alternative use.

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	North East London Foundation Trust
Name of Provider CEO	John Brouder
Signature (electronic or typed)	John Brouder

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Not fully – NELFT would like to fully understand the forecasting and how the final outturn was agreed. Would be helpful to align to schemes also
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	NELFT have not had the opportunity to be able to review and analyse the detailed impact of the schemes which are described in the BCF but NELFT are fully committed to work with Thurrock Health and social care partners in order to achieve a consensus and agree joints plans
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	NELFT are committed to seeing a reduction in unplanned care admissions and welcome the opportunity to develop services which enable the people of Thurrock to be cared for appropriately in their community

Name of Health & Wellbeing Board	Thurrock
Name of Provider organisation	South Essex Partnership Trust
Name of Provider CEO	Sally Morris
Signature (electronic or typed)	Sally Morris

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	13,573
	2014/15 Plan	12,680
	2015/16 Plan	12,236
	14/15 Change compared to 13/14 outturn	-6.6%
	15/16 Change compared to planned 14/15 outturn	-3.5%
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	485

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	No.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	We have not yet been able to review and analyse the detailed impacts of the schemes within the BCF but are continuing to work actively with Thurrock Health and Social Care partners to do so.
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	Reductions of emergency admissions to the extent proposed would be welcomed by SEPT.